KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

ANNUAL PERFORMANCE PLAN

2023/24

GROWING KWAZULU-NATAL TOGETHER

KwaZulu-Natal Department of Health
KZN Department of Health
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FOREWORD BY THE EXECUTIVE AUTHORITY

We are pleased to present the Annual Performance Plan (APP) for the new financial year 2023/24, which is the blueprint that sets out our policy direction and related key priorities.

One of our main objectives is to place the health, wellbeing, and best interests of the people of this Province at the centre of all that we do.

Our programme of action is underpinned by a number of imperatives, chief among which is the improvement of people's health status through the creation of a culture of disease prevention, promoting healthy lifestyles, early disease screening and testing, as well as improving the quality of healthcare and access thereto, to mention but a few.

As outlined in the mission of the National Development of Health, we need to consistently improve the Province's healthcare service delivery system by focusing on access, equity, efficiency, quality and sustainability.

Our own mission as the KwaZulu-Natal Department of Health is to "develop and implement a sustainable, coordinated, integrated and comprehensive health system at all levels, based on the Primary Health Care approach through the District Health System, to ensure universal access to health care."

This is reflected in one of our impact objective of achieving "Increased Life Expectancy", as well as the three outcome statements of the Department, which are:

- Improving the quality of and access to care, through universal health coverage and readiness for the National Health Insurance;
- Improving the client experience of care; and
- Reduced morbidity and mortality.

The Annual Performance Plan 2023/24 has gone through consultations with internal and external stakeholders. It is shaped by the priorities of the National Development Plan (NDP) 2030, the Medium Term Strategic Framework (MTSF) 2019-2024, the Provincial Growth and Development Plan (PGDP) 2030, other sector priorities, the burden of disease and the demand for services.

Details for the actual performance of the Department during 2021/22 are included in the Annual Report 21/22 and selected achievements and challenges are reflected as follows:

- The Department managed 23 906 112 vists at Primary Health Care (PHC) level;
- There were 13 126 378 people who were screened for mental health;
- The mother to child HIV transmission rate remained at 0.4%;
- The number of severe acute malnutrition deaths under 5 years increased from 164 to 185, pneumonia deaths under 5 years increased from 148 to 185 and the diarrhoea deaths under 5 years increased from 133 to 138;
- The incidence of diarrhoea increased from 3.7/1000 to 6.5/1000; pneumonia incidence increased from 11.5/1000 to 17.5/1000; and severe acute malnutrition incidence increased from 1.2/1000 to 1.6/1000;
- The number of children under 1 year that were fully immunised increased from 217 217 to 242 394
- A total of 3 955 243 people were tested for HIV and a total of 1 541 952 patients remained on Antiretroviral Therapy (ART) at the end of March 2022
- The maternal mortality in facility rate decreased from 125.2 (123.9) per 100 000 live births to 100.6 per 100 000 live births
- The Department had 70 201 filled posts. This was an increase of 1 122 employees from 69 079 in Financial year 2020/21.

Plans for the 2023/24 financial year in respect of the various programmes, are as follows:

- In 2023/24, the Department will procure equipment to expand the implementation of the KZN eHealth system to additional hospitals. The Department plans to roll out the eHealth system in 68.1 percent of our hospitals (or 47 out of 70 hospitals), including the new Dr Pixley Ka Isaka Seme Memorial Hospital (DPKISMH), in 2023/24
- In terms of the medico-legal unit, a reassessment and adjustment of staffing and structure will be conducted to facilitate a model that appropriately and adequately deals with the growing challenge of medico-legal claims. The objective in this regard is to enable the implementation of workable and practical strategies to reduce contingent liabilities

- The Department plans to increase general practitioners (GP) contracted in the province via the National Health Insurance (NHI) grant from 119 in 22/23 to 130 in 23/24. The increase in contracted GPs assists to reduce the relative cost of health care and increase access to medical professionals in needy communities
- Increase the number of clients on ARV treatment from 1 564 327 to 1 622 676 in 2023/24 (As at the end of December 2022, there were 1 564 327 patients on ARV therapy
- Screen at least 90% of clients attending health care facilities for TB (head count)
- The Department plans to increase the average number of daily operational ambulances from 179 in Q2 of 22/23 to 200 by 31 March 2024

The Department will continue to implement the rationing of services in district and specialised hospitals across the province, particularly where there is a trend of low bed occupancy rates and low demand for services.

Specific plans in this regard are:

- Commission district services at Clairwood Hospital and Richmond Hospital
- Transfer patients with intellectual disabilities from Ekuhlengeni Hospital to Umngeni Hospital
- Merge Doris Goodwin Hospital with Harry Gwala (Ex-Edendale) Hospital
- Increase the number of beds dedicated to rehabilitation services at Hillcrest Hospital
- Develop Hillcrest Hospital 10-year Infrastructure Plan to create a specialised rehab hospital.
- Finalize the Clinical Outreach policy, which is aimed at ensuring equitable access to specialist guided clinical services by all citizens in the Province.

The Department will oversee the complete commissioning of Dr Pixley Ka Isaka Seme Memorial Hospital (DPKISMH) in 2023/24, including Paediatric Services, Obstetrics & Gynaecology (O&G) services

The Department will award 120 new bursaries to first year nursing students.

Accreditation will be sought with the South African Nursing Council (SANC) and Council for Higher Education (CHE) for Post-Graduate Diplomas in Nursing. The KZN College of Nursing is continuing with plans to offer the new Post Graduate Diplomas to in-service Professional nurses of the KZN DOH. The programmes can, however, only be offered once accreditation has been received from the South African Nursing Council and the Council on Higher Education.

The KZN College of Nursing has, to date, submitted 9 Post Graduate Diploma programmes for accreditation, and the outcome is currently pending.

The Department will award 480 bursaries in the 2023 academic year to internal employees to study various qualifications. This is in line with the Departmental bursary policy for part-time studies, which affords internal employees an opportunity for skills development. This enables career pathing through the improvement of current qualifications, and aims to improve employee performance

The HPCSA has accredited the Department for 1 170 medical intern posts and these posts are funded though voted funds (570 posts) and through the Human Resources (HR) and Training grant (600 posts). The Department has been allocated 1 270 Community Service personnel in various categories

The COVID-19 vaccination programme will continue in 2023/24, at fixed facilities in all Districts, on a daily basis. This includes weekends for facilities that are operating for 7 days a week. Demand creation in this regard is on-going.

COVID-19 vaccination will be integrated into the mainstream vaccination programme in PHC facilities.

In the next MTEF period, the Department will continue to improve availability, reliability and maintainability of the existing infrastructure assets. To this end, the Department is committed to the following:

- Complete the installation of Replacement Perimeter fences
- Complete the Elevated Water Tanks Installation Programmes
- Complete installation and/or replacement of Standby Generators sets
- Clinical briefs for 11 new clinics will be completed by August 2023, paving the way for the construction of these facilities, which will greatly improve access to Primary Health Care for scores of people.
- Tender documents for a project to renovate and upgrade the Midlands Laundry at Fort Napier have been completed and the process is set to be advertised.
- The tender document to equip Cato Manor Laundry with an additional tunnel washer has also been completed the project is to be advertised.

- The design work on the upgrading of four hospitals from district to regional level of care will be fast-tracked within the next MTEF. The planning and design phase for the four regional hospitals and the northern tertiary hospital will be completed in 2023/24. Furthermore, the Department will commence with Obstetric and Gynae services with the

view to add other services to the package of service at the 4 hospitals

The hospitals are:

- Vryheid;
- Bethesda;
- Dundee; and
- Christ the King Hospital

The commitment to build a New Tertiary Hospital in the North of the Province is also being honoured and the draft Business Case for this project is being circulated for comments.

In a bid to improve the management of health infrastructure in the Province, the "hub and spoke" model has been adopted, entailing de-centralisation of head-office personnel to the three Infrastructure Management Hubs, which are being established in the Province.

It is anticipated that these hubs will bring about improved turnaround times on infrastructure-related matters that require specialised skill, as well as improve pro-active maintenance.

There are ongoing discussions with Eskom to exclude hospitals from load-shedding, which impacts on critical engineering equipment, thereby resulting in high diesel costs and breakdowns.

The Department will also continue planning a number of Mental Health community outreach projects.

The Roll-out of quality health improvement programmes in health facilities will continue. This assists to prepare facilities to meet the quality standards required for certification and accreditation for National Health Insurance (NHI).

The Department will implement a scale-up plan to increase PHC facilities that obtain Ideal Clinic Status. The aim for this is to realise the target of 100 percent of clinics achieving Ideal Clinic status by 2024.

The Department will aim to improve complaint management and ensure recourse for those who are aggrieved. To this end, the Department is working on improving the mechanisms through which the public is able to lodge complaints and receive further assistance, including the development of a mobile application (App).

We will implement the Infection Prevention and Control Strategy to further reduce healthcare associated infections throughout the province

We will also develop and implement health facility accreditation and licensing systems to ensure that private hospitals, Stand-alone Operating Theatres and Emergency Medical Services (EMS) are compliant with legal prescripts. This is being undertaken to meet the required certification and accreditation standards as part of the National Health Insurance (NHI) implementation. We appeal to our staff to apply themselves fully in carrying out their tasks in service of the people of this Province. We urge them to treat themselves, their colleagues, and – most importantly – the public, with utmost respect, dignity and courtesy at all times.

Thank you

Ms Nomagugu Simelane

Executive Authority

Date 2023 -03- 16

NOTES

STATEMENT BY THE ACCOUNTING OFFICER

I hereby present the *KwaZulu-Natal Department of Health (KZN DOH) Annual Performance Plan (APP 2023/24),* a bold statement of intent on how this Department will execute its mandate during the remaining medium term period.

The Annual Performance Plan 2023/24 has gone through rigorous consultation with internal and external stakeholders. The three over-arching outcomes of our APP aim to address the all-important impact of "Increased Life Expectancy".

The first outcome, which is "universal health coverage" goes beyond just looking at how accessible we are as a Department in making the services available to our people.

It also addresses the need to overhaul our public health system through improved quality of care, improved governance through functional Clinic Committees and Hospital Boards, as well as access to professional nurses and medical officers. This outcome also seeks to track the Department's progress in achieving a clean audit.

Furthermore, the outcome of "improved client experience of care" considers our clients' perception of the services that we provide. The outcome tracks our clients' level of satisfaction with the services provided through the use of the compliments and complaints mechanism systems, as well as patient safety at the different levels of care.

The third outcome, which is "reduced morbidity and mortality," focuses on improving our understanding of deaths that occur at the different levels of care in order to further reduce the rate of maternal and child (under-5) mortality.

Improving child and maternal health is paramount to us and as such, the Department is planning to invest a considerable amount of resources in further improving health outcomes for this target group.

The focus in this regard is on the reduction of morbidity and mortality for both communicable and non-communicable diseases. Even with ever-shrinking resources, we will continue to seek ways to invest in public awareness, prevention and treatment efforts to reverse the spread of HIV and AIDS.

We will continue to prepare the health platform for Universal Health coverage, while seeking ways to improve our Information, Communication and Technology system towards better client experience and efficient record-keeping, which will lead to a reduced medico-legal claims bill.

The Department will continue to expend all possible efforts towards the attainment of a clean audit, while balancing service delivery and resource management.

We will also fast-track the implementation of community based health services at various levels of care, including Ward-Based Outreach Teams, School Health Teams, Central Chronic Medicines Dispensing and Distribution / Ikhemisi Eduze Nawe, public health education, Operation Sukuma Sakhe, as well as the contracting of General Practitioners at clinics. Furthermore, the Department will continue to consolidate our partnerships with all relevant stakeholders, including our social partners, in order to deliver quality healthcare.

We call upon all our staff at various levels to carry themselves with utmost professionalism and treat all our healthcare users with courtesy and respect. We implore them to hold on to, and espouse, noble values such as:

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

For the 2023/23 medium term period, we will be seized with improving our systems, services, and outputs through our bold plan of action.

I therefore commit, on behalf of the Department and its human capital, that our collective efforts will be geared towards the achievement of these plans.

Thank you

Dr SC Tshabalala

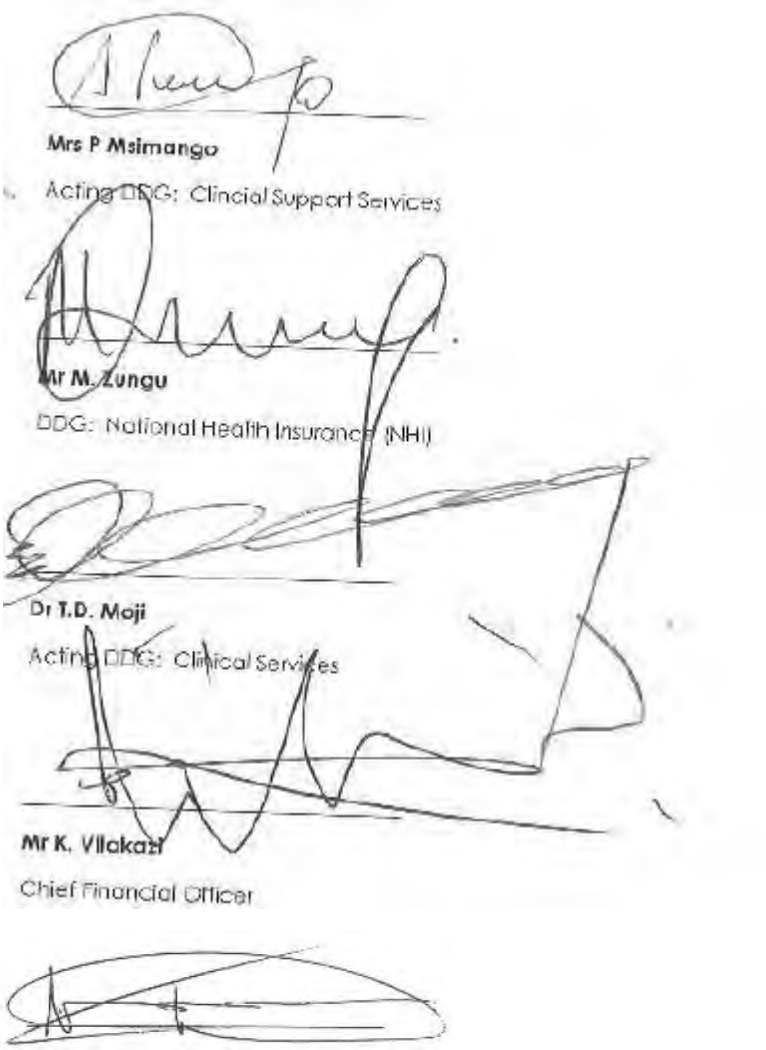
Accounting Officer: KwaZulu-Natal Department of Health

Date: 2023 -03- 10

OFFICIAL SIGN OFF

It is hereby certified that this Annual Performance Plan:

- Was developed by the Management of the KwaZulu-Natal Department of Health under the guidance of the MEC for Health: Ms Nomagugu Simelane
- Takes into account all the relevant policies, legislation and other mandates for which the KwaZulu-Natal Department of Health is responsible.
- Accurately reflects the Outcomes and Outputs, which the KwaZulu-Natal Department of Health will endeavour to achieve over the period 2023-2026.



