health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Annual Performance Plan

2014/15 – 2016/17

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FOREWORD BY THE EXECUTIVE AUTHORITY

As we celebrate our vibrant democracy and approach the end of the current term of office, we note with pride the great strides we have made in redressing historical imbalances in health service delivery in the Province.

Progress is evident in the various progressive shifts from previously fragmented institution–based services to more comprehensive and integrated primary health care and community-based services, augmenting the Constitutional right of all citizens to have access to health care closer to where they live. That said, we acknowledge the work that still needs to be done to ensure universal health access for citizens in our province.

Scientific evidence attests to the fact that health investments are beginning to show a positive impact on the quadruple burden of disease:

- Significant reduction in mother to child transmission of HIV (from 6.8% in 2010/11 to 2.1% in 2013/14);
- Year on year decrease in the number of maternal deaths in facilities (from 353 in 2010/11 to 317 in 2012/13);
- Significant reduction of the TB incidence (from 1 149 per 100 000 population to 844 per 100 000 population in 2013/14); and
- Increase in life expectancy from 45.7 to 53.4 years for males and 51 to 58.7 years for females.

The 2014/15 Annual Performance Plan was crafted following a high level assessment and analysis of health system and service delivery successes, constraints and demands. The focus remains on high impact strategies to improve health system effectiveness and reverse the quadruple burden of disease. The Department will build on past successes and actively explore innovative solutions within current financial constraints.

I remain committed to provide the necessary leadership and support to ensure that we continue to strive for excellence in service delivery.

I hereby endorse the 2014/15 Annual Performance Plan as guiding framework within which the Department will execute its mandate in serving the people of KwaZulu-Natal.

.....

Dr SM Dhlomo

Member of the Executive Council (MEC)

KwaZulu-Natal Department of Health

Date: 22 March 2014

STATEMENT BY THE HEAD OF DEPARTMENT

I am pleased to present the Department's Annual Performance Plan for the financial year 2014/15, including the MTEF cycle up to 2016/17. During the last four years the Department made significant progress towards establishing an enabling environment to spearhead implementation of strategies targeting core Province-specific priorities as well as national priorities identified in the National Health System 10 Point Plan and Negotiated Service Delivery Agreement for Health.

The high burden of disease remains a concern, although carefully considered investments in priority programmes and services paid off as eloquently proved by empirical evidence. The reduction in mother to child transmission of HIV, reduced TB incidence, and improved child survival is encouraging and serve as motivation to do better.

As we move forward in our transformation agenda, the focus will be on unfinished business during the 2014/15 financial year. The Department will focus on:

- Health system strengthening including efficient leadership and management.
- Programmes to improve TB outcomes.
- Programmes to reduce HIV infection and effective management of patients living with HIV and AIDS.
- Implementation of the Strategy to reduce Non-Communicable Diseases.
- Expansion of PHC re-engineering, supported by innovations tested in the National Health Insurance pilot districts.
- Strengthening Emergency Medical Services and Forensic Pathology Services.
- Human resources for health including innovative training options in response to demand for health professionals.
- Strengthening information and performance management.
- Strengthening financial management.
- Health facility infrastructure.

Inherent in all the above will be the principles of accessibility, equity, quality, community participation, appropriate technology, and inter-governmental and inter-sectoral consultation and cooperation. Multi-sector collaboration, including implementation of the Provincial Growth and Development Plan with oversight from the Office of the Premier, will ensure that the core business of the Department is aligned with the National Development Plan 2030 and the 2014-2019 Medium Term Strategic Framework.

The Department plan to actively explore innovative options to service delivery especially in light of the fiscal challenges. Partnerships with the scientific community will be strengthened to ensure evidence-based decision-making and planning.

Dr SM Zungu

Head of Department

KwaZulu-Natal Department of Health

Date: 20 March 2014

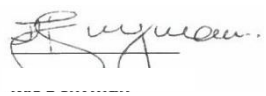
OFFICIAL SIGN-OFF: KZN DEPARTMENT OF HEALTH 2014/15 - 2016/17 ANNUAL PERFORMANCE PLAN

It is hereby certified that the 2014/15 – 2016/17 Annual Performance Plan for the KwaZulu-Natal Department of Health:

1. Was developed by the Provincial Department of Health in KwaZulu-Natal with leadership from the MEC for Health and the Head of Department.

2. Complies with the National Customised Framework, the National Health System 10 Point Plan, reviewed Negotiated Service Delivery Agreement for Health, the 2014-2019 Strategic Plan of the KwaZulu-Natal Department of Health, the Medium Term Strategic Framework 2014-2019, National Development Plan 2030, Provincial Growth and Development Plan 2030 and other long term plans.

3. The Plan reflects the performance targets which the Department will endeavor to achieve given the resources and budget for the 2014/15 – 2016/17 MTEF.



Mrs E Snyman

Manager: Strategic Planning

Date: 14 March 2014

Mr J Govender

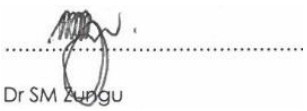
General Manager: Planning, Monitoring & Evaluation

Date: 14 March 2014

Mr S Mkhize

Acting Chief Financial Officer

Date: 18 March 2014



Accounting Officer: KwaZulu-Natal Health

Date: 20 March 2014

Approved by

Dr SM Dhlomo

Executive Authority: KwaZulu-Natal Health

Date: 22 March 2014

PART A
STRATEGIC OVERVIEW

1. STRATEGIC OVERVIEW

1.1 VISION, MISSION AND VALUES

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

VISION

Optimal health status for all persons in KwaZulu-Natal

MISSION

To develop a sustainable, coordinated, integrated and comprehensive health system at all levels, based on the Primary Health Care approach through the District Health System

VALUES

Trust built on truth, integrity and reconciliation

Open communication, transparency and consultation

Commitment to performance

Courage to learn, change and innovate

1.2 STRATEGIC GOALS

To comply with directives from the Department Performance Monitoring and Evaluation and the National Department of Health, the national customised priorities (National Sub-Outputs - NSOs) have been added to the Provincial Strategic Goals for the current 2010-2014 planning cycle (Table 1). National priorities have been aligned with the National Development Plan 2030 and draft Medium Term Strategic Framework 2014-2019 and included in the Provincial Annual Performance Plan for 2014/15. Departmental priorities have been aligned with the vision and core priorities of the Provincial Growth and Development Plan 2030.

Table 1: (1a) Strategic Goals

Goal Statement	Rationale	Expected Outcomes
STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES *2014/15 National Sub-Outputs (NSOs)* *National Sub-Output 6: Re-engineering of PHC* *National Sub-Output 7: Universal health coverage* *National Sub-Output 8: Human Resources for Health*		
Transform the Provincial health care system through implementation of the Service Transformation Plan (STP) 10 core components to improve equity, access and availability, efficiency, quality and effective management that will enhance service delivery and improve the health outcomes of all citizens in the Province.	An efficient and well-functioning health care system with the potential to respond to the burden of disease and health needs in the Province.	• Transformation in line with STP imperatives and the National Health System 10-Point Plan. • Improved access, equity, efficiency, effectiveness and utilisation of health services. • Improved Human Resource Management Services including reconfiguration of organisational structures, appropriate placement of staff (appropriate skills mix and competencies), appropriate norms and standards to respond to burden of disease and package of services, strengthened performance management and decreased vacancy rates. • Improved Financial & Supply Chain Management efficiency and accountability to curb over-expenditure, improve return on investment and value for money, and budget aligned with service delivery priorities and needs. • Appropriate response to the burden of disease and consequent health needs. • Improved governance including regulatory framework, policies and delegations to facilitate implementation of the Strategic Plan. • Decentralised delegations, controls and accountability. • Improved information systems and processes, data quality and information management and improved performance monitoring, evaluation and reporting.
NSO 6: *Implementation of the PHC re-engineering model including; District Clinical Specialist Teams; School Health Teams; and Ward-Based Teams.* ***NSO 7:*** *Phased implementation of*		• *Revitalisation of infrastructure to improve service delivery.* • *District Clinical Specialist Teams:* – *Eleven complete nursing specialist teams (1 team per district) by 2014/15* – *Four complete medical specialist*

Goal Statement	Rationale	Expected Outcomes
the National Health Insurance Building Blocks in the three pilot districts ***NSO 8:*** *Implementation of the Human Resources for Health Strategy and Plan; Decentralised training model with PHC focus for Health Sciences in collaboration with the University of KZN; Increase production and equitable distribution of appropriate human resources; and Improve facility management.*		*teams (1 team per Region) by 2014/15* • *159 School Health Teams by 2014/15* • *95 Ward-Based Outreach Teams established by 2014/15*
STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES *2014/15 National Customised Sub-Outputs (NSOs)* *National Sub-Output 2: Health Facility Planning* *National Sub-Output 3: Improved financial management in the health sector* *National Sub-Output 4: Efficient health management information system for improved decision making* *National Sub-Output 5: Improved quality of care*		
Achieving the best possible health outcomes through effective utilisation of resources within the funding envelope.	Improved compliance with legislative/ policy requirements and National Core Standards for Quality in order to improve clinical and health outcomes.	• Accreditation (certification) of health facilities in line with National Core Standards for Quality. • Improved management capacity. • Improved health outcomes and increased life expectancy. • Improved performance towards achieving the Millennium Development Goal (MDG) targets. • Patient satisfaction with public health services.
NSO 2: *Improving health facility planning* ***NSO 3:*** *Improving financial management and control* ***NSO 4:*** *Improving health information systems, quality and management of data for improved decision-making* ***NSO 5:*** *Improve quality of care through implementation of National Core Standards*		• *Improved health facility planning* • *100% of facilities conditionally compliant (50% - 75%) to the National Core Standards by 2019* • *Unqualified audit opinion by 2019*
STRATEGIC GOAL 3: REDUCE MORBIDITY AND MORTALITY DUE TO COMMUNICABLE DISEASES AND NON-COMMUNICABLE CONDITIONS AND ILLNESSES. *2014/15 National Customised Sub-Outputs (NSOs)* *National Sub-Output 1: Prevent and reduce the disease burden and promote health*		
Implement integrated high impact strategies to improve prevention, detection, referral, management, follow-up and support of communicable diseases and non-communicable illnesses and conditions at all levels of care.	Reduction of preventable and modifiable causes of morbidity and mortality at community and facility level contributing to a reduction in morbidity and mortality.	• Decrease in morbidity and mortality – with specific reference to preventable causes. • Improved performance towards achievement of MDG and NSDA targets i.e. HIV and AIDS; TB; Maternal & Child Health; Malaria; and Change in trends of non-communicable disease patterns.
NSO 1: *Implementing integrated high impact strategies to:* • *Improve TB outcomes* • *Reduce HIV incidence and manage prevalence*		• *Increase overall life expectancy of males to 58.4 years and females to 62.7 years by 2019* • *Reduce HIV Incidence to 1% by 2019* • *Eliminate Malaria by 2019*

Goal Statement	Rationale	Expected Outcomes
• *Eradicate malaria* • *Reduce maternal, infant and child morbidity and mortality* • *Reduce non-communicable (NCD) diseases and manage NCD prevalence* • *Contribute towards reducing intentional and unintentional injuries and violence*		• *Reduce mother to child transmission rate to <0.5% by 2019* • *Reduce (facility) maternal mortality ratio by 20% to 128.3 per 100 000 live births by 2019 (NCCEMD).* • *Reduce infant mortality by 20% to 33.6 per 1000 live births by 2019 (ASSA2008)* • *Reduce child mortality by 20% to 47.8 per 1000 live births by 2019 (ASSA2008)* • *Reduce hypertension incidence from 23.6/1000 to 21.6/1000 by 2016/17* • *Reduce diabetes mellitus incidence from 2.2/1000 to 1.9/1000 by 2016/17*

1.3 SITUATIONAL ANALYSIS

1.3.1 Demographic Profile

KwaZulu-Natal, the second most populous province in South Africa, occupies 7.6% (92,100 sq. km) of the total land surface of South Africa with a population density of ±107.52 people per sq. km ranging between 7 people per km^2 in Kwa Sani Municipality (Sisonke) and 1 502 people per km^2 in eThekwini Metro (Census 2011).

The Province comprises 1 Metropol, 10 Districts, 50 Municipalities and 828 Wards. The Sisonke District has been renamed as Harry Gwala – awaiting Gazetting before changing in APP.

The Province shares borders with the Eastern Cape in the South, Free State and Lesotho in the West, Mpumalanga in the North West, and Swaziland and Mozambique in the North.

Patients from Mpumalanga, Mozambique and Swaziland utilise health services in the northern districts of Umkhanyakude and Zululand, while patients from the Eastern Cape utilise health services in the southern districts of Ugu and Sisonke. It is not possible to determine the extent of cross-border utilisation of health services which impact on planning and resource allocation.

The Province is adjoined by three international countries with associated border posts namely:

- Lesotho: Sani Pass International Border Post within Sisonke District.
- Swaziland: Golela International Border Post within Zululand District.
- Mozambique: Manguzi International Border Post within Umkhanyakude District

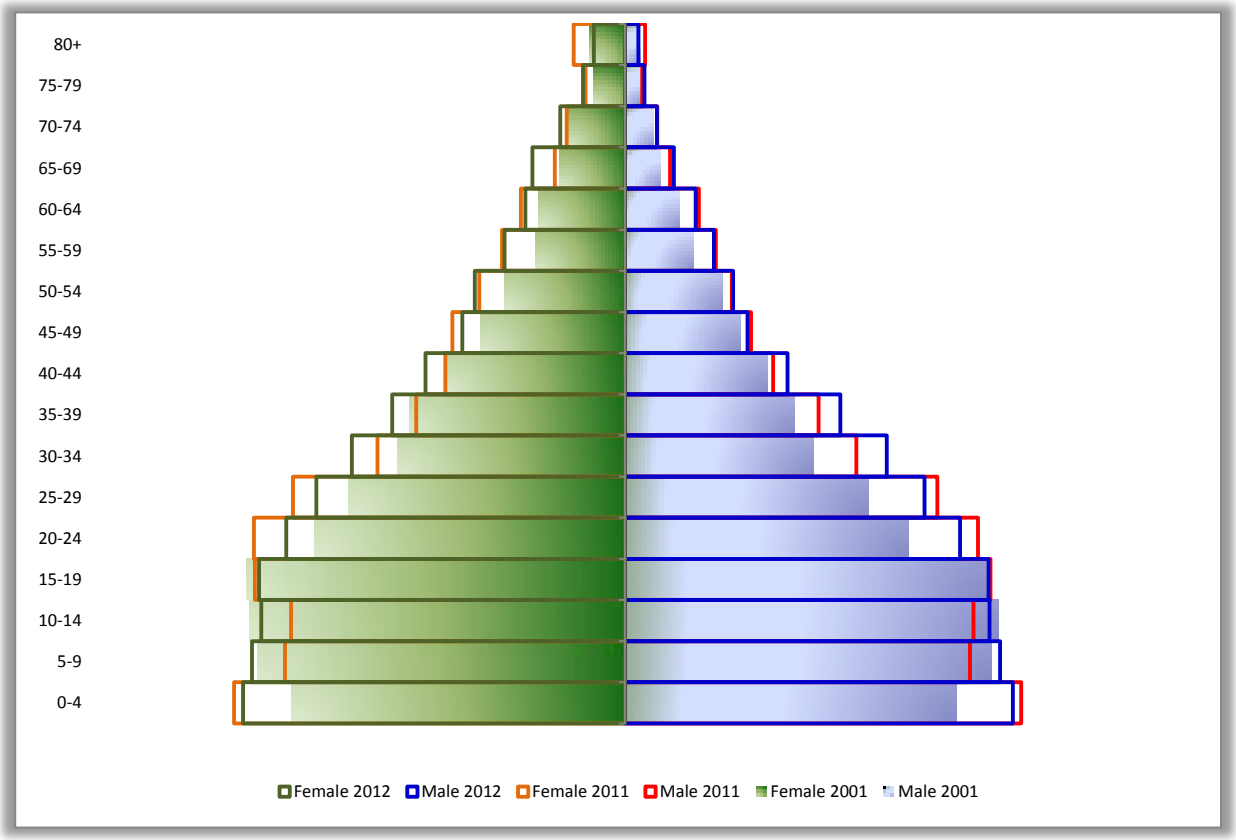
According to mid-year population estimates (Stats SA 2013), the KZN population increased from 10 267 300 in 2011 (Census 2011) to 10 457 907 in 2013. The DHIS population, used for service delivery information, is 10 785 397 for 2013/14 (Table 2).

Females comprise 52.4% of the KZN population and males 47.6%; 32.6% of the total population is under the age of 15 years; 59.8% between 15 and 65 years; and 7.5% over the age of 65 years (Figure 1).

More than one third of the population resides in eThekwini which points to unique service delivery challenges as compared to other districts (Table 2).

According to Stats SA, the fertility rates in KwaZulu-Natal decreased from 3.2 children per woman in 2001 to 2.67 in 2011. The life expectancy for males increased from 45.7 to 53.4 years and for females increased from 51 to 58.7 years between 2001 and 2011.

Figure 1: KZN Population Pyramid 2001, 2011, and 2012



Source: Statistics South Africa

Table 2: KZN Total Population per District

District	2011 (Census)	2012/13 DHIS (1.8%)	2013/14 DHIS (3.1%)	2014/15 Year 1 (1.05%)	2015/16 Year 2 (1.03%)	2016/17 Year 3 (1.0%)
Ugu	722 484	735 778	771 421	796 126	804 326	812 369
Umgungundlovu	1 017 763	1 036 489	1 077 834	1 089 151	1 100 369	1 111 373
Uthukela	668 848	681 154	705 018	712 421	719 759	726 957
Umzinyathi	510 838	520 237	520 604	526 070	531 489	536 804
Amajuba	499 839	509 036	519 890	525 349	530 760	536 068
Zululand	803 575	818 360	867 932	877 045	886 079	894 940
Umkhanyakude	625 846	637 362	673 236	680 305	687 312	694 185
Uthungulu	907 519	924 217	986 080	996 434	1 006 697	1 016 763
Ilembe	606 809	617 975	635 026	641 694	648 303	654 786
Harry Gwala	461 419	469 909	516 693	522 118	527 496	532 770
eThekwini	3 442 361	3 505 700	3 511 761	3 548 634	3 585 185	3 621 037
KwaZulu-Natal	**10 267 300**	**10 457 907**	**10 785 397**	**10 898 644**	**11 010 900**	**11 121 009**

- 2012/13 and 2013/14 populations: Data from DHIS (based on Stats SA Mid-Year Estimates).
- Rural Development Nodes (including Umzimkhulu Municipality in Sisonke) highlighted in light blue.

- Estimated population growth indicated in brackets. Projected population will serve as baseline although it will be reviewed/ adjusted annually based on mid-year population estimates published by Stats SA.
- 2012 and 2013 population: Used population from the District Health Information System (populated by the National Department of Health) as per Statistics SA mid-year projections in order to align with historic service delivery reporting.

Table 3: KZN Uninsured Population per District

Districts	Uninsured Population	2011/12	2012/13	2013/14	2014/15 Year 1	2015/16 Year 2	2016/17 Year 3
Ugu	90.8%	656 015	668 086	700 450	722 882	730 328	737 631
Umgungundlovu	80.3%	817 264	832 301	865 501	874 588	883 396	892 433
Uthukela	93.7%	626 711	638 241	660 602	667 738	674 395	681 159
Umzinyathi	91.2%	465 976	474 456	474 790	479 776	484 718	489 565
Amajuba	88.2%	440 858	448 969	458 542	463 358	468 130	472 812
Zululand	91.8%	737 681	751 254	796 761	805 127	813 421	821 555
Umkhanyakude	95.1%	595 180	606 131	640 247	646 970	653 634	660 170
Uthungulu	84.2%	765 947	778 191	830 279	838 997	847 639	856 114
Ilembe	90.8%	550 983	561 121	576 604	852 658	588 659	594 546
Harry Gwala	92.1%	424 967	432 786	475 874	480 871	485 824	490 681
eThekwini	74.2%	2 554 231	2 601 229	2 605 727	2 633 086	2 660 207	2 686 809
KwaZulu-Natal	**87.7%**	**9 004 422**	**9 170 707**	**9 458 793**	**9 558 111**	**9 656 559**	**9 753 125**

- Uninsured population per district (%): District Health Barometer 2012/13 (4).
- Rural Development Nodes (including Umzimkhulu Municipality in Sisonke) highlighted in light blue.
- Uninsured population calculated on total projected population in Table 2.
- Although universal access (national/ provincial vision) includes both insured and uninsured people, the immediate challenge remains to improve access to the significant proportion of uninsured people in the province.

1.3.2 Socio-Economic Profile

According to Census 2011, the average household income in the province increased from R 38 905 in 2001 (ranging between R 18 952 in Sisonke and R 56 220 in eThekwini) to R 83 050 in 2011 (ranging between R 45 903 in Sisonke and R 112 830 in eThekwini).

The 2012 General Household Survey estimated that approximately 47% of the provincial population live on incomes below the poverty line. Of the 880 623 indigent households in the province, 594 638 (68%) receive indigent water support and 172 780 (20%) indigent electricity support (MDG Country Report, 2013).

Table 4: KZN Socio-Economic Profile

	2001	2013
Households in KZN		
Number of households	2 117 274	2 539 429
Average household size	4.4	3.9
Socio-economic determinants		

	2001	2013
Average household income	R 38 905	R 83 050
Unemployment rate	49%	33%
Informal housing (households)	226 174	211 546
Access to basic services (household)		
Households using electricity for cooking	1 008 491 *(47.6%)*	1 743 283 *(68.6%)*
Households with no access to piped water	582 600 *(27.5%)*	357 398 *(14.1%)*
Blue Drop Score (Water)	65% *(2010)*	92.9% *(2012)*
Households with no sanitation	339 497 *(16%)*	159 070 *(6.3%)*
Households with no refuse removal	219 673 *(10.4%)*	151 203 *(6%)*
Social determinants		
Female-headed households	46.5%	46.6%
Child-headed households	0.8%	0.9%
Education		
Population 5-24 years not attending school	1 271 135	1 060 805

Source: Statistics SA

Children are still disproportionately affected by poverty in the province with nearly three-quarters (73.5%) of children living in poor households compared with 64.5% nationally. The percentage of children in households where no adults were employed increased from 38.2% (2001) to 40.6% (2012) as compared with 32.4% nationally (8).

The percentage of children living in households that reported hunger decreased from 37.3% (2001) to 16.9% (2012), while 34.3% of children live in households that experience inadequate or severely inadequate access to food compared to 30.6% nationally (8).

1.3.3 Epidemiological Profile/ Burden of Disease

According to the KZN Hospital Survey 2011, 39% of patients admitted in public hospitals are admitted for infectious diseases; 37.4% for non-communicable conditions; and 23.6% for injuries. Nearly one third of female admissions (24.3%) are for normal vaginal delivery.

Admissions with HIV as primary condition are rare, with most patients admitted with infections such as TB and pneumonia (22%) as primary cause and HIV as underlying cause.

The burden of HIV is shared at District and Regional Hospitals with 57.5% of HIV positive patients admitted in District Hospitals (25% of total admissions) and 42.5% in Regional Hospitals (20% of total admissions) (p<.001).

Infectious diseases (59.3%) are the leading Immediate cause of death; while the underlying causes of death included HIV infection (44%) and hypertension and diabetes 11.1% TB remains the leading cause of death in KZN (15.9%) followed by intestinal infectious diseases (5.7%) and influenza and pneumonia 5.6% (KZN Hospital Survey, 2011).

Maternal, Neonatal, Child and Women's Health

The provincial institutional maternal mortality ratio (iMMR) decreased from 194.2 per 100 000 live births to 160.3 per 100 000 live births between 2010 and 2012.

Underlying causes of death were non-pregnancy related infections (43.1%); obstetric haemorrhage (12.4%); medical/ surgical disorders (12.4%); hypertension (9.7%); and miscarriage (5.8%) – (2010-2012 Confidential Enquiry into Maternal Deaths in SA - NCCEMD). Table 5 compares the provincial iMMR per level of care in public health hospitals (DHIS).

Table 5: Maternal deaths per level of care

Level	2010/11	2011/12	2012/13
Number of maternal deaths per level of care (facility)			
District	112	101	86
Regional	180	217	196

Level	2010/11	2011/12	2012/13
Tertiary	3	3	18
Central	6	10	12
KZN	**301**	**331**	**312**
Number of live births per level of care			
District	86 365	84 665	86 568
Regional	76 421	80 822	75 955
Tertiary	1 378	1 549	1 328
Central	379	457	496
KZN	**164 543**	**167 493**	**164 347**
Facility maternal mortality ratio per 100 000 live births			
District	129.7	119.3	99.3
Regional	235.5	268.5	258
Tertiary	217.7	193.7	1 355.4
Central	1 583.1	2 188.2	2 419.4
KZN	**182.9**	**197.6**	**189.8**

Source: DHIS

According to antenatal care surveillance data, the HIV prevalence amongst pregnant women showed a consistent decrease between 2009 and 2011:

- All pregnant women: Decreased from 39.5% to 37.4%;
- 15-19 year old pregnant women: Decreased from 22% to 16.8%; and
- 20-24 year old pregnant women: Decreased from 37.2% to 33.3%.

Almost 5% of babies born in the province have a birth weight below 2 000 grams, and more than 3 000 babies do not survive the neonatal period. It is estimated that 65% of neonatal deaths occur in district hospitals with a current neonatal mortality rate of 10.8/1000 (2013/14 DHIS). Early facility neonatal mortality ranges between 3.6/1000 in the Amajuba District and 19.1/1000 in the Umgungundlovu District (DHIS).

According to ASSA2008 projections, the infant mortality rate is 42/1000 live births (SA 33/1000) and the under-5 mortality rate 60/1000 live births (SA 47/1000). This is important as the 2007 death notifications indicated that 21.9% of deaths are during the neonatal period, 54% between 1-12 months of age, and 24.1% between 1-5 years of age.

According to data from the Child Health Problem Identification Programme, the infant and under-5 mortality rates in the province were 32.9/1000 and 44.6/1000 in 2010 which equates to 1 in 22 children born in KZN dying before their fifth birthday. Over a third of these deaths (38.7%) occurred outside health facilities, and amongst those deaths occurring in the public health sector 56.5% of infant deaths occurred in District Hospitals (Dr N McKerrow).

Regardless of the level of care, 2.6% of children presenting to the public sector were dead on arrival at the facility; 31.5% of deaths occur within the first 24 hours of admission; and a further 25.7% between the first and third day of admission i.e. 57.2% of childhood deaths occur within 72 hours of admission to a hospital.

According to the 2011 Hospital Survey, the most common reasons for admission in children under 5 years were gastroenteritis (21%), pneumonia (20%) and neonatal conditions (14%) including sepsis, jaundice, preterm delivery/low birth weight, respiratory distress syndrome and congenital pneumonia.

According to the 2009 Saving Childrens Report, 60% of children who died in public health hospitals were malnourished and 50% had clinical evidence of AIDS (9).

According to SANHAINES-1, 15.8% of children are stunted and 5.3% wasted. The underweight for age under 5 years decreased from 19.4/1000 (2010/11) to 13.8/1000 in 2013/14 (DHIS).

HIV, AIDS and STIs

According to ASSA2008 projections, the HIV incidence is 1.01% (total general population); 3.48% (women 15-19 years); and 2.42% (youth 15-24 years). The estimated prevalence rate in the general population is 15.2%, compared to the 37.4% prevalence in antenatal women in 2011 (ANC surveillance).

According to the same projections, HIV infections in the general population increased from 1 550 955 (2009) to 1 628 536 in 2013, constituting approximately 28% of the national infections.

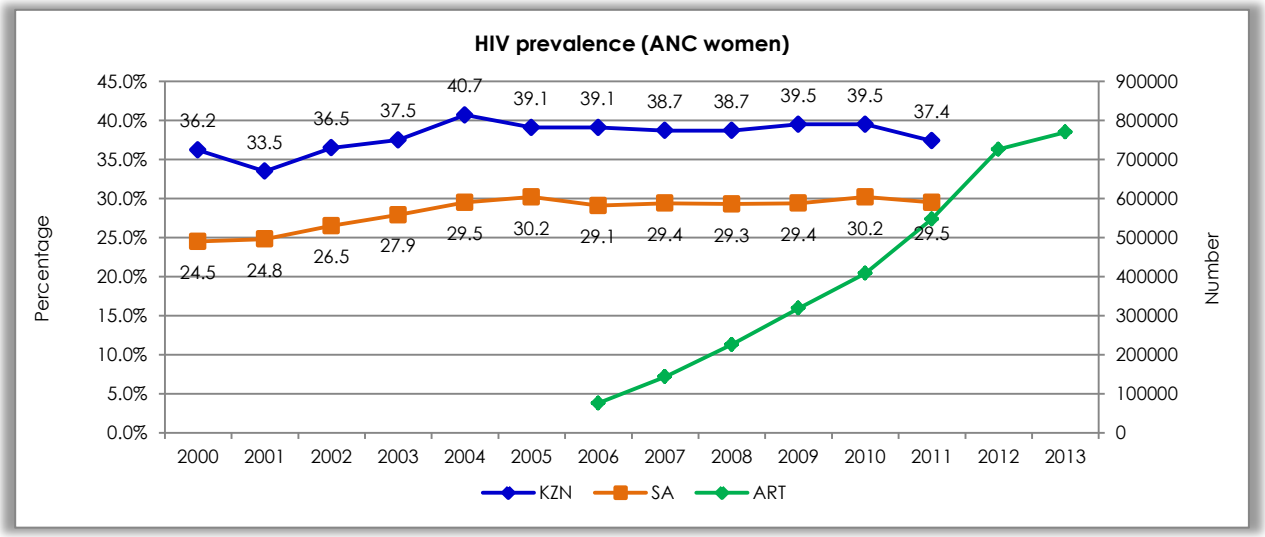
AIDS sick patients *(untreated HIV stage 4 plus one quarter of those on ART experiencing HIV stages 5 and 6)* increased from 143 241 (2009) to 168 173 in 2013.

The number of patients treated for sexually transmitted infections (new cases) increased from 455 627 (2010/11) to 471 781 in 2012/13 (DHIS).

According to Stats SA, HIV related deaths in the province decreased from 67 429 to 54 337 between 2008 and 2010, which can be attributed to successes in the management of the HIV, AIDS and related infections.

The province reported the highest HIV prevalence among pregnant women for the past 13 years (Graph 1), reaching 37.4% (35.8-39.0) in 2011 compared to 29.5% (28.7-30.2) nationally (National ANC Surveillance).

Graph 1: HIV Prevalence (ANC Women) and Patients on ART



Source: National HIV Surveillance under ANC Women 2011 and DHIS

Tuberculosis

Approximately 80% of global TB cases are reported in South Africa. KwaZulu-Natal has the highest HIV and TB disease burden in SA with an estimated HIV-TB co-infection rate of 70%.

The provincial TB incidence decreased from 1 090 new cases per 100 000 population in 2011 to 889 new cases per 100 000 population in 2012 (31% of all TB cases nationally).

Drug-resistant TB is increasing (Table 6) with a current incidence of 26.8 cases per 100 000 population making it the highest incidence in the world.

The mortality rates among MDR-TB/HIV co-infected patients are exceedingly high (71% one year mortality) with approximately 15% of MDR-TB/HIV co-infected patients receiving ART at the time of their diagnosis.

Table 6: TB Notification and MDR-TB (ETR.net)

District	TB Notification		MDR-TB cases put on treatment	
	2011	2012	2012	2013 (Q3)
Ugu	1 410	1 221	167	268
Umgungundlovu	1 100	884	211	284
Uthukela	782	686	-	28
Umzinyathi	1 000	810	61	63
Amajuba	730	654	-	-
Zululand	1 192	940	321	264

District	TB Notification		MDR-TB cases put on treatment	
	2011	2012	2012	2013 (Q3)
Umkhanyakude	1 145	907	220	231
Uthungulu	1 141	652	386	314
Ilembe	1 110	877	-	97
Harry Gwala	1 172	1 043	160	135
eThekwini	1 212	1 103	1 069	1 348
KZN	**1 090**	**889**	**2 553**	**2 898**

Non-Communicable Diseases

According to the World Health Organisation (WHO), non-communicable diseases constituted 63% of all deaths in 2008 including cardiovascular disease (48%), cancers (21%), chronic respiratory diseases (12%) and diabetes (3%). It is further estimated that deaths due to non-communicable diseases will increase by 17-24% in the African Region over the next 10 years.

According to the 2012 General Household Survey, 19.8% of the total South African population and 20% of the population in KZN suffer from chronic diseases.

According to the 2011 KZN Hospital Survey, hypertension, cancer, diabetes (type 2 most common) and concurrent diabetes and hypertension are the most common non-communicable diseases admitted in KZN public health hospitals. The most common cancers admitted in hospitals are cancer of the cervix, breast cancer and cancer of the oesophagus. Most cancers occurred after the age of 30.

Diabetes incidence decreased from 3 per 1000 population (2010/11) to 1.3 per 1000 population in 2013/14. The hypertension incidence decreased from 29.8 per 1000 population (2010/11) to 23.6 per 1000 population in 2013/14 (DHIS).

Dental caries is the most common condition affecting children in South Africa with an estimated 91% of children (6 years old) with untreated tooth decay.

Mental Health

The burden of mental disorders is considerable with approximately 14.3% of adults (15 years and older) and 17% of children/adolescents (under 15 years) estimated to have a mental disorder. In KZN, an estimated 955 814 adults (13.6%) and 420 651 children and adolescents (11.5%) have a mental disorder.

The co-morbidity between mental disorders, substance use disorders and physical conditions such as HIV and AIDS, heart disease, diabetes, trauma, etc. is significant with an estimated 43.7% of HIV infected individuals and 15-20% of perinatal mothers having a mental disorder. Chronic mental disorders such as schizophrenia, bipolar disorder and major depressive disorder are independently associated with increased risk for metabolic syndrome, diabetes, heart disease and obesity.

HIV and AIDS are associated with a significantly increased burden of neuropsychiatric disease and disability including depression, anxiety, psychosis and dementia. Mortality due to AIDS has a significant impact on especially children whom are orphaned and therefore placing them at increased risk for mental disorders.

There are an estimated 657 880 people living with HIV and AIDS in KZN with a mental disorder. One-year prevalence rates of mental disorders in people living with HIV in SA are estimated as 31% anxiety disorders; 25% depression; 15% alcohol abuse and dependence; and 24% HIV-associated neurocognitive disorder. This has major implications for programmes aimed at the prevention of HIV as well as those focused on improving adherence to treatment.

Intentional and Unintentional Injuries

According to the 2011 Hospital Survey, the majority of admissions for injury include assault (35.5%), accidental injury (26.2%), motor vehicle accidents (19.6%), burns (8.9%), accidental poisoning (5.6%) and snake bites (4.2%).

In 2010, the pre-hospital trauma rate was approximately 11.6 per 1000 population and 12.9 per 1000 in public district and regional hospitals (17). This equated to 100 000 EMS calls

for trauma and around 160 000 visits per year in public hospitals in KZN.

Malaria

Three districts (Umkhanyakude, Zululand and Uthungulu) are endemic to malaria, with approximately 2.5 million people (or ±22.7% of the total population in the province) at risk of contracting the disease.

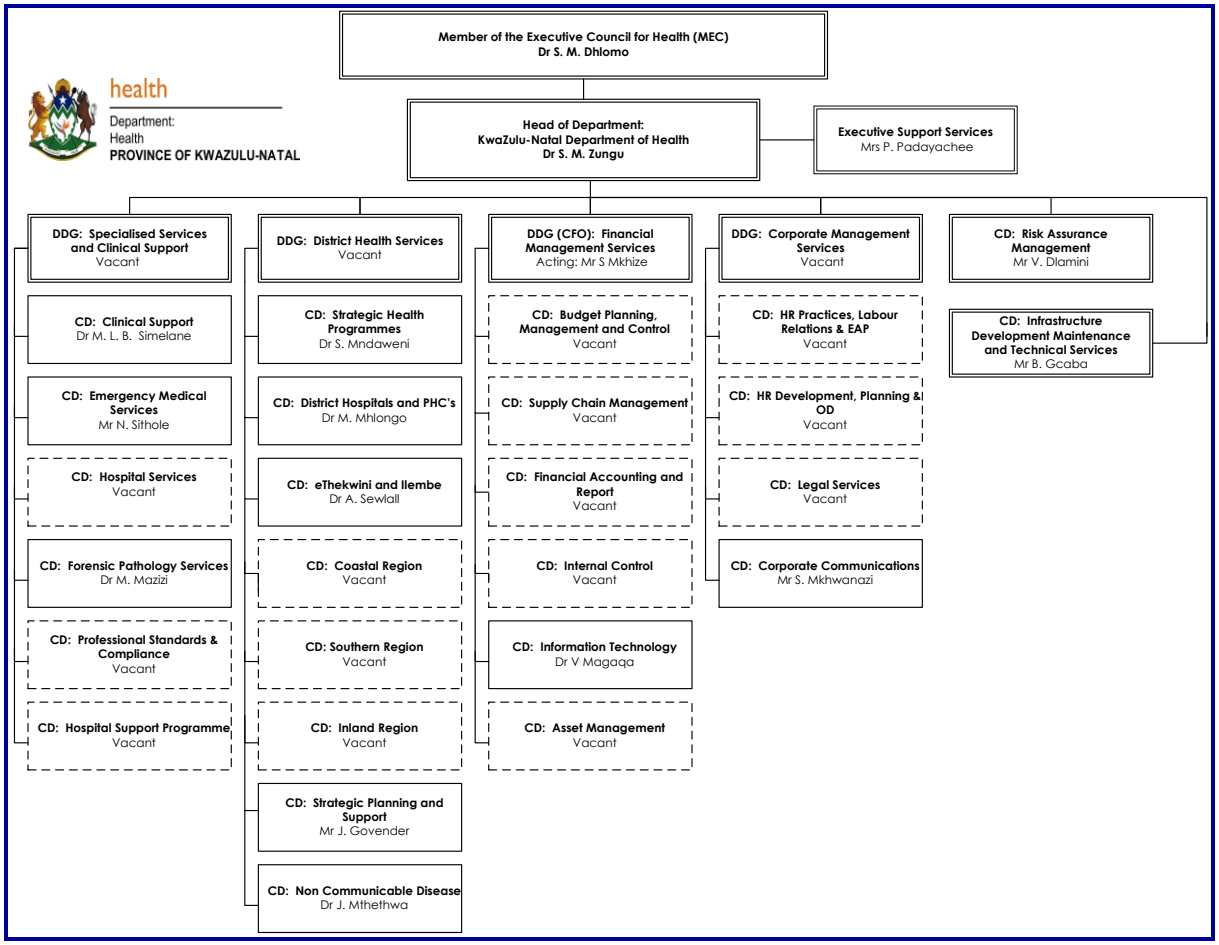
Between 2000 and 2010, new malaria cases decreased from 41 786 to 380 and deaths decreased from 340 to 5.

1.4 ORGANISATIONAL ENVIRONMENT

The reviewed macro organisational structure has been approved by the Department of Public Service and Administration (Figure 1). Implementation of the structure, dependent on a limited funding envelope, is expected to improve leadership, oversight and give impetus to improved service delivery and system strengthening.

The high vacancy rate (Figure 2) is considered one of the high risks and as a result of the high turnover rate and limited funding envelope for filling of "new" posts.

Figure 2: Macro Organisational Structure

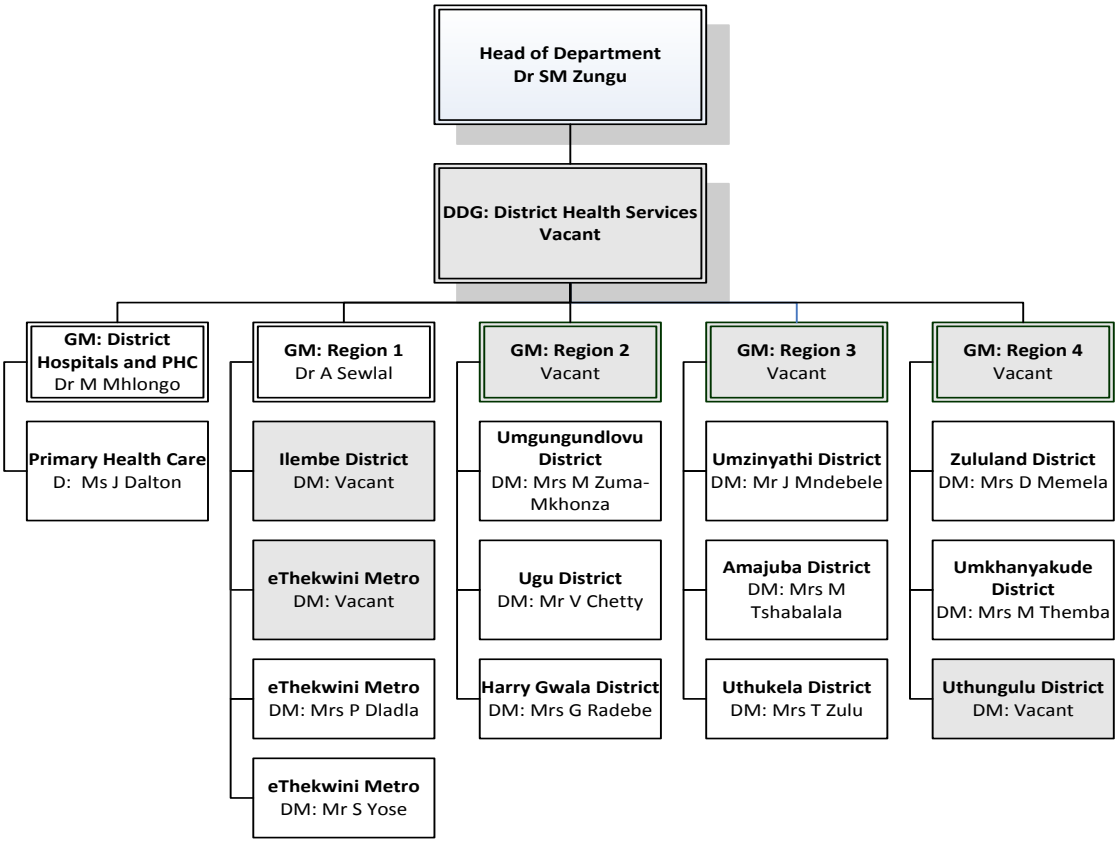


Source: Persal and OES

New organisational arrangements for the geographical management areas make provision for four Health Regions, each managed by a General Manager (level 14) reporting to the Deputy Director General: District Health Services. Three of these Regional General Manager posts are vacant (Figure 3).

The eThekwini Metro structure makes provision for 1 District Manager (level 14 – post vacant) and two Deputy District Manager posts (level 13) that are filled.

Figure 3: KwaZulu-Natal Health Regions



Source: Persal and OES

Imbalances in service structures and staff mix

Generic structures, developed for PHC clinics (including CHCs) and hospitals, are not fully aligned with the service delivery platform and burden of disease hence resulting in inequities in resource allocation, staff mix, workload and expenditure. It inevitably impact on service delivery and response to service demands.

The lack of a high level gap analysis on the distribution of human resources impacts negatively on short, medium and long-term planning and high impact strategies to address inequities and demand. This is considered a high risk taking into consideration the limited funding envelope.

The Department, in collaboration with the University of KwaZulu-Natal, commenced with a high level gap analysis and proposed human resource model to inform an appropriate high level short, medium and long-term strategy for allocation of human resources. The project will be implemented in 2014/15 using a phased approach.

Phase 1

Determine current distribution of human resources and average workload per staff category and level of care (Persal, WISN and service delivery data will be used).

High level analyses of human resources versus service delivery platform (standard package of services per level of care) per facility.

Summarise the burden of disease at municipal level to inform staffing norms/ standards in specific geographic areas.

Phase 2

Multi-disciplinary task team develop appropriate evidence-based human resource norms and standards using burden of disease data, current health care utilisation patterns, and health worker capacity. National norms and standards will be used as departure point.

Phase 3

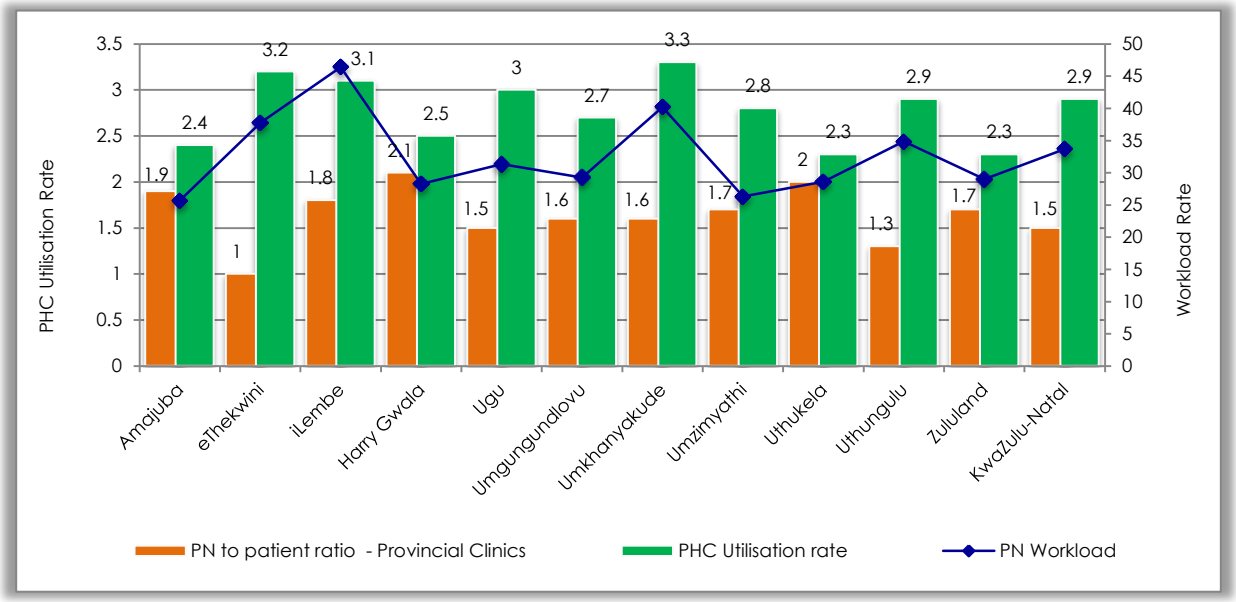
Costing of the proposed Human Resource Plan (2014-2019) - using scenario planning.

Model the additional number of staff (health care and allied health care professionals) required between 2014-2019 (using proposed norms and standards) including requirements for production of professionals by training institutions inside and outside KZN.

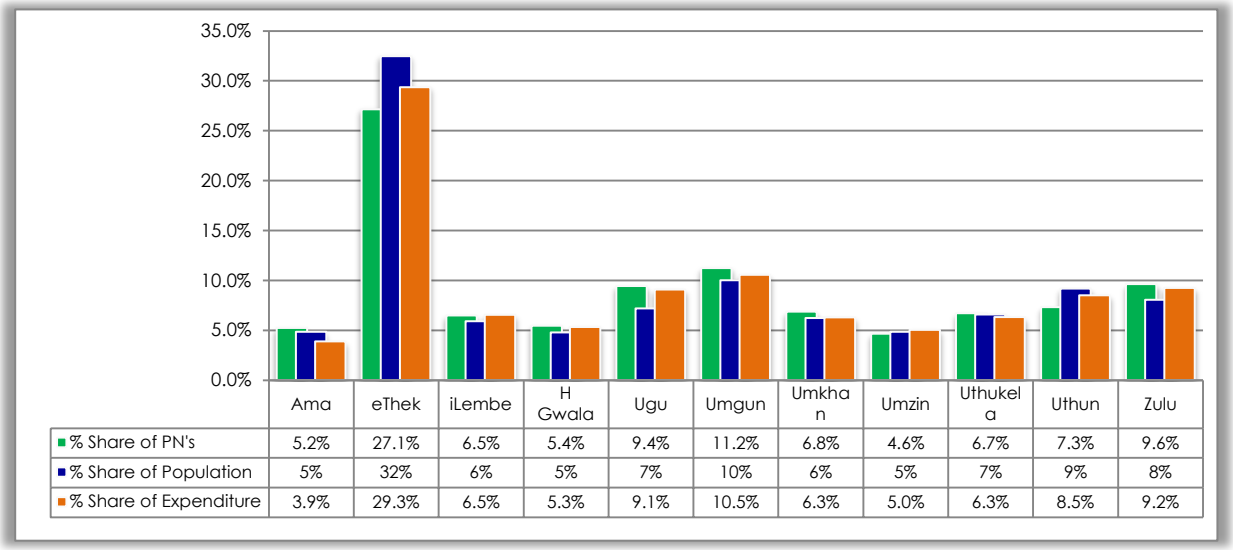
New innovations to strengthen human resources for health will be incorporated in the model.

Graphs 2 and 3 indicate resource inequities at PHC level (2012/13 DHER). This is also the case in point at facility level. This will be addressed through review of generic structures (all facilities) based on research results mentioned above.

Graph 2: PHC utilisation versus workload (2012/13 DHER Report)



Graph 3: Resource equity – 2012/13 (2012/13 DHER Report)



	Ama	eThek	iLembe	H Gwala	Ugu	Umgun	Umkhan	Umzin	Uthukela	Uthun	Zulu
% Share of PN's	5.2%	27.1%	6.5%	5.4%	9.4%	11.2%	6.8%	4.6%	6.7%	7.3%	9.6%
% Share of Population	5%	32%	6%	5%	7%	10%	6%	5%	7%	9%	8%
% Share of Expenditure	3.9%	29.3%	6.5%	5.3%	9.1%	10.5%	6.3%	5.0%	6.3%	8.5%	9.2%

Deployment of staff

The 2014-2019 Human Resource Plan will make provision for restructuring of the workforce with appropriate policies to formalise management of restructuring.

Staff recruitment and retention

The main challenges remain evidence-based restructuring of the current service delivery platform, aligning the service delivery and training platforms, and insufficient funding to implement appropriate organisational structures.

Recruitment of appropriately qualified staff, in especially rural areas, remains a critical challenge which impact on sustainability of services. Despite introduction of Occupational Specific Dispensation, Medical Specialist still shows a high vacancy rate within the province. To address the shortfall of medical officers, the Department sent an additional 343 students to Cuba for training and increased bursaries for health sciences training.

The Health Professions Council of South Africa (HPCSA) accredited the province for 817 Registrar posts. On 5 July 2013, there were 628 Registrars on the Programme with 18 who had completed time and/or exams and who remain on the programme as they have not been able to secure posts as Medical Officers or Specialists.

Retention of Registrars remains a challenge due to funding constraints.

The workforce is relatively young with 29.5% between the ages of 25 to 34 years. Staff over the age of 60 years (4.5%) include retired clinical professionals recruited and employed in a sessional or temporary capacity to supplement the workforce. This emphasise the need for succession planning, training and mentoring.

The high turn-over rate (13.6%) is due to 9 191 service termination transactions processed in July 2013 (7 745 or 84% CCGs). CCGs were re-appointed as abnormal appointments.

In August 2012 the Department abolished 9 444 unfunded posts and in November 2012 another 6 072 as per Cabinet resolution. This resulted in a dramatic decrease in vacancy rates (funded posts) compared to previous years.

For purpose of planning, growth in staff numbers are being used as marker of an appropriate response to the increased demand for services and human resources.

Absenteeism

The high burden of disease continues to impact on absenteeism in the workplace, while effective management of annual and sick leave remains a challenge with significant implications for service delivery.

A project, aimed at updating leave records (annual and sick leave) commenced in 2013/14. This will be actively monitored in 2014/15.

Training and Development

The alignment of nurse training with medium and long-term plans remains a challenge which affects planning for production and placement of qualified nursing staff. This will be addressed in 2014/15 with the development of an integrated Human Resources Plan.

Project 148: Based on figures obtained from the HPCSA, there are approximately 9 000 people with a qualification in Basic Life Support (BLS), and an additional 3 000 people were trained in BLS by the SANDF for the FIFA Soccer World Cup in 2010. A total of 148 of these qualified people reside in KZN.

The Department developed a remedial training plan to accommodate these personnel (Project 148). Out of 3 intakes (68 trainees), 56 have been successfully trained to date. The 4th intake (18 trainees) commenced training on 6 February 2013. These students will form the pool of potential candidates for future recruitment.

Cuban Training Programme: Expanded from 44 students in 2009/10 to 484 students in 2012/13 with another 344 students being recruited during the 2012 academic year (Table 7). Rural districts will benefit from increased allocations.

Table 7: Cuban Training Programme

District	Placed Students	Scholarship	Expanded Programme (2012)	Total 2013
Amajuba	8	8	23	31
eThekwini	2	4	25	29
Ilembe	2	7	23	30
Umgungundlovu	10	9	31	40
Uthukela	10	8	23	31
Umzinyathi	2	6	29	35
Umkhanyakude	12	7	34	41
Uthungulu	7	3	45	48
Zululand	9	8	64	72
Ugu	9	6	25	31
Harry Gwala	0	3	22	25
Total	**71**	**69**	**344**	**484**

49 Artisan students commenced training and 103 completed their trade qualification; 1 244 Students completed their ABET studies; and 1 409 unemployed students commenced training in 2012/13 with 640 completing their studies.

Mid-Level Workers: An estimated R2.5 million was used for implementation of various programmes relating to Mid-Level Workers. The Department is awaiting approval of the 240 credits policy in order for HETU to support Mid-Level Worker training.

Clinical Associates (3-year programme aimed at filling the gap of doctors in rural hospitals): 69 intakes in 2012/13 - 12 graduates receiving the Bachelor's Degree in Medical and Clinical Practice.

Pharmacist Assistants: 153 intakes in 2012/13 and 24 employed. Training through the Health Science Academy supported with funding from PEPFAR, HWSETA and Skills Development Fund. Negotiations commenced between Department and UKZN for training in KZN.

Dental Assistants: There is an oversupply of Dental Assistants (produced by DUT) with more than 240 currently unemployed. The Department was unable to finalise the employment of 40 unemployed Dental Assistants in 2012/13.

Project 148 (EMS): 89 intakes (Basic Ambulance Assistants) with 53 students expected to graduate in May 2013.

Physiotherapy Technicians: 29 intakes in 2012/13 with 14 graduating.

Nutrition Advisors (programme facilitated by the Faculty of Agriculture at UKZN since May 2012): 400 intakes in 2012/13 with 397 graduating.

Internships: 400 intakes in 2012/13 and 80 permanent placements in the Department.

Speech/ Audiology Technicians: Negotiations with UKZN is at an advance stage and training is expected to commence in 2014.

See Programme 8 for Health Infrastructure.

Table 8: (A2) Health Personnel - 2013/14

Categories of Staff	Number employed	% of total employed	Number per 100,000 people	Number per 100,000 uninsured people	Vacancy rate	% of total personnel budget	Annual cost per staff member
Medical Officers	3 127	3.8%	29	34.53	0.7%	5.29	R 479 392
Medical Specialists	619	0.8%	5.74	6.83	0.2%	2.97	R 813 775
Dentists	139	0.2%	1.29	1.53	0%	0.38	R 500 526
Dental Specialists	0	0%	0	0	0%	0	R 00
Professional Nurses	14 471	17.8%	134.22	159.78	1.8%	17.51	R 199 520
Enrolled Nurses	10 266	12.6%	95.22	113.35	0.9%	6.95	R 107 914
Enrolled Nursing Auxiliaries	6 289	7.7%	58.33	69.44	0.8%	3.67	R 86 715
Student Nurses	1 691	2.1%	15.68	18.67	0.5%	0.68	R 235 434
Pharmacists	710	0.9%	6.59	7.84	0.2%	1.58	R 415 059
Physiotherapists	277	0.3%	2.57	3.06	0%	0.32	R 213 819
Occupational Therapists	173	0.2%	1.60	1.91	0%	0.16	R 197 173
Radiographers	585	0.7%	5.43	6.46	0.1%	0.82	R 226 172
Emergency Medical Staff	3 079	3.8%	28.56	34.00	0.1%	2.38	R 117 384
Nutritionists and Dieticians	198	0.2%	1.83	2.09	0%	0.19	R 199 060
Community Care Givers	9 868	12.1%	91.53	108.96	0%	1.06	R 18 198
All Other Personnel	29 891	36.7%	277.24	330.05	4%		
Total	**81 383**	**100%**	**754.83**	**898.61**	**9.4%**		

- *Community Care Givers*: There are currently 21 filled CCG posts and 9 847 abnormal appointments. As a result, there are approximately 81 000 employees, 71 500 filled posts, and 78 000 total posts.

1.1 PROVINCIAL SERVICE DELIVERY ENVIRONMENT

Table 9: Public Health Facilities in KZN (DHIS November 2013)

District	PHC Clinics (Provincial and LG)							Hospitals (Public + State Aided)						
	Clinics	Community Health Centres	Satellite Clinics	Special Clinics	Mobile Service	Health Posts	TOTAL PHC	District	Regional	Tertiary	Central	Specialised TB	Specialised Psychiatric	Chronic
Ugu	56	2			17		**75**	3	1			1		
Umgungundlovu	63	3	1	2	20		**89**	2	1	1		2	3	
Uthukela	44	1	1		21		**67**	2	1					
Umzinyathi	55			1	11		**67**	4				1		
Amajuba	25				10		**35**	1	2					
Zululand	72	1	2		21		**96**	5				1+2	1	
Umkhanyakude	58				16		**74**	5						
Uthungulu	63	1			23	2	**89**	6	1	1				
Ilembe	38	2	1		15		**56**	3	1					
Harry Gwala	37	1			13	5	**56**	4				1	1	
eThekwini	133	8	7	24	66		**238**	2+2	6+1	-	1	4	1	2
KZN	**644**	**19**	**12**	**27**	**233**	**7**	**942**	**38+2**	**13+1**	**2**	**1**	**12**	**6**	**2**

The Department took over the McCords State Aided Hospital (classified as Regional Hospital) on 1 February 2014. Classification will be reviewed based on the new service delivery platform/ package of services.

Lower Umfolozi War Memorial Hospital (Classified as Regional Hospital) is rendering Mother and Child services (catchment including Uthungulu, Zululand and Umkhanyakude districts).

Ngwelezane Hospital (classified Tertiary Hospital) renders level 1, 2 and 3 services. There is no District Hospital in the UMhlatuze Municipality (Richards Bay area).

Newcastle Hospital (classified as Regional Hospital) is rendering Mother and Child services for the Amajuba, part of Umzinyathi and Zululand Districts.

Madadeni Hospital (classified as Regional Hospital) is rendering level 1, 2 and 3 services. There is only one small District Hospital (52 beds) in Amajuba District (Emadlangeni Municipality).

Low efficiencies of the previous SANTA Hospitals and some Specialised Psychiatric Hospitals are a concern that will be addressed as part of the rationalisation of hospital services in the coming MTEF.

Job creation: Since January 2011, the Department created a total of 6 071 jobs excluding positions that were advertised under various professional categories.

A total of 438 positions were advertised for Basic Life Support personnel in 2012/13. This is in addition to 332 positions that were created and filled by unemployed Basic Life Support personnel in 2011/12.

A total of 100 Tradesman's Aids posts have been filled in June 2012 as part of the District Maintenance Team Project. Local maintenance teams are recruited for maintenance and repairs at health facilities to reduce the backlog of infrastructure minor works, to improve hotel aspects of facilities, and improve quality control in line with the "Make Me Look Like a Hospital" project and National Core Standards.

9 800 CCGs had their contracts renewed from April 2013 contributing to employment in the Department and reduction in the vacancy rate.

As part of the Provincial Youth Community Ambassador Programme the Department created career opportunities in Nursing, Nutritional Advisors (10 appointments), Orthotics/ Prosthetics Technicians (30 appointments), and Clinical Associates (8 appointments). Potential candidates have the option to apply for bursaries from the Department.

The PHC headcount increased with 6.1% (1 795 909) between 2011/12 and 2012/13. Children under 5 years constituted 16.3% of the total headcount in 2012/13. The Provincial Department of Health remains the main provider of PHC services (83%), followed by Local Government (15.5%), State Aided providers (0.9%), Non Profit Organisations (0.2%), and other (0.05%).

Clinics, with attached PHC Teams, show an upward trend in patient activity (14.7% in 2012/13) compared to the average provincial increase of 6.1%. The distinctive decline in the number of patients accessing PHC services at hospital level (cases not referred) and corresponding incline in the number of patients utilising services at clinic level is noteworthy to improved PHC and positive behaviour change in the utilisation of health services (appropriate entry of the health care system).

Forty-seven (47) LG clinics were provincialised during 2012/13. Clinics in the eThekwini Metro and Umhlathuze Municipality has not been provincialised and continued to render services through a Service Level Agreement.

Table 10: National and Provincial Priorities

Customised Key Actions 2014/15 (National Department of Health)	Strategies and Interventions for 2014/15 (KwaZulu-Natal Department of Health)
National Sub-Outcome 1: Prevent and reduce the disease burden and promote health	
Maternal, Neonatal, Child & Women's Health and Nutrition • Prevention of Mother-to-Child-Transmission of HIV (PMTCT). • Basic Antenatal Care (BANC). • Preventative services and growth monitoring. • Cervical cancer prevention and screening.	***Maternal, Neonatal, Child & Women's Health and Nutrition*** • "Reaching 3 Million Women and Young Girls with Sexual & Reproductive Health Services by 2015" Campaign. Primary target Grade 8 and 9 girls; and Secondary target all women in reproductive age group. • Human Resources for Maternal and Child Health focusing on: – Clustering of Hospitals for improved Caesarian Section outcomes. – Piloting revised CCG Scope of Practice for MCWH. – Clinical Associates within the MCWH context. – Advanced Midwifes (quality of care). • Harmonisation of EMS services and identified District Hospitals and delivery facilities. • Integrated management of ANC patients inclusive of TB and HIV treatment at point of care. • Management of obstetric cases. • HPV vaccination. ***Child survival*** • *Community level:* CIMCI and Phila Mntwana. • *PHC Clinics:* Well child services (includes <12); IMCI case management; Paediatric HAART initiation; and Management of diarrhoea, pneumonia and malnutrition. • *Hospital Level:* Ten steps on management of severe malnutrition; Emergency neonatal and child care; Neonatal care; Piloting of retrieval teams with EMS and High/ Intensive Care. • Prevention of HIV transmission post cessation of breast feeding. • Initiation of TB screening and initiation of treatment in children under-5 years.
HIV and AIDS	***HIV and AIDS***

Customised Key Actions 2014/15 (National Department of Health)	Strategies and Interventions for 2014/15 (KwaZulu-Natal Department of Health)
• Access to ART. • Interventions to reduce HIV mortality. • Medical Male Circumcision (MMC) as part of the male sexual and reproductive health programme.	• HIola Manje Zivikele Campaign – testing for HIV at least once a year, screening for TB and contraceptives for unwanted pregnancies. • Anti-Sugar Daddy Campaign - community dialogues targeting men, truck and taxi industry, business sector, traditional leadership and youth. • MMC – Inter-sectoral and Traditional Leadership collaboration. • ART programme. • Post-Exposure Prophylaxis.
TB • TB treatment outcomes. • Reduce TB mortality.	***TB*** • Community-based management of MDR-TB (Injection Teams). • Roll-out of GeneXpert Technology. • Infection prevention and control in facilities. • TB prevention in children. • Improve efficiencies at ex Santa TB Hospitals.
Non-Communicable Diseases • Intersectional collaboration with focus on 6 pillars of healthy lifestyles. • Cataract surgery. • Inter-sectoral response against violence and injury.	***Non-Communicable Diseases*** • Integrated Chronic Disease Management Model. • Human resource strengthening (task shifting, mentoring & development). • Medicine supply, pre-dispensing and distribution at community level. • Adherence to treatment - "Mpilonde"/ support groups. • NCD surveillance systems.
	Malaria • Early diagnosis and treatment • Research to monitor drug efficacy.
	Social determinants of health • Integrated ward-based services through Operation Sukuma Sakhe. • Municipal Health Services including access to water, sanitation, and control of wasted and hazardous substances, Food Safety and Control and Vector Control. • Technical support and M&E for Municipal Health Services.
National Sub-Outcome 2: Health Facility Planning	
• Development and implementation of long term health plans. • Norms and standards for health facilities infrastructure. • Teams of engineers in the building industry.	• Innovation projects e.g. alternative options to replace requirements for new facilities. • Re-directing funding towards maintenance. • Delivery/ procurement models that are non-capital intensive. • Integrated Management Tool (project management).
National Sub-Outcome 3: Improved financial management in the health sector	
• Audit findings from Auditor-General of South Africa (AGSA).	• Audit findings from AGSA. • Cost centres.
National Sub-Outcome 4: Efficient health management information system for improved decision making	
• National integrated patient-based information system in accordance with the Normative Standards Framework.	• Data management systems, processes and tools. • Information technology including Telemedicine (eHealth and mHealth). • Performance-based monitoring and evaluation. • Research for health. • Evidence-based planning.
National Sub-Outcome 5: Improved quality of care	
• Office of Health Standards Compliance. • Compliance with National Core	• National Core Standards. • Decentralised training model in collaboration with UKZN. • Clinical governance including outreach and oversight.