Mr S. Mhlongo
Acting Chief Director: Infrastructure Development

Ms T. Mngqithi
Chief Director: Risk Assurance Management Services

Mr J Govender

Chief Director: Health Service Delivery Planning, Monitoring and Evaluation

Mrs N. Moodley

Director: Strategic Planning

2023 -03- 16

Dr SC Tshabalala Date:

Accounting Officer: KwaZulu-Natal

Approved by:

2023 -03- 16

Ms Nomagugu Simelane Date

Executive Authority

ABBREVIATIONS

Abbreviation	Description
AGL	Adherence of Guidelines
AIDS	Acquired Immune Deficiency Syndrome
AIP	Audit Improvement Plan
ALOS	Average Length of Stay
ANC	Antenatal Care
APP	Annual Performance Plan
ART	Anti-Retroviral Therapy
AWG	Action Work Group
BAS	Basic Accounting System
BANC+	Basic Antenatal Care Plus
BOD	Burden of Disease
BUR	Bed Utilisation Rate
CCG(s)	Community Care Giver(s)
CCMDD	Centralised Chronic Medicine Dispensing and Distribution
CDC	Communicable Disease Control
CFR	Case Fatality Rate
CHC(s)	Community Health Centre(s)
CHE	Council for Higher Education
CHW	Community Health Worker
CJM	Charles James Memorial Hospital
COE	Compensation of Employees
COS	Community Outreach Services
COSH	Church of Scotland Hospital
COVID-19	Coronavirus Disease first identified in 2019
CPAP	Continuous Positive Airway Pressure
CYPR	Couple Year Protection Rate
DCST	District Clinical Specialist Team
DHIS	District Health Information System
DHS	District Health System
DPC	Disease Prevention and Control
DPME	Department Planning Monitoring and Evaluation
DPSA	Department of Public Service and Administration
DR-TB	Drug Resistant Tuberculosis
ECD	Early Child Development
EMS	Emergency Medical Services
EPWP	Expanded Public Works Programme

Abbreviation	Description
ERIG	Equine Immunoglobulin
ETR.Net	Electronic Register for TB
FIO	Facility Information Officer
GBVF	Gender Based Violence and Femicide
GDP	Gross Domestic Product
GP's	General Practitioners
HAI	Hospital Acquired Infections
HIV	Human Immunodeficiency Virus
HOD	Head of Department
HPC	Health Portfolio Committee
HPRS	Health Patient Registration System
HPV	Human Papilloma Virus
HRD	Human Resource Development
HRIG	Humna Immunoglobulin
HTS	Health Technology Services
JOC	The Joint Opertions Committee
IALCH	Inkosi Albert Luthuli Central Hospital
ICD	International Classification of Diseases
ICT	Information Communication Technology
ICU	Intensive Care Unit
IMCI	Integrated Management of Child Illnesses
KMC	Kangaroo Mother Care
KZN	KwaZulu-Natal
KZNCN	KwaZulu-Natal College of Nursing
LAM	Lipoarabinomannan
LTF	Lost to follow-up
MCWH	Maternal Child and Women's Health
MDR-TB	Multi Drug Resistant Tuberculosis
MEC	Member of the Executive Council
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio Indicator
MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework
MUAC	Measurement of Upper Arm Circumference
NBD	National Burden of Disease
nCPAP	Nasal Continous Positive Airways Pressure

Abbreviation	Description
NCD(s)	Non-Communicable Disease(s)
NDP	National Development Plan
NGO(s)	Non-Governmental Organisation(s)
NHI	National Health Insurance
OES	Occupation Efficiency Service
OHSC	Office of the Health Standards Compliance
OMBU's	Obstetric Maternity Birth Units
OPD	Out-Patient Department
OTP	Office of the Premier
PCHF	Provincial Consultative Health Form (PCHF)
PCR	Polymerase Chain Reaction
PDE	Patient Day Equivalent
PGDP	Provincial Growth and Development Plan
PHC	Primary Health Care
PLWHIV	People living HIV
PPE	Personal Protective Equipment
PPSD	Provincial Pharmaceutical Supply Depot
PPT	Planned Patient Transport
RFA	Results for Action
SAC	Severity Assessment Code

Abbreviation	Description
SAM	Severe Acute Malnutrition
SANC	South African Nursing Council
SAPC	South African Pharmaceutical Council
SBR	Still Birth Rate
SCM	Supply Chain Management
SDIP	Service Delivery Improvement Plan
SITA	State Information Technology Agency
SHP	Strategic Health Programmes
SO	Strategic Objective
SOP's	Standard Operating Procedures
Stats SA	Statistics South Africa
TB	Tuberculosis
TCC	Thuthuzela care centres
THP's	Traditional Health Practitioners
TLD	Tenofovir disoproxil, lamivudine, dolutegravir
TROA	Total Patients Remaining on ART
UHC	Universal Health Coverage
WBOT(s)	Ward Based Outreach Team(s)
XDR-TB	Extreme Drug Resistant Tuberculosis
YLL	Years of Life Lost

NOTES

PART A: OUR MANDATE

1. UPDATES TO THE RELEVANT LEGISLATIVE AND POLICY MANDATES

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

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

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

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

People also have the right to access information if it is required for the exercise or protection of a right;

This may arise in relation to accessing one's own medical records from a health facility for the purposes of lodging a complaint or for giving consent for medical treatment; and

This right also enables people to exercise their autonomy in decisions related to their own health, an important part of the right to human dignity and bodily integrity in terms of sections 9 and 12 of the Constitutions respectively.

National Health Act, 2003 (Act No. 61 of 2003) Provides a framework for a structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services. The objectives of the National Health Act (NHA) are to:

1. Unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa;

2. Provide for a system of co-operative governance and management of health services, within national guidelines, norms and standards, in which each province, municipality and health district must deliver quality health care services;

3. Establish a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognized standards of research and a spirit of enquiry and advocacy which encourage participation;

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

(1) Everyone has the right to have access to:

(a) Health care services, including reproductive health care;

(b) Sufficient food and water; and

(c) Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights; and

(3) No one may be refused emergency medical treatment.

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

2. LEGISLATIVE AND POLICY MANDATES (NATIONAL HEALTH ACT AND OTHER LEGISLATION)

2.1 LEGISLATION FALLING UNDER THE DEPARTMENT OF HEALTH'S PORTFOLIO

4. Promote a spirit of co-operation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans; and

5. Create the foundation of the health care system, and understood alongside other laws and policies, which relate to health in South Africa.

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

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

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

especially in mines, and for compensation in respect of those diseases.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Disaster Management Act: Classification of a National Disaster: COVID-19 (coronavirus). Notice on the classification of the COVID-19 pandemic as a National Disaster based on the potential magnitude and severity of the COVID -19 pandemic on 15 March 2020.

2.2 OTHER LEGISLATION APPLICABLE TO THE DEPARTMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Preferential Procurement Policy Framework (Act 5 of 2000) and the Preferential Procurement Regulations of 2001 - Establishes the obligation of government to award preferential procurement points to enterprises owned by historically disadvantaged persons, including females.

Protection of Personal Information (Act 4 of 2013) - sets out the minimum standards regarding accessing and 'processing' of any personal information belonging to another.

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

3.1 NATIONAL HEALTH INSURANCE (NHI) BILL

South Africa is at the brink of effecting significant and much needed changes to its health system financing mechanisms. The changes are based on the principles of ensuring the right to health for all, entrenching equity, social solidarity, and efficiency and effectiveness in the health system in order to realise Universal Health Coverage. To achieve Universal Health Coverage, institutional and organisational reforms are required to address structural inefficiencies; ensure accountability for the quality of the health services rendered and ultimately to improve health outcomes particularly focusing on the poor, vulnerable and disadvantaged groups.

In many countries, effective Universal Health Coverage has been shown to contribute to improvements in key indicators such as life expectancy through reductions in morbidity, premature mortality (especially maternal and child mortality) and disability. An increasing life expectancy is both an indicator and a proxy outcome of any country's progress towards Universal Health Coverage.

The phased implementation of NHI is intended to ensure integrated health financing mechanisms that draw on the capacity of the public and private sectors to the benefit of all South Africans. The policy objective of NHI is to ensure that

everyone has access to appropriate, efficient, affordable and quality health services.

An external evaluation of the first phase of National Health Insurance was published in July 2019. Phase 2 of the NHI Programme commenced during 2017, with official gazetting of the National Health Insurance as the Policy of South Africa. The National Department of Health drafted and published the National Health Insurance Bill for public comments on 21 June 2018. During AUgu st 2019, the National Department of Health sent the National Health Insurance Bill to Parliament for public consultation.

3.2 PROVINCIAL STRATEGY ALIGNMENT TO THE REVISED DRAFT DEPARTMENT OF PLANNING, MONITORING AND EVALUATION (DPME) PLANNING FRAMEWORK

The following Impact and Outcomes were adopted by The KwaZulu-Natal Department of Health for the 2020/21 to 2024/25 planning cycle. The Impact and Outcomes are listed below:

Impact: *Increased Life Expectancy*

Outcome: *Universal Health Coverage*

Outcome: *Improved Client Experience of Care*

Outcome: *Reduced Morbidity and Mortality*

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

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

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

- National Health Insurance (NHI) Bill
- National Development Plan (NDP): Vision 2030
- Sustainable Development Goals (SDGs) 2030
- Revised Medium Term Strategic Framework (MTSF) and NDP Implementation Plan 2019-2024 Provincial Growth and Development Strategy/plan (PGDS/P) 2020
- Plan of Action to Mitigate a COVID-19 Resurgence in South Africa
- KZN Economic Recovery Plan for COVID-19
- National Annual Strategic Plan (2022 – 2024)

The table below illustrates the alignment of the PDoH Impact and outcomes to Health Sector Policies and Strategies:

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

KZN DOH Impact and Outcome 2020-2025	Revised MTSF Outcomes 2019-2024	National Development Plan: Vision 2030 goals	Sustainable Development Goals	Provincial Growth and Development Strategy (PGDS) 2021	Health sector's strategy 2019-2024	National Annual Strategic Plan (NASP) Interventions for 2023/24
Impact: Increased Life Expectancy	**Outcome:** Progressive improvement in total life expectancy of South Africans	**Goal 1**: Life expectancy at birth increases to 70 years		**Outcome:** Progressive improvement in the total life expectancy of South Africans	**Goal 1**: Increase Life Expectancy improve Health and Prevent Disease *Inter sectoral collaboration to address social determinants of health*	**6.** Vaccination
Outcome: Universal Health Coverage	**Outcome:** Universal health coverage for all South Africans achieved by 2030	**Goal 6**: Complete Health Systems reforms **Goal 8:** NHI-Universal health care coverage achieved. **Goal 6a**: Strengthen the district health system **Goal 7:** Primary Health care teams provide care to families and communities **Goal 9**: Fill posts with skilled, committed and competent individuals	**3.8** - Achieve universal health coverage (UHC) **3.7** Ensure universal access to sexual and reproductive health-care services	**Outcome:** Universal health coverage for all South Africans achieved by 2030 **Outcome:** Improved educational and health outcomes and skills development for all women, girls, youth and persons with disabilities	**Goal 2**: Achieve UHC by Implementing NHI **Strategic Objective (SO)**: *Progressively achieve Universal Health Coverage through NHI* ***SO**: Improve quality and safety of care* **SO**: *Provide leadership and enhance governance in the health sector for improved quality of care* **SO:** Improve community engagement and reorient the system towards Primary Health Care through Community based health Programmes to promote health **SO**: Improve equity, training and enhance management of Human Resources for Health **SO**: Improving availability to medical products, and equipment **SO**: Robust and effective health information systems to automate business processes and improve evidence based decision making **SO**: Execute the infrastructure plan to ensure adequate, appropriately distributed and well maintained health facilities	**2.** Jobs **5.** Digitalisation **6.** Vaccination **10.** Public procurement
Improved Client Experience of Care		**Goal** 9: Fill posts with skilled, committed and competent individuals			**SO:** Improve community engagement and reorient the system towards Primary Health Care through Community based health Programmes to promote health	

KZN DOH Impact and Outcome 2020-2025	Revised MTSF Outcomes 2019-2024	National Development Plan: Vision 2030 goals	Sustainable Development Goals	Provincial Growth and Development Strategy (PGDS) 2021	Health sector's strategy 2019-2024	National Annual Strategic Plan (NASP) Interventions for 2023/24
Reduced Morbidity and Mortality	**Outcome**: Reduce maternal and child mortality **Priority 3**: Education Skills and Health **Outcome**: Improved educational and health outcomes and skills development for all women, girls, youth and persons with disabilities	**Goal 1a**: Improvement in evidence-based preventative and therapeutic intervention for HIV. **Goal 2**: Progressively improve TB prevention and cure **Goal 3**: Maternal Mortality <100 per 100 000 live births, Infant mortality < 20 per 1000 live births. **Goal 4:** Reduce prevalence on non-communicable chronic diseases by 28% **Goal 5**: Reduce Injury, accidents and violence by 50 percent from 2010 levels.	**2.2** End all forms of malnutrition **3.1** By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births **3.2** By 2030, end preventable deaths of new-borns and children under 5 years of age **3.3** By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases (NTDs) **3.7** Ensure universal access to sexual and reproductive health-care services, By 2030, reduce by one third premature mortality from non-communicable diseases **3.5** Strengthen the prevention and treatment of substance abuse, **3.6** By 2020, halve the number of global deaths and injuries from road traffic accidents **3.7** Ensure universal access to sexual and reproductive health-care services, **3.9** Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	**Outcome:** Progressive improvement in the total life expectancy of South Africans **Outcome:** Reduce maternal and child mortality **Outcome**: Improved educational and health outcomes and skills development for all women, girls, youth and persons with disabilities	**Goal 1**: Increase Life Expectancy improve Health and Prevent Disease **SO**: *Improve health outcomes by responding to the quadruple burden of disease of South Africa*	**6.** Vaccination

The Strategic and Annual Performance Plans are further aligned to the National Health Insurance Bill, the Public Service Regulations and the Health Compact Pillars.

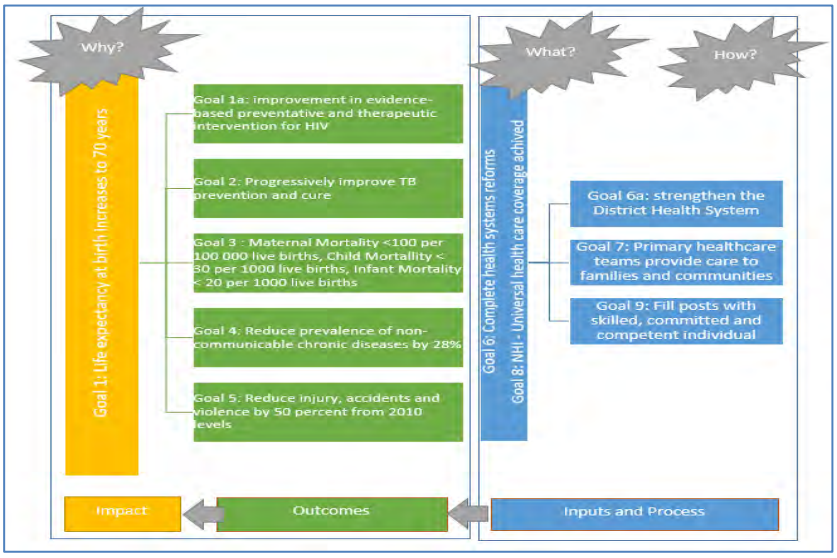
The Department of health responds to Priority 3: Education, Skills and health of the PGDS. The Action Work Group (AWG) E is led by the Department of Health and is supported by the Office of the Premier (OTP), Department of Social Development (DSD), Cooperative Governance and Traditional Affairs (CoGTA), Department of Education (DOE), Private facilities, Civil society including local business and The Active citizens organization.

Table 2: PGDS Outcomes

PGDS OUTCOMES	HEALTH INTERVENTIONS
Universal Health Coverage for all South Africans achieved by 2030	Expansion of UHC preparedness in all 10 KZN Districts plus 1 Metro
	Roll out a quality health improvement programme in public health facilities to ensure that they meet the quality standards required for certification and accreditation for NHI
	Mitigate the risks related to medical litigation
	Improved quality of primary healthcare services through expansion of the Ideal Clinic Programme
	Implement HRH plan 2020/21- 2024/25 to address the human resources requirements, including filling critical vacant posts for full implementation of universal healthcare
	Maintain provincial nursing colleges
	Expand the primary healthcare system by contracting 10000 community health workers (CHWs) into the public health system[1]
	Strategic Health Infrastructure
	E-Health Systems
Progressive improvement in the total life expectancy of South Africans	Drive provincial health wellness and healthy lifestyle campaigns to reduce the burden of disease and ill health
	COVID-19 Mitigation
	Malaria Elimination Programme
	Healthy and Active Lifestyles Multisectoral Programme
Reduce maternal and child mortality	Provide good quality antenatal care
	Immunisation programme implemented
	Improve the integrated management of childhood disease services
Improved educational and health outcomes and skills development for all women, girls, youth and persons with disabilities	Targeted programmes to up-scale existing campaigns and programmes on new HIV infections among youth, women and persons with Disabilities
	Targeted programme on adolescent sexual and reproductive health and rights, including addressing teenage pregnancies and risky behaviour
	Mainstream gender, youth and disability issues in programs on access to universal education, life skills, skills development and training an in different field of study, including STEM (DOE)

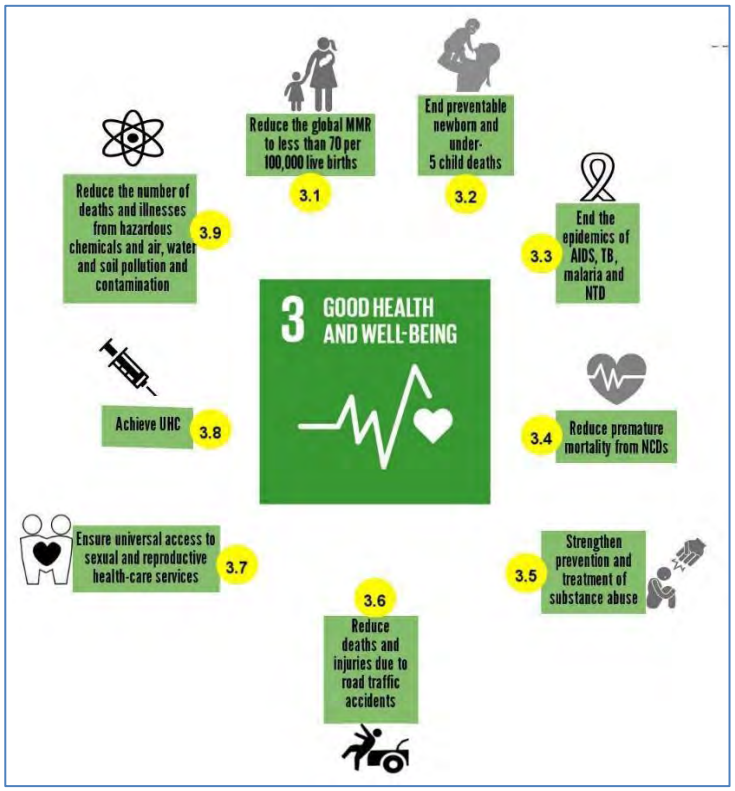
[1] CHW integration/absorption is a National competency – KZN contribution is on contracting of CHWs) AWG E

3.3 NATIONAL DEVELOPMENT PLAN: VISION 2030



The National Development Plan (NDP) (Chapter 10) has outlined 9 goals for the health system that it must reach by 2030. The **NDP goals are best described using conventional public health logic framework**. The **overarching goal** that measures impact is "Average male and female life expectancy at birth increases to at least 70 years". The **next 4 goals measure health outcomes**, requiring the health system to **reduce premature mortality and morbidity**. Last **4 goals are tracking the health system that essentially measure inputs and processes** to derive outcomes

3.4 Sustainable Development Goals



Goal 3. Ensure healthy lives and promote well-being for all at all ages

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate

3.b Support the research and development of vaccines and medicines for the communicable and non-communicable

diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Department of Home Affairs Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States

Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

3.5 Medium Term Strategic Framework and NDP Implementation Plan 2019-2024

The plan comprehensively responds to the priorities identified by cabinet of 6th administration of democratic South Africa, which are embodied in the Revised Medium-Term Strategic Framework (MTSF) for period 2019-2024.

Over the strategic 5-year period, the Provincial Department of Health's response is structured into One Impact and Three Outcomes. These Impacts and Outcomes are aligned to the Pillars of the Presidential Health Summit compact, as outlined in the table below.

Table 3: Alignment of Outcomes to Pillars of Presidential Health Summit Compact

MTSF 2019-2024 Impacts (National)	MTSF 2019-2024 (KZN) Interventions	Health sector's strategy 2019-2024	Presidential Health Summit Compact Pillars
Impact: **Life expectancy of South Africans improved from 65 in 2019 to 67 by 2024**	• *Drive provincial health wellness and healthy lifestyle campaigns to reduce the burden of disease and ill health* • *COVID-19 Mitigation (Due to the nature of COVID-19 and the continuous changes in strategy based on emerging bodies of evidence, the outer year targets may be revised* • *Implementation of the Malaria Elimination Programme* • *Healthy and Active Lifestyles Multisectoral Programme*	*Impact: Increased Life Expectancy* *Outcome: reduced Morbidity and Mortality*	*N/A*
Impact: **Universal Health Coverage for all South Africans progressively achieved by 2030**	• *Expansion of Universal Health Coverage (UHC) preparedness in all 10 KZN Districts plus 1 Metro* • *Roll out a quality health improvement programme in public health facilities to ensure that they meet the quality standards required for certification and accreditation for (National Health Insurance) NHI* • *Mitigate the risks related to medical litigation* • *Improved quality of primary healthcare services through expansion of the Ideal* • *Clinic Programme* • *Implement the HRH plan 2021/22 to 2024/25 to address the human resources requirements, within the allocated funding envelope, including filling vacant funded posts for full implementation of universal healthcare* • *Maintain provincial nursing colleges* • *Expand the primary healthcare system by contracting 10 350 - community health workers (CHWs) into the public health system.* • *Strategic Health Infrastructure* • *Implementation of E-Health Systems*	*Outcome: Universal Health Coverage*	***Pillar 4:*** *Engage the private sector in improving the access, coverage and quality of health services; and* ***Pillar 6****: Improve the efficiency of public sector financial management systems and processes*
		Outcome: Universal Health Coverage	***Pillar 5:*** *Improve the quality, safety and quantity of health services provided with a focus on to primary health care.*
			Pillar 7: *Strengthen Governance and Leadership to improve oversight, accountability and health system performance at all levels*
		Outcome: Improved Client Experience of Care	***Pillar 8****: Engage and empower the community to ensure adequate and appropriate community based care*
		Outcome: Universal Health Coverage	***Pillar 1****: Augment Human Resources for Health Operational Plan*
		Outcome: Universal Health Coverage *Outcome: Improved Client Experience of Care*	***Pillar 2:*** *Ensure improved access to essential medicines, vaccines and medical products through better management of supply chain equipment and machinery* ***Pillar 6:*** *Improve the efficiency of public sector financial management systems and processes*
		Outcome: Universal Health	***Pillar 9:*** *Develop an Information System that will guide the health system policies,*

MTSF 2019-2024 Impacts (National)	MTSF 2019-2024 (KZN) Interventions	Health sector's strategy 2019-2024	Presidential Health Summit Compact Pillars
		Coverage	*strategies and investments*
		Outcome: Universal Health Coverage	***Pillar 3:*** *Execute the infrastructure plan to ensure adequate, appropriately distributed and well-maintained health facilities*
Impact: **All women, girls, youth and persons with disabilities enjoy good quality health care and better life opportunities**	• *Targeted programme on adolescent sexual and reproductive health and rights, including addressing teenage pregnancies and risky behaviour* • *Targeted programmes to up-scale existing campaigns and programmes on new HIV infections among youth, women and persons with Disabilities* • *Improve the integrated management of childhood disease services* • *Immunisation programme implemented* • *Reduce Infant Mortality rate to <24 per 1 000 live births by 2024* • *Provide good quality antenatal care*		

4. UPDATES TO RELEVANT COURT RULINGS

BILLS IN PROGRESS:

National Health Insurance (NHI) Bill - The Portfolio Committee on Health finalised its virtual public hearings on the National Health Insurance (NHI) in February 2022. Provincial public hearings, took place between 25 October 2019 and 24 February 2020. These included visits to 33 district municipalities across all nine provinces.

National health Amendment bill – Bill 29 of 2018 (Private Member's Bill) seeks to extend clinic hours- as per the 2019 SAHR, the bill had lapsed but could be revived.

Social Service Practitioners Draft Bill, 2019 – The bill proposed to replace the current Social Service Professions Act 110 of 1978 in its entirety

Copyright Amendment Bill (Bill 13 of 2017) – Exceptions are needed to enable persons with visual impairment access to content in suitable formats

Cannabis for private purposes bill, 2020 - Medicinal cannabis has been used for the management of spasticity, which is a common feature of cerebral palsy. Cannabidiol has been registered in other jurisdictions for the management of uncontrolled seizures in children, associated with Lennox-Gastaut and Dravet syndromes, as well as tuberous sclerosis complex.

Medico – Legal Claims

The high volume of medical claims and the backlog on court proceedings resulted in an increase in contingent liability of medico-legal cases to R 27.8 billion.

The number and value of the claims that were successfully defended in 2020/21 and the two financial years prior thereto.

- An assessment of the impact of the lack of proper record-keeping on the liability of the department for claims paid in 2020/21 and the two financial years prior thereto, either by way of court order or a settlement.
- Strategies adopted by the department to mitigate its liability in respect of medico-legal claims, including but not limited to early investigation and settlement of claims where liability is established, improved record-keeping for evidential purposes, use of alternative dispute resolution mechanisms, use of private sector expert legal practitioners to defend claims, contingency fee arrangements and training of staff to avoid future claims, and the like.
- Progress made in law reform and legislative interventions pertaining to medico-legal claims in the public health sector, including capping of claims and other interventions as proposed by National Treasury in 2020.

PART B: OUR STRATEGIC FOCUS

VISION

Optimal health for all persons in KwaZulu-Natal.

MISSION

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

VALUES

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

5. UPDATED SITUATIONAL ANALYSIS

OVERVIEW OF KWAZULU-NATAL

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

It covers an area of 94 361 km² which is the third smallest in the country, and has a population of 11 563 183 for 2021/22 (Web DHIS 2021/11/23), making it the second most populous province in South Africa following Gauteng. The capital is Pietermaritzburg and the largest city is Durban. Other major cities and towns include Richards Bay, Port Shepstone, Newcastle, Estcourt, Ladysmith and Richmond.

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

Agriculture is also central to the economy. The sugar cane plantations along the coastal belt are the mainstay of KwaZulu-Natal's agriculture. The coastal belt is also a large producer of subtropical fruit, while the farmers inland concentrate on vegetable, dairy and stock farming. Another source of income is forestry in the areas around Vryheid, Eshowe, Richmond, Harding and Ngome.

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

Table 4: KwaZulu-Natal Demographic Data

Demographic Data	KwaZulu-Natal
Geographical area	94,361 km²
Total population (Statistics South Africa, Mid-year estimate 2021)	11,563,183
Population density (Based on SA Mid-year estimates 2021)	122.5 per Km²
Percentage of population with medical insurance (General Household Survey, 2021) [2]	10.5%

Source: Web DHIS Stats SA Mid-year estimates 2021 (2021/11/23)

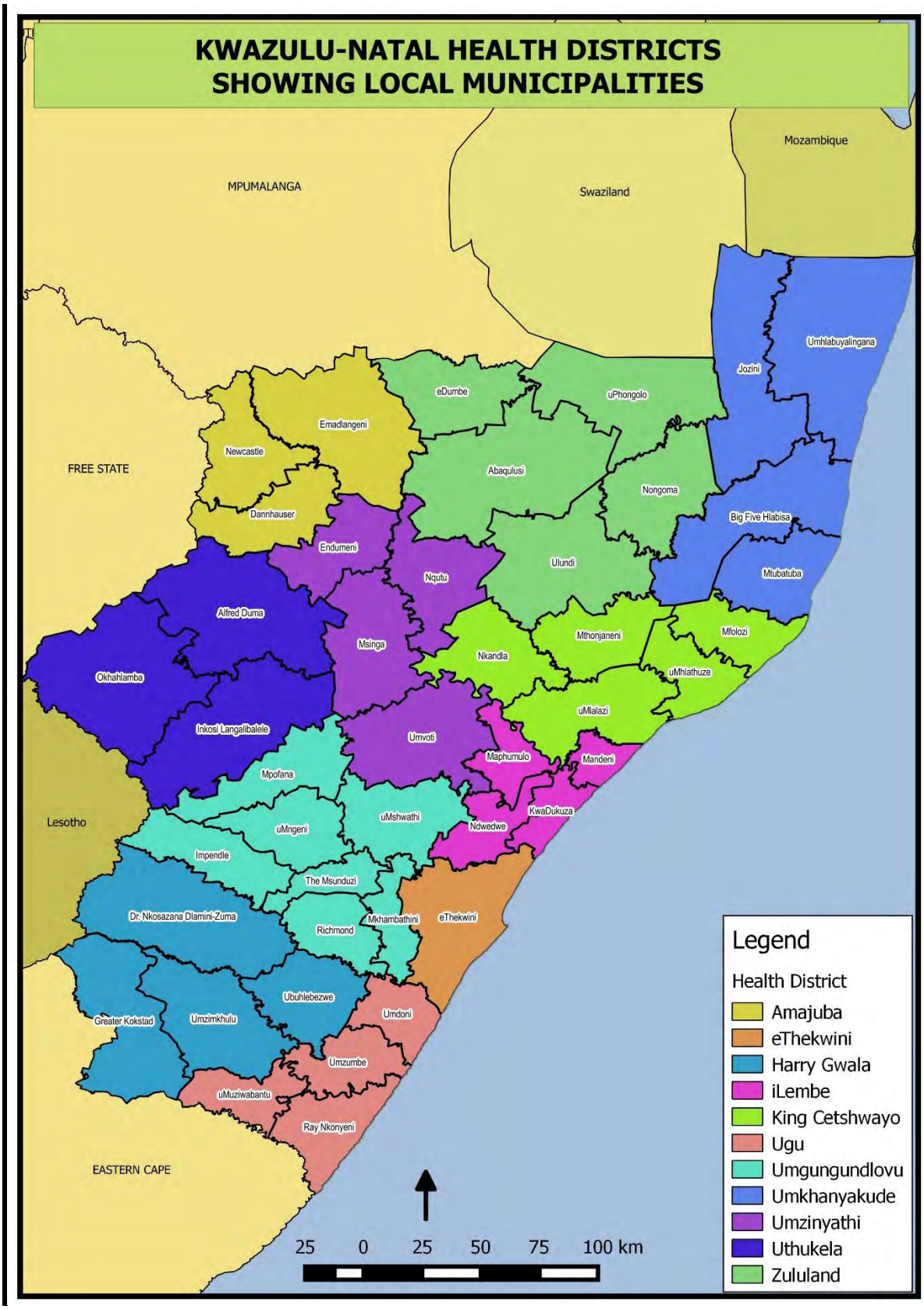
6. EXTERNAL ENVIRONMENT ANALYSIS

DEMOGRAPHY

There is a reduction in international migration, which is indicative of the COVID-19 travel restrictions and subsequent impact on migratory patterns since March 2020. Migration is an important demographic process, as it shapes the age structure and distribution of the provincial population (and so the country's population structure).

[2] The General Household Survey has been delayed. As soon as the information is available, this table will be updated

Map 1: Map of KZN and Districts / Metroplotian (KZN, Department of Health Geographical Information System)



In South Africa, about 28,07% of the population is aged younger than 15 years (1 701 million) and approximately 9,2% (5,59 million) is 60 years or older. The proportion of elderly persons aged 60 years and older in South Africa, and in KwaZulu-Natal is increasing over time and as such policies and programmes to care for the needs of this growing population should be prioritised.

The population pyramids show a decline in the proportion of young children and the youth over time, with a relative increase in the proportion of older people, especially those over the age of 65 years. These changes are true for both KZN and the country as a whole. The changes in the structure of the pyramid can be explained by:

- The decreasing fertility rate across the whole of South Africa including KZN (2.53)
- The increasing life expectancy across the whole country. Life expectancy has increased from 47.4 year (in 2001-2006) to 57.8 years (2022) for males and 52.1 years to 64.2 (2022) years for females.

Figure 1: Trends in Provincial population compared to National population

Source: SAHR20/21

KZN has the 3rd highest proportion of children under 5 years (33.6%), together with Limpopo (33.6%) and the Eastern Cape (32.7%). KZN has the 2nd largest population, and in reality this means that KZN has more children under 5 years (1,208,676 actual children under 5 years), than any other province in South Africa.

Within the Province, eThekwini Metro and uMgungundlovu district, have the largest number of actual children under 5 years old at 365,431 and 114,102 respectively. However proportionally, uMzinyathi has the largest proportion of children under 5 years, at 13.5%, of their total population. uMzinyathi District also has the highest poverty headcount per household at between 24% to 29% of the population.

As the population pyramids change, the populations of KZN and the country will no longer be predominantly young or youth based. This will mean that, although child health should remain a focus for the health services, planning should also take into account the increase in the diseases of middle and older age, relative to previous years and relative to the whole population. Diseases affecting older age groups include diabetes, hypertension and their sequelae such as cardiovascular diseases. The epidemiological profile of the Province and the Country already reflects this increase. As far as possible, the focus of the health system should be to prevent these diseases through education around and facilitation of, improved nutrition and lifestyles. There is a high proportion of deaths between the ages of 35 and 59 years, which suggests that non-communicable diseases, as well as communicable diseases (including (Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrom (HIV/AIDS)), are taking their toll on this age group.

KZN has the lowest proportion of older population (60 years and above) living within the Province.

iLembe and eThekwini districts have the highest proportion of over 60 population at 9.6% (66,712 people) and 9.5% (382,561 people) respectively. uMzinyathi has the lowest proportion of over 60 year olds living in the district, at 6.5% (37 372 people).

The proportion of males in KZN in the older age groups are consistently smaller relative to the proportion of females. This may be due to the fact that males tend to seek work outside the Province. Migration streams show that over 200 000 people migrated from KZN to Gauteng during each of the periods 2011-2016 and 2016-2021. The relatively smaller male population may also be caused by poorer health seeking behaviour by males and a strong focus on women's health. Health services need to have strategies that will improve the health seeking behaviour of men, as well as preventing and treating trauma related conditions which affects the male population to a greater extentThan the female population.