Customised Key Actions 2014/15 (National Department of Health)	Strategies and Interventions for 2014/15 (KwaZulu-Natal Department of Health)
Standards. • Patient satisfaction with public health services.	
National Sub-Outcome 6: Implement Re-engineering of PHC	
• Ward-based outreach teams. • School health services. • District Clinical Specialist Teams. • Community-Based Rehabilitation.	• Re-engineering of PHC. • Integration through Provincial Growth and Development Plan. • Alternative models of service delivery.
National Sub-Outcome 7: Universal health coverage	
• Building blocks of NHI. • National Pricing Commission to regulate health care in the private sector.	• NHI in 3 pilot districts. • Linking NHI sites with other districts for accelerated implementation of good practice models. • Research to inform alternative models of service delivery.
National Sub-Outcome 8: Improve Human Resources for Health	
• Production of Human Resources of Health. • Norms for the provision of Human Resource for Health. • Produce, cost and implement Human Resource for Health Plans. • Appropriately qualified and adequately skilled CEOs are appointed in all hospitals.	• Decentralised training model with PHC focus in collaboration with UKZN. • Mid-level Worker and Clinical Associate programme(s). • HR gap analysis and costing of proposed structures in collaboration with HEARD and UKZN. • Alignment of Provincial/District HR Plan(s) with Human Resource for Health Strategy (including Essential Post List). • Human Resource Development and Training with specific emphasis on identified skills gaps. • Recruitment of Hospital CEO's in accordance with re-classification of hospitals. • Consolidate monitoring and evaluation. • EMS and FPS human resource needs to support turnaround strategies. • Develop, adopt and implement alternate models for service delivery to address human resource shortages in peri-urban and rural areas.

1.2 LEGISLATIVE MANDATES AND NEW POLICY INITIATIVES

No new legislation promulgated since tabling of the 2013/14 Annual Performance Plan.

1.3 OVERVIEW OF THE 2013/14 BUDGET AND MTEF ESTIMATES

In 2011/12, the Department over-spent by R122.022 million, attributed to ongoing processing of various categories of OSD, filling of critical posts required for restructuring of service delivery, increased payments to the National Health Laboratory Services related to an agreement to increase the monthly payment from R34 million to R43 million (backdated to January 2011), and once-off payment of R50 million towards HIV and AIDS costs, as per a special request from the National Department of Health.

An amount of R81.838 million was included against Provincial roll-overs, being an approved roll-over of R63.953 million from 2009/10, of commitments relating to the Hospital Revitalisation component of the Health Facility Revitalisation Grant, which was under-spent in 2009/10, and a roll-over of R17.885 million from 2010/11 in respect of the Comprehensive HIV and AIDS Grant.

In 2012/13, the Department received provincial cash resources of R252.320 million including:

- R12 million for an immunisation campaign to reduce child morbidity and mortality.
- R6.250 million to improve the Departmental PABX telecommunication systems.
- R185.963 million to manage pressures of accelerated infrastructure projects.
- The balance of R48.107 million was top-up funding for the cost of the higher than budgeted 2012 wage agreement, not fully funded by National Treasury.

In 2012/13, the Department over-spent by R99.603 million. This was related to filling of critical Primary Health Care posts, addressing critical resource gaps in municipal clinics taken over from local government, and commissioning new Community Health Centres and the new King Dinuzulu District Hospital.

In the 2013/14 Adjusted Appropriation, the Department received a roll-over of R14.949 million in respect of the National Health Insurance Conditional Grant. The funds were to be used for medical and surgical equipment and information technology equipment, which was ordered in 2012/13 but only delivered in 2013/14. Furthermore, in 2013/14 the Department received additional funding of R268.580 million from provincial cash resources including:

- R17 million for the McCords Hospital take-over costs and malpractice insurance premiums.
- R200 million from equitable share funding to manage infrastructure pressures.
- R1 million for Operation Sukuma Sakhe initiatives - identified by the MEC.
- R50.580 million for the upgrading and refurbishment of the Regional Laundry in Dundee.

The projected over-spending of R367.164 million in 2013/14 relates mainly to pressures in the Comprehensive HIV and AIDS Grant largely driven by exponential increase in the number of ARV patients and the lack of reliable funding formulae for this programme. Adding to this pressure are take-over and running costs for the McCords Hospital, as well as pressures in computer, agency and support services costs.

Note that, over the 2014/15 MTEF, the Health Facility Revitalisation Grant declines to zero in the outer year due to the reforms that were made to the Provincial Infrastructure Grant system intended to institutionalise better planning for infrastructure. National Treasury notified provinces in 2012 that they will be required to bid for infrastructure allocation two years in advance and financial incentives will be built into the Infrastructure Grant for provinces that implement best practices.

The Department was largely successful in bidding for the 2015/16 infrastructure allocations although the amount is less than 2014/15 due to technical problems in the bidding process. The Department and Provincial Treasury are still liaising with National Treasury in this regard and the possibility exists for further adjustments during 2014/15. The bidding process for 2016/17 will commence in 2014/15, hence no allocation at this stage.

The Department will be rolling out the HPV vaccine in 2014/15 as part of the cervical cancer prevention strategy. Funding for the roll-out in 2014/15 and 2015/16 will be made available through the National Department of Health as an indirect grant. An amount of R42.661 million is added to the Provincial Equitable Share in 2016/17 as the programme becomes integrated into the normal business of provincial health departments.

In the 2013/14 MTEF, the following changes were made to the Department's baseline:

- Carry-through costs for the 2012 wage agreement.
- National priority funding for rollout of the TB-GeneXpert programme.
- Once-off funding for the upgrading and refurbishment of the Regional Laundry in Dundee.
- National Treasury took a decision to impose 1, 2 and 3 per cent baseline cuts on all spheres of government (i.e. National, Provincial and Local) in order to curb the national deficit as public spending is growing faster than revenue collection. In addition, KZN received reduced equitable share allocations based on the 2011 Census data. This results in a substantial reduction in annual budget over the entire period.

In the 2014/15 MTEF, the following changes are made to the Department's baseline:

- Carry-through costs of re-grading of clerical staff.
- Carry-through costs for previous wage agreements.
- Funding for roll-out of the Human Papillomavirus (HPV) vaccine commencing in 2016/17.
- Additional funding related to the take-over costs for the McCords Hospital.
- Additional funding (2014/15 only) for operational costs at St. Mary's Hospital, pending report of the transaction advisor investigating the possible provincialisation of the hospital.

1.3.1 Expenditure Estimates

Table 11: (A8) Summary of Payments and Estimates

Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Administration (1)	463 648	576 425	633 958	591 078	594 710	622 846	581 340	597 700	629 378
District Health Services (2)	9 279 280	10 301 546	11 833 923	13 063 776	13 123 062	13 410 064	14 720 035	15 965 338	17 057 963
Emergency Medical Services (3)	822 618	1 070 387	926 036	972 362	971 026	995 298	1 073 438	1 133 728	1 193 816
Provincial Hospital Services (4)	6 034 776	7 449 620	7 827 401	8 326 401	8 410 037	8 447 455	8 788 275	9 356 526	9 852 422
Central Hospital Services (5)	2 103 382	2 512 654	2 762 971	2 922 125	2 951 979	2 952 968	3 079 392	3 290 427	3 464 820
Health Sciences and Training (6)	832 279	860 457	901 968	992 246	1 022 270	1 012 752	1 051 400	1 104 853	1 163 410
Health Care Support Services (7)	111 756	125 030	130 678	143 286	123 393	122 258	140 959	145 536	172 149
Health Facilities Management (8)	1 087 247	1 894 999	2 373 597	1 636 603	1 944 867	1 944 867	1 479 357	1 287 471	287 802
Sub-total	**20 734 986**	**24 791 118**	**27 390 533**	**28 647 877**	**29 141 344**	**29 508 508**	**30 914 196**	**32 881 579**	**33 821 760**
Direct charges against National Revenue Fund									
Total	**20 734 986**	**24 791 118**	**27 390 533**	**28 647 877**	**29 141 344**	**29 508 508**	**30 914 196**	**32 881 579**	**33 821 760**
Unauthorised expenditure (1st charge)									
Change to 2011/12 budget estimate	**20 734 986**	**24 791 118**	**27 390 533**	**28 647 877**	**29 141 344**	**29 508 508**	**30 914 196**	**32 881 579**	**33 821 760**

Table 12: (A9) Summary of Provincial Expenditure Estimates by Economic Classification

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Current payments	**19 186 343**	**22 374 653**	**24 746 845**	**26 585 714**	**26 553 971**	**26 855 393**	**28 624 542**	**30 769 781**	**32 650 686**
Compensation of employees	12 935 381	15 118 307	16 886 345	18 355 557	18 652 036	18 676 690	20 188 402	21 700 138	22 919 325
Goods and services	**6 250 962**	**7 256 326**	**7 860 500**	**8 230 157**	**7 901 830**	**8 178 583**	**8 436 140**	**9 069 643**	**9 731 361**
Communication	82 047	83 607	90 818	95 423	92 923	92 509	112 863	108 020	116 985
Computer Services	80 192	164 578	152 689	153 089	139 920	173 415	133 765	96 801	98 275
Consultants, Contractors and special services	1 641 387	1 929 547	1 911 844	1 746 611	1 996 525	1 915 242	1 941 899	2 026 344	2 205 040
Inventory	3 360 373	3 631 544	4 198 476	4 587 446	4 192 435	4 451 520	4 676 629	5 162 300	5 595 723
Operating leases	96 543	43 400	109 010	46 337	113 971	107 991	116 150	114 590	116 944
Rental and Hiring	55 796	65 974		448					
Travel and subsistence	38 063	54 336	75 510	68 669	60 498	62 604	71 374	74 985	81 275
Interest and rent on land		20			105	120			
Maintenance , repair and running costs	Included under Contractors and Inventory to avoid double counting								
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	896 561	1 283 340	1 322 153	1 532 982	1 305 111	1 374 710	1 383 460	1 486 603	1 517 117
Transfers and subsidies to	**562 374**	**515 845**	**486 764**	**655 168**	**748 981**	**818 562**	**692 479**	**676 450**	**739 608**
Provinces and municipalities	126 756	88 878	26 330	148 683	161 496	161 340	137 663	154 790	172 415
Departmental agencies and accounts	18 942	23 249	25 351	27 851	11 847	11 862	13 069	14 097	33 744
Higher Education Institution			57			470			
Non-profit institutions	289 009	273 487	277 586	274 168	252 168	279 243	250 647	212 110	224 022
Households	127 667	130 231	157 440	204 466	323 470	365 647	291 100	295 453	309 427
Payments for capital assets	**980 640**	**1 900 011**	**2 156 923**	**1 406 995**	**1 838 385**	**1 834 546**	**1 597 175**	**1 435 348**	**431 466**
Buildings and other fixed structures	778 749	1 048 172	1 662 936	864 152	1 425 231	1 429 376	1 249 773	1 076 903	54 731
Machinery and equipment	201 093	825 384	493 987	542 843	413 154	405 170	347 402	358 445	376 735
Land and sub-soil assets	798	26 455							
Payment for financial assets	**5 629**	**609**	**1**		**7**	**7**			

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Total economic classification	**20 734 986**	**24 791 118**	**27 390 533**	**28 647 877**	**29 141 344**	**29 508 508**	**30 914 196**	**32 881 579**	**33 821 760**
Unauthorised expenditure (1st charge) not available for spending									
Total	**20 734 986**	**24 791 118**	**27 390 533**	**28 647 877**	**29 141 344**	**29 508 508**	**30 914 196**	**32 881 579**	**33 821 760**

1.3.2 Relating Expenditure Trends to Specific Goals

Table 13: (A10) Trends in Provincial Public Health Expenditure (R'000)

Expenditure R'000	Audited/ Actual			Estimate 2013/14	Medium Term Projections		
	2010/11	2011 /12	2012/13		2014/15	2015/16	2016/17
Current prices							
Total	20 734 986	24 791 118	27 390 533	29 508 508	30 914 196	32 881 579	33 821 760
Total per person	2 047.06	2 421.75	2 647.57	2 821.92	2 924.35	3 076.45	3 129.75
Total per uninsured person	2 339.50	2 767.71	3 025.79	3 217.69	3 334.49	3 507.92	3 568.70
Constant (2010/11) Price							
Total	20 734 986	23 883 543	24 964 803	25 468 947	25 315 184	25 546 722	24 954 585
Total per person	2 047.06	2 333.09	2 413.10	2 435.61	2 394.71	2 390.19	2 309.21
Total per uninsured person	2 339.50	2 666.39	2 757.83	2 777.21	2 730.57	2 725.41	2 633.08
% of Total spent on:-							
DHS	44.75%	41.55%	43.20%	45.44%	47.62%	48.55%	50.43%
PHS	29.10%	30.05%	28.58%	28.63%	28.43%	28.46%	29.13%
CHS	10.14%	10.14%	10.09%	10.01%	9.96%	10.01%	10.24%
All personnel	12 935 381	15 118 307	16 886 345	18 676 690	20 188 402	21 700 138	22 919 325
Capital	980 640	1 900 011	2 156 923	1 834 546	1 597 175	1 435 348	431 466

Expenditure R'000	Audited/ Actual			Estimate 2013/14	Medium Term Projections		
	2010/11	2011 /12	2012/13		2014/15	2015/16	2016/17
Health as % of total public expenditure	30.6%	31.5%	32%	32.1%	32%	32.1%	32%

Table 14: Conditional Grants Expenditure Trends (R'000)

Conditional Grants R'000	Audited Actual			Estimate 2013/14	Medium Term Projections		
	2010/11	2011/12	2012/13		2014/15	2015/16	2016/17
National Tertiary Services	1 102 517	1 201 831	1 323 114	1 415 731	1 496 427	1 565 263	1 648 222
HIV and AIDS	1 500 926	1 907 312	2 226 706	2 852 072	3 257 992	3 874 085	4356 963
Hospital Facility Revitalisation Grant	578 019	906 169	1 176 514	1 267 116	1 162 469	1 090 431	
Health Professions Training and Development	235 771	249 917	261 860	276 262	292 837	306 308	322 542
National Health Insurance Grant			17 115	24 649	14 000	14 793	15 577
Forensic Pathology Services	152 406	161 550					
2010 World Cup Health Preparation Strategy	3 538						
EPWP Grant for the Social Sector	2 555	25 775			2 581		
EPWP Incentive Grant for Provinces		536	1 000	16 000	2 850	1 000	3 000
AFCON Health and Medical Services Grant			1 672				
Total	**3 575 732**	**4 453 090**	**5 007 983**	**5 851 830**	**6 228 886**	**6 850 880**	**6 343 324**

1.4 STRATEGIC PLANNING PROCESS

Eleven district reviews were conducted in April 2013 to inform the 2014/15 District Health Plans. Reviews were attended by (Acting) Regional Managers, Facility Management Teams, service providers, and Development Partners.

Provincial review held on 26 April 2013 under leadership of the Head of Department and attended by the MEC for Health. The review was attended by 208 Senior Provincial and District Managers – identified preliminary priorities for 2014/15.

The 2012/13 Annual Report was tabled on 29 August 2013 as per Legislative directive.

Five (5) decentralised District Health Expenditure Review (DHER) workshops were conducted during April and May 2013, attended by 166 District and Facility Managers. Final DHER Reports were submitted to Senior Management and the National Department of Health on 20 September 2013.

Five decentralised district planning workshops were conducted during July and August 2013, attended by 178 District and Facility Managers. Draft 1 DHPs submitted to the National Department of Health on 29 November 2013.

Four 2-day National Strategic Planning Committee meetings attended between April and November 2013. All meetings focussed on the 2014-2019 health sector response to imperatives in the NDP 2030 and MTSF 2014-2019. Representatives from the Department Performance Monitoring and Evaluation (DPME) and National Treasury attended all meetings.

National Health Council Technical Advisory Committee (NHC TAC) and Strategic Planning meeting on 13-14 November 2013 with the objective to align the Health Sector goals and strategic objectives with the MTSF. The draft customised framework was presented to the NHC TAC for approval.

The Department hosted two Provincial Strategic Planning workshops in October 2013:

8-9 October 2013: Expert Working Group (96 senior delegates) developed a strategic concept document to guide wider provincial consultation. Process led by the Head of Department and facilitated by the Provincial Strategic Planning Component. Delegates included Senior Provincial and District Managers, Clinical experts, University of KZN and Development Partners. The process included 6 Commissions focussing on DHS; Hospital and Clinical Services; Human Resources for Health; Finance, Research, Information and Risk Management; Emergency Medical Services and Forensic Pathology services; and Integration, Governance and Infrastructure.

29-30 October 2013: Process led by the Head of Department and attended by the MEC for Health. The workshop was attended by 231 managers as well as representatives from the National and Provincial Planning Commissions, UKZN delegation, Development Partners, Portfolio Committee, and Provincial and District Health Councils. Five commissions unpacked Human Resources for Health, EMS and Forensic Services, Non-Communicable Diseases and PHC, Strategic Health Programmes, and Hospital and Clinical Support. The 2014-2019 priorities are based on these deliberations.

Draft 2014/15 APPs were submitted to Provincial Treasury on 22 August 2013 (draft 1), 27 November 2013 (draft 2), and 10 January 2014 (draft 3). The draft customised national template (with customised priorities) received from the National Department of Health on 8 January 2014. The 2014/15 APP will be tabled in the Provincial Legislature in March 2014. Amendments, post-election, will be incorporated for re-tabling in June 2014.

Draft APPs were submitted to the Portfolio Committee for Health, National Health and ManCo.

Other consultations

June 14, 2013: Treasury Workshop in collaboration with the Provincial Planning Commission with objective to brief departments on requirements for Strategic and Annual Performance Plans, including monitoring and evaluation.

October to December: Budget re-prioritisation workshops with all districts with strong focus on interpretation of expenditure trends and service delivery outcomes - first phase of budget process for 2014/15.

November 2013: Infrastructure re-prioritisation and budget allocation workshops with all districts. The process will be completed by March 2014.

Provincial Planning Commission: Monthly meetings (PGDP Steering Committee) to refine integrated response to the PGDP.

Partnership with the University of KwaZulu-Natal (UKZN) Health Sciences: Ongoing consultation to restructure the training platform through innovation in order to address human resource gaps in the province and improve equity.

Technical notes

The customised health sector template includes national priorities, goals, strategic objectives and indicators per budget programme/ sub-programme. A sub-set of these indicators are selected by the NDOH and National Treasury for quarterly reporting to both national departments.

Provinces have the scope to add additional province-specific indicators per financial programme.

All performance measures (national and provincial) are included in the provincial reporting system and are being reported quarterly and annually in the Annual Report.

From 2014/15 onwards, all provinces will report on the same indicators, which will be monitored by the DPME to ensure comprehensive response towards performance against targets contained in the NDP and MTSF.

Note

The 2014/15 APP has been aligned with the 2010-2014 Strategic Plan with focus on the 2014-2019 customised priorities (NDP 2030 and draft MTSF 2014-2019) as per directive from the Department Planning Performance Monitoring and Evaluation and National Department of Health.

Presentation of Core Business: 2014/15 Annual Performance Plan

The 2014/15 APP is the 5th annual plan for the 2010-2014 strategic planning cycle and adheres to imperatives contained in the National Health Act (Act No. 61 of 2003) and Regulations; KZN Health Act (Act No. 1 of 2009) and Regulations; Public Finance Management Act (Act No. 1 of 1999) and Amendments; Treasury Regulations (amended February 2007); and Promotion of Access to Information Act, 2000.

The plan covers the period 1 April 2014 to 31 March 2015 and has been aligned with Budget Programmes and Sub-Programmes as prescribed by National Treasury Regulations and Guidelines.

Part A: Provides an overview of the provincial health perspective; strategic goals and objectives; and details of changes to the 5-year Strategic Plan based on policy development, changes in the Departmental mandate, and changes in the disease profile and consequent service delivery approaches.

Part B: Provides planning information on individual Programmes and Sub-Programmes including specific performance measures and targets.

Part C: Details links with other relevant plans.

Part D: Provides for abbreviations and references used for compilation of the APP.

Annexure 1: Provides detailed information on all indicators/ performance measures used in the APP. This will be posted on the Departmental website with the APP.

The National Department of Health, through consultation with National Treasury and Provincial Departments of Health, customised the APP template within the framework of the updated *Framework for Strategic Plans and Annual Performance Plans of National and Provincial Government Departments* (National Treasury August 2010). The Framework ensures

that plans are aligned with the revised Medium Term Strategic Framework (MTSF), Performance Agreements between Ministers and the President, and Sectoral Service Delivery Agreements.

National performance indicators have been determined by the National Department of Health in consultation with Provinces and National Treasury (referred herein as "*Performance Indicators*" in Part B of the APP).

These indicators will be monitored quarterly and formal progress reports "*Provincial Quarterly Performance Reports or PQRS*" will be submitted to Senior Management, the Provincial Health Portfolio Committee, Provincial/ National Treasury and the National Department of Health. Reports will be published quarterly on the National Treasury website.

The Department identified province specific indicators, based on provincial priorities and key focus areas (within the national framework) to ensure effective tracking of performance and health outcomes.

Provincial indicators and targets are reflected in Part B of the APP as "*Provincial Strategic Objectives, Indicators and Performance Targets*". Indicators are linked with provincial strategic goals and objectives.

The APP reflects only core/ macro priorities and performance measures. Supporting (secondary or sub-set) indicators and targets are included in Component, Programme, District and Institutional Operational Plans.

All indicators and targets (APP and Operational Plans) are included in the Monitoring, Evaluation and Reporting Framework to ensure comprehensive monitoring, evaluation and reporting on performance output and health outcomes.

The Public Audit Act, 2004 empowers the Auditor-General of South Africa (AGSA) to audit and report on the accounts, financial statements and financial information of all National and Provincial State Departments and Administrations. The formal audit opinion of the AGSA is expressed annually in the Annual Report.

Quarterly performance targets (Part B) serve as a yardstick for quarterly reviews and reporting.

2. PROGRAMME 1: ADMINISTRATION

Programme Purpose and Structure

There are no changes to the Programme 1 structure.

Purpose

To conduct the strategic management and overall administration of the Department of Health

Sub-Programme 1.1: Office of the Member of the Executive Council (MEC)

Render advisory, secretarial and office support services. This sub-programme also renders secretarial support, administrative, public relations/ communication and parliamentary support

Sub-Programme 1.2: Office of the Head of Department (all Head Office Components)

Policy formulation, overall management and administration support of the Department and the respective regions and institutions within the Department

2.1 OVERVIEW

The policies that govern Programme 1 stem from the prevailing legislative framework(s) that govern the Public Service as a whole. These policies are transversal and sector specific in nature. Whilst the Department subscribes to and adopts the legal prescripts in all its activities, it is nonetheless cognisant of the democratic values and principles enshrined in Section 195 of the Constitution.

The macro organisational structure has been approved by the Department of Public Service and Administration and alignment of micro structures commenced.

In 2014/15 there will be a strong focus on alignment of the Human Resources for Health Plan with service delivery imperatives. Various projects, designed to inform short, medium and long-term plans, will be prioritised to close the gap between demand and supply of human resources.

Innovative models to address human resource gaps will be explored in 2014/15 including Mid-Level Worker Programmes, Clinical Associate Programmes (commencing with maternal and child health), and various other options targeting system strengthening.

New training options will be explored in collaboration with the University of KwaZulu-Natal. A Joint Task Team, consisting of senior managers of the Department and College of Health Sciences UKZN, commenced with the development of a decentralised training model to give expression to the PHC focus. This process will continue in 2014/15 and will make provision for the alignment of the service delivery and training platforms.

The Memorandum of Agreement between the University and Department will be re-negotiated taking into consideration the vision of both entities.

The Provincial Health Council was established on 12 August 2012, and five District Health Councils were established in 2013 i.e. Amajuba (April); Uthungulu (April); Umkhanyakude (July); Harry Gwala (July) and Umgungundlovu (November). The remainder will be established in 2014/15.

The Department hosted the Provincial Consultative Health Forum summits annually since 2010/11.

The main focus of Programme 1 during 2014/15 will be on health system strengthening.

2.2 PRIORITIES AND FOCUS AREAS

- National and Provincial District Health Information Management Policies.
- Information Technology (and eHealth) Strategy 2014-2019.
- Provincial Monitoring and Evaluation Framework.
- Provincial Health Research Policy and Guidelines.
- Annual Provincial HR Plan (including HRD Plan) 2014/15.
- National Human Resource for Health Strategy 2012-2016.
- National Nursing Strategy 2016.

Provincial Priorities	Key Focus Areas
1. Financial and Supply Chain Management *NSO 3: Improved financial management in the health sector*	• Audit and Risk. • Financial management and accountability. • Financial austerity measures. • Cost Centres at facility level. • Supply Chain Management.
2. Data quality and information management *NSO 4: Efficient health management information system for improved decision making*	• IT Governance and infrastructure including bandwidth connectivity, back-up solutions, Telecoms, SLAs with external vendors, improved IT security. • E-Health, M-Health and telemedicine. • Performance-based monitoring and evaluation. • Data and information management and data quality. • GIS for planning and service strengthening. • Regional (level 1) Ethics Committees. • Research for Health including (but not exclusive to): – Human resources gap analysis, resource allocation and costing (2014/15 – 2015/16). – Analysis of burden and cost of trauma in KZN (2014/15). – Gap analyses of research conducted in KZN using research priorities generated by districts (2014/15). – Perceptions/attitudes of men to MMC in KZN (2014/15).

		– MDR-TB outcomes in KZN (2014/15). • Provincial and decentralised planning competencies.
3.	Human Resources for Health *NSO 8: Improve Human Resources for Health*	• Alignment of organisational structures with service delivery and training platforms. • Alignment of Human Resources Plan with service delivery demands (based on gap analysis and proposed model). • Reform(s) in Health Sciences training in partnership with UKZN. • Performance management and Development (EPMDS).
4.	Food Service Management	• Food Service Management strategy.
5.	National Health Laboratory Services (NHLS) and Blood Services	• Electronic gatekeeping and Point of Care Testing (NHLS). • Management of blood services.
6.	Security Services	• Compliance with security service standards.
7.	Legal compliance to various legislative prescripts	• Compendium of legislation that supports the development of policies and guidelines for core and non-core services. • Audit of Laws Project. • Awareness of applicable legislation to ensure compliance and adherence.

2.3 CUSTOMISED PERFORMANCE INDICATORS AND TARGETS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 8: Improve Human Resources for Health*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 4: Efficient health management information system for improved decision-making*

Table 15: (ADMIN2) Customised Performance Indicators - Administration

Strategic Objective Statement	Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Finalise and implement the long-term Provincial Human Resources for Health Plan by April 2015	1. Develop Provincial Human Resources for Health Plan	Approved Plan	Annual Yes/No	Yes	Yes	Yes	Yes (2013/14 HR Plan)	Long-term HR Plan developed	Yes (Review)	Yes (Review)
Finalise and implement the approved 2010-2020 KZN Service Transformation Plan by April 2015	2. Develop Provincial Long Term Health Plan	Approved Plan	Annual Yes/No	Draft	Draft	Draft	Draft	Finalise long-term plan	Yes (Review)	Yes (Review)
Implement a web-based District Health Information System at 80% PHC facilities by 2019	3. Proportion of facilities connected to the internet	IT database – Internet rollout report	Quarterly %	Not reported	Not reported	Not reported	8%	Clinics 25%	Clinics 45%	Clinics 70%
	Facilities connected to the internet	*IT database internet roll-out report*	*No*	-	-	-	*52*	*163*	*295*	*461*
	Facilities total	*DHIS calculates*	*No*	-	-	-	*644*	*650*	*654*	*659*

- *Indicator 3 [Facilities connected to the internet]*: The indicator refers to clinics (including CHCs) and is linked to DHIS reporting. 100% CHCs are currently connected to the internet.

2.4 PROVINCIAL STRATEGIC OBJECTIVES AND TARGETS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 8: Improve Human Resources for Health*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 4: Efficient health management information system for improved decision-making*

Table 16: (ADMIN1) Provincial Strategic Objectives and Targets - Administration

Strategic Objective Statement	Performance Indicators	Data Source	Frequency / Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17
HUMAN RESOURCE MANAGEMENT SERVICES										
Provide sufficient staff with appropriate skills per occupational group within framework of provincial norms by 2019	1. Medical Officers per 100,000 people	Manually Calculated	Annual No per 100,000	24.4	30.3*	32	28.2	30.6	32.9	35.4
	Number of Medical Officers appointed	*Persal*	*No*	*2 551*	*3 227*	*3 429*	*3 037*	*3 335*	*3 633*	*3 933*
	Total population	*Stats SA*	*Population*	*10 449 300*	*10 622 204*	*10 703 920*	*10 785 397*	*10 898 644*	*11 010 900*	*11 121 009*
	2. Professional Nurses per 100,000 people	Manually Calculated	Annual No per 100,000	130.1	137.4	145.5	132.3	134.8	137.1	139.8
	Number of Professional Nurses appointed	*Persal*	*No*	*13 602*	*14 601*	*15 579*	*14 269*	*14 696*	*15 101*	*15 550*
	Total population	*Stats SA*	*Population*	*10 449 300*	*10 622 204*	*10 703 920*	*10 785 397*	*10 898 644*	*11 010 900*	*11 121 009*
	3. Pharmacists per 100,000 people	Manually Calculated	Annual No per 100,000	4.8	5.6	6.3	6.5	6.8	7	7.3
	Number of Pharmacists appointed	*Persal*	*No*	*512*	*606*	*671*	*701*	*737*	*773*	*810*
	Total population	*Stats SA*	*Population*	*10 449 300*	*10 622 204*	*10 703 920*	*10 785 397*	*10 898 644*	*11 010 900*	*11 121 009*

Strategic Objective Statement	Performance Indicators	Data Source	Frequency / Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17
All personnel comply with performance management requirements by March 2015	4. Number of Hospital Managers who have signed Performance Agreements (PA's)	EPMDS database/ Signed PAs	Annual No	Not reported	55	50	60	72 or 100%	72 or 100%	72 or 100%
	5. Number of District Managers who have signed PA's	EPMDS database/ Signed PAs	Annual No	11	11	11	11	11	11	11
	6. Percentage of Head Office Managers (Level 13 and above) who have signed PA's	EPMDS database/ Signed PAs	Annual %	46%	46%	58%	70%	100%	100%	100%
	Head Office Managers (level 13 and above) who signed PAs	*EPMDS database*	*No*	*18*	*18*	*29*	*38*	-	-	-
	Number of Head Office Managers (level 13 and above)	*Persal*	*No*	*39*	*39*	*50*	*54*	-	-	-
INFORMATION MANAGEMENT										
Expand telemedicine to all districts by 2019	7. Number of functional Tele-Medicine sites	Telemedicine Register	Annual No	35	37	37	38	50	58	65
Implement the reviewed M&E Framework at all levels of care by March 2017	8. Provincial M&E Framework implemented	Provincial M&E Framework	Annual Yes/No	Not reported	Not reported	Not reported	Not reported	Framework reviewed	Framework implemented	Two evaluation projects completed
Strengthen research for health	9. Number of level 1 Health Ethics Review Boards established	Appointment letters	Annual No	Not reported	Not reported	Not reported	Not reported	1	1	2
Establish 4 Regional Level 1 Health Ethics Review Boards by March 2017	10. Number of in-house research projects completed	Final research report(s)	Annual No	Not reported	Not reported	Not reported	Not reported	5	2 (including phase 2 of 2014/15 study)	1 (Phase 1, 2 and 3 of 2014/15 study)
Establish appropriate data information systems and tools to ensure unqualified audit outcomes by 2016/17	11. Proportion of facilities implementing the PHC tick register and daily capturing tool	PHC tick registers/ Daily capturing tools	Annual %	Not reported	Not reported	Not reported	Not reported	100% (PHC tick register) 25% (Daily capturing tool)	100% 50% (cumulative)	100% 75% (cumulative)

Strategic Objective Statement	Performance Indicators	Data Source	Frequency / Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17
	Facilities implementing PHC tick register/ daily capturing tool	*PHC Tick Register*	*No*	-	-	-	-	*650*	*654*	*659*
		Daily Capturing Tool	*No*	-	-	-	-	*162*	*327*	*494*
	Facilities total	*DHIS calculates*	*No*	-	-	-	-	*650*	*654*	*659*
FOOD SERVICES										
All public hospitals score >75% on the Food Service Monitoring Standards Grading System by 2019	12. Proportion of facilities that scored >75% on the Food Service Monitoring Standards Grading System	Food Services Grading Register	Annual %	Not reported	Not reported	Not reported	36.6%	55.5%	69.4%	83.3%
	Facilities scoring more than 75% on the FSMSGS	*Grading Register*	*No*	-	-	-	*26*	*40*	*50*	*60*
	Public Health Hospitals total	*DHIS calculates*	*No*	-	-	-	*71*	*72*	*72*	*72*
All public hospitals serve standardised and nutritionally balanced menus by 2019	13. Number of in-house Food Service Units serving 3 Provincial standardized menus	Food Service Unit database	Annual No	Not reported	Not reported	Not reported	15	20	23	23
	14. Number of facilities compliant with 2 priority Food Safety Standards	Food Service database	Annual No	Not reported	Not reported	Not reported	30	45	55	70
SECURITY SERVICES										
All public health facilities comply with security policy requirements by 2019	15. Proportion of health facilities with operational security committees	Security Audit results	Annual No	Not reported	Not reported	Not reported	Not reported	50%	75%	100%
	Facilities with operational security committees	*Security audit results/Minutes*	*No*	-	-	-	-	*361*	*544*	*731*
	Facilities total	*DHIS calculates*	*No*	-	-	-	-	*722*	*726*	*731*

Strategic Objective Statement	Performance Indicators	Data Source	Frequency / Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17
	16. Proportion of health facilities fenced with access control at the gate	Facility Security Audit Results	Annual %	Not reported	Not reported	Not reported	Not reported	50%	75%	100%
	Facilities fenced with access control	*Security audit results/Minutes*	*No*	-	-	-	-	*361*	*544*	*731*
	Facilities total	*DHIS calculates*	*No*	-	-	-	-	*722*	*726*	*731*

- *Indicators 1-3 [Health Professionals per population]*: Also monitored as part of the Provincial Growth and Development Plan (PGDP). Persal data is based on actual data at the end of September 2013. MTEF projections are based on funded posts - not making provision for intended reviewed structures. Population projections used average growth of 1.05% (2014/15); 1.03% (2015/16); and 1% (2016/17). Population will be reviewed annually to align with Stats SA projections.

- *Indicator 10 [In-house research projects]*: Identified research projects include (1) HR gap analysis; (2) Analysis of burden and cost of trauma in KZN; (3) Gap analysis of research in KZN; (4) Analysis of perception and attitudes of men to MMC; (5) Outcomes of MDR-TB in KZN.

- *Indicator 11 [PHC Tick Register/Daily Capture Sheet]*: Indicator forms part of a broader strategy to improve data quality.

- *Indicator 15 [Security Committees]*: Establishment of Security Committees will be reviewed once National Security Policy has been finalised.

- *Indicator 16 [Fencing and access control]*: Current security weaknesses (specific to infrastructure) will be addressed as part of the process to establish fencing at all facilities. This will be determined by the funding envelope.

2.5 TARGETS: 2014/15

Table 17: (ADMIN3) 2014/15 Targets - Administration

Performance Indicators	Targets 2014/15	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Proportion of health facilities connected to the internet	25%	8%	15%	20%	25%
Annual Targets					
2. Develop Provincial Human Resources for Health Plan	Yes				Yes
3. Develop Provincial Long Term Health Plan	Yes				Yes
4. Medical Officers per 100,000 people	30.6				30.6
5. Professional Nurses per 100 000 people	135.8				135.8
6. Pharmacists per 100 000 people	6.8				6.8
7. Number of Hospital Managers who have signed Performance Agreements(PAs)	72 (100%)	72			
8. Number of District Managers who have signed Performance Agreements(PAs)	11 (100%)	11			
9. Percentage of Head Office Managers (Level 13 and above) who have signed Performance Agreements (PAs)	100%	100%			
10. Number of functional Tele-Medicine sites	50				50
11. Provincial M&E Framework implemented	Framework reviewed				Framework reviewed
12. Number of level 1 Health Ethics Review Boards established	1				1
13. Number of in-house research projects completed	5				5
17. Proportion of facilities implementing the PHC tick register/ daily capturing tool	100% Tick register				100% Tick register
	25% daily capturing tool				25% daily capturing tool
18. Proportion of facilities that scored >75% on the Food Service Monitoring Standards Grading System	55.5%				55.5%
19. Number of in-house Food Service Units serving 3 Provincial standardized menus	20				20
20. Number of facilities compliant with 2 priority Food Safety Standards	45				45
21. Proportion of health facilities with operational security committees	50%				50%
22. Proportion of health facilities fenced with access control at the gate	50%				50%

2.6 RECONSILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 18: (ADMIN4 a) Summary of Payments and Estimates - Programme 1

Sub-Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
MEC's Office	14 452	15 615	20 371	18 419	19 416	18 928	19 498	20 672	21 768
Management	449 196	560 810	613 587	572 659	575 294	603 918	561 842	577 028	607 610
Sub-Total	**463 648**	**576 425**	**633 958**	**591 078**	**594 710**	622 846	**581 340**	**597 700**	**629 378**
Unauthorized expenditure (1st charge) not available for spending									
Total	**463 648**	**576 425**	**633 958**	**591 078**	**594 710**	622 846	**581 340**	**597 700**	**629 378**

Table 19: (ADMIN4 b) Summary of Payments and Estimates by Economic Classification - Programme 1

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Current payments	**454 816**	**463 100**	**531 385**	**559 879**	**553 070**	**578 300**	**571 829**	**564 117**	**594 015**
Compensation of employees	183 201	208 965	246 972	273 032	276 230	276 376	307 734	335 390	353 166
Goods and services	**271 615**	**254 115**	**284 413**	**286 847**	**276 840**	**301 924**	**264 095**	**228 727**	**240 850**
Communication	5 130	3 210	7 143	6 888	5 381	3 944	13 820	6 111	6 435
Computer Services	76 119	144 531	140 220	147 719	128 715	151 315	122 490	93 329	98 275
Consultants, Contractors and special services	16 989	40 719	48 780	17 670	70 524	25 262	31 930	28 683	30 203
Inventory	4 828	6 456	8 011	10 231	3 761	4 483	4 930	5 177	5 451
Operating leases	63 064	6 392	5 471	6 731	5 936	4 098	4 570	4 799	5 053
Travel and subsistence	13 038	16 312	22 714	19 823	17 782	19 951	22 100	23 205	24 435

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Interest and rent on land		20							
Maintenance, repair and running costs	Included under Contractors and inventory to prevent double counting								
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	92 447	36 495	52 074	77 785	44 737	92 867	64 255	67 423	70 996
Transfers and subsidies to	**1 750**	**3 392**	**6 172**	**3 549**	**1 549**	**2 037**	**3061**	**3 133**	**3 299**
Provinces and municipalities	33	26	95	48	48	48	60	132	139
Departmental agencies and accounts		1		1	1	4	1	1	1
Households	1 717	3 365	6 077	3 500	1 500	1985	3 000	3 000	3 159
Payments for capital assets	**6 702**	**109 386**	**96 400**	**27 650**	**40 084**	**42 502**	**6450**	**30 450**	**32 064**
Machinery and equipment	6 702	109 386	96 400	27 650	40 084	42 502	6 450	30 450	32 064
Payment for financial assets	380	547	1		7	7			
Total economic classification	**463 648**	**576 425**	**633 958**	**591 078**	**594 710**	**622 846**	**581 340**	**597 700**	**629 378**
Unauthorised expenditure (1st charge) not available for spending									
Total economic classification	**463 648**	**576 425**	**633 958**	**591 078**	**594 710**	**622 846**	**581 340**	**597 700**	**629 378**

Performance and Expenditure Trends

It is Departmental policy to keep the Programme 1 allocation to a maximum of 2 per cent of the total budget, which has been maintained over the past 4 years.

In 2014/15, Programme 1 has been allocated 1.8 per cent of the vote compared to 2 per cent in the 2013/14 revised estimate.

The increasing trend in *Compensation of employees* from 2010/11, as well as the increase over the 2014/15 MTEF, relates to the need to improve management capacity at Head Office for improved leadership.

The high growth from 2011/12 to 2013/14 is due to the allocation of additional resources to strengthen financial management capacity in order to improve audit outcomes, and filling of various critical posts related to Supply Chain and Asset Management functions.

The 2014/15 MTEF makes provision for improving management capacity at Head Office as part of systems strengthening.

The increase in the 2013/14 Adjusted Appropriation and Revised Estimate was mainly for provision of already committed computer equipment projects. In the 2014/15 MTEF, amounts are provided to replace essential equipment.

2.7 RISK MANAGEMENT

Potential Risks	Mitigating Factors
1. Budget limitations versus increasing service demands.	• Re-prioritisation and improved management control through implementation of costing framework.
2. Poor data quality (all information systems) jeopardizing evidence-based decision-making and planning.	• Implementation of information management strategy.
3. Ad hoc planning increasing unfunded mandates.	• Strengthen budget control.
4. Inadequate human resources for health to respond to burden of disease and concomitant service demands.	• Implementation of Human Resources Plan (including Essential Post List) to improve HR management in line with service delivery demands.
5. Inadequate management competencies.	• Management training/ mentoring strategy.

3. PROGRAMME 2: DISTRICT HEALTH SERVICES

Programme Purpose and Structure

There are no changes to the structure of Programme 2.

Purpose

To render Primary Health Care and District Hospital Services.

Sub-Programme 2.1: District Management

Planning and administration of health services; manage personnel and financial administration; co-ordination and management of Day Hospital Organisation and Community Health Services rendered by Local Authorities and Non-Governmental Organisations within the Metro; determine working methods and procedures and exercising district control

Sub-Programme 2.2: Community Health Clinics

Render a nurse driven Primary Health Care service at clinic level including visiting points, mobile and local authority clinics

Sub-Programme 2.3: Community Health Centres

Render primary health services with full-time Medical Officers in respect of mother and child, health promotion, geriatrics, occupational therapy, physiotherapy, and psychiatry

Sub-Programme 2.4: Community-Based Service

Render a community-based health service at non–health facilities in respect of home-based care, abuse victims, mental and chronic care, school health, etc.

Sub-Programme 2.5: Other Community Services

Render environmental, port health and part-time district surgeon services, etc.

Programme 2.6: HIV and AIDS

Render a Primary Health Care service in respect of HIV and AIDS campaigns and special projects

Sub-Programme 2.7: Nutrition

Render nutrition services aimed at specific target groups and combines direct and indirect nutrition interventions to address malnutrition

Sub-Programme 2.8: Coroner Services

Render forensic and medico legal services to establish the circumstances and causes of unnatural death

Sub-Programme 2.9: District Hospitals

Render hospital services at General Practitioner level

PRIMARY HEALTH CARE

3.1 OVERVIEW

During 2012/13, districts were consolidated into 4 Regions (Table 20), each with a Regional (General) Manager. One post is filled (Region 1), while three District Managers currently acting in the remaining three posts. The Department will explore different options for sub-district management in 2014/15 starting with the eThekwini Metro.

Table 20: Districts and Regions

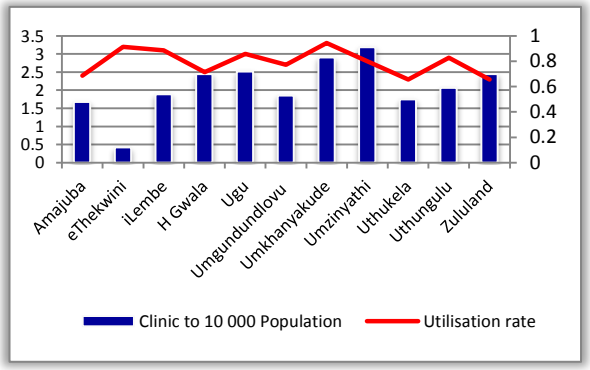
Region	District
Region 1	eThekwini Metro iLembe District
Region 2	Umgungundlovu District Harry Gwala District Ugu District
Region 3	Amajuba District Umzinyathi District Uthukela District
Region 4	Uthungulu District Umkhanyakude District Zululand District

Province (83.3%) and Local Government (15.5%) remain the primary providers of PHC services in the province, together responsible for 98.8% of the total PHC headcount.

All PHC services (with the exception of uMhlatuze Municipality and eThekwini Metro) have been provincialised. Provincialisation of the 2 clinics in uMhlatuze has been prioritised for 2014/15. Infrastructure challenges, staff shortage and lease agreements in provincialised clinics remain a challenge and have been prioritised in 2013/14 and 2014/15.

Two new CHC's will be commissioned in 2014/15 i.e. Pomeroy in Umzinyathi and Dannhauser in Amajuba. The expansion and upgrade of Inanda and Gamalakhe CHC's also commenced to accommodate increased patient load.

Graph 4: Clinic to 10 000 population ratio versus Utilisation rate



Inequities still exist at district and facility level which affect utilisation and cost (Graph 2). This will be addressed through implementation of the Human Resources for Health Strategy in the 2014/15 MTEF.

Although generic structures have been developed for PHC facilities it does not make provision for clinic-specific needs and demands. Structures will therefore be reviewed to make provision for improved supervision of inter alia Ward-Based and School Health Teams, as well as adequate staff/skills mix to accommodate the increased case load as a result of the decanting of ARV patients and improved community-based PHC.

There are currently 51 partially staffed and 33 fully staffed WBOTs rendering services at community level. The Department needs an additional 1 523 Ward-Based Outreach Teams (WBOTs) to comply with the national norm of 1 WBOT per 6 660 population. Serious budget constraints however slow down expansion of teams and alternative approaches will be explored to fill the gap.

Recruitment and retention of Specialists for the District Clinical Specialists Teams remain a

challenge. The Department therefore strive to appoint at least one complete team per Region (complete medical and nursing components) and 11 teams comprising the full nursing component. Recruitment and retention strategies will be prioritised during the MTEF.

Implementation of the Mental Health Strategy 2014-2019 will commence in 2014/15. At PHC level focus will be on integration at PHC level (community-based and fixed facilities) to increase access and improve management of mental health care users.

The establishment of psycho-social rehabilitation hubs to facilitate rehabilitation at community level has been prioritised.

The mental health care package of services has been approved in 2013/14 with implementation in April 2014. Successful implementation of the strategy will be dependent on availability of resources.

Implementation of the Out-patient Community-Based Substance Abuse Model commenced at KwaMashu and Turton CHCs. The model includes strategies to reduce injuries and violence (National Development Plan 2030).

The Department is finalising the Provincial Non-Communicable Disease Strategy 2014-2019 which will be prioritised (within the limited funding envelope) as part of PHC re-engineering and inter-sectoral collaboration during the MTEF.

3.2 PHC PRIORITIES AND FOCUS AREAS

- PHC Re-Engineering Strategy
- National Health Insurance Business Plans
- National / Provincial Non-Communicable Diseases Strategies 2013-2019
- National/ Provincial Mental Health Care Strategies 2014-2019
- Integrated Chronic Disease Management Model

Priorities	Focus Areas
1. PHC re-engineering *NSO 5: Improved quality of care* *NSO 6: Re-engineering of PHC* *NSO 7: Universal health coverage*	• Regional/ Sub-District organisational service arrangements. • PHC re-engineering and innovations to improve universal access and equity. • National Core Standards. • National Health Insurance (NHI) - twinning with non-NHI sites.
2. Health promotion and disease prevention	• Curriculum reform - engagement with academic institutions. • Community-based substance abuse rehabilitation. • Health screening and testing services.

Priorities	Focus Areas
	• Prevention of blindness - early screening, refraction and cataract surgery.
	• Programmes targeting overweight and obesity.
	• Adult, child and adolescent mental health and substance abuse.
3. Social determinants of health	• Integrated ward-based services (Provincial Growth and Development Plan as vehicle).
	• Municipal Health Services including access to water, sanitation, and control of wasted and hazardous substances, Food Control & Safety and Vector Control.
	• Technical support and M&E for Municipal Health Services.

3.3 DISTRICT HEALTH SERVICE FIXED FACILITIES (DHIS)

Table 21: (DHS1) District Health Service – 2013/14 (DHIS)

Health District	Facility Type	Number of facilities	Total PHC headcount 2012/13	Per Capita Utilisation	District Population (*DHIS 2013*)
Ugu	Mobiles	17	2 278 312	3	733 228
	Fixed Clinics (including LG/satellite)	56			
	CHCs (including LG)	2			
	Total Fixed Clinics	*58*			
	District Hospitals	3			
Umgungundlovu	Mobiles	20	2 932 133	2.7	1 052 730
	Fixed Clinics (including LG/satellite)	63			
	CHCs (including LG)	3			
	Total Fixed Clinics	66			
	District Hospitals	2			
Uthukela	Mobiles	21	1 646 398	2.3	682 798
	Fixed Clinics (including LG/satellite)	44			
	CHCs (including LG)	1			
	Total Fixed Clinics	*45*			
	District Hospitals	2			
Umzinyathi	Mobiles	11	1 451 706	2.8	514 217
	Fixed Clinics (including LG/satellite)	55			
	CHCs (including LG)	0			
	Total Fixed Clinics	*55*			
	District Hospitals	4			

Health District	Facility Type	Number of facilities	Total PHC headcount 2012/13	Per Capita Utilisation	District Population (*DHIS 2013*)
Amajuba	Mobiles	10	1 243 103	2.4	507 468
	Fixed Clinics (including LG/satellite)	25			
	CHCs (including LG)	0			
	Total Fixed Clinics	*25*			
	District Hospitals	1			
Zululand	Mobiles	21	2 026 512	2.3	824 091
	Fixed Clinics (including LG/satellite)	72			
	CHCs (including LG)	1			
	Total Fixed Clinics	*73*			
	District Hospitals	5			
Umkhanyakude	Mobiles	16	2 194 114	3.3	638 011
	Fixed Clinics (including LG/satellite)	58			
	CHCs (including LG)	0			
	Total Fixed Clinics	*58*			
	District Hospitals	5			
Uthungulu	Mobiles	23	2 876 822	2.9	937 793
	Fixed Clinics (including LG/satellite)	63			
	CHCs (including LG)	1			
	Total Fixed Clinics	*64*			
	District Hospitals	6			
Ilembe	Mobiles	15	1 990 434	3.1	630 464
	Fixed Clinics (including LG/satellite)	38			
	CHCs (including LG)	2			
	Total Fixed Clinics	*40*			
	District Hospitals	3			
Harry Gwala	Mobiles	13	1 268 640	2.5	471 904
	Fixed Clinics (including LG/satellite)	37			
	CHCs (including LG)	1			
	Total Fixed Clinics	*38*			
	District Hospitals	4			
eThekwini	Mobiles	66	11 202 353	3.2	3 464 205
	Fixed Clinics (including LG/satellite)	133			
	CHCs (including LG)	8			
	Total Fixed Clinics	*141*			
	District Hospitals	3			
Province	Mobiles	233	31 110 527	2.9	10 456 909
	Fixed Clinics (including LG/satellite)	644			
	CHCs (including LG)	19			
	Total Fixed Clinics	*663*			
	District Hospitals	38			

Source: Number of fixed facilities: DHIS (excludes NGO's); Headcount/ PHC utilisation: 2012/13 Annual Report; Population: DHIS 2013 data (based on Stats SA 2013 estimates).

3.4 CUSTOMISED SITUATION ANALYSIS INDICATORS

Table 22: (DHS2) Customised Situation Analysis Indicators – PHC 2012/13

Indicators	Type	Provincial 2012/13	Ugu 2012/13	Umgungundlovu 2012/13	Uthukela 2012/13	Umzinyathi 2012/13	Amajuba 2012/13	Zululand 2012/13	Umkhanyakude 2012/13	Uthungulu 2012/13	Ilembe 2012/13	Harry Gwala 2012/13	eThekwini 2012/13
1. Provincial PHC expenditure per uninsured person	R	R 689*	R 888	R 777	R 685	R 788	R 682	R 758	R 876	R 700	R 820	R 780	R 592
Total expenditure on PHC services	*R'000*	*6 567 175*	*576 590*	*703 877*	*406 821*	*344 982*	*298 141*	*551 851*	*493 502*	*579 733*	*438 040*	*337 540*	*1 738 167*
Number of uninsured people in the Province (Stats SA)	*No*	*9 526 488*	*648 961*	*905 501*	*593 733*	*437 547*	*437 102*	*728 483*	*563 212*	*827 688*	*534 425*	*432 603*	*2 935 555*
2. PHC utilisation rate (annualised)	%	2.9	3	2.7	2.3	2.8	2.4	2.3	3.3	2.9	3.1	2.5	3.2
PHC headcount total	*No*	*31 110 527*	*2 278 312*	*2 932 133*	*1 646 398*	*1 451 706*	*1 243 103*	*2 026 512*	*2 194 114*	*2 876 822*	*1 990 434*	*1 268 640*	*11 202 353*
Population Total	*No*	*10 703 920*	*767 999*	*1 071 600*	*702 645*	*517 807*	*517 284*	*862 112*	*666 521*	*979 513*	*632 453*	*511 957*	*3 474 029*
3. Outreach Households (OHH) registration visit coverage	%	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported
4. PHC supervisor visit rate (fixed clinic/ CHC/ CDC)	%	65.1%	66.8%	39.7%	52.6%	65.4%	54.5%	73.5%	92.4%	69.1%	71.8%	73.4%	58.5%
PHC supervisor visit (fixed clinic/ CHC/ CDC)	*No*	*4 789*	*457*	*276*	*246*	*369*	*170*	*582*	*621*	*539*	*310*	*370*	*849*

Indicators	Type	Provincial 2012/13	Ugu 2012/13	Umgungundlovu 2012/13	Uthukela 2012/13	Umzinyathi 2012/13	Amajuba 2012/13	Zululand 2012/13	Umkhanyakude 2012/13	Uthungulu 2012/13	Ilembe 2012/13	Harry Gwala 2012/13	eThekwini 2012/13
Fixed clinics plus fixed CHCs/CDCs	*No*	*613*	*57*	*58*	*39*	*47*	*26*	*66*	*56*	*65*	*36*	*42*	*121*
5. Complaint resolution within 25 working days rate	%	75.1%	67%	76.4%	46.1%	66.9%	84.7%	62.8%	67.3%	67.5%	67.2%	75.1%	89.7%
Complaint resolved within 25 working days	*No.*	*3 344*	*252*	*556*	*41*	*111*	*228*	*216*	*332*	*313*	*137*	*136*	*1 022*
Complaint resolved	*No.*	*4 456*	*376*	*728*	*89*	*166*	*270*	*344*	*493*	*464*	*204*	*181*	*1 141*
6. Percentage of PHC facilities conducting patient satisfaction surveys (PSS)	%	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported
7. PHC patient satisfaction rate	%	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported
8. Number of fully fledged District Clinical Specialist Teams appointed	No	0	0	0	0	0	0	0	0	0	0	0	0
9. Number of fully fledged Ward Based Outreach Teams appointed (cumulative)	No	45	0	4	0	8	10	5	0	0	0	6 (Externally funded)	12
10. School ISHP coverage (annualised)	%	60%	Not confirmed	Not confirmed	Not confirmed	Not confirmed	Not confirmed	Not confirmed	Not confirmed	Not confirmed	Not confirmed	Not confirmed	Not confirmed
Schools with any learner screened	*No*	*2 671*	*-*	*-*	*-*	*-*	*-*	*-*	*-*	*-*	*-*	*-*	*-*

Indicators	Type	Provincial 2012/13	Ugu 2012/13	Umgungundlovu 2012/13	Uthukela 2012/13	Umzinyathi 2012/13	Amajuba 2012/13	Zululand 2012/13	Umkhanyakude 2012/13	Uthungulu 2012/13	Ilembe 2012/13	Harry Gwala 2012/13	eThekwini 2012/13
Schools total	*No*	*4 425*	-	-	-	-	-	-	-	-	-	-	-
11. School Grade 1 screening coverage (annualised)	%	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported
12. School Grade 4 screening coverage (annualised)	%	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported
13. School Grade 8 screening coverage (annualised)	%	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported
14. Percentage of fixed facilities that have conducted gap assessments for compliance against the national core standards	%	82.6%	94.8%	42.8%	97.3%	93.3%	100%	46%	57%	77.4%	97.1%	100%	100%
Fixed facilities self-assessed	*No*	*481*	*55*	*24*	*36*	*42*	*24*	*29*	*42*	*48*	*34*	*37*	*109*
Fixed facilities total	*No*	*582*	*58*	*56*	*37*	*45*	*24*	*63*	*56*	*62*	*35*	*37*	*109*
15. Compliance rate of PHC facilities (of National Core Standards)	%	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported

- Source: 2012/13 Annual Report (Indicator 14: 2013/14 APP and Indicator 10: DHP's 2014/15).
- *Indicator 5*: In 2012/13 the department monitored Complaints resolved (not within 25 days).

- *Indicator* 9: This data is based on a snap district survey and not on the number of teams reporting community-based data on DHIS (as required in national definition) – the DHIS module was activated in 2013/14.

3.5 CUSTOMISED PERFORMANCE INDICATORS AND TARGETS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 6: Re-engineering of PHC*
- *Sub-Output 7: Universal health coverage*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 5: Improved quality of care*

Table 23: (DHS4) Customised Performance Indicators - PHC

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Increase the Provincial PHC expenditure per uninsured person to R 907 by March 2015	1. Provincial PHC expenditure per uninsured person	BAS/Stats SA	Annual R	R 526*	R 641*	R 689*	R 857	R 907	R 1 011	R 1 083
	Total expenditure on PHC services	*BAS*	*R'000*	*4 845 428*	*5 704 222*	*6 567 175*	*7 762 701*	*8 616 019*	*9 668 107*	*10 426 309*
	Uninsured population in KZN	*DHIS/Stats SA*	*No*	*9 195 384*	*8 895 443*	*9 526 488*	*9 056 593*	*9 489 132*	*9 555 556*	*9 622 444*
Increase PHC efficiencies and increase the number of visits per person to PHC services from 2.9 to 3 by March 2015	2. PHC utilisation rate (annualised)	DHIS	Quarterly No per person	2.5	2.7	2.9	3	3	3.1	3.1
	PHC headcount total	*DHIS/PHC tick register*	*No*	*26 494 623*	*29 314 618*	*31 110 527*	*32 411 248*	*33 221 529*	*34 052 067*	*34 903 369*
	Population total (KZN)	*DHIS/Stats SA*	*Population*	*10 449 300*	*10 622 204*	*10 703 920*	*10 781 659*	*10 571 312*	*10 688 165*	*10 806 538*

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Scale up implementation of PHC re-engineering including coverage at household level	3. Outreach Households (OHH) registration visit coverage	DHIS	Quarterly %	Not reported	Not reported	Not reported	DHIS module not fully activated	Establish baseline	Dependent on baseline	-
	OHH registration visit	*DHIS/Tick register WBOT*	*No*	-	-	-	-	-	-	-
	OHH in population	*District Records*	*No*	-	-	-	-	-	-	-
Improve the supervision visit rate to more than 75% by March 2017	4. PHC supervisor visit rate (fixed clinic/ CHC/ CDC)	DHIS	Quarterly %	63.3%	62.2%	65.1%	63.8%	66.4%	68%	75%
	PHC supervisor visit (fixed clinic/CHC/CDC)	*Supervisor checklists*	*No*	*4 440*	*4 578*	*4 784*	*2 446*	*5 148*	*5 328*	*5 532*
	Fixed clinics plus fixed CHCs/CDCs	*DHIS calculates*	*No*	*585*	*613*	*613*	*644*[1]	*650*	*654*	*659*
Improve the complaint resolution within 25 working days rate to 80% by March 2017	5. Complaint resolution within 25 working days rate	DHIS	Quarterly %	Not reported	Not reported	Not reported	Not reported	70%	75%	80%
	Complaints resolved within 25 working days	*Complaint register*	*No*	-	-	-	-	-	-	-
	Total number complaints resolved	*Complaint register*	*No*	-	-	-	-	-	-	-
100% of PHC facilities conducting patient satisfaction surveys by March 2015	6. Percentage of fixed PHC facilities conducting patient satisfaction surveys (PSS)	DHIS	Annual %	Not reported	Not reported	Not reported	Not available	100%	100%	100%
	Number PHC facilities conducting annual PSS	*Survey reports*	*No*	-	-	-	-	650	654	659
	Number PHC facilities total	*DHIS calculates*	*No*	-	-	-	-	*650*	*654*	*659*

[1] Includes Provincial, LG, Satellite and Specialised clinics

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Improve the patient satisfaction rate to 80% by March 2017	7. Patient satisfaction rate	DHIS calculates	Annual %	Not reported	Not reported	Not reported	Not reported	70%	75%	80%
	Patients satisfied with health service	*Survey reports*	*No*	-	-	-	-	-	-	-
	Patients participating in PSS	*Survey reports*	*No*	-	-	-	-	-	-	-
Increase District Clinical Specialist Teams to 11 Teams with all Nursing posts filled and 4 (of 11 Teams) with all Nursing and Specialist posts filled by March 2015	8. Number of fully fledged District Clinical Specialist Teams appointed	District Management/ Appointment letters	Quarterly No	Not reported	Not reported	0 complete teams	0 complete (9 incomplete)	11 Teams with all Nursing posts filled	11 Teams with all Nursing posts filled	11 Teams with all Nursing posts filled
								2 of 11 Teams with all Nursing and Medical Specialist posts filled	3 of 11 Teams with all Nursing and Medical Specialist posts filled	4 of 11 Teams with all Nursing and Medical Specialist posts filled
Increase the number of Ward-Based Outreach Teams to 115 by March 2017	9. Number of fully fledged Ward Based Outreach Teams appointed (cumulative)	District Management /Appointment letters	Quarterly No	Not reported	12 (includes both fully and partially staffed)	45 (includes both fully and partially staffed)	33 fully staffed (51 partially staffed: total 84 teams)[2]	57 cum (fully staffed) (24)	82 cum (fully staffed) (25)	107 cum (fully staffed) (25)
Increase the school health coverage to at least 80% by March 2017	10. School ISHP coverage (annualised)	DHIS	Quarterly %	50.3%	55%	60%	46%	70%	75%	80%
	School with any learner screened	*DHIS/Tick register SHS*	*No*	-	*2 268*	*2 671*	*3 006*	*4 577*	*4 904*	*5 231*
	Schools total	*DHIS/DOE database*	*No*	-	*4 124*	*4 425*	*6 536*	*6 539*[3]	*6 539*	*6 539*
	11. School Grade 1 screening coverage (annualised)	DHIS	Quarterly %	Not reported	Not reported	Not reported	Not reported	Establish Baseline	Determined by baseline	-
	School Grade 1 learners screened	*DHIS/Tick register SHS*	*No*	-	-	-	-	-	-	-

[2] 33 Teams submitted reports through DHIS (required as per National DOH definition of "fully fledged" Ward Based Team)
[3] Projected data for 2014/15 and outer-years could not be sourced from the Department of Education. The 2013/14 number of schools used to set targets for the 3 years. Data will be adjusted once information is sourced

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	School Grade 1 learners total	*DHIS/DOE database*	*No*	-	-	-	-	-	-	-
	12. School Grade 4 screening coverage (annualised)	DHIS	Quarterly %	Not reported	Not reported	Not reported	Not reported	Establish Baseline	Determined by baseline	-
	School Grade 4 learners screened	*DHIS/Tick register SHS*	*No*	-	-	-	-	-	-	-
	School Grade 4 learners total	*DOE database*	*No*	-	-	-	-	-	-	-
	13. School Grade 8 screening coverage (annualised)	DHIS	Quarterly %	Not reported	Not reported	Not reported	Not reported	Establish baseline	Determined by baseline	-
	School Grade 8 learners screened	*DHIS/Tick register SHS*	*No*	-	-	-	-	-	-	-
	School Grade 8 learners total	*DOE database*	*No*	-	-	-	-	-	-	-
100% of facilities conditionally compliant (50% - 75%) to the National Core Standards by 2019	14. Percentage of fixed PHC facilities that have conducted gap assessments for compliance against the national core standards	QA Assessment records	Quarterly %	Not reported	81.9%	82.6%	Not available	90%	100%	100%
	Fixed PHC facilities self-assessed	*QA register*	*No*	-	*481*	*481*	-	*585*	*654*	*659*
	Fixed PHC facilities total	*DHIS calculates*	*No*	-	*587*	*582*	*644*	*650*	*654*	*659*
	15. Compliance rate of PHC facilities (National Core Standards)	QA assessment records	Quarterly %	Not reported	Not reported	Not reported	Not available	25%	35%	50%
	PHC facilities compliant to National Core Standards	*QA assessment records*	*No*	-	-	-	-	*162*	*228*	*329*
	PHC facilities total	*DHIS calculates*	*No*	-	-	-	-	*650*	*654*	*659*

- *Indicator 1 [Expenditure]:* Historic expenditure adjusted from previous Annual Reports using BAS expenditure for Sub-Programmes 2.2 to 2.7. Projections based on the projected population and budget allocation for MTEF.
- *Indicator 3 [Outreach households' coverage]:* The DHIS module is not yet fully functional. Data in the system is therefore too incomplete for reporting.
- *Indicator 5 [Complaints resolved with 25 days rate]*: Previously monitored Complaints Resolved.
- *Indicator 8 and 9 [District Clinical Specialist and Ward-Based Teams]:* Due to challenges with recruitment and retention of Specialists the Department will implement teams in a phased approach to ensure equity in all districts. Appointment of teams will be determined by the funding envelope.
- *Indicator 9 [Fully fledged Ward Based Teams]:* The target makes provision for fully staffed teams only, and not the partially staffed teams. For coverage, partially staffed teams should be considered if they are able to fulfil their mandate. Appointment of teams will form part of the total human resource provisions made at district level and will be dependent on the funding envelope.
- *Indicator 10-13 [School Health Services]:* The number of schools will be reviewed annually to align with the Education database for the number of schools.
- *Indicators 11, 12 &13 [School screening coverage]:* Due to the lack of baseline information the department will establish baselines in 2014/15 to inform outer year targets.

3.6 PROVINCIAL STRATEGIC OBJECTIVES AND TARGETS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 3: Improved financial management*
- *National Sub-Output 5: Improved quality of care*
- *National Sub-Output 6: Re-engineering of PHC*

Table 24: (DHS3-A) Provincial Strategic Objectives and Targets - PHC

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17
Increase the PHC utilisation under 5 years to 5.2 visits per child by	1. PHC utilisation rate under 5 years (annualised)	DHIS	Quarterly No per person	4.5	4.6	4.7	5	5	5.1	5.2

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17
March 2017	*PHC headcount under 5*	*DHIS/PHC tick register*	*No*	*5 065 881*	*5 161 689*	*5 173 787*	*5 446 408*	5 582 568	5 772 132	5 865 185
	Population under 5 years (KZN)	*DHIS/Stats SA*	*No*	*1 125 751*	*1 118 510*	*1 104 893*	*1 093 704*	*1 164 688*	*1 154 059*	*1 142 878*
Increase the PHC expenditure per client to R299 by March 2017	2. Expenditure per PHC headcount	DHIS/BAS	Quarterly R	R 182*	R 194*	R 221	R 239	R 259	R 284	R 299
	Total expenditure PHC	BAS	R'000	*4 845 428*	*5 704 222*	*6 567 175*	*7 762 701*	*8 616 019*	*9 668 107*	*10 426 309*
	PHC headcount total	DHIS calculates	No	*26 494 623*	*29 314 618*	*31 110 527*	*32 411 248*	*33 221 529*	*34 052 067*	*34 903 369*
Increase School Health Teams to 250 by 2019	3. Number of School Health Teams (cumulative)	District Records/ Persal	Quarterly No (cum)	Not reported	86 cum	147 cum (61)	148 cum (1)	159 cum (11)	171 cum (12)	183 cum (12)
	4. Number of accredited Health Promoting Schools (cumulative)	Health Promotion database	Quarterly No (cum)	188	210 cum (22)	247 cum (37)	272 cum (25)	295 cum (23)	319 cum (24)	343 cum (24)
Improve efficiencies in dental health by reducing the dental extraction to restoration ratio to less than 18:1 by March 2017	5. Dental extraction to restoration ratio	DHIS	Quarterly Ratio	27:1	20:1	16:1	37:1*	20:1	19:1	18:1
	Tooth extraction	*DHIS/Tick register*	*No*	*500 299*	*449 901*	*474 838*	*114 698**	-	-	-
	Tooth restoration	*DHIS/Tick register*	*No*	*17 957*	*20 996*	*29 161*	*3 139**	-	-	-

- *Indicator 2 [Expenditure PHC headcount]*: Historic data adjusted to include expenditure in Sub-Programmes 2.2 – 2.7.
- *Indicator 5 [Dental extraction versus restoration]*: 2013/14 Mid-year data is inconsistent and being verified for correction.

3.7 TARGETS FOR 2014/15

Table 25: (DHS5) 2014/15 Targets - PHC

Performance Indicators	Targets 2014/15	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. PHC utilisation rate (annualised)	3	3	3	3	3
2. Outreach Households (OHH) registration visit coverage	Establish baseline	-	-	-	Baseline established
3. PHC supervisor visit rate (fixed clinic / CHC / CDC)	66.4%	64%	65%	66%	66.4%
4. Complaints resolution within 25 working days rate	70%	61%	65%	68%	70%
5. Number of fully fledged District Clinical Specialist Teams appointed	4	1	1	1	1
6. Number of fully fledged Ward Based Outreach Teams appointed (cumulative)	57 cum - fully staffed (24)	39 cum - fully staffed (6)	45 cum - fully staffed (6)	51 cum - fully staffed (6)	57 cum - fully staffed (6)
7. School ISHP coverage (annualised)	70%	65%	68%	69%	70%
8. School Grade 1 screening coverage (annualised)	Establish baseline	-	-	-	Baseline established
9. School Grade 4 screening coverage (annualised)	Establish baseline	-	-	-	Baseline established
10. School Grade 8 screening coverage (annualised)	Establish baseline	-	-	-	Baseline established
11. Percentage of fixed PHC facilities that have conducted gap assessments for compliance against the national core standards	90%	85%	87%	89%	90%
12. Compliance rate of PHC Facilities (National Core Standards)	25%	0%	15%	20%	25%
13. PHC utilisation rate under 5 (annualised)	5	5	5	5	5
14. Expenditure per PHC headcount	R 259	R 249	R 250	R 253	R 259
15. Number of School Health Teams (cum)	159 cum (11)	151 cum (3)	154 cum (3)	157 cum (3)	159 cum (2)
16. Number of accredited Health Promoting Schools (cumulative)	23 (295)	6 (278)	6 (284)	6 (290)	5 (295)
17. Dental extraction to restoration ratio	20:1	25:1	24:1	23:1	20:1
Annual Targets					
18. Provincial PHC expenditure per uninsured person	R 907				R 907
19. Percentage of fixed facilities conducting patient satisfaction surveys (PSS)	100%				100%
20. PHC patient satisfaction rate	70%				70%

HIV, AIDS, STI & TB CONTROL (HAST)

3.8 OVERVIEW

HIV AND AIDS

Male Medical Circumcision (MMC)

Two additional MMC satellite centres will be established at Ngwelezane and Clairwood Hospitals. Current sites performing more than 15 MMC's per day will be used as high volume sites to fast track rapid MMC expansion.

The revised MMC marketing plan will change emphasis in 2014/15 to improve reach to men living in family units (hostels) and working in industry i.e. Toyota.

The Department will engage with private practitioners and religious and ethnic structures to ensure more comprehensive reporting on the total number of circumcisions performed.

Sexually Transmitted Infections (STIs)

It is unlikely that the KZNPSP (KwaZulu-Natal Provincial Strategic Plan) target for STI treated new episode incidence (0.5%) will be achieved by 2016. The partner treatment rate is poor with only 17.9% of partners treated in 2012/13. This has been identified as one of the key focus areas (High Transmission Areas) in 2014/15.

Condom Distribution

Distribution points have been rolled out to taxi ranks, tribal authorities, municipal offices, beaches, market areas, universities and correctional services with community-based distribution through MMC Coordinators and CCGs as part of the Condom Escalation Plan. In order to comply with the National Department of Health's strategy to distribute 1 billion condoms within 3 years, the KZN target increased to distribution of 212 million condoms in 2014/15.

Ante Retroviral Treatment (ART)

Decentralised initiation of ART requires urgent up-skilling of staff including complimenting the inadequate skills mix in ART Roving Teams. Inadequate infrastructure (consultation rooms and storage space for medicines) remains a serious challenge with no immediate solution at facility level as a result of the dwindling infrastructure budget.

The challenge of patients lost to follow-up has increased in direct proportion to the increase in the ART programme and the amendments of the CD4 count in the National Policy. Integration with PHC makes provision for CCG's (Community Care Givers) to follow up on ART patients which will improve compliance rates.

The Pre-ART programme will introduce a follow-up strategy as part of the Tier.net project aiming at tracking patients six monthly prior to admittance on the ART programme. This strategy will replace the current ineffective registers.

The Conditional Grant allocation remains insufficient (compared to demand) and the Equitable Share allocation is not sustainable with the declining baseline budget year on year. The challenge of re-prioritisation of budget allocation with regards to *COE* versus *Goods and services* to accommodate increased demand for antiretroviral medication remains a serious challenge.

The NHLS service has been improved by increasing the number of laboratories for CD4 count and viral load at strategic points. Improved turn-around times for results through provision of courier services for specimens, SMS printers for printing of results and specimen tracking system improved management.

TB/HIV Integration

Rollout of the Isoniazid Preventive Therapy (IPT) Policy (2010) is slower than expected with a total

of 464 699 HIV positive patients initiated on IPT. The programme will be scaled up in 2014/15.

Home and Community-Based Care

Referral, follow-up and support at household level has been strengthened with the number of home visits per annum increasing from 760 161 (2009/10) to 3 551 790 (2012/13). Impact of household support will be monitored as part of the comprehensive strategy.

Information Management

From a total of 608 ART initiating sites, 463 sites are currently implementing the Tier.net system, and 97 sites have completed back capturing and are able to do live capturing (cohort reporting).

Amidst significant achievements in the HIV and AIDS programme, the following remain challenges that have been targeted for intervention in the MTEF:

Infrastructure challenges: Inadequate consulting rooms to accommodate demand for HCT and ART. *Strategies to mitigate*: (1) Decentralised ART services through introduction of Long Life Care and Wellness Clubs; and (2) Integration with Ward-Based Teams to provide ART services at household level.

ART patients lost to follow-up: Strategies to mitigate: (1) Matter escalated to the Provincial Council on AIDS and established the Provincial Multi-Sectoral Task Team to engage the media; bogus traditional and spiritual leaders/ operations which purports to cure HIV and AIDS have been closed down due to interventions of the task team and leadership at local level (Mayors and Counsellors); and (2) New Electronic Patient Management System (TIER.net) reduce lost to follow-up patients as the web-based system makes it possible to monitor movements of patients on HAART.

Inadequate condom distribution and reporting: Condom distribution rate below target, and data dis-aggregated in the DHIS not representative of all condom distribution points. *Strategies to mitigate*: (1) Implementation of a new Condom Distribution Strategy; (2) TIER.net captures all condom distribution sites information.

Increase in STIs: There is still a high volume of new STI infections within the province, with poor partner follow-up and treatment. *Strategies to mitigate:* Target high risk groups including High Transmission Areas.

TUBERCULOSIS (TB)

TB services are available in all public health facilities. Laboratory coverage for microscopy is good (80 microscopy centres), although culture services are still centralised in one laboratory at Inkosi Albert Luthuli Central Hospital (IALCH). This impact on result turn-around times which delays diagnosis and appropriate management.

There are 8 DR-TB (Drug-Resistant Tuberculosis) management units in KZN (7 decentralised and 1 centralised) with no decentralised units in Ilembe, Amajuba and Uthukela Districts. Patients from these three districts are initiated on treatment at King Dinuzulu Hospital.

The extended waiting list at King Dinuzulu Hospital (managing all provincial TB drug resistant children, XDR-TB patients and referral from districts with inadequate resources which accounts for 30% - 40% of overall workload) is a concern and confirms the urgency to develop more decentralised units to reduce waiting times and workload in King Dinuzulu and improve access for improved outcomes.

Once the OPD structure in King Dinuzulu has been commissioned the TB ward will be commissioned thus increasing the number of beds for TB in eThekwini from 377 to 590.

To further reduce the workload at King Dinuzulu, infrastructure upgrades at Madadeni, Estcourt and Montebello Hospitals have been prioritised for the 2014/15 – 2016/17 MTEF.

In 2014/15, four decentralised XDR-TB initiation sites will be established at Murchison, Greytown M3, Thulasizwe and Manguzi Hospitals. This would have an immediate impact on the workload at King Dinuzulu.

The decongestion of follow-up patients has been alleviated in Zululand by Thulasizwe patients being decanted to Itshelejuba and Benedictine Hospitals for follow-up treatment and consultation and nurse initiated treatment at Vryheid hospital. Murchison Hospital and Turton CHC also provide nurse initiated treatment to improve treatment outcomes in Ugu.

A total of 122 TB/ DR-TB and HIV outreach teams have been established to strengthen the MDR-TB community-based programme. Budget for a further 32 cars and 59 PN's has been requested to supplement existing resources during the MTEF.

The PHC approach used in Umgungundlovu and eThekwini (PHC structures attached to the District Office) is not effective for community-based outreach due to the long delays in communication and will be reviewed.

Wellness programmes for staff working in high-risk areas will be prioritised in the MTEF.

Rationalisation of TB Hospitals (including ex-SANTA hospitals) will be reviewed and actioned in the coming MTEF to improve efficiencies. This will form part of the long-term plan for TB services in KZN.

Table 26: MDR Injection Teams vs. MDR cases

District	No of TB Teams (2012/2013)	No. of MDR Cases (2012/13)
EThekwini	19	1 322
UGu	2	196
UMgungundlovu	33	253
UThukela	2.5	0
UMzinyathi	26	63
Amajuba	11	0
Zululand	9	311
UMkhanyakude	7	180
UThungulu	18	211
ILembe	3	0
Harry Gwala	1	68
Provincial	**131.5**	**2 604**

GeneXpert Rollout

To date, 38 machines have been installed in the Province including eThekwini (13), Harry Gwala (7 small machines), Umgungundlovu (4 medium machines), Ilembe (3) and Amajuba (3). UThukela does not have access while the rest of the districts (Umzinyathi (2) Uthungulu (2), Umkhanyakude (2) Zululand (2) have limited access. Ugu district does not have machines but has full access to the test through machines at eThekwini.

3.9 HAST PRIORITIES AND FOCUS AREAS

- National/Provincial Strategic Plans for HIV, AIDS, STI and TB 2012-2016.
- Provincial 5-year Strategy for TB Control (draft).
- MMC Escalation Plan.

Priorities	Focus Areas
1. Prevention and management of TB/HIV and STI *NSO 1: Prevent and reduce the burden of disease and promote health*	• MMC; condom distribution; anti-sugar daddy campaign; post exposure prophylaxis (PEP) for especially children; STI prevention, and high intensity programmes for key populations. • IPT; IPC for TB; Integration; Initiation of HAART. • Directly Observed Treatment (DOT) strategy. • Integration of TB/ HIV/ MCWH/ Oral health and EMS. • Health Screening and Testing. • ART (including follow-up).
2. Information Management *NSO 4: Efficient health management information system for improved decision making*	• Improve data quality through M&E. • Use of data for planning (evidence-based).

3.10 CUSTOMISED SITUATION ANALYSIS INDICATORS

Table 27: (HIV1) Customised Situation Analysis Indicators – HAST 2012/13

Indicator	Type	Provincial 2012/13	Ugu 2012/13	Umgungundlovu 2012/13	Uthukela 2012/13	Umzinyathi 2012/13	Amajuba 2012/13	Zululand 2012/13	Umkhanyakude 2012/13	Uthungulu 2012/13	Ilembe 2012/13	Harry Gwala 2012/13	eThekwini 2012/13
1. Total clients remaining on ART (TROA) at end of the month	No	726 338	48 892	85 489	40 729	37 071	33 346	54 454	53 373	77 449	42 442	32 201	220 892
2. Number of male medical circumcisions conducted	No	12 228	6 091	13 562	8 760	8 843	10 384	6 854	6 275	12 921	6 460	6 268	35 080
3. TB (new pulmonary) defaulter rate	%	5.4%	4.6%	5.4%	3.8%	1.9%	5.2%	5.3%	2.9%	1.9%	3.3%	6.8%	7.5%
All smear+ TB cases defaulted	*No*	*1 809*	*137*	*143*	*47*	*24*	*72*	*111*	*69*	*60*	*67*	*76*	*1 003*
New smear+ PTB cases	*No*	*33 731*	*2 998*	*2 659*	*1 222*	*1 295*	*1 376*	*2 093*	*2 391*	*3 145*	*2 022*	*1 125*	*13 405*
4. TB AFB sputum result turn-around time under 48 hours rate	%	70.1%	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
TB AFB sputum result received within 48 hrs	*No*	*487 257*	-	-	-	-	-	-	-	-	-	-	-

Indicator	Type	Provincial 2012/13	Ugu 2012/13	Umgungundlovu 2012/13	Uthukela 2012/13	Umzinyathi 2012/13	Amajuba 2012/13	Zululand 2012/13	Umkhanyakude 2012/13	Uthungulu 2012/13	Ilembe 2012/13	Harry Gwala 2012/13	eThekwini 2012/13
TB AFB sputum samples sent	*No*	*694 643*	-	-	-	-	-	-	-	-	-	-	-
5. TB new client treatment success rate	%	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported
6. HIV testing coverage 15-49 years (annualised)	%	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported
7. TB (new pulmonary) cure rate	%	73.5%	72.8%	80.9%	69.6%	85.8%	66.9%	76.4%	64.4%	84%	83.9%	72.7%	69.3%
TB (new pulmonary) client cured	*No*	*24 799*	*2 183*	*2 151*	*850*	*1 111*	*920*	*1 600*	*1 540*	*2 641*	*1 697*	*818*	*9 288*
TB (new pulmonary) client initiated on treatment	*No*	*33 731*	*2 998*	*2 659*	*1 222*	*1 295*	*1 376*	*2 093*	*2 391*	*3 145*	*2 022*	*1 125*	*13 405*
8. TB MDR confirmed treatment initiation rate	%	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported

- *Indicator 3 [TB (new pulmonary) defaulter rate]*: The definition (data elements) changed between 2012/13 and 2013/14 in NIDS. For purpose of reporting in the table above, the 2012/13 definition has been used.

3.11 CUSTOMISED PERFORMANCE INDICATORS AND TARGETS

PROVINCIAL STRATEGIC GOAL 3: REDUCE MORBIDITY AND MORTALITY DUE TO COMMUNICABLE DISEASES AND NON-COMMUNICABLE CONDITIONS AND ILLNESSES

- *National Sub-Output 1: Prevent and reduce the burden of disease and promote health*

Table 28: (HIV3) Customised Performance Indicators - HAST

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Manage HIV prevalence by increasing the number of patients on ART to1 368 247 (cumulative) by March 2017	1. Total clients remaining on ART (TROA) at end of the month	DHIS calculates/ ART Register	Quarterly No	408 238	547 411	726 338	770 009 cum	1 038 556 cum (268 547)	1 192 247 cum (153 691)	1 368 247 cum (176 000)
Reduce HIV Incidence to less than 1% by 2019	2. Number of male medical circumcisions conducted	MMC Register/DHIS calculates	Quarterly DHIS/ Theatre register	33 817	137 823 cum	258 946 cum	339 997 cum	631 374 cum (291 377)	1 097 577 cum (466 203)	1 738 956 cum (641 379)
Reduce the TB (new pulmonary) defaulter rate to 3.5% by March 2017	3. TB (new pulmonary) defaulter rate	ETR.Net calculates	Quarterly %	7%	6.7%	5.4%	4.9%	4.5%	4%	3.5%
	TB (new pulmonary) treatment defaulter	*TB register*	*No*	-	*2 075*	*1 809*	*1 688*	*1 629*	*1 530*	*1 415*
	TB (new pulmonary) client initiated on treatment	*TB Register*	*No*	-	*30 787*	*33 731*	*34 240*	*36 192*	*38 255*	*40 435*
Improve the sputum turn-around time under 48 hours to 85% by March 2016	4. TB AFB sputum result turn-around time under 48 hours rate	ETR.Net calculates	Quarterly %	71%	81%	70.1%	74%	80%	85%	85%
	TB AFB sputum result received within 48 hours	*TB register*	*No*	-	*778 211*	*487 257*	*581 256*	*733 328*	*909 281*	*1 061 131*
	TB AFB sputum sample sent	*TB Register*	*No*	-	*961 874*	*694 643*	*785 484*	*916 660*	*1 069 742*	*1 248 389*

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Improve TB outcomes by improving the treatment success rate to 85% by March 2015	5. TB new client treatment success rate	ETR.Net calculates	Quarterly %	69%	68.4%	70.1%	81.5%	85%	85%	85%
	TB clients cured OR completed treatment	*TB register*	*No*	*23 184*	*21 983*	*24 500*	*27 912*	*30 956*	*32 257*	*33 611*
	TB (new pulmonary) clients initiated on treatment	*TB Register*	*No*	*33 600*	*32 139*	*34 951*	*34 240*	*36 419*	*37 949*	*39 542*
Increase the HIV testing coverage to 60% by March 2017	6. HIV testing coverage (15-49 years) (annualised)	DHIS calculates	Quarterly %	Not reported	Not reported	Not reported	30.7%	58.2%	59.4%	60%
	HIV test client 15-49 years	*DHIS/Tick register PHC & Counsellor*	*No*	-	-	-	*1 810 056*	*3 302 304*	*3 384 862*	*3 469 831*
	Population 15-49 years	*DHIS/Stats SA*	*Population*	-	-	-	*5 888 343*	*5 669 282*	*5 697 177*	*5 780 841*
Increase the TB cure rate to 85% by March 2015	7. TB (new pulmonary) cure rate	ETR.Net calculates	Quarterly %	68.2%	69.8%	73.5%	79.4%	85%	85%	85%
	TB (new pulmonary) client cured	*TB register*	*No*	*21 960*	*21 478*	*24 799*	*26 250*	*29 962*	*31 310*	*32 719*
	TB (new pulmonary) client initiated on treatment	*TB Register*	*No*	*32 200*	*30 787*	*33 731*	*33 062*	*35 249*	*36 835*	*38 493*
Increase the number of TB MDR patients initiated on treatment to 66% by March 2017	8. TB MDR confirmed treatment initiation rate	EDR calculates	Quarterly %	Not reported	Not reported	Not reported	53% (baseline)	57.8%	60%	66%
	TB MDR confirmed client initiated on treatment	*EDR Register*	*No*	-	-	-	*2 061*	*2 200*	*2 100*	*2 000*
	TB MDR confirmed new client	*EDR Register*	*No*	-	-	-	*3 888*	*3 800*	*3 500*	*3 000*

- *Indicator 3 [TB (new pulmonary) defaulter rate]*: The definition (data elements) changed in the National Data Indicator System (NIDS) between 2012/13 and 2013/14. NIDS definition quoted.

- *Indicator 6 [HIV testing coverage]*: The indicator changed from HCT testing rate (testing vs. counselling) monitored between 2010/11 and 2012/13, to testing coverage (testing vs. population) in 2013/14 and onward – hence previous data not quoted.

3.12 PROVINCIAL STRATEGIC OBJECTIVES AND TARGETS

PROVINCIAL STRATEGIC GOAL 3: REDUCE MORBIDITY AND MORTALITY DUE TO COMMUNICABLE DISEASES AND NON-COMMUNICABLE CONDITIONS AND ILLNESSES

- *National Sub-Output 1: Prevent and reduce the burden of disease and promote health*

Table 29: (HIV2) Provincial Strategic Objectives and Targets - HAST

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Decrease the TB death rate to 3.5% by March 2017	1. TB death rate	ETR.Net	Annual %	6.2%	5.2%	5.4%	4.8%	4.5%	4%	3.5%
	TB client death during treatment	*TB Register*	*No*	-	-	*1 402*	*1 056*	*1 215*	*1 140*	*1 050*
	New smear positive pulmonary cases registered	*TB Register*	*No*	-	-	*25 851*	*21 565*	*27 000*	*28 500*	*30 000*
Increase the number of MDR TB patients that started the regimen iv treatment to 3 550 by March 2017	2. Number of patients that started regimen iv treatment (MDR-TB)	EDR Web	Annual No	Not reported	Not reported	2 667	2 555	3 000	3 500	3 550
Ensure that 80% of diagnosed MDR/XDR-TB	3. MDR-TB six month interim outcome	EDR Web	Annual %	Not reported	Not reported	61%	65%	70%	75%	80%

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
patients are initiated on treatment by March 2017	*Number of clients with a negative culture at 6 months who started treatment for 9 months*	*EDR register*	*No*	-	-	*1 593*	*1 998*	*2 380*	*2 400*	*2 400*
	Total patients who started treatment in the same period	*EDR register*	*No*	-	-	*2 588*	*3 073*	*3 400*	*3 200*	*3 000*
	4. Number of patients that started XDR-TB treatment	EDR Web	Annual No	Not reported	Not reported	265	216	350	400	425
	5. XDR-TB six month interim outcome	EDR Web	Annual %	Not reported	Not reported	35.85%	55%	55%	60%	65%
	Number of clients with a negative culture at six months who has had started treatment for 9 months	*EDR register*	*No*	-	-	*90*	*85*	*110*	*120*	*130*
	Total of patients who started treatment in the same period	*EDR register*	*No*	-	-	*251*	*153*	*200*	*200*	*200*
Reduce the TB incidence to 600 patients per 100,000 population by March 2017	6. TB incidence (per 100 000 population)	ETR.Net	Annual No per 100,000	Not reported	1 149/100 000	1 027/100 000	844 /100 000	800 /100 000	700 /100 000	600 /100 000
	New TB infections	*ETR.Net/ TB Register*	*No*	-	*122 058*	*109 995*	*91 061*	*84 570*	*74 817*	*64 839*
	Total population in KZN	*DHIS/Stats SA*	*Population*	-	*10 622 204*	*10 703 920*	*10 781 659*	*10 571 312*	*10 688 165*	*10 806 538*
Reduce the HIV incidence to less than 1% by 2019	7. HIV incidence	ASSA2008	Annual %	1.01%	1.01%	1.01%	1.01%	1.01%	1.01%	1.01%
Scale up prevention services in all districts	8. STI treated new episode incidence (annualised)	DHIS	Quarterly No per 1000	65/ 1000	68.8/ 1000	64.9/ 1000	62.1/ 1000	20 / 1000	14.9/ 1000	9.9/ 1000

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	STI treated – new episode	*DHIS/Tick register PHC/ casualty*	*No*	*455 627*	*492 215*	*471 781*	*440 486*	*143 001*	*108 947*	*73 795*
	Population 15 years and older	*DHIS/Stats SA*	*Population*	*-*	*7 153 184*	*7 264 197*	*7 088 328*	*7 150 063*	*7 263 166*	*7 379 574*
	9. Male condom distribution coverage (annualised)	DHIS	Quarterly No per male	8.1	9	17.1[4]	16[5]	64	63	62
	Male condoms distributed	*DHIS/Stock cards*	*No*	*27 491 985*	*31 914 706*	*59 771 737*	*56 936 989*[6]	*212 000 000*	*212 000 0000*	*212 000 000*
	Population 15 years and older male	*DHIS/Stats SA*	*Population*	*-*	*3 440 461*	*3 493 699*	*3 544 164*	*3 314 204*	*3 370 510*	*3 428 447*

- *Indicator 1[TB death rate]*: The denominator "TB (new pulmonary) client initiated on treatment" is used in the NIDS calculation, however the Province only includes new smear positive deaths in the numerator, therefore to align the numerator and denominator only "new smear positive cases registered pulmonary" is used as the denominator.
- *Indicator 8 [STI treated new episode incidence]*: Targets very ambitious – aligned with the expected outcomes in the Provincial Strategic Plan for HIV, AIDS, STI and TB.
- *Indicator 9 [Male condom distribution coverage]*: 2013/14 Estimated performance (and targets for MTEF) includes distribution from all distribution sites including NGOs.

[4] The Provincial Treasury Report (15.1) excludes condoms distributed by NGO's and private facilities/organisations hence variation between the two reports
[5] Includes all distribution sites
[6] Includes all distribution sites – In Public Health/LG services = 31 456 469

3.13 TARGETS FOR 2014/15

Table 30: (HIV4) 2014/15 Targets - HAST

Performance Indicators	Targets 2014/15	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Total clients remaining on ART (TROA) at end of the month	1 038 556 cum (268 547)	837 145 cum (67 136)	904 281 cum (67 136)	971 417 cum (67 136)	1 038 556 cum (67 139)
2. Number of male medical circumcisions conducted	291 377	72 844	82 000	70 000	66 533
3. TB (new pulmonary) defaulter rate	4.5%	4.8%	4.7%	4.6%	4.5%
4. TB AFB sputum result turn-around time under 48 hours rate	80%	76%	77%	79%	80%
5. TB new client treatment success rate	85%	83%	84%	85%	85%
6. HIV testing coverage (15 – 49 years) (annualised)	58.2%	37%	43%	50%	58.2%
7. TB (new pulmonary) cure rate	85%	81%	83%	84%	85%
8. TB MDR confirmed treatment initiation rate	57.8%	53.5%	55%	56.5%	57.8%
9. STI treated new episode incidence (annualised)	20/1000	55/1000	40/1000	35/1000	20/1000
10. Male condom distribution rate (annualised)	64	28	40	52	64
Annual Targets					
11. TB death rate	4.5%				4.5%
12. Number of patients that started regimen iv treatment (MDR-TB)	3 000				3 000
13. MDR-TB Six month interim outcome	70%				70%
14. Number of patients that started XDR-TB treatment	350				350
15. XDR-TB Six month interim outcome	55%				55%
16. TB Incidence (per 100 000 population)	800/ 100 000				800/100 00
17. HIV Incidence (annual)	1.01%				1.01%

MATERNAL, NEONATAL, CHILD & WOMEN'S HEALTH (MNCWH) AND NUTRITION

3.14 OVERVIEW

The focus of the Maternal Child and Woman's Health programme will be to sustain the gains made to date. There will be no expansion during the MTEF.

The national flagship programme "Reach 3 Million Young People by 2015" for Family Planning will continue to integrate with the HAST Unit.

There are 26 operational Midwife/ Maternity Obstetric Units (MOU's) in the Province, with 8 (30%) considered economically unviable with less than 120 deliveries per annum (highlighted in orange in Table 31).

Table 31: Deliveries in MOU's (DHIS)

District	Facility	2012/13	2011/12	2010/11
Amajuba	Madadeni 1	42	3	9
	Nellies Farm	84	77	65
	Osizweni 2	282	200	150
eThekwini	Halley Stott	253	218	331
	KwaMakhutha	238	225	224
	KwaNdengezi	156	158	150
	Lindelani	385	368	322
	Ntuzuma	311	196	243
	Umlazi D	91	166	116
	Umlazi U21	187	239	136
iLembe	Isithebe	292	277	273
Harry Gwala	Ixopo	2	0	0
	Underberg	54	51	0
	Elim	44	28	38
	Ntabeni	299	155	181
uMgungun-dlovu	East Boom	302	288	87
	Richmond	273	242	181
Umkhan-yakude	KwaMsane	780	853	871
	Macabuzela	99	92	102
	Mbazwana	65	55	59
Uthukela	Injisuthi	484	507	536
	Ntabamhlope	332	313	236
	Oliviershoek	352	371	311
Uthungulu	Phaphamani	305	357	226
	Thokozani	912	651	441
Zululand	Pongola	192	167	23

Seven (27%) MOU's reported significant increases in deliveries over the last 3 years. Thokozani Clinic (Uthungulu) increased with 106% with the 2 MOU's in uMhlatuze alleviating the burden on LUWMH by 12.7% (1 217/ 9 543).

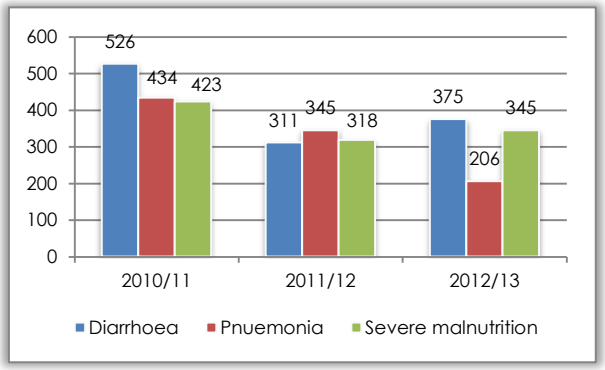
No additional MOUs are planned for 2014/15 which will allow the Programme to consolidate and sustain gains made during 2012/13 and to improve the functionality and quality of care rendered at MOU's.

Antenatal care remains a firm priority and forms part of the CARMMA Strategy. Poor health seeking behaviour of pregnant women limits the long term target of 95% visits before 20 weeks of pregnancy and will be addressed through OSS and the CARMMA strategies.

The focus of the Expanded Programme on Immunisation (EPI) for 2014/15 will be to sustain the achievements of 2013/14 reaching the target for both the national Measles and Polio Campaigns.

The child health focus for 2014/15 will again be to sustain gains made during the previous 3 years with emphasis on the treatment of pneumonia, diarrhoea and the early identification of malnutrition.

Graph 5: Deaths in children under 5 years



Source: DHIS

The number of pneumonia deaths in children under-5 years has decreased in proportion to the increase in Pneumococcal vaccine coverage (97.4% in 2012/13). The gains made in diarrhoea in 2011/12 have not been improved despite high immunisation coverage for Rotavirus (102.1% in 2012/13).

The roll-out of the HPV vaccination for Grade 4 girls will commence in March 2014 through the school health programme and will allow two campaigns within a calendar year. All public schools and special schools will be targeted with a national target of 80% coverage.

Phase 2 of the Nutrition Advisor project will be completed during 2013/14. The placement of Nutrition Advisors at all PHC clinics will contribute to increased case detection of malnutrition and referral if treatment cannot be managed at the PHC level.

The use of Mid Upper Arm Circumference (MUAC) measurement as a screening tool makes detection of malnutrition in the community and at PHC level simple and increases case detection and early referral of Severe Acute Malnutrition (SAM) cases.

The creation of Phila Mntwana centres, run by CCG's, will increase access to and coverage of the Vitamin A supplementation and Growth Monitoring and Promotion (GMP) programmes at community level, thereby promoting early detection and early referral of malnourished children.

The Human Milk Banking Project commenced in 2011/12 with drafting of the Guidelines for the Establishment and Operation of Human Milk Banks in KwaZulu-Natal. KZN currently has 5 operational breastmilk banks, with support provided to Stanger and Newcastle Hospitals in 2013/14 to establish breastmilk banks within their facilities. The model will ensure that the Province has 11 functional central human milk banks by March 2017.

The model proposes the employment of Lactation Advisors at health facilities, dependant on the number of maternity beds. The lactation advisors will support the early initiation and establishment of breastfeeding as well as human breastmilk donors.

"Experience in many developed countries has shown that the centralisation of specialised services such as neonatal and paediatric critical care services is both efficient and effective with respect to both the cost of the service and health outcomes for newborn babies and children. However to be effective such centralised services must be supported by an appropriate system for the transporting of critically ill newborn babies and children. Furthermore when inter-facility transfers of critically ill children are undertaken by specialised Retrieval Teams there is not only a reduction in morbidity and adverse events during the transfer (29.6% incidence without a specialised Retrieval Team compared to 2.8% with a team) but also a lower mortality rate amongst children transported by such a team compared to children who were not transported at all (OR6.68)." *Dr N McKerrow "Proposal for Paediatric Services for KwaZulu-Natal, 12 December 2013".*

The four tiers for the Components of Paediatric Care and Services will be the focus for the MTEF period to improve maternal and child health outcomes.

The roll-out of the SMS Project will be based in Umgungundlovu (NHI Pilot site) and eThekwini with the assistance of partners. This allows specific health related messages and reminders to be sent at specific times during a women's pregnancy and has been proven to improve maternal outcomes.

3.15 PRIORITIES AND FOCUS AREAS

- National MNCWH Strategy 2012-2016 (CARMMA and Contraceptive Strategies included).
- Provincial MNCWH Strategy.
- Provincial Neonatal Strategy.

Priorities	Focus Areas
1. Implementation of CARMMA *NSO 1: Prevent and reduce the burden of disease and promote health*	• "Reach 3 Million Young People by 2015" Flagship Programme – improve access to Family Planning. • Early initiation of antenatal care. • Human Resources for Maternal and Child Health: – Clustering of Hospitals for improved Caesarian Section outcomes; – Piloting revised CCG Scope of Practice for MCWH; – Improve use of al associates within the MCWH context; and – Improve quality of care provided by Advanced Midwives. • Harmonisation of EMS services to identified District Hospitals and MOUs. • Integrated management of ANC patients inclusive of treatment for TB and HIV at point of care. • Improve quality of management of obstetric cases. • HPV vaccination.
2. Increase child survival	• *Community level:* CIMCI; Phila Mntwana. • *PHC Clinic:* Well child services (includes <12 year old children); IMCI case management; Paediatric HAART initiation; Management of diarrhoea, pneumonia and malnutrition. • *Hospital level:* Ten steps on management of severe malnutrition; Emergency neonatal and child care; Strengthening of Neonatal care; Piloting of retrieval teams with EMS and High Care / Intensive Care. • Prevention of HIV transmission post cessation of breast feeding. • Increase TB and initiation of screening of TB in children under-5.

3.16 CUSTOMISED SITUATION ANALYSIS INDICATORS

Table 32: (MCWH1) Customised Situation Analysis Indicators - MNCWH and Nutrition 2012/13

Indicator	Type	Provincial 2012/13	Ugu 2012/13	Umgungundlovu 2012/13	Uthukela 2012/13	Umzinyathi 2012/13	Amajuba 2012/13	Zululand 2012/13	Umkhanyakude 2012/13	Uthungulu 2012/13	Ilembe 2012/13	Harry Gwala 2012/13	eThekwini 2012/13
1. Immunisation coverage under 1 year (annualized)	%	95.1%	98.7%	102.4%	97.8%	100.7%	80.9%	78.8%	104%	107.4%	99.1%	81.9%	94.5%
Immunised fully under 1 year - new	*No*	*202 617*	*13 662*	*16 089*	*14 446*	*12 491*	*7 884*	*16 244*	*14 636*	*20 752*	*11 513*	*10 531*	*64 369*
Population under 1 year	*No*	*213 213*	*13 877*	*15 887*	*14 809*	*12 391*	*9 788*	*20 648*	*14 044*	*19 301*	*11 655*	*12 916*	*67 900*
2. Vitamin A dose 12 – 59 months coverage (annualized)	%	43.7%	44.1%	30.9%	33.7%	43.1%	34.6%	31.4%	33.2%	43.6%	50.4%	43.7%	57.7%
Vitamin A dose 12 - 59 months	*No*	*776 254*	*56 709*	*53 199*	*41 549*	*43 995*	*28 411*	*52 224*	*45 219*	*73 979*	*51 809*	*45 096*	*284 064*
Population 12-59 months	*No*	*891 682*	*64 641*	*86 994*	*61 920*	*51 215*	*41 304*	*83 284*	*68 536*	*85 219*	*51 679*	*51 701*	*245 184*
3. Deworming 12-59 months coverage (annualised)	%	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported
4. Child under 2 years underweight for age incidence (annualised)	No per 1000	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported
5. Measles 1st dose under 1 year coverage (annualized)	%	96.5%	100.1%	101.7%	97.9%	102.2%	83.8%	81.7%	109.1%	107%	104.3%	85.8%	94.8%
Measles 1st dose under 1 year	*No*	*205 691*	*13 844*	*15 983*	*14 464*	*12 673*	*8 169*	*16 833*	*15 351*	*20 673*	*12 118*	*11 052*	*64 531*
Population under 1 year	*No*	*213 213*	*13 877*	*15 887*	*14 809*	*12 391*	*9 788*	*20 648*	*14 044*	*19 301*	*11 655*	*12 916*	*67 900*
6. Pneumococcal Vaccine (PCV) 3rd dose coverage (annualized)	%	97.4%	100.9%	102.7%	98.1%	101.5%	85.1%	81.2%	107.7%	109.2%	103.9%	85.6%	96.9%
PCV 3rd dose	*No*	*207 531*	*13 964*	*16 128*	*14 499*	*12 587*	*8 297*	*16 731*	*15 160*	*21 098*	*12 067*	*11 017*	*65 983*
Population under 1 year	*No*	*213 213*	*13 877*	*15 887*	*14 809*	*12 391*	*9 788*	*20 648*	*14 044*	*19 301*	*11 655*	*12 916*	*67 900*

Indicator	Type	Provincial 2012/13	Ugu 2012/13	Umgungundlovu 2012/13	Uthukela 2012/13	Umzinyathi 2012/13	Amajuba 2012/13	Zululand 2012/13	Umkhanyakude 2012/13	Uthungulu 2012/13	Ilembe 2012/13	Harry Gwala 2012/13	eThekwini 2012/13
7. Rota Virus (RV) 2nd dose coverage (annualised)	%	102.1%	101.4%	105.9%	96.6%	106.3%	93.9%	86.5%	113.6%	110.3%	112.7%	86.3%	104.3%
RV 2nd dose	No	*217 609*	*14 026*	*16 637*	*14 264*	*13 190*	*9 155*	*17 824*	*15 993*	*21 306*	*13 089*	*11 115*	*71 010*
Population under 1 year	No	*213 213*	*13 877*	*15 887*	*14 809*	*12 391*	*9 788*	*20 648*	*14 044*	*19 301*	*11 655*	*12 916*	*67 900*
8. Cervical cancer screening coverage (annualised)	%	81.8%	95.3%	92.9%	65.2%	140.2%	60.7%	79.8%	82.9%	70.6%	69.6%	78.6%	80.4%
Cervical cancer screening in women 30 years and older	No	*172 000*	-	-	-	-	-	-	-	-	-	-	-
Population 30 years and older female/10	No	*1 653 008*	-	-	-	-	-	-	-	-	-	-	-
HPV vaccine coverage amongst Grade 4 girls	%	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported
9. Antenatal 1st visits before 20 weeks rate	%	46.4%	49.1%	46.5%	39.5%	49.8%	41.3%	48.3%	54.2%	46%	45.3%	45.6%	45.3%
ANC 1st visit before 20 weeks	No	*104 507*	*7 267*	*11 206*	*8 473*	*6 587*	*5 679*	*10 027*	*7 751*	*11 518*	*6 875*	*6 191*	*39 040*
Antenatal 1st visit total	No	*225 121*	*14 281*	*20 958*	*14 008*	*13 131*	*9 675*	*19 413*	*16 927*	*21 341*	*12 561*	*11 386*	*71 440*
10. Infant given NVP within 72 hours after birth uptake rate	%	94.6%	100.1%	98.9%	100%	98.3%	99.7%	89%	98.7%	98.2%	101.1%	99.5%	86.7%
Infant given NVP within 72 hours after birth	No	*64 415*	*5 272*	*6 896*	*4 152*	*3 204*	*3 104*	*5 204*	*5 116*	*6 663*	*4 060*	*2 687*	*18 237*
Live birth to HIV positive woman	No	*68 121*	*5 267*	*6 976*	*4 154*	*3 258*	*3 112*	*5 646*	*5 783*	*6 783*	*4 016*	*2 701*	*21 025*
11. Infant 1st PCR test positive around 6 weeks rate	%	2.2%	2.6%	2.5%	2.2%	1.5%	1.5%	2.5%	3.7%	1.7%	2.8%	2.2%	1.8%
Infant 1st PCR test positive around 6 weeks	No	*1 702*	*159*	*188*	*124*	*65*	*50*	*165*	*203*	*110*	*142*	*77*	*419*

Indicator	Type	Provincial 2012/13	Ugu 2012/13	Umgungundlovu 2012/13	Uthukela 2012/13	Umzinyathi 2012/13	Amajuba 2012/13	Zululand 2012/13	Umkhanyakude 2012/13	Uthungulu 2012/13	Ilembe 2012/13	Harry Gwala 2012/13	eThekwini 2012/13
Infant 1st PCR test around 6 weeks	*No*	*78 040*	*6 038*	*7 434*	*5 614*	*4 285*	*3 371*	*6 650*	*6 226*	*6 620*	*5 062*	*3 478*	*23 262*
12. Couple year protection rate (annualized)	%	37.5%	32.3%	57.8%	64.3%	49.9%	65.3%	30.9%	31.5%	31.9%	31.1%	31.7%	27.4%
Contraceptive years dispensed[7]		*1 019 668*	*62 251*	*158 901*	*112 424*	*61 642*	*86 100*	*68 922*	*51 261*	*79 595*	*50 089*	*40 925*	*247 557*
Population 15-49 years female		*2 936 748*	*206 904*	*298 093*	*187 110*	*131 471*	*141 185*	*227 493*	*172 176*	*266 866*	*173 065*	*136 946*	*995 439*
13. Maternal mortality in facility ratio (annualized)	No per 100k	166/100k	171/100k	285/100k	225/100k	38/100k	111/100k	109/100k	91/100k	292/100k	104/100k	101/100k	182/100k
Maternal deaths in facility	*No*	*317*	*21*	*48*	*28*	*4*	*11*	*18*	*14*	*53*	*10*	*8*	*102*
Live births in facility	*No*	*191 587*	*13 468*	*17 181*	*12 618*	*11 519*	*8 830*	*16 130*	*14 480*	*19 890*	*10 470*	*8 648*	*58 353*
14. Delivery in facility under 18 years rate	%	9.3%	10.5%	9.8%	9.1%	9.9%	10.1%	11.1%	11.4%	8.1%	9.4%	10.9%	8%
Delivery in facility women under 18 years	*No*	*17 878*	*1 419*	*1 723*	*1 154*	*1 122*	*870*	*1 758*	*1 628*	*1 578*	*971*	*939*	*4 716*
Delivery in facility total	*No*	*192 659*	*13 469*	*17 504*	*12 656*	*11 552*	*8 770*	*16 245*	*14 433*	*19 653*	*10 486*	*8 678*	*59 213*
15. Child under 1 year mortality in facility rate (annualized)	%	6.1%	7.4%	8.4%	6.9%	7%	4.2%	11%	7.4%	8.6%	10%	11.1%	2.8%
Inpatient deaths under 1 year	*No*	*2 978*	*258*	*319*	*282*	*214*	*109*	*262*	*146*	*486*	*190*	*175*	*537*
Inpatient separations under 1 year	*No*	*46 024*	*3 130*	*3 550*	*3 706*	*2 832*	*2 319*	*2 145*	*1 796*	*5 111*	*1 675*	*1 353*	*18 407*
16. Inpatient death under 5 years rate	%	5.2%	5.3%	7%	6%	5.9%	3.9%	9.8%	5.9%	7.6%	6.4%	7.4%	2.6%
Inpatient deaths under 5 years	*No*	*3 831*	*311*	*459*	*336*	*269*	*128*	*419*	*213*	*585*	*239*	*207*	*665*

[7] This data is from DHIS and not from the closed-off DHIS data file, as this data element was only introduced in 2013/14

Indicator	Type	Provincial 2012/13	Ugu 2012/13	Umgungundlovu 2012/13	Uthukela 2012/13	Umzinyathi 2012/13	Amajuba 2012/13	Zululand 2012/13	Umkhanyakude 2012/13	Uthungulu 2012/13	Ilembe 2012/13	Harry Gwala 2012/13	eThekwini 2012/13
Inpatient separations under 5 years	*No*	*69 661*	*5 411*	*6 254*	*5 206*	*4 208*	*3 050*	*3 865*	*3 371*	*7 230*	*3 460*	*2 484*	*25 122*
17. Child under 5 years severe acute malnutrition case fatality rate	%	10.9%	10.9%	9.0%	13.5%	30.5%	9.7%	19.3%	10.0%	16.0%	8.3%	17.6%	4.1%
Child under 5 years severe acute malnutrition death	*No*	*345*	*32*	*35*	*26*	*58*	*6*	*27*	*21*	*38*	*36*	*32*	*34*
Child under 5 years severe acute malnutrition admitted	*No*	*3 162*	*294*	*387*	*192*	*190*	*62*	*140*	*209*	*238*	*432*	*182*	*836*
18. Child under 5 years diarrhoea case fatality rate	%	4.3%	5.0%	2.9%	4.1%	4.3%	1.0%	4.8%	8.0%	3.0%	5.5%	5.6%	4.2%
Child under 5 years with diarrhoea death	*No*	*375*	*34*	*23*	*44*	*19*	*5*	*43*	*47*	*25*	*37*	*32*	*66*
Child under 5 years with diarrhoea admitted	*No*	*8 669*	*682*	*798*	*1 070*	*440*	*524*	*905*	*590*	*832*	*670*	*568*	*1 590*
19. Child under 5 years pneumonia case fatality rate	%	2.6%	1.8%	3.1%	2.9%	4.1%	1.9%	5.7%	1.9%	5.8%	2.0%	2.6%	1.1%
Child under 5 years pneumonia death	*No*	*206*	*16*	*34*	*16*	*17*	*9*	*29*	*11*	*29*	*11*	*15*	*19*
Child under 5 years pneumonia admitted	*No*	*7 945*	*875*	*1 112*	*547*	*414*	*478*	*513*	*590*	*496*	*537*	*577*	*1 806*

- Source: 2012/13 Annual Report and DHIS.
- *Indicators 16 and 17 [Inpatient deaths]*: Changed expression from % to number per 1000 between 2012/13 and 2013/14.

3.17 CUSTOMISED PERFORMANCE INDICATORS AND TARGETS

PROVINCIAL STRATEGIC GOAL 3: REDUCE MORBIDITY AND MORTALITY DUE TO COMMUNICABLE DISEASES AND NON-COMMUNICABLE CONDITIONS AND ILLNESSES

- *National Sub-Output 1: Prevent and reduce the burden of disease and promote health*

Table 33: (MCWH3) Customised Performance Indicators - MNCWH and Nutrition

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Increase immunisation coverage to more than 90% in all districts by March 2017	1. Immunisation coverage under 1 year (annualised)	DHIS	Quarterly %	86%	97%	95.1%[8]	95.8%	96%	96.3%	96.6%
	Immunised fully under 1 year - new	*DHIS/Tick register PHC*	*No*	*188 456*	*212 468*	*202 617*	*203 528*	*205 563*	*207 619*	*209 695*
	Population under 1 year	*DHIS/Stats SA*	*Population*	*222 948*	*219 033*	*213 213*	*212 497*	*213 984*	*215 481*	*216 989*
Increase Vitamin A supplementation to 65% by March 2017	2. Vitamin A dose 12 – 59 months coverage (annualised)[9]	DHIS	Quarterly %	32.6%	42%	43.7%	51.2%	55%	60%	65%
	Vitamin A dose 12 - 59 months	*DHIS/Tick register PHC*	*No*	*594 749*	*769 685*	*776 254*	*903 838*	*975 891*	*1 072 060*	*1 169 528*
	Population 12-59 months	*DHIS/Stats SA*	*Population*	*-*	*1 804 178*	*1 783 364*	*1 762 014*	*1 774 348*	*1 786 768*	*1 799 275*
Increase the number of children 12-59 months who received the deworming regime with 20% from baseline by March 2017	3. Deworming dose 12-59 months coverage (annualised)	DHIS	Quarterly %	Not reported	Not reported	Not reported	Not reported	Establish baseline	Determined by baseline	-
	Deworming dose 12-59 months	*Tick Register PHC*	*No*	*-*	*-*	*-*	*-*	*-*	*-*	*-*
	Population 12-59 months (multiplied by 2)	*DHIS/ Stats SA*	*Population*	*-*	*-*	*-*	*-*	*-*	*-*	*-*

[8] All actual data with DHIS as source are based on the DHIS calculation to ensure standardisation in reporting
[9] Inclusive of CCG Coverage from 2013/14 onwards

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Reduce the number of underweight for age children with more than 20% of baseline by March 2017	4. Child under 2 years underweight for age incidence (annualised)	DHIS	Quarterly %	Not Reported	Not Reported	Not Reported	Not reported	20/ 1 000	17/ 1 000	15/ 1 000
	Child under 2 years underweight new (weight between – 2SD and -3SD new)	*DHIS/Tick register PHC*	*No*	-	-	-	-	*9 571*	*8 220*	*7 325*
	Population under 2 years	*DHIS/Stats SA*	*Population*	-	-	-	-	*478 573*	*483 502*	*488 337*
Increase immunisation coverage to more than 90% in all districts by March 2017	5. Measles 1st dose under 1 year coverage (annualised)	DHIS	Quarterly %	88%	98.9%	96.5%	93.1%	94.6%	96.4%	98.1%
	Measles 1st dose under 1 year	*DHIS/Tick register PHC*	*No*	*194 943*	*216 704*	*205 691*	*197 810*	*202 755*	*207 824*	*213 020*
	Population under 1 year	*DHIS/Stats SA*	*Population*	*222 948*	*219 033*	*213 213*	*212 497*	*213 984*	*215 481*	*216 989*
	6. Pneumococcal Vaccine (PCV) 3rd dose coverage (annualised)	DHIS	Quarterly %	80%	95.9%	97.4%	95.1%	96.2%	97.5%	98.7%
	PCV 3rd dose	*DHIS/Tick register PHC*	*No*	*176 868*	*210 097*	*207 531*	*202 002*	*206 042*	*210 163*	*214 360*
	Population under 1 year	*DHIS/Stats SA*	*Population*	*222 948*	*219 033*	*213 213*	*212 497*	*213 984*	*215 481*	*216 989*
	7. Rota Virus (RV) 2nd dose coverage (annualised)	DHIS	Quarterly %	81%	103.5%	102.1%	103.7%	104.4%	105.2%	106%
	RV 2nd dose	*DHIS/Tick register PHC*	*No*	*178 690*	*226 776*	*217 609*	*220 238*	*223 421*	*226 772*	*230 174*
	Population under 1 year	*DHIS/Stats SA*	*Population*	*222 948*	*219 033*	*213 213*	*212 497*	*213 984*	*215 481*	*216 989*
Maintain a cervical cancer screening coverage of more than 80% from March 2015	8 Cervical cancer screening coverage (annualised)	DHIS	Quarterly %	57.4%	76.1%	81.8%	79.2%	79.7%	80.4%	81%
	Cervical cancer screening in women 30 years and older	*DHIS/Tick register PHC/ Hospital register*	*No*	-	*159 096*	*172 000*	*168 686*	*182 444*	*188 319*	*193 688*

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	Population 30 years and older female/10	*DHIS/Stats SA*	*Population*	-	*209 051*	*165 300*	*213 129*	*228 913*	*234 228*	*239 122*
Maintain an HPV coverage amongst Grade 4 girls of more than 80% from 2016/17	9 HPV 1st dose coverage	DHIS	Quarterly %	Not reported	Not reported	Not reported	Not reported	Establish baseline	Dependent on baseline	-
	HPV vaccine Grade 4 girls	*DHIS/Tick Register school health*	*No*	-	-	-	-	-		
	Grade 4 girls multiplied by 2	*DHIS/DOE enrolment*	*No*	-	-	-	-	-		
Increase the proportion of women attending antenatal care to 60% by March 2017	10. Antenatal 1st visit before 20 weeks rate	DHIS	Quarterly %	36%	41%	46.4%	54.4%	60%	60%	60%
	Antenatal 1st visit before 20 weeks	*DHIS/Tick register PHC*	*No*	*91 665*	*91 525*	*104 507*	*131 586*	*137 635*	*139 012*	*140 402*
	Antenatal 1st visit total	*DHIS calculates*	*No*	*116 913*[10]	*223 145*	*225 121*	*372 608*	*229 392*	*231 686*	*234 003*
Reduce the mother to child transmission rate to <0.5% by March 2019	11. Infant given NVP within 72 hours after birth uptake rate	DHIS	Quarterly %	78.6%	98%	94.6%	99.6%	98%	98%	100%
	Infant given NVP within 72 hours after birth	*DHIS/Tick register OPD/ PHC, delivery register*	*No*	*61 640*	*66 262*	*64 415*	*65 938*	*67 893*	*69 048*	*71 625*
	Live births to HIV positive woman	*DHIS/Delivery register*	*No*	-	*67 886*	*68 121*	*67 366*	*69 279*	*70 457*	*71 655*
	12. Infant 1st PCR test positive around 6 weeks rate	DHIS	Quarterly %	6.8%	4%	2.2%	1.8%	1.2%	<1%	<1%
	Infant 1st PCR test positive around 6 weeks	*DHIS/Tick register PHC*	*No*	*4 328*	*2 900*	*1 702*	*1 388*	*1 007*	*905*	*972*
	Total number of babies tested 6 weeks after birth for HIV	*DHIS/Tick register PHC*	*No*	*66 871*	*73 193*	*78 040*	*77 976*	*83 971*	*90 535*	*97 220*

[10] Data quality questionable

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Increase the couple year protection rate to 70% by March 2019	13. Couple year protection rate (annualised)	DHIS	Quarterly %	24.1%	25.5%	37.5%	50.7%	45%	50%	55%
	Contraceptive years dispensed	*DHIS calculates*	*No*	*-*	*-*	*1 019 668*	*1 225 832*	*1 303 494*	*1 464 872*	*1 631 318*
	Population 15-49 years female	*DHIS/Stats SA*	*Population*	*-*	*-*	*2 936 748*	*2 418 784*	*2 896 654*	*2 929 745*	*2 966 034*
Reduce the maternal mortality in facilities to 119 deaths per 100 000 live births (or less) by March 2017	14. Maternal mortality in facility ratio (annualised)	DHIS	Annual Ratio per 100,000	195/ 100k	190.6/ 100k	165.5/ 100k	135.6/ 100k	133/ 100k	126/ 100k	119/ 100k
	Maternal death in facility	*DHIS/Midnight census*	*No*	*353*	*363*	*317*	*266*	*265*	*255*	*245*
	Live births in facility	*DHIS/Delivery register*	*No*	*-*	*190 452*	*191 587*	*196 146*	*199 284*	*202 473*	*205 712*
Reduce deliveries in facilities under 18 to less than 8.5% by March 2017	15. Delivery in facility under 18 years rate	DHIS	Annual %	8.9%	9.3%	9.3%	9.4%	9%	8.8%	8.5%
	Delivery in facility to woman under 18 years	*DHIS/Delivery register*	*No*	*16 564*	*17 933*	*17 878*	*18 510*	*18 232*	*17 959*	*17 689*
	Delivery in facility total	*DHIS/Delivery register*	*No*	*-*	*193 375*	*192 659*	*197 928*	*200 897*	*203 910*	*206 969*
Reduce the under 1 year mortality rate in facilities to 4.8% (or less) by March 2017	16. Child under 1 year mortality in facility rate (annualised)	DHIS	Annual %	9.1%	7%	6.5%	6.6%	5.6%	5.2%	4.8%
	Inpatient death under 1 year	*DHIS calculates*	*No*	*1 484*	*2 342*	*2 978*	*3 104*	*2 800*	*2 600*	*2 400*
	Inpatient separations under 1 year	*DHIS calculates*	*No*	*-*	*33 257*	*46 024*	*48 078*	*50 000*	*50 000*	*50 000*
Reduce the under 5 inpatient death rate in facilities to 4.3% (or less) by March 2017	17. Inpatient death under 5 years rate	DHIS	Annual %	7.6%	4.8%	5.2%	5%	4.7%	4.5%	4.3%
	Inpatient deaths under 5 years	*DHIS calculates*	*No*	*1 659*	*2 779*	*3 831*	*3 902*	*3 512*	*3 525*	*3 225*
	Inpatient separations under 5 years	*DHIS calculates*	*No*	*-*	*57 774*	*69 661*	*72 726*	*74 083*	*75 000*	*75 000*

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Decrease severe acute malnutrition fatality rate in children under 5 to 7.4% (or less) by March 2017	18. Child under 5 years severe acute malnutrition case fatality rate	DHIS	Annual %	12.1%	9.2%	10.9%	11%	10.2%	8.7%	7.4%
	Child under 5 years severe acute malnutrition death	*DHIS/Tick Register*	*No*	*430*	*318*	*345*	*382*	*344*	*310*	*279*
	Child under 5 years severe acute malnutrition admitted	*Admission records*	*No*	*3 558*	*3 458*	*3 162*	*3 462*	*3 352*	*3 553*	*3 766*
Decrease the diarrhoea case fatality rate in children under 5 to 2.6% (or less) by March 2017	19. Child under 5 years diarrhoea case fatality rate	DHIS	Annual %	7.1%	4.3%	4.3%	3.6%	3.6%	3.2%	2.6%
	Child under 5 years with diarrhoea death	*DHIS/Tick Register*	*No*	*547*	*311*	*375*	*406*	*339*	*329*	*296*
	Child under 5 years with diarrhoea admitted	*Admission records*	*No*	*7 691*	*7 205*	*8 669*	*11 228*	*9 415*	*10 224*	*11 103*
Decrease the pneumonia case fatality rate in children under 5 to 2.1% (or less) by March 2017	20. Child under 5 years pneumonia case fatality rate	DHIS	Annual %	5.4%	3.7%	2.6%	3.3%	2.9%	2.4%	2.1%
	Child under 5 years with pneumonia death	*DHIS/Tick Register*	*No*	*434*	*345*	*206*	*280*	*252*	*227*	*204*
	Child under 5 years with pneumonia admitted	*Admission records*	*No*	*8 035*	*9 204*	*7 945*	*8 482*	*8 549*	*9 199*	*9 898*

- *Indicator 4 [Child under 2 years underweight for age incidence]*: Previously (2010/11 – 2013/14) monitored "children under 5 years".
- *Indicator 9 [HPV vaccine coverage amongst Grade 4 girls]:* The vaccine will be introduced in 2014. The proposed national target is 80% (baseline will however be determined in 2014/15).
- *Indicator 14 [Maternal mortality in facility ratio]*: Target based on the 20% decrease proposed by the National Department of Health.
- *Indicator 16 [Child under 1 year mortality in facility rate (annualised]*: Between 2010/11 and 2012/13 monitored as a percentage in DHIS with denominator "Total births in facility" with expression as percentage. The indicator denominator changed in the 2013 NIDS/DHIS to "Population estimated live births" with expression per 1000.
- *Indicator 17 [Inpatient death under 5 years]*: Between 2010/11 and 2012/13 expressed as percentage in NIDS/DHIS. Changed to expression per 1000 in 2013/14.