SOCIAL DETERMINANTS OF HEALTH

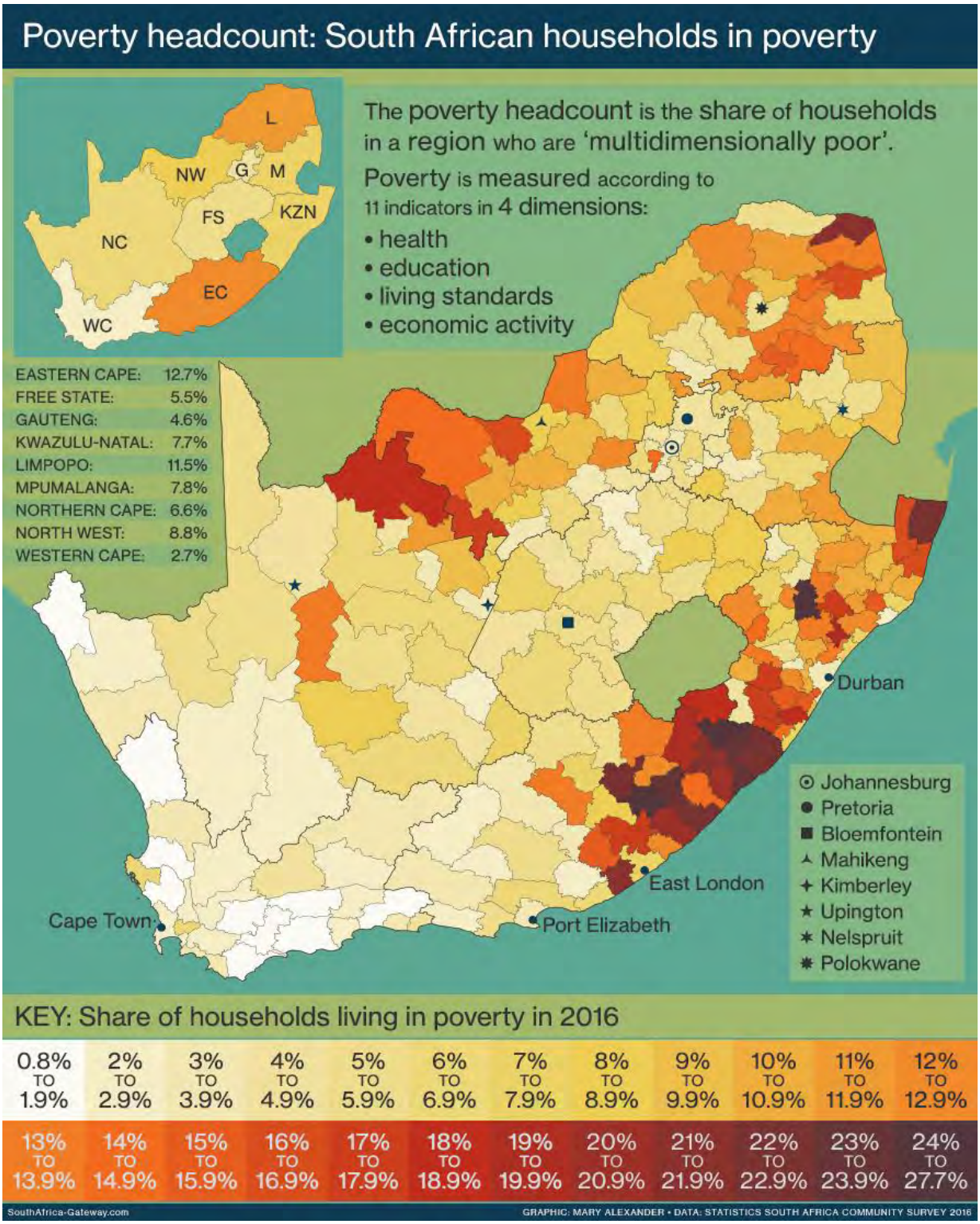
Globally, it is recognised that health outcomes are not only affected by access to, and quality of health services provided. Health outcomes are influenced by multidimensional and complex factors linked to the social determinants of health, which include a range of social, political, economic, environmental,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

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

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

Comparing 2011 and 2016 data, there was a decline in people living in informal dwellings and an increase in traditional dwellings. The Province has made gains in the access to piped water and electricity though in the Mkhanyakude continues to have a high percentage of households with no access to piped water and electricity for lighting, food preparation and storage.

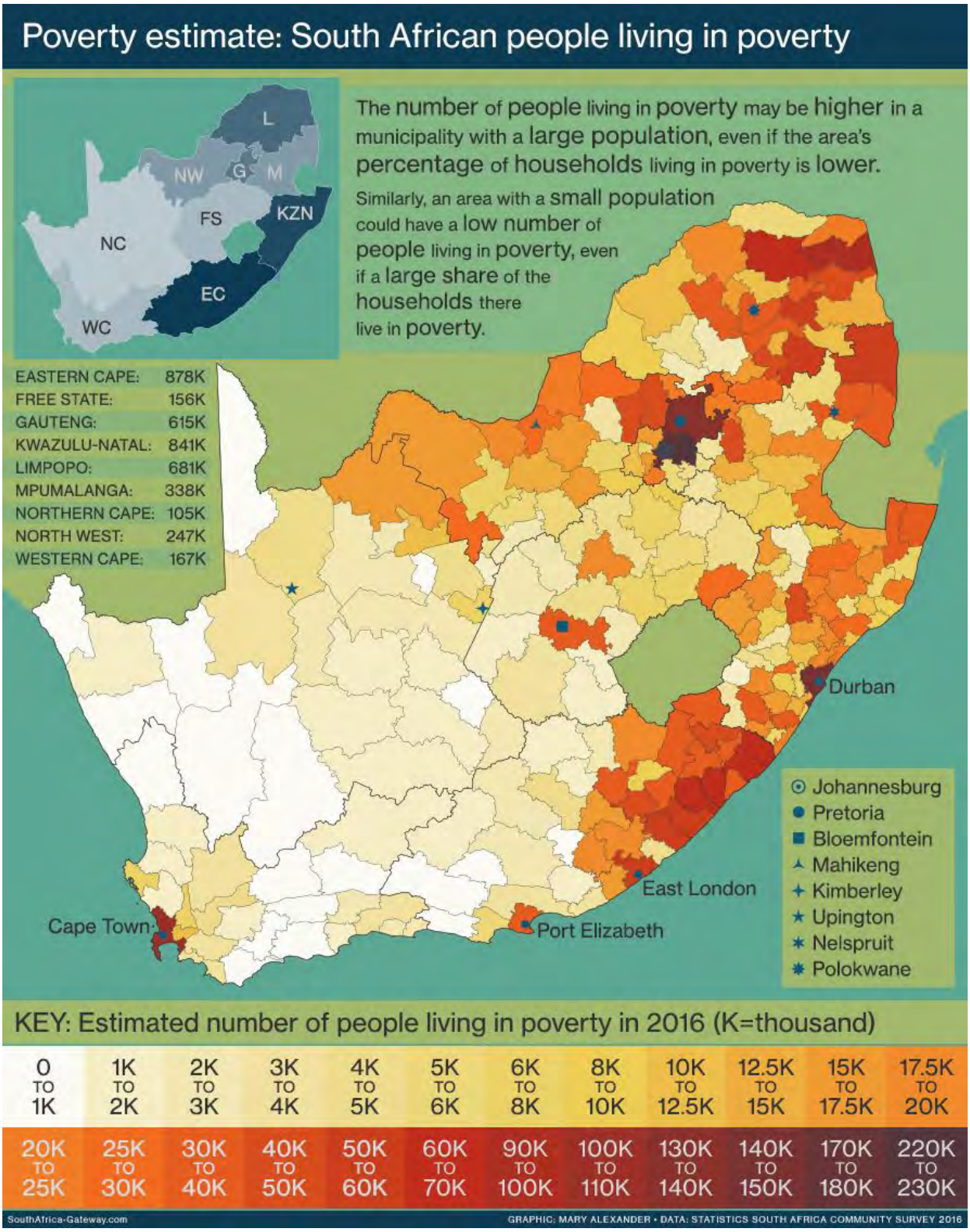
Map 2: Poverty headcount of South African Households



Source: https://southafrica-info.com/people/mapping-poverty-in-south-africa/ (12th August 2022).

The map shows that the Eastern Cape and KwaZulu-Natal have high levels of households living in poverty with Msingaand Nquthu Sub-Districts having 24% to 27.7% of total households living in poverty. These sub-Districts are supported by Ward Based Outreach Teams who use Church of Scotland Hospital (COSH) in Msinga, and Charles James Memorial Hospital (CJMH) in Nquthu as referral points.

Map 3: Poverty Estimate in South Africa



Source: https://southafrica-info.com/people/mapping-poverty-in-south-africa/ (12th August 2022)

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

Map 4 displays the percentage of households living in poverty. In KZN, 7.7% of the households live in poverty. This poverty score is multidimensional and views poverty in terms of 4 dimensions, namely, health, education, living standards and

economic activity. Map 5 presents the number of people living in poverty, this represents 841 000 people in KZN.

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

Table 5: Health Indicators by Province

Indicators	Province									RSA
	WC	EC	NC	FS	KZN	NW	GP	MP	LP	
% of orphans aged 7 – 18 years attending educational institutions	78.9%	95.0%	97.5%	96.3%	90.6%	88.8%	93.4%	93.0%	97.3%	91.9%
% of people 20 years and older with no schooling	0.7%	4.6%	3.2%	2.6%	4.4%	3.9%	1.0%	6.3%	7.1%	3.2%
% of persons with medical aid coverage	23.7%	10.6%	19.6%	16.3%	10.5%	15.3%	24.1%	9.1%	8.2%	16.1%
% of households for which the usual place of consultation is a public facility	52.0%	82.1%	65.2%	69.0%	78.7%	76.6%	64.2%	84.7%	85.4%	71.8%

Source: Stats SA Midyear Estimates 2022

KwaZulu-Natal has a low percentage of medical aid coverage at 10.5% against the national average of 16.1% and 24.1% in Gauteng despite being the 2nd most populous province. In effect, this means there are 10,326,801 people relying on public health facilities in KZN.

Table 6: Education indicators by Province

Indicators	Province									RSA
	WC	EC	NC	FS	KZN	NW	GP	MP	LP	
% of learners in public schools benefitting from the nutrition programme	53.5%	88.3%	73.8%	84.6%	80.6%	87.8%	61.1%	89.6%	92.1%	77.8%
Adult literacy rates (persons 20 years and older with less than Grade 7 as highest level of education)	6.8%	15.1%	13.6%	12.6%	13.2%	16.3%	4.7%	14.8%	14.9%	10.7%

Source: Stats SA Midyear Estimates 2022

In KwaZulu-Natal, 80.6% of learners at public schools are benefitting from the nutrition progamme which is less than Eastern Cape Province, who has a similar poverty index. This should be viewed within the context that KZN has a larger population and by default, a larger number of children of school going age.

Table 7: Agriculture Indicators By Province

Indicators	Province									RSA
	WC	EC	NC	FS	KZN	NW	GP	MP	LP	
Percentage of households who engaged in agricultural activities during the past 12 months	2.9%	33.4%	13.0%	20.2%	20.4%	11.2%	6.4%	32.2%	37.9%	17.2%
Food access adequate	80.5%	76.3%	64.2%	75.6%	79.1%	69.1%	81.6%	67.4%	94.3%	79.1%
Food access inadequate	12.6%	17.0%	25.3%	12.2%	14.2%	22.6%	14.9%	18.0%	4.0%	14.6%
Food access severely inadequate	6.9%	6.7%	10.5%	12.2%	6.7%	8.3%	3.5%	14.6%	1.7%	6.4%

Source: Stats SA Midyear Estimates 2022

KZN has a large proportion of subsistence farmers, especially in the more rural and deep rural areas being inland and in the north of the Province. Access to food resources in KZN is similar to the national averages, although severe malnutrition under 5 years continues to be a challenge in some of the more remote regions of KZN.

Socio economic factors have the potential to affect how the Province progresses on meeting the MTSF Priority 3 of

Education and Health. To mitigate against the impact of these factors on the health of the population, the Department focuses on the promotion of health. These include the development of systems and provincial guidelines for promotion of healthy lifestyles; advocating for healthy environments in which to live, learn, work and play as well as mediation on different interests in the promotion of health. Health promotion also includes; lobbying for those who are least socially and economically powerful in the community and orientation to Health Promotion in different settings e.g. schools, clinics, hospitals, workplaces, taxi ranks, markets places and homes. (http://www.kznhealth.gov.za/healthprom.htm;2020).

Further to the promotion of health for the community and staff in its employ, the Departmental Community Health Workers (CHWs) have a key role in linking communities to assistance to deal with the effects of socio economic status on health. The National Development Plan (NDP) 2030 states that households must have access to a well-trained community-based health worker. The plan unpacks the important role that CHW's can and should play in addressing the social determinants of health through health education and prompt referral to health and other services.

Apart from the community health workers and ward based outreach teams that help to link communities to care and services across the Departments, the Department has a role in the Provincial Action Work Groups. Action work groups (AWGs) have been established to implement and monitor implementation of the Provincial Growth and Development Plan. The Office of the Premier (OTP) plays an oversight role for the Provinical Growth and Development Plan (PGDP) implementation within sector departments. The Department of Health contributes to the PGDP Strategic Goal 3: Human and Community Development, Strategic Objective (SO) 3.2, which is "Enhanced Health of Communities and Citizens". AWG E is responsible for SO 3.2, comprising of the Departments of Education, Sports & Recreation, Social Development, Agriculture & Rural Development, Arts & Culture, Public Works, COGTA, OTP, and the Private Health Services in the Province.

Table 8: Social determinants of health per district

	Year	Amajuba	eThekwini Metro	Harry Gwala	iLembe	King Cetshwayo	Ugu	uMgungundlovu	uMkhanyakude	uMzinyathi	uThukela	Zululand
Percentage of female headed households	2016	48.4%	42.1%	53.9%	47.1%	49.8%	49.9%	46.4%	54.2%	58.9%	58.7%	53.8%
Unemployment rate	2011	39.1%	27.1%	36%	30.6%	34.7%	35.2%	30.4%	42.8%	36.6%	39.6%	41.1%
Youth unemployment rate (15 – 34 years)	2011	50.3%	39%	44.4%	37.2%	44.4%	45.1%	39.5%	51.2%	45.6%	49.3%	51.2%
Percentage of population 20 years and older with no schooling	2016	12.3%	8.6%	25%	22%	24%	17.9%	11.7%	32.7%	39.9%	20.3%	24%
Percentage without matric	2016	63.4%	56.9%	76.5%	67.2%	64%	68.1%	63.1%	68.95%	73.1%	66.7%	67.6%
Percentage without higher education	2016	91%	89.1%	93.6%	93.7%	90.8%	91.9%	87.2%	93.6%	93.6%	93.4%	72.6%
Formal dwellings	2016	84.4%	81.5%	41.7%	73.9%	70.6%	58.6%	76.7%	70.1%	47%	69.8%	62.1%
Percentage of households using electricity for lighting	2016	92.1%	89.9%	81.2%	85.2%	91.9%	84.2%	92.8%	53%	69.8%	85.5%	84.9%
Percentage of households with flush toilet connected to sewerage	2016	52%	30.7%	18.4%	20.4%	27.4%	20.8%	40.5%	7,5%	27.7%	29%	18.7%
Percentage of households with weekly refusal removal	2016	53.8%	21.9%	23.1%	32.5%	27.3%	19.7%	41.4%	4%	15.5%	31.3%	22.3%
Percentage of households with piped water inside dwellings	2016	37.3%	39.2%	11.4%	18.2%	26.9%	21.2%	37.7%	6.9%	23%	22.3%	14.6%
Drinking water system (Blue Drop) Performance rating	2014	58.2%	95.9%	63.4%	86.7%	74.1%	66.3%	89.5%	57.9%	78%	34.5%	51.2%

Source: Stats SA, 2014 Blue Drop Report

EPIDEMIOLOGY AND QUADRUPLE BURDEN OF DISEASE

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

LEADING CAUSES OF DEATH

The mortality data source in South Africa is Statistics SA (Stats SA) which uses data obtained from death notification administrative forms (Form BI-1663 and Form DHA-1663), filed by the Department of Home Affairs. Furthermore, death notifications by Stats SA are compiled using the International Classification of Diseases (ICD). KwaZulu-Natal faces a convergence of infectious and chronic disease of lifestyle from which years of life are lost [2,3]. Similar to the pattern of death in 2017, the highest percentage of deaths were recorded in Gauteng province at 20% (90 974) with KwaZulu-Natal reporting the second highest rate at 18.7% (84,778) (StasSa 2018).

The five leading causes of death in KwaZulu-Natal are other forms of heart diseases (8.2%), diabetes (7.1%), TB (6.8%), cerebrovascular disease 5.7%) and HIV (5.4%). Tuberculosis (TB) and other forms of heart disease were the two leading causes of deaths among men at 8.4% and 6.9% respectively while chronic disease i.e. other forms of heart disease and diabetes were responsible for 9.5% of females deaths (StatsSA 2018). Intestinal infectious diseases was responsible for the highest number of deaths at 6.3% followed by influenza and pneumonia at 6.2% in children aged 1-14 years. This highlights the need to investigate the types of intestinal infectious diseases responsible for the high mortality rate among children and strengthen strategies to prevent and treat such infestations. Tuberculosis followed by HIV caused mortality in 12.1% and 11.5% of young people aged 15-44. Diabetes and TB caused mortality among those between the ages of 45-64 at 9.3% and 8.2% respectively (StatsSA 2018). Among districts, TB was the leading cause of death in most districts namely Amajuba, Harry Gwala, Ugu, uThukela, iLembe and King Cetshwayo while HIV was the highest cause of mortality in uMkhanyakude and Zululand. Other forms of heart disease was responsible for highest deaths in uMzinyathi and eThekwini and diabetes caused the highest deaths in uMgungundlovu (StatsSA 2018).