3.18 PROVINCIAL STRATEGIC OBJECTIVES AND TARGETS

PROVINCIAL STRATEGIC GOAL 3: REDUCE MORBIDITY AND MORTALITY DUE TO COMMUNICABLE DISEASES AND NON-COMMUNICABLE CONDITIONS AND ILLNESSES

- *National Sub-Output 1: Prevent and reduce the burden of disease and promote health*

Table 34: (MCWH2) Provincial Strategic Objectives and Targets - MNCWH and Nutrition

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/actual Performance			Estimated Performance	Medium Term Targets		
				2010/10	2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17
Increase postnatal follow-up visit within 6 days to 75.5% by March 2017	1. Mother postnatal visit within 6 days rate	DHIS	Quarterly %	31%	58.1%	69.4%	72.3%	73.3%	74.4%	75.5%
	Mother postnatal visit within 6 days after delivery	*DHIS/Tick register PHC*	*No*	*-*	*112 418*	*133 758*	*143 002*	*147 292*	*151 711*	*156 262*
	Delivery in facility total	*DHIS/Delivery register*	*No*	*-*	*193 375*	*192 659*	*197 728*	*200 897*	*203 910*	*206 969*
Reduce the neonatal mortality in facility rate to 9.1 neonatal deaths per 1000 live births by March 2017	2. Neonatal mortality in facility rate (annualised)	DHIS	Quarterly No per 1000	10.4/1000	10.7/ 1000	10.4/ 1000	10.8/ 1000	10/ 1000	9.5/ 1000	9.1/ 1000
	Inpatient death neonatal	*DHIS/Midnight census*	*No*	*1 936*	*2 041*	*2 001*	*2 048*	*1 900*	*1 850*	*1 729*
	Population estimated live births	*DHIS/Delivery register*	*No*	*185 346*	*190 452*	*191 587*	*196 146* [11]	*190 000*	*190 000*	*190 000*
Decrease infant mortality to 37 deaths per 1000 live births by March 2017 (ASSA)	3. Infant mortality rate	ASSA2008	Annual No per 1000 pop	44/ 1000	43/ 1000	42/ 1000	42/ 1000	41/ 1000	39/ 1000	37/ 1000
Decrease under 5 mortality to 57 deaths per 1000 live births by March 2017 (ASSA)	4. Under 5 mortality rate	ASSA2008	Annual No per 1000 pop	64/ 1000	63/ 1000	61/ 1000	60/ 1000	59/ 1000	58/ 1000	57/ 1000
Improve exclusive breastfeeding to 65% in March 2017	5. Infant exclusively breastfed at HepB 3rd dose rate	DHIS	Quarterly %	Not reported	26.1%	63%	50%	55%	60%	65%

[11] Refers to live births in facility and not estimated population-based estimates

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/actual Performance			Estimated Performance	Medium Term Targets		
				2010/10	2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17
	Infant exclusively breastfed at HepB 3rd dose	*Tick Register PHC*	*No*	-	-	-	-			
	HepB 3rd dose	*Tick Register PHC*	*No*	-	-	-	-			
Decrease diarrhoea incidence by at least 20% per annum	6. Child under 5 years diarrhoea with dehydration incidence (annualised)	DHIS	Annual No per 1000	27/ 1000	20.7/ 1000	9.5/ 1000	15.9/ 1000	14.2/ 1000	12.9/ 1000	11.6/ 1000
	Child under 5 years diarrhoea with dehydration new	*PHC Tick Register*	*No*	*30 729*	*37 364*	*17 013*	*17 414*	*16 538*	*14 887*	*13 257*
	Population under 5 years	*DHIS/Stats SA*	*No*	-	*1 804 178*	*1 783 364*	*1 093 704*	*1 164 688*	*1 154 059*	*1 142 878*
Decrease pneumonia incidence with at least 20% per annum	7. Child under 5 years pneumonia incidence (annualised)	DHIS	Annual No per 1000	147/ 1000	143/ 1000	118.5/ 1000	100.8/ 1000	97.6/ 1000	88.9/ 1000	87/ 1000
	Child under 5 years with pneumonia new	*PHC Tick Register*	*No*	*334 368*	*257 997*	*130 557*	*110 274*	*107 864*	*99 138*	*98 112*
	Population under 5 years	*DHIS/Stats SA*	*No*	-	*1 804 178*	*1 783 364*	*1 093 704*	*1 164 688*	*1 154 059*	*1 142 878*
Decrease severe acute malnutrition incidence by at least 20% per annum	8. Child under 5 years severe acute malnutrition incidence (annualised)	DHIS	Annual No per 1000	7/ 1000	6.7/ 1000	6.5/ 1000	5.8/ 1000	5.1/ 1000	4.6/ 1000	4/ 1000
	Child under 5 years with severe acute malnutrition new	*DHIS/Tick register PHC*	*No*	-	*7 522*	*7 137*	*6 328*	*5 696*	*5 127*	*4 615*
	Population under 5 years	*DHIS/Stats SA*	*No*	-	*1 118 510*	*1 104 893*	*1 093 704*	*1 164 688*	*1 154 059*	*1 142 878*
Increase the weighing coverage to 90% (or more) by March 2017	9. Weighing coverage under 1 year (annualised)	DHIS	Quarterly %	Not reported	Not Reported	67.1%	74.3%	80%	85%	90%
	Children under 1 year weighed	*DHIS/Tick register CCG records*	*No*	-	-	*1 716 124*	*1 938 540*	2 054 246	2 197 906	2 343 481
	Population under 1 year	*DHIS/Stats SA*	*No*	-	-	*2 558 556*	*2 549 964*	*2 567 808*	*2 585 772*	*2 603 868*

3.19 TARGETS FOR 2014/15

Table 35: (MCWH4) 2014/15 Targets – MNCWH and Nutrition

Performance Indicators	Targets 2014/15	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Immunisation coverage under 1 year (annualised)	96%	95.8%	95.8%	95.9%	96%
2. Vitamin A coverage 12 – 59 months (annualised)	55%	54%	54%	55%	55%
3. Deworming dose 12-59 months coverage (annualised)	Determine baseline	-	-	-	Baseline determined
4. Child under 2 years underweight for age incidence (annualised)	20/ 1000	23/ 1000	22/ 1000	21/ 1000	20/ 1000
5. Measles 1st dose under 1 year coverage (annualised)	94.6%	93.5%	94%	94.2%	94.6%
6. Pneumococcal Vaccine (PCV) 3rd dose coverage (annualised)	96.2%	95.1%	95.7%	96%	96.2%
7. Rota Virus (RV) 2nd dose coverage (annualised)	104.4%	103.7%	104%	104.1%	104.4%
8. Cervical cancer screening coverage (annualised))	79.7%	79.2%	79.4%	79.6%	79.7%
9. HPV vaccine coverage amongst Grade 4 girls	Determine baseline	-	-	-	Baseline determined
10. Antenatal 1st visit before 20 weeks rate	60%	55%	57%	59%	60%
11. Infant given NVP within 72 hours after delivery uptake rate	98%	98%	98%	98%	98%
12. Infant 1st PCR test positive around 6 weeks	1.2%	1.7%	1.4%	1.2%	1.2%
13. Couple year protection rate (annualised)	45%	40%	43%	44%	45%
14. Mother postnatal visit within 6 days rate	73.3%	72.3%	72.9%	73%	73.3%
15. Infant exclusively breastfed at HepB 3rd dose rate	55%	52%	53%	54%	55%
16. Weighing coverage under 1 year (annualised)	80%	75%	76%	78%	80%
Annual Targets					
17. Maternal mortality in facility ratio (annualised)	133/ 100 000				133/ 100 000
18. Delivery in facility under 18 years rate	9%				9%
19. Child under 1 year mortality in facility rate (annualised)	5.6%				5.6%
20. Inpatient death under 5 years rate	4.7%				4.7%
21. Child under 5 years severe acute malnutrition case fatality rate	10.2%				10.2%
22. Child under 5 years diarrhoea case fatality rate	3.6%				3.6%
23. Child under 5 years pneumonia case fatality rate	2.9%				2.9%
24. Neonatal mortality in facility rate (annualised)	8.6/1000				8.6/ 1000
25. Infant mortality rate	41/ 1000				41/ 1000
26. Under 5 mortality rate	59/ 1000				59/ 1000

Performance Indicators	Targets 2014/15	Targets			
		Q1	Q2	Q3	Q4
27. Child under 5 yeas diarrhea with dehydration incidence (annualized)	14.2/ 1000				14.2/ 1000
28. Child under 5 years pneumonia incidence (annualised)	97.6/ 1000				97.6/ 1000
29. Child under 5 severe acute malnutrition incidence (annualised)	5.1/ 1000				5.1/ 1000

DISEASE PREVENTION AND CONTROL (DPC)

3.20 OVERVIEW

Malaria Programme

The use of DDT in the control of malaria has been highly effective although it is slowly being phased out due to concerns over the impact on the environment itself hence contributing to the poor acceptance of spraying as one of the major intervention methods in the fight against malaria.

The shortage of infrastructure, curtailed by budget limitations, continues to hamper progress in this programme.

The focus of the Malaria Programme is to maintain the gains made in previous years and to maintain preventative strategies to eliminate malaria by 2018.

The current Indoor Residual Spraying was supported and launched by the Honourable Premier of KZN in October 2013 within malaria affected communities.

Non-Communicable Diseases (NCDs)

The WHO estimated that deaths due to non-communicable diseases will increase by 17-24% in the African Region over the next 10 years. According to the 2012 General Household Survey, 19.8% of the total South African population and 20% of the population in KZN suffer from chronic diseases.

The KZN Hospital Survey (2011) shows that hypertension, cancer, diabetes (type 2 most common) and concurrent diabetes and hypertension are the most common non-communicable diseases admitted in KZN public health hospitals.

The Provincial Strategy for Non-Communicable Diseases (2014-2019) will be finalised in 2014/15 to provide the framework for intensified NCD strategies and interventions. The department will focus on the 6 pillars for healthy lifestyles implemented across all programmes/ services.

The Healthy Lifestyles Legacy Project, launched by the MEC for Health in 2013/14, will be expanded to promote overall health and wellbeing. Health Promoting Schools (245) and schools implementing healthy lifestyle interventions (339) will be sustained and increased through integration with PHC re-engineering and OSS. The number of households participating in the Healthy Homes Project (1 073) will be expanded as part of improved community-based services to promote community ownership for health.

The Chronic Diseases Management and the Chronic Medicine Dispensing Model(s) will be rolled out to districts during the MTEF.

Adherence to treatment will be one of the core strategies addressed through Mpilonde community support groups.

Strategies for the prevention of blindness will be scaled up including expansion of cataract surgery services in collaboration with partners.

Rehabilitation services, including provision of human resources, will be targeted during the MTEF as part of the integrated approach.

3.21 PRIORITIES AND FOCUS AREAS

Priorities	Focus Areas
1. Revitalisation of Environmental Health services *NSO 1: Prevent and reduce the burden of disease and promote health*	• Municipal Health services through technical support. • Control of waste and hazardous substances. • Food Safety and Control. • Vector control.
2. Maintain malaria incidence at <1/1000 population and malaria case fatality rate at <1%	• Early diagnosis and treatment. • Research to monitor drug efficacy.
3. Sustain Communicable Disease Control	• Epidemic preparedness.
4. Improve control of NCDs through health system strengthening and reform	• Chronic Disease Management Model. • Human resource strengthening (task shifting, mentoring & development). • Medicine supply, pre-dispensing and distribution at community level. • Adherence to treatment (NCDs and CDs) - "Mpilonde"/ support groups.
5. Monitor NCDs and main risk factors – including innovation research	• Surveillance mechanism for NCDs. • Integrated health information system including monitoring, evaluation and research.
6. Address social determinants of health	• Integrated ward-based services through OSS. • Municipal Health Services including access to water, sanitation, and control of wasted and hazardous substances, Food Safety and Control and Vector Control. • Technical support and M&E for Municipal Health Services.

3.22 CUSTOMISED SITUATION ANALYSIS INDICATORS

Table 36: (DCP1) Customised Situation Analysis Indicators - DPC 2012/13

Indicator	Type	Provincial 2012/13	Ugu 2012/13	UMgungundlovu 2012/13	Uthukela 2012/13	Umzinyathi 2012/13	Amajuba 2012/13	Zululand 2012/13	Umkhanyakude 2012/13	Uthungulu 2012/13	Ilembe 2012/13	Harry Gwala 2012/13	eThekwini 2012/13
1. Hypertension incidence (annualised)[12]	No per 1000	22.8/1000	23 /1000	22 /1000	14 /1000	24 /1000	19 /1000	17 /1000	24 /1000	33 /1000	16 /1000	28 /1000	23 /1000
Hypertension client treatment new	*No*	*55 041*	*3 823*	*5 611*	*2 070*	*2 296*	*2 168*	*2 579*	*2 622*	*6 515*	*2 277*	*2 552*	*22 528*
Population 40 years and older	*No*	*2 409 836*	*164 383*	*248 129*	*138 145*	*94 480*	*111 641*	*146 640*	*106 790*	*192 530*	*134 030*	*90 529*	*945 697*
2. Diabetes incidence (annualised)	No per 1000	2.2/1000	1.5/1000	2.6/1000	0.6/1000	1.1/1000	2.6/1000	1.4/1000	1.1/1000	1.6/1000	1.7/1000	2.3/1000	2.9/1000
Diabetes client treatment new	*No*	*23 856*	*1 079*	*2 260*	*598*	*379*	*773*	*812*	*423*	*2 941*	*872*	*660*	*13 059*
Population total	*No*	*10 703 920*	*767 996*	*1 071 596*	*702 644*	*517 806*	*517 280*	*862 110*	*666 579*	*979 511*	*632 452*	*511 958*	*3 474 033*
3. Malaria case fatality rate	%	1.3%	0%	0%	0%	0%	0%	33.3%	1.1%	3%	0%	0%	0%
Number of deaths due to malaria (new)	*No*	*6*	*0*	*0*	*0*	*0*	*0*	*1*	*2*	*3*	*0*	*0*	*0*
Number of malaria cases (new)	*No*	*459*	*8*	*15*	*0*	*0*	*0*	*3*	*180*	*100*	*12*	*0*	*141*

[12] This calculation was done manually and was not automatically calculated by DHIS

Indicator	Type	Provincial 2012/13	Ugu 2012/13	UMgungundlovu 2012/13	Uthukela 2012/13	Umzinyathi 2012/13	Amajuba 2012/13	Zululand 2012/13	Umkhanyakude 2012/13	Uthungulu 2012/13	Ilembe 2012/13	Harry Gwala 2012/13	eThekwini 2012/13
4. Cataract surgery rate (uninsured population)	No per million uninsured population	931.2/ 1 mil	1 393.5/ 1 mil	1 682 .9/ 1 mil	247.2/ 1 mil	536.7/ 1 mil	781.6/ 1 mil	0/1 mil	887.6/ 1 mil	1 565/ 1 mil	811.2/ 1 mil	982.8/ 1 mil	916.9/ 1 mil
Cataract surgery total	*No*	*8 871*	*1 006*	*1 587*	*165*	*264*	*376*	*0*	*562*	*1 349*	*472*	*478*	*2 612*
Population uninsured	*No*	*9 526 488*	*721 919*	*943 008*	*667 512*	*491 916*	*481 074*	*810 385*	*633 194*	*861 971*	*581 856*	*486 359*	*2 848 703*

3.23 CUSTOMISED PERFORMANCE INDICATORS AND TARGETS

PROVINCIAL STRATEGIC GOAL 3: REDUCE MORBIDITY AND MORTALITY DUE TO COMMUNICABLE DISEASES AND NON-COMMUNICABLE CONDITIONS AND ILLNESSES

- *National Sub-Output 1: Prevent and reduce the burden of disease and promote health*

Table 37: (DCP3) Customised Performance Indicators - DPC

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Decrease hypertension incidence by at least 20% per annum	1 Hypertension incidence (annualised)	DHIS	Quarterly No per 1000	29.8/ 1000	29.5/ 1000	22.8/ 1000	23.6/ 1000	22.8/ 1000	22.4/ 1000	21.6/ 1000
	Hypertension client treatment new	*DHIS/PHC tick registers*	*No*	*70 973*	*70 821*	*55 041*	*56 982*	*58 074*	*58 566*	*57 908*
	Population 40 years and older	*DHIS/Stats SA*	*Population*	*2 376 334*	*2 393 085*	*2 409 836*	*2 426 704*	*2 547 127*	*2 614 590*	*2 680 949*

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Decrease diabetes incidence by at least 20% per annum	2 Diabetes incidence (annualised)	DHIS	Quarterly No per 1000	3/ 1000	2.2/ 1000	2.2/ 1000	1.3/ 1000	2.1/ 1000	2/ 1000	1.9/ 1000
	Diabetes client treatment new	*DHIS/PHC tick registers*	*No*	*31 673*	*23 307*	*23 856*	*14 180*[13]	22 199	21 376	20 532
	Population total	*DHIS/Stats SA*	*Population*	*10 449 300*	*10 622 204*	*10 703 920*	10 781 659	*10 571 312*	*10 688 165*	*10 806 538*
Eradicate malaria by 2017	3 Malaria case fatality rate	Malaria register	Annual %	1.3%	0.75%	1.3%	2%	<0.5%	<0.5%	<0.5%
	Number of deaths due to malaria (new)	*Malaria register/Tick sheets PHC*	*No*	*5*	*4*	*6*	*12*	-	-	-
	Number of malaria cases (new)	*Malaria register/Tick sheets PHC*	*No*	*380*	*531*	*459*	*552*	-	-	-
Increase the number of cataract surgeries to 11 118 (or more) by March 2017	4 Cataract surgery rate – uninsured population (annualised)	DHIS	Quarterly No per 1mil uninsured population	757/ 1mil	1 030.8/ 1 mil	931.2/ 1 mil	628/ 1mil	749/ 1mil	930/ 1mil	1 154/ 1mil
	Cataract surgery total	*DHIS/Theatre register*	*No*	-	*9 170*	*8 871*	*5 930*	*7 116*	*8 895*	*11 118*
	Population uninsured	*DHIS/Stats SA*	*Population*	-	*8 895 443*	*9 526 488*	*9 433 951*	*9 499 988*	*9 566 487*	*9 633 452*

[13] Data quality is questionable and must be verified as it appears inconsistent with trend without a reasonable explanation

3.24 PROVINCIAL STRATEGIC OBJECTIVES AND TARGETS

PROVINCIAL STRATEGIC GOAL 3: REDUCE MORBIDITY AND MORTALITY DUE TO COMMUNICABLE DISEASES AND NON-COMMUNICABLE CONDITIONS AND ILLNESSES

- *National Sub-Output 1: Prevent and reduce the burden of disease and promote health*

Table 38: (DCP2) Provincial Strategic Objectives and Targets - DCP

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17
Eradicate malaria by 2017	1. Malaria incidence per 1000 population at risk	Malaria register	Annual Per 1000 population at risk	0.57/ 1000	0.79/ 1000	0.11/ 1000	0.81/ 1000	<1/ 1000	<1/ 1000	<1/ 1000
	Number of malaria cases (new)	*Malaria register/Tick register PHC*	*No*	*380*	*531*	*75*	*552*	*<644*	*<649*	*<655*
	Population Umkhanyakude	*DHIS/Stats SA*	*Population*	*666 524*	*666 524*	*666 524*	*673 238*	*643 760*	*649 645*	*655 616*

3.25 TARGETS FOR 2014/15

Table 39: (DCP4) 2014/15 Targets - DCP

Performance Indicator	Targets 2014/15	Targets			
		Q1	Q2	Q3	Q4
1 Hypertension incidence (annualised)	22.8/1000	23/ 1000	23/ 1000	22.9/ 1000	22.8/ 1000
2 Diabetes incidence (annualised)	2.1/1000	2.1/ 1000	2.1/ 1000	2.1/ 1000	2.1/ 1000
3 Cataract surgery rate - uninsured population (annualised)	749/1mil	678/ 1mil	688/ 1mil	701/ 1mil	749/ 1mil
Annual Targets					
4 Malaria case fatality rate	<0.5%				<0.5%
5 Malaria incidence per 1,000 population at risk	<1/ 1000				<1/ 1000

DISTRICT HOSPITALS

3.26 OVERVIEW

There are 39 classified District Hospitals in the Province (38 Public and 1 State Aided Hospital i.e. St Mary's in eThekwini). The Department formally took over the McCords (State Aided) Hospital on the 1st of February 2014. The hospital will continue to function as District Hospital in Central eThekwini.

There are 8 257 usable beds (0.77 beds per 1 000 population) compared with the provincial norm of 0.66 beds per 1 000 population.

Bed utilisation remains below the acceptable efficiency norm of 75% (Table 40). Psychiatric beds are consistently under severe pressure, which inevitably impact on quality of care. Psychiatric bed norms are under review as part of the 5-year Mental Health Strategy in an effort to improve alignment with the burden of disease and increasing demand.

Average length of stay consistently exceeds the national norm of 3.5 days, although the high burden of disease, lack of step-down facilities, and late reporting to facilities may warrant longer hospital stay (Table 40).

Table 40: District Hospital BUR and ALOS per clinic al domain

Year		Total BUR and ALOS	Gynae	Maternity	Medicine	Orthopaedic	Paediatric	Psychiatric	Surgery	TB
2009/10	BUR	**64.3%**	83.5%	60.1%	82.5%	79.1%	54.8%	109.5%	67.1%	70.2%
	ALOS	**6 days**	3 days	3 days	7.1 days	10.5 days	6.4 days	11.8 days	6.6 days	18.5 days
2010/11	BUR	**62.6%**	83.9%	56%	56%	47.4%	53.4%	143.5%	63.3%	68.7%
	ALOS	**6.1 days**	3.2 days	2.9 days	7.4 days	10.5 days	6.2 days	13.2 days	6.5 days	18.6 days
2011/12	BUR	**63%**	141%	60.7%	86.3%	54.6%	54.1%	145.7%	73.3%	67.5%
	ALOS	**6 days**	3.1 days	3 days	7.4 days	11.3 days	6.3 days	11.4 days	6.5 days	20.1 days
2012/13	BUR	**63.2%**	65.3%	56.1%	75.2%	52.4%	47.6%	130.3%	62%	65.4%
	ALOS	**5.6 days**	3.4 days	3.1 days	7.5 days	11.1 days	6.4 days	12 days	6.4 days	18.9 days

- Source: DHIS
- Legends for table above: Green: Target exceeded – efficient; Red: Over utilised which might lead to inefficiencies

Classification of hospitals is under review as part of the rationalisation of hospital services that will be intensified over the MTEF. This is in line with system strengthening and optimisation of resources.

King Dinuzulu Hospital is officially classified as Regional Hospital with DHIS classification as Specialised TB Hospital. The hospital provides District Hospital services (400 level 1 beds commissioned in January 2013), limited tertiary services and Specialised TB and Psychiatric services. DHIS reporting (as Specialised TB) skew patient activity in eThekwini, and will be corrected in 2014/15.

St Francis Hospital is classified as a Specialised Psychiatric Hospital but at a ground level renders a basic package of level 1 services, mostly chronic conditions, and is grossly under-utilised.

Additional funding has been earmarked in the MTEF for the *St Mary's Hospital in Marianhill (State Aided),* classified as medium District Hospital. The hospital provides services in a densely populated area with no other level one hospital in the area.

Regional Hospitals (7 with Gateway clinics) reported a decrease of 175 157 unreferred cases from PHC over the last 2 years. District Hospitals (30 with Gateway clinics) reported a decrease of 41 142 unreferred cases over the same period. It is expected that re-engineering of PHC will further reduce hospital activity which is in line with the MTEF priority.

Cost Centres will be established (in a phased approach) over the MTEF to improve financial management and provide accurate financial and service delivery data for decision-making and planning.

Implementation of the National Core Standards will be prioritised over the MTEF. The latest assessment of the "Make Me Look Like a Hospital" project, aimed at intensified implementation of the basic principles of the Core Standards, indicates that:

- 80% of facilities show improvement in staff attitudes.
- 83% of facilities demonstrate improvement in cleanliness (supported by the National Cleanest Government Project Initiative).
- 92% of facilities are compliant with Patient Safety and Security criteria.
- 100% of facilities are compliant with criteria for Availability of Medicines and Blood Products.
- Improved Patient Waiting Times i.e. Outpatients (33%); Pharmacy (67%); and Patient files (42%).
- 100% of facilities are implementing the Infection Prevention and Control policies and guidelines. No facility is compliant with the IPC criteria for infrastructure.

The Human Resources for Health Strategy will include strategies for the provisioning of adequate resources for optimal care in District Hospitals. *See Human Resources for Health priorities (Programme 1).*

The decentralised training initiative that will be developed during the next strategic cycle will strengthen clinical care at District Hospital level. Outreach and oversight functions will be reviewed to make provision for an effective decentralised model.

The Department will prioritise the filling of all Hospital Manager posts to ensure improved efficiencies at facility level. Development programmes, included in the HR strategy, will also be prioritised during the MTEF.

3.27 PRIORITIES AND FOCUS AREAS

Priorities	Focus Areas
1. Improve hospital efficiency and governance *NSO 5: Improved quality of care*	• Rationalisation of hospital services. • Performance Management and Development. • Cost centers (phased approach over MTEF). • Business process re-engineering and decentralised delegations. • Referral pathways (including EMS).
2. Improve infrastructure	• Facilities Audit to inform medium/long term plans.

	NSO 2: Health Facility Planning	• Maintenance as per approved Infrastructure Plan.
3.	Improved quality and efficiency	• National Core Standards. • Patient management system including bed bureau system. • Strengthen outreach and support programmes.
4.	Support Services	• Support and transversal services including Food; Garden; Security and Laundry Services. • SCM processes and systems (decentralised delegations).
5.	Improve Human Resource for Health *NSO 8: Improved Human Resources for Health*	• Mentorship programmes. • Rotate Registrars (review of Registrar Programme in partnership with UKZN). • Decentralised Training Model with a PHC Focus for Health Sciences in partnership with UKZN.

3.28 CUSTOMISED SITUATION ANALYSIS INDICATORS

Table 41: (DHS6) Customised Situation Analysis Indicators - District Hospitals 2012/13

Indicators	Type	Provincial 2012/13	Ugu 2012/13	Umgungundlovu 2012/13	Uthukela 2012/13	Umzinyathi 2012/13	Amajuba 2012/13	Zululand 2012/13	Umkhanyakude 2012/13	Uthungulu 2012/13	Ilembe 2012/13	Harry Gwala 2012/13	eThekwini 2012/13
1. Average length of stay - total	Days	5.6 Days	6.2 Days	5 Days	5.1 Days	6 Days	3 Days	6.1 Days	5.5 Days	6.8 Days	6.8 Days	5.4 Days	4.2 Days
In-patient days - total	*No*	*1 968 788*	*204 086*	*143 544*	*101 033*	*243 243*	*9 706*	*304 382*	*268 256*	*222 843*	*89 149*	*163 525*	*219 021*
Day patients	*No*	*15 315*	*155*	*112*	*232*	*59*	*907*	*195*	*1 923*	*59*	*714*	*163*	*10 796*
Separations	*No*	*353 017*	*32 951*	*28 483*	*20 013*	*40 536*	*3 337*	*50 130*	*48 917*	*32 655*	*13 240*	*30 054*	*52 701*
2. Inpatient bed utilisation rate - total	%	63.2%	74.1%	73.1%	56.2%	57.6%	53.6%	65.6%	59.6%	52%	63.8%	60.8%	76.3%
In-patient days - total	*No*	*1 968 788*	*204 086*	*143 544*	*101 033*	*243 243*	*9 706*	*304 382*	*268 256*	*222 843*	*89 149*	*163 525*	*219 021*
Day patients	*No*	*15 315*	*155*	*112*	*232*	*59*	*907*	*195*	*1 923*	*59*	*714*	*163*	*10 796*
Usable beds	*No*	*3 128 354*	*273 537*	*195 275*	*179 215*	*421 210*	*18 980*	*461 603*	*450 410*	*426 290*	*140 038*	*268 640*	*293 156*
3. Expenditure per patient day equivalent	R	R 1 756	R 1 588	R 1 441	R 1 742	R 1 609	R 1 620	R 1 158	R 1 700	R 1 626	R 1 593	R 1 578	R 1 581
Expenditure total	*R'000*	*4 901 829*	*432 069*	*410 792*	*251 482*	*557 506*	*43 999*	*694 249*	*608 649*	*538 544*	*222 652*	*371 442*	*301 545*
Patient day equivalent	*No*	*2 791 065*	*299 908*	*235 808*	*156 297*	*344 063*	*37 989*	*408 725*	*374 286*	*338 079*	*141 099*	*234 908*	*220 202*

Indicators	Type	Provincial 2012/13	Ugu 2012/13	Umgungundlovu 2012/13	Uthukela 2012/13	Umzinyathi 2012/13	Amajuba 2012/13	Zululand 2012/13	Umkhanyakude 2012/13	Uthungulu 2012/13	Ilembe 2012/13	Harry Gwala 2012/13	eThekwini 2012/13
4. Complaints resolution within 25 working days rate	%	77.9%	55.5%	73.4%	56.7%	87.2%	100%[14]	71.9%	79.5%	84.8%	66.7%	76.1%	119.8%
Complaints resolved within 25 days	No	*1 808*	*252*	*152*	*85*	*34*	-	*41*	*271*	*358*	*30*	*194*	*346*
Complaints resolved	No	*2 308*	*454*	*213*	*150*	*39*	-	*57*	*341*	*422*	*45*	*257*	*285*
5. Mental health admission rate	%	1.5%	2.4%	2.6%	1.8%	1.4%	0.6%	1.6%	0.6%	0.8%	2.8%	2%	0.7%
Mental health admissions total	No	*5 177*	*775*	*754*	*365*	*560*	*20*	*818*	*287*	*271*	*374*	*604*	*349*
Inpatient separations	No	*353 017*	*32 951*	*28 483*	*20 013*	*40 536*	*3 337*	*50 130*	*48 917*	*32 655*	*13 240*	*30 054*	*52 701*
6. Patient satisfaction rate	%	84%	84%	No data	76%	87%	80%	88%	86%	88%	81%	70%	85%
Number satisfied customers	No	*2 351*	*210*	-	*76*	*348*	*80*	*414*	*374*	*367*	*114*	*225*	*143*
Number users participated in survey	No	*2 801*	*249*	-	*100*	*400*	*100*	*468*	*437*	*419*	*140*	*320*	*168*

[14] Amajuba District data received after finalisation of the Annual Report (100% - 45/45) – data therefore not included in calculating the Provincial average

Indicators	Type	Provincial 2012/13	Ugu 2012/13	Umgungundlovu 2012/13	Uthukela 2012/13	Umzinyathi 2012/13	Amajuba 2012/13	Zululand 2012/13	Umkhanyakude 2012/13	Uthungulu 2012/13	Ilembe 2012/13	Harry Gwala 2012/13	eThekwini 2012/13
7. Percentage of hospitals that have conducted gap assessments for compliance against the National Core Standards	No	94.5%	100%	100%	100%	100%	100%	100%	100%	66.6%	100%	100%	100%
District Hospitals that conducted self-assessments	*No*	*35*	*3*	*2*	*2*	*4*	*1*	*5*	*5*	*4*	*3*	*4*	*2*
Number of District Hospitals	*No*	*37*	*3*	*2*	*2*	*4*	*1*	*5*	*5*	*6*	*3*	*4*	*2*
8. Proportion of District Hospitals assessed as compliant with the Extreme Measures of National Core Standards	%	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported

- Data for eThekwini includes the 2 State-Aided Hospitals (Excluding State-Aided Hospitals [220 202] and including State Aided Hospitals [350 709]).
- Data for Zululand is excluding Pongola State-Aided Hospital which is classified as a Private Hospital on DHIS.
- *Indicators 1, 2 and 5*: Data elements for these indicators changed between 2012/3 and 2013/14. See notes on following table for details.
- *Indicator 3 [Expenditure per PDE]*: Should include all expenditure incurred in Sub-Programme 2.9 and Programme 4 to align the numerator with the denominator (PDE).

3.29 CUSTOMISED PERFORMANCE INDICATORS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 3: Improved financial management in the health sector*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 5: Improved quality of care*

Table 42: (DHS8) Customised Performance Indicators - District Hospitals

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Improve hospital efficiencies by implementing the long-term plan for hospital revitalisation 2014 -2019	1. Average length of stay- total	DHIS	Quarterly Days	6.1 Days[15]	5.8 Days	5.6 Days	5.8 Days	5.6 Days	5.5 Days	5.5 Days
	In-patient days - total	*Midnight census*	*No*	*1 935 881*	*1 973 596*	*1 968 788*	*2 003 030*	*2 023 060*	*2 043 291*	*2 063 724*
	Day patients	*Midnight census*	*No*	*15 717*	*13 825*	*15 315*	*7 884*	*8 186*	*8 208*	*8 325*
	Inpatient separations	*DHIS calculates*	*No*	*-*	*337 550*	*353 017*	*344 898**	*360 262*	*367 467*	*374 817*
	2. Inpatient bed utilisation rate – total	DHIS	Quarterly %	63.8%	63.7%	63.2%	70.6%	63.8%	64.5%	65.1%
	In-patient days - total	*Midnight census*	*No*	*1 935 881*	*1 973 596*	*1 968 788*	*2 003 030*	*2 023 060*	*2 043 291*	*2 063 724*
	Day patients	*Midnight census*	*No*	*15 717*	*13 825*	*15 315*	*7 884*	*8 186*	*8 208*	*8 325*
	Inpatient bed days available	*Management*	*No*	*-*	*3 170 390*	*3 128 354*	*3 173 310**	*3 173 310*	*3 173 310*	*3 173 310*
Maintain expenditure per PDE within the provincial norms	3. Expenditure per patient day equivalent (PDE)	BAS/DHIS	Quarterly R	R 1 391*	R 1 434*	R 1 756*	R 1 854	R 2 038	R 2 146	R 2 301

[15] This data is questionable when reviewed in relation to the disruptions experienced by the Health Section during the Public Servants Strike

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	Expenditure total	*BAS*	*R'000*	*4 177 839*	*4 289 725*	*4 901 829*	*5 279 103*	*5 699 359*	*5 891 136*	*6 204 036*
	Patient day equivalent	*DHIS calculates*	*No*	*3 002 516*	*2 990 662*	*2 791 065*	*2 846 516*	*2 795 279*	*2 744 964*	*2 695 554*
Improve the complaint resolution within 25 working days rate to 75% (or more) by March 2016	4. Complaint resolution within 25 working days rate	DHIS	Quarterly %	78%	68.2%	79.2%	63.2%	70%	75%	75%
	Complaints resolved within 25 working days	*PSS*	*No*	*-*	*1 585*	*1 808*	*1 610*	*1 883*	*2 130*	*2 250*
	Complaints resolved	*PSS*	*No*	*-*	*2 321*	*2 308*	*2 548*	*2 691*	*2 841*	*3 000*
Implement the 5-year Mental Health Care Strategy to improve mental health care services at all levels	5. Mental health admission rate	DHIS	Quarterly %	1.3%	1.5%	1.5%	1%	1.1%	1.5%	1.4%
	Mental health admissions total	*DHIS calculates*	*No*	*4 185*	*5 010*	*5 177*	*3 564*	*3 963*	*5 512*	*5 247*
	Inpatient separations	*DHIS calculates*	*No*	*313 610*	*325 873*	*344 100*	*344 898**	*360 262*	*367 467*	*374 817*
Improve the patient satisfaction rate to 85% by March 2017	6. Patient satisfaction rate	DHIS	Annual %	Not reported	78%	84%	Not available	75%	80%	85%
	Number satisfied customers	*PSS*	*No*	*-*	*-*	*2 351*	*-*	*2 100*	*2 240*	*2 380*
	Number users participated in survey	*PSS*	*No*	*-*	*-*	*2 801*	*-*	*2 800*	*2 800*	*2 800*
80% of facilities conditionally compliant (50% - 75%) to the National Core Standards by March 2019	7. Proportion of hospitals that have conducted gap assessments for compliance against the National Core Standards	DHIS/ Assessment records	Annual %	Not reported	100%	94.6%	Not available	100%	100%	100%
	District Hospitals self-assessed for compliance	*Assessment records*	*No*	*-*	*37*	*35*	*-*	*37*	*37*	*37*
	District Hospitals total	*DHIS calculates*	*No*	*-*	*37*	*37*	*37*	*37*	*37*	*37*

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	8. Proportion of District Hospitals assessed as compliant with the Extreme Measures of National Core Standards	QA/DHIS calculates	Quarterly %	Not reported	Not reported	Not reported	Not reported	15%	30%	50%
	District Hospitals fully compliant with extreme measures of National Core Standards	*QA assessment records*	*No*	-	-	-	-	*5*	*11*	*16*
	District Hospitals total	*DHIS calculates*	*No*	-	-	-	-	*37*	*37*	*37*

- The provincial data for District Hospitals includes the 2 State-Aided Hospitals in eThekwini but excludes Pongola State-Aided Hospital in Zululand. (Pongola State-Aided Hospital's PDE 3 002).
- The number of district hospitals could increase over the MTEF due the take-over of State-Aided Hospitals.
- *Indicator 1: [Average Length of Stay]*: The denominator changed in 2013/14 from Separations to Inpatient Separations.
- *Indicator 2: [Inpatient Bed Utilisation Rate]*: The denominator changed in 2013/14 from Useable Beds to Inpatient Bed days available.
- *Indicator 3: [Expenditure per PDE]*: This should include all expenditure incurred in Sub-Programme 2.9 and Programme 4 to align the numerator with the denominator (PDE).
- *Indicator 5: [Mental Health Admission Rate]*: The denominator changed in 2013/14 from total admissions to Inpatient Separations

3.30 PROVINCIAL STRATEGIC OBJECTIVES AND TARGETS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 3: Improved financial management in the health sector*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 5: Improved quality of care*

Table 43: (DHS7-A) Provincial Strategic Objectives and Targets - District Hospitals

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17
Improve hospital efficiencies by implementing the long-term plan for hospital revitalisation 2014-2019	1. Delivery by caesarean section rate	DHIS calculates	Quarterly %	27.4%	26%	27%	27.3%	27.6%	27.6%	27.6%
	Delivery by caesarean section	*Delivery register*	*No*	*23 461*	*22 819*	*23 523*	*24 364*	*25 001*	*25 379*	*25 709*
	Delivery in facility total	*Delivery register*	*No*	*85 728*	*87 843*	*87 124*	*89 408*	*90 570*	*91 788*	*92 940*
	2. OPD headcount- total	DHIS/OPD tick register	Quarterly No	2 664 297	2 698 087	2 611 405	2 574 414	2 533 223	2 492 692	2 452 809
	3. OPD headcount not referred new	DHIS/OPD tick register	Quarterly No	298 320	475 782	458 379	520 414	495 049	534 653	577 426

3.31 TARGETS FOR 2014/15

Table 44: (DHS9) 2014/15 Targets – District Hospitals

Performance Indicators	Targets 2014/15	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Average length of stay- total	5.6 Days	5.7 Days	5.7 Days	5.6 Days	5.6 Days
2. Inpatient Bed utilisation rate – total	63.8%	69%	67%	65%	63.8%
3. Expenditure per patient day equivalent	R 2 038	R 1 985	R 1 990	R 2 000	R 2 038
4. Complaint resolution within 25 working days rate	70%	65%	67%	69%	70%
5. Mental health admission rate	1.1%	1%	1%	1%	1.1%
6. Proportion of District Hospitals assessed as compliant with the Extreme Measures of National Core Standards	15%	- 0%	- 0%	- 0%	15%
7. Delivery by caesarean section rate	27.6%	27.6%	27.6%	27.6%	27.6%
8. OPD headcount - total	2 533 223	633 305	633 305	633 305	633 308
9. OPD headcount not referred new	495 049	123 762	123 762	123 762	123 762
Annual Targets					
10. Patient Satisfaction Rate	75%				75%
11. Proportion of hospitals that have conducted gap assessments for compliance against the National Core Standards	100%				100%

3.32 RISK MANAGEMENT: PROGRAMME 2

Potential Risks	Mitigating Factors
1. Classification of hospitals not in line with service delivery platform – low efficiencies and increased cost.	• Review classification as part of revitalisation of hospital services – aligned with long-term plan for hospital services.
2. Poor integration of programmes at PHC level – including community-based services (inter-sectoral).	• Pilot integrated child health strategy and scale up implementation of integrated services (Provincial Growth and Development Plan).
3. Impact of HIV, AIDS and TB on health outcomes.	• Scale up prevention and treatment programmes. Prioritise integration of HIV/ AIDS, TB and MNCWH Programmes at all levels.
4. Socio-economic determinants of health.	• Scale up community-based services including participation in OSS – Provincial Growth and Development Plan.
5. Increasing burden of disease without concomitant resources.	• Re-prioritisation and improved evidence-based M&E and reporting.

3.33 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 45: (DHS11-A) Summary of Payments and Estimates - Programme 2

Sub-Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
	2010/11	2011/12	2012/123	2013/14			2014/15	2015/16	2016/17
District Management	133 675	165 967	218 769	201 548	217 355	212 894	246 328	238 357	250 990
Community Health Clinics	2 054 214	2 314 985	2 480 474	2 832 671	2 864 331	2 894 334	3 055 573	3 351 017	3 454 180
Community Health Centres	628 582	767 716	955 757	1 030 648	1 041 619	1 057 906	1 296 961	1 376 940	1 449 918
Community Based Services	101 399	25 774	790				2 580		
Other Community Services	524 369	616 453	693 031	854 055	914 405	914 996	955 141	1 015 904	1 112 408
HIV and AIDS	1 500 250	1 914 057	2 392 690	2 652 072	2 652 072	2 846 150	3 257 992	3 874 085	4 356 983
Nutrition	36 614	65 237	44 433	49 348	49 348	49 315	47 772	50 161	52 820
Coroner Services	122 338	141 632	146 150	159 265	157 241	155 366	158 329	167 738	176 628
District Hospitals	4 177 839	4 289 725	4 901 829	5 284 169	5 226 691	5 279 103	5 699 359	5 891 136	6 204 036
Total economic classification	**9 279 280**	**10 301 546**	**11 833 923**	**13 063 776**	**13 123 062**	**13 410 064**	**14 720 035**	**15 965 338**	**17 057 963**

Table 46: (DHS11-B) Summary of Payments and Estimates by Economic Classification - Programme 2

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Current payments	**8 850 195**	**9 823 474**	**11 466 027**	**12 532 421**	**12 623 523**	**12 857 002**	**14 210 678**	**15 482 420**	**16 538 488**
Compensation of employees	6 016 821	6 846 189	7 916 084	8 706 221	8 905 277	8 938 420	9 832 214	10 690 888	11 326 737
Goods and services	**2 833 374**	**2 977 285**	**3 549 944**	**3 826 200**	**3 718 246**	**3 918 567**	**4 378 464**	**4 791 532**	**5 211 750**
Communication	42 686	44 070	46 241	48 636	50 863	52 377	61 750	64 540	71 201
Computer Services	218	108	8			8141	11 275	3 472	0

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Consultants, Contractors and special services	556 358	592 151	569 440	574 547	642 364	621 720	695 346	692 439	771 977
Inventory	1 855 033	1 889 481	2 386 725	2 625 702	2 425 476	2 609 529	2 879 796	3 265 599	3 600 331
Operating leases	17 310	17 674	19 804	21 717	20 599	19 591	24 286	25 461	26 589
Travel and subsistence	12 992	17 701	22 818	19 582	20 267	21 106	23 485	24 660	28 283
Interest and rent on land						15			
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	3 48 777	416 100	504 908	536 016	558 465	585 750	682 526	715 361	713 370
Transfers and subsidies to	**398 098**	**327 024**	**270 091**	**408 044**	**393 487**	**447 010**	**391 617**	**369 166**	**397 138**
Provinces and municipalities	124 850	86 807	24 232	145 584	158 027	158 027	134 838	151 748	169 212
Departmental agencies and accounts	27	130	6	31	31	31	32	33	35
Non-profit institutions	247 899	213 387	204 686	225 339	203 339	230 392	220 147	179 010	189 168
Households	25 322	26 700	41 167	37 090	32 090	58 560	36 600	38 375	38 724
Payments for capital assets	**28 298**	**151 005**	**97 805**	**123 311**	**106 052**	**106 052**	**117 740**	**113 752**	**122 338**
Machinery and equipment	28 298	151 005	97 805	123 311	106 052	106 052	117 740	113 752	122 338
Payment for financial assets	**2 689**	**43**							
Total economic classification	**9 279 280**	**10 301 546**	**11 833 923**	**13 063 776**	**13 123 062**	**13 410 064**	**14 720 035**	**15 965 338**	**17 057 963**

Performance and Expenditure Trends

The significant allocation to the programme supports the PHC vision.

The NHI Grant commenced in 2012/13, aimed at funding the two national pilot districts. This funding decreased in 2013/14 due to a new indirect National Health Grant, which will be spent by the National Department of Health on behalf of provinces.

The increase in 2011/12 relates to capacity building at District Office level to improve service delivery, as well as the 2011 wage agreement. The 2014/15 MTEF provides for the commissioning of Dannhauser and Pomeroy Community Health Centres, as well as additional funding for the carry-through costs of the relevant wage agreements and inflationary costs.

The strong growth from 2010/11 to 2013/14 in the *Community Health Clinics and Community Health Centres Sub-Programmes* includes additional funding for the various wage agreements, OSDs for medical personnel, funding for inflationary costs in medical related *Goods and services* and reducing infant and child mortality. The increase from 2011/12 was also due to national priority funding for personnel and goods, family health teams and for the general policy adjustment, as well as funding to encourage growth in PHC service delivery.

The increase in 2012/13 was mainly related to the increased costs of medicines, vaccines, municipal payments and increased patient demand at PHC level, the addressing of critical staff needs at primary health care (PHC) level, which included closing the gaps in resource allocation e.g. filling of essential posts and basic medical equipment in municipal clinics taken over from local government.

The 2011/12 decrease in the *Sub-Programme: Community Based Services* resulted from the absorption of the majority of the CCGs into the HIV and AIDS Sub-Programme and the takeover of the HIV and AIDS NIP sites from NGOs. Expenditure for CCGs placed into programmes where the costs are incurred, hence no spending or allocations from 2013/14 onward.

The increase from 2011/12 onwards in the *Sub-Programme: Other Community Services* was due to the introduction of Community Nursing services and an additional intake of Community Doctors as result of the extension of the Medical Intern Programme to two years, as well as the various OSDs for medical personnel.

The strong growth in the *HIV and AIDS Sub-Programme* relates mainly to increases in the Comprehensive HIV and AIDS Grant to cater for increased uptake of patients on ARV therapy. Additional funds were allocated in 2012/13 to assist with the increase of the ARV threshold to a CD4 count of 350, with a further increase in 2012/13 for equipment and the increasing costs of ARV medication.

The high projected spending in the 2013/14 Revised Estimate (and against *Goods and services*) relates to expected over-spending of the Comprehensive HIV and AIDS Grant, particularly regarding the cost of ARVs. The strong growth over the 2014/15 MTEF and in 2016/17 in particular, aligns with the growth in the Comprehensive HIV and AIDS Grant.

The peak in 2011/12 in the *Sub-Programme: Nutrition* was due to once-off equitable share support provided to the Nutritional Programme. In 2012/13 this co-funding was phased out as effective management processes and controls were put in place, with HIV and AIDS based nutrition funded from the Grant and against the HIV and AIDS Sub-Programme. The relatively flat growth over the 2014/15 MTEF is due to strict cost-cutting to ensure more critical services can be funded.

The *Sub-Programme: Coroner Services* was funded through the Forensic Pathology Services grant until 2011/12. From 2012/13, these services were paid from the department's equitable share. The reduction in 2012/13 resulted from the scaling down in the replacement of mortuary vehicles due to cost-cutting measures.

The *Sub-Programme: District Hospitals* increase in 2012/13 was largely as a result of delays in the processing of the OSD for Occupational Therapists due to programmatic challenges at a national level and filling of essential posts.

Adding to the growth in 2012/13 was the restructuring and commissioning of the King Dinuzulu District Hospital. The reduction in the 2013/14 Adjusted Appropriation relates to forced savings to address pressures in the Community Health Clinics sub-programme and to Programme 4: Provincial Hospital Services to address pressures in *Compensation of employees* and medico-legal claims, respectively.

The increase in *Compensation of employees* in 2012/13 relates to an increased number of School Health Teams, Ward-Based Outreach Teams, District Clinical Specialist Teams, and TB Tracing and Injection Teams. In 2014/15 and 2015/16, additional funding is included from the Comprehensive HIV and AIDS Grant to improve treatment access.

The fluctuations in *Transfers and subsidies to: Provinces and municipalities* are mainly due to the provincialisation process for municipal clinics. The significant increase from 2013/14 onward relates to the eThekwini Metro and uMhlathuze Municipality additional funding to increase access to HIV, AIDS and TB treatment.

Spending against *Transfers and subsidies to: Households* relates to staff exit costs and medico-legal claims. This is a once-off cost and accounts for the decrease in 2014/15.

The significant increase against *Machinery and equipment* in 2011/12 was for the replacement of deteriorating essential equipment and the purchase of mobile clinics and other service delivery vehicles. This process did not continue in 2012/13 due to forced savings implemented by the Department in order to offset pressures in infrastructure projects already on site, hence the decrease in 2012/13. In the 2014/15 MTEF, amounts are provided to replace essential equipment at a reduced rate, due to the baseline cuts.

Notes

4. PROGRAMME 3: EMERGENCY MEDICAL SERVICES

Programme Purpose and Structure

The previous structure included Sub-Programme 3.3: Disaster Management - Municipal mandate.

Purpose

To render pre-hospital Emergency Medical Services including Inter-hospital Transfers and Planned Patient Transport

Sub-Programme 3.1: Emergency Medical Services

Render Emergency Medical Services including Ambulance Services, Special Operations, and Communication and Air Ambulance services.

Sub-Programme 3.2: Planned Patient Transport (PPT)

Render Planned Patient Transport including Local Outpatient Transport (within the boundaries of a given town or local area) and Inter-City/Town Outpatient Transport (Into referral centres).

4.1 OVERVIEW

To comply with the national norm of 1 ambulance per 10,000 population the Province would need 1 079 operational ambulances, which translates to 871 additional ambulances. Given the limited funding envelope it is highly unlikely that the Department will achieve this norm in the foreseeable future

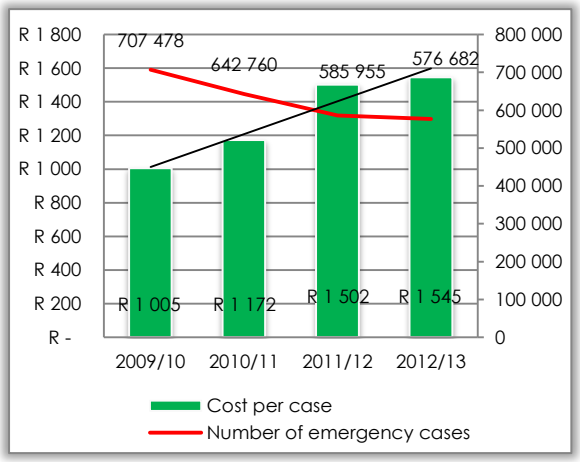
Aero Medical Services (AMS), with 2 rotor wing and 1 fixed wing aircraft, render much needed services in especially more rural areas and provides critical outreach support to areas with poor access to resources e.g. specialist skills and competencies.

The establishment of a strategic business unit for Aero Medical Services, prioritised in 2014/15, will further optimise the service.

The cost per emergency case has increased phenomenally (53%) between 2009/10 and 2012/13 from R1 005 to R 1 545. During the same period, the number of cases decreased by 18% or 130 796 cases.

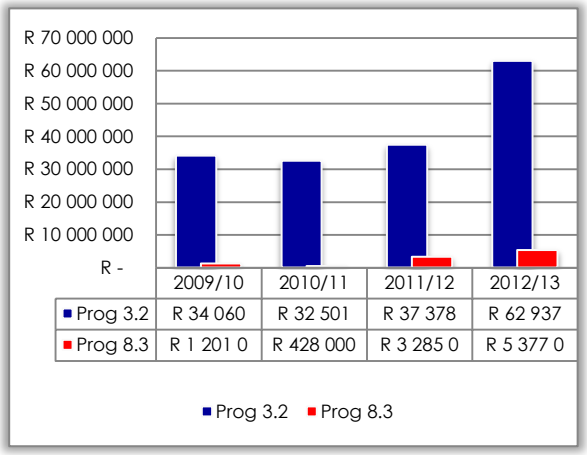
This increase in cost per emergency case will put tremendous pressure on service improvement, especially taking into consideration the under-performance of the programme and limited funding envelope (Graph 7).

Graph 6: Response times versus Programme 3 - Current expenditure



Expenditure under sub-programme 3.2 (Planned Patient Transport) has increased steadily against expenditure occurred in sub-programme 8.3 (EMS/ PPT Infrastructure) over the 4 year review period (Graph 8).

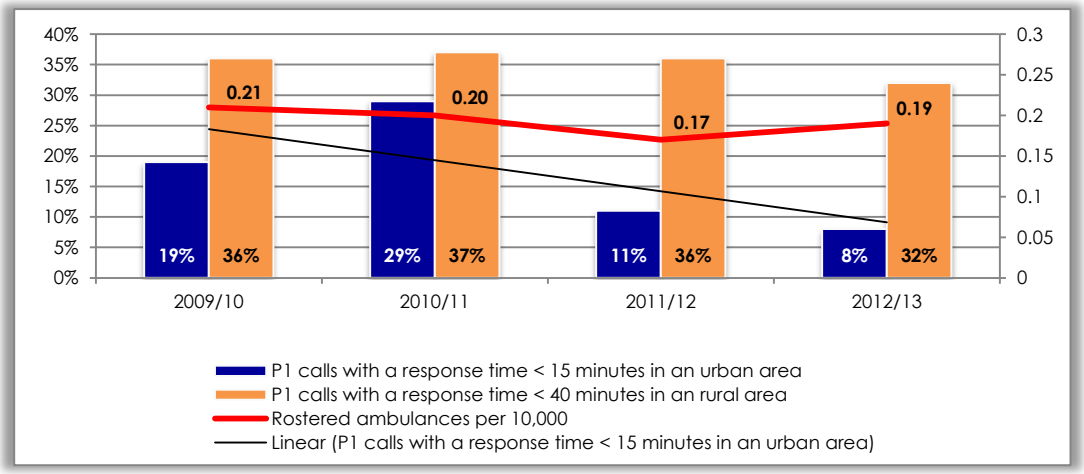
Graph 7: Expenditure for Sub-Programme 3.2



P1 call response times in both urban and rural areas show a year on year decrease since 2010/11 in spite of considerable investment in vehicles and human resources during the same period (Graph 9).

Improving response times are dependent on a multitude of factors, some of which are extraneous to the Department including poor road infrastructure, poor road and residential signage, topography, geographical distribution of households and health facilities in especially hard to reach areas. Internally, the most common challenges include shortage of vehicles, equipment, and trained/skilled staff.

Graph 8: Response times versus rostered ambulances



A reviewed turn-around strategy has been developed to improve EMS and IFT efficiencies. The strategy in turm makes provision for integration with service delivery and a robust monitoring and evaluation component

4.2 PRIORITIES AND FOCUS AREAS

Priorities	Focus Areas
1. Access and response times	• Obstetric ambulances, inter facility transfer (IFT) and emergency ambulances (operational ambulances per shift). • Clustered Communications Centres. • Aero Medical Services.

Priorities	Focus Areas
	• Strategic satellite / standby points for emergency vehicles. • Integration of services with Primary Health Care. • Patient database management.
2. Patient Transport Services (PTS)	• Shuttle services as part of intra district PTS. • PTS Hubs for inter-district PTS. • Patient coordination points at receiving institutions. • Electronic patient booking system for PTS services.
3. Improve infrastructure development *NSO 2: Health Facility Planning*	• Purpose built wash bays and sluice facilities. • Customised facilities for EMS.
4. Quality of care *NSO 5: Improved quality of care*	• Integrated health service delivery. • Appropriately qualified staff in Communications Centres.
5. Human resource capacity and management *NSO 8: Improved Human Resources for Health*	• Supervisors and Managers.
6. Revenue generation *NSO 3: Improved financial management in the health sector*	• Strategic Business Unit for Aero Medical Services. • Revenue Generation Unit.
7. Information management and communication technology *NSO 4: Efficient health management information system for improved decision making*	• IT infrastructure for information management. • Mobile data terminals (MDT's).

4.3 CUSTOMISED SITUATION ANALYSIS INDICATORS

Table 47: (EMS1) Situation Analysis Indicators - EMS and PPT 2012/13

Quarterly Indicators	Data Source	Type	Province 2012/13	Ugu 2012/13	UMgungundlovu 2012/13	Uthukela 2012/13	UMzinyathi 2012/13	Amajuba 2012/13	Zululand 2012/13	UMkhanyakude 2012/13	Uthungulu 2012/13	Ilembe 2012/13	Harry Gwala 2012/13	eThekwini 2012/13
1. EMS operational ambulance coverage	EMS database	No Per 10,000	0.20	0.20	0.17	0.27	0.31	0.35	0.21	0.27	0.20	0.21	0.31	0.12
EMS operational ambulances	*EMS database*	*No*	*212*	*15*	*18*	*19*	*16*	*18*	*18*	*18*	*20*	*13*	*16*	*41*
Total population	*Stats SA*	*No*	*10 703 920*	*767 999*	*1 071 600*	*702 645*	*517 807*	*517 284*	*862 112*	*666 521*	*979 513*	*632 453*	*511 957*	*3 434 029*
2. EMS P1 urban response under 15 minutes rate	EMS database	%	8.4%	6.3%	19.4%	6.9%	40%	78%	N/A	N/A	27.2%	5%	N/A	4.9%
No P1 urban calls with response times under 15 minutes	*EMS database*	*No*	*14 336*	*807*	*3 897*	*1 200*	*859*	*1 586*	*-*	*-*	*289*	*550*	*-*	*5 148*
All P1 urban call outs	*EMS database*	*No*	*171 053*	*12 723*	*20 116*	*17 485*	*2 147*	*2 033*	*-*	*-*	*1 063*	*10 925*	*-*	*104 105*
3. EMS P1 rural response under 40 minutes rate	EMS database	%	32.1%	16.5%	12.5%	20.4%	31.5%	82.6%	46%	20%	34%	15%	18%	19.7%
No P1 rural calls with response times under 40 minutes	*EMS database*	*No*	*69 903*	*2 379*	*1 792*	*2 993*	*10 246*	*17 158*	*14 442*	*3 535*	*10 372*	*2 109*	*4 801*	*76*
All P1 rural call outs	*EMS database*	*No*	*217 491*	*14 377*	*14 328*	*14 672*	*32 554*	*20 764*	*31 407*	*17 660*	*30 518*	*14 099*	*26 727*	*385*
4. EMS P1 call response under 60 minutes rate	EMS database	%	40%	34.6%	30.7%	51.5%	50.4%	86.7%	74.4%	26.7%	51.5%	23.6%	26.7%	18.9%

Quarterly Indicators	Data Source	Type	Province 2012/13	Ugu 2012/13	UMgungundlovu 2012/13	UThukela 2012/13	UMzinyathi 2012/13	Amajuba 2012/13	Zululand 2012/13	UMkhanyakude 2012/13	UThungulu 2012/13	Ilembe 2012/13	Harry Gwala 2012/13	eThekwini 2012/13
No of P1 calls with response times within 60min	*EMS database*	*No*	*222 142*	*14 166*	*21 595*	*23 337*	*21 972*	*38 151*	*31 665*	*7 435*	*21 254*	*9 368*	*10 083*	*23 116*
All P1 call outs	*EMS database*	*No*	*555 860*	*40 929*	*70 419*	*45 323*	*43 555*	*43 994*	*42 578*	*27 828*	*41 241*	*39 638*	*37 795*	*122 560*

Source: From 2012/13 Annual Report unless otherwise indicated

4.4 CUSTOMISED PERFORMANCE INDICATORS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 3: Improved financial management in the health sector*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 5: Improved quality of care*

Table 48: (EMS3) Customised Performance Indicators - EMS and PPT

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Improve access to emergency medical services and response times	1. EMS operational ambulance coverage (annualised)	EMS database	Quarterly No per 10,000 pop	0.20	0.17	0.19	0.19	0.26	0.32	0.39

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	EMS operational ambulances	*EMS database*	*No*	-	*185*	*212*	*208*	*290*	*356*	*431*
	Total population	*Stats SA*	*No*	-	*10 622 204*	*10 703 920*	*10 781 659*	*10 898 644*	*11 010 900*	*11 121 009*
	2. EMS P1 urban response under 15 minutes rate	EMS database	Quarterly %	29%	11.4%	8.4%	6%	15%	22%	30%
	No P1 urban calls with response times under 15 minutes	*EMS database*	*No*	-	*16 242*	*14 336*	*10 432*	*28 223*	*45 534*	*68 301*
	All P1 urban call outs	*EMS database*	*No*	-	*142 864*	*171 053*	*172 452*	*188 158*	*206 973*	*227 670*
	3. EMS P1 rural response under 40 minutes rate	EMS database	Quarterly %	37%	35.9%	32.1%	34%	40%	50%	55%
	No P1 rural calls with response times under 40 minutes	*EMS database*	*No*	-	*66 567*	*69 903*	*24 888*	*95 696*	*131 582*	*173 687*
	All P1 rural call outs	*EMS database*	*No*	-	*185 479*	*217 491*	*73 716*	*239 240*	*263 164*	*315 796*
	4. EMS P1 call response under 60 minutes rate	EMS database	Quarterly %	53%	51.4%	40%	46%	65%	75%	80%
	No of P1 calls with response times within 60min	*EMS database*	*No*	-	*259 496*	*222 142*	*178 388*	*397 439*	*504 442*	*591 879*
	All P1 call outs	*EMS database*	*No*	-	*504 393*	*555 860*	*386 048*	*611 446*	*672 590*	*739 849*

- *Indicator 4 [Response under 60min]*: This indicator changed in 2013/14 from all call outs to P1 call outs.

4.5 PROVINCIAL STRATEGIC OBJECTIVES AND TARGETS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 3: Improved financial management in the health sector*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 5: Improved quality of care*

Table 49: (EMS2) Provincial Strategic Objectives and Targets – EMS and PPT

Strategic Objective Statements	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/1	2012 /13	2013/14	2014/15	2015/16	2016/17
Provision of inter-facility and emergency transport	1. EMS clients total	EMS database/EMS register	Quarterly No	642 760	585 955	576 682	597 448	610 000	620 000	630 000
	2. EMS inter-facility transfer	EMS database/EMS register	Quarterly No	122 337	171 868	185 489	185 848	220 000	230 000	240 000
Increase the number of obstetric ambulances to one per facility (72) by March 2017	3. Number of additional obstetric ambulances introduced	Handover documents	Annual No	Not reported	Not reported	Not reported	Not reported	32 (72 cum)	0	0
Increase the number of inter-facility transport to 72 vehicles by March 2017	4. Number of additional IFT ambulances introduced	Hanover documents	Annual No	Not reported	Not reported	Not reported	Not reported	34 (72 cum)	0	0
Increase the number of daily operational ambulances to 431 by March 2017	5. Average actual operational ambulances	Daily Operations reports	Annual No	Not reported	Not reported	Not reported	Not reported	290	356	431
Rationalise Communication Centres during 2014-2019	6. Number of clustered Communications Centres established and operational	Infrastructure project report/ Com Centres reporting	Annual No	Not reported	Not reported	Not reported	Not reported	1 PMB	2 (3 cum) Empangeni and eThekwini	1 (4 cum) Dundee/ Ladysmith

Strategic Objective Statements	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/1	2012 /13	2013/14	2014/15	2015/16	2016/17
Increase purpose built wash bays with sluice facilities to 27 by March 2017	7. Number of purpose built wash bays with sluice facilities built	Infrastructure project report	Annual No	Not reported	Not reported	Not reported	Not reported	9	9	9
Increase revenue collection for EMS	8. Amount of Revenue generated	BAS	Annual R	Not reported	Not reported	Not reported	Not reported	R 15 million	R 17 million	R 19 million
Increase the number of bases with access to internet to 47 by March 2017	9. Number of bases with access to computers and intranet/ e-mail	IT roll-out report	Annual No	Not reported	Not reported	Not reported	Not reported	48	48	47

- The sub-set indicators to monitor the turn-around strategy have been included in the EMS and Provincial Operational Plans. Robust monitoring of all indicators will be prioritised in the 2014/15 MTEF.

4.6 TARGETS FOR 2014/15

Table 50: (EMS4) 2014/15 Targets – EMS and PPT

Performance Indicators	Targets 2014/15	Targets Q1	Q2	Q3	Q4
Quarterly Targets					
1. EMS operational ambulance coverage (annualised)	0.26/10 000	0.26/ 10 000	0.26/ 10 000	0.26/ 10 000	0.26/ 10 000
2. EMS P1 urban response under 15 minutes rate	15%	10%	10%	15%	15%
3. EMS P1 rural response under 40 minutes rate	40%	30%	35%	40%	40%
4. EMS P1 call response under 60 minutes rate	65%	50%	55%	65%	65%
5. EMS clients total	610 000	148 000	152 000	154 000	156 000
6. EMS inter-facility transfer	220 000	50 000	55 000	57 000	58 000
Annual Targets					
7. Number of additional obstetric ambulances introduced	32 (72 cum)				32 (72 cum)
8. Number of additional IFT ambulances introduced	34 (72 cum)				34 (72 cum)
9. Number of additional emergency ambulances introduced	0				0
10. Average actual operational ambulances	290				290
11. Number of clustered Communications Centres established and operational	2 PMB and eThekwini				2 PMB and eThekwini
12. Number of purpose built wash bays with sluice facilities built	9				9
13. Number of bases compliant with National Core Standards	79				79
14. Revenue generated	R 15 million				R 15 million
15. Number of bases with access to computers and intranet/ e-mail	48				48

4.7 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 51: (EMS5-A) Expenditure Estimates - Programme 3

Sub-Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Emergency Transport	790 015	1 032 954	863 099	907 217	911 181	959 416	1 012 736	1 068 971	1 125 626
Planned Patient Transport	32 603	37 433	62 937	65 145	59 845	35 882	60 702	64 757	68 189
Total	**822 618**	**1 070 387**	**926 036**	**972 362**	**971 026**	**995 298**	**1 073 438**	**1 133 728**	**1 193 816**

Table 52: (EMS5-B) Summary of Provincial Expenditure Estimates by Economic Classification - Programme 3

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/1
Current payments	**733 709**	**856 411**	**870 638**	**936 252**	**934 952**	**959 619**	**1 026 957**	**1 093 538**	**1 151 496**
Compensation of employees	521 434	595 253	641 810	702 642	710 642	713 131	751 280	801 017	843 471
Goods and services	**212 275**	**261 158**	**228 827**	**233 610**	**224 310**	**246 488**	**275 677**	**292 521**	**308 025**
Communication	9 786	9 574	10 766	11 654	9 166	8 913	9 058	9 601	10 110
Computer Services						2 233			
Consultants, Contractors and special services	69 158	86 220	66 924	28 037	97 404	89 356	159 551	170 407	179 439
Inventory	83 717	106 933	98 348	128 278	42 140	69 771	25 211	26 732	28 149
Operating leases	4 722	4 469	2 591	3 138	5 056	2 433	2 520	2 671	2 813
Travel and subsistence	3 266	4 936	4 991	6 211	4 469	4 078	5 100	5 406	5 693
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	41 626	49 026	45 209	56 292	65 939	69 568	74 229	77 704	81 822
Transfers and subsidies to	**2 966**	**3 230**	**4 165**	**6 110**	**4 774**	**4 419**	**4 340**	**4 552**	**4 793**

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/1
Provinces and municipalities	1 461	1 842	1 537	2 415	2 879	2 680	2 040	2 142	2 256
Households	1 505	1 388	2 628	3 695	1 895	1739	2 300	2 410	2 538
Payments for capital assets	**85 673**	**210 745**	**51 234**	**30 000**	**31 300**	**31 260**	**42 141**	**35 638**	**37 527**
Buildings and other fixed structures	19								
Machinery and equipment	85 654	210 745	51 234	30 000	31 300	31 260	42 141	35 638	37 527
Payment for financial assets	270	1							
Total economic classification	**822 618**	**1 070 387**	**926 036**	**972 362**	**971 026**	**995 298**	**1 073 438**	**1 133 728**	**1 193 816**

Performance and Expenditure Trends

The significant increase in 2011/12 relates to the appointment of additional emergency personnel and procurement of emergency medical vehicles. The reduction in 2012/13 is attributed to savings from replacement of ageing emergency fleet vehicles with lower repair and fuel costs for new ambulances. Funding increased in 2013/14 to provide for inflationary adjustments and the gradual filling of vacant posts and slow increase in the number of ambulances.

The overall increase in the sub-programme: Planned Patient Transport results from the successful implementation of the inter-hospital transfer programme.

The increase in *Compensation of employees* from 2011/12 onward relates to the various wage agreements, the introduction of the OSD for emergency personnel, as well as reprioritisation of funding to bring the salaries of emergency medical workers in line with those in other provinces to retain staff and avoid strike action. The high growth in 2013/14 relates to the planned absorption of trainees, the strengthening of obstetrical ambulance services, and provision for standard danger allowances to various categories of Emergency Medical Services personnel.

The main cost drivers under *Goods and services* are fuel and repairs to emergency vehicles, the latter being related to the rough terrain in rural areas. The increase in 2011/12 relates mainly to an increase in fuel costs and vehicle maintenance costs. The negative growth in 2012/13 relates mainly to lower costs on maintenance and repairs of the new fleet of vehicles.

The reduction in the 2013/14 Adjusted Appropriation was due to forced savings to address the pressures within the programme such as the implementation of danger allowances and the installation of night goggles in helicopters linked to aero-medical services. The high growth in 2014/15 is attributable to the high cost of fuel and related maintenance and repair costs. The growth over the remainder of the 2014/15 MTEF provides for inflation only.

The variable trend in *Transfers and subsidies to: Provinces and municipalities* over the entire period is driven by the size of the emergency medical service fleet, with ambulances being procured and the old fleet being disposed of, and registration and licensing costs thereof.

With regard to *Transfers and subsidies to: Households,* the inflated 2012/13 figure relates to a legal claim against the department by the First Aid League, and an increase in staff exit costs.

Regarding *Machinery and equipment*, the significant increase in 2011/12 is attributed to the late delivery of ambulances ordered in 2010/11 and additional ambulances purchased to address shortages and drive to meet the national norms for ambulances per population.

The reduced amount from 2013/14 onward relates to the reprioritisation of funding which will be reviewed during 2015/16, with funding provided only for the replacement of ambulances.

4.8 RISK MANAGEMENT

Potential Risks	Mitigating Factors
1. Infrastructure backlogs including accommodation, office space, ambulance bases, customised wash bays and sluice facilities.	• Prioritisation in U-AMP.
2. Perpetuating backlog/ shortage of	• Implementation of the reviewed EMS strategy

ambulances and trained staff with a limiting funding envelope for the MTEF.	and re-prioritisation based on the funding envelope.
3. Compromised quality due to inadequate skills pool (EMS qualifications).	• Revived EMS Training College and review of training strategy.
4. Cross infections to EMS clinical staff and patients.	• Implementation of Infection Prevention and Control Policy – compliance to ambulance specifications for infection control.
5. Delayed or non-response to emergency calls.	• Improvement on the call categorization/ prioritization.
6. Sexual and physical assault to EMS personnel.	• Community awareness campaigns.
7. Delays in finalisation of disciplinary cases of personnel.	• Recruit labour specialists.
8. High vehicle accident rate (ambulance personnel).	• Institute driver training programme.
9. No skilled technical staff to support technology.	• Establish Technical Component with qualified technical staff.
10. No skilled computer literate staff in Management Centres.	• Establish structure/ career path for Management Centre staff.
11. Staff resistance to amalgamation.	• Implementation of change management process.

Notes

5. PROGRAMME 4: REGIONAL AND SPECIALISED HOSPITALS

Programme Purpose and Structure

There are no changes to the Programme 4 structure.

Purpose

Deliver hospital services, which are accessible, appropriate, and effective and provide general specialist services, including a specialized rehabilitation service, as well as a platform for training health professionals and research.

Sub-Programme 4.1: General (Regional) Hospitals

Render hospital services at a general specialist level and a platform for training of health workers and research.

Sub-Programme 4.2: Specialised Tuberculosis Hospitals

Convert present Tuberculosis hospitals into strategically placed centres of excellence in which a small percentage of patients may undergo hospitalisation under conditions, which allow for isolation during the intensive phase of treatment, as well as the application of the standardized multi-drug resistant (MDR) protocols.

Sub-Programme 4.3: Specialised Psychiatric/ Mental Health Hospitals

Render a specialist psychiatric hospital service for people with mental illness and intellectual disability and provide a platform for the training of health workers and research.

Sub-Programme 4.4: Chronic Medical Hospitals

Provide medium to long term care to patients who require rehabilitation and/or a minimum degree of active medical care but cannot be sent home. These patients are often unable to access ambulatory care at our services or their socio-economic or family circumstances do not allow for them to be cared for at home.

Sub-Programme 4.5: Oral and Dental Training Centre

Render an affordable and comprehensive oral health service and training, based on the primary health care approach.

SUB-PROGRAMME 4.1: REGIONAL HOSPITALS

5.1 OVERVIEW

There are 13 Regional Hospitals making provision for 6 771 usable beds (0.63 beds per 1000 population) compared with the Provincial norm of 0.23 beds per 1000 population.

Regional hospitals continue to render a basket of district and regional package of services, partly due to inequitable distribution of regional services. There are no Regional Hospitals in Umzinyathi, Zululand, Umkhanyakude and Sisonke Districts.

Unreferred cases, entering health services at inappropriate levels, range between 0% and 86.1% which clearly indicate service gaps in the current health system.

The lack of cost centres (and appropriate information systems) jeopardise appropriate costing per level of care which negatively impact on evidence-based planning.

Classification of hospitals will be reviewed based on the current versus proposed service delivery and training platforms in order to ensure optimal utilisation of hospitals.

The Department officially took over the St Aidens Hospital (classified as Regional Hospital) in 2014.

The service package has not been finalised and proposed classification will be based on the final service package.

King Dinuzulu Hospital is currently classified as Regional Hospital and reporting as Specialised TB Hospital. Bed allocation in the hospital includes 320 TB beds, 130 Psychiatric beds (66 operational), and 400 district beds (369 operational). Classification and reporting have been prioritised for 2014/15.

5.2 PRIORITIES AND FOCUS AREAS

Priorities	Focus Areas
1. Improve hospital efficiency and governance *NSO 5: Improved quality of care and* *NSO 8: Human Resources for Health*	• Rationalisation of hospital services (classification; alignment of service delivery and training platforms, centres of service excellence). • Performance Management and Development. • Establishment of cost centers. • Decentralised delegations and accountability.
2. Infrastructure *NSO 2: Health facility planning*	• Facilities audit to inform medium/long term plans. • Maintenance as per U-Amp.
3. Improved patient care *NSO 5: Improved quality of care*	• Implementation of National Core Standards. • Establish improved patient management system including bed bureau. • Clinical Governance including outreach and support programmes.
4. Improve Human Resource for Health *NSO 8: Improve Human Resources for Health*	• Management capacity and accountability - CEOs. • Human Resources for Health Strategy (gap analysis for Regional Hospitals) and management of critical posts.

5.3 CUSTOMISED PERFORMANCE INDICATORS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 3: Improved financial management in the health sector*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 5: Improved quality of care*

Table 53: (PHS2) Customised Performance Indicators - Regional Hospitals

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Improve hospital efficiencies by implementing the long-term plan for hospital revitalisation 2014-2019	1. Average length of stay – total	DHIS	Quarterly Days	5.2 Days	5.3 Days	5.4 Days	6.1 Days	5.3 Days	5.3 Days	5.2 Days
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*1 971 248*	*2 086 603*	*1 930 175*	*1 927 620*	*1 882 625*	*1 854 385*	*1 826 569*
	Day Patients	*DHIS/ Midnight Census*	*No*	*50 285*	*35 051*	*41 603*	*42 786*	*46 399*	*46 863*	*47 332*
	Separations	*DHIS calculates*	*No*	*383 712*	*381 657*	*361 422*	*363 974*	*361 062*	*358 174*	*355 308*
	2. Inpatient bed utilisation rate – total	DHIS	Quarterly %	66.5%	78.4%	75.2%	86.5%	76.5%	78.6%	80.6%
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*1 971 248*	*2 086 603*	*1 930 175*	*1 927 620*	*1 882 625*	*1 854 385*	*1 826 569*
	Day Patients	*DHIS/ Midnight Census*	*No*	*50 285*	*35 051*	*41 603*	*42 786*	*46 399*	*46 863*	*47 332*
	Number of usable beds	*DHIS/ FIO*	*No*	*98 658*	*2 675 778*	*2 591 934*	*2 484 300*	*2 488 257*	*2 388 726*	*2 293 177*
Maintain expenditure per PDE within the provincial norms	3. Expenditure per patient day equivalent (PDE)	BAS/DHIS	Quarterly R	R 1 372*	R 1 872*	R 2 067*	R 2 191	R 2 241	R 2 342	R 2 418
	Total expenditure Regional Hospital	*BAS*	*R'000*	*4 473 068*	*5 773 286*	*6 375 683*	*6 891 397*	*7 114 952*	*7 582 087*	*7 983 938*
	Patient day equivalents	*DHIS calculates*	*No*	*3 258 388*	*3 343 858*	*3 083 881*	*3 144 956*	*3 173 510*	*3 236 980*	*3 301 719*

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Improve the complaint resolution within 25 working days rate to 80% (or more) by March 2017	4. Complaint resolution within 25 working days rate	DHIS	Quarterly %	55.9%*	66%	57.4%	61.9%	70%	75%	80%
	Total number of complaints resolved within 25 days in reporting period	*Complaints register*	*No*	*803*	*534*	*529*	*470*	-	-	-
	Total number of complaints received during the same reporting period	*Complaints register*	*No*	*1 434*	*807*	*916*	*759*	-	-	-
Implement the 5-year Mental Health Care Strategy	5. Mental health admission rate	DHIS	Quarterly %	1.3%	1.4%	1.2%	1.2%	1.4%	1.4%	1.3%
	Mental health admissions total	*DHIS calculates*	*No*	*4 940*	*5 679*	*4 365*	*3 818*	*4 321*	*4 278*	*4 235*
	Inpatient separations	*DHIS calculates*	*No*	*375 610*	*385 005*	*361 422*	*310 162*	*362 145*	*362 869*	*363 595*
Improve the patient satisfaction rate to 90% by March 2017	6. Patient satisfaction rate	DHIS	Annual %	Not reported	60%	76%	Not available	80%	85%	90%
	Total number of users that were satisfied with the services they received	*PSS results*	*No*	-	-	*1 178*	-	-	-	-
	The total number of users that participated in Client Satisfaction Survey	*PSS results*	*No*	-	-	*1 545*	-	-	-	-
80% of facilities conditionally compliant (50% - 75%) to the National Core Standards by March 2019	7. Percentage of Regional Hospitals that have conducted gap assessments for compliance against the National Core Standards	QA database	Quarterly %	Not reported	Not reported	Not reported	100%	100%	100%	100%
	Regional Hospitals that conducted gap assessments for compliance	*QA database/ Self-assessment reports*	*No*	-	-	-	*13*	*13*	*13*	*13*
	Regional Hospitals total	*DHIS calculates*	*No*	-	-	-	*13*	*13*	*13*	*13*

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	8. Proportion of Regional Hospitals assessed as compliant with the Extreme Measures of National Core Standards	QA database	Quarterly %	Not reported	Not reported	Not reported	Not reported	23%	35%	50%
	Regional Hospitals fully compliant with all Extreme Measures of National Core Standards	*QA database/ Self-assessment reports*	*No*	-	-	-	-	*3*	*5*	*7*
	Regional Hospitals total	*DHIS calculates*	*No*	-	-	-	-	*13*	*13*	*13*

5.4 PROVINCIAL STRATEGIC OBJECTIVES AND TARGETS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 3: Improved financial management in the health sector*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 5: Improved quality of care*

Table 54: (PHS1-A) Provincial Strategic Objectives and Targets - Regional Hospitals

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Improve hospital efficiencies by implementing the long-term plan for hospital revitalisation 2014/15-2019	1. Delivery by caesarean section rate	DHIS	Quarterly %	35.6%	38.2%	39.8%	39.4%	39.3%	39%	38.6%
	Number of caesarean sections performed	*DHIS/Delivery Register*	*No*	*28 253*	*31 259*	*30 393*	*30 106*	*30 477*	*30 681*	*30 881*
	Total number of deliveries in the facility	*DHIS/Delivery Register*	*No*	*79 159*	*81 790*	*76 306*	*76 324*	*77 459*	*78 621*	*79 800*
	2. OPD headcount - total	*DHIS/OPD tick register*	Quarterly No	3 195 790	3 336 687	3 158 541	3 237 542	3 211 626	3 241 743	3 276 180
	3. OPD headcount - new case not referred	*DHIS/OPD tick register*	Quarterly No	272 216	552 314	397 096	308 572	395 111	393 135	391 169

5.5 TARGETS FOR 2014/15

Table 55: (PHS4-A) 2014/15 Targets – Regional Hospitals

Performance Indicator	Target 2014/15	Target Q1	Q2	Q3	Q4
Quarterly Targets					
1. Average length of stay – total	5.3 Days	5.9 Days	5.7 Days	5.5 Days	5.3 Days
2. Inpatient bed utilisation rate – total	76.5%	75%	75.5%	76%	76.5%
3. Expenditure per patient day equivalent	R 2 241	R 2 195	R 2 150	R 2 200	R 2 241
4. Complaint resolution within 25 working days rate	70%	63%	66%	68%	70%
5. Mental health admission rate	1.4%	1.2%	1.2%	1.3%	1.4%
6. Percentage of Regional Hospitals that have conducted gap assessments for compliance against the National Core Standards	100%	50%	75%	90%	100%
7. Proportion of Regional Hospitals assessed as compliant with the Extreme Measures of National Core Standards	23%	8%	8%	15%	23%
8. Delivery by caesarean section rate	39.3%	39.4%	39.4%	39.3%	39.3%
9. OPD headcount – total	3 211 626	802 906	802 906	802 906	802 904
10. OPD headcount - new case not referred	395 111	98 778	98 778	98 778	98 778
Annual Targets					
11. Patient Satisfaction Rate	80%				80%

5.6 RISK MANAGEMENT - REGIONAL HOSPITALS

Potential Risks	Mitigating Factors
1. Generic structures not in line with service platform.	• Organisational review commenced.
2. Limited funding envelope for development of the service delivery platform and inadequate financial management	• Establish Cost Centres (5-year plan). • Re-prioritisation within funding envelope (long-term plan). • Strengthening financial services including supply chain management and contract management. • Robust expenditure reviews (provincial, district and institutions).
3. Lack of a comprehensive gap analysis (clinical/ skills gap); Provincial/District HRPs not prioritising filling of critical posts at institutional/ district level; high turn-over rate (rural/urban) affecting skills gap; lack of joint decision-	• Skills gap analysis/staff profiling; determine staffing norms aligned with service platform and burden of disease; align HR Plan with service demand and training platform. • Essential Post List (prioritisation of critical posts)

making in prioritising critical posts.	within funding envelope.
4. Poor data quality, poor information management and monitoring and evaluation.	• Implement the Information management strategy. • Review M&E structures/function at institutional level.
5. Training platform not aligned with PHC vision (Health Sciences); inadequate supply of health workers; training centralised to eThekwini and Umgungundlovu.	• Review training platform in partnership with UKZN – decentralised training model with PHC focus. Include basic, Registrar, Intern, Nurse and Mid-Level Worker training.

SUB-PROGRAMME 4.2: SPECIALISED TB HOSPITALS

5.7 OVERVIEW

TB clients are admitted when access to community-based care is not available or their clinical condition warrants admission. Clients should be discharged to outpatient care at clinic level as soon as they can be managed effectively in the community with DOT support.

Referral from PHC clinics and General Hospitals to Specialised TB Hospitals is indicated if at least one of the following admission criteria is met:

1. Medical reason for admission: When clients diagnosed with TB are too ill or weak to go home, including severely emaciated TB clients without other complications.
2. Re-treatment TB patients that require streptomycin injections that cannot be managed at clinic level.
3. Social or socio-medical reasons: When clinic or community supported care cannot be achieved, particularly in the case of high-risk groups including alcohol or drug dependence, mentally ill clients or previously non-compliant clients.

There are nine decentralised MDR-TB units and one centralised unit. These units are responsible for treatment initiation and management of MDR-TB patients in a defined geographical area, initially as inpatients, and then as outpatients.

The ultimate objective for the Province is to have one decentralised site in each district to ensure equitable access to services. The table below includes the TB Control Programme plans for MDR-TB which will contribute towards decreasing the patient load in King Dinuzulu Hospital.

Opening of the additional decentralised sites also forms part of the plan to decant patients from former SANTA hospitals.

Table 56: MDR-TB Decentralized and Satellite Sites

District	Decentralised MDR-TB Management Units	No. of MDR-TB beds – Decentralised Units	MDR-TB Satellite Sites	Proposed New Units to ensure equitable access and distribution of resources
Ugu	Murchison	40	Dustan Farrell	-
eThekwini	King Dinuzulu	377	FOSA, Don McKenzie, Charles James	-
Zululand	Thulasizwe	65	Itshelejuba, Nkonjeni, Benedictine	-
Harry Gwala	St Margaret's	30	Rietvlei	-
Umkhanyakude	Manguzi Hlabisa	40 35	Bethesda, Mseleni and Mosvold	-
UThungulu	Catherine Booth	40	Ngwelezana, Eshowe and Mbongolwane	-
ILembe	None	0	None	Montebello Hospital has been identified as decentralised MDR-TB unit for ILembe. 12 beds have been identified for MDR-TB in the hospital without provision for Outpatient services. As interim measure one of the Park homes donated by URC will be used in interim.
UMgungundlovu	Doris Goodwin	64	Edendale	-
UMzinyathi	Greytown	37	COSH and CJM	-
UThukela	None	0	None	Estcourt Hospital has been identified as the decentralised MDR-TB unit for UThukela. 12 beds have been identified with the identified ward being suitable for the management of infectious diseases. There is no space for Outpatient services, and temporary utilisation of a park home donated by URC will be used.
Amajuba	None	0	None	Madadeni Hospital identified as the decentralised MDR-TB unit. 32 dedicated MDR-TB beds are unofficially dedicated for MDR-TB while current patients are initiated on treatment at King Dinuzulu Hospital. Building has been identified although in need of renovation and repair. MDR-TB initiation of treatment will start once renovations are complete.

Source: KZN TB Control Programme

One of the criteria for the admission of patients to Specialised TB Hospitals is for re-treatment TB cases that require streptomycin injections that cannot be managed at a clinic. With the introduction of GeneXpert, the criterion became null and void. Patients resistant to Rifampicin are treated as MDR-TB patients and the Retreatment patients after relapse, default or failure who are Rifampicin-susceptible are put on the regimen for new patients (Regimen 1). There is therefore no need for the retreatment regimen (Regimen 2) which includes Streptomycin injections.

The Department is in the process to review utilisation of the former SANTA Hospitals as a result of poor efficiencies.

The workload at King Dinuzulu Hospital is a concern that will be addressed as part of the rationalisation of hospitals over the MTEF.

5.8 PRIORITIES AND FOCUS AREAS

Priorities	Focus Areas
1. Decentralised and Satellite MDR TB Units *NSO 2: Health Facility Planning*	• Review service platform for the management of MDR-TB in line with rationalisation process. • Community-based management of MDR-TB linked with in-patient care and PHC re-engineering. • Review of post establishments (based on gap analysis) and fast track filling of critical posts.
2. Overhaul Specialised TB Hospitals as part of rationalisation of hospital services *NSO 1: Prevent and reduce the disease burden and promote health* *NSO 5: Improved quality of care* *NSO 8: Improved Human Resources for Health*	• Review options for ex-SANTA Hospitals to improve efficiencies in response to burden of disease.

5.9 CUSTOMISED PERFORMANCE INDICATORS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 3: Improved financial management in the health sector*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 5: Improved quality of care*

Table 57: (PHS2-B) Customised Performance Indicators - Specialised TB Hospitals

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Improve hospital efficiencies by implementing the long-term plan for hospital revitalisation 2014-2019	1. Inpatient bed utilisation rate – total	DHIS	Quarterly %	67.7%	62.2%	55.6%	53.7%	56.1%	56.7%	57.3%
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*443 404*	*424 248*	*400 051*	*382 016*	*396 050*	*392 090*	*388 169*
	Day Patients	*DHIS/ Midnight Census*	*No*	*8 334*	*2 691*	*1 212*	*680*	*1 200*	*1 188*	*1 176*
	Number of usable beds	*DHIS*	*No*	*661 361*	*610 280*	*720 285*	*712 986*	*705 879*	*691 762*	*677 926*
Maintain expenditure per PDE within the provincial norms	2. Expenditure per patient day equivalent (PDE)[16]	BAS/DHIS	Quarterly R	R 1 705*	R 1 813*	R 1 217	R 1 323	R 1 435	R 1 551	R 1 664
	Total expenditure TB Hospitals	*BAS*	*R'000*	*832 030*	*891 705*	*591 900*	*628 315*	*669 183*	*710 328*	*747 975*
	Patient day equivalents	*DHIS calculates*	*No*	*487 890*	*491 803*	*486 284*	*474 662*	*466 118*	*457 728*	*449 489*
Improve the complaint resolution within 25 working days rate to 80% (or more) by March 2017	3. Complaint resolution within 25 working days rate	DHIS	Quarterly %	Not reported	Not reported	Not reported	20.4%	60%	70%	80%
	Total number of complaints resolved within 25 days in reporting period	*Complaints Register*	*No*	*-*	*-*	*-*	*34*	*-*	*-*	*-*

[16] For planning purposes, NHLS costs for Genie Expert and NPI's have been included in the projected budget figures

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	Total number of complaints received during the same reporting period	*Complaints Register*	*No*	-	-	-	*152*	-	-	-
Implement the 5-year Mental Health Care Strategy	4. Mental health admission rate	DHIS	Quarterly %	5.5%	5.3%	3.7%	1.6% [17]	3.7%	3.6%	3.5%
	Mental health admissions total	*DHIS calculates*	*No*	*343*	*327*	*482*	*332*	*472*	*463*	*454*
	Inpatient separations	*DHIS calculates*	*No*	*6 208*	*6 116*	*12 892*	*21 154*	*12 931*	*12 969*	*13 008*
Improve the patient satisfaction rate to 75% by March 2017	5. Patient satisfaction rate	DHIS	Annual %	Not reported	Not reported	Not reported	Not reported	Establish baseline	Dependent on baseline	-
	Total number of users that were satisfied with the services they received	*Survey results*	*No*	-	-	-	-	-	-	-
	The total number of users that participated in PSS	*Survey results*	*No*	-	-	-	-	-	-	-
80% of facilities conditionally compliant (50% - 75%) to the National Core Standards by March 2019	6. Percentage of TB Hospitals that have conducted gap assessments for compliance against the National Core Standards	QA database	Quarterly %	Not reported	Not reported	0	0	100%	100%	100%
	TB Hospitals that conducted gap assessments for compliance against National Core Standards	*Assessment records*	*No*	-	-	*0*	*0*	*10*	*10*	*10*
	TB Hospitals total	*DHIS calculates*	*No*	-	-	*0*	*0*	*10*	*10*	*10*
	7. Proportion of TB Hospitals assessed as compliant with the Extreme Measures of National Core Standards	QA database	Quarterly %	Not reported	Not reported	0	0	20%	40%	60%

[17] Data is questionable and are being verified – not available at time of tabling the plan

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	TB Hospitals fully compliant (75%-100%) to all extreme measures of National Core Standards	*QA assessment records*	*No*	*-*	*-*	*0*	*0*	*2*	*4*	*6*
	TB Hospitals total	*DHIS calculates*	*No*	*-*	*-*	*0*	*0*	*10*	*10*	*10*

- Indicator 6 and 7: Number of hospital excluding State Aided Hospitals

5.10 PROVINCIAL STRATEGIC OBJECTIVES AND TARGETS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 3: Improved financial management in the health sector*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 5: Improved quality of care*

Table 58: (PHS1-D) Provincial Strategic Objectives and Targets - Specialised TB Hospitals

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Improve hospital efficiencies by implementing the long-term plan for hospital revitalisation 2014-2019	1. Average length of stay – total	DHIS	Quarterly Days	46.2 Days	39.9 Days	26.1 Days	19.1 Days	25.6 Days	25.1 Days	24.6 Days
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*443 404*	*424 248*	*400 051*	*420 884*	*396 050*	*392 090*	*388 169*
	Day Patients	*DHIS/ Midnight Census*	*No*	*8 334*	*2 691*	*1 212*	*680*	*1 200*	*1 188*	*1 176*
	Separations	*DHIS calculates*	*No*	*9 690*	*10 662*	*15 354*	*22 036*	*15 487*	*15 642*	*15 799*
	2. OPD headcount – total	DHIS/OPD tick register	Quarterly No	133 666	206 452	236 657	271 638	263 306	269 889	276 636
	3. OPD headcount - new case not referred	DHIS/OPD tick register	Quarterly No	1 595	2 839	20 449	31 258	20 653	20 860	21 069

5.11 TARGETS FOR 2014/15

Table 59: (PHS4-B) 2014/15 Targets – Specialised TB Hospitals

Performance Indicators	Targets 2014/15	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Inpatient bed utilisation rate – total	56.1%	53%	54%	55%	56.1%
2. Expenditure per patient day equivalent (PDE)	R 1 435	R 1 215	R 1 300	R 1 390	R 1 435
3. Complaint resolution within 25 working days rate	60%	30%	40%	50%	60%
4. Mental health admission rate	3.7%	3.5%	3.5%	3.6%	3.7%
5. Percentage of TB Hospitals that have conducted gap assessments for compliance against the National Core Standards	100%	25%	50%	75%	100%
6. Proportion of TB Hospitals assessed as compliant with the Extreme Measures of National Core Standards	20%	0%	0%	10%	20%
7. Average Length of Stay	25.6 Days	25.6 Days	25.6 Days	25.6 Days	25.6 Days
8. OPD headcount – total	263 306	65 826	65 826	65 826	65 868
9. OPD headcount – new case not referred	20 653	5 163	5 163	5 163	5 163
Annual Targets					
10. Patient Satisfaction Rate	Establish baseline				Baseline established

5.12 RISK MANAGEMENT

Potential Risks	Mitigating Factors
1. Poor hospital efficiencies	• Hospital revitalisation strategy (5-year strategy) – including previous SANTA hospitals
2. Poor data quality and evidence-based planning	• Information strategy
3. Poor monitoring, evaluation and reporting	• Review of M&E function at institutional level
4. Costing model outdated and not aligned with burden of disease	• Establishing cost centres (5-year plan)

SUB-PROGRAMME 4.3: SPECIALISED PSYCHIATRIC HOSPITALS

5.13 OVERVIEW

There are 6 Specialised Psychiatric Hospitals in the Province including St Francis Hospital in Zululand (17 Psychiatric beds) which is not functioning as Specialised hospital. Classification of the hospital will be reviewed as part of the rationalisation of hospital services in 2014/15.

King Dinuzulu Hospital has 66 of 130 psychiatric beds commissioned as some of the wards have been closed down awaiting extensive upgrade and maintenance.

Table 60: Specialised Psychiatric Services beds

Hospital	Approved Beds	Usable Beds
Town Hill	425	304
Fort Napier	450	370
UMzimkhulu	320	320
King Dinuzulu	130	66
Umgeni	624	321
Ekuhlengeni	1100	965

Source: Mental Health Programme

The main challenges that will be addressed as part of the Mental Health Care Strategy 2014-2019 include:

- Lack of an Adolescent Observation Unit at Fort Napier Hospital.
- Inadequate human resources including trained and skilled Advanced Psychiatric and Forensic Nurses, Clinical Psychologists that all play a vital role in forensic assessment and community outreach services and Specialists.
- Slow progress with the infrastructure projects for Specialised Psychiatric Hospitals.
- Inadequate security fencing at psychiatric hospitals resulting in absconding of State Patients from security facilities.

5.14 PRIORITIES AND FOCUS AREAS

Priorities	Focus Areas
1. Revitalisation of Psychiatric services *NSO 1: Prevent and reduce the disease burden and promote health* *NSO 2: Health Facility Planning* *NSO 5: Improved quality of care* *NSO 8: Improved Human Resources for Health*	• Implement the Mental Health Care Strategy 2014-2019. • Expedite full commissioning of King Dinuzulu (George V) Psychiatric Hospital.

5.15 CUSTOMISED PERFORMANCE INDICATORS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 3: Improved financial management in the health sector*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 5: Improved quality of care*

Table 61: (PHS2-C) Customised Performance Indicators - Specialised Psychiatric Hospitals

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Improve hospital efficiencies by implementing the long-term plan for hospital revitalisation 2014-2019	1. Inpatient bed utilisation rate – total	DHIS	Quarterly Rate	72.6%	72%[18]	68.7%	69.4%	69.4%	70%	70.8%
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*641 154*	*645 803*	*641 542*	639 132	*635 127*	*628 775*	*622 488*
	Day Patients	*DHIS/ Midnight Census*	*No*	*14 853*	*6 (17 881)*	*2*	*0*	*2*	*2*	*2*
	Number of usable beds	*DHIS*	*No*	*892 918*	*900 455*	*934 107*	*919 148*	*915 425*	*897 116*	*879 174*
Maintain expenditure per PDE within the provincial norms	2. Expenditure per patient day equivalent (PDE)	BAS/DHIS	Quarterly R	R 828*	R 911*	R 991*	R 1 151	R 1 129	R 1 206	R 1 263
	Total expenditure Psychiatric Hospitals	*BAS*	*R'000*	*533 949*	*570 999*	*641 667*	*692 950*	*743 815*	*788 396*	*830 181*
	Patient day equivalents	*DHIS calculates*	*No*	*644 497*	*626 312*	*647 115*	*601 632*	*650 351*	*653 602*	*656 870*
Improve the complaint resolution within 25 working days rate to 95%	3. Complaint resolution within 25 working days rate	DHIS	Quarterly %	Not reported	Not reported	Not reported	82.2%	85%	90%	95%

[18] Data corrected since publishing of the 2011/12 Annual Report – BUR changed from 83.3% to 72%

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
(or more) by March 2017	*Total number of complaints resolved within 25 days in reporting period*	*Complaints register*	*No*	-	-	-	*37*			
	Total number of complaints received during the same reporting period	*Complaints register*	*No*	-	-	-	*45*			
Improve the patient satisfaction rate to 85% by March 2017	4. Patient satisfaction rate	DHIS	Annual %	Not reported	Not reported	Not reported	Not available	Establish baseline	Dependent on baseline	-
	Total number of users that were satisfied with the services they received	*Survey results*	*No*	-	-	-	-	-	-	-
	The total number of users that participated in Client Satisfaction Survey	*Survey results*	*No*	-	-	-	-	-	-	-
80% of facilities conditionally compliant (50% - 75%) to the National Core Standards by March 2019	5. Percentage of Psychiatric Hospitals that have conducted gap assessments for compliance against the National Core Standards	QA database	%	Not reported	Not reported	0	0	100%	100%	100%
	Psychiatric Hospitals that conducted gap assessments for compliance	*QA assessment records*	*No*	-	-	*0*	*0*	*6*	*6*	*6*
	Psychiatric Hospitals total	*DHIS calculates*	*No*	-	-	*0*	*0*	*6*	*6*	*6*
	6. Proportion of Psychiatric Hospitals assessed as compliant with the Extreme Measures of National Core Standards	QA database	%	Not reported	Not reported	Not reported	Not reported	17%	33%	50%
	Psychiatric Hospitals fully compliant (75%-100%) to all extreme measures of National Core Standards	*QA assessment records*	*No*	-	-	-	-	*1*	*2*	*3*

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	Psychiatric Hospitals total	*DHIS calculates*	*No*	-	-	-	-	6	6	6

5.16 PROVINCIAL STRATEGIC OBJECTIVES AND TARGETS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 3: Improved financial management in the health sector*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 5: Improved quality of care*

Table 62: (PHS1-F) Provincial Strategic Objectives and Targets - Specialised Psychiatric Hospitals

Strategic Objective Statement	Performance Indicators	Data Source	Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Improve hospital efficiencies by implementing the long-term plan for hospital revitalisation 2014/15-2019	1. Average length of stay – total	DHIS	Days	219.5 Days	254 Days	264 Days	295.9 Days	260 Days	256.2 Days	252.3 Days
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*641 154*	*645 803*	*641 542*	639 132	*635 127*	*628 775*	*622 488*
	Day Patients	*DHIS/ Midnight Census*	*No*	*14 853*	*6*	*2*	*0*	*2*	*2*	*2*
	Separations	*DHIS calculates*	*No*	*2954*	*2 533*	*2 430*	*2 160*	*2 442*	*2 454*	*2 467*
	2. OPD headcount – total	DHIS/OPD tick register	No	10 322	15 425	17 647	15 834	17 682	17 718	17 753
	3. OPD headcount - new case not referred	DHIS/OPD tick register	No	166	986	1 003	508	993	983	973

5.17 TARGETS FOR 2014/15

Table 63: (PHS4-C) 2014/15 Targets – Specialised Psychiatric Hospitals

Performance Indicator	Target 2014/15	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Inpatient bed utilisation rate – total	69.4%	67%	68%	69%	69.4%
2. Expenditure per patient day equivalent	R 1 129	R 995	R 1 000	R 1 097	R 1 129
3. Complaint resolution within 25 working days rate	85%	82.2%	83%	84%	85%
4. Percentage of Psychiatric Hospitals that have conducted gap assessments for compliance against the National Core Standards	100%	25%	50%	75%	100%
5. Proportion of Psychiatric Hospitals assessed as compliant with the Extreme Measures of National Core Standards	17%	0%	0%	0%	17%
6. Average Length of Stay	260 Days	266 Days	264 Days	262 Days	260 Days
7. OPD headcount – total	17 682	4 420	4 420	4 420	4 420
8. OPD headcount – new case not referred	993	248	248	248	248
Annual Targets					
9. Patient Satisfaction Rate	Establish baseline				Baseline established

5.18 RISK MANAGEMENT

Potential Risks	Mitigating Factors
1. Inequities in distribution of institutions	• Rationalisation of services as per Mental Health Strategy.
2. Inability to cost services	• Cost centres in all institutions.
3. Inadequate skills mix and competencies in mental health services	• Mental Health Strategy.

SUB-PROGRAMME 4.4: CHRONIC HOSPITALS

5.19 OVERVIEW

McCord Hospital (previously State Aided) has been taken over by the Department of Health on 1 February 2014. The hospital has 100 beds and the service platform makes provision for Sub-acute/ palliative (General and Paediatric) service package; and General outpatient services from Monday to Friday (excluding public holidays) from 08:00 to 17:00 with no admissions via the outpatient service. All admissions will be referred to other institutions.

5.20 PRIORITIES AND FOCUS AREAS

Priorities	Focus Areas
1. Revitalisation of Chronic and Sub-Acute Hospital services *NSO 1: Prevent and reduce the disease burden and promote health* *NSO 2: Health Facility Planning* *NSO 5: Improved quality of care* *NSO 8: Improved Human Resources for Health*	• Review service delivery platform of all institutions. • Implement the national core standards to improve efficiency and quality. • Improve management capacity and accountability. • Critical review of efficiency indicators.

5.21 CUSTOMISED PERFORMANCE INDICATORS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 3: Improved financial management in the health sector*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 5: Improved quality of care*

Table 64: (PHS2-D) Customised Performance Indicators - Chronic/Sub-Acute Hospitals

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Improve hospital efficiencies by implementing the long-term plan for hospital revitalisation 2014/15-2019	1. Inpatient bed utilisation rate – total	DHIS	Quarterly Rate	63.4%	61.2%	67.4%	78.7%	68%	68.7%	69%
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*132 819*	*131 436*	*129 037*	*116 200*	*127 747*	*126 469*	*125 204*
	Day Patients	*DHIS/ Midnight Census*	*No*	*1 885*	*0*	*354*	*272*	*356*	*358*	*359*
	Number of usable beds	*DHIS/ FIO*	*No*	*210 871*	*151 840*	*191 707*	*149 215*	*187 873*	*184 115*	*180 433*
Maintain expenditure per PDE within the provincial norms	2. Expenditure per patient day equivalent (PDE)	BAS/DHIS	Quarterly R	R 1 051*	R 1 097*	R 1 217*	R 1 851	R 1 409	R 1 449	R1 481
	Total expenditure – Chronic Hospitals	*BAS*	*R'000*	*183 463*	*199 149*	*203 283*	*218 731*	*242 501*	*256 829*	*270 441*
	Patient day equivalent	*DHIS calculates*	*No*	*174 525*	*181 411*	*167 007*	*118 120*	*172 017*	*177 178*	*182 493*
Implement the 5-year Mental Health Care Strategy	3. Mental health admission rate	DHIS calculates	Quarterly %	0%	0%	0%	0%	0%	0%	0%
	Mental health admissions total	*DHIS calculates*	*No*	*0*	*0*	*0*	*0*	-	-	-
	Inpatient separations	*DHIS calculates*	*No*	*2 068*	*3 842*	*3 063*	*3 610*	-	-	-

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Improve the complaint resolution within 25 working days rate to 75% (or more) by March 2017	4. Complaint resolution within 25 working days rate	DHIS	Quarterly %	Not reported	Not reported	Not reported	Not available	50%	60%	70%
	Complaints resolved within 25 days	*PSS*	*No*	-	-	-	-	-	-	-
	Total number complaints received	*PSS*	*No*	-	-	-	-	-	-	-
Improve the patient satisfaction rate to 85% by March 2017	5. Patient satisfaction rate	DHIS	Annual %	Not reported	Not reported	Not reported	Not reported	Establish baseline	Dependent on baseline	-
	Total number of users that were satisfied with the services they received	*Survey results*	*No*	-	-	-	-	-	-	-
	The total number of users that participated in Client Satisfaction Survey	*Survey results*	*No*	-	-	-	-	-	-	-
80% of facilities conditionally compliant (50% - 75%) to the National Core Standards by March 2019	6. Percentage of Chronic/Sub-acute Hospitals that have conducted gap assessments for compliance against the National Core Standards	QA database	%	Not reported	Not reported	Not reported	0	100%	100%	100%
	Chronic/Sub-acute Hospitals that conducted gap assessments for compliance	*QA assessment records*	*No*	-	-	-	*0*	*2*	*2*	*2*
	Chronic/Sub-acute Hospitals total	*DHIS calculates*	*No*	-	-	-	*0*	*2*	*2*	*2*
	7. Proportion of Chronic/Sub-acute Hospitals assessed as compliant with the Extreme Measures of National Core Standards	QA database	%	Not reported	Not reported	Not reported	0	50%	100%	100%

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	Chronic/Sub-acute Hospitals fully compliant (75%-100%) to all extreme measures of National Core Standards	*QA assessment records*	*No*	-	-	-	*0*	*1*	*2*	*2*
	Chronic/Sub-acute Hospitals total	*DHIS calculates*	*No*	-	-	-	*0*	*2*	*2*	*2*

- 2011/12 Average Length of Stay – updated data used, considering that what was reported on the Annual Report would be an outlier (22.1 days)

5.22 PROVINCIAL STRATEGIC OBJECTIVES AND TARGETS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 3: Improved financial management in the health sector*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 5: Improved quality of care*

Table 65: (PHS1-H) Provincial Strategic Objectives and Annual Targets - Chronic/Sub-Acute Hospitals

Strategic Objective Statement	Performance Indicators	Data Source	Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Improve hospital efficiencies by implementing the long-term plan for hospital revitalisation 2014-2019	1. Average length of stay – total	DHIS	Days	37.2 Days	33.5 Days	39.1 Days	35.8 Days	38.5 Days	37.9 Days	37.4 Days
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*132 819*	*130 183*	*129 037*	*126 334*	*127 747*	*126 469*	*125 204*
	Day Patients	*DHIS/ Midnight Census*	*No*	*1 885*	*2 982*	*354*	*0*	*356*	*358*	*359*
	Separations	*DHIS calculates*	*No*	*3 591*	*3 884*	*3 302*	*3 528*	*3 319*	*3 335*	*3 352*
	2. OPD headcount – total	DHIS/OPD tick register	No	136 951	158 684	115 055	6 296	113 904	112 765	111 638
	3. OPD headcount – new cases not referred	DHIS/OPD tick register	No	20 987	157 386	109 232	Being verified	108 140	107 058	105 988

5.23 TARGETS FOR 2014/15

Table 66: (PHS4-D) 2014/15 Targets – Chronic/Sub-Acute Hospitals

Performance Indicator	Target 2014/15	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Inpatient Bed utilisation rate – total	68%	66.5%	67%	67.5%	68%
2. Expenditure per patient day equivalent	R 1 409	R 1 750	R 1 649	R 1 503	R 1 409
3. Mental health admission rate	0%	0%	0%	0%	0%
4. Complaint resolution within 25 working days rate	50%	35%	40%	45%	50%
5. Percentage of Chronic/Sub-acute Hospitals that have conducted gap assessments for compliance against the National Core Standards	100%	100%	100%	100%	100%
6. Proportion of Chronic/Sub-acute Hospitals assessed as compliant with the Extreme Measures of National Core Standards	50%	0%	0%	0%	50%
7. Average Length of Stay	38.5 days	39.9 days	39.5 days	39 days	38.5 days
8. OPD headcount -total	113 904	28 476	28 476	28 476	28 476
9. OPD headcount – new cases not referred	108 140	27 035	27 035	27 035	27 035
Annual Targets					
10. Patient Satisfaction Rate	Establish baseline				Baseline established

5.24 RISK MANAGEMENT

Potential Risks	Mitigating Factors
1. Service delivery platform	• Rationalisation of hospital services
2. Poor hospital efficiencies	

SUB-PROGRAMME 4.5: ORAL AND DENTAL TRAINING CENTRE

5.25 OVERVIEW

The Oral and Dental Training Centre is situated at King Dinuzulu Hospital in eThekwini District. The centre is responsible for training Oral Hygienists and Dental Therapists as well as offering Primary and Secondary Oral and Dental health services. The centre produces about 5 Oral Hygienists and about 40 Dental Therapists at a time.

The Department of Health is working with the University of KwaZulu-Natal (UKZN) to revitalise the Oral and Dental Training centre. The revitalisation plan includes adding 7- 8 dental chairs (UKZN), increasing the space and recruiting more specialists (Maxillo-facial and Orthodontists). The Training centre should increase the number of Oral Hygienists trained,

considering that they are the face of Dental care in preventive services and they comprise only about 0.1% of the students produced by the Training centre.

5.26 PRIORITIES AND FOCUS AREAS

Priorities	Focus Areas
1. Revitalisation of the Oral and Dental Training Centre	• Revitalisation Plan in collaboration with UKZN

ADDINGTON CHILDREN'S HOSPITAL

This facility is currently functioning as a children's clinic. The next Phase (2014) includes refurbishing the outside of the Old Nursing Home and Prince Wing – no funding from the DOH. A total budget of R 13 million has been allocated for CoE and G&S for the Assessment Centre.

5.27 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 67: (PHS4-A) Summary of Payments and Estimates - Programme 4

Sub-Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
General [Regional] Hospitals	4 473 068	5 773 286	6 375 683	6 766 177	6 849 277	6 891 397	7 114 952	7 582 087	7 983 938
Tuberculosis Hospitals	832 030	891 705	591 900	624 381	624 391	628 315	669 183	710 328	747 975
Psychiatric Hospitals	533 949	570 999	641 667	700 652	701 182	692 950	743 815	788 396	830 181
Sub-acute, step-down and chronic medical hospitals	183 463	199 149	203 283	219 021	218 917	218 731	242 501	256 829	270 441
Dental training hospital	12 266	14 481	14 868	16 170	16 270	16 062	17 824	18 886	19 887
Other specialised hospitals	-	-							
Total	**6 034 776**	**7 449 620**	**7 827 401**	**8 326 401**	**8 410 037**	**8 447 455**	**8 788 275**	**9 356 526**	**9 852 422**

Table 68: (PHS4-B) Summary of payments and expenditure by Economic Classification - Programme 4

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Current payments	**5 941 971**	**7 317 820**	**7 745 523**	**8 220 260**	**8 248 260**	**8 273 858**	**8 634 529**	**9 163 024**	**9 648 664**
Compensation of employees	4 479 044	5 505 036	5 851 153	6 288 416	6 378 416	6 370 970	6 814 383	7 239 517	7 623 211
Goods and services	**1 462 927**	**1 812 784**	**1 894 370**	**1 931 844**	**1 869 739**	**1 902 783**	**1 820 146**	**1 923 507**	**2 025 453**
Communication	19 167	21 595	21 634	22 009	21 966	22 288	21 287	22 496	23 688
Computer Services	1 425	108	805	-	2 868	2949			
Consultants, Contractors and special services	304 312	434 582	397 721	327 518	343 481	331 548	229 211	246 131	259 176
Inventory	886 720	1 035 287	1 104 040	1 196 693	1 100 242	1 146 214	1 166 457	1 234 763	1 300 205

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Operating leases	9 484	11 225	10 794	11 734	10 323	9 887	11 904	12 555	13 220
Travel and subsistence	3 856	5 723	5 236	5 724	5 374	4 948	7 460	7 786	8 199
Interest and rent on land					105	105			
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	237 963	304 264	354 140	368 166	385 394	384 854	383 827	399 776	420 964
Transfers and subsidies	**71 742**	**71 253**	**70 795**	**51 441**	**108 077**	**122 717**	**67 085**	**69 752**	**73 449**
Provinces and municipalities	229	111	287	525	361	361	549	581	612
Departmental agencies and accounts	54	47	56	56	56	16	36	63	66
Non-profit institutions	32 600	35 802	37 770	28 829	28 829	28 829	30 500	33 100	34 854
Households	38 859	35 293	32 682	22 031	78 831	93 511	36 000	36 008	37 916
Payments for capital assets	**18 863**	**60 532**	**11 083**	**54 700**	**53 700**	**50 880**	**86 661**	**123 750**	**130 309**
Buildings and other fixed structures	0					78			
Machinery and equipment	18 863	60 532	11 083	54 700	53 700	50 802	86 661	123 750	130 309
Payment for financial assets	**2 200**	**15**							
Total economic classification	**6 034 776**	**7 449 620**	**7 827 401**	**8 326 401**	**8 410 037**	**8 447 455**	**8 788 275**	**9 356 526**	**9 852 422**

Performance and Expenditure Trends

General (Regional) Hospitals: The significant increase in 2011/12 includes once-off funding for essential equipment and motor vehicles, funding for various national priorities, costs of OSD, Registrars moved to this programme, the replacement of redundant essential hospital equipment and the filling of critical posts. The increase in the 2013/14 Revised Estimate relates to the commissioning of 80 beds at Lower Umfolozi War Memorial (LUWM) Hospital, increased cost of medicines, and funding for unbudgeted medico-legal claims against the Department. The 2013/14 *Main Appropriation* included the carry-through costs for the wage agreements, OSDs and national health priorities.

Specialised Tuberculosis Hospitals: Shows a peak in 2011/12 due to additional funding provided against *Goods and services* for the purchase of patient clothing and bed linen. The reduction in 2012/13 relates mainly to a decision to move funding to other categories of hospitals dealing with TB as well as a reduction in NHLS costs in TB hospitals due to the successful flat fee arbitration. The 2014/15 MTEF includes inflationary increases only.

Specialised Psychiatric Hospitals: The increasing trend relates to the various wage agreements and OSD. The 2014/15 MTEF includes carry-through costs and inflationary increases only.

*Sub-Acute, Step-down and Chronic Ho*spitals: Increase in 2011/12 relates to staff exit costs and medico-legal claims as well as the purchase of critical medical equipment and additional patient clothing and bed linen. In 2012/13, Clairwood Hospital was reclassified into this sub-programme.

Dental Training Centre: Steady growth with inflationary growth over the 2014/15 MTEF.

In the 2013/14 Adjusted Appropriation, the increase is to fund the higher than expected 2013 wage agreement and clerical re-grading, as well as funds moved within the programme from forced savings in *Goods and services* to address the commissioning of 80 additional beds at LUWM Hospital. In the 2014/15 MTEF, provision is made for the employment of food services staff, due to the decision to in-source this service. Additional budget was also allocated for the carry-through costs of the commissioning of additional beds at the LUWM Hospital and to cover the existing *Compensation of employees'* budget gaps in this programme.

The notable increase in *Goods and services* in 2011/12 was due to increased payments to the NHLS related to an agreement to increase the monthly payment from R34 million to R43 million, backdated to January 2011, increased stock levels for medical supplies, as well as clearing of payment backlogs which arose due to some facilities not paying within 30 days. The slower growth in 2012/13 was a result of reduced NHLS costs as mentioned above, as well as efficiency savings against medicine and medical supplies. Included from 2013/14 onward, is national priority funding for improving norms and standards at public hospitals, additional capacity for purchasing *Goods and services* and funding for the general policy adjustment.

The reduction in the 2013/14 Adjusted Appropriation is attributed to efficiency gains realised from high cost drivers such as medicine, vaccines, blood products, medical and surgical inventory items, medical gas and medical waste removal. The minimal increase in 2014/15 is due to the shifting of funds from *Goods and services* to *Compensation of employee* related to the proposed employment of food services staff, due to the decision to in-source this service.

The high spending against *Transfers and subsidies to: Households* in 2010/11 relates to a number of medico-legal claims. The increase in the 2013/14 Adjusted Appropriation provides for increased staff exit costs and medico-legal claims, with a significant peak in once-off spending expected in the Revised Estimate. There is no provision for medico-legal claims in the 2014/15 MTEF due to budget cuts, hence the drop in 2014/15 and minimal growth thereafter. This will be reviewed in-year as medico-legal costs arise.

6. PROGRAMME 5: CENTRAL AND TERTIARY HOSPITALS

Programme Purpose and Structure

There are no changes to the structure of Programme 5.

Purpose

To provide tertiary health services and creates a platform for the training of health workers.

Sub-Programme 5.1: Central Hospitals

Render highly specialised medical health and quaternary services on a national basis and serve as platform for the training of health workers and research.

6.1 OVERVIEW

There are two designated Tertiary Hospitals (Greys and Ngwelezane) and two Central Hospitals (King Edward VIII and Inkosi Albert Luthuli) in KZN.

The current service packages rendered in these hospitals include:

- IALCH: 100% Tertiary
- Greys: 80% Tertiary and 20% Regional
- KEH: 50% Tertiary and 50% Regional
- Ngwelezane: 33% Tertiary, 42% Regional and 25% District.

Tertiary Hospitals receive additional budget allocations from the National Tertiary Services Grant (NTSG) with the purpose to compensate for supra–provincial nature of tertiary service provision and spill-over effects. The NTSG allocations in KZN include: IALCH (40%), Greys (40%), KEH (15%) and Ngwelezane (5%).

Lower Umfolozi War Memorial and Madadeni Hospitals offer a specialised Mother and Child services package, however did not receive funding from the NTSG.

There are no cost centres, although the Meditech system that has been introduced in these hospitals includes a module for cost centres. Meditech implementation at Greys Hospital will include the cost centre module and the one at King Edward VIII will not include the cost centre module because of insufficient funding.

Challenges that will be addressed in 2014/15 include:

The package of services at Ngwelezane Hospital as a result of limited/no access to level 1 and 2 services in the Umhlathuze Municipality. As a result, provisioning of tertiary services is limited due to infrastructure limitations, inadequate staffing and limited funding envelope.

Eleven Regional Hospitals provide limited Tertiary Services to improve access to a limited basket of tertiary services. Inadequate human resources however challenge this arrangement that will be reviewed.

Hospital establishments have not been approved hence delays in appointment of critical staff.

Expansion of services at Greys and KEH are curtailed due to the limited funding envelope.

The high attrition rate amongst clinical staff (not getting OSD) e.g. Radiotherapy, Renal, O&G and Oncology remains a concern.

The department and UKZN commenced with review of the Joint Establishment to improve oversight.

6.2 PRIORITIES AND FOCUS AREAS

Priorities	Focus Areas
1. Improve governance and hospital efficiencies *NSO 3: Improved financial management in the health sector* *NSO 4: Efficient health management information system for improved decision making*	• Performance management and accountability – decentralized delegations. • Cost centers (phased approach). • Training and development for Managers. • Business processes re-engineering. • Establish appropriate service delivery and training platform.
2. Review referral pathways	• Review referral pathways (including EMS responsiveness).
3. Infrastructure *NSO 2: Health Facility Planning*	• Facilities audit to inform Infrastructure priorities. • Upgrade identified Accident and Emergency Units.
4. Improved patient care *NSO 5: Improved quality of care*	• Accelerate Implementation of Core Standards. • Patient management system including Bed Bureau system.
5. Support Services	• Improved management of Food, Garden, Security and Laundry Services. • Address bottlenecks in SCM for major equipment.
6. Improve Human Resource for Health *NSO 8: Improved Human Resources for Health*	• Strengthen the outreach and support programme by Specialists. • Exchange programme and mentorship of health care professionals to enhance clinical competency; in partnership with the Medical School and College of Nursing.

CENTRAL HOSPITAL – INKOSI ALBERT LUTHULI CENTRAL HOSPITAL

6.3 CUSTOMISED PERFORMANCE INDICATORS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 3: Improved financial management in the health sector*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 5: Improved quality of care*

Table 69: (CHS2) Customised Performance Indicators - Central Hospital[19]

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Improve hospital efficiencies by implementing the long-term plan for hospital revitalisation 2014/15-2019	1. Average length of stay – total	DHIS	Quarterly Days	8.6 Days	9.1 Days	8.4 Days	8.6 Days	7.8 Days	7.5 Days	7.2 Days
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*197 618*	*220 104*	*217 577*	*219 690*	*221 008*	*222 334*	*223 668*
	Day Patients	*DHIS/ Midnight Census*	*No*	*1 676*	*1 037*	*1 526*	*1 820*	*1 996*	*2 251*	*2 567*
	Separations	*DHIS calculates*	*No*	*22 371*	*24 331*	*26 068*	*25 622*	*28 625*	*29 913*	*31 259*
	2. Inpatient bed utilisation rate – total	DHIS	Quarterly %	66.7%	72.5%	70.5%	71.8%	71.9%	72.8%	73.6%
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*197 618*	*220 104*	*217 577*	*219 690*	*221 008*	*222 334*	*223 668*
	Day Patients	*DHIS/ Midnight Census*	*No*	*1 676*	*1 037*	*1 526*	*1 820*	*1 996*	*2 251*	*2 567*
	Number of usable beds	*DHIS/ FIO*	*No*	*297 751*	*304 291*	*309 920*	*308 524*	*308 370*	*306 829*	*305 294*

[19] Although King Edward VIII Hospital has been classified as Central Hospital it is still rendering predominantly regional and some tertiary services and therefore report as Regional Hospital in DHIS. The classification is relevant to the new hospital and classification will therefore be reviewed

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Maintain expenditure per PDE within the provincial norms	3. Expenditure per patient day equivalent (PDE)	BAS/DHIS	Quarterly R	R 2 754*	R 2 700*	R 2 937*	R 3 121	R 3 083	R 3 201	R 3 334
	Total expenditure Central Hospital	*BAS*	*R'000*	*689 717*	*758 623*	*873 086*	*889 796*	*888 645*	*932 870*	*982 312*
	Patient day equivalents	*DHIS calculates*	*No*	*250 387*	*280 971*	*279 186*	*285 074*	*288 210*	*291 380*	*294 585*
Improve the complaint resolution within 25 working days rate to 75% (or more) by March 2017	4. Complaints resolution within 25 working days rate	DHIS	Quarterly %	75%	85.7%	84.6%	80%	85%	90%	90%
	Number of complaints resolved within 25 days in reporting period	*Complaints register*	*No*	-	*36*	*22*	*36*	-	-	-
	Number of complaints received during the same reporting period	*Complaints register*	*No*	-	*42*	*26*	*45*	-	-	-
Implement the 5-year Mental Health Care Strategy	5. Mental health admission rate	DHIS	Quarterly %	0%	0%	0%	0%	0%	0%	0%
	Mental health admissions total	*DHIS calculates*	*No*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*
	Inpatient separations	*DHIS calculates*	*No*	-	-	-	-	-	-	-
Improve the patient satisfaction rate to 95% by March 2017	6. Patient satisfaction rate	DHIS/ Patient Satisfaction Module	Annual %	Not reported	96%	90%	Not available	90%	90%	95%
	Users satisfied with the services they received	*Survey results*	*No*	-	-	*18*	-	-	-	-
	Total number of users that participated in PSS	*Survey results*	*No*	-	-	*20*	-	-	-	-
80% of facilities conditionally compliant (50% - 75%) to the National Core Standards by March 2019	7. Percentage of Central Hospitals that have conducted gap assessment for compliance against the National Core Standards	QA database	Quarterly %	Not reported	Not reported	100%	100%	100%	100%	100%

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	Central Hospitals that conducted gap assessments for compliance	*Assessment records*	*No*	-	-	*1*	*1*	*1*	*1*	*1*
	Central Hospitals total	*DHIS calculates*	*No*	-	-	*1*	*1*	*1*	*1*	*1*
	8. Proportion of Central Hospital assessed as compliant with the extreme measures of National Core Standards	Assessment records	Quarterly %	Not reported	Not reported	Not reported	Not reported	100%	100%	100%
	Central Hospitals compliant with all Extreme Measures of National Core Standards	*Assessment records*	*No*	-	-	-	-	*1*	*1*	*1*
	Central Hospitals total	*DHIS calculates*	*No*	-	-	-	-	*1*	*1*	*1*

6.4 PROVINCIAL STRATEGIC OBJECTIVES AND TARGETS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 3: Improved financial management in the health sector*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 5: Improved quality of care*

Table 70: (CHS1-B) Provincial Strategic Objectives and Targets - Central Hospital

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Improve hospital efficiencies by implementing the long-term plan for hospital revitalisation 2014/15-2019	1. Delivery by caesarean section rate	DHIS	Quarterly %	70.5%	74.7%	79.8%	77.2%	77.2%	77.1%	76.4%
	Number of caesarean sections performed	*Delivery Register*	*No*	*284*	*355*	*394*	*380*	*388*	*395*	*403*
	Total number of deliveries in the facility	*Delivery Register*	*No*	*403*	*475*	*494*	*492*	*502*	*512*	*527*
	2. OPD headcount – total	DHIS/ Tick Register OPD	Quarterly No	170 986	178 484	179 617	189 100	193 828	198 673	203 640

6.5 TARGETS FOR 2014/15

Table 71: (CHS3) 2014/15 Targets – Central Hospital

Performance Indicators	Targets 2014/15	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Average length of stay – total	7.8 Days	8.4 Days	8.1 Days	7.9 Days	7.8 Days
2. Inpatient bed utilisation rate – total	71.9%	71.8%	71.8%	71.9%	71.9%
3. Expenditure per patient day equivalent (PDE)	R 3 083	R 3 003	R 3 033	R 3 073	R 3 083
4. Complaints resolution within 25 working days rate	85%	85%	85%	85%	85%
5. Mental health admission rate	0%	0%	0%	0%	0%
6. Percentage of Central Hospitals that have conducted gap assessment for compliance against the National Core Standards	100%	100%	100%	100%	100%
7. Proportion of Central Hospitals assessed as compliant with the extreme measures of National Core Standards	100%	0%	0%	0%	100%
8. Delivery by caesarean section rate	77.2%	77.2%	77.2%	77.2%	77.2%
9. OPD headcount – total	193 828	48 457	48 457	48 457	48 457
Annual Targets					
10. Patient satisfaction rate	90%				90%

TERTIARY HOSPITALS – GREYS AND NGWELEZANE HOSPITALS

6.6 CUSTOMISED PERFORMANCE INDICATORS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 3: Improved financial management in the health sector*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 5: Improved quality of care*

Table 72: (THS2) Customised Performance Indicators - Tertiary Hospitals

Strategic Objective Statement	Performance Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12[20]	2012/13	2013/14	2014/15	2015/16	2016/17
Improve hospital efficiencies by implementing the long-term plan for hospital revitalisation 2014-2019	1. Average length of stay – total	DHIS	Quarterly Days	9.9 Days	9.9 Days	10.2 Days	10.4 Days	9.3 Days	8.7 Days	8.2 Days
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*126 207*	*126 616*	*294 660*	*322 928*	*330 569*	*342 139*	*354 113*
	Day Patients	*DHIS/ Midnight Census*	*No*	*177*	*670*	*371*	*1 608*	*1 769*	*1 946*	*2 140*
	Separations	*DHIS calculates*	*No*	*12 633*	*12 785*	*28 801*	*31 118*	*35 904*	*39 494*	*43 444*
	2. Inpatient bed utilisation rate – total	DHIS	Quarterly %	73.1%	70.5%	85.3%	106%	75%	75%	75%
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*126 207*	*126 616*	*294 660*	*322 928*	*285 820*	*277 246*	*268 928*
	Day Patients	*DHIS/ Midnight Census*	*No*	*177*	*670*	*371*	*1 608*	*1 769*	*1 946*	*2 140*
	Number of usable beds	*DHIS/ FIO*	*No*	*172 755*	*185 055*	*345 632*	*302 009*	*354 273*	*363 130*	*372 208*

[20] For purpose of trend analysis, data for Ngwelezane Hospital was included in the 2011/12 reporting year (although not formally categorised as Tertiary in 2011/12)

Strategic Objective Statement	Performance Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12[20]	2012/13	2013/14	2014/15	2015/16	2016/17
Maintain expenditure per PDE within the provincial norms	3. Expenditure per patient day equivalent (PDE)	BAS/DHIS	Quarterly R	R 7 390*	R 9 177*	R 4 605	R 4 705	R 4 841	R 5 048	R 5 151
	Total expenditure Tertiary Hospital	*BAS*	*R'000*	*1 413 665*	*1 754 031*	*1 889 885*	*2 063 172*	*2 190 747*	*2 357 557*	*2 482 508*
	Patient day equivalents	*DHIS calculates*	*No*	*191 274*	*191 113*	*410 345*	*438 482*	*452 513*	*466 994*	*481 938*
Improve the complaint resolution within 25 working days rate to 90% (or more) by March 2017	4. Complaint resolution within 25 working days rate	DHIS	Quarterly %	100%	92%	83.3%	76.3%	90%	90%	90%
	Total number of complaints resolved within 25 days in reporting period	*Complaints Register*	*No*	-	*199*	*280*	*90*	-	-	-
	Total number of complaints received during the same reporting period	*Complaints Register*	*No*	-	*216*	*336*	*118*	-	-	-
Implement the 5-year Mental Health Care Strategy	5. Mental health admission rate	DHIS calculates	Quarterly %	0.03%	0.06%	1.6%	3.4%	1.6%	1.6%	1.5%
	Mental health admissions total	*DHIS calculates*	*No*	*5*	*8*	*467*	*528*	*458*	*449*	*420*
	Inpatient separations	*DHIS calculates*	*No*	*12 633*	*12 291*	*28 801*	*15 516*	*28 225*	*27 660*	*27 107*
Improve the patient satisfaction rate to 90% by March 2017	6. Patient satisfaction rate	DHIS: Patient Satisfaction Module	Annual %	Not reported	80%	85%	Not available	90%	90%	90%
	Total number of users that were satisfied with the services they received	*Survey results*	*No*	-	-	*17*	-	-	-	-
	The total number of users that participated in PSS	*Survey results*	*No*	-	-	*20*	-	-	-	-

Strategic Objective Statement	Performance Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12[20]	2012/13	2013/14	2014/15	2015/16	2016/17
100% of facilities conditionally compliant (50% - 75%) to the National Core Standards by March 2019	7. Percentage of Tertiary Hospitals that have conducted gap assessments for compliance against the National Core Standards	Assessment records	Annual %	Not reported	Not reported	100%	100%	100%	100%	100%
	Tertiary Hospitals that conducted gap assessments for compliance	*Assessment records*	*No*	-	-	2	2	2	2	2
	Tertiary Hospitals total	*DHIS calculates*	*No*	-	-	2	2	2	2	2
	9. Proportion of Tertiary Hospitals assessed as compliant with the extreme measures of National Core Standards	Assessment records	Annual %	Not reported	Not reported	Not reported	Not reported	50%	50%	100%
	Tertiary Hospitals compliant with all Extreme Measures of National Core Standards	*Assessment records*	*No*	-	-	-	-	*1*	*1*	2
	Tertiary Hospitals total	*DHIS calculates*	*No*	-	-	-	-	2	2	2

- Indicator 1 [Average length of stay]: Ngwelezane [9.5 days] and Greys [11.5 days]. This has significant cost implications and needs to be investigated in relation to admission and discharge criteria and level 1 and 2 services.
- Indicator 2 [Inpatient bed utilisation rate]: Ngwelezane [139.2%] and Greys [81.2%]. The over-utilisation at Ngwelezane is a serious concern also taking into consideration the number of level 1 patients managed at the hospital due to lack of a District Hospital in the UMhlatuze Municipality.