Overall, eThekwini and uMgungundlovu districts contributed to the highest numbers of deaths in the Province. This can be attributed to their larger population sizes relative to the other districts.

Respiratory and intestinal infectious diseases are the leading causes of death among both male and female infants (less than 1 year old). Pneumonia, diarrhoea, malnutrition and respiratory diseases have been reported as the main causes of death among infants in KZN. These illnesses frequently occur together, in vicious cycles of poverty and ill health. These illnesses, together with malnutrition, pose particularly high risks to HIV-infected infants, who have been reported to be at high risk of death should they become infected wth these diseases.

Among the 1-14 years old age group, *influenza and pneumonia* and *other forms of heart disease,* were the leading causes of death among males and females respectively in previous years. In 2018 however, the leading cause of death was intestinal infectious diseases at 6.3% which may be unexpected. TB and HIV were among the top six causes of death in this age group but more so for females[1]. Influenza, pneumonia, HIV and TB are under-researched among this age group probably due to ethical bureaucracy that researchers have to go through in studying this age group. More research is needed on intestinal infectious diseases in children between the ages of 1-14. The Province may need to prioritize clinical and socio-economical research around this age group.

Most deaths (24,718 of the total 43,719) in the Province occurred in the 15-44 year[1] age group. The top two causes of death in this age group were TB and HIV, for both females and males. About 11.8% of deaths were due to TB among males and 14.7% of deaths were due to HIV among females. This aligns with previous studies conducted in KZN that showed that females carry the highest HIV burden in the Province. TB and HIV frequently occur as comorbidities and therefore are expected to have similar trajectories especially in this age group. Additionaly, *other forms of heart diseases* were third and fourth leading causes of death among males and females respectively. This also aligns with previous studies which showed the predominance of cardiac diaseases and hypertension in this age group. The Province aims to prioritize community level health promotion programmes for this age group in order to lower risk factors (such as obesity and type two diabetes) and thus reduce the number of deaths due to these causes in the Province.

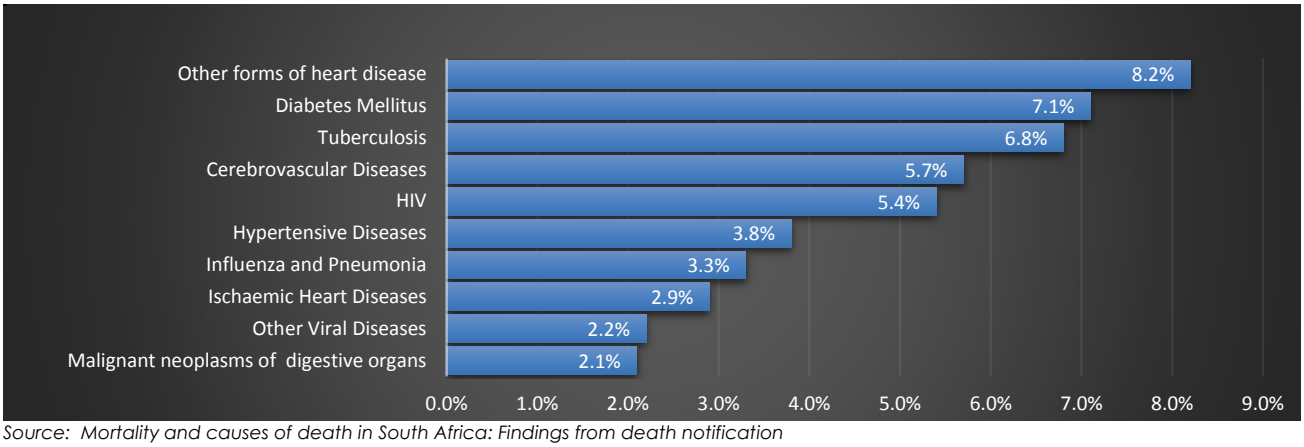
Tuberculosis is the third leading causes of death in KZN and ranks number one as the leading cause of death among men in the 45-64 years age group, causing 10.2% of deaths in this age group. Men more than women in this age group are susceptible to death due to TB as shown in previous studies. TB

mortality has been found to be attributed to smoking and men tend to smoke more than females hence the high TB mortality among men. Moreover, worldwide, men have been shown to be more likely to default their TB treatment leading to death. Among women of the 45-64 years age group, TB was the sixth leading cause of death. This calls for an urgent male-targeted strategy for mitigating the high TB mortality among men in KZN. Diabetes mellitus is the leading cause of death among females in the 45-64 years age group, causing 12.8% of deaths. As shown in previous studies, the prevalence of diabetes is higher among adult women than adult men. Furthermore, comorbidities (especially hypertension) are prevalent in this age group (45-64 years old) causing more deaths especially due to *other forms of heat diseases* which caused 7.6% and 8.8% of deaths among males and females in the same age group.

Non communicable diseases are the most common causes of deaths among adults who are over 65 year old. *Other forms of heart disease* and diabetes were the leading causes of deaths among men (10.9%) and women (13.1%) respectively.

The integrated management of both communicable and non communicable diseases needs to be prioritized in order to reduce the mortality rate in the province. Risk factors such as smoking and low physical activity must be addressed at community level. Poverty remains a risk factor for diseases such as pneumonia and diarrhoea and must be reduced across the province. District-specific concerns such as the high number of deaths among the 15-44 years old group in iLembe district should be investigated further.

Graph 1: The ten leading underlying Natural Causes of Death, KZN 2018



Source: Mortality and causes of death in South Africa: Findings from death notification

A staggering 27.7% of deaths are due to cardio- and cerebrovascular diseases and their risk factors, i.e. "other forms of heart disease", diabetes mellitus, cerebrovascular disease, hypertension, and ischemic heart disease. "Other forms of heart disease" includes congestive heart failure, myocardial infarction, cardiomyopathy etc. The risk factors for these diseases are linked. For example, congestive heart failure often occurs as a result of coronary heart disease, and coronary heart disease is directly linked to hypertension and diabetes. In addition to contributing to cardio- and cerebrovascular deaths, hypertension and diabetes are listed below as causes of death on their own, and are thus critical factors to address in KZN in order to reduce morbidity and mortality.

The increasing prevalence of high blood pressure is connected to rising levels of obesity which affects 68% and 31% in women and men in South Africa respectively (National Department of Health Statistics South Africa, 2016). Similarly, obesity is also a major risk factor for the development of diabetes. To reduce mortality in adults in KZN, the major areas of focus need to be cardio- and cerebrovascular diseases and their risk factors - hypertension and type 2 diabetes mellitus. The best strategies to reduce mortality from these conditions are firstly to prevent them from occurring by implementing programmes that reduce obesity, for example through continuous education and facilitating the adoption of healthy lifestyles by communities. These programmes should take into account the economic status of communities – poorer people may be less able to adopt the healthy lifestyles (including healthy eating patterns) required to prevent and reduce obesity levels. Secondly, the health services provided at primary health care level should focus more on detection and treatment of early disease. Although efforts have been made to detect and treat hypertension and diabetes through the interventions of Community Health Workers, they have not been as successful as hoped, with a significant proportion of patients referred from households not presenting at clinics for confirmation of diagnosis and initiation of treatment (Madela et al 2020). Further efforts around health promotion and health education must be made in this regard.

Communicable diseases remain an important cause of death in KZN. The related infections of HIV and TB caused 5.4% and 6.8% of deaths respectively. KZN has one of the highest prevalence of HIV in the world, and this drives the TB epidemic and may also impact on the incidence and outcomes of other infectious diseases such as pneumonia. It is essential that efforts to detect and treat HIV infection continue. In addition, the contribution of poverty to HIV, TB and other infectious diseases should not be underestimated. Poor nutrition, overcrowding in homes, and lack of water and sanitation facilities continue to contribute to the incidence of infectious diseases in KZN. Addressing these gaps is critical to reducing mortality due to infectious diseases in the province. Vaccination against all infectious diseases remains the most important health systems intervention to reduce mortality due to these pathogens.

MORBIDITY PROFILE

Table 9: Examples of causes of death in each broad cause group

Broad cause group	Examples
Communicable diseases (excluding HIV and TB) maternal, perinatal and nutritional disorders (Comm/Mat/Peri/Nut)	Diarrhoeal diseases Meningitis & encephalitis Maternal conditions Perinatal conditions Nutrition disorders
HIV-related and TB (HIV and TB)	HIV-related Tuberculosis
Non-communicable diseases (NCDs)	Cerebrovascular disease Diabetes mellitus Ischaemic heart disease Cancer
Injuries	Transport injuries Interpersonal violence

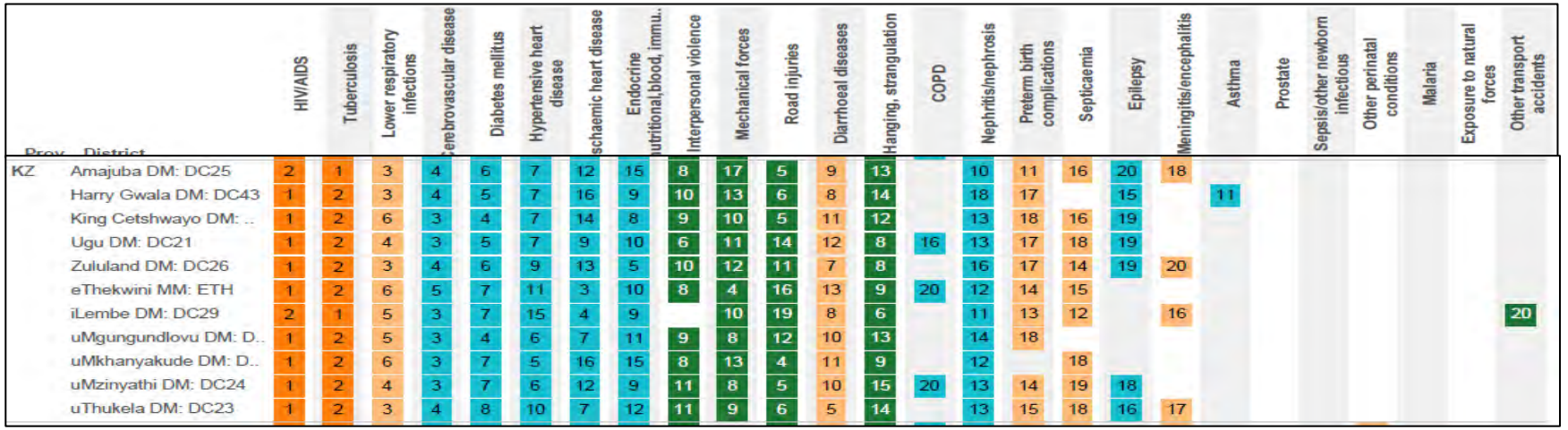
The ICD classification contains a detailed list of causes of mortality that is too extensive for public health use. For this reason, the ICD codes were aggregated according to the National Burden of Disease (NBD) list, which is a condensed list of conditions containing the most prevalent diseases across South Africa, including those of public health importance. The NBD list of causes was aggregated into three broad cause groups, namely communicable diseases together with perinatal, maternal and nutritional conditions (Comm/Mat/Peri/Nutr); non-communicable diseases (NCDs); and injuries, as indicated in the 2000 NBD study (Table 9: Examples of causes of death in each broad cause group). Given the large burden caused by HIV-related deaths, which form part of the communicable disease group, these deaths were separated into a fourth group. Since many HIV deaths are misclassified to tuberculosis (TB), the TB deaths were reported with the HIV deaths.

'Years of life lost (YLL)' is a measure of premature mortality based on the age at death and thus highlights the causes of death that should be targeted for prevention. The number of deaths, age distribution and the seasonal trends for each year were examined and compared for all districts. Rates were calculated using the population estimates from the District Health Information Software (DHIS), based on 2002–2018 district cohort estimates developed by Stats SA (2013).

It is important to note that a large proportion of HIV deaths has been misattributed to immediate causes of death such as TB, diarrhoeal diseases and lower respiratory infections, and that since many injury-related deaths are misclassified to ill-defined intent, the ranking of injury causes may be unreliable.

In 1997, 2007 and 2017, the three leading single causes of YLL's in South aFrica wsere HIV-related conditions, TB and pneumonia, with diarrhoea ranking third and forth respectively in 1997 and 2007, suggesting that HIV-related mortality remains the leading cause of YLL's in the majority of districts in South Africa. Cardiovascular conditions also ranked in the top 10 leading causes and gained more prominence in ranking in 2017, when YLLs ranked fourth for cerbrobascular diseae, fifth for diabetes mellitus, sixth for hypertensive disease and seventh for ischaemic heart disease compared to 1997 when only three of these conditions ranked fifrth, seventh and ninth. Also, in the top 10 leading causes of YLLs across South Africa are interpersonal violence and road injuries, except for 2017 when road injuries were not among the tope 10 leading YLLs (Neethling, Groenewald et al. 2020).

Figure 2: Trends in leading causes of premature mortality at Districts in the KwaZulu-Natal Province between 2010 and 2017



Source: District Health Barometer 2018

Table 10: Provincial Overview In The Trends In Leading Causes Of Premature Mortality Between 2010 And 2017

RANK:	1	2	3	4	5	6	7	8	9	10
KZN	**HIV/AIDS**	**Tuberculosis (TB)**	**Cerebrovascular disease (CVD)**	**Lower respiratory infections (LRI)**	**Diabetes mellitus (DM)**	**Ischaemic heart disease (ISH)**	**Mechanical forces**	**Hypertensive heart disease (HTH)**	**Interpersonal violence (IPV)**	**Road injuries**
	14.8%	10.7%	6.0%	5.5%	4.4%	4.0%	3.8%	3.4%	3.3%	2.9%
Amajuba	TB	HIV	LRI	CVD	Road Injuries	Diabetes	Hypertensive	IPV	Diarrhoea	Nephritis
eThekwini	HIV	TB	Ischaemic heart	Mechanical	CVD	LRI	Diabetes	IPV	Hanging	Endocrine
Harry Gwala	HIV	TB	LRI	CVD	Diabetes	Road Injuries	Hypertensive	Diarrhoea	Endocrine	IPV
iLembe	TB	HIV	CVD	Ischaemic heart	LRI	Hanging	Diabetes	Diarrhoea	Endocrine	Mechanical Forces
King Cetshwayo	HIV	TB	CVD	Diabetes	Road Injuries	LRI	Hypertensive	Endocrine	IPV	Mechanical Forces
Ugu	HIV	TB	CVD	LRI	DM	IPV	Hypertensive	Hanging	Isoschemic	Endocrine
uMgungundlovu	HIV	TB	CVD	Diabetes	LRI	Hypertensive	Isoschemic	Mechanical	IPV	Diarrhoea
uMkhanyakude	HIV	TB	CVD	Road Injuries	Hypertensive	LRI	Diabetes	IPV	Hanging	
uMzinyathi	HIV	TB	CVD	LRI	Road Injuries	Hypertensive	Diabetes	Mechanical	Endocrine	Diarrhoea
uThukela	HIV	TB	LRI	CVD	Diarrhoea	Road Injuries	Ischaemic	Diabetes	Mechanical	Hypertensive

RANK:	1	2	3	4	5	6	7	8	9	10
KZN	**HIV/AIDS**	**Tuberculosis (TB)**	**Cerebrovascular disease (CVD)**	**Lower respiratory infections (LRI)**	**Diabetes mellitus (DM)**	**Ischaemic heart disease (ISH)**	**Mechanical forces**	**Hypertensive heart disease (HTH)**	**Interpersonal violence (IPV)**	**Road injuries**
	14.8%	10.7%	6.0%	5.5%	4.4%	4.0%	3.8%	3.4%	3.3%	2.9%
Zululand	HIV	TB	LRI	CVD	Endocrine	Diabetes	Diarrhoea	Hanging	Hypertensive	IPV

The provincial overview of the trends of the leading causes of premature death between 2010 and 2017. Overall, all Districts were shown to have suffered premature mortality due to HIV and related illnesses such as TB and lower respiratory infections. This is similar to the Provincial profile depicted in Figure 4. Five out of the 11 Districts mirrored the Provincial top three leading causes of premature mortality (HIV, TB and cerebrovascular disease). These were the King Cetshwayo, Ugu , uMgungundlovu, uMkhanyakude and uMzinyathi Districts. The remaining causes of premature mortality at Districts were non-communicable diseases and injuries which is similar to the Provincial profile.