6.7 PROVINCIAL STRATEGIC OBJECTIVES AND TARGETS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 3: Improved financial management in the health sector*

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-Output 5: Improved quality of care*

Table 73: (THS1-B) Provincial Strategic Objectives and Targets - Tertiary Hospitals

Strategic Objective Statement	Performance Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12[21]	2012/13	2013/14	2014/15	2015/16	2016/17
Improve hospital efficiencies by implementing the long-term plan for hospital revitalisation 2014/15-2019	1. Delivery by caesarean section rate	DHIS	Quarterly %	67.8%	69%	73.2%	71.9%	71.4%	71%	70.6%
	Number of caesarean sections performed	*Delivery Register*	*No*	*1 421*	*1 093*	*1 004*	*882*	*864*	*847*	*830*
	Total number of deliveries in the facility	*Delivery Register*	*No*	*2 095*	*1 585*	*1 372*	*1 226*	*1 209*	*1 193*	*1 176*
	2. OPD headcount – total	DHIS/ Tick Register OPD	Quarterly No	189 510	188 637	314 027	326 030	315 472	316 418	317 367
	3. OPD headcount – new cases not referred	DHIS/ Tick Register OPD	Quarterly No	0	0	30 962	34 030	*30 807*	*30 653*	*30 500*

- *Indicator 1 [Caesarean section rate]*: The indicator is relevant to Greys Hospital only - no deliveries in Ngwelezane Hospital [all maternal health services in Lower Umfolozi War Memorial Hospital]

[21] For purpose of trend analysis, data for Ngwelezane Hospital was included in the 2011/12 reporting year (although not formally categorised as Tertiary in 2011/12)

6.8 TARGETS FOR 2014/15

Table 74: (THS3) 2014/15 Targets – Tertiary Hospitals

Performance Indicators	Targets 2014/15	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Average length of stay – total	9.3 Days	10 Days	9.7 Days	9.5 Days	9.3 Days
2. Inpatient bed utilisation rate – total	75%	60%	65%	70%	75%
3. Expenditure per patient day equivalent (PDE)	R 4 841	R 4 790	R 4 795	R 4 800	R 4 841
4. Complaint resolution within 25 working days rate	90%	90%	90%	90%	90%
5. Mental health admission rate	1.6%	1.5%	1.5%	1.5%	1.6%
6. Delivery by caesarean section rate	71.4%	72.5%	72%	71.6%	71.4%
7. OPD headcount – total	315 472	78 868	78 868	78 868	78 868
8. OPD headcount – new cases not referred	30 807	7 702	7 702	7 702	7 702
9. Percentage of Tertiary Hospitals that have conducted gap assessments for compliance against the National Core Standards	100%	100%	100%	100%	100%
10. Proportion of Tertiary Hospitals assessed as compliant with the extreme measures of National Core Standards	50%	0%	0%	0%	50%
Annual Targets					
11. Patient Satisfaction Rate	90%				90%

6.9 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 75: (CH7-A) Summary of Payments and Estimates - Programme 5

Sub-Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Central Hospitals	689 717	758 623	873 086	834 199	840 499	889 796	888 645	932 870	982 312
Tertiary Hospitals	1 413 665	1 754 031	1 889 885	2 087 926	2 111 480	2 063 172	2 190 747	2 357 557	2 482 508
Total	**2 103 382**	**2 512 654**	**2 762 971**	**2 922 125**	**2 951 979**	**2 952 968**	**3 079 392**	**3 290 427**	**3 464 820**

Table 76: (CH7-B) Summary of Payments and Estimates by Economic Classification - Programme 5

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Current payments	**2 083 951**	**2 504 543**	**2 752 833**	**2 898 365**	**2 920 217**	**2 920 035**	**3 053 388**	**3 241 331**	**3 413 122**
Compensation of employees	942 537	1 154 360	1 383 329	1 515 000	1 533 000	1 530 744	1 619 167	1 716 839	1 807 831
Goods and services	**1 141 414**	**1 350 183**	**1 369 504**	**1 383 365**	**1 387 217**	**1 389 291**	**1 434 221**	**1 524 492**	**1 605 290**
Communication	3 106	3 405	3 433	3 300	3 627	3 460	4 700	2 835	2 985
Computer Services	251	422	5534	-	3 528	3909	-	-	-
Consultants, Contractors and special services	633 063	721 738	749 381	727 468	753 305	754 125	798 650	861 333	906 984
Inventory	459 172	559 310	553 925	588 815	568 841	572 190	564 762	593 009	624 438
Operating leases	430	1 813	523	1 300	530	508	918	964	1 015
Travel and subsistence	701	1 338	1 242	1 592	1 110	1 080	1 000	1 050	1 106
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	44 691	62 157	55 466	60 890	56 272	54 015	64 191	65 301	68 762

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Transfers and subsidies to	**7 817**	**2 257**	**2 773**	**2 760**	**4 762**	**4 524**	**5 004**	**5 096**	**5 366**
Provinces and municipalities	6	4	9	10	12	16	4	4	4
Households	7 811	2 253	2 764	2 750	4 750	4 456	5 000	5 092	5 362
Payments for capital assets	**11 559**	**5 854**	**7 365**	**21 000**	**27 000**	**28 409**	**21 000**	**44 000**	**46 332**
Machinery and equipment	11 559	5 854	7 365	21 000	27 000	28 409	21 000	44 000	46 332
Payment for financial assets	**55**	**-**							
Total economic classification	**2 103 382**	**2 512 654**	**2 762 971**	**2 922 125**	**2 951 979**	**2 952 968**	**3 079 392**	**3 290 427**	**3 464 820**

Performance and Expenditure Trends

The positive trend is due to the increasing demand for tertiary and central hospital services, various OSDs, annual wage agreements, and related carry-through costs. The significant increase in 2011/12 relates mainly to the high inflation rate on medicines, medical supplies and service costs, the Rand/Dollar exchange rate, as well as increased costs of blood products and increased stock levels of medical supplies to meet the increasing demand of services. The 2011/12 expenditure also included the capacity building national priority (originally allocated in the 2009/10 MTEF to commence in 2011/12), and additional funding provided in 2011/12 for the previously mentioned national priorities.

The increase in the 2012/13 *Compensation of employees* includes the higher than expected 2012 wage agreement and service improvement in Greys Hospital. The 2014/15 MTEF comprises carry-through costs for previous wage agreements and national priorities and increases in the National Tertiary Services grant (NTSG).

The notable increase in *Goods and services* in 2011/12 was mainly due to the high inflation rate on medical supplies, medicines and medical services, the Rand/Dollar exchange rate, increased costs of blood products, as well as increased stock levels of medical supplies to meet the increasing demand for services. In the 2012/13 audit report, the ruling by the A-G was that all equipment expenditure incurred against the PPP agreement for IALCH should be paid from current expenditure. Funding was therefore shifted from *Machinery and equipment* to this category and the historical figures were adjusted accordingly for comparative purpose. The lower trends in 2012/13 and 2013/14 are attributed to efficiency gains from high cost drivers such as medicines, medical supplies and blood products. The 2013/14 Adjusted Appropriation provided for the roll-over from 2012/13 of committed NHI grant funding. Growth over the 2014/15 MTEF caters for inflation only.

The high expenditure against *Transfers and subsidies to: Households* in 2010/11 relates to medico-legal claims against the department, while the increase in the 2013/14 Adjusted Appropriation relates to higher than expected staff exit costs.

The significant decrease against *Machinery and equipment* in 2011/12 relates mainly to delays in tender processes in respect of the supply of essential cardiology equipment for Grey's Hospital. The 2012/13 expenditure was adjusted to give effect to the Auditor General ruling regarding the PPP, as mentioned above. However, this was mitigated by the replacement of critical medical equipment at Grey's following the decision to decentralise the procurement of this equipment from Programme 8. The increase in the 2013/14 Adjusted Appropriation was for critical medical equipment ordered in 2012/13, but only delivered in 2013/14. The increase in 2015/16 and 2016/17 provides for the planned replacement and modernisation of tertiary services critical major medical equipment.

6.10 RISK MANAGEMENT

Potential Risks	Mitigating Factors
1. Increasing service demands without concomitant resources.	• Rationalisation of hospital services to improve equity and inform placement of staff.
2. Inadequate service delivery platform to accommodate the training platform.	• Rationalisation of hospital services, long-term Human Resources for Health Plan.
3. Ineffective information system and management.	• Roll-out of Hospital Information System (including Cost Centre Modules).

Notes

7. PROGRAMME 6: HEALTH SCIENCES AND TRAINING

Programme Purpose and Structure

There are no changes to the structure of Programme 6.

Purpose

Render training and development opportunities for actual and potential employees of the Department of Health

Sub-Programme 6.1: Nurse Training College

Train nurses at undergraduate and post-basic level. Target group includes actual and potential employees

Sub-Programme 6.2: EMS Training College

Train rescue and ambulance personnel. Target group includes actual and potential employees

Sub-Programme 6.3: Bursaries

Provision of bursaries for health science training programmes at under- and postgraduate levels, targeting actual and potential employees

Sub-Programme 6.4: PHC Training

Provision of PHC related training for personnel, provided by the regions

Sub-Programme 6.5: Training (Other)

Provision of skills development programmes for all occupational categories in the Department. Target group includes actual and potential employees.

7.1 OVERVIEW

KZN College of Nursing – (KZNCN)

Nursing Colleges have been declared Higher Education Institutions after 13 June 2013 in compliance with the provisions of the Higher Education Amendment, Act No. 21 of 2011 and the Further Education and Training Colleges Amendment Act, 2012 (Act No. 3 of 2012). Failure to comply with requirements will render KZNCN unable to continue training.

Infrastructure continues to be a challenge in the delivery of nurse training in KZN with infrastructure upgrades in progress at Edendale, Addington and Ngwelezana Campuses.

The lack of national norms/ standards jeopardise determination of actual nurse shortages and quantification of nurses per category, which in turn affect planning for nurse intake.

Table 77: Production of 4-year students and students in bridging programme 2009-2011

Training Institution	2009	2010	2011
4-Year Students			
UKZN	70	69	70
KZNCN	348	489	502
Total	**418**	**558**	**572**
Bridging Programme			
KZNCN	417	412	470
Private	894	807	1 162
Total	**1 311**	**1 219**	**1 632**

EMS Training College

Between 2011/12 and 2012/13, staff with training in BLS decreased from 1 959 to 1 810; staff with training in ILS increased from 725 to 780; staff with training as Emergency Care Technicians 17; and staff with training as Paramedics (ALS) increased from 91 to 94.

Project 148: Based on figures obtained from the HPCSA, there are approximately 9 000 people with a qualification in Basic Life Support (BLS), and an additional 3 000 people were trained in BLS by the SANDF for the FIFA Soccer World Cup in 2010. A total of 148 of these trained people reside in KZN and the Department therefore developed a remedial training plan to accommodate these personnel (Project 148).

Out of 3 intakes comprising 68 trainees, 56 have been successfully trained to date. The 4th intake comprising 18 trainees commenced on 6th February 2013. These students will form the pool of potential candidates for future recruitment.

Bursaries

The Departmental Bursary Policy has been aligned with the Provincial Bursary Policy and control measures have been finalised to ensure compliance with the PFMA e.g. breach of contract. In 2012/13, there were 536 bursary holders at University and 68 Clinical Associates. One hundred and eighty-seven (187) bursary graduates were placed in institutions during January 2013, and 701 bursaries were awarded to in-service trainees during 2012/13.

PHC Training

The KwaZulu-Natal College of Nursing continues to prioritise PHC training. This training continues through the NEIs of the KwaZulu-Natal College of Nursing and University of KwaZulu-Natal. A projected number of 200 are targeted for training annually.

Human Resource Development

The Department will embark on numerous new training strategies to address the increasing skills gap.

7.2 PRIORITIES AND FOCUS AREAS

- 5-Year Human Resource Development Strategy (in draft)
- National Human Resources for Health Strategy 2012-2016
- Nursing Strategy

Priorities	Focus Areas
1. Accreditation of KZNCN as Institution of Higher Education. *NSO 8: Improved Human Resources for Health*	• Implementation of Accreditation Plan. • Align student intake with service delivery demand and long-term plan.
2. HRD Strategy	• Align with HR Plan and training needs/demands.

Priorities	Focus Areas
	• Mid-Level Worker programmes in collaboration with UKZN.
3. Improve emergency training	• Revitalization of the College of Emergency Care.
	• Acquire suitable student accommodation for the COEC.
	• Increase output of training for emergency personnel (Emergency Care Assistant and Emergency Care Technicians).
	• Introduce first aid training for community members - target youth.

7.3 CUSTOMISED PERFORMANCE INDICATORS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 8: Improved Human Resources for Health*

Table 78: (HST2) Customised Performance Indicators - Health Sciences and Training

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Increase enrolment of Medicine, Nursing and Pharmacy students annually by 10% per annum	1. Basic Professional nurse students graduating	KZNCN Registration Records	Annual No	1 664	1 963	2 058	*2 303*	800	800	800
Ensure 100% of bursary holders are appointed in public health facilities	2. Proportion of bursary holders permanently appointed	HRD database	Annual %	Not reported	Not reported	Not reported	Not reported	Establish baseline	-	-
	Bursary holders permanently appointed	*Persal*	*No*	-	-	-	-			
	Bursary Holders total	*HRD database*	*No*	-	-	-	-			

- Indicator 1 (Targets): Graduates include R425: 4 year Professional Nurse course and R683: 2 year Bridging to Professional Nurse

7.4 PROVINCIAL STRATEGIC OBJECTIVES AND TARGETS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

- *National Sub-Output 8: Improved Human Resources for Health*

Table 79: (HST1-B) Provincial Strategic Objectives and Targets - Health Sciences and Training

Strategic Objective Statement	Performance Indicators	Data source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
SUB-PROGRAMME 6.1: NURSE TRAINING COLLEGE										
Increase enrolment of Advanced Midwives by at least 10% per annum	1. Number of Advanced Midwifes graduating per annum	KZNCN Database	Annual No	105	120	107	100	150	50	50
SUB-PROGRAMME 6.2: EMS TRAINING COLLEGE										
Increase the number of student intakes to improve quality of care	2. Number of Intermediate Life Support graduates per annum	EMS College register	Annual No	42	86	88	90	144	144	144
	3. Number of Emergency Care Technician graduates per annum	EMS College register	Annual No	0	0	0	*0*	30	60	60

- Indicator 1: Includes R212: Post Basic – Advanced Midwifery and Neonatal Nursing Science and special project in partnership with UKZN

7.5 TARGETS FOR 2014/15

Table 80: (HST3) 2014/15 Targets – Health Sciences and Training

Performance Indicators	Targets 2014/15	Targets Q1	Q2	Q3	Q4
Annual Targets					
1. Basic Professional nurse students graduating	1400				1 400
2. Proportion of bursary holders permanently appointed	Establish baseline				Baseline established
3. Number of Advanced Midwifes graduating per annum	150				150
4. Number of Intermediate Life Support graduates per annum	144				144
5. Number of Emergency Care Technician graduates per annum	30				30

7.6 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 81: (HST4-A) Expenditure Estimates: Health Sciences and Training - Programme 6

Sub-Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised estimate	Medium-Term Expenditure Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Nurse training colleges	367 268	355 905	334 032	348 035	309 027	298 351	302 768	321 743	338 795
EMS training colleges	14 118	11 417	10 904	12 453	5 481	5 401	7 570	7 983	8 406
Bursaries	54 272	64 433	82 997	138 000	206 004	213 507	216 950	219 560	231 197
PHC training	73 061	58 922	54 574	57 912	49 912	47 795	52 172	55 563	58 508
Other training	323 560	369 780	419 461	435 846	451 846	447 698	471 940	500 004	526 504
Total	**832 279**	**860 457**	**901 968**	**992 246**	**1 022 270**	**1 012 752**	**1 051 400**	**1 104 853**	**1 163 410**

Table 82: (HST4-B) Summary of Provincial Expenditure Estimates by Economic Classification - Programme 6

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2014/15	2015/16
Current payments	**763 205**	**776 485**	**804 266**	**839 509**	**803 509**	**795 346**	**824 702**	**874 210**	**920 543**
Compensation of employees	717 464	720 257	746 254	763 333	740 333	740 733	766 143	812 351	855 406
Goods and services	**45 741**	**56 228**	**58 012**	**76 176**	**63 176**	**54 613**	**58 559**	**61 859**	**65 138**
Communication	1 424	1 181	1 201	1 842	1 414	1 081	1 650	1 809	1 905
Computer Services	-	-			2 067	2 126			
Consultants, Contractors and special services	8 120	306	145	1 682	1 500	1 966	1 262	1 374	1 447
Inventory	3 996	4 431	4 301	7 454	6 349	3 810	5 550	6 067	6 389
Operating leases	1 508	1 249	1 168	1 640	1 475	1 428	1 850	2 029	2 137
Travel and subsistence	3 799	8 297	18 048	14 951	11 157	11 109	12 136	12 780	13 457

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2014/15	2015/16
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	26 894	40 758	33 148	48 607	39 214	33 093	36 111	37 800	39 803
Transfers and subsidies	**68 625**	**83 361**	**96 138**	**146 737**	**214 761**	**216 231**	**220 698**	**224 043**	**235 917**
Provinces and municipalities	25	26	33	22	42	49	48	53	56
Departmental agencies and accounts	7 637	8 588	10 119	11 315	11 315	11 315	13 000	14 000	14 742
Higher education institutions			57			470			
Non-profit institutions	8 510	14 298	15 130						
Households	52 453	60 449	70 799	135 400	203 404	204 397	207 650	209 990	221 119
Payments for capital assets	**427**	**610**	**1 564**	**6 000**	**4 000**	**1 175**	**6 000**	**6 600**	**6 950**
Machinery and equipment	427	610	1 564	6 000	4 000	1 175	6 000	6 600	6 950
Payments for financial assets	22	1							
Total economic classification	**832 279**	**860 457**	**901 968**	**992 246**	**1 022 270**	**1 012 752**	**1 051 400**	**1 104 853**	**1 163 410**

7.7 RISK MANAGEMENT

Potential Risk	Mitigating Factors
1. Poor infrastructure nursing colleges including student accommodation.	• Inclusion in Infrastructure Plan – aligned with accreditation/rationalisation of colleges plan.
2. Information management system.	• Implementation of Information Management strategy.
3. Non-alignment of training and development plans with service demands.	• Alignment of HRD strategy.

Performance and Expenditure Trends

The increasing trend in *Compensation of employees* can largely be attributed to the various OSDs and wage agreements, the introduction of a compulsory two-year internship for medical doctors and the drive to increase the capacity of nursing personnel. Also contributing was a training drive, increased bursary allocation and provision for the intake of medical, dental, pharmaceutical, and other interns.

The small increase in 2011/12 and the negative growth in the EMS Training Colleges Sub-Programme is attributed to the college not being functional due to inability to find a suitable venue. The increase in 2012/13 relates to the training of an additional 148 learners in basic life and support skills for emergency and medical rescue services, as well as the training of additional doctors under the Cuban Doctors' programme - *EMS Training Colleges and Bursaries Sub-Programmes*.

The reduction in *Compensation of employees* in the 2013/14 Adjusted Appropriation is due to the movement of student nurses from the more expensive salary system to a system of stipends. Also contributing to the reduction was cost-cutting aimed at reducing training and travelling costs. The increase in *Transfers and subsidies to: Households* in the 2013/14 Adjusted Appropriation is attributed to the pressures in bursary payments related to the unbudgeted increase in student numbers on the Cuban Doctors' programme. The trends over the 2014/15 MTEF are for inflationary purposes only.

The increases in the *Sub-Programme: Bursaries* in 2011/12 and 2012/13 resulted from a decision to provide additional funding to increase training of personnel in health related fields. The increase in the 2013/14 Adjusted Appropriation relates to the unbudgeted increase in student numbers on the Cuban Doctors' programme.

In the *Sub-Programme: Training "Other"* the increase over the seven-year period is due to the extension of the medical internship period to two years and the OSD for doctors. The increase in 2011/12 is attributed to the training of additional health personnel to address the current shortage of staff in the department. Additional funding for this purpose is also provided in the 2014/15 MTEF, together with the carry-through costs of the various wage agreements.

There has been a steady increase in *Compensation of employees*. The low growth in 2012/13 through to 2014/15 reflects the change in department's policy, with regard to student nurses being paid by stipend and no longer on the more expensive permanent salary basis. The decision to discontinue certain nurse training programmes in light of budget cuts also contributed to this low growth in *Compensation of employees*. The decrease in the 2013/14 Adjusted Appropriation relates to the stipend payments for student nurses mentioned previously.

The fluctuating trend in *Goods and services* is attributed to the travelling costs related to the Cuban Doctors' programme, as well as the training of personnel in health related fields. The

decrease in the 2013/14 Adjusted Appropriation was due to forced savings to address the previously mentioned bursary pressures related to the Cuban Doctors' programme. Growth over the 2014/15 MTEF addresses inflationary pressures only.

The category *Transfers and subsidies to: Departmental agencies and accounts* shows strong growth from 2011/12 through to 2013/14, which is ascribed to the HWSETA levy, which is in line with the growth in *Compensation of employees*.

The increase in the expenditure against *Transfers and subsidies to: Non-profit institutions* in 2011/12 results from the decision to pay OSD related costs, as well as a departmental commitment to provide funding to allow NGOs to increase their medical salaries in line with the province. The ceasing of funding from 2013/14 is attributed to the planned provincialisation of McCord Hospital during 2013/14.

The significant increase in *Transfers and subsidies to: Households* over the entire period relates to the department's decision to implement intensive training programmes through bursaries in order to address the shortage of personnel in the health fields, including the previously mentioned Cuban Doctors' programme. The low growth in 2014/15 is due to the decision to no longer expand the bursary programme due to budget pressures.

The increase against *Machinery and equipment* from 2011/12 to 2013/14 relates to provision of additional equipment at the various training campuses. The reduced amount in the 2013/14 Adjusted Appropriation relates to funding moved to the service delivery programmes, to address pressures in these programmes. The budget over the 2014/15 MTEF seeks to address shortages that have arisen in the past and grows marginally from a relatively high base in 2014/15.

8. PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

Programme Purpose and Structure

There are no changes to the structure of Programme 7.

Purpose

To render support services required by the Department to realise its aims.

Sub-Programme 7.1: Laundry Services

Render laundry services to hospitals, care and rehabilitation centres and certain local authorities.

Sub-Programme 7.2: Engineering Services

Render a maintenance service to equipment and engineering installations, and minor maintenance to buildings.

Sub-Programme 7.3: Forensic Services

Render specialised forensic and medico-legal services in order to establish the circumstances and causes surrounding unnatural death.

Sub-Programme 7.4: Orthotic and Prosthetic Services

Render specialised orthotic and prosthetic services.

Sub-Programme 7.5: Medicine Trading Account

Manage the supply of pharmaceuticals and medical sundries to hospitals, Community Health Centres and local authorities.

SUB-PROGRAMME 7.1: LAUNDRY SERVICES

8.1 OVERVIEW

During 2012/13, the Department procured new linen and installed new laundry equipment in 42 hospitals. The commissioning of the KwaZulu-Natal Central Laundry was planned for the 1st of April 2013, while the upgrade of the Northern Natal Laundry is in the initial phase of planning.

Current challenges, that informed strategies for 2014/15 include:

- Ageing machinery and equipment result in frequent breakdowns; extended waiting times for repairs; and shortage of clean linen at hospitals.
- Poor quality of linen increasing cost.
- Poor management of laundry services and staff shortages.

The Department reviewed the Policy on Disposal of Linen which will be actively monitored as part of the Laundry Improvement Plan.

8.2 PRIORITIES AND FOCUS AREAS

Priorities	Focus Areas
1. Improve laundry services	• Implement and monitor the Laundry Improvement Plan. • Infrastructure upgrade of the Northern Natal Laundry. • Introduction of the Laundry Management System. • All laundries use detergents with approved specifications • Training and development of laundry staff. • Balanced distribution of laundry machines between Hospitals.

SUB-PROGRAMME 7.3: FORENSIC (PATHOLOGY) SERVICES

8.3 OVERVIEW

Forensic Pathology Services (FPS)

Rationalisation and professionalisation of FPS was prioritised in 2013/14. The organisational structure has been reviewed (awaiting final approval) and all staff have been exposed to the induction training programme.

Two Medical Officers have been appointed in Ladysmith and 1 Specialist each in Phoenix and Pinetown. Additional posts were created for Forensic Pathology Officers. Contracting of Private Practitioners to conduct post mortems (on a fee for service basis) commenced, replacing the previous sessional arrangement. Chemical laboratory facilities for alcohol tests have been established in Gale Street.

Since 2009, a total of 6 new mortuaries have been built, 4 were upgraded, and the infrastructure of the Greytown mortuary has been completed.

During 2012/13, a total of 9 administrative purpose vehicles and 14 mortuary vans have been procured. One specialised vehicle has been procured for PIER (Promotion and Prevention, Information, Education and Relations), and will be used at taxi ranks and road block campaigns (taking blood for alcohol testing and testing for vision, BP and diabetes).

Accreditation of facilities: Baseline assessments have been conducted in all facilities and a customised tool developed to standardise the implementation and monitoring of quality improvement strategies.

Preparation commenced for the establishment of a tele-autopsy site at Gale Street Mortuary. The site inspection was completed in 2012/13.

Clinical Medico-Legal Services

There are 35 Crisis Centres and 7 Thuthuzela Care Centres (TCC) in the Province to strengthen clinical medico-legal services with a focus on survivors of rape. The 7 TCCs are based at Prince Mshiyeni, Mahatma Ghandi, Edendale, RK Khan, Ngwelezane, Port Shepstone, and Stanger Hospitals.

Review of the current organisational arrangements for Clinical Medico-Legal Services commenced in 2013/14.

8.4 PRIORITIES AND FOCUS AREAS

Priorities	Focus Areas	
Strengthen Forensic Pathology Services	1. *Mortuary Services*	• Implement the Mortuary Improvement Plan. • Improved Mortuary Management System (electronic surveillance).
	2. *Clinical Medico Legal Services*	• Strengthen Clinical Medico Legal Services (Thuthuzela Centres; training of frontline staff in management of medico-legal cases). • Thuthuzela Centres.

SUB-PROGRAMME 7.5 - MEDICINE TRADING ACCOUNT

8.5 OVERVIEW

The Ministerial Task Team on Procurement Reform recommended the phasing out of Depots in favour of direct deliveries to facilities. The task team will undertake an in-depth cost-benefit analysis of outsourced Depot services and use analysis to inform new strategy.

The task team further recommended the implementation of a Central Chronic Dispensing Unit (Western Cape Model) and investigation of using retail pharmacies & other options for the supply of chronic medicines to patients.

It is proposed that KZN adopts a Hybrid Model for procurement and distribution of pharmaceuticals inclusive of:

Direct Delivery Model: ±70% of volume distributed directly from suppliers to health facilities. This will include outsourced Chronic Medication Dispensing Services with supplies delivered directly to the warehouse of contracted service provider(s) who will dispense and distribute chronic medication for convenient collection by clients /patients. This strategy is aligned to the wider concept of universal access to health care as per the National Health Insurance (NHI) policy.

Depot Stock Holding: ±20% of volume distributed via PPSD.

Cross-Docking Model: ±10% of volume distributed to PPSD and immediately transited to facilities.

8.6 PRIORITIES AND FOCUS AREAS

Priorities	Focus Areas
1. Improve pharmaceutical management	• Training and development (including training of Pharmaceutical Assistants).
2. Improve efficiencies and clinical governance	• Community-based distribution of chronic medication.

8.7 PROVINCIAL STRATEGIC OBJECTIVES AND TARGETS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES
PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

Table 83: (HCSS1) Provincial Strategic Objectives and Targets - Health Care Support Services

Strategic Objective Statement	Performance Indicators	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
SUB-PROGRAMME 7.5: PHARMACEUTICAL SERVICES										
Reduce medicine stock out to less than 1% in PPSD and facilities by 2019	1. Percentage of Pharmacies that obtained A and B grading on inspection	Pharmacy records	Annual %	Not reported	71%	80%	85%	90%	90%	90%
	Pharmacies with A or B Grading	*Pharmacy records*	*No*	-	*61*	*71*	*76*	*80*	*80*	*80*
	Number of pharmacies	*Pharmacy records*	*No*	-	*86*	*89*	*89*	*89*	*89*	*89*
	2. Tracer medicine stock-out rate (PPSD)	Pharmacy records	Quarterly %	No data	13.2%	9%	<5%	<5%	<5%	<5%
	Number of tracer medicine out of stock	*Pharmacy records*	*No*	-	*5*	*19*	-	-	-	-
	Total number of tracer medicine expected to be in stock	*Pharmacy records*	*No*	-	*38*	*220*	-	-	-	-
	3. Tracer medicine stock-out rate (Institutions)	Pharmacy records	Quarterly %	0.17%	0.7%	1.4%	<5%	<5%	<5%	<5%
	Number of tracer medicines stock out in bulk store	*Pharmacy records*	*No*	-	*1 951*	*3 638*	-	-	-	-

Strategic Objective Statement	Performance Indicators	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	Number of tracer medicines expected to be stocked in the bulk store	*Pharmacy records*	*No*	-	*277 020*	*255 220*	-	-	-	-

8.8 2014/15 TARGETS: HEALTH CARE SUPPORT SERVICES

Table 84: (HCSS3) Targets for 2014/15 – Health Care Support Services

Programme Performance Indicators	Targets 2014/15	Targets Q1	Q2	Q3	Q4
Quarterly Targets					
1. Tracer medicine stock-out rate (PPSD)	<5%	<5%	<5%	<5%	<5%
2. Tracer medicine stock-out rate (Institutions)	<5%	<5%	<5%	<5%	<5%
Annual Targets					
3. Percentage of Pharmacies that obtained A and B grading on inspection	90%				90%

8.9 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 85: (HCSS4-A) Expenditure Estimates: Health Care Support Services

Sub-Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Laundries	77 550	85 054	90 172	102 246	98 196	96 516	104 578	106 978	112 648
Orthotic and prosthetic services	23 442	26 005	25 336	25 036	25 197	25 742	36 381	38 558	40 602
Medicines trading account	10 764	13 971	15 170	16 004	0	0			18 900
Total	**111 756**	**125 030**	**130 678**	**143 286**	**123 393**	**122 258**	**140 959**	**145 536**	**172 149**

Table 86: (HCSS3-B) Summary of Payments and Estimates by Economic Classification - Programme 7

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Current payments	**100 327**	**110 448**	**112 663**	**126 157**	**116 157**	**115 039**	**132 685**	**143 673**	**151 288**
Compensation of employees	69 843	75 511	78 745	92 285	82 285	81 135	89 900	99 136	104 503
Goods and services	**30 484**	**34 937**	**33 918**	**33 872**	**33 872**	**33 904**	**42 785**	**44 537**	**46 785**
Communication	415	563	384	583	494	434	598	628	661
Computer Services	1	-							
Consultants, Contractors and special services	1 089	571	281	374	3 746	4 522	1 034	1 062	1 118
Inventory	20 933	24 016	22 845	22 554	18 140	17 737	29 797	30 927	32 453
Operating leases	25	45	26	57	98	92	105	111	117
Travel and subsistence	26	29	103	88	65	58	93	98	103
Other including Assets<5000, training and development, property payments,	7995	9 713	10 279	10 216	11 329	11 061	11 158	11 711	12 332

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
operating expenditure and venues and facilities									
Transfers and subsidies to	**11 376**	**14 545**	**16 630**	**16 527**	**1 571**	**1 602**	**674**	**708**	**19 646**
Provinces and municipalities	152	62	137	79	127	159	124	130	137
Departmental agencies and accounts	11 224	14 483	15 170	16 448	444	444			18 900
Households			1 323		1 000	999	550	578	609
Payments for capital assets	40	35	1 385	602	5 665	5 617	7 600	1 155	1 216
Machinery and equipment	40	35	1 385	602	5 665	5 617	7 600	1 155	1 216
Payments for financial assets	13	2							
Total economic classification	**111 756**	**125 030**	**130 678**	**143 286**	**123 393**	**122 258**	**140 959**	**145 536**	**172 149**

8.10 RISK MANAGEMENT

Potential Risk	Mitigating Factors
1. Poor data quality, monitoring, evaluation and reporting.	• Integrated data management strategy in collaboration with Data Management and Monitoring and Evaluation.
2. Inadequate infrastructure (space) for storage of pharmaceuticals in warehouse and facilities compounded by infrastructure backlogs.	• Participation in re-prioritisation of infrastructure priorities.
3. Inadequate human resources including Pharmacists and Pharmacy Assistants.	• Review training strategy including training of Mid-Level Workers (Pharmacy Assistants). • Recruitment and retention strategy.

Performance and Expenditure Trends

From 2013/14, the Department has centralised within Programme 7, the Laundry Services and the Orthotic and Prosthetic Services as separate Sub-Programmes, which is in line with the budget and programme structure for the Health sector. These functions were previously spread over Programmes 2, 4 and 5. Historical data has been adjusted accordingly.

The high growth against the *Medicine Trading Account Sub-Programme* in 2011/12 results from the additional funding to enable the provincial Medical Supply Centre to carry sufficient medical stock to meet demand. The reduction in the 2013/14 Adjusted Appropriation was due to the account having sufficient funding for the supply of pharmaceuticals and medical sundries, with no top-up needed. This situation is carried through to 2015/16, but will be reviewed in-year for the next budget process. This also accounts for the trend against *Transfers and subsidies to: Departmental agencies and accounts*.

The notable increase in 2014/15 against the *Laundry Services Sub-Programme* is due to the additional linen and laundry vehicles for the commissioning of the Prince Mshiyeni Laundry.

Compensation of employees grows steadily over the seven-year period, driven mainly by the various higher than expected wage agreements. During the 2013/14 *EPRE* budget process, the eThekwini Forensic Pathology Laboratory Services funding of R10 million was misallocated as *Compensation of employees* in the Laundry Services Sub-Programme, and this funding was now shifted to Programme 2 against the Other Community Services sub-programme, hence the reduction in the 2013/14 Adjusted Appropriation.

Expenditure against *Machinery and equipment* relates to office equipment and laundry vehicles. The increase in the 2013/14 Adjusted Appropriation relates to savings within the category in Programme 2 being moved to this programme, to provide for the procurement of 10 laundry vehicles, as the existing vehicles are beyond repair. The department is planning once-off purchase of special/modified laundry vehicles in 2014/15, hence the drop in 2015/16 and an inflationary increase in 2016/17.

9. PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

Programme Purpose and Structure

There are no changes to the structure of Programme 8.

Purpose

Provision of new health facilities and the refurbishment, upgrading and maintenance of existing facilities

Sub-Programme 8.1: Community Health Facilities

Construction of new facilities and refurbishment, upgrading and maintenance of existing Community Health Centres, Primary Health Care clinics and facilities

Sub-Programme 8.2: Emergency Medical Services

Construction of new facilities and refurbishment, upgrading and maintenance of existing EMS facilities

Sub-Programme 8.3: District Hospitals

Construction of new facilities and refurbishment, upgrading and maintenance of existing District Hospitals

Sub-Programme 8.4: Provincial (Regional) Hospital Services

Construction of new facilities and refurbishment, upgrading and maintenance of existing Provincial/ Regional Hospitals and Specialised Hospitals

Sub-Programme 8.5: Central Hospital Services

Construction of new facilities and refurbishment, upgrading and maintenance of existing Tertiary and Central Hospitals

Sub-Programme 8.6: Other Facilities

Construction of new facilities and refurbishment, upgrading and maintenance of other health facilities including forensic pathology facilities and nursing colleges and schools

9.1 OVERVIEW

For the period 2009/10 to 2012/13, a total of 56 major projects to the value of R2.138 billion have been completed. These projects included 14 hospitals, 4 CHCs, 23 clinics, and 10 mortuaries. One of the most significant projects was the revitalisation of the King Dinuzulu Hospital Complex (former King George V Hospital) which included the building of a new 400 bed District Hospital.

In 2011/12, the Department finalised a Provincial Maintenance Plan, managed from Head Office, to ensure that health institutions are well maintained. A total of 372 vacant posts were funded to establish District Maintenance Teams, and to date, a total of 70 posts have been filled.

Whilst progress in this Programme is commendable, the shortfall in funding has led to the curtailment of a number of critical infrastructure projects, including the Pixley ka Isaka Seme and the Dr John Dube hospitals in the Inanda/ Newtown/ KwaMashu areas.

With the R 600 million budget cut, projects will have to be re-prioritised to ensure that critical projects, essential for improved service delivery, is prioritised in the medium and long-term plans.

The focus on PHC re-engineering requires that access to services be analysed, and where appropriate, additional access points or innovations to improve service delivery be investigated. This will assist in appropriate

allocation taking into consideration proportion of the Infrastructure budget to total budget.

Revitalisation Projects

Edendale Hospital: Work forms part of the NHI Facility Improvement Plan. Construction valued at R136.5 million is due for completion by July 2014.

Rietvlei Hospital: The first phase of the new staff accommodation, valued at R110 million, is complete with the second phase due for completion in March 2014. Phase 4 of the Rietvlei Project, estimated at R200 million, has been put on hold due to inadequate funding.

King Dinuzulu Hospital: New District Hospital is complete with 369 out of 400 beds operational. Construction of the new TB Complex with 320 beds and new 130-bed Psychiatric unit, valued at R 161.2 million, is due for completion in May 2014.

King Edward VIII Hospital: Project of R 61million is complete and R 138.5 million will be spent on staff accommodation, the Family Clinic and stormwater/ roads upgrades with completion expected by March 2015.

Lower Umfolozi War Memorial Hospital: Additions and alterations to the value of R 347.8 million are due for completion in February 2015.

Ngwelezane Hospital: The new theatre complex has been prioritised at an estimated cost of R560 million.

The new *Pixley Isaka ka Seme Regional Hospital* is due to start construction in July 2014.

Dr John Dube Hospital: Design is complete. Due to budget cuts, construction of the hospital is indefinitely postponed. The Department is exploring alternative funding models including Public Private Partnerships.

Mental Health Priorities: Madadeni Hospital, Port Shepstone, Ladysmith, Stanger and Mahatma Ghandi have been prioritised for the MTEF. The prioritised hospitals are at different project phases.

New Clinics Construction Programme: Construction of new clinics must be re-prioritised due to budget constraints. New infrastructure requirements are estimated at R 26.5 billion based on the STP. Unprecedented budget cuts therefore require innovative options to replace new projects:

- Re-prioritisation of urgent and essential projects.
- Postponing new projects not yet in the construction stage.
- Reduce the number of major refurbishment projects.
- Re-direct funds towards maintenance to improve current infrastructure.
- Close selected institutions which are too expensive to upgrade.
- Consider delivery/ procurement models that are non-capital intensive.
- Explore other innovations e.g. mobile clinics, rail, etc.

Infrastructure Maintenance

The Infrastructure Maintenance strategy has been developed in accordance with the Infrastructure Delivery Model System (IDMS). Maintenance of facilities have been divided into two main categories namely capital and current maintenance. The capital maintenance is made up of major refurbishments, rehabilitations and replacement of major equipment such as lifts, autoclaves and generators whilst the current maintenance is based on servicing, repairs and minor planned maintenance.

The capital maintenance projects are combined to form renovations and refurbishment projects which fall outside the current investment and thereby is procured and managed in the capital investment which is outlined in the Infrastructure Reporting Model (IRM). These projects include

Addington Hospital Refurbishment and Renovations to the Core Block, King Edward VIII Hospital, Edendale Nursing College and Townhill Hospital. These types of projects are categorised as capital projects but in essence are maintenance projects aimed at restoring the infrastructure for safe and effective use.

There is currently almost a 50/50 split between capital maintenance and current maintenance which in total equates to R 748, 432 million. In comparison, the Department is currently spending twice as much on maintenance of existing infrastructure as it is on the provision for new facilities. This is due to the fact that many of the Department's large facilities have historically deteriorated to such an extent that restoration of the existing facilities and major investment in the replacement of equipment is needed to bring them back to its original functional state.

The Department manages maintenance of facilities through institutional maintenance (mainly for the smaller maintenance projects at facilities) and capital maintenance projects managed by Head Office through the implementing agents.

The total amount allocated in the 2013/14 Financial Year for institutional maintenance for all eleven (11) districts, including maintenance at Head Office, is R 373, 719 million and are broken down into four (4) categories (Table 88). These maintenance projects are procured and managed by districts and institutions.

Table 87: Institutional Maintenance Categories

Category	Description
A	Day to Day Maintenance
B	Planned Servicing Plant and Equipment
C	Planned Maintenance by Institutional Staff
D	Planned Maintenance by Contractors Implemented by Institution

The maintenance performance over the last five (5) years shows that the Department has spent on average close to 90% of its allocated maintenance budgets (Table 89). It is clear that the average percentage budget allocation for maintenance is in the order of 20% of the overall annual budget.

The Department has developed a turnaround strategy whereby districts provide their maintenance needs and are motivated through that plan. The other main intervention in the districts was to develop term contracts for building/ civil work. These term contracts are not yet in place but plans are in place to ensure that these term contracts will be in place by March 2014.

Table 88 : Historical Performance of Maintenance Programme

	Expenditure	Maintenance Budget Allocation	Percentage of Budget Spent	Total Yearly Budget Allocations	Percentage of Total Yearly budget
2008/09	R 314 595	R 395 700	80%	R 1 282 456	31%
2009/10	R 219 036	R 260 288	84%	R 1 343 933	19%
2010/11	R 216 555	R 216 555	100%	R 1 473 641	15%
2011/12	R373 217	R 373 217	100%	R 1 839 334	20%

	Expenditure	Maintenance Budget Allocation	Percentage of Budget Spent	Total Yearly Budget Allocations	Percentage of Total Yearly budget
2012/13	R 351 200	R 387 034	91%	R 1 917 104	20%
2013/14		R 373 719		R 1 633 608	23%
Total	**R1 474 603**	**R 1 632 794**	**90%**	**R 7 856 468**	**21%**

Table 89: Historical Performance of Maintenance Programme per District

Maintenance Budget vs. Expenditure	2012/2013		2013/2014			2014/2015
	BAS Budget	Actual Expenditure	BAS Budget	BAS Budget Revised at Mid Term	Actual Expenditure (to end Dec 2013)	BAS Budget
Amajuba	2,108,000	11,083,572	16,041,000	10,822,000	5,522,984	4,000,000
Metros KZ	54,225,000	58,365,777	97,747,000	70,000,000	46,680,428	18,000,000
iLembe	14,568,000	7,902,615	16,458,000	13,830,000	9,633,840	12,000,000
Ugu	24,151,000	24,728,078	26,146,000	23,000,000	15,372,186	20,000,000
uMgungundlovu	42,928,000	52,296,960	59,522,000	51,140,000	29,288,990	30,000,000
Umkhanyakude	22,057,000	14,482,079	30,785,000	14,000,000	12,567,147	10,000,000
Umzinyathi	14,718,000	15,500,603	30,469,000	15,000,000	11,418,255	16,000,000
Uthukela	9,642,000	10,918,874	12,506,000	11,000,000	7,057,954	10,000,000
uThungulu	20,866,000	18,068,010	37,306,000	28,115,000	13,855,592	11,000,000
Zululand	20,178,000	17,087,595	25,396,000	13,000,000	11,540,291	14,000,000
Head Office	1,464,000	3,192,099	5,076,000	6,000,000	4,273,677	4,000,000
Sisonke	19,507,000	9,235,008	16,267,000	11,736,000	6,735,694	10,000,000
TOTAL	**256,412,000**	**242,861,271**	**373,719,000**	**267,643,000**	**173,947,036**	**159,000,000**

Expanded Public Works Programme (EPWP)

The 2013/14 Departmental overall plan submitted to National consists of 465 active projects on the ground currently being reported upon. The plan has been subdivided into 3 main programmes namely (1) Capital infrastructure development programme Department of Public Works; (2) Department of Health internally managed programmes, and (3) Capital infrastructure development programme managed by the Independent Development Trust (IDT).

The Department has fully implemented the new IRS EPWP capturing system introduced by the National Department of Public Works, The programme is faster and more user-friendly and it enabled the Department to update information on internally managed programmes.

In preventing continued lack of reporting of Provincial Public Works information on health projects, the Department deployed an official onto the programme to assist with capturing of information on IRS.

In 2013/14 the Department also implemented lift manning project under the auspices of EPWP programme aimed at reducing abuse currently suspected to contribute in the malfunctioning of lifts in institutions.

The total programme allocation for 2013/14 financial year, including equitable share, is R 16 million (R3 Million from EPWP National Grant).

The Department created 3 398 accumulative work opportunities against the target of 3 745 (91% in the third quarter of 2013/14). Of these opportunities, 49% were given to female beneficiaries whilst youth and disabled persons participated at 109% and 200% respectively of planned targets. The success in the main in respect of youth and disabled persons was due to our internally managed programme which is dominated by youth, women and disabled persons.

In terms of Expenditure on labour the Department is doing well at 81% (cumulative in quarter 3 of 2013/14).

Table 90: Quarter 3 Job creation and Demographics - overall performance against Annual Plan

Performance area	Original plan	Revised plan	Q1 Actual	Q2 Actual	Q3 Actual	Total to Date	% Progress Against Revised Annual Plan
No of Job Opportunities/ No of People	2 888	3 745	2 402	2 858	3 398	3 398	91%
Women	1 580	1985	740	861	975	975	49%
Youth	1 155	2 172	1 647	1 946	2 370	2 370	109%
People with Disabilities	6	11	5	11	31	31	282%
Man. Days of work	547 455	876 692	58 466	211 903	82 331	352 700	40%
Full Time Equivalent Jobs	2 881	3 812	254	490	356	1 534	40%
Planned Labour expenditure	51 262 000	51 262 000	15 077 016	20 104 707	6 084 690	41 266 413	81%

Table 91: Quarter 3 Job creation and Demographics Overall performance against Annual Plan per Implementing Agent

Performance Area	Q3 Target	Q3 Actual	Q3 Actual %	Quarter 3 Actual Performance		
				Department of Health	Public Works	IDT
No of Job Opportunities/ No of People	93 625	3 398	363%	1 017	1 551	830
Women	49 625	975	196%	595	265	115
Youth	543	2 370	436%	673	1 050	647
People with Disabilities	3	31	1033%	29	2	0
Man. Days of work	219 173	82 331	38%	62 588	6 311	13 432
Full Time Equivalent Jobs	953	254	27%	126	61	67
Planned Labour expenditure	12 815 500	6 084 690	47%	5 390 629	601 070	92 991

Table 92: Progress Report on Maintenance of Buildings, Garden and Grounds

District	Planned number of beneficiaries	Actual Number of beneficiaries to date	% Number of beneficiaries to date Against Planned
Amajuba	50	58	116%
Ilembe	72	61	85%
Sisonke	99	95	96%
Ugu	138	178	129%
Umgungundlovu	104	111	107%
Umkhanyakude	105	108	103%
Umzinyathi	94	134	143%
Uthukela	69	82	119%
Uthungulu	127	111	87%
Zululand	101	119	118%
Total	**959**	**1057**	**110%**

Replacement of all expired 12 months contracts were completed in quarter 3 of 2013/14. The programme managed to create 1 017 of 3 398 work opportunities.

The 2014/15 programme cost is estimated at approximately R 23 million (increase of R6 million from the current financial year's budget of R16 million). The number of participating institutions will increase from 376 to 500 due to newly build institutions and the recently provincialised clinics. As result of the aforesaid and the introduction of the lift manning programme, the number of beneficiaries will increase from 959 to 1 057 in 2014/15.

Expenditure Performance

Table 93: Expenditure

Month	Project	Actual	% Achieved
April	680 000	676 016	99%
May	680 000	840 788	124%
June	1 464 000	1 716 581	117%
Quarter 1 Total	**2 824 000**	**3 233 384**	**114%**
July	1 464 000	2 283 944	156%
August	1 464 000	1 214 079	83%
September	1 464 000	1 879 800	128%
Quarter 2 Total	**4 392 000**	**5 377 824**	**122%**
October	1 464 000	1 459 739	100%
November	1 464 000	2 393 903	164%
December	1 464 000	1 536 987	0%
Quarter 3 Total	**4 392 000**	**5 390 629**	**123%**
January	1 464 000	0	0%
February	1 464 000	0	0%
March	1 464 000	0	0%
Quarter 4 Total	**4 392 000**	**0**	**0%**
Total to Date	**16 000 000**	**14 001 838**	**88%**
Projected final Expenditure: 18 801 838			
Projected over expenditure: 2 801 838			

The total 2013/14 budget for EPWP is R16 million including R 3 million Grant and R13 million equitable share. On 31 December 2013,

expenditure was R 14 001 838 (over-expenditure of R 2. 8 million).

The over-expenditure is as a result of the institutions that were added during the financial year which were not part of the original plan, as well as Lift Manning Programme which was introduced for Addington, King Edward and Newcastle Hospital.

The Department has complied with DORA reporting requirements in 2013/14.

Implementation Systems

The Provincial Infrastructure Delivery Model System (IDMS)

The Infrastructure Delivery Management Toolkit has been developed through collaboration with National Treasury as the basis for consistent and improved public sector infrastructure delivery. It provides a systematic approach to infrastructure delivery covering the full cycle from needs identification, planning and budgeting through to procurement, construction, handover and maintenance. It also provides appropriate procedures and guidelines for delivery managers in the public sector by linking them to relevant policy, legislation and regulation that underpin the planned implementation of government's infrastructure.

Government has identified infrastructure delivery as one of the key mechanisms to enhance socio-economic growth and development. The 12 Outcomes of Government in the Medium Term Strategic Framework are dependent on an effective and efficient infrastructure delivery platform. For this reason, Government allocates substantial financial resources to the KwaZulu-Natal Provincial Government to invest in infrastructure delivery.

The IDMS requirements are to align and restructure the infrastructure unit in line with the generic structure developed by the National Department of Health. The Provincial Infrastructure Unit structure has been aligned to the generic structure issued by DPSA.

Progress has been made towards filling some of the critical posts in this regard and the following critical post has been advertised: Hospital Engineers (8) at Stanger, Mahatma Ghandi, Ladysmith, Port Shepstone, RK Khan, Madadeni, Addington and King Dinuzulu Hospitals; Professional Project Managers (8) and Control Engineering Technologist (1). In order to strengthen and improve infrastructure planning and implementation of building maintenance in the Department the unit has prioritised a Director: Planning and Director: Maintenance and Technical Support.

Infrastructure Project Assemble Tool

IPAT is an excel-based Infrastructure Project Assembly Tool that plays a significant role in the IDMS process. The Department adopted iPAT into the IDMS process as a Gate Zero tool that allows pre-filtering of projects that should not proceed to Gate One, which is the U-AMP stage.

Project Management Information System (PMIS)

Officials have been trained on the use of Project Portfolio Office, which is commonly referred to as PPO. The Department is therefore able to capture project data electronically onto the PMIS programme. The aim is to capture 100% financial project information in order to extract the IRM automatically from PPO in the future.

Primary Health Care Priorities

The current Annual Infrastructure Plan consists of 13 newly proposed clinics which have been designed but may not advance to tender stage due to serious shortage of funding. Sixteen (16) new clinics are currently under construction and 14 clinics are being renovated and/or upgraded.

The three clinics that were left unfinished due to the termination of the NANZA contract are Mkhuphula, Ngabayena and Msizini. The

Department approached IDT to complete these projects. Completion cost evaluations commenced and clinics will be back in construction during the 2014/15 financial year.

Psychiatric Services Infrastructure Upgrading Priorities

The planned construction of 25-bedded psychiatric units has been moved to outer years due to budget cuts. The units are planned in specific identified hospitals to improve equity and access to services (Stanger, Mahatma Ghandi, Port Shepstone, Umzimkhulu and Madadeni Hospitals). Major revamping projects are currently being completed at Fort Napier, Umgeni and Townhill Hospitals.

9.2 PRIORITIES AND FOCUS AREAS

Priorities	Focus Areas
1. Innovation to adapt to budget challenges *NSO 2: Health Facility Planning*	• Innovation projects e.g. alternative options to replace requirements for new facilities. • Re-directing funding towards maintenance. • Delivery/ procurement models that are non-capital intensive.
2. Decentralised re-prioritisation of projects	• Decentralised planning as per STP.
3. Improve project management	• Integrated Management Tool.

9.3 CUSTOMISED PERFORMANCE INDICATORS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-output 2: Health Facility Planning*

Table 94: (HFM2) Customised Performance Indicators - Health Facilities Management

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Mid-Year Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Ensure all districts are spending at least 15% of their infrastructure on maintenance (preventative and scheduled) by 2019	1. Proportion of Programme 8 budget spent on maintenance (preventative and scheduled)	BAS	Quarterly %	Not reported	Not reported	Not reported	Not reported	11%	12%	11%
	Expenditure on maintenance (preventive and scheduled)	*BAS*	*R'000*	-	-	-	-	*R159 000*	*R159 000*	*R159 000*
	Infrastructure budget	*BAS*	*R*	-	-	-	-	*R1 497 776*	*R 1312 088*	*R1 461 630*
	2. Number of districts spending more than 90% of maintenance budget	BAS	Quarterly No	Not reported	Not reported	Not reported	Not reported	11	11	11

9.4 PROVINCIAL STRATEGIC OBJECTIVES AND TARGETS

PROVINCIAL STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

PROVINCIAL STRATEGIC GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

- *National Sub-output 2: Health Facility Planning*

Table 95: (HFM 1) Provincial Strategic Objectives and Targets – Health Facilities Management

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Mid-Year Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Job Creation through Expanded Public Works Programme (EPWP)	1. Number of jobs created through the EPWP	IRS and EPWP Quarterly reports	Quarterly No	Not reported	1 300	2 485	2 858	2 300	2 200	2 000
Delivery of new clinical infrastructure in line with approved IPIP (Infrastructure Programme Implementation Plan)	2. Number of new clinical projects with completed construction	IRM,PMIS and monthly reports	Quarterly No	14	6	6	15	6	3	3
Delivery of new clinical infrastructure in line with approved IPIP (Infrastructure Programme Implementation Plan)	3. Number of new clinical projects where commissioning is complete	IRM,PMIS and monthly reports	Quarterly No	23	24	6	6	15	6	3
Upgrading & renovation of existing clinical infrastructure in line with approved IPIP	4. Number of upgrading and renovation projects with completed construction	IRM,PMIS and monthly reports	Quarterly No	41	13	38	31	49	66	19
To overhaul Provincial health	5. Percentage of maintenance budget spent *Maintenance budget spent* *Maintenance budget*	IRM,PMIS and monthly reports *BAS* *BAS*	Quarterly % *R* *R*	3%	54%	14%	37%	100%	100%	100%

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Mid-Year Performance	Medium Term Targets		
				2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Revitalisation of Hospital Infrastructure	6. Hospital revitalisation expenditure as percentage of total annual budget	IRM,PMIS and monthly reports	Quarterly %	27%	33%	27%	19%	44%	59%	113%
	Hospital revitalisation expenditure	*BAS*	*R*	*295 261*	*624 099*	*652 041*	*369 429*	*646 132*	*760 115*	*326 562*
	Infrastructure budget	*BAS*	*R*	*1 087 247*	*1 894 999*	*2 373 597*	*1 944 867*	*1 479 357*	*1 287 471*	*287 802*

- *Indicator 6 [Infrastructure Budget]*: The infrastructure budget will be re-negotiated for outer year as per National Treasury Directive.

9.5 TARGETS FOR 2014/15

Table 96: (HFM3) Quarterly Targets for Health Facilities Management 2014/15

	Targets 2014/15	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Number of jobs created through the EPWP	2 300	575	575	575	575
2. Number of new clinical projects with completed construction	6	1	3 (4)	1 (5)	1 (6)
3. Number of new clinical projects where commissioning is complete	15	0	2	5 (7)	8 (15)
4. Number of upgrading and renovation projects with completed construction	49	0	13	14 (27)	22 (49)
5. Percentage of maintenance budget spent	100%	25%	50%	75%	100%
Annual Targets					
6. Hospital revitalisation expenditure as percentage of total annual budget	R646 132 44%				R646 132 44%
7. Proportion of Programme 8 budget spent on maintenance (preventative and scheduled)	11%				11%

	Targets 2014/15	Targets			
		Q1	Q2	Q3	Q4
8. Number of districts spending more than 90% of maintenance budget	11				11

9.6 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 97: (HFM4-A) Expenditure Estimates: Health Care Support Services - Programme 8

Sub-Programme R'000	Audited outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term expenditure estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Community Health Facilities	347 565	426 102	562 070	162 723	559 509	575 760	266 614	110 478	42 249
District Hospitals	424 314	720 786	651 614	519 777	769 143	664 852	461 884	228 268	17 463
EMS	428	3 285	5 377	9 679	1 010	1 066	1 737	1 737	1 737
Provincial Hospitals	204 691	531 961	812 898	514 276	355 636	436 920	607 395	742 939	129 497
Central Hospitals	11 982	4 720	28 598	25 281	12 824	17 731	12 230	33 961	6 331
Other facilities	98 267	208 145	313 041	404 867	246 745	248 538	129 497	170 088	90 525
Total	**1 087 247**	**1 894 999**	**2 373 597**	**1 636 603**	**1 944 867**	**1 944 867**	**1 479 357**	**1 287 471**	**287 802**

Table 98: (HFM4-B) Summary of Provincial Expenditure Estimates by Economic Classification - Programme 8

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
Current payments	**258 169**	**522 372**	**463 510**	**472 871**	**354 283**	**356 194**	**169 774**	**207 468**	**233 071**
Compensation of employees	5 037	12 736	21 998	14 628	25 853	25 181	7 581	5 000	5 000
Goods and services	**253 132**	**509 636**	**441 511**	**458 243**	**328 430**	**331 013**	**162 193**	**202 468**	**228 071**
Communication	333	9	16	511	12	12			
Computer Services	2 178	19 409	6 123	5 370	2 742	2 742			
Consultants, Contractors and special services	52 298	53 260	79 173	69 315	84 201	86 743	24 915	24 915	54 696
Inventory	45974	5630	20 280	7 319	27 486	27 786	118	26	1804
Operating leases		533	68 633	20	69 954	69 954	69 997	66 000	66 000
Rental and hiring	55 796	65 968							
Travel and subsistence	385		358	698	274	274			
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	96168	364 827	266 929	375 010	143 761	143 502	67 163	111 527	105 570
Transfers and subsidies to		**10 783**	**20 000**	**20 000**	**20 000**	**20 022**			
Non-profit institutions		10 000	20 000	20 000	20 000	20 022			
Households		783							
Payments for capital assets	**829 078**	**1 361 844**	**1 890 088**	**1 143 732**	**1 570 584**	**1 568 651**	**1 309 583**	**1 080 003**	**54 731**
Buildings and other fixed structures	778 730	1 048 172	1 662 936	864 152	1 425 231	1 429 298	1 249 773	1 076 903	54 731
Machinery and equipment	49 550	287 217	227 152	279 580	145 353	139 353	59 810	3 100	0
Land and sub-soil assets	798	26 455							
Total economic classification	**1 087 247**	**1 894 999**	**2 373 597**	**1 636 603**	**1 944 867**	**1 944 867**	**1 479 357**	**1 287 471**	**287 802**

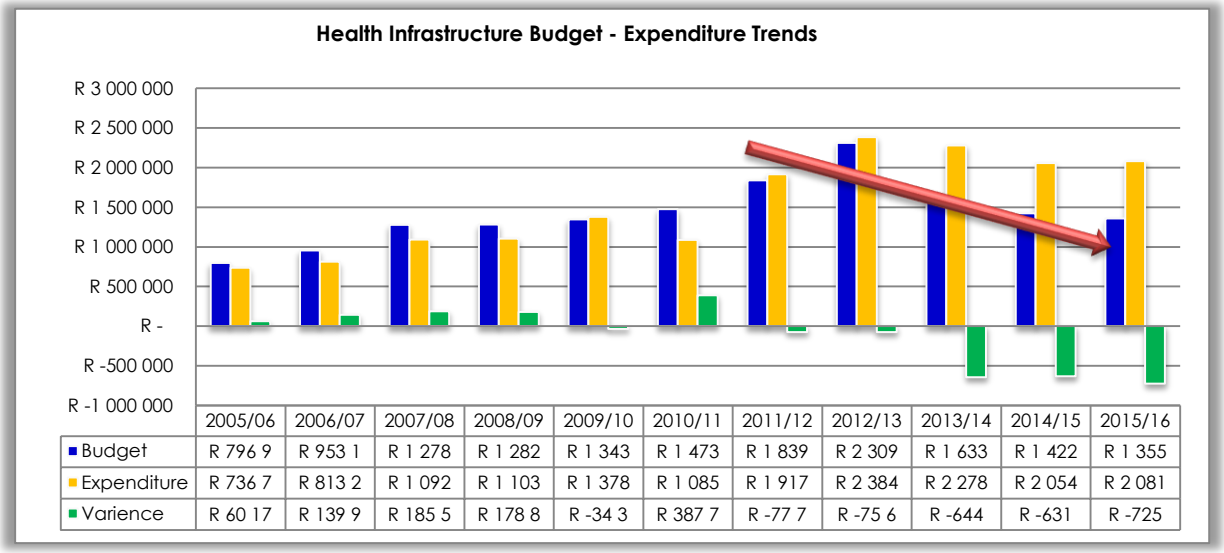
Performance and Expenditure Trends

In 2009/10, the Department spent 45% of the Revitalisation allocation, and in 2010/11 improved expenditure to 56% of the allocated budget. In 2011/12, the Department appointed a full-time Civil Engineer, three Architects and three Quantity Surveyors to manage infrastructure development work to improve efficiencies and to ensure improved expenditure.