Some Districts such as eThekwini, iLembe, Ugu, uMkhanyakude and Zululand experienced self-harm injuries such as hanging as one of the leading causes of premature mortality which is different to the Provincial profile. Seven of the Districts suffered premature mortality as a result of diarrhoeal diseases, which is in contrast to the Provincial profile. Diarrhoeal diseases, which is a communicable disease, is usually found in children under 5 years. This may be linked to water and sanitation as well as nutrition (https://www.who.int/news-room/fact-sheets/detail/diarrhoeal-disease). Access to adequate sanitation may be poor in urban districts such as uMgungundlovu where the rate of diarrhoeal diseases was high, as well as in rural districts. A high prevalence of diarrhoeal disease may also be due to the high number of people living with HIV (https://www.who.int/news-room/fact-sheets/detail/diarrhoeal-disease).

Other conditions which appear different to the Provincial profile of the leading causes of premature mortality is Nephritis at the Amajuba District and endocrine disorders found at eThekwini, Harry Gwala, iLembe , King Cetshwayo District (KCD), Ugu , uMzinyathi and Zululand Districts.

The rise in hanging injuries, diarrhoeal diseases, and endocrine disorders as leading causes of premature mortality, and needs to be further investigated. These may provide insight into underlying conditions such as mental health, poor nutrition, diet and obesity, high cholesterol, lack of physical activity and may also be indicators of pre-existing diseases.

In summary, whilst the Province has implemented prevention, treatment and care interventions for achieving the UNAIDS 95-95-95 targets and is working towards attaining the Sustainable Development Goals (SDG) that were adopted, the Provincial and District profile of the leading causes of premature mortality show that we are still far from realising the SDG goals. These goals include SDG .3.3 which aims to end the epidemics of Acquired Immune Deficiency Syndrome (AIDS), TB, malaria and neglected tropical diseases and hepatitis, water-borne diseases and other communicable diseases by 2030 (Neethling, Groenewald et al. 2020). Non-communicable conditions and injuries are largely preventable and the Province and Districts need to focus on improving interventions that would decrease the burden of disease. Further investigations are required in the rise of other condition at the District level.

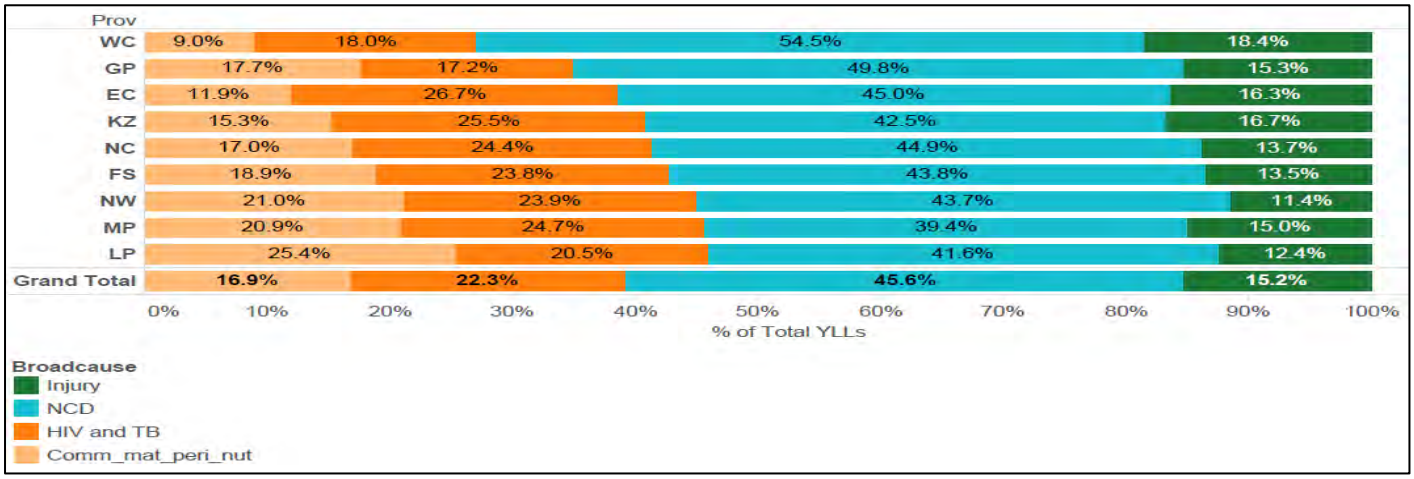
BURDEN OF DISEASE

The overall HIV prevalence rate is estimated at approximately 13,9% among the South African population. The total number of people living with HIV (PLWHIV) is estimated at approximately 8,45 million in 2022. For adults aged 15–49 years, an estimated 19,6% of the population is HIV positive. (Stats SA Midyear Estimates 2022).

In KZN, 5.5% of the population is categorised as disabled, at 583,000 people, the biggest proportion of the country's 2,454,000 disabled people. This is not translating into the number of disabled people accessing health services. By the United Nations Definition, 26.5% of people 60 years and older are disable and 12.1% of persons over 60 years and older are severely disabled. KZN has the least proportion of population 60 years and over when compared nationally.

Figure 3 below provides the National broad cause of years of life lost in 2017. A major proportion of years of life lost is actually due to non-communicable diseases (45.6%) followed by HIV and TB (22.3%). This was followed by communicable, maternal, perinatal and nutrition (16.9%) and injuries (15.2%). The KZN profile showed a similar trend in the years of life lost.

Figure 3: Percentage of years of life lost by broad cause by province, 2017

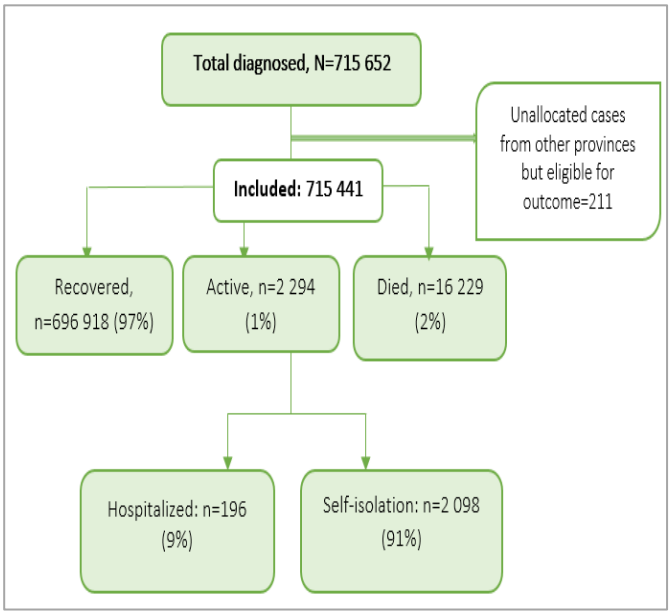


Source: Neethling, Groenewald et al, 2020

IMPACT OF COVID-19 AS AT 30TH JUNE 2022

The influence and impact of COVID-19 is declining over the reporting period. KZN ranks 2nd highest in terms of number of confirmed cases nationally, contributing 18% totward the total burde. As at 30th June 2022, the 7 Day moving average has declined (127 – 82 / day). In terms of fatalities, KZN is the 4th highest nationally, following the Eastern Cape, Gauteng and the Western Cape, and contributes about 16% of the total deaths country wide. The number of daily hospitalisations is declining both in the public and private sectors.

Figure 4: Summary of laboratory confirmed cases, KZN (5th March 2020 to 30th June 2022)



Source: KZN DoH COVID-19 Data Collection Tools

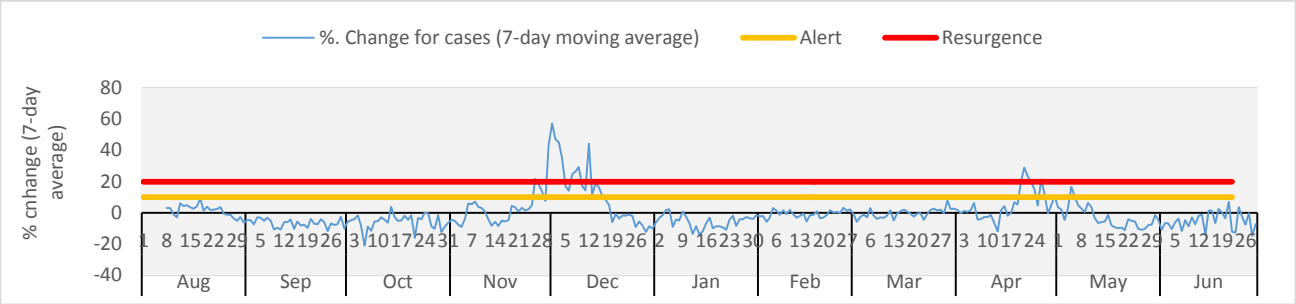
Table 11: Distribution of cases and COVID-19 deaths by district, KwaZulu-Natal, 5 Mar 2020–30 Jun 2022

District	New cases	%. New cases	Total cases	%.Total cases	New deaths	Total deaths	%. Total deaths	Case Fatality rate (%)
Amajuba	2	4 3%	27 649	3 9%	0	1 093	6 7%	4 0%
eThekwini	24	51 1%	350 966	49 0%	1	5 682	35 0%	1 6%
Harry Gwala	3	6 4%	15 978	2 2%	0	583	3 6%	3 6%
iLembe	0	0 0%	43 056	6 0%	0	851	5 2%	2 0%
King Cetshwayo	4	8 5%	54 049	7 6%	0	1 468	9 0%	2 7%
Ugu	5	10 6%	35 167	4 9%	0	999	6 2%	2 8%
uMgungundlovu	5	10 6%	83 602	11 7%	0	2 224	13 7%	2 7%
uMkhanyakude	1	2 1%	22 218	3 1%	0	773	4 8%	3 5%
uMzinyathi	1	2 1%	17 772	2 5%	0	869	5 4%	4 9%
uThukela	0	0 0%	31 729	4 4%	0	981	6 0%	3 1%
Zululand	2	4 3%	29 116	4 1%	0	696	4 3%	2 4%
Unallocated	0	0 0%	4 350	0 6%	0	10	0 1%	0 2%
Total	**47**	**100%**	**715 652**	**100%**	**1**	**16 229**	**100%**	**2 3%**

***NB: Due to transfer in and out of patients, some patients demise in the districts they were transferred to, contributing to a change in the number of deaths by the district after reallocation.**

Source: KZN DoH COVID-19 Data Collection Tools

Graph 2: Resurgence monitoring using percentage change, KwaZulu-Natal, 1 Aug-30 Jun 2022



KZN continues to observe a fluctuation in the number of daily cases. With the 47 cases received on 30 June 2022, the resurgence monitoring line dropped below the Zero threshold. On 30 June 2022, KZN had 196 patients admitted to the public (n=46, 23%) and private (n=150, 77%) hospitals. Of those admitted, 31 patients (16%) required intensive care services in private (n=25, 80%) and public (n=6, 20%) sectors. Among those who required intensive care, (n=8, 26%) were ventilated.

Operational bed occupancy status, public sector: Of the total available COVID-19 dedicated isolation beds (n=2 905), 2% were occupied. Of the total ICU beds (n=106) allocated in the public sector, 5% were occupied. These are according to the number of beds reported at the provincial level as of 30 Jun 2022.

Table 12: Operational bed status for COVID-19 patients, public sector, KwaZulu-Natal, 30 Jun 2022

District	Isolation beds						ICU beds		
	Total beds	Occupied (n)	%. Occupied	New admissions	Oxygenated (n)	% Oxygenated	Total beds	Occupied (n)	%. Occupied
Amajuba	189	0	0%	0	0	0%	19	0	0%
eThekwini	1,322	9	1%	0	3	28%	40	2	8%
Harry Gwala	109	1	2%	0	0	50%	0	0	0%
iLembe	177	6	2%	0	1	0%	6	0	0%
King Cetshwayo	189	6	3%	2	2	0%	16	3	13%
Ugu	121	3	1%	0	0	100%	4	0	0%
uMgungundlovu	277	5	5%	1	0	54%	15	0	0%
uMkhanyakude	119	5	2%	0	0	0%	0	0	0%
uMzinyathi	171	5	6%	0	0	18%	0	0	0%
uThukela	62	3	16%	0	1	20%	6	0	0%
Zululand	169	3	1%	0	0	100%	0	0	0%
Total	**2,905**	**46**	**2%**	**3**	**7**	**28%**	**106**	**5**	**5%**

Source: KZN DoH COVID-19 Data Collection Tools

Table 13: Total cases and recoveries by district, KwaZulu-Natal, 5 Mar 2020–30 Jun 2022

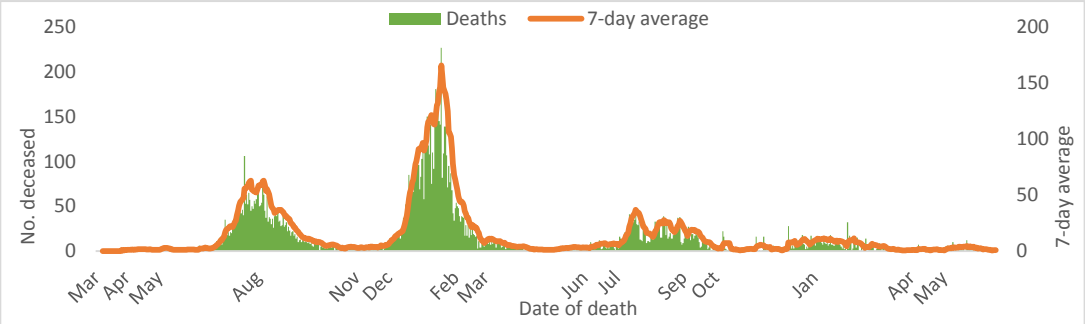
District	Total cases	Active cases		Deaths		Recoveries	
		no. active	%. active	no. deaths	%. deaths	no. recovered	%. Recoveries
Amajuba	27 649	6	0 0%	1 093	4 0%	26 550	96 0%
eThekwini	350 966	270	0 1%	5 682	1 6%	345 014	98 3%
Harry Gwala	15 978	511	3 2%	583	3 6%	14 884	93 2%
iLembe	43 056	707	1 6%	851	2 0%	41 498	96 4%
King Cetshwayo	54 049	28	0 1%	1 468	2 7%	52 553	97 2%
Ugu	34 956	272	0 8%	999	2 9%	33 685	96 4%
uMgungundlovu	83 602	193	0 2%	2 224	2 7%	81 185	97 1%
uMkhanyakude	22 218	22	0 1%	773	3 5%	21 423	96 4%
uMzinyathi	17 772	31	0 2%	869	4 9%	16 872	94 9%
uThukela	31 729	85	0 3%	981	3 1%	30 663	96 6%
Zululand	29 116	46	0 2%	696	2 4%	28 374	97 5%
Unallocated	4 350	123	2 8%	10	0 2%	4 217	96 9%
Total	**715 441**	**2 294**	**0 3%**	**16 229**	**2 3%**	**696 918**	**97 4%**
*** Ugu: 211 cases from Eastern Cape removed from calculating recoveries; *Patients unallocated but eligible for the outcome (inactive)**							

Source: KZN DoH COVID-19 Data Collection Tools

The overall proportion of recoveries for the province is 97% (n=696,918). The proportion of recoveries in all the districts is above 90% The Province has had a total of 16,229 deaths (case fatality rate: 2.3%) since the beginning of the pandemic.

Within the province, eThekwini Metro Municipality continues to contribute 35% of the reported deaths (n=5 682). The median age for the deaths was 66 years (range 0-105). Of the total deaths, 10,703 (66%) had comorbidities.

Graph 3: Deaths and 7-day moving average by date of death, KwaZulu-Natal, 28 Mar 2020-30 Jun 2022



Source: KZN DoH COVID-19 Data Collection Tools

Table 14: Vaccination status, 30 Jun 2022

Report Date: 30 June 2022		Number of Sites Open Today: 363	Total Vaccinations Done Today:		3 499
Target Group	Target	Today's (1st Dose) Vaccinations	Total Registered/ Vaccinated	Percentage	Balance still to be vaccinated
Total HCW Vaccinated	162142	0	146 859	91	15 283
60yrs + Vaccinated	955048	23	643 516	67	311 532
50-59yrs Vaccinated	808 981	80	490 190	61	318 791
35 – 49yrs vaccinated	2 022 619	215	964 724	48	1 057 895
18-34yrs Vaccinated	3 433 147	532	1 073 972	31	2 359 175
12 - 17yrs Vaccinated	1 305 712	128	314 610	24	991 102
Total Public & Private 1st Dose	7 219 795	1 049	**3 172 402**	**43,94**	**4 047 393**
Total Fully Vaccinated	7 219 795		**2 863 698**	**39,66**	**4 356 097**
Total Partially Vaccinated	7 219 795		**308 704**	**4,28**	
Total Received a Booster Dose	2 863 698		**516 054**	**18,02**	
Total Vaccinations done to date 1st & 2nd Doses			**5 760 199**		

NB: Please note that the private sector is not included in the daily age group vaccinations above and the actual age group daily vaccination coverage is higher than detailed in this report. A more comprehensive report is released weekly. However, the total EVDS registered/ Vaccinated are a true reflection of latest data, including the private sector as per the National Vaccination Dashboard & EVDS. The booster doses include both Sisonke and the National Vaccination program doses.