In 2012/13 expenditure was on target:

- *Infrastructure Expenditure (R2 348 684)*: 124% of the original and 103% of the adjusted budget was spent.
- *Hospital Revitalisation (R652 041)*: 115% of the original and 111% of the adjusted budget was spent.
- *Health Infrastructure Grant (R573 367)*: 146% of the original and 100% of the adjusted budget was spent.
- *Nursing College Grant (R16 673)*: 101% of the original and 101% of the adjusted budget spent.
- *Equitable Share (R1 142 599)*: 122% of the original and 101% of the adjusted budget spent.

Graph 9: Health Infrastructure Expenditure Trends



	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Budget	R 796 9	R 953 1	R 1 278	R 1 282	R 1 343	R 1 473	R 1 839	R 2 309	R 1 633	R 1 422	R 1 355
Expenditure	R 736 7	R 813 2	R 1 092	R 1 103	R 1 378	R 1 085	R 1 917	R 2 384	R 2 278	R 2 054	R 2 081
Varience	R 60 17	R 139 9	R 185 5	R 178 8	R -34 3	R 387 7	R -77 7	R -75 6	R -644	R -631	R -725

The increasing trend from 2010/11 to 2012/13 is largely the result of an intensive drive to improve and maintain health infrastructure as well as increasing Conditional Grant funding (especially Health Facility Revitalisation Grant) and equitable share.

The increase in *Compensation of employees* from 2011/12 to 2013/14 is due to implementation of the EPWP Integrated Grant for Provinces, which utilises local people to maintain grounds and clean buildings. The decrease in 2014/15 onward is due to the low level of funding from the Grant in 2014/15.

The day-to-day maintenance drive accounts for the substantial increase against *Goods and services* in 2011/12. The reduction in *Goods and services* in 2012/13 is as a result of the hired/ leased properties being paid under capital projects, which has been reversed in 2013/14. The reduction in the 2013/14 Adjusted Appropriation is due to provincial tenders not being in place, poor performing contractors and lack of capacity at some institutions to manage maintenance functions. The level of funding for maintenance decreases over the 2014/15 MTEF due to the base line budget cuts, as the

department has a large carry-through commitment against capital projects.

Contributing to the increase in the overall baseline in 2011/12 was the improvement in performance of Ithala and IDT in the delivery of CHCs and nursing accommodation projects. Expenditure in 2011/12 also included an additional R63.953 million rolled over from 2009/10 in respect of the Hospital Revitalisation component.

In 2012/13, the Health Facility Revitalisation Grant received additional funding of R180 million and R20 million, respectively. In addition, R185.963 million was allocated from provincial cash resources due to acceleration in infrastructure projects, including pressures in the supply of laundry and essential health technology equipment and R6.250 million for the upgrade of the PABX and communication system.

Additional funding was provided in 2013/14 for the refurbishment of Nurses Training Colleges provided in the Nurses Colleges and Schools component of the Health Facility Revitalisation Grant, as well as additional funding allocated under *Current payments* to enable the department to address capacity issues in order to provide better support to infrastructure management. The Hospital Revitalisation and Health Infrastructure components of the Health Facility Revitalisation Grant also received additional funding in 2015/16.

In the 2013/14 Adjusted Appropriation, the Health Infrastructure component received an additional R110 million conditional grant funding and R200million of equitable share funding due to the acceleration of infrastructure projects which include three CHC's, the Regional Laundry in eThekwini and clinics in Umlalazi, Msinga, Mthonjaneni and Jozini.

With regard to *Transfers and subsidies to: Non-profit institutions,* the department transferred R10 million in 2011/12 and R20 million in 2012/13, and will transfer a further R20 million in 2013/14 to the KZN Children's Hospital Trust for the development and refurbishment of the KZN Children's Hospital in the eThekwini Metro.

The high growth against *Machinery and equipment* in 2011/12 was once-off payments for essential medical equipment. The negative growth in 2012/13 can mainly be attributed to reprioritisation made, as the funding was required for the committed and contracted capital projects which were already in the construction phase.

Land and subsoil assets – The trend under this item is driven by the unplanned purchase of land during the construction phase of the projects. In 2010/11 there was a purchase of land for the continuation of the Hospital Revitalisation component project at the Lower Umfolozi War Memorial Hospital, where extra accommodation was provided for a paediatric ICU and High Care Unit. In 2011/12, the department was obliged to purchase additional land for the Dr Pixley ka Seme Hospital due to its status having been changed from a district hospital to a regional hospital and the purchase of the Richmond Chest Hospital.

9.7 RISK MANAGEMENT

Potential Risks	Mitigating Factors
• Infrastructure budget cuts require undoing of state of readiness (33% budget cut by 2014/15)	• Re-prioritisation of Projects
• Project supervision and compliance to project timelines [High].	• Outsourcing and period contracts.

Potential Risks	Mitigating Factors
• Difficulty in recruiting and retaining staff with engineering and related skills and competencies [High].	• Review recruitment and retention strategy.
• Unfunded mandates including unplanned new facilities and upgrades of facilities not in maintenance plan. Delays in rationalisation and alignment of plans [High].	• Alignment of long-term plans.

PART C

LINKS TO OTHER PLANS

INFRASTRUCTURE PLANS

Table 99: Health Infrastructure Grant

	Project name	Project status	Project details	Construction/ Maintenance		Total project cost (R'000)	Previous year expenditure	2014/15 (R'000)	2015/16 (R'000)	2016/17 (R'000)
				Start	Completion					
1	Addington Hospital	Tender	Upgrade 3rd floor theatres	01/ 06/ 2014	30/ 09/ 2014	R 30 000	R 4 200	R 25 450	R 350	R -
2	Ntambanana Clinic	Design	Clinic maintenance & upgrade programme 2006-2007 Phase 2 (Completion of cancelled contract)	03/ 05/ 2014	03/ 12/ 2014	R 6 500	R -	R 6 172	R 328	R -

Table 100: Nursing Colleges and Schools Grant

	Project name	Project status	Project details	Construction/ Maintenance		Total project cost (R'000)	Previous year expenditure	2014/15 (R'000)	2015/16 (R'000)	2016/17 (R'000)
				Start	Completion					
1	Benedictine Hospital (NC)	Design	Student accommodation (40 beds) – phase 1	30/ 09/ 2014	30/ 03/ 2016	R 35 000	R 646	R 5 000	R 28 354	R 1 000
2	Charles Johnson Memorial Hospital	Design	Internal upgrading of nurses residence (phase 2)	30/04/2014	30/ 04/2015	R 5 400	R -	R 5 000	R 400	R -
3	Greys Hospital (NC)	Design	Upgrade remaining floors – new classroom space	30/ 05/ 2014	30/ 05/ 2015	R 23 000	R -	R 9 000	R 12 000	R 2 000
4	Nkonjeni NC	Design	Flats to accommodate 50 nursing staff and students	30/ 05/2014	30/ 05/ 2016	R 34 036	R -	R 11 000	R 18 036	R 5 000

Table 101: Hospital Revitalisation Grant

	Project name	Project status	Type project details	Construction		Total project cost (R'000)	Previous year expenditure	2014/15 (R'000)	2015/16 (R'000)	2016/17 (R'000)
				Start	Completion					
1	Dr Pixley Ka Seme Hospital (new)	Design	New 500 bed Regional Hospital	10/ 08/ 2014	30/ 03/ 2018	R 1 851 986	R 122 726	R 100 000	R 416 972	R 606 288
2	Edendale Hospital	Design	Health Technology Equipment	31/ 08/ 2014	31/ 03/ 2015	R 22 000	R -	R 22 000	R -	R -
3	Edendale Hospital	Design	Predictive (Condition Assessment) Maintenance Phase 1	10/ 08/ 2014	10/ 08/ 2017	R 100 000	R 2 100	R 10 000	R 33 000	R 33 000
4	Hlabisa Hospital	Design	Upgrade Pharmacy, OPD	01/ 11/ 2014	01/ 11/ 2016	R 102 000	R 836	R 14 000	R 35 000	R 50 000
5	King Dinuzulu Hospital	Tender	Construction of New Level 1 Hospital (incl. additional work)	28/ 01/ 2014	28/ 07/ 2014	R 8 630	R 2 254	R 6 161	R 215	R -
6	King Dinuzulu Hospital	Design	Provide roofs to TB Surgical Wards, Walkways and Ramps. Reconfigure used Building to EMS Base	15/ 07/ 2014	15/ 07/ 2015	R 13 000	R -	R 5 000	R 7 000	R 1 000
7	King Dinuzulu Hospital	Tender	Lift Installation: Double Lift to AC Multi Storey	01/ 05/ 2013	01/ 08/ 2014	R 1 865	R 1 400	R 465	R -	R -
8	King Dinuzulu Hospital	Tender	Lift Installation: Single Lift to AC Multi Storey	13/ 03/ 2013	13/ 03/ 2014	R 762	R 702	R 60	R -	R -
9	King Edward VIII Hospital	Design	Unblocking and repair of stormwater pipes (to include sub drainage)	13/ 07/ 2014	30/ 06/ 2015	R 33 930	R 2 484	R 13 840	R 16 691	R 915
10	King Edward VIII Hospital	Design	Repairs and Renovations to MOPD and Upgrade to Theatres, ICU, Nursery and High Care wards in Block 'S'	01/ 11/ 2014	01/ 05/ 2017	R 248 000	R 9 036	R 20 000	R 80 000	R 80 000
11	LUWMH	Design	Decanting from and to existing main Hospital building	02/ 04/ 2014	31/ 03/ 2015	R 150	R -	R 150	R -	R -
12	Madadeni Hospital	Tender	Replacement of Boiler	10/ 04/ 2014	10/ 11/ 2014	R 9 800	R 400	R 9 300	R 100	
13	Ngwelezane Hospital	Design	Security Upgrade	02/ 04/ 2015	01/ 04/ 2016	R 10 000	R -	R 1 000	R 5 000	R 4 000
14	Ngwelezane Hospital	Design	Construct new 192 beds medical wards to replace wards E,F,G,H and demolish the existing Crisis Centre park home and construct new Crisis centre, demolish old wards E,F,G,H.	15/07/2014	01/ 01/ 2017	R 320 000	R 12 700	R 35 000	R 100 000	R 120 000

	Project name	Project status	Type project details	Construction		Total project cost (R'000)	Previous year expenditure	2014/15 (R'000)	2015/16 (R'000)	2016/17 (R'000)
				Start	Completion					
15	Rietvlei Hospital	Design	Connection of electricity to the sewer treatment works plant	30/ 07/ 2014	30/ 03/ 2015	R 614	R -	R 614	R -	R -
16	King Dinuzulu Hospital	Design	Health Technology Equipment	01/ 04/ 2014	31/ 03/ 2015	R 121 612	R 94 978	R 9 790	R -	R -
17	King Edward VIII Hospital	Design	Health Technology Equipment	01/ 04/ 2014	31/ 03/ 2015	R 30 644	R 21 224	R 1 650	R -	R -
18	LUWMH	Design	Health Technology Equipment	01/ 04/ 2014	31/ 03/ 2015	R 73 072	R 33 972	R 12 100	R -	R -
19	Ngwelezane Hospital	Design	Health Technology Equipment	01/ 04/ 2014	31/ 03/ 2015	R 60 771	R 40 401	R 7 370	R -	R -
20	Rietvlei Hospital	Design	Health Technology Equipment	01/ 04/ 2014	31/ 03/ 2015	R 53 370	R 40 669	R 6 900	R -	R -

Table 102: Equitable Share

	Project name	Project status	Type project details	Construction		Total project cost (R'000)	Previous year expenditure	2014/15 (R'000)	2015/16 (R'000)	2016/17 (R'000)
				Start	Completion					
1	Addington Hospital	Design	Upgrade / replace 5 Otis Lifts, 2 Kone Lifts and 7 Schindler Lifts	01/ 04/ 2014	31/ 03/ 2015	R 13 000	R -	R 12 675	R 325	R -
2	Addington Hospital	Design	Replace and install 1 x 500kVA with larger unit	01/ 04/ 2014	31/ 03/ 2015	R 1 500	R -	R 1 463	R 38	R -
3	Addington Hospital	Design	Replacement 3 Autoclaves	01/ 04/ 2014	31/ 03/ 2015	R 986	R -	R 961	R 25	R -
4	Addington Hospital	Design	Phase 3: Replacement 1 Autoclave	01/ 04/ 2014	31/ 03/ 2015	R 350	R -	R 341	R 9	R -
5	Appelsbosch Hospital	Design	Replace and install 1 300kVA with larger unit	01/ 04/ 2014	31/ 03/ 2015	R 1 000	R -	R 975	R 25	R -
6	Catherine Booth	Design	Replace and install 1 200kVA with larger unit	01/ 04/ 2014	31/ 03/ 2015	R 800	R -	R 780	R 20	R -
7	Charles Johnson Memorial Hospital	Design	Replace and install 1 500kVA with larger unit	01/ 04/ 2014	31/ 03/ 2015	R 1 500	R -	R 1 463	R 38	R -
8	Charles Johnson Memorial Hospital	Design	Phase 3: Replacement 1 Autoclave	01/ 04/ 2014	31/ 03/ 2015	R 350	R -	R 341	R 9	R -

	Project name	Project status	Type project details	Construction		Total project cost (R'000)	Previous year expenditure	2014/15 (R'000)	2015/16 (R'000)	2016/17 (R'000)
				Start	Completion					
9	Charles Johnson Memorial Hospital	Design	Upgrade / replace 2 Schindler Lifts	01/ 04/ 2014	31/ 03/ 2015	R 1 750	R -	R 1 706	R 44	R -
10	Church Of Scotland Hospital	Design	Replacement Theatre and CSSD Chiller	01/ 06/ 2014	01/ 12/ 2014	R 900	R -	R 900	R -	R -
11	Church Of Scotland Hospital	Design	Phase 3: Replacement 1 Autoclave	01/ 04/ 2014	31/ 03/ 2015	R 350	R -	R 341	R 9	R -
12	Dundee Regional Laundry	Design	Upgrade the Regional Laundry: Buildings and Equipment	03/ 11/ 2014	28/ 02/ 2016	R 100 000	R 300	R 10 000	R 84 700	R 5 000
13	Edumbe CHC	Design	Replacement 1 Autoclave	01/ 04/ 2014	31/ 03/ 2015	R 373	R -	R 364	R 9	R -
14	EG & Usher Memorial Hospital	Design	Replace and install 1 500kVA with larger unit	01/ 04/ 2014	31/ 03/ 2015	R 1 500	R -	R 1 463	R 38	R -
15	EG & Usher Memorial Hospital	Design	Replacement 2 Autoclaves	01/ 04/ 2014	31/ 03/ 2015	R 658	R -	R 642	R 16	R -
16	Eshowe Hospital	Design	Upgrade / replace 4 Otis Lifts	01/ 04/ 2014	31/ 03/ 2015	R 5 000	R -	R 4 875	R 125	R -
17	Eshowe Hospital	Design	Phase 3: Replacement 1 Autoclave	01/ 04/ 2014	31/ 03/ 2015	R 350	R -	R 341	R 9	R -
18	Feasibility Investigations	Feasibility	Feasibility Investigations, Multi Year Plans	01/ 04/ 2014	30/ 03/ 2015	R 3 000	R -	R 1 000	R 1 000	R 1 000
19	Gale Street Mortuary	Design	Reconfigure 2nd floor to a new Forensic Pathology Lab for National Health	-	-	R 15 000	R -	R 15 000	R -	R -
20	Greytown Hospital	Design	Replace and install 1 300kVA with larger unit	01/ 04/ 2014	31/ 03/ 2015	R 1 000	R -	R 975	R 25	R -
21	Greytown Hospital	Design	Replacement of Theatre Chiller	11/ 06/ 2014	12/ 12/ 2014	R 350	R -	R 350	R -	R -
22	Greytown TB Hospital	Design	Replace and install 1 50kVA with larger unit	01/ 04/ 2014	31/ 03/ 2015	R 250	R -	R 244	R 6	R -
23	Highway House : Mayville	Design	Upgrading of A/C (Replacement of Central plant compressors)	01/ 05/ 2014	01/ 11/ 2014	R 7 500	R -	R 7 320	R 180	R -
24	Hillcrest Hospital	Design	Replace and install 1 200kVA with larger unit	01/ 04/ 2014	31/ 03/ 2015	R 750	R -	R 731	R 19	R -
25	Hlabisa Hospital	Design	Replace and install 1 500kVA with larger unit	01/ 04/ 2014	31/ 03/ 2015	R 1 500	R -	R 1 463	R 38	R -
26	King Edward VIII Hospital	Design	Replacement 1 Autoclave	01/ 04/ 2014	31/ 03/ 2015	R 350	R -	R 341	R 9	R -

	Project name	Project status	Type project details	Construction		Total project cost (R'000)	Previous year expenditure	2014/15 (R'000)	2015/16 (R'000)	2016/17 (R'000)
				Start	Completion					
27	Kwashoba Clinic	Tender	Clinic Maintenance & Upgrading Programme Phase 1 (Completion of cancelled contract)	01/ 03/ 2014	01/ 10/ 2014	R 5 700	R 54	R 5 511	R 135	R -
28	Madadeni Hospital	Design	Predictive (Condition Assessment) Maintenance	15/ 04/ 2014	15/ 04/ 2016	R 85 000	R 2 000	R 18 000	R 56 000	R 9 000
29	Mahatma Ghandhi Hospital	Design	Replacement 2 Autoclaves	01/ 04/ 2014	31/ 03/ 2015	R 704	R -	R 686	R 18	R -
30	Mayor's Walk CPS	Design	Upgrade / replace 1 Hoist	01/ 04/ 2014	31/ 03/ 2015	R 750	R -	R 731	R 19	R -
31	Mbongolwane Hospital	Design	Phase 3: Replacement 1 Autoclave	01/ 04/ 2014	31/ 03/ 2015	R 350	R -	R 341	R 9	R -
32	Melmoth-New District Hospital	Design	Development of Business Case	20/ 07/ 2014	20/ 05/ 2015	R 500	R -	R 500	R -	R -
33	Montebello Hospital	Design	Replace and install 1 300kVA with larger unit	01/ 04/ 2014	31/ 03/ 2015	R 1 000	R -	R 975	R 25	R -
34	Mosvold	Design	Phase 3: Replacement 1 Autoclave	01/ 04/ 2014	31/ 03/ 2015	R 350	R -	R 341	R 9	R -
35	Mosvold Hospital	Design	Replace and install 1 300kVA with larger unit	01/ 04/ 2014	31/ 03/ 2015	R 1 500	R -	R 1 463	R 38	R -
36	Mosvold Hospital	Design	Replacement 1 Autoclave	01/ 04/ 2014	31/ 03/ 2015	R 338	R -	R 330	R 8	R -
37	Natalia Building	Design	Relocate EMS Provincial Health Operational Centre from 16th floor to Ground floor West Wing and remove wall carpet on all floors	01/ 07/ 2014	01/ 07/ 2015	R 75 689	R -	R 49 738	R 25 951	R -
38	Ndwedwe CHC	Design	Replace and install 1 200kVA with larger unit	01/ 04/ 2014	31/ 03/ 2015	R 1 000	R -	R 975	R 25	R -
39	Newcastle Hospital	Design	Replacement 1 Autoclave	01/ 04/ 2014	31/ 03/ 2015	R 353	R -	R 344	R 9	R -
40	Newcastle Hospital	Design	Predictive (Condition Assessment) Maintenance	15/ 04/ 2014	15/ 04/ 2016	R 72 000	R 2 000	R 18 000	R 43 500	R 8 500
41	Nkonjeni Hospital	Identified	Build a new, OPD/Casualty, Neonatal Facility and renovate existing	30/ 01/ 2016	30/ 05/ 2018	R 100 000	R -	R 1 000	R 8 750	R 39 750
42	Northdale Hospital	Design	Upgrade / replace 4 Otis Lifts	01/ 04/ 2014	31/ 03/ 2015	R 4 000	R -	R 3 900	R 100	R -
43	Northdale Hospital	Design	Condition Assessment	01/ 04/ 2014	31/ 03/ 2015	R 800	R -	R 800	R -	R -
44	Nseleni CHC	Design	Replacement 1 Autoclaves	01/ 04/ 2014	31/ 03/ 2015	R 348	R -	R 339	R 9	R -

	Project name	Project status	Type project details	Construction		Total project cost (R'000)	Previous year expenditure	2014/15 (R'000)	2015/16 (R'000)	2016/17 (R'000)
				Start	Completion					
45	Osindisweni Hospital	Design	Replace and install 1 200kVA with larger unit	01/ 04/ 2014	31/ 03/ 2015	R 1 000	R -	R 975	R 25	R -
46	Phoenix CHC	Design	Upgrade / replace 1 Schindler Lifts	01/ 04/ 2014	31/ 03/ 2015	R 750	R -	R 731	R 19	R -
47	Port Shepstone Hospital	Design	New Multi Departmental Co Block	-	-	R 1 500	R -	R 1 500	R -	R -
48	Port Shepstone Hospital	Design	Replacement 2 Autoclaves	01/ 04/ 2014	31/ 03/ 2015	R 618	R -	R 603	R 15	R -
49	Prince Mshiyeni Memorial Hospital	Design	Upgrade fire system	12/ 07/ 2014	15/ 07/ 2015	R 64 000	R 2 400	R 20 000	R 40 000	R 1 600
50	RK Khan Hospital	Design	Upgrading of 4 lifts: Nurses Home	30/ 06/ 2014	30/ 03/ 2015	R 2 000	R -	R 1 141	R 35	R -
51	RK Khan Hospital	Identified	Reconfigure existing building to provide for a neonatal nursery	05/ 04/ 2015	05/ 10/ 2016	R 30 000	R 124	R 2 000	R 10 000	R 20 000
52	RK Khan Hospital	Design	Repairs to collapsing bank	01/ 05/ 2014	11/ 07/ 2014	R 1 300	R 124	R 1 141	R 35	R -
53	RK Khan Hospital	Design	Completion of P Block (Completion contract)	01/ 06/ 2014	01/ 06/ 2015	R 35 242	R -	R 10 000	R 23 542	R 1 700
54	RK Khan Hospital	Design	Replacement 1 Autoclave	01/ 04/ 2014	31/ 03/ 2015	R 358	R -	R 349	R 9	R -
55	St Aidens Hospital	Design	Replacement 1 Autoclave	01/ 04/ 2014	31/ 03/ 2015	R 370	R -	R 361	R 9	R -
56	St Aidens Hospital	Design	Purchase of Hospital	01/ 04/ 2014	31/ 03/ 2015	R 60 000	R -	R 60 000	R -	R -
57	St Andrews Hospital	Design	Replace and install 1 300kVA with larger unit	01/ 04/ 2014	31/ 03/ 2015	R 1 500	R -	R 1 463	R 38	R -
58	St Apollinaris Hospital	Identified	Reconfigure existing building to provide for a neonatal nursery	01/ 04/ 2015	31/ 03/ 2016	R 2 500	R -	R -	R 500	R 1 900
59	St Apollinaris Hospital	Design	Replacement 1 Autoclave	01/ 04/ 2014	31/ 03/ 2015	R 353	R -	R 344	R 9	R -
60	St Margaret's Hospital	Feasibility	Development of a Master Plan	01/ 04/ 2014	31/ 03/ 2015	R 200	R -	R 200	R -	R -
61	St Margaret's Hospital	Design	Replacement 1 Autoclave	01/ 04/ 2014	31/ 03/ 2015	R 342	R -	R 333	R 9	R -
62	Stanger Hospital	Design	Replacement of 1 Chiller for the entire Hospital	01/ 04/ 2014	01/ 12/ 2014	R 2 200	R 150	R 2 000	R 50	R -
63	Stanger Hospital	Design	Upgrade / replace 1 Otis Lifts and 1 Hoist	01/ 04/ 2014	31/ 03/ 2015	R 2 200	R -	R 2 145	R 55	R -

	Project name	Project status	Type project details	Construction		Total project cost (R'000)	Previous year expenditure	2014/15 (R'000)	2015/16 (R'000)	2016/17 (R'000)
				Start	Completion					
64	Sundumbili CHC	Design	Replace and install 1 100kVA with larger unit	01/ 04/ 2014	31/ 03/ 2015	R 850	R -	R 829	R 21	R -
65	Tongaat CHC	Design	Replace and install 1 100kVA with larger unit	01/ 04/ 2014	31/ 03/ 2015	R 850	R -	R 829	R 21	R -
66	Vryheid Hospital	Identified	Reconfigure existing building to provide for a neonatal nursery	15/ 01/ 2015	31/ 07/ 2015	R 2 000	R -	R 1 950	R 50	R -
67	Vryheid Hospital	Design	Upgrade / replace 2 Otis Lifts	01/ 04/ 2014	31/ 03/ 2015	R 2 000	R -	R 1 950	R 50	R -
68	Old Boys Model School - Offices	Design	Conversion of existing building to new SCM offices	15/ 06/ 2014	15/ 12/ 2015	R 20 000	R 483	R 5 000	R 13 178	R 500

CONDITIONAL GRANTS

Table 103: Conditional Grants 2014/15

Purpose of the Grant	Performance Indicators 2014/15	Targets 2014/15
Comprehensive HIV and AIDS Conditional Grant		
• To enable the health sector to develop an effective response to HIV and AIDS including universal access to HIV Counselling and Testing. • To support implementation of the National Operational Plan for Comprehensive HIV and AIDS Treatment and Care. • To subsidise in-part funding for the Antiretroviral Treatment Plan.	1. Total number of fixed public health facilities offering ART services	618
	2. Total clients started on ART during this month - naïve	180 000
	3. Number of beneficiaries served by Home-Based Carers	3 000 000
	4. Number of active Home-Based Carers receiving stipends	10 621
	5. Number of male condoms distributed	212 000 000
	6. Number of female condoms distributed	2 800 000
	7. Number of High Transmission Area intervention sites (new and old)	118
	8. Number of HIV positive clients screened for TB	414 646
	9. Number of HIV positive clients started on IPT	331 716
	10. Number of Lay Counsellors receiving stipends	2 621
	11. Number of clients pre-test counselled on HIV testing (including antenatal)	3 632 536
	12. Number of clients tested for HIV (including antenatal)	3 302 304
	13. Number of fixed health facilities offering MMC services	78
	14. Number of public health facilities offering Post Exposure Prophylaxis for sexual assault cases	110
	15. Number of sexual assault cases offered ARV prophylaxis (new)	4 900
	16. Number of Step Down Facilities/ Units	4
National Tertiary Services Grant		
• To ensure provision of tertiary health services for all South African citizens. • To compensate tertiary facilities for the costs associated with provision of these services including cross border patients.	1. Number of National Central and Tertiary Hospitals providing components of Tertiary services	4
Health Professional Training and Development Grant		
• Support provinces to fund service costs associated with training of health science trainees on the public service platform. • Co-funding of the National Human Resources Plan for Health in expanding undergraduate medical education for 2012 and beyond (2025).	1. Number of Registrars supervised	700
National Health Grant		
• To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health including inter alia, health technology, organisational systems (OD) and quality assurance (QA). • Supplement expenditure on health infrastructure delivered through public-private partnerships	1. Number of new clinical projects with completed construction	6
	2. Number of new clinical projects where commissioning is complete	15
	3. Number of upgrading and renovation projects with completed construction	49
National Health Insurance Grant		

Purpose of the Grant	Performance Indicators 2014/15	Targets 2014/15
• Develop frameworks and models that can be used to roll out the National Health Insurance (NHI) pilots in districts and central hospitals critical to achieving the phased implementation of NHI	1. Review referral systems 2. Medical equipment procured	3 districts All facilities as per procurement plan

PUBLIC ENTITIES

The reduction in the 2013/14 Adjusted Appropriation is a result of the previously mentioned reduction in transfer to McCord Hospital following its take-over by the province, as well as delays in signing SLAs for various NGOs.

The significant decrease in funding in 2014/15 is due to the ceasing of funding for McCord Hospital as it has been taken over as a provincial hospital and funding will be from other categories. In addition, the funding for the KZN Children's Hospital Trust for the development and refurbishment of this hospital in the eThekwini Metro ceases due to the completion of the contract.

Table 104: Public Entities

Name of Public Entity	Mandate	Current Annual Budget (R'000)
1. Austerville Halfway House	2.2: Community Health Clinics	548
2. Azalea House	2.2: Community Health Clinics	506
3. Bekulwandle Bekimpelo	2.2: Community Health Clinics	8 141
4. Benedictine (Thwasana) Clinic	2.2: Community Health Clinics	88
5. Claremont Day Care Centre	2.2: Community Health Clinics	387
6. Day Care Club 91	2.2: Community Health Clinics	105
7. Ekukhanyeni Clinic (AIDS Step-Down Care)	2.2: Community Health Clinics	938
8. Elandskop Clinic	2.2: Community Health Clinics	440
9. Enkumane Clinic	2.2: Community Health Clinics	265
10. Ethembeni Care Centre	2.6: HIV and AIDS	5 027
11. Genesis Care Centres	2.6: HIV and AIDS	2 890
12. Happy Hour Various	2.2: Community Health Clinics	7 340
13. Hlanganani Ngothando	2.2: Community Health Clinics	219
14. Ikwezi Cripple Care	2.2: Community Health Clinics	1 197
15. John Peattie House	2.2: Community Health Clinics	1 407
16. Jona Vaughn Centre	2.2: Community Health Clinics	2 461
17. Lynn House	2.2: Community Health Clinics	616
18. Madeline Manor	2.2: Community Health Clinics	886
19. Masada Workshop	2.2: Community Health Clinics	78
20. Masibambeni Day Care Centre	2.2: Community Health Clinics	155
21. Philanjalo Hospice (Step-Down Centre)	2.6: HIV and AIDS	2 525
22. Rainbow Haven	2.2: Community Health Clinics	406
23. Scadifa Centre	2.2: Community Health Clinics	1 000
24. St Luke Home	2.2: Community Health Clinics	453
25. Sunfield Home	2.2: Community Health Clinics	319

29. Umlazi Halfway House	2.2: Community Health Clinics	274
26. Mountain View Hospital	4.2: Specialised TB	9 772
27. Siloah Hospital	4.2: Specialised TB	18 768
28. St Mary's Hospital Marianhill	2.7: District Hospitals	120 557
30. Earmarked for re-allocation to districts	-	*14 988*

PUBLIC PRIVATE PARTNERSHIPS

Table 105: Public Private Partnership

Name of PPP	Purpose	Outputs	Current Annual Budget (R'000)	Date of Termination	Measures to ensure smooth transfer of responsibilities
Inkosi Albert Luthuli Central Hospital The Department in partnership with Impilo Consortium (Pty) Ltd and Cowslip Investments (Pty) Ltd	The Impilo Consortium is responsible for the provision of the following goods and services: Supply equipment and information management and technology (IM&T) systems and replace the equipment and IM&T systems to ensure that they remain state of the art. Supply and replace non-medical equipment. Provide all services necessary to manage Project Assets in accordance with Best Industry Practice. Maintain and replace Departmental Assets in terms of the replacement schedules. Provide or procure Utilities, Consumables and Surgical Instruments. Provide Facility Management Services.	Delivery of non-clinical services to IALCH	R 657 435	The 15 year contract with Impilo Consortium (Pty) Ltd will terminate in 2016/17.	Termination arrangements are detailed in the project agreement in clauses 35, 36, 37 and the penalty regime (Schedule 15). The Provincial Treasury PPP Unit is rendering assistance to the Department of Health regarding its exit strategy.

In 2002/03, the department entered into a PPP with Impilo Consortium (Pty) Ltd. The agreement covered the provision of equipment, information management and technology and facilities management for the IALCH. This agreement enables the department to focus on the clinical services at the hospital, and to promote the hospital as a central referral hospital, operating at the highest standards in terms of quality, efficiency, effectiveness and patient focused care.

CONCLUSION

The Department stays unwavering in its commitment to improved service delivery and better health outcomes. Implementation of the 2014/15 Annual Performance Plan will be monitored robustly and quarterly reports will serve as yardstick for decisive informed action.

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ABBREVIATIONS

Abbreviation	Description
	A
ACSM	Advocacy, Communication and Social Mobilisation
AGSA	Auditor General of South Africa
AIDS	Acquired Immune Deficiency Syndrome
ALS	Advanced Life Support
AMS	Air Mercy Services
ANC	Ante Natal Care
APP	Annual Performance Plan
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
ASSA	AIDS Committee of Actuarial Society of South Africa
	B
BANC	Basic Ante Natal Care
BAS	Basic Accounting System
BLS	Basic Life Support
BUR	Bed Utilisation Rate
	C
CARMMA	Campaign on Accelerated Reduction of Maternal and child Mortality in Africa
CCG's	Community Care Givers
CCMDU	Central Chronic Medication Dispensing Unit
CDC	Communicable Disease Control
CEO(s)	Chief Executive Officer(s)
CFO	Chief Financial Officer
CFR	Case Fatality Rate
CHC(s)	Community Health Centre(s)
COE	Compensation of Employees
COEC	College of Emergency Care
COGTA	Cooperative Governance and Traditional Affairs
CPSS	Central Pharmaceutical Supply Store
	D
DBE	Department of Basic Education
DHER(s)	District Health Expenditure Review(s)
DHIS	District Health Information System
DHP's	District Health Plans
DHS	District Health System
DOE	Department of Education
DOH	Department of Health
DOT	Directly Observed Treatment
DPC	Disease Prevention and Control
DPME	Department Performance Monitoring and Evaluation
DPSA	Department of Public Service and Administration
DQPR	District Quarterly Progress Report
	E
ECP	Emergency Care Practitioner
ECT	Emergency Care Technician
EGKS	Electronic Gate Keeping System
EH	Environmental Health
EHP	Environmental Health Practitioner
EMS	Emergency Medical Services
EN's	Enrolled Nurses
ENA's	Enrolled Nursing Assistant(s)
EPI	Expanded Programme on Immunisation
EPMDS	Employee Performance Management and Development System
EPT	Emergency Patient Transport

Abbreviation	Description
EPWP	Expanded Public Works Programme
ESMOE	Essential Steps in Management of Obstetric Emergencies
ETBR	Electronic Tuberculosis Register
ETR.net	Electronic Register for TB
F	
FPS	Forensic Pathology Services
FSMSGS	Food Services Monitoring Standard Grading System
G	
GHS	General Household Survey
GIS	Geographic Information System
GOBIFFF	Growth monitoring, Oral rehydration therapy, Breast feeding, Immunisation, Family spacing, Family education, Food supplementation
G&S	Good and Services
H	
HAART	Highly Active Ante-Retroviral Therapy
HAST	HIV, AIDS, STI and TB
HCSS	Health Care Support Services
HCT	HIV Counselling and Testing
HCRW	Health Care Risk Waste
HIV	Human Immuno Virus
HFM	Health Facilities Management
HOD	Head of Department
HPS	Health Promoting Schools
HPTDG	Health Professional Training and Development Grant
HR	Human Resources
HRD	Human Resource Development
HRMS	Human Resources Management Services
HRP	Human Resource Plan
HST	Health Systems Trust
HTA's	High Transmission Areas
I	
IALCH	Inkosi Albert Luthuli Central Hospital
IDT	Independent Development Trust
IDIP	Infrastructure Delivery Improvement Programme
IDMS	Infrastructure Delivery Management Programme
IFT	Inter Facility Transfer
ILS	Intermediate Life Support
IMCI	Integrated Management of Childhood Illnesses
IPAT	Infrastructure Project Assemble Tool
IPC	Infection Prevention & Control
IPIP	Infrastructure Programme Implementation Plan
IPT	Ionized Preventive Therapy
IRM	Infrastructure Reporting Model
IT	Information Technology
IT	Information Technology
IYCF	Infant, Youth, Child Feeding
K	
KRA(s)	Key Result Area(s)
KZN	KwaZulu-Natal
KZNPSP	KwaZulu-Natal Provincial Strategic Plan for HIV, AIDS, STI and TB
L	
LG	Local Government
M	
M&E	Monitoring and Evaluation
MC&WH	Maternal Child & Women's Health
MDG	Millennium Development Goals
MDR-TB	Multi Drug Resistant Tuberculosis

Abbreviation	Description
MDT(s)	Media Data Terminal(s)
MEC	Member of the Executive Council
MIP	Massification Implementation Plan
MMC	Medical Male Circumcision
MMR	Maternal Mortality Rate
MNC&WH	Maternal, Neonatal, Child & Women's Health
MOU	Maternity Obstetric Unit
MRC	Medical Research Council
MTEF	Medium Term Expenditure Framework
MTS	Modernisation of Tertiary Services
MTSF	Medium Term Strategic Framework
MTCT	Mother To Child Transmission
MUAC	Mid-Upper Arm Circumference
N	
NCE	National Confidential Enquiries
NDOH	National Department of Health
NDP	National Development Plan
NGO's	Non-Governmental Organisations
NHC	National Health Council
NHC TAC	National Health Council Technical Advisory Committee
NHI	National Health Insurance
NHIS	National Health Information System
NHLS	National Health Laboratory Services
NHS	National Health System
NIMART	Nurse Initiated and Managed Antiretroviral Therapy
NIP	National Integrated Nutrition Programme
NSDA	Negotiated Service Delivery Agreement
NSO	National Sub-Output
NSP	National Strategic Plan
NTSG	National Tertiary Services Grant
NVP	Nevirapine
O	
ODTC	Oral and Dental Training Centre
OHH	Outreach Households
OPD	Out-Patient Department
OSD	Occupation Specific Dispensation
OSS	Operation Sukuma Sakhe
OTP	Office of the Premier
P	
PA(s)	Performance Agreement(s)
P1 Calls	Priority 1 calls
PCR	Polymerase Chain Reaction
PCV	Pneumococcal Vaccine
PDE	Patient Day Equivalent
PEP	Post Exposure Prophylaxis
PERSAL	Personnel and Salaries System
PFMA	Public Finance Management Act
PGDS	Provincial Growth and Development Strategy
PGDP	Provincial Growth and Development Plan
PHC	Primary Health Care
PHRC	Provincial Health Research Committee
PHREC	Provincial Health Research and Ethics Committee
PPIP	Perinatal Problem Identification Programme
PITC	Patient Initiated Testing & Counselling
PICT	Provider Initiated Counselling & Testing
PIDC	Provincial Infrastructure Delivery Committee
PMDS	Performance Management and Development System

Abbreviation	Description
PMSC	Provincial Medical Supply Centre
PMTCT	Prevention of Mother to Child Transmission
PN	Professional Nurse
PPIP	Peri-Natal Problem Identification Programme
PPSD	Provincial Pharmaceutical Supply Depot
PPT	Planned Patient Transport
PQRS	Provincial Quarterly Reporting System
PTB	Pulmonary Tuberculosis
PTS	Patient Transport Services
PSS	Patient Satisfaction Survey
PwC	Price water house Coopers
R	
RV	Rota Virus
S	
SANC	South African Nursing Council
SAPC	South African Pharmacy Council
SADHS	South African Demographic & Health Survey
SCM	Supply Chain Management
SHS	School Health Services
SITA	State Information and Technology Agency
SMS	Senior Management Service
SP	Strategic Plan
Stats SA	Statistics South Africa
STI's	Sexually Transmitted Infections
STP	Service Transformation Plan
T	
TB	Tuberculosis
TCC	Thuthuzela Care Centres
U	
UKZN	University of KwaZulu-Natal
U-AMP	User–Asset Management Plan
V	
VCT	Voluntary Counseling and Testing
W	
WHO	World Health Organisation
WISN	Workload Indicators of Staffing Need
X	
XDR-TB	Extreme Drug Resistant Tuberculosis
Y	
YLL	Years of Life Lost

ANNEXURE 1: DEFINITIONS

For more information the following attached documents can be consulted on http://www:kznhealth.gov.za

1. KwaZulu-Natal Department of Health Data Management Policy.
2. SOP Collection and verification of data at PHC level.
3. SOP collection and verification of data at hospital level.

Note:

- New indicators, not monitored in the previous Annual Performance Plan, are indicated as "New Indicator".
- Customised health indicators (National Department of Health) are highlighted in light orange.
- Population information obtained through the District Health Information System (system populated by the National Department of Health based on projected population data from Statistics South Africa).

TECHNICAL INDICATOR DESCRIPTIONS AND TARGETS

Indicator title	Identifies the title of the indicator.
Short definition	Provides a brief explanation of the indicator.
Purpose	Provides a brief explanation of what the indicator is measuring and why it is important.
Source	Quote where the information is coming from – details available on http://www.kznhealth.gov.za
Method of calculation	Describes how the indicator is calculated (numerator and denominator formula).
Calculation type	Identifies how the indicator is reported and whether the indicator is cumulative or non-cumulative.
Type of indicator	Identifies whether the indicator is measuring input, output, outcome or impact (process, efficiency, economy or equity).
Reporting cycle	Identifies if indicator is reported quarterly, bi-annually, annually or at a longer time interval.
Data limitations	Identifies limitations with data, including factors that might be beyond the Department's control.

Desired performance	Identifies whether actual performance that is higher or lower than targeted performance is desirable.
Indicator responsibility	Identifies who is responsible for managing and reporting the indicator.

PROGRAMME 1: ADMINISTRATION

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Develop Provincial long term health plan *Previously referred to "Published Service Transformation Plan"*	Develop a provincial strategic long-term plan (10-year plan) aligned with the National Development Plan (NDP) and aimed at health system strengthening and improved service delivery.	Monitor compliance with long-term plan including NDP and national goals.	Provincial Long-Term Plan (Service Transformation Plan)	N/A	N/A	Output	Annual	None.	Plan approved and implemented.	Planning Unit and Management
Develop Provincial Human Resources for Health Plan	Develop a provincial strategic human resources plan aligned with the provincial long-term plan to make provision for human resources for health.	Monitor compliance with human resources for health plan.	Provincial Human Resource Plan	N/A	N/A	Output	Annual	None.	Plan approved and implemented.	HR Planning and Management
Proportion of facilities connected to the internet ***New Indicator***	Proportion of health facilities connected to the internet.	Monitor improved connectivity and ICT progress at facility level.	IT database (internet rollout report) DHIS reporting	***Numerator*** SUM(Facilities connected to the internet) ***Denominator*** SUM(Facilities in the province as per DHIS)	%	Input	Quarterly	None.	Higher percentage connectivity desired.	IT Unit
Number of Hospital Managers who have signed Performance Agreements	The number Hospital Managers who have signed Performance Agreements with supervisors for the reporting period.	Monitor effective performance management and development.	Performance Management records (HRMS)	SUM(Hospital Managers with signed Performance Agreements for the reporting period)	Number	Input	Annual	None.	Higher number desired (100%) – effective oversight.	Performance Management (HRMS), all Senior Managers
Number of District Managers who have signed Performance Agreements	The number of District Managers who have signed Performance Agreements with supervisors for the reporting period.	Monitor performance management and development.	Performance Management records (HRMS)	SUM(District Managers with signed Performance Agreements for the reporting period)	Number	Input	Annual	None.	Higher number desired (100%) – effective oversight.	Performance Management (HRMS), all Senior Managers

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Percentage of Head Office Managers (Level 13 and above) who have signed Performance Agreements	The percentage of Senior Managers at Head Office (level 13 and above) who have signed Performance Agreements with supervisors for the reporting period.	Monitor performance management and development.	Performance Management records (HRMS)	***Numerator*** SUM(Head Office Managers (level 13 and above) with signed Performance Agreements for reporting period) ***Denominator*** SUM(Head Office Managers (level 13 and above) on Persal)	%	Input	Annual	None.	Higher number desired (100%) – effective oversight.	Performance Management (HRMS), all Senior Managers
Number of functional tele-medicine sites	Use of telemedicine (on-line) to improve access to clinical training and development.	Monitor availability of on-line facilities to expand access to training and development.	Telemedicine database	SUM(On-line tele-medicine sites)	Number	Input	Annual	Accuracy of telemedicine database.	Higher number desired – improved access to distance training and development.	Tele-medicine Unit
Medical Officers per 100,000 population	Medical Officers in posts on the last day of March of a specific year per 100,000 people.	Monitor equity/ improved human resource allocation with specific reference to Medical Officers.	Persal (Medical Officers) Stats SA (population)	***Numerator*** SUM(Medical Officers in posts on the 31st of March) ***Denominator*** SUM(Total population in KZN) x 100,000	Number per 100,000	Input	Annual	Dependant on the accuracy of Persal data.	Higher number desired – improved access to healthcare. Budget limitations may limit appointments.	HRMS, DHS & Specialised Services
Professional Nurses per 100,000 population	Professional Nurses in posts on the last day of March of a specific year per 100,000 people.	Monitor equity/ improved human resource allocation with specific reference to Professional Nurses.	Persal (Professional Nurses) Stats SA (population)	***Numerator*** SUM(Professional Nurses in posts on the 31st of March) ***Denominator*** SUM(Total population in KZN) x 100,000	Number per 100,000	Input	Annual	Dependant on accuracy of Persal data.	Higher number desired – improved access to healthcare. Budget limitations may limit appointments.	HRMS, DHS & Clinical Services
Pharmacists per 100,000 population	Pharmacists in posts on the last day of March per 100,000 people.	Monitor equity/ improved human resource allocation with specific reference to Pharmacists.	Persal (Pharmacists) Stats SA (population)	***Numerator*** SUM(Pharmacists in posts on the 31st of March) ***Denominator*** SUM(Total population in KZN) x 100,000	Number per 100,000	Input	Annual	Dependant on accuracy of Persal data.	Higher number desired – improved access to healthcare. Budget limitations may limit appointments.	HRMS, DHS & Clinical Services
Provincial M&E Framework implemented	A provincial framework within which performance M&E is implemented.	Monitor effective M&E at all levels.	Provincial M&E Framework	N/A	N/A	Input	Annual	Limited capacity to monitor implementation at especially facility level.	Full compliance to provincial M&E Framework.	M&E Unit
Number of Level 1 Health Ethics Review Boards established ***New Indicator***	Official Board(s) established to approve and monitor research for health (excluding Clinical Trials).	Monitor improved research processes and systems.	Appointment letters of Board Members	SUM(Level 1 Health Ethics Review Boards)	Number	Input	Annual	None.	Full compliance with targets.	Epidemiology and Health Research Unit

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of in-house research projects completed ***New Indicator***	Research for health directly related to identified health research priorities facilitated by the Epidemiology and Health Research Manager.	Monitor research for health.	Research Reports	SUM(Research projects facilitated by Epidemiology & Research Unit completed)	Number	Output	Annual	None.	Higher number desired.	Epidemiology and Health Research Unit
Proportion of facilities implementing the PHC tick register and daily capturing tool ***New Indicator***	Implementation of standardised data tools to improve data quality.	Monitor data quality and audit outcomes for Performance Information.	PHC tick registers and daily capturing tools	***Numerator*** SUM(Facilities implementing PHC tick register and daily capturing tool) ***Denominator*** SUM(Number PHC facilities)	%	Input	Annual	Inadequate monitoring at facility level.	Higher percentage desired – improved compliance with provincial Data Management Policy.	Data Management Unit
Proportion of facilities that scored >75% on the Food Service Monitoring Standards Grading System ***New Indicator***	The proportion of facilities that comply with more than 75% of the food service standards as measured using a customised grading system.	Monitor the quality of Food Services.	Food Services monitoring reports	***Numerator*** SUM(Facilities that score more than 75% on the Food Service Monitoring Standards Grading System) ***Denominator*** SUM(Number of facilities)	%	Output	Annual	Accurate and updated reports.	Higher percentage desired – indicating higher standard.	Clinical Support Unit
Number of in-house Food Service Units serving 3 Provincial standardized menus ***New Indicator***	In-house food service providers that comply with the standardised food menus.	Monitor the quality of Food Services.	In-house menus	SUM(Facilities that provide 3 provincially standardised menus)	Number	Output	Annual	Accurate and updated reports.	Higher percentage desired – indicating higher standard of compliance.	Clinical Support Unit
Number of facilities compliant with 2 priority Food Safety Standards ***New Indicator***	Facilities that implement the food safety standards and comply with priority standards.	Monitor the quality of Food Services.	Food Services monitoring reports	SUM(Facilities that comply with 2 priorities of Food Safety Standards)	Number	Output	Annual	Accurate and updated reports.	Higher percentage desired – indicating higher standard of compliance.	Clinical Support Unit
Proportion of health facilities with operational Security Committees ***New Indicator***	Dedicated Security Committees to ensure compliance with Security Policy and patient/ staff safety.	Monitor effective security systems at facility level.	Committee meeting reports	***Numerator*** SUM(Health facilities with operational Security Committees) ***Denominator*** SUM(Number of health facilities)	%	Input	Annual	None.	Higher percentage desired – improved security systems.	Security Manager

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Proportion of health facilities fenced with access control at the gate ***New Indicator***	Facilities that comply with standard fencing and gate control.	Monitor safety and security at facility level.	Security audit results	***Numerator*** SUM(Facilities with fencing and gate access control) ***Denominator*** SUM(Total facilities)	%	Input	Annual	None.	Higher percentage desired – improved safety.	Security Manager

PROGRAMME 2: DISTRICT HEALTH SERVICES

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Provincial PHC expenditure per uninsured person	Provincial PHC expenditure per uninsured person (no medical aid) attending any public health PHC service in KZN.	Monitor expenditure trends in service delivery at PHC level (per uninsured person) to determine economies of scale and efficiency.	BAS (expenditure) Stats SA (population) General Household Survey (% uninsured population)	***Numerator*** SUM(Provincial expenditure including Sub-Programmes 2.2-2.7) ***Denominator*** 87.7% of total population in KZN	Rand	Input	Annual	Accuracy of data (BAS and DHIS).	Higher expenditure desired – points to prioritisation of PHC services.	DHS and CFO
PHC utilisation rate (annualised)	The average number of PHC visits per person per year in the catchment population (herein referred to as KZN). All clients are counted once a day regardless of the number of services provided to the client on that day.	Monitor access and utilisation of PHC services.	PHC Tick Register (headcount) Stats SA (population) DHIS calculates	***Numerator*** SUM([PHC headcount under 5 years in KZN]) + SUM([PHC headcount 5 years and older in KZN]) ***Denominator*** SUM([Total population in KZN])	Number per person Annualised	Output	Quarterly	Accuracy of estimated population from Stats SA and accuracy of data at facility level.	Higher utilisation rate desired – improved access and utilisation of public health services.	DHS
Outreach Households (OHH) registration visit coverage (annualised) ***New Indicator***	Proportion of households in the target wards covered by Ward-Based Outreach Teams.	Monitor implementation and outcomes of PHC re-engineering – specifically related to Ward-Based Teams.	Tick Register WBOT Stats SA (households) DHIS calculates	***Numerator*** SUM([OHH registration visit]) ***Denominator*** SUM([OHH households in the KZN population])	% Annualised	Output	Quarterly	Accuracy of data collected at source level.	Higher coverage desired – improved household coverage.	DHS

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
PHC supervisor visit rate (fixed clinic/ CHC/ CDC)	Percentage of fixed public health clinics, CHCs and CDCs visited by a supervisor once a month as prescribed in the PHC Supervision Manual (official supervisor report completed per visit).	Monitor supervision and clinical governance in fixed public health PHC services.	Supervision Records Quality Improvement Plans DHIS calculates	***Numerator*** SUM([PHC supervisor visit (fixed clinic/CHC/CDC)]) ***Denominator*** SUM([Fixed clinic]) + SUM([Fixed CHC/CDC])	%	Quality	Quarterly	Dependant on accurate reporting of the purpose of the visit by the supervisor.	Higher rate desired – improved supportive supervision at facility level.	DHS
Complaints resolution within 25 working days rate	Percentage of complaints resolved within 25 working days as proportion of all complaints resolved in the same period.	Monitor efficiency of the response to customer concerns/ complaints in PHC.	Complaints Register DHIS calculates – Patient Satisfaction Module	***Numerator*** SUM(Complaints resolved within 25 working days) ***Denominator*** SUM(Complaints resolved])	%	Output	Quarterly	Accuracy of complaints registers.	Higher rate desired – more efficient response to complaints and compliance to Batho Pele.	Quality Assurance Unit and Ombudsperson
Percentage of PHC facilities conducting patient satisfaction surveys ***New Indicator***	The proportion PHC facilities that conduct annual patient satisfaction surveys to determine patient satisfaction with PHC services.	Monitor patient satisfaction with PHC services.	Patient Satisfaction Survey records DHIS – Patient Satisfaction Module	***Numerator*** COUNT(Provincial PHC fixed facilities that conducted an annual patient satisfaction survey for reporting period) ***Denominator*** COUNT(Provincial PHC fixed facilities in KZN during the same reporting period)	%	Quality	Annual	Efficiency of reporting system.	Higher percentage desired – compliance to Batho Pele.	Quality Assurance Unit
PHC patient satisfaction rate ***New Indicator***	Proportion of PHC users that participated in the patient satisfaction survey that were satisfied with PHC services.	Monitor patient satisfaction with public health PHC services.	Patient Satisfaction Survey results DHIS – Patient Satisfaction Module	***Numerator*** COUNT(Number of survey participants that were satisfied with PHC services) ***Denominator*** COUNT(Number of users that participated in the PHC Patient Satisfaction Survey)	%	Quality	Annual	Generalised - depends on the number of users participating in the survey.	Higher rate desired – compliance to Batho Pele and improved quality.	Quality Assurance Unit and Ombudsperson
Number of fully fledged District Clinical Specialist Teams appointed (cumulative)	Number of District Clinical Specialist Teams, with the full staff component, appointed as part of PHC re-engineering.	Monitor availability of Clinical Specialists in the District Health System.	Persal/ Establishment District Management	COUNT(Full District Clinical Specialist Teams appointed) Nursing: Advanced Midwife; Specialist PHC Nurse; and Specialist Paediatric Nurse Medical: Specialist Gynaecologist; Specialist Paediatrician; Specialist Anaesthetist; Family Physician	Number Cumulative	Input	Quarterly	None.	Higher number desired – improved access to Specialists at district level.	DHS and MNCWH Unit

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of fully fledged Ward-Based Outreach Teams appointed (cumulative)	Number of Ward-Based Outreach Teams (WBOTs) with full staffing structure appointed to function at community level as part of PHC re-engineering.	Monitor outreach services at community and household level as part of PHC re-engineering.	Persal/ Establishment District Management	COUNT(Ward-Based Outreach Teams appointed) Team: Professional Nurse, Enrolled Nurse, at least 6 CCGs	Number Cumulative	Input	Annual	Incorrect linking of staff to Persal and BAS.	Higher number desired – improved availability of outreach services at household level.	DHS
School ISHP coverage (annualised)	The percentage of schools where the Integrated School Health Programme (ISHP) service package (as per School Health Service Policy) was provided during the reporting period.	Monitor implementation of the ISHP and equitable school health coverage.	Tick Register School Health DBE (school quintile classification) DHIS calculates	***Numerator*** COUNT([School learners in catchment schools screened total]) ([Schools where the ISHP service package was provided]) ***Denominator*** COUNT([Schools in catchment area total]) - School Quintile classification	% Annualised	Output	Quarterly	Accurate number of schools based on Department of Basic Education (DBE) records and quality of data at source level.	Higher coverage desired – more children receiving health services at school(s).	DHS
School Grade 1 screening coverage (annualised) ***New Indicator***	Proportion of Grade 1 learners in catchment area screened by a nurse in line with the ISHP service package.	Monitor implementation of the Integrated School Health Programme.	Tick Register School Health DBE (school quintile classification) DHIS calculates	***Numerator*** SUM(School Grade 1 learners in catchment area screened) ***Denominator*** SUM(School Grade 1 learners total in catchment area)	% Annualised	Output	Quarterly	Accurate number of schools based on DBE records and quality of data at source level.	Higher coverage desired - more children receiving health services at school(s).	DHS
School Grade 4 screening coverage (annualised) ***New Indicator***	Proportion of Grade 4 learners screened by a nurse in line with the ISHP service package.	Monitor implementation of the Integrated School Health Programme.	Tick Register School Health DBE (school quintile classification) DHIS calculates	***Numerator*** SUM(School Grade 4 learners in catchment area screened) ***Denominator*** SUM(School Grade 4 learners total in catchment area)	% Annualised	Output	Quarterly	Accurate number of schools based on DBE records and quality of data at source level.	Higher coverage desired - more children receiving health services at school(s).	DHS
School Grade 8 screening coverage (annualised) ***New Indicator***	Proportion of Grade 8 learners screened by a nurse in line with the ISHP service package.	Monitor implementation of the Integrated School Health Programme.	Tick Register School Health DBE (school quintile classification) DHIS calculates	***Numerator*** SUM(School Grade 8 learners in catchment area screened) ***Denominator*** SUM(School Grade 8 learners total in catchment area)	% Annualised	Process	Quarterly	Accurate number of schools based on DBE records and quality of data at source level.	Higher coverage desired - more children receiving health services at school(s).	DHS

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Percentage of fixed PHC facilities that have conducted gap assessments for compliance against the national core standards ***New Indicator***	The proportion of fixed PHC facilities (including CHCs) conducting self-assessments to determine compliance to the National Core Standards using customised assessment tools.	Monitor compliance to the National Core Standards.	Self-assessment records DHIS (facilities)	***Numerator*** COUNT(Fixed PHC facilities (including CHCs) self-assessed for compliance to the National Core Standards) ***Denominator*** COUNT(Fixed PHC facilities (including CHCs) in KZN)	%	Quality	Quarterly	Efficiency of data systems and records.	Higher percentage desired – improved self-monitoring of compliance to National Core Standards.	Quality Assurance Unit
Compliance rate of fixed PHC facilities to National Core Standards	The proportion fixed PHC facilities (including CHCs) that comply with standards contained in the national core standards.	Monitor compliance to the national core standards.	Assessment records	***Numerator*** SUM([Compliant fixed PHC clinics] + [Compliant CHCs]) ***Denominator*** COUNT(Fixed PHC clinics and CHCs in KZN)	%	Outcome	Quarterly	None.	Higher rate desired – improved efficiency and quality.	Quality Assurance Unit
Utilisation rate under 5 years PHC (annualised)	Average number of PHC visits per year per child under 5 years in the catchment population.	Monitor access and utilisation of PHC services by children under-5 years of age.	PHC Tick Register (headcount) Stats SA (population) DHIS calculates	***Numerator*** SUM([PHC headcount under 5 years in KZN]) ***Denominator*** SUM([Female under 5 years in KZN]) + SUM([Male under 5 years in KZN])	Number per child under 5 years Annualised	Output	Quarterly	Accuracy of estimated under-5 population from Stats SA and accuracy of data at facility level.	Higher rate desired – more children accessing health care at public health facilities.	DHS
Expenditure per PHC headcount	Provincial expenditure per person visiting public health PHC services.	Monitor PHC expenditure trends and economy of scale.	BAS (expenditure) P HC Tick Register DHIS (headcount)	***Numerator*** SUM([Provincial expenditure on PHC services (Sub-Programmes 2.2-2.7)] ***Denominator*** SUM(PHC total headcount)	Rand	Efficiency	Quarterly	Efficient record management at facility level and accuracy of BAS.	Lower expenditure may indicate efficient use of resources; higher expenditure may indicate improved access to PHC.	DHS and Budget Control
Number of School Health Teams (cumulative)	Number of School Health Teams appointed to render services at schools clustered to a PHC clinic as part of PHC re-engineering.	Monitor school health services as part of PHC re-engineering.	Persal and District Management	COUNT(School Health Teams appointed – cumulative)	Number Cumulative	Input	Annual	None.	Higher number desired – improved school coverage.	DHS

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of accredited Health Promoting Schools (cumulative)	The number of schools officially accredited as Health Promoting Schools (HPS's) by an external Assessment Authority. Accreditation is based on full compliance to the national norms and standards for Health Promoting Schools.	Monitor implementation of community ownership for health promotion at schools in line with the Ottawa Charter's 5 Action Areas to expand the role of learners as partners in health and to improve accountability for health at household level.	Health Promoting Schools database	COUNT(Schools accredited as Health Promoting School by an external assessment authority)	Number Cumulative	Outcome	Quarterly	Accuracy and completeness of the HPS database.	Higher number desired – community ownership for health promotion.	DHS
Dental extraction to restoration ratio	The number of teeth extracted compared with the number of teeth restored.	Monitors overall quality of dental health services.	Dental Tick Register DHIS calculates	***Numerator*** SUM([Tooth extraction]) ***Denominator*** SUM([Tooth restoration])	Number	Output	Quarterly	Efficient record management at facility level.	Decreased ratio desired – improved oral health services.	Oral Health Unit

SUB-PROGRAMME HIV, AIDS, TB & STI CONTROL

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Total clients remaining on ART(TROA) at the end of the month	The cumulative number of patients remaining on an ARV regimen at the end of the month.	Monitor the number of patients on ARV treatment as part of effective management of HIV prevalence.	ART Register DHIS calculates	SUM([Naïve including PEP and PMTCT]) + SUM([experienced]) + SUM([transfer-in]) + SUM([restart]) minus SUM([Died, lost to follow-up, transfer-out])	Number Cumulative	Input	Quarterly	Dependent on accuracy of data from reporting facilities.	Higher number desired – improved management of eligible clients.	HIV and AIDS Unit
Number of male medical circumcisions conducted	The number of adult male medical circumcisions conducted - cumulative.	Monitor the number of male medical circumcision as part of the prevention strategies to reduce new HIV infections.	Theatre Circumcision Register DHIS calculates	SUM([Adult males (15 years and older) circumcised in a specific period]) + SUM([All circumcisions previously performed])	Number Cumulative	Output	Quarterly	Dependent on accuracy of data from reporting facilities.	Higher number desired – improved access and uptake.	HIV and AIDS Unit
TB (new pulmonary) defaulter rate	Percentage new smear positive (pulmonary) TB clients who interrupted/defaulted treatment.	Monitor compliance to TB treatment.	TB Register ETR.net calculates	***Numerator*** SUM([TB (new pulmonary) treatment defaulter]) ***Denominator*** SUM([TB (new pulmonary) client initiated on treatment])	%	Outcome	Quarterly	Dependent on quality of data from reporting facility and functionality of information system.	Lower defaulter rate desired – improved case holding and improved TB outcomes.	TB Unit

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
TB AFB sputum result turn-around time under 48 hours rate	Percentage of TB Acid Fast Bacilli (AFB) results received within 48 hours of submitting specimen to the laboratory - Exclude samples send for culture and sensitivity.	Monitor turn-around time of sputa samples - received by facility (SMS or printed report) within 48 hours from when specimen (including pre-treatment and follow-up specimens) was collected.	TB Register ETR.net calculates	***Numerator*** SUM([TB AFB sputum result received within 48 hours]) ***Denominator*** SUM([TB AFB sputum samples sent])	%	Process/ Quality	Quarterly	Accuracy of capturing the date/ time that samples were dispatched and/or received	Higher rate desired – improved turn-around time.	TB Unit
TB new client treatment success rate	Proportion TB patients (all types of TB) cured plus those who completed treatment.	Monitor success of TB treatment for all types of TB.	TB Register ETR.net calculates	***Numerator*** SUM([TB client cured OR completed treatment]) ***Denominator*** SUM([TB (new pulmonary) client initiated on treatment])	%	Outcome	Quarterly	Dependent on the quality of data from reporting facility.	Higher rate desired – improved treatment success.	TB Unit
HIV testing coverage (15-49 years) – annualised ***New Indicator***	Clients tested for HIV as proportion of population 15-49 years.	Monitor annual testing of persons 15-49 years old who are not known HIV positive.	Tick Register PHC Counsellor Tick Register Stats SA (population) DHIS calculates	***Numerator*** SUM([HIV test client 15-49 years]) ***Denominator*** SUM([Female 15-44 years]) + SUM([Male 15-44 years]) + SUM([Female 45-49 years]) + SUM([Male 45-49 years])	% Annualised	Output	Quarterly	Accuracy dependent on quality of data from reporting entity.	Higher coverage desired – more people knowing their HIV status.	HIV and AIDS Unit
TB (new pulmonary) cure rate	Proportion of new TB smear positive and culture positive (pulmonary TB) clients cured.	Monitor cure of new pulmonary TB clients.	TB Register ETR.net calculates	***Numerator*** SUM([TB (new pulmonary) client cured]) ***Denominator*** SUM([TB (new pulmonary) client initiated on treatment])	%	Outcome	Annual	Accuracy dependent on quality of data from reporting facility.	Higher rate desired – improved TB outcomes.	TB Unit
TB-MDR confirmed treatment initiation rate ***New Indicator***	Proportion confirmed new MDR-TB patients initiated on treatment.	Monitor treatment and treatment outcomes of MDR-TB patients.	MDR-TB Register EDR Web calculates	***Numerator*** SUM(TB-MDR confirmed client initiated on treatment) ***Denominator*** SUM(TB-MDR confirmed new client)	%	Output	Quarterly	Accuracy dependent on quality of data from reporting facility.	Higher rate desired – increased number of patients on treatment.	TB Unit
TB death rate ***New Indicator***	The proportion of TB clients who died during treatment.	Monitor death during the TB treatment.	TB Register ETR.net calculates	***Numerator*** SUM(TB client death during treatment) ***Denominator*** SUM(TB new pulmonary client initiated on treatment)	%	Impact	Quarterly	Dependent on accuracy of data from reporting facilities.	Reduced rate desired – improved detection and management of TB.	TB Unit