Source: KZN DoH COVID-19 Data Collection Tools

IMPACT OF THE KZN APRIL 2022 FLOODS

As at Septembr 2022, there was approximately R 185 089 654 worth of damage to health infrastructure that unfolded through the KZN Floods in 2022. Implementation of the flood damage recovery projects are ongoing. Progress to date can be summarized as 14 completed projects, 24 projects still in construction phase, 40 projects at tender documentation stage, 1 in design, 1 in planning and one has been cancelled giving a total of 82 projects undertaken in response to the flood damage. Some construction projects that are in the planning and design stage have complex design issues that require consutlants to be appointed prior to proceeding. This includes Fort Napier Hospital which falls under the Amafa Heritage Framework and Goodwins Clinic which requires structural integrity evaluation. Public works is currently appointing consultants. KwaMsane Clinic project was cancelled as damages fall within the day to day maintenance budget.

The second approach is quarterly progress reports on the Environmental health Interventions employed during the floods. The Joint Operations Committee (JOC) meetings were initially held once a week, however these have since been reduced to one a month with reports presented at the Provinical Joint Commtitee Meetings.

The last approach was the Disaster Management Workshops planned from 1st September 2022 to all health care facilities. This 2 Day diseaster management workshop has been conducted for 3 of the districts being Amajuba, uThukela and uMzinyathi. Workshops for the remaining districts are on track to be completed by the end of the financial year.

Stakeholders of the KwaZulu-Natal Department of Health

Apart from the uninsured population that features as the main stakeholder of the KZN DOH, the Service Charter provides a list of the stakeholders and the channels used to engage with them. The information is housed in the table below:

Table 15: Stakeholders and consultation from the KZN DoH Service Charter 2022/23

Customer and Stake holder	Influence	Interest	Linkages with other stakeholders	Consultation Mechanism
Citizens/Patients	Low	High	Direct recipient of public health services	Sectoral Parliaments (Youth, Women, Workers, Disability, Elderly Persons, amongst others) Taking Legislature to the people Oversight visits by the Health Portfolio Committee and Legislature Hospital Boards & Clinic Committees Ombudsperson Community consultations Community events and Health Programmes Provincial health Operations centre Public relations Network Provincial health Consultative Forum Meetings, Forums and other platforms
Departmental Personnel	Low	High	Instrumental in providing public health services to the public	Meetings and Forums Circulars/ Directives and Newsletters Internet & Intranet Brochures and Leaflets Staff Focused Events Employee Wellness programmes
External Stakeholders				
Tertiary Academic Institutions	Low	High	Generating knowledge for all sectors of society. They prepare students for employment.	• Meetings • Forums • Written and formal communications • Formal hearings/ presentations • Internet & intranet • Tele - & video conferencing & Skype for business • Various inter – Governmental Forums • Provincial Consultative Health Forum (PCHF) • Provincial Health Council (PHC) meetings
Non-Governmental Organisations (NGO's), Faith Based Organisations (FBO's), and Church Based Organisations (CBO's)	Low	High	Participate in planning and implementation of the NDP	
Traditional Health Practitioners	Low	Low	Provides alternative health services to the general public	
Other National and Provincial departments	High	High	Key players in legislative and regulatory environment	
Mayors and other Local Government	High	High	Key players in legislative and regulatory environment	
Provincial Legislature	High	High	Approval of policy documents and plans	
Traditional Healers	Low	Low	Alternative healers operating within the same public space	
Office of Health Standard Compliance (OHSC)	High	High	Oversight body for compliance of health standards	
Private Sector Organisations	Low	High	Provision of capital and employment opportunities through partnerships and investment	
Office of the Auditor General	High	High	Audit role on compliance with legislation	
Health Portfolio Committee	High	High	Approval of policy documents and plans	
Finance Portfolio Committee	High	High	Approval of policy documents and plans	
Standing Committee on Public	High	High	Approval of policy documents and plans	

Customer and Stake holder	Influence	Interest	Linkages with other stakeholders	Consultation Mechanism
Accounts				
Suppliers and Service Providers	Low	Low	Providers of services and supplies	
Organised Labour	High	High	Main negotiators of working conditions and terms of employment between employers and employees	
Civil Society	High	High	Participates in planning and implementation of the NDP. Holds government and the private sector accountable	

Vulnerable Key Populations

Operation Sukuma Sakhe

The provincial government launched the "war on poverty" campaign in response to the National campaign as unpacked in the 2008 State of the Nation Address. In KwaZulu-Natal, the campaign was launched in three presidential nodal areas. In April 2011, the programme was relaunched as Operation Sukuma Sakhe. The top five priorities of the provincial government embedded in the service delivery model of Sukuma Sakhe: rural development /agrarian reform and food security; creating decent work and economic growth; fighting crime; education; and health.

According to the Sukuma Sakhe implementation model document, the desired outcome of the service delivery model is "the implementation of a comprehensive, efficient, effective, quality service delivery system that contributes to a self-reliant society in a sustainable manner".

Gender Based Violence and Femicide (GBVF)

Gender mainstreaming ensures that women are equitably represented within the Department and focuses on 4 main areas namely 1) Economic Empowerment, 2) Equitable employment, 3) Policy reviews to incorporate gender and 4) Internship Progammes. The Department has 48.8% of women in Senior Management Services with 707 (30%) female interns employed for 22/23. Systems to monitor economic empowerment are being developed to monitor the percentage of contracts and tenders awarded to women owned companies, as the system is currently manual based. Fourteen percent (14%) of the Goods and Services budget was for procurement from female suppliers equating at R 632 863 580. Suppliers with disabilities accounted for 0.26% of the quarterly Goods and Services budget at R 11 264 305.

The core function for health with regards to Gender Based Violence and Femicide is centered around the care provided to victims and the correct procedure for the collection of specimens for prosecution of offenders. Care is provided through the 10 TTC's with an 11th due for opening during 22/23. Thutuzela Care Centres (TCC's) are managed under the hospitals and the department ensures that forensic medicine governance is in place to avoid secondary victimisation. This includes how children are handled within these centres and to ensure that the evidence collected will be able to be used in court to allow for a successful prosecution.

Forensic nurse training is instrumental in ensuring that nurses will be able to assist doctors to cope with the work load in causality, are able to collect samples correctly and are qualified to testify in court. In 2021, the Forensic Nurse Training was approved by South African Nursing Council (SANC) which enhanced the nurses credibility to testify in court. The Department is in the process of identifying the most suitable service provider to provide the training.

Post care for the victims is provided with HIV prophylaxis's, prevention of pregnancy and comfort packs. Advocacy campaigns are conducted with various Non-Government Organisations (NGO's) improve quick reporting by victims to institutions to allow for the collection of evidence.

The Department is developing a Forensic Medicine Strategy and Implementation Plan as a response to Gender Based Violence and femicide with particular focus on children who are the most affected. The strategy will focus on access to care, reducing morbidity and mortality related to GBV and improving the patients experience of care.

Military Veteran's Health

The Military Veterans programme is housed under the non-communicable diseases component in the KZN Department of Health. The 23/24 plans are pending the finalisation of the Provincial Plans, under development by the Office of The Premier (OTP) Military Veterans Unit. Once the Provincial Military Veterans plan is drafted through OTP, it will be shared with Departments to input and will then be approved for implementation.

Farm Workers and Farm Dwellers

The KZN department has embarked on provision of integrated outreach health services in communities where the vulnerable groups can be reached. Farm dwellers/workers are reached through COVID-19 vaccination campaigns in selected districts.

Service Delivery Improvement

The review of the complaints lodged against the Department was conducted as the basis for identifying services to be included in the Service Delivery Improvement Plan (SDIP). Hospital Services were selected as a key service based on the fact that they had more complaints reported than Primary Health Care Services[3].

The biggest proportion of complaints for hospital services arose from the patient care category and this informed the selection of patient care as the key service that the department will focus on during the SDIP period.

The district hospital complaints on patient care comprises 56 percent of all hospital complaints on patient care. This guided the final selection of the key service for the SDIP which is provision of district hospital services.

The analysis of details of district hospital patient care complaints revealed that 85% of the patient complaints came from the top ten[4] in the list of 22 subcategories. These include: Service issues, Skills and conduct, Environment, Safety incidents, Quality of care, Access and admission, Staffing and resources, Delays, Treatment, and Respect dignity and caring.

7. INTERNAL ENVIRONMENT ANALYSIS

Service Delivery Platform / Public Health Facilities

Table 16: Health facilities per District, KZN,

District	Primary Health Care			Hospitals							
	Mobiles	Fixed Clinics[5]	Community Health Centres	District	Regional	Tertiary	Central	Specialised TB	Specialised Other	Specialised Psych	Chronic / Sub-Acute
Amajuba	8	24	1	1	2	0	0	0	0	0	0
eThekwini	21	105	8	4	6	1	1	0	1	1	2
Harry Gwala	15	38	2	4	0	0	0	0	0	1	0
iLembe	11	34	2	3	1	0	0	0	0	0	0
King Cetshwayo	16	63	1	6	1	1	0	0	0	0	0
Ugu	16	52	2	3	1	0	0	0	0	0	0
uMgungundlovu	16	50	3	2	1	1	0	1	0	3	0
uMkhanyakude	20	58	1	5	0	0	0	0	0	0	0
uMzinyathi	13	53	1	4	0	0	0	1	0	0	0
uThukela	14	36	1	2	1	0	0	0	0	0	0
Zululand	23	74	1	5	0	0	0	1	0	1	0
KZN Total	**173**	**587**	**23**	**39**	**13**	**3**	**1**	**3**	**1**	**6**	**2**

Source: DHIS Quarter 4 of 2021/22

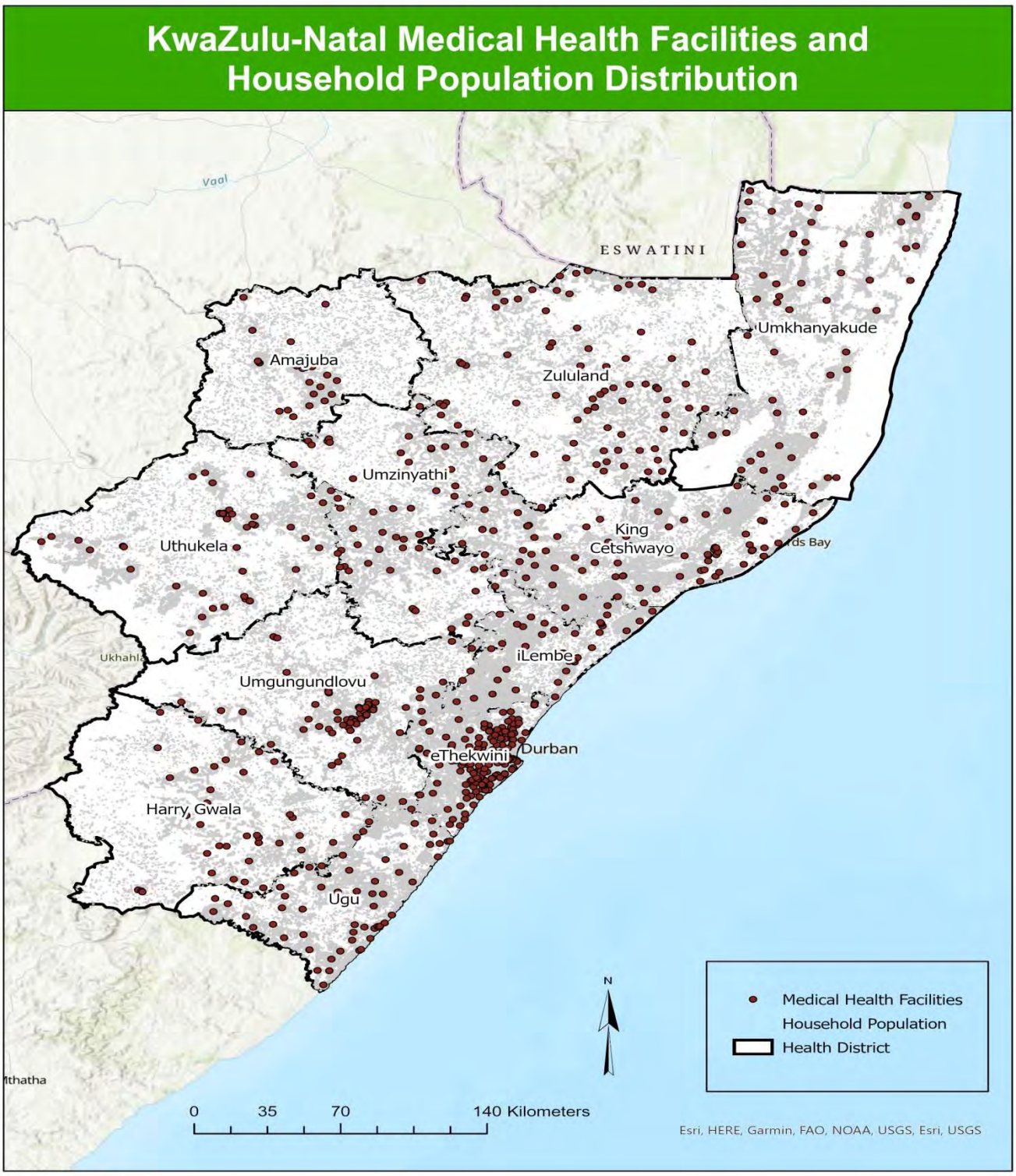
[3] Ideal Clinic Monitoring system used as source information system and it includes only hospital and primary health care services

[4] Top ten in terms of frequency during analysis

[5] Provincial and Local Authority

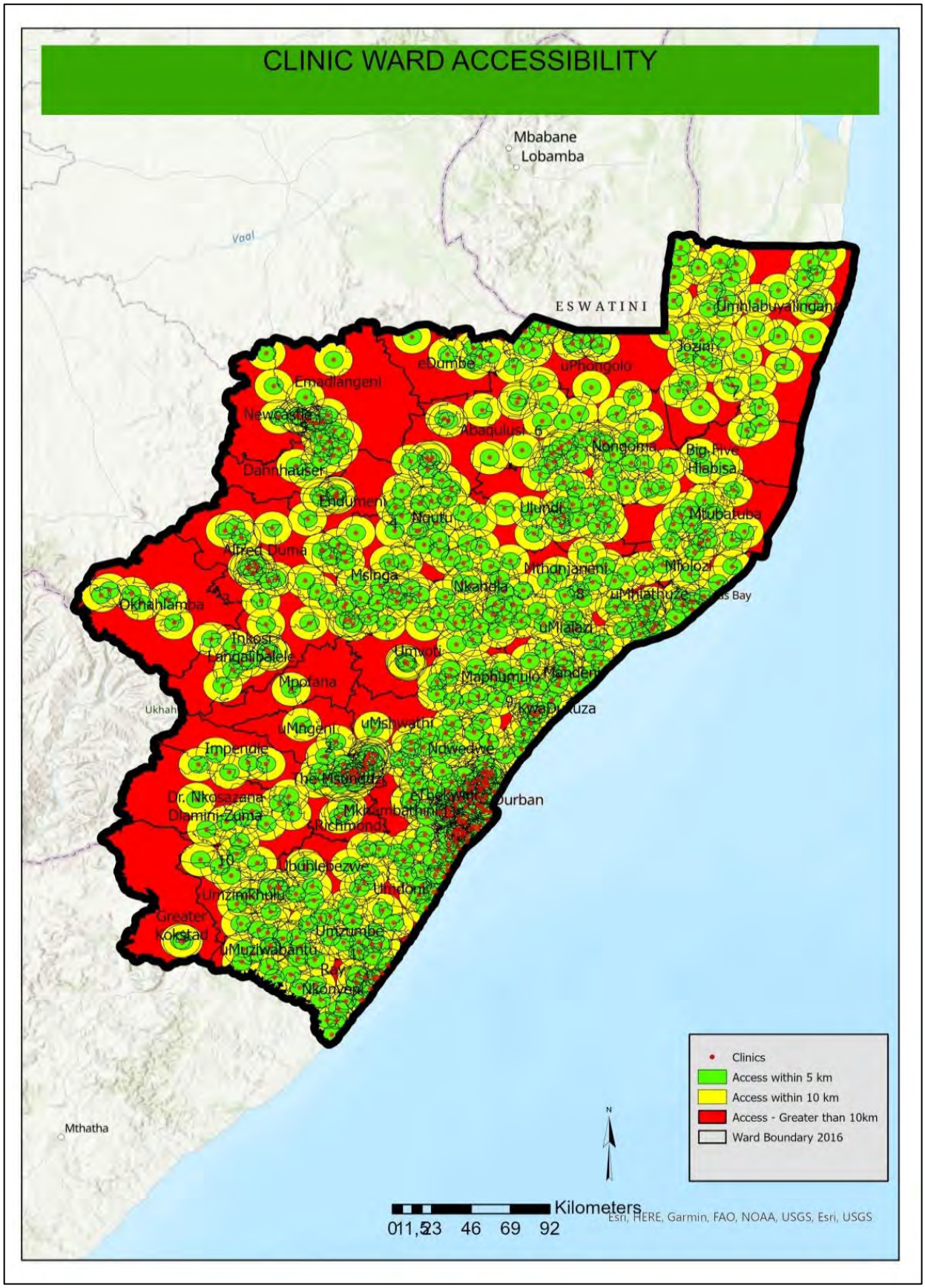
The following map details the relationship between the health facilities in respect to their location from the communities. This highlights where there are gaps in services delivery with regards to the provision of fixed PHC health facilities, and mobile services need to be engaged.