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of patients that started regimen iv treatment (MDR-TB) ***New Indicator***	The number of MDR-TB cases registered on treatment regimen iv in a specific time period (including new and previously treated).	Monitor management and outcomes of drug-resistant TB – surveillance.	EDR Web MDR-TB Register	SUM(Patients started regimen iv treatment for MDR-TB)	Number	Input	Annual	Dependent on data completeness and accuracy at facility level.	A higher number might indicate good case finding while lesser number, regardless of intensified case finding, may indicate decreasing disease incidence.	TB Unit
MDR-TB six month interim outcome ***New Indicator***	The proportion of patients that culture converted at six months who have had 9 months of treatment.	Monitor management and outcomes of drug-resistant TB - surveillance.	EDR Web MDR-TB Register	***Numerator*** SUM(Patients with a negative culture at 6 months who started treatment for 9 months) ***Denominator*** SUM(Patients who started treatment in the same period)	%	Outcome	Annual	Dependent on data completeness and accuracy at facility level.	Higher percentage desired - good case holding practices.	TB Unit
Number of patients that started XDR-TB treatment ***New Indicator***	The number of XDR-TB cases registered in a specific time period (including new and previously treated).	Monitor management and outcomes of drug-resistant TB - surveillance.	EDR Web XDR-TB Register	SUM(Patients started the treatment regime for XDR-TB)	%	Input	Annual	Dependent on data completeness and accuracy at facility level.	A higher number might indicate good case finding while lower number, regardless of intensified case finding, may indicate decreasing disease incidence.	TB Unit
XDR-TB six month interim outcome ***New Indicator***	The proportion of patients that culture converted at six months who have had 9 months of treatment.	Monitor management and outcomes of drug-resistant TB - surveillance.	EDR Web XDR-TB Register	***Numerator*** SUM(Clients with a negative culture at six months who has had started treatment for 9 months) ***Denominator*** SUM(Patients who started treatment in the same period)	%	Outcome	Annual	Dependent on data completeness and accuracy at facility level.	Higher percentage desired - good case holding practices.	TB Unit
TB incidence (per 100 000 people) ***New Indicator***	The number of new TB infections per 100,000 people.	Monitor new TB infections.	TB Register ETR.net Stats SA (population)	***Numerator*** SUM(New confirmed TB) ***Denominator*** Total population in KZN	Number per 100,000 people	Impact	Annual	Dependent on accuracy of data from reporting facilities.	Reduced incidence desired – improved prevention of TB.	TB Unit
HIV incidence	New HIV infections in the general population.	Monitor the impact of the HIV and AIDS Programmes on new HIV infections.	ASSA2008 projections Stats SA (population)	***Numerator*** SUM(New HIV infections in specific period) ***Denominator*** Total population in KZN	%	Impact	Annual	Not routinely collected. ASSA2008 or Stats SA projections used.	Reduced incidence desired – effective prevention programmes.	HIV and AIDS Unit

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
STI treated new episode incidence (annualised)	Proportion of people 15 years and older treated for a new sexually transmitted infection episode (annualised).	Monitor treatment of STIs, which include HIV and more than 20 disease-causing organisms and syndromes.	Stats SA (population) Tick Register PHC Stats SA (population) DHIS calculates	***Numerator*** SUM([STI treated new episode]) ***Denominator*** SUM([Female 15-44 years]) + SUM([Male 15-44 years]) + SUM([Female 45 years and older]) + SUM([Male 45 years and older])	Number per 1,000 Annualised	Outcome	Quarterly	Dependent on accuracy of data from reporting facilities.	Decreased incidence desired – effective prevention programmes.	HIV and AIDS Unit
Male condom distribution coverage (annualised)	Number of male condoms distributed to clients via the facility or via factories, offices, restaurants, NGOs or other outlets - per male 15 years and older.	Monitor distribution of male condoms for prevention of HIV and other STIs, and for contraceptive purposes.	Stock cards Stats SA (population) DHIS calculates	***Numerator*** SUM([Male condoms distributed]) ***Denominator*** SUM([Male 15-44 years]) + SUM([Male 45 years and older])	Number Annualised	Input	Quarterly	Dependent on accuracy of data and effective information system.	Higher coverage desired – effective distribution of condoms as part of prevention strategies.	HIV and AIDS Unit

SUB-PROGRAMME MATERNAL, NEONATAL, CHILD AND WOMEN'S HEALTH AND NUTRITION

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Immunisation coverage under 1 year (annualised)	Percentage children under 1 year who completed their primary course of immunisation. Child counted once as fully immunised when receiving the last vaccine in the course (usually the 1st measles and PCV3 vaccines) and if there is documented proof of all required vaccines (BCG, OPV1, DTaP-IPV/Hib 1, 2, 3, HepB 1, 2, 3, PCV 1, 2, 3, RV 1,2 and measles 1) on the Road to Health Card/Booklet.	Monitor implementation of the Extended Programme on Immunisation (EPI) and impact on vaccine preventable conditions.	Tick Register PHC Stats SA (population) DHIS calculates	***Numerator*** SUM([Immunised fully under 1 year new]) ***Denominator*** SUM([Female 1 year]) + SUM([Male under 1 year])	% Annualised	Output	Quarterly	Reliant on under-1 population estimates from Stats SA and accurate recording of children under-1 that are fully immunised.	Higher coverage desired – greater number of children immunised.	MNCWH Unit
Vitamin A dose 12-59 months coverage (annualised)	Percentage of children 12-59 months that received vitamin A 200,000 units every six months (twice a year).	Monitor vitamin A supplementation to children aged 12-59 months.	Tick Register PHC Stats SA (population) DHIS calculates	***Numerator*** SUM([Vitamin A 12-59 months]) ***Denominator*** SUM([Female 1 year]) + SUM([Female 02-04 years]) + SUM([Male 1 year]) + SUM([Male 02-04 years])) * 2	% Annualised	Output	Quarterly	Reliant on child population estimates from StatsSA and accuracy of data from reporting facilities.	Higher coverage desired – improved nutrition/ supplementation support.	Nutrition Unit
Deworming 12-59 months coverage (annualised) ***New Indicator***	Percentage of children 12-59 months who received deworming medication (preferably every six months between 12 to 59 months).	Monitor parasite control interventions in children aged 12-59 months.	Tick Register PHC Stats SA (population) DHIS calculates	***Numerator*** SUM(Deworming dose 12-59 months) ***Denominator*** SUM(Female 1 year) + SUM(Female 2-4 years) + SUM(Male 1 year) + SUM(Male 2-4 years)	% Annualised	Output	Quarterly	Accuracy of data from reporting facilities.	Higher coverage desired – improved parasite control.	DHS

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Child under 2 years underweight for age incidence (annualised) ***New Indicator*** *Previously monitored "Child under 5 years underweight for age incidence"*	Children under 2 years newly diagnosed as underweight (weight between -2 and -3 standard deviations) per 1000 children under-2 years in the population.	Monitor prevention of malnutrition during the 1000 days between start of pregnancy and second birthday. Improve early detection of poor growth as part of prevention and management to improve child health outcomes.	Tick Register PHC/OPD Stats SA (population) DHIS calculates	***Numerator*** SUM(Child under 2 years underweight-new(weight between -2SD -3SD (Standard Deviation) ***Denominator*** SUM(Female under 2 years) + SUM(Male under 2 years)	Per 1000 Annualised	Outcome	Quarterly	Accuracy dependent on quality of data from reporting facilities.	Lower incidence desired – reduced malnutrition and improved child health outcomes.	Nutrition and MNCWH Units
Measles 1st dose under 1 year coverage (annualised)	Percentage of children under 1 year who received the measles 1st dose, preferably 9 months after birth.	Monitor protection of children less than 1 year against measles as part of the elimination of measles strategy.	Tick Register PHC Stats SA (population) DHIS calculates	***Numerator*** SUM([Measles 1st dose under 1 year]) ***Denominator*** SUM([Female under 1 year]) + SUM([Male under 1 year])	% Annualised	Output	Quarterly	Reliant on under-1 population estimates from Stats SA and accuracy of data at facilities.	Higher coverage desired – improved measles coverage and improved child health outcomes.	MNCWH Unit
PCV 3rd dose coverage (annualised)	Percentage children under 1 year who received Pneumococcal (PCV) 3rd dose, normally at 9 months. Vaccines given as part of mass vaccination campaigns not included.	Monitor EPI and protection of children against pneumococcal disease.	Tick Register PHC Stats SA (population) DHIS calculates	***Numerator*** SUM([PCV 3rd dose under 1 year]) **Denominator** SUM([Female under 1 year]) + SUM([Male under 1 year])	% Annualised	Output	Quarterly	Reliant on under-1 population estimates from Stats SA and accuracy of data at facilities.	Higher coverage desired – increased PCV coverage.	MNCWH Unit
RV 2nd dose coverage (annualised)	Percentage children under 1 year who received RV 2nd dose, normally at 14 weeks but NOT later than 24 weeks. Vaccines given as part of mass vaccination campaigns not included.	Monitor the EPI and protection of children against the rota virus.	Tick Register PHC Stats SA (population) DHIS calculates	***Numerator*** SUM([RV 2nd dose under 1 year]) **Denominator** SUM([Female under 1 year]) + SUM([Male under 1 year])	% Annualised	Output	Quarterly	Reliant on under-1 population estimates from Stats SA and accuracy of data at facilities.	Higher coverage desired – increased RV coverage.	MNCWH Unit
Cervical cancer screening coverage (annualised)	Proportion of women, 30 years and older, who had a routine cervical cancer smear in the reporting year (targeting 10% of women over 30 years per annum).	Monitor implementation of Cervical Cancer Screening Policy.	Tick Register PHC Cervical Cancer Screening Registers Stats SA (population) DHIS calculates	***Numerator*** SUM(Cervical cancer screening 30 years and older) ***Denominator*** SUM(Female 30-34 years) + SUM(Female 35-39 years) + SUM(Female 40-44 years) + SUM(45 years and older)/10	% Annualised	Output	Quarterly	Dependent on accuracy of screening data (excluding diagnostic and repeat Pap smears).	Higher coverage desired – more women screened for cervical cancer.	MNCWH Unit

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
HPV vaccine coverage amongst Grade 4 girls ***New Indicator***	Grade 4 girls receiving the HPV vaccine as part of the cervical cancer prevention programme.	Monitor HPV vaccine coverage.	DBE learner enrolment Tick Register School Health DHIS calculates	***Numerator*** SUM(Grade 4 girls receiving the HPV vaccine) ***Denominator*** SUM(Grade 4 girls in KZN)	% Annualised	Output	Quarterly	Dependent on accuracy of reporting.	Higher coverage desired – more Grade 4 girls receiving the HPV vaccine to prevent cervical cancer.	DHS & MNCWH Unit
Antenatal 1st visit before 20 weeks rate	Women who have a booking visit (first visit) before 20 weeks of pregnancy as proportion of all antenatal 1st visits.	Monitor early utilisation of antenatal care services.	Tick Register PHC DHIS calculates	***Numerator*** SUM([Antenatal 1st visit before 20 weeks]) ***Denominator*** SUM([Antenatal 1st visit 20 weeks or later]) + SUM([Antenatal 1st visit before 20 weeks])	%	Process	Quarterly	Dependant on the accuracy of data at facility level.	Higher rate desired – more women accessing antenatal care before 20 weeks.	MNCWH Unit
Infant given NVP within 72 hours after birth uptake rate	Infants given Nevirapine (NVP) within 72 hours of birth as proportion of live births to HIV positive women.	Monitor implementation of the PMTCT guidelines in terms of NVP for HIV exposed babies.	Tick Register PHC/OPD Delivery Register DHIS calculates	***Numerator*** SUM([Infant given Nevirapine within 72 hours after birth]) ***Denominator*** SUM([Live birth to HIV positive woman])	%	Input	Quarterly	Dependant on the accuracy of data collection and management at facility.	Increased rate desired –improved compliance to guidelines and more babies receiving treatment to prevent MTCT.	MNCWH Unit
Infant 1st PCR test positive around 6 weeks rate	Infants tested PCR positive for the first time around 6 weeks after birth as proportion of infants PCR tested around 6 weeks.	Monitor positivity in HIV exposed infants around 6 weeks after birth to determine the effectiveness of the PMTCT programme.	Tick Register PHC DHIS calculates	***Numerator*** SUM([Infant 1st PCR test positive around 6 weeks after birth]) ***Denominator*** SUM([Infant 1st PCR test around 6 weeks after birth])	%	Outcome	Quarterly	Dependant on the accuracy of data collection and management at facility.	Reduced rate desired –improved PMTCT outcomes i.e. reduction in mother to child transmission of HIV.	MNCWH Unit
Couple year protection rate (annualised)	Women using modern contraceptive methods, including sterilisation, as percentage of the female population 15-44 years.	Monitor access to and utilisation of modern contraceptive methods in females of reproductive age.	Tick Register PHC OPD/ Delivery/ Theatre Register Stats SA (population) DHIS calculates	***Numerator*** SUM([Oral pill cycle]) / 13) + SUM([Medroxyprogesterone injection]) / 4) + SUM([Norethisterone Enanthate injection]) / 6) + SUM([IUCD inserted]) * 4) + SUM([Male condoms distributed]) / 200) + SUM([Sterilisation - male]) * 20) + SUM([Sterilisation - female]) * 10) ***Denominator*** SUM([Female 15-44 years in KZN])	% Annualised	Outcome	Annual	Reliant on accuracy of data at facilities.	Higher rate desired – more women using a modern method of contraception.	MNCWH Unit

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Maternal mortality in facility ratio (annualised)	Women who died in hospital as a result of childbearing, during pregnancy or within 42 days of delivery or termination of pregnancy, per 100,000 live births in the facility.	Used as a proxy for the population-based maternal mortality rate and used to monitor trends in causes of maternal deaths and management outcomes in health facilities between official surveys.	Midnight census Delivery Register DHIS calculates	***Numerator*** SUM([Maternal death in facility]) ***Denominator*** SUM([Live births in facility])	Number per 100,000 live births Annualised	Impact	Quarterly	Dependant on the accuracy/ timeliness of data/ reported maternal deaths from facilities. Current information excludes deaths in private facilities and in communities.	Lower ratio desired – decrease in maternal deaths in facilities.	MNCWH Unit
Delivery in facility under 18 years rate	Deliveries to women under the age of 18 years as proportion of total deliveries in public health facilities.	Monitor deliveries to women under-18 years as proportion of total deliveries.	Delivery Register DHIS calculates	***Numerator*** SUM([Delivery in facility under 18 years]) ***Denominator*** SUM([Delivery in facility total])	%	Outcome	Quarterly	Dependant on the accuracy of data collection and management at facility level.	Lower rate desired – decrease in number of deliveries to women under-18 years.	MNCWH Unit
Child under 1 year mortality in facility rate	Proportion of children under-1 year admitted/ separated who died during their stay in public health facilities.	Monitor treatment outcomes of children under-1 year in public health facilities.	Midnight census Tick register inpatient under-1 year DHIS calculates	***Numerator*** SUM([Inpatient death under 1 year]) ***Denominator*** SUM([Inpatient death under-1 year]) + SUM([Inpatient discharge under 1 year]) + SUM([Inpatient transfer out under 1 year])	%	Outcome	Quarterly	Dependant on the accuracy of data at facility level.	Lower rate desired – fewer children under-1 year dying in public health facilities.	MNCWH Unit
Inpatient death under 5 year rate	Percentage of children under 5 years admitted/ separated who died during their stay in public health facilities.	Monitor treatment outcomes for children under 5 years admitted in public health facilities (includes under-1 year deaths).	Midnight census Tick Register in-patient under 5 DHIS calculates	***Numerator*** SUM([Inpatient death under 5 years]) ***Denominator*** SUM([Inpatient death under 5 years]) + SUM([Inpatient discharge under 5 years]) + SUM([Inpatient transfer out under 5 years])	%	Impact	Quarterly	Dependant on the accuracy of data at facility level.	Lower rate desired – fewer children under-5 years dying in public health facilities.	MNCWH Unit
Child under 5 years severe acute malnutrition n case fatality rate ***New Indicator***	The proportion of children under 5 years admitted in public health facilities with severe acute malnutrition that died in the facility.	Monitor the treatment outcome for children under-5 years who were admitted with severe acute malnutrition.	Tick Register in-patient under-5 DHIS calculates	***Numerator*** SUM(Child under 5 years with severe acute malnutrition death) ***Denominator*** SUM(Child under 5 years with severe acute malnutrition admitted)	%	Impact	Quarterly	Accuracy dependent on quality of data from reporting facilities.	Lower rate desired – improved management outcomes.	MNCWH Unit

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Child under 5 years diarrhoea case fatality rate ***New Indicator***	The proportion of children under-5 years admitted with diarrhoea in public health facilities that died in the facility.	Monitor the treatment outcome for children under-5 years who were admitted with diarrhoea.	Tick Register in-patient under-5 DHIS calculates	***Numerator*** SUM(Child under 5 years with diarrhoea death) ***Denominator*** SUM(Child under 5 years with diarrhoea admitted)	%	Impact	Quarterly	Accuracy dependent on quality of data from reporting facilities.	Lower rate desired – improved management outcomes.	MNCWH Unit
Child under 5 years pneumonia case fatality rate ***New Indicator***	The percentage of children under-5 years admitted with pneumonia in public health facilities that died in the facility.	Monitor the treatment outcome for children under-5 years who were admitted with pneumonia.	Tick Register inpatient under-5 DHIS calculates	***Numerator*** SUM(Child under 5 years with pneumonia death) ***Denominator*** SUM(Child under 5 years with pneumonia admitted)	%	Impact	Quarterly	Accuracy dependent on quality of data from reporting facilities.	Lower rate desired – improved management outcomes.	MNCWH Unit
Mother postnatal visit within 6 days rate	Mothers who receive postnatal care within 6 days after delivery as proportion of deliveries in public health facilities.	Monitor access to and utilisation of postnatal services.	Tick Register PHC DHIS calculates	***Numerator*** SUM([Mother postnatal visit within 6 days after delivery]) ***Denominator*** SUM([Delivery in facility total])	%	Process	Quarterly	Reliant on accuracy of data at facilities.	Higher rate desired – improved postnatal care. May be more than 100% in areas with low delivery in facility rates - mothers who delivered outside health facilities seek postnatal care at nearest facility.	MNCWH Unit
Neonatal mortality in facility rate (annualised) ***New Indicator***	Inpatient deaths within the first 28 days of life per 1,000 estimated live births.	Monitor trends in neonatal mortality in public health facilities.	Stats SA (population) DHIS calculates	***Numerator*** SUM([Inpatient death 0-7 days]) + SUM([Inpatient death 8-28 days]) ***Denominator*** SUM([Female under 1 year]) + SUM([Male under 1 year])) * 1.03	% Annualised	Impact	Quarterly	Reliant on accuracy of data at facilities.	Lower percentage desired – improved neonatal management outcomes.	MNCWH Unit
Infant mortality rate	Proportion of children less than one year old who die in one year per 1000 population under 1 year.	Monitor trends in infant mortality - MDG 4.	South African Demographic and Health Surveys (SADHS) - done every 5 years OR ASSA2008 projections (currently using) Stats SA (population)	***Numerator*** SUM(Children less than one year old that die in one year in the province) ***Denominator*** SUM(Total population under 1 year) x1000	Number per 1000 population under 1 year	Impact	Annual – ASSA2008 projected data	Empirical population-based data are not frequently available – SADHS only conducted every 5 years.	Lower rate desired.	MNCWH Unit

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Under 5 years mortality rate	Proportion of children less than five years old that die in one year per 1000 population under 5 years.	Monitor trends in under-5 mortality - MDG 4.	South African Demographic and Health Survey (SADHS) – done every 5 years OR ASSA2008 projections (currently using) Stats SA (population)	***Numerator*** SUM(Children less than five years that die in one year in the province) ***Denominator*** SUM(Total population under 5 years) x1000	Number per 1000 population under 5 years	Impact	Annual – ASSA2008 projected data	Empirical population-based data are not frequently available – SADHS only conducted every 5 years.	Lower rate desired.	MNCWH Unit
Infant exclusively breastfed at HepB 3rd dose rate ***New Indicator***	Proportion of infants that are exclusively breastfed at 14 weeks. This includes all infants that have received only breast milk in the last 24 hours at their 14 week immunisation visit for hepatitis B vaccine 3rd dose.	Monitor the number of exclusively breastfed infants which will be used as a proxy for exclusive breastfeeding at 6 months - contributing to the MDG 4.	Tick register PHC DHIS calculates	***Numerator*** SUM(Infant exclusively breastfed at HepB 3rd dose) ***Denominator*** SUM(HepB 3rd dose under 1 year)	%	Output	Quarterly	Accuracy dependent on quality of data from reporting facility.	Increase rate desired – reduced risk of mother to child transmission of HIV.	Nutrition and MNCWH Units
Child under 5 years diarrhea with dehydration incidence (annualised)	Children under 5 years newly diagnosed with diarrhoea with dehydration per 1000 children under-5 years in the population.	Monitor the burden of disease of diarrhoea with dehydration (IMCI classification) in children under-5 years.	Tick Register PHC Stats SA (population) DHIS calculates	***Numerator*** SUM(child under 5years with diarrhoea with dehydration new) ***Denominator*** SUM(female under 5years) + SUM(male under 5years)	Number per 1000 population Annualised	Outcome	Quarterly	Accuracy dependent on quality of data from reporting facility.	Lower incidence desired – lower burden of diarrhoea disease.	MNCWH Unit
Child under 5 years pneumonia incidence (annualised)	Children under 5 years newly diagnosed with pneumonia per 1000 children under-5 years in the population.	Monitor prevention and diagnosis of pneumonia (IMCI definition) in children under-5 years.	Tick Register PHC Stats SA (population) DHIS calculates	***Numerator*** SUM(child under 5 years with pneumonia new) ***Denominator*** SUM(female under 5years) + SUM(male under 5 years)	Number per 1000 population Annualised	Outcome	Quarterly	Accuracy dependent on quality of data from reporting facility.	Lower incidence desired – lower burden of pneumonia disease.	MNCWH Unit
Child under 5 years severe acute malnutrition incidence (annualised)	Children under 5 years newly diagnosed with severe acute malnutrition per 1000 children under-5 years in the population.	Monitor prevention and diagnosis of severe acute malnutrition in children less than 5 years.	Tick Register PHC Stats SA (population) DHIS calculates	***Numerator*** SUM([Child under 5 years with severe acute malnutrition new]) ***Denominator*** SUM([Female under 5 years]) + SUM([Male under 5 years])	Number per 1000 population Annualised	Outcome	Quarterly	Accuracy dependent on quality of data from reporting facility	Lower incidence desired – lower burden of severe acute malnutrition disease.	Nutrition & MNCWH Units

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Weighing coverage under 1 year (annualised)	The children under-1 year weighed during the reporting period as a percentage of the total number of expected weighing in the target population. Expected weighing is defined as one weighing per month (12 per year) for children under 1 year.	Monitor if all children under-1 years of age that present to public health facilities are weighed to promote and monitor growth and development.	Tick Register PHC Stats SA (population) DHIS calculates	***Numerator*** SUM([Number of children under 1 year weighed]) ***Denominator*** SUM([Female under 1 year]) + SUM([Male under 1 year])	% Annualised	Output	Quarterly	Accuracy is dependent on quality of data from reporting facility.	Higher coverage desired – improved growth monitoring and early detection of malnutrition.	Nutrition Unit

SUB-PROGRAMME DISEASE CONTROL AND PREVENTION

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Hypertension incidence (annualised) ***New Indicator***	Newly diagnosed hypertension clients initiated on treatment per 1000 population 40 years and older. The number of hypertension clients under 40 years is very small hence monitoring population 40 years and older who is the main risk group.	Monitor programme performance and disease trends (including hypertension) to inform preventative strategies.	Tick Register PHC Register OPD Stats SA (population) DHIS calculates	***Numerator*** SUM(Hypertension client treatment new) ***Denominator*** SUM(female 40 – 44 years) + SUM(female 45 years and older) + SUM(male 40 - 44 years) + SUM(male 45 years and older)	Number per 1000 population Annualised	Outcome	Monthly	Accuracy is dependent on quality of data from reporting facility.	Lower incidence desired – improved management of hypertensive patients.	NCD Unit
Diabetes incidence (annualised) ***New Indicator***	Newly diagnosed diabetes clients initiated on treatment per 1000 population.	Monitor programme performance and disease trends (including diabetes) to inform preventative strategies.	Tick Register PHC Register OPD Stats SA (population) DHIS calculates	***Numerator*** SUM(Diabetes client under 18 years new) + SUM(Diabetes client 18 years and older) ***Denominator*** SUM(Total population)	Number per 1000 population Annualised	Outcome	Monthly	Accuracy is dependent on quality of data from reporting facility.	Lower incidence desired – improved management of diabetic patients.	NCD Unit
Malaria case fatality rate	Deaths from malaria as a percentage of the number of malaria cases reported.	Monitor the number of malaria deaths as part of the national malaria elimination strategy.	Tick Register PHC Malaria Control and Surveillance database	***Numerator*** SUM(Deaths from malaria) ***Denominator*** SUM(Number of Malaria cases reported)	%	Outcome	Annual	Accuracy dependant on quality of data from health facilities.	Lower rate desired – improved prevention and management of malaria.	Malaria Control Unit

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Cataract surgery rate (uninsured population)	Clients who had cataract surgery per 1 million uninsured population.	Monitor access to cataract surgery and the number of cataract operations as part of prevention of blindness strategy.	Theatre Register Stats SA (population) General Household Survey (% uninsured population) DHIS calculates	Numerator SUM([Cataract surgery total]) **Denominator** SUM([87.7% of the total population in KZN])	Number per 1mil uninsured population	Output	Quarterly	Accuracy dependant on quality of data from health facilities.	Higher rate desired – increased accessibility to sight restoration.	NCD Unit
Malaria incidence per 1000 population at risk	New malaria cases as proportion of 1000 population at risk (high-risk areas based on malaria cases).	Monitor the new malaria cases in endemic areas as proportion of the population at risk - MDG 6.	Tick Register PHC CDC Surveillance database Stats SA (population)	***Numerator*** SUM(New reported malaria cases) ***Denominator*** SUM(Umkhanyakude population) *Population at risk referring to endemic areas – Umkhanyakude District in KZN identified as endemic district*	Number per 1000 population at risk (endemic areas)	Outcome	Annual	Dependent on accuracy of reporting.	Lower incidence desired – improved prevention towards elimination of malaria.	Malaria Control Unit

PROGRAMMES 2, 4 AND 5 - HOSPITAL SERVICES

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Average length of stay – total	The average number of client days an admitted client spends in hospital before separation.	Monitors effectiveness and efficiency of hospitals.	Midnight census DHIS calculates	***Numerator*** SUM([Inpatient days - total]) + SUM([Day patients - total]) * 0.5) ***Denominator*** SUM([Inpatient deaths - total]) + SUM([Inpatient discharges - total]) + SUM([Inpatient transfers out - total])	Days	Efficiency	Quarterly	Accurate reporting from reporting facilities.	Low average length of stay reflects high levels of efficiency. High efficiency levels may however hide compromised quality.	DHS and Hospital Services
Inpatient bed utilisation rate – total	Inpatient bed days used as proportion of maximum Inpatient bed days available.	Monitors effectiveness and efficiency of hospitals.	Midnight census DHIS calculates	***Numerator*** SUM([Inpatient days - total]) + SUM([Day patients - total]) * 0.5) ***Denominator*** SUM([Inpatient beds - total]) *30.42	%	Efficiency	Quarterly	Accurate reporting from reporting facilities.	Higher bed utilisation desired – resource constraints might be a limiting factor.	DHS and Hospital Services

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Expenditure per patient day equivalent (PDE)	The average cost per patient day in public health hospitals.	Monitor effective and efficient management of resources and inpatient facilities in public health hospitals.	BAS (expenditure) DHIS calculates	***Numerator*** SUM([Expenditure total]) – calculated per level of care (Budget Programmes for District, Regional, Specialised, Tertiary and Central Hospitals) ***Denominator*** SUM([Inpatient days - total]) + SUM([Day patients - total]) * 0.5) + ((SUM([OPD headcount - total]) + SUM([Emergency headcount total])) * 0.33333333) - calculated per level of care (Budget Programmes for District, Regional, Specialised, Tertiary and Central Hospitals)	Rand	Efficiency	Quarterly	Accuracy dependent on data quality	Lower expenditure may indicate efficient use of resources although the burden of disease can increase expenditure.	DHS, Hospital Services and Budget Control
Complaint resolved within 25 working days	Client complaints resolved within 25 working days as proportion of all complaints resolved.	Monitor management and response to complaints including turnaround time.	Complaints Register DHIS	***Numerator*** SUM([Complaint resolved within 25 working days]) ***Denominator*** SUM([Complaints resolved])	%	Output Quality	Quarterly	Accuracy of data in the complaints registers.	Higher percentage desired – better management of complaints and compliance to Batho Pele.	Quality Assurance Unit and Ombudsperson
Mental health admission rate ***New Indicator***	Mental health users admitted/ separated in a specific period compared to the total admission and separations in public health hospitals during the same period.	Monitor trends in mental health admissions in public health facilities (excluding Specialised Psychiatric Hospitals).	Midnight Census DHIS calculates	***Numerator*** SUM(Mental Health admission under 18 years) + SUM(Mental Health admission 18 years and older) ***Denominator*** SUM(Day patient-total) + SUM(Inpatient deaths –total) + SUM(Inpatient discharges-total) + SUM(Inpatient transfers out-total)	%	Output	Quarterly	Accuracy of data at facility level.	Lower rate desired – improved prevention and PHC management (long-term). Initially may report higher rate due to burden of disease and inadequate PHC management/ access.	Mental Health Unit
Patient satisfaction rate	The proportion of health care users that participated in the Patient Satisfaction Survey that were satisfied with public health hospital services.	Monitor patient satisfaction with public health hospital services.	Patient Satisfaction Survey results Quality Assurance database	***Numerator*** SUM(Survey participants satisfied with services in public health hospitals) ***Denominator*** SUM(Users that participated in the Survey)	%	Output	Annual	Generalised - depends on the number of users participating in the survey.	Higher percentage desired – improved patient satisfaction and compliance with Batho Pele.	Quality Assurance Unit

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Proportion of hospitals that have conducted gap assessments for compliance against the National Core Standards	Proportion of hospitals conducting gap-assessments to determine compliance with the National Core Standards using the official assessment tools.	Monitor performance and compliance with the National Core Standards.	Self-assessment reports Quality Assurance database	***Numerator*** SUM(Hospitals self-assessed against national core standards annually) ***Denominator*** SUM(Public health hospitals in KZN)	%	Quality	Annual	Accuracy of Quality Assurance database and reporting from facilities.	Higher percentage desired – improved efficiencies and quality.	Quality Assurance Unit
Percentage of hospitals compliant to all Extreme Measures of the National Core Standards ***New Indicator***	Percentage of public health hospitals that comply with the Extreme Measures of the National Core Standards (as identified in the Core Standard Guidelines).	Monitor compliance to National Core Standards.	Quality Assurance database Assessment records DHIS (hospitals)	***Numerator*** SUM(Public health hospitals that comply with Extreme Measures of National Core Standards) ***Denominator*** SUM(Public health hospitals in KZN)	%	Outcome	Annual	Accuracy of Quality Assurance database.	Higher percentage desired – improved compliance to Extreme Measures of the National Core Standards.	Quality Assurance Unit
Delivery by caesarean section rate	Delivery by caesarean section as proportion/ percentage of the total number of deliveries in public health facilities.	Monitor access to caesarean section, availability of resources and quality of maternal care during caesarean section.	Delivery Register DHIS calculates	***Numerator*** SUM([Delivery by caesarean section]) ***Denominator*** SUM([Delivery in facility total])	%	Output	Monthly	Accuracy dependant on quality of data from reporting facility.	Dependent on burden of disease and availability of resources.	MNCWH Unit and Hospital Services
OPD headcount – total	Total clients attending general or specialist outpatient clinics.	Monitor patient activity (numbers) at outpatient clinics partly to track burden of disease trends, workload and utilisation/ allocation of resources.	Tick register OPD DHIS calculates	***Sum*** • OPD specialist clinic headcount • OPD general clinic headcount (including follow-up and new cases not referred)	Number	Output	Quarterly	Dependant on quality of data from reporting facility.	Higher patient numbers may indicate an increased burden of disease, increased reliance on public health services or lacking PHC system.	DHS and Hospital Services
OPD new client not referred rate ***New Indicator***	Proportion of OPD new clients without a referral letter from a clinic or Medical Officer.	Monitor utilisation trends of clients by-passing PHC to enter the health system at hospital level, and the impact of PHC re-engineering on OPD utilisation. Not including OPD follow-up and emergency cases.	DHIS Tick register OPD	***Numerator*** SUM(OPD headcount not referred new) ***Denominator*** SUM(OPD headcount not referred new) + SUM(OPD headcount referred new)	%	Output	Quarterly	Dependent on quality/ completeness of data from facility.	Lower percentage desired – improved PHC services.	DHS and Hospital Services

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
EMS operational ambulance coverage (annualised)	Number of operational ambulances per 10 000 population (includes obstetric ambulances).	Monitors compliance with the norm for operational ambulances to meet population needs.	Tick Register EMS Stats SA (population) EMS database	***Numerator*** COUNT([EMS operational ambulances]) ***Denominator*** COUNT([Total population])	Rate per 10,000 population Annualised	Input	Quarterly	Accuracy of reporting operational ambulances.	Higher number desired – improved response times.	EMS Unit
EMS P1 urban response under 15 minutes rate	Proportion P1 calls in urban locations with response times under 15 minutes.	Monitors compliance with the norm for critically ill or injured clients to receive EMS within 15 minutes in urban areas.	Tick Register EMS EMS database	***Numerator*** COUNT([EMS P1 urban response under 15 minutes]) ***Denominator*** COUNT([EMS P1 urban calls])	%	Output	Quarterly	Accuracy dependant on quality of data from reporting EMS station and information system.	Higher percentage desired – improved response times.	EMS Unit
EMS P1 rural response under 40 minutes rate	Proportion P1 calls in rural locations with response times under 40 minutes.	Monitors compliance with the norm for critically ill or injured clients to receive EMS within 40 minutes in rural areas.	Tick Register EMS EMS database	***Numerator*** COUNT([EMS P1 rural response under 40 minutes]) ***Denominator*** COUNT([EMS P1 rural calls]) *Rural areas: Rural Development Nodes.*	%	Output	Quarterly	Accuracy dependant on quality of data from reporting EMS station and information system.	Higher percentage desired – improved response times.	EMS Unit
EMS P1 call response under 60 minutes rate	Proportion of all P1 calls with response times under 60 minutes.	Monitor compliance with the norm for all critically ill or injured clients to receive EMS within 60 minutes. This includes P1 urban responses less than 15 minutes and P1 rural calls less than 40 minutes.	Tick Register EMS EMS database	***Numerator*** COUNT([EMS P1 response under 60 minutes total]) ***Denominator*** COUNT([EMS P1 calls total])	%	Output	Quarterly	Accuracy dependant on quality of data from reporting EMS station and information system.	Higher percentage desired – improved response times.	EMS Unit
EMS clients total	Proportion of EMS calls which resulted in clients being transported.	Monitor the proportion of calls which resulted in clients being transported to health facilities in relation to the total number of calls dispatched by the Communications Centre.	Tick Register EMS EMS database	***Numerator*** COUNT([EMS call client transported]) ***Denominator*** COUNT([EMS calls total])	%	Output	Quarterly	Accuracy dependant on quality of data from reporting EMS station and information system.	Dependent on emergency cases.	EMS Unit
EMS inter-facility transfer	Inter-facility (from one in-patient facility to another in-patient facility) transferred as proportion of total EMS clients transported.	Monitor the use of ambulances for inter-facility transfers as opposed to emergency responses.	Tick Register EMS EMS database	***Numerator*** COUNT([EMS inter-facility transfer]) ***Denominator*** COUNT([EMS clients total])	%	Output	Quarterly	Accuracy dependant on quality of data from reporting EMS station and information system.	Higher percentage desired – improved efficiency.	EMS Unit

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of new obstetric ambulances introduced ***New Indicator***	Specialised ambulances introduced to improve access to obstetric care.	Monitor access and response for obstetric patients.	Transport asset register	COUNT(New obstetric ambulances introduced)	Number	Input	Annual	None.	Higher number desired – dependent on funding envelope.	EMS Unit
Number of new IFT ambulances introduced ***New Indicator***	Inter facility ambulances to improve patient transport between facilities.	Monitor efficiencies of inter facility transport.	Transport asset register	COUNT(New inter facility transport ambulances introduced)	Number	Input	Annual	None.	Higher number desired – dependent on funding envelope.	EMS Unit
Number of new emergency ambulances introduced ***New Indicator***	Ambulances used for emergency calls.	Monitor EMS efficiencies.	Transport asset register	COUNT(New emergency ambulances introduced)	Number	Input	Annual	None.	Higher number desired – dependent on funding envelope.	EMS Unit
Average actual operational ambulances ***New Indicator***	The number of active ambulances at EMS stations.	Monitor EMS efficiencies.	EMS database EMS call centre records EMS tick register	***Numerator*** COUNT(Ambulances ***Denominator*** COUNT(Total number of operational ambulances at ambulance stations)	%	Output	Annual	Data completeness at EMS Stations.	Higher percentage desired – improved access and response.	EMS Unit
Number of clustered Communica-tions Centres established and operational ***New Indicator***	Combining identified Communication Centres to improve optimisation of scarce resources.	Rationalisation of Communication Centres.	Infrastructure Project Records Communication Centre	COUNT(Clustered Communication Centres operational)	Number	Input	Annual	None.	Higher number desired – dependent on funding envelope.	EMS Unit
Number of purpose built wash bays with sluice facilities built ***New Indicator***	Construction of wash bays and sluice facilities that comply with EMS and infection prevention and control specifications.	Monitor quality standards for EMS.	Infrastructure Project Records Wash Bays	COUNT(Purpose built wash bays with sluice facilities)	Number	Input	Annual	None.	Higher number desired – dependent on funding envelope.	EMS Unit
Number of bases compliant with National Core Standards ***New Indicator***	Ambulance bases that comply with all the National Core Standards for EMS.	Monitor compliance to EMS standards.	Assessment records	COUNT(Bases compliant with National Core Standards)	Number	Outcome	Annual	None.	Higher percentage desired – improved quality and efficiency.	EMS Unit
Revenue generated ***New Indicator***	Revenue generated through fees from private EMS users.	Monitor revenue collection.	BAS	Revenue generated by EMS	R	Output	Annual	None.	Increased revenue desired.	EMS Unit

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of bases with access to computers and intranet/ e-mail ***New Indicator***	EMS bases with internet connectivity.	Monitor internet accessibility as part of improved information management.	IT internet rollout report	COUNT(Bases with access to computers and internet)	Number	Input	Annual	Data completeness.	Higher number desired – dependent on funding envelope and connectivity.	EMS Unit

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Basic Professional Nurse students graduating	Number of student nurses that graduate from the basic nursing course.	Monitor the production of Professional Nurses.	Student registration.	COUNT([Basic nurse students graduating at UKZN annually]) + ([Basic Nurse students graduating at UKZN annually])	Number	Input	Annual	Effective reporting system,	Increased number desired – improved human resources for health.	KZNCN Principal
Proportion of bursary holders permanently appointed ***New Indicator***	The proportion of bursary holders that are permanently appointed.	Monitor the absorption of bursary holder in the provincial/ public health system.	Persal HRD Bursary Register Letters of appointment	***Numerator*** COUNT(Bursary holders permanently appointed in KZN) ***Denominator*** COUNT(Bursary holders in KZN)	%	Input	Annual	Accuracy of Persal data and reporting system.	Increased percentage desired.	HRD Unit
Number of Advanced Midwifes graduating annually ***New Indicator***	Number of students that obtained a post basic nursing qualification in Advanced Midwifery.	Monitor production of Advanced Midwifes.	Student registration	COUNT(Advanced Midwife students graduated)	Number	Input	Annual	None.	Increased number desired – improved skills mix and value for money.	KZNCN Principal
Number of Intermediate Life Support graduates per annum	Number of students obtaining a qualification in Intermediate Life Support.	Monitor production of EMS personnel.	Student registration	COUNT(Intermediate Life Support students graduated)	Number	Input	Annual	None.	Higher number desired – improved EMS capacity.	EMS Unit
Number of Emergency Care Technician graduates per annum	Number of students obtaining the qualification of Emergency Care Technician.	Monitor production of EMS personnel.	Student registration	COUNT(Emergency Care Technician students graduating)	Number	Input	Annual	None.	Higher number desired – improved EMS capacity.	EMS Unit

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Percentage of Pharmacies that obtained A or B grading on inspection	The proportion of Pharmacies that comply with the South African Pharmacy Council standards on inspection.	Monitor compliance to national standards for pharmacies.	Assessment records	***Numerator*** COUNT(Pharmacies with A or B grading on inspection) ***Denominator*** COUNT(Number of Pharmacies).	%	Quality	Annual	None.	Higher percentage desired – improved efficiencies.	Pharmacy Unit
Tracer medicine stock-out rate (PPSD)	Any item on the Tracer Medicine List that had a zero balance in the Bulk Store (PPSD) on a Stock Control System.	Monitor shortages in tracer medicines.	Pharmacy stock cards	***Numerator*** COUNT(Any tracer medicine stock-out in bulk store - PPSD) ***Denominator*** COUNT(Number of tracer medicine expected to be in bulk store - PPSD)	%	Efficiency	Quarterly	None.	Lower stock-out rate desired – improved management.	Pharmacy Unit
Tracer medicine stock-out rate (Institutions)	Any item on the Tracer Medicine List that had a zero balance in Bulk Store (facilities) on the Stock Control System. Percentage of fixed facilities with tracer medicine stock-outs (>0) during the reporting period. A facility should be counted once as having a stock-out during the reporting period.	Monitor shortages in Tracer medicines and effectiveness of medicine management.	Pharmacy stock cards	***Numerator*** COUNT([Any tracer item drug stock out (clinic/CHC/CDC)]) ***Denominator*** COUNT([Fixed clinic]) + SUM([Fixed CHC/CDC])	%	Process	Quarterly	Data accuracy at facility level.	Lower stock-out rate desired – improved management.	Pharmacy Unit

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Proportion of infrastructure budget spent on maintenance (preventative and scheduled) ***New Indicator***	Proportion of the total infrastructure budget spent on maintenance.	Monitor efficient use of infrastructure budget to improve health facilities.	BAS	***Numerator*** Budget spent on maintenance ***Denominator*** Total maintenance budget	%	Output	Annual	None.	Allocated budget spent.	Infrastructure Development Unit
Number of districts spending more than 90% of maintenance budget ***New Indicator***	Districts spending more than 90% of their allocated maintenance budget.	Monitor infrastructure expenditure.	BAS	COUNT(Districts spending 90% or more of allocated maintenance budget)	Number	Output	Annual	None.	90% or more – efficient use of resources.	Infrastructure Development Unit
Number of jobs created through the EPWP ***New Indicator***	Job creation through EPWP.	Track job creation.	Appointment letters EPWP database	COUNT(Jobs created through EPWP in reporting period)	Number	Input	Annual	None.	Higher number – improved job opportunities.	Infrastructure Development Unit
Number of new clinical projects with completed construction ***New Indicator***	New clinical projects with completed construction.	Monitor project plans and delivery of infrastructure as per U-AMP.	Project reports/ plan	COUNT(New clinical projects with completed construction in reporting period)	Number	Output	Annual	None.	As per project plan.	Infrastructure Development Unit
Number of new clinical projects where commissioning is complete ***New Indicator***	New clinical projects commissioned.	Monitor project plans and delivery of infrastructure as per U-AMP.	Project reports/ plan	COUNT(New clinical projects commissioned during reporting period)	Number	Output	Annual	None.	As per project plan.	Infrastructure Development Unit
Number of upgrading and renovation projects with completed construction ***New Indicator***	Upgrading and renovation projects with completed construction.	Monitor project plans and delivery of infrastructure as per U-AMP.	Project reports/ plan	COUNT(Number upgrading and renovation projects completed during reporting period)	Number	Output	Annual	None.	As per project plan.	Infrastructure Development Unit

Indicator	Short Definition	Purpose of Indicator	Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Percentage of maintenance budget spent ***New Indicator***	Percentage of maintenance budget spent.	Monitor financial management and service delivery.	BAS	***Numerator*** Expenditure on maintenance ***Denominator*** Budget allocation for maintenance	%	Input	Annual	None.	100% budget spent.	Infrastructure Development Unit
Hospital revitalisation expenditure as percentage of total annual budget ***New Indicator***	Proportion of infrastructure budget spent on maintenance.	Monitor financial management.	BAS	***Numerator*** Budget spent on hospital revitalisation ***Denominator*** Total infrastructure budget	%	Input	Annual	None.	100% of allocation.	Infrastructure Development Unit

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Amendments to the 2010-2014 Strategic Plan (Strategic) Objectives

ANNEXURE 2: AMENDMENTS TO THE 2010-2014 STRATEGIC PLAN

NOTE: Additional (Strategic) Objectives, added in the 2014/15 Annual Performance Plan, is highlighted in light green.

PAGE	(STRATEGIC) OBJECTIVES 2010-2014 STRATEGIC PLAN	PAGE	AMENDED (STRATEGIC) OBJECTIVES AND COMMENTS
PROGRAMME 1: ADMINISTRATION			
52	Strategic Plan 2010-2014: To finalise and implement Provincial Health Plans aligned with the NHS and MTSF priorities for 2010-2014	**Removed 2014/15 APP:** The 2010-2014 Strategic Plan was tabled in March 2010 Indicators moved to the 2014/15 Provincial Operational Plan: "Tabled Annual Performance Plan" and "Number of approved District Health Plans"	
52	Strategic Plan 2010-2014: To finalise and implement the 2010-2020 KZN Service Transformation Plan including 10 Core Components aligned with the NHS 10-Point Plan	46	**Amended 2014/15 APP:** "Finalise and implement the approved 2010-2020 KZN Service Transformation Plan by April 2015"
53	Strategic Plan 2010-2014: To prepare and submit the KZN Health Act (1 of 2009) Regulations for promulgation in 2010	**Removed 2012/13 APP:** Target achieved. The KZN Health Act, 2009 (Act No. 1 of 2009) was promulgated in 2012 (6 September 2012)	
53	Strategic Plan 2010-2014: To implement a Finance & SCM Turn-Around Strategy to improve compliance with the PFMA and Treasury Regulations, eliminate over-expenditure by 2012/13 and ensure an annual unqualified audit opinion on financial statements from the AGSA	**Removed 2014/15 APP:** Indicators moved to the 2014/15 Provincial Operational Plan: "Annual unqualified audit opinion for financial statements"; and "Number of approved District Health Expenditure Reviews"	
54	Strategic Plan 2010-2014: To align the Human Resources Plan with the Service Transformation Plan (STP) and implement as part of the Human Resources Turn-Around Strategy	46	**Amended 2014/15 APP:** "Finalise and implement the long-term Provincial Human Resources for Health Plan by April 2015"
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN - (HUMAN RESOURCES FOR HEALTH)			
47	Provide sufficient staff with appropriate skills per occupational group within framework of Provincial norms by 2019		
48	All personnel comply with performance management requirements by March 2015		
55	Strategic Plan 2010-2014: To expand the Registrar training programme to increase the pool of Specialists by retaining 75% of qualified Registrars by 2014/15	**Removed 2014/15 APP:** The Registrar Programme is under review based on the reduced funding envelope. The Programme objectives are being monitored/ reported by the Programme Manager	
55	Strategic Plan 2010-2014: To implement an integrated Health Information Turn-Around Strategy to improve data quality and ensure an annual unqualified audit opinion on performance information from the AGSA from 2010/11 – 2014/15	**Removed 2014/15 APP:** Replaced with more specific (Strategic) Objectives listed below. Indicators moved to the 2014/15 Provincial Operational Plan: "Annual unqualified audit opinion for performance information"; "Annual Report tabled"; and "Number of progress reports on implementation of the 10-Point Plan"	
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN - (HEALTH INFORMATION)			
46	Implement a web-based District Health Information System at 80% PHC facilities by 2019		
48	Expand telemedicine to all districts by 2019		
48	Implement the reviewed M&E Framework at all levels of care by March 2017		

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Amendments to the 2010-2014 Strategic Plan (Strategic) Objectives

PAGE	(STRATEGIC) OBJECTIVES 2010-2014 STRATEGIC PLAN	PAGE	AMENDED (STRATEGIC) OBJECTIVES AND COMMENTS
48	Strengthen research for health		
48	Establish 4 Regional Level 1 Health Ethics Review Boards by March 2017		
48	Establish appropriate data information systems and tools to ensure unqualified audit outcomes by 2016/17		
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN (FOOD AND SECURITY SERVICES)			
49	All public hospitals score >75% on the Food Service Monitoring Standards Grading System by 2019		
49	All public hospitals serve standardised and nutritionally balanced menus by 2019		
49	All public health facilities comply with security policy requirements by 2019		
PROGRAMME 2: DISTRICT HEALTH SERVICES			
86	Strategic Plan 2010-2014: Revitalise PHC as per STP Implementation Plan	**Removed 2014/15 APP:**	Replaced with more specific (Strategic) Objectives listed below
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN - (PRIMARY HEALTH CARE)			
63	Increase the Provincial PHC expenditure per uninsured person to R 907 by March 2015		
68	Increase the PHC expenditure per client to R299 by March 2017		
63	Increase PHC efficiencies and increase the number of visits per person to PHC services from 2.9 to 3 by March 2015		
67	Increase the PHC utilisation under 5 years to 5.2 visits per child by March 2017		
64	Scale up implementation of PHC re-engineering including coverage at household level		
64	Improve the supervision visit rate to more than 75% by March 2017		
65	Increase District Clinical Specialist Teams to 11 Teams with all Nursing posts filled and 4 (of 11 Teams) with all Nursing and Specialist posts filled by March 2015		
65	Increase the number of Ward-Based Outreach Teams to 115 by March 2017		
68	Increase School Health Teams to 250 by 2019		
65	Increase the school health coverage to at least 80% by March 2017		
68	Improve efficiencies in dental health by reducing the dental extraction to restoration ratio to less than 18:1 by March 2017		
117	Implement the 5-year Mental Health Care Strategy to improve mental health care services at all levels (District Hospitals)		
119	Improve hospital efficiencies by implementing the long-term plan for hospital revitalisation 2014-2019 (District Hospitals)		
116	Maintain expenditure per PDE within the provincial norms (District Hospitals)		
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN: (NON-COMMUNICABLE DISEASES)			
106	Decrease hypertension incidence by at least 20% per annum		
106	Decrease diabetes incidence by at least 20% per annum		
107	Increase the number of cataract surgeries to 11 118 (or more) by March 2017		
86	Strategic Plan 2010-2014: Implementation of National Core Standards towards accreditation of 50% PHC clinics, 100% CHC's and 100% District Hospitals by 2014/15	**Removed 2014/15 APP:**	Replaced with more specific (Strategic) Objectives listed below

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PAGE	(STRATEGIC) OBJECTIVES 2010-2014 STRATEGIC PLAN	PAGE	AMENDED (STRATEGIC) OBJECTIVES AND COMMENTS
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN - (QUALITY ASSURANCE)			
64	Improve the complaint resolution within 25 working days rate to 80% by March 2017 (PHC)		
64	100% of PHC facilities conducting patient satisfaction surveys by March 2015 (PHC)		
65	Improve the patient satisfaction rate to 80% by March 2017 (PHC)		
66	100% of facilities conditionally compliant (50% - 75%) to the National Core Standards by 2019 (PHC)		
117	Improve the patient satisfaction rate to 85% by March 2017 (District Hospitals)		
117	80% of facilities conditionally compliant (50% - 75%) to the National Core Standards by March 2019 (District Hospitals)		
117	Improve the complaint resolution within 25 working days rate to 75% (or more) by March 2016 (District Hospitals)		
86	Strategic Plan 2010-2014: Reduce morbidity and mortality by reducing the HIV incidence with 50% by 2011/12 and 60% by 2014/15	76	**Reviewed 2014/15 APP:** "Reduce HIV incidence to less than 1% by 2019"
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN - (HIV, AIDS AND STI)			
76	Manage HIV prevalence by increasing the number of patients on ART to1 368 247 (cumulative) by March 2017		
77	Increase the HIV testing coverage to 60% by March 2017		
79	Scale up prevention services in all districts		
87	Strategic Plan 2010-2014: Reduce morbidity and mortality by reducing mother to child transmission to ≤ 5% by 2014/15	96	**Reviewed 2014/15 APP:** "Reduce the mother to child transmission rate to less than 0.5% by March 2019"
87	Strategic Plan 2010-2014: Reduce morbidity and mortality by improving the TB cure rate to 70% by 2014/15	77	**Reviewed 2014/15 APP:** "Increase the TB cure rate to 85% by March 2015"
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN - (TUBERCULOSIS)			
76	Reduce the TB (new pulmonary) defaulter rate to 3.5% by March 2017		
76	Improve the sputum turn-around time under 48 hours to 85% by March 2016		
77	Improve TB outcomes by improving the treatment success rate to 85% by March 2015		
77	Increase the number of TB MDR patients initiated on treatment to 66% by March 2017		
78	Decrease the TB death rate to 3.5% by March 2017		
78	Increase the number of MDR TB patients that started the regimen iv treatment to 3 550 by March 2017		
78	Ensure that 80% of diagnosed MDR/XDR-TB patients are initiated on treatment by March 2017		
79	Reduce the TB incidence to 600 patients per 100,000 population by March 2017		
87	Strategic Plan 2010-2014: Maintain preventative strategies to reduce and maintain the malaria incidence at ≤ 1/1000 population by 2010/11	107	**Reviewed 2014/15 APP:** Eradicate malaria by 2017
87	Strategic Plan 2010-2014: Reduce maternal mortality to ≤ 100/ 100 000 by 2014/15 (National MDG target)	97	**Reviewed 2014/15 APP:** "Reduce the maternal mortality in facilities to 119 deaths per 100 000 live births (or less) by March 2017" – based on Provincial performance

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Amendments to the 2010-2014 Strategic Plan (Strategic) Objectives

PAGE	(STRATEGIC) OBJECTIVES 2010-2014 STRATEGIC PLAN	PAGE	AMENDED (STRATEGIC) OBJECTIVES AND COMMENTS
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN - (MATERNAL, NEONATAL, CHILD AND WOMEN'S HEALTH)			
96	Increase the proportion of women attending antenatal care to 60% by March 2017		
97	Reduce deliveries in facilities under 18 to less than 8.5% by March 2017		
99	Increase postnatal follow-up visit within 6 days to 75.5% by March 2017		
99	Reduce the neonatal mortality in facility rate to 9.1 neonatal deaths per 1000 live births by March 2017		
99	Decrease infant mortality to 37 deaths per 1000 live births by March 2017 (ASSA)		
87	Strategic Plan 2010-2014: Reduce child mortality to 30-45/1000 live births by 2014/15 (National MDG target)	97	**Reviewed 2014/15 APP:** "Reduce the under 1 year mortality rate in facilities to 4.8% (or less) by March 2017" – proxy indicator
88	Strategic Plan 2010-2014: Reduce under-5 mortality to 29/1000 live births by 2014/15 (National MDG target)	99	**Reviewed 2014/15 APP:** "Decrease under 5 mortality to 57 deaths per 1000 live births by March 2017" – ASSA projections
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN - (MATERNAL, NEONATAL, CHILD AND WOMEN'S HEALTH)			
94	Increase immunisation coverage to more than 90% in all districts by March 2017		
94	Increase Vitamin A supplementation to 65% by March 2017		
94	Increase the number of children 12-59 months who received the deworming regime with 20% from baseline by March 2017		
97	Reduce the under 5 inpatient death rate in facilities to 4.3% (or less) by March 2017		
98	Decrease the diarrhoea case fatality rate in children under 5 to 2.6% (or less) by March 2017		
98	Decrease the pneumonia case fatality rate in children under 5 to 2.1% (or less) by March 2017		
100	Decrease diarrhoea incidence by at least 20% per annum		
100	Decrease pneumonia incidence with at least 20% per annum		
88	Strategic Plan 2010-2014: Reduce severe malnutrition under-5 year incidence to 6/1000 by 2014/15.	100	**Reviewed 2014/15 APP:** "Decrease severe acute malnutrition incidence by at least 20% per annum"
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN - (NUTRITION)			
95	Reduce the number of underweight for age children with more than 20% of baseline by March 2017		
98	Decrease severe acute malnutrition fatality rate in children under 5 to 7.4% (or less) by March 2017		
99	Improve exclusive breastfeeding to 65% in March 2017		
100	Increase the weighing coverage to 90% (or more) by March 2017		
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN – (WOMEN'S HEALTH)			
95	Maintain a cervical cancer screening coverage of more than 80% from March 2015		
96	Maintain an HPV coverage amongst Grade 4 girls of more than 80% from 2016/17		
97	Increase the couple year protection rate to 70% by March 2019		

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Amendments to the 2010-2014 Strategic Plan (Strategic) Objectives

PAGE	(STRATEGIC) OBJECTIVES 2010-2014 STRATEGIC PLAN	PAGE	AMENDED (STRATEGIC) OBJECTIVES AND COMMENTS
PROGRAMME 3: EMERGENCY MEDICAL SERVICES			
95	Strategic Plan 2010-2014: To revitalise EMS and improve response times to <40 min in rural and <15 min in urban areas in >70% cases by 2014/15.	**Removed 2014/15 APP:** Replaced with (Strategic) Objectives listed below	
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN - (EMERGENCY MEDICAL SERVICES)			
130	Improve access to emergency medical services and response times		
132	Provision of inter-facility and emergency transport		
132	Increase the number of obstetric ambulances to one per facility (72) by March 2017		
132	Increase the number of inter-facility transport to 72 vehicles by March 2017		
132	Increase the number of daily operational ambulances to 431 by March 2017		
132	Rationalise Communication Centres during 2014-2019		
133	Increase purpose built wash bays with sluice facilities to 27 by March 2017		
133	Increase revenue collection for EMS		
133	Increase the number of bases with access to internet to 47 by March 2017		
PROGRAMME 4: REGIONAL AND SPECIALISED HOSPITALS			
103	Strategic Plan 2010-2014: To implement the nationally approved delegations for Hospital Managers by 2010/11	**Removed in 2011/12**	
103	Strategic Plan 2010-2014: To implement the Financial Turn-Around Strategy to eliminate over-expenditure in 100% Regional Hospitals by 2012/13	142	**Reviewed 2014/15 APP:** "Maintain expenditure per PDE within the provincial norms"
103	Strategic Plan 2010-2014: To implement the National Core Standards in 100% Regional Hospitals by 2010/11 for accreditation of 14/14 Regional Hospitals by 2012/13	143	**Reviewed 2014/15:** "80% of facilities conditionally compliant (50% - 75%) to the National Core Standards by March 2019"
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN - (REGIONAL AND SPECIALISED HOSPITALS)			
143	Improve the complaint resolution within 25 working days rate to 80% (or more) by March 2017		
143	Improve the patient satisfaction rate to 90% by March 2017		
104	Strategic Plan 2010-2014: To rationalise hospital services in line with the approved STP and Service Delivery Plan	142	**Reviewed 2014/15 APP:** "Improve hospital efficiencies by implementing the long-term plan for hospital revitalisation 2014-2019"
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN - (REGIONAL AND SPECIALISED HOSPITALS)			
143	Implement the 5-year Mental Health Care Strategy		
PROGRAMME 5: TERTIARY AND CENTRAL HOSPITALS			
111	Strategic Plan 2010-2014: To implement the nationally approved delegations for Hospital Managers by 2010/11	**Removed 2011/12**	
111	Strategic Plan 2010-2014: To implement the Financial Turn-Around Strategy to eliminate	173	**Reviewed 2014/15 APP:** "Maintain expenditure per PDE within the provincial norms"

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Amendments to the 2010-2014 Strategic Plan (Strategic) Objectives

PAGE	(STRATEGIC) OBJECTIVES 2010-2014 STRATEGIC PLAN	PAGE	AMENDED (STRATEGIC) OBJECTIVES AND COMMENTS
	over-expenditure by 2012/13		
111	Strategic Plan 2010-2014: To implement the National Core Standards in 2/2 Tertiary/ Central Hospitals by 2010/11 and accredit 2/2 hospitals by 2012/13	173	**Reviewed 2014/15 APP:** "80% of facilities conditionally compliant (50% - 75%) to the National Core Standards by March 2019"
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN - (TERTIARY AND CENTRAL HOSPITALS)			
173	Improve the complaint resolution within 25 working days rate to 75% (or more) by March 2017		
173	Improve the patient satisfaction rate to 95% by March 2017		
112	Strategic Plan 2010-2014: To rationalise hospital services in line with the approved STP Implementation Plan	172	**Reviewed 2014/15 APP:** "Improve hospital efficiencies by implementing the long-term plan for hospital revitalisation 2014/15-2019"
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN - (TERTIARY AND CENTRAL HOSPITALS)			
173	Implement the 5-year Mental Health Care Strategy		
PROGRAMME 6: HEALTH SCIENCES AND TRAINING			
118	Strategic Plan 2010-2014: To develop and implement a Learning Strategy for Managers based on the skills audit results and enrol 100% Hospital Managers by 2012/13	**Removed 2012/13.** Replaced with the indicators listed below (2014/15 APP)	
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN - (HEALTH SCIENCES AND TRAINING)			
189	Increase enrolment of Medicine, Nursing and Pharmacy students annually by 10% per annum		
189	Ensure 100% of bursary holders are appointed in public health facilities		
190	Increase enrolment of Advanced Midwives by at least 10% per annum		
190	Increase the number of student intakes to improve quality of care		
PROGRAMME 7: SUPPORT SERVICES (PHARMACEUTICAL SERVICES)			
124	Strategic Plan 2010-2014: Improve compliance with Pharmaceutical Regulations and legislation with 80% of pharmacies obtaining A or B grading on inspection by 2014/15 and PPSD being fully compliant with Regulations by 2012/13	**Removed 2014/15 APP:** Indicators still monitored under objective listed below	
124	Strategic Plan 2010-2014: Reduce tracer medicine (including ARV and TB medicines) stock-out rate to <1% by 2014	200	**Reviewed 2014/15:** "Reduce medicine stock out to less than 1% in PPSD and facilities by 2019"
PROGRAMME 8: HEALTH FACILITIES MANAGEMENT			
129	Strategic Plan 2010-2014: To deliver new clinical infrastructure in line with the STP and approved Infrastructure Programme Implementation Plan (IPIP).	215	**Reviewed 2014/15 APP:** "Delivery of new clinical infrastructure in line with approved IPIP (Infrastructure Programme Implementation Plan)"
129	Strategic Plan 2010-2014: To upgrade and renovate existing clinical infrastructure in accordance with the STP and approved IPIP.	215	**Reviewed 2014/15 APP:** "Upgrading & renovation of existing clinical infrastructure in line with approved IPIP"
129	Strategic Plan 2010-2014: To undertake the acquisition of properties including vacant land for building purposes.	**Removed 2014/15 APP:** Programme reporting	

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Amendments to the 2010-2014 Strategic Plan (Strategic) Objectives

PAGE	(STRATEGIC) OBJECTIVES 2010-2014 STRATEGIC PLAN	PAGE	AMENDED (STRATEGIC) OBJECTIVES AND COMMENTS
(STRATEGIC) OBJECTIVES ADDED IN THE 2014/15 ANNUAL PERFORMANCE PLAN - (HEALTH FACILITIES MANAGEMENT)			
214	Ensure all districts are spending at least 15% of their infrastructure on maintenance (preventative and scheduled) by 2019		
215	Job Creation through Expanded Public Works Programme (EPWP)		
216	Revitalisation of Hospital Infrastructure		

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