Map 4: Service Delivery Platform



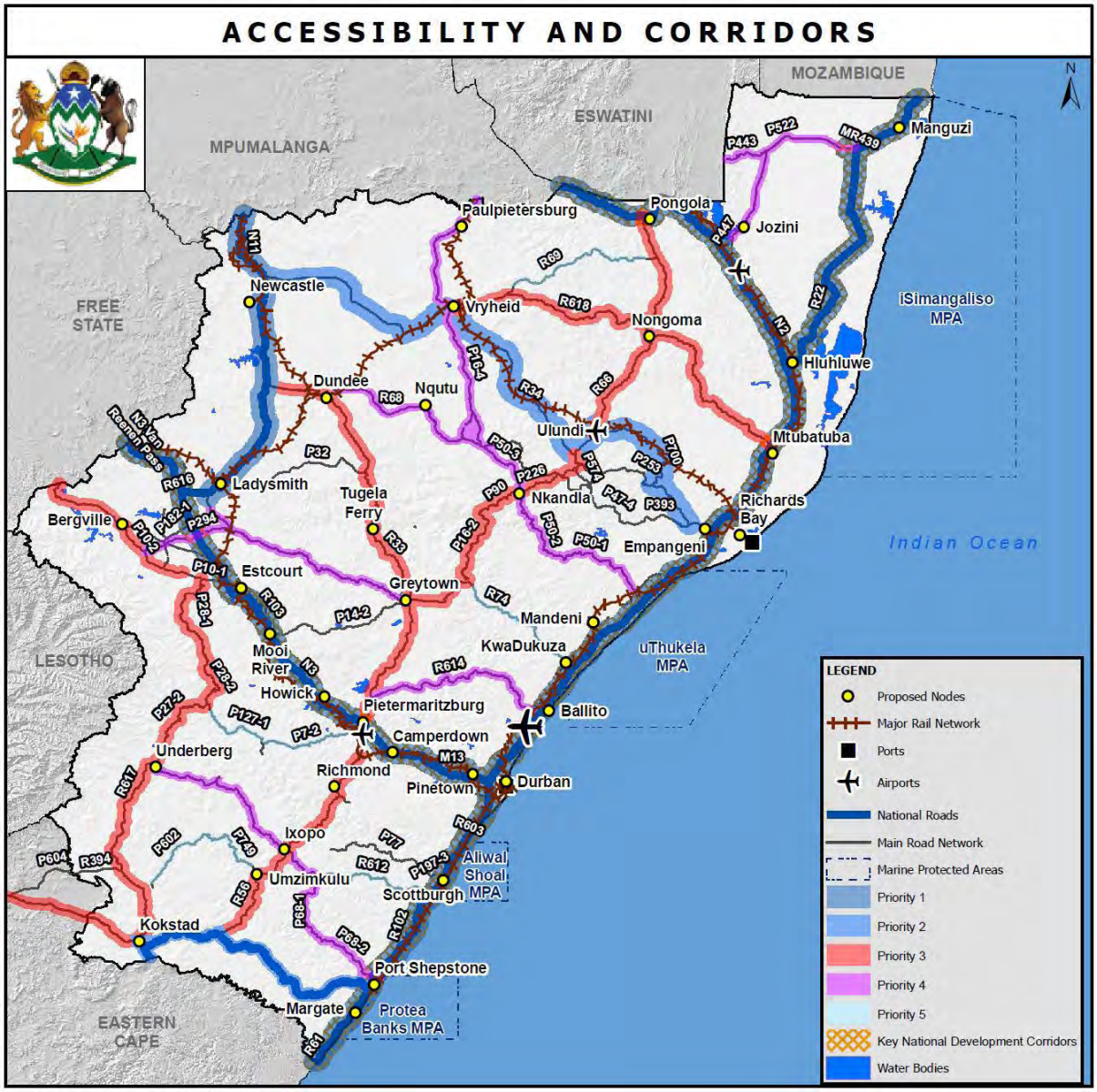
Source: KZN Geographical Information Sysems (GIS)

Map 5: Map showing accessibility of PHC services



Source: KZN Geographical Information Sysems (GIS)

Map 6: Accessibility and Corridors



Source: KZN Spatial Development Framework – February 2022

Service Coverage Gaps

The map above is from the KZN Spatial Development Framework and identifies regional centers earmarked for future development by the Province, to expand and grow both economically and in terms of social justice including access to health services.

There are 4 districts that do not have a regional hospital within their borders, and as such, access to Level 2 health services is compromised. The Department has identified district hospitals located within the regional development centres identified by the KZN Spatial Development Framework, for upgrading to regional hospitals. These include Dundee Hospital (uMzinyathi District), Christ the King Hospital (Harry Gwala District), Bethesda Hospital (uMkhanyakude District) and Vryheid Hospital (Zululand District) to be converted to regional hospitals to ensure equity in accessibility of level 2 services.

Up north, access to level 3 services is severely compromised, and as such a tertiary hospital has been proposed for this part of KZN at Empangeni / Richard's Bay area. This is an economic hub of the KZN and as such is growing at a faster rate due to rural / urban migration trends and the availability of jobs in this area.

OUTCOME: UNIVERSAL HEALTH COVERAGE

Under this Outcome, challenges with regards to the service delivery platform will be discussed, along with other indicators that relate to the universal accessibility of services including EMS, HR and NHI.

The South African health system is characterized by several challenges including the high cost drivers in the public sector, fragmentation of funding pools, and poor access to quality health services. The medical sins (overstocking of medication, theft and incineration, and moonlighting) continue to be a challenge in a financially constrained environment. Combined with poor access to quality emergency medical services, overspending and a skills workplace mix that is not always conducive to providing efficient and effective health care services, all contribute to placing pressure on existing resources. Vulnerable groups are also prioritised in terms of accessibility of services, under this outcome.

The Universal Health Coverage (UHC) service index is low at 59% (21/22), compared to the five year target of 73.5%. This is due to targets in the tracer indicators not being met. The high volume of medical claims and the backlog on court proceedings resulted in an increase in contingent liability of medico-legal cases for 21/22 to R 27.8 billion, pushing the performance further away from the original 24/25 target of R 32 billion. Non-compliance to the non-negotiable vital elements in certain sub-domains, contained within the Ideal Clinic Framework, resulted in the 28.2% actual performance on the percentage of facilities certified by Office of the Health Standards Compliance (OHSC). The percentages of PHC facilities with functional clinic committees and hospitals with functional hospital boards decreased from the baselines due to expired membership and is at 22.7% and 50%, respectively against the 100% targets. Four hundred and Five Professional nurses (PNs) and 100 medical officers were employed which increased staff to population ratios.. The increases in the staffing numbers, is attributed to employment of additional nurses for COVID-19 purposes and allocation of additional Community Service Practitioners and Medical Interns (As at 2022/23).

In 20/21, 104 General Practitioners (GPs) were contracted as part of the NHI programme. Challenges were experienced regarding the placement and retaining of GP's due to the rural nature of part of KZN. The Department plans on maintaining the number of GP's at 130 for the 5 year period due to budget constraints.

In 19/20, 7,934,794 clients were registered on Health Patient Registration System (HPRS) as part of the NHI's initiatives. In 21/22, the number of patients registered increased to 11,445,107 however duplications on the system due to facilities working offline could be contributing to the inflated figure.

Budgetary constraints resulted in lower than expected number of Community Health Workers contracted into the health system at 10,245 CHW's (21/22). The status quo will be maintained going forward into the next planning cycle.

Unavailability of computer equipment caused delays in the roll-out of the E-health System to identified facilities. The percentage of hospitals with a stable Information Communication technology (ICT) connectivity increased from 58 hospitals (20/21 to 63 (21/22). The percentage of PHC facilities with a stable ICT connectivity remained at 80%, 11.2% lower than the 21/22 target. The underperformance is attributed to State Information Technology Agency (SITA) delays in upgrading internet bandwidth.

Emergency Medical Services (EMS) operates at the frontline of the health service system and therefore has a direct impact on the patient outcome due to accessibility of treatment in an emergency situation.

In 21/22 the percentage of response times to red codes (P1) within 30 minutes for urban areas was 42.9% and the percentage of response times to red codes (P1) within 60 minutes for rural areas was 51.1%. In 21/22, the total number of EMS clients was 494,071 and the number of inter-facility transfers was 164,218. The population per scheduled operational ambulance is currently 1 ambulance per 61,820 capita as opposed to the national norm of 1 ambulance per 10,000 population. This gap places pressure on the delivery of services. A further 767 operational ambulances are required in KZN in order to meet the national norms. The average number of daily operational ambulances during 21/22 was 196, which equates to 20% of the required number of ambulances, as per National norms.

Response times are not only determined by the number of operational ambulances available but also by influencing factors like staffing, terrain, road infrastructure, demand / case load, rural /deep rural areas where road names and house numbers do not exist as well as weather conditions.

In addition, to the operational ambulances required to actively provide the service, pool ambulances are required in order to cater for scheduled maintenance, vehicle repairs, accident damage repairs and routine disinfecting and spring cleaning of ambulances.

Factors that contribute to poor response times can be broadly categorized :

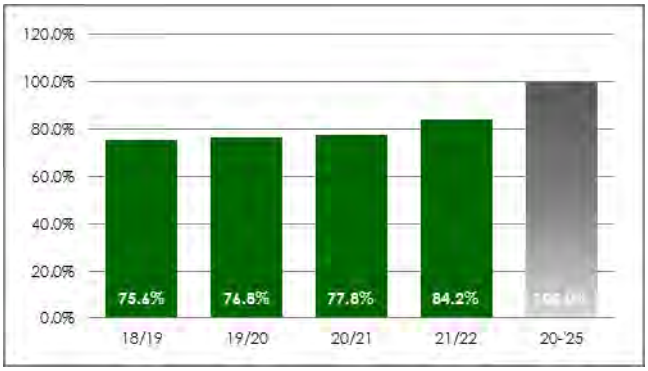
- Unclear or incomplete information from caller resulting in call delays (e.g. incorrect address)
- Communication challenges
- Discrepancies on boundaries
- Insufficient resources for workload (vehicles and staff)
- Traffic congestion

There were no bursaries awarded to first year health professions students and nurses trained on Post Graduate Nurse Specialist Programmes in 21/22 due to financial constraints and the KZN College of Nursing not being accredited by the South African Nursing Council and Council on Higher Education to offer the Post Graduate Nurse Specialist Programmes, respectively. The number of officials training through the EMS College dropped from 6,175 in 20/21 to 5,395 in 21/22.

Inadequate human resources and equipment resulted in an increase in percentage of facilities reporting clean linen stock outs. The percentage of pharmacies with either Grade A or Grade B Status with the South African Pharmacy Council (SAPC) decreased from 97.8% in 20/21 to 92% in 21/22. Some of the challenges included unavailability of equipment, reference material and infrastructural limitations. The Tracer Medicine Stock-Out rate at the Provincial Pharmaceutical Supply Depot (PPSD) decreased by 25% between 20/21 and 21/22 despite the supply constraints due to suppliers not being able to meet the demand. These constraints subsequently led to an increase in facility stock out rates.

An increase in percentage of preventative maintenance expenditure from 30% in 20/21 to 37.1% in 21/22 was reported. The number of new and replacement projects completed increased by 57% between 20/21 and 21/22 and the target was not met due to, among other things, slow implementation of projects by the implementing agent.

Graph 4: Ideal Clinic Status Obtained Rate (

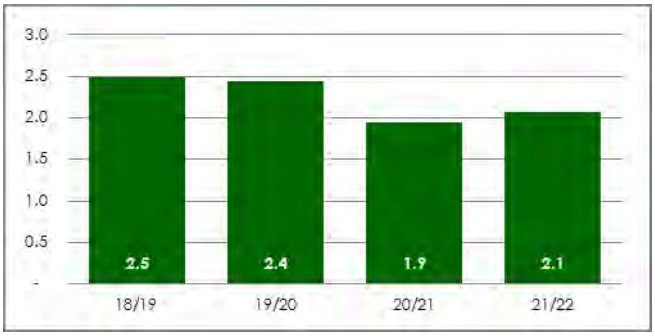


Source: Ideal Health Facility Software

Accessibility of *quality* primary health care services remains a cornerstone of PHC re-engineering and the basis of a community-centered approach to providing health services. PHC Utilisation Rate, PHC Utilisation Rate Under 5 Years, and Cost per PHC headcount are indicators that relate to the efficient and effective utilization of resources and allow for increased / improved access to health services.

The Ideal Clinic programme in KZN, has reached a point where the current status quo needs to be maintained. When the KZN Department of Health took over municipal health services, there were many clinics in town centres that did not meet the Ideal Clinic Infrastructure requirements, for the 3 streams (Acute, Chronic and MCWH). Some of these clinics are strategically located, emphasized by their high workload, and cannot be easily relocated. The rental agreements on these properties does not allow for structural change, or for the Department to provide preventative or capital maintenance. Until suitable replacement facilities can be purchased to house these clinics, these clinics will remain uncompliant. This situation will be further exacerbated, as the Department is in discussions to take over the 59 Local Government clinics in eThekwini in 22/23.

Graph 5: PHC Utilisation Rate



Source: DHIS

The PHC headcount has decreased by 16.2% (21/22) from the baseline year of 18/19. This equates to a drop of 4,619,251 actual patient visits, attributed to the restrictions implemented because of the COVID-19 pandemic. Between 20/21 and 21/22, there was an increase of 4.8% (1, 096,231) in actual patient headcount. If taken into consideration with the Community Outreach services, this equates to an utilisation rate of 3 annual PHC visits, per capita for the 21/22 [6].

The biggest increase for PHC headcount, between 20/21 and 21/22 is in the age group 5 – 9 years at 12.2% (101,165 increased headcount). The under 5 PHC headcount has also increased by 403,297 patient headcount (10.8%). The smallest

[6] 23,906,112 PHC headcount + 10,524,511 Community Outreach headcount = 34,430,623 / 11 563 185

increase in headcount, was in the 20 years and older age group, at 2.6% or 450,711 PHC headcounts.

uMkhanyakude, is the district with the highest PHC utilisation rate based on a PHC headcount of 2,055,081. Harry Gwala has the lowest PHC Headcount at 1, 018, 407.

It was expected that with the decrease in PHC Headcount numbers, the OPD Not referred new cases would increase, however this trend did not materialise, with a 20.5% (151,449) decrease seen in the OPD Not referred new between 21/22 and the baseline (18/19), again assumed due to COVID-19 and the restrictions.

Graph 6: PHC Utilisation Rate Under 5 Years

Source: DHIS

The Under 5 utilisation rate has increased, proportionally with the increase in the PHC Headcount and the return of patients into public health facilities following the COVID-19 pandemic.

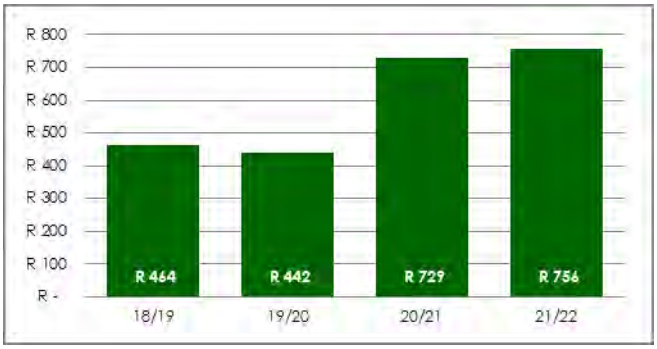
The recommended PHC utilisation rate for under 5 years, by the NDoH, is 5 visits per year. If this norm was applied, the PHC headcount for under 5 years would need to increase to 6,240,480 visits per annum. Currently, the audited data reflects 3,743,054, which is 60%[7] of the targeted headcount. Should the Community Outreach Services (COS) figure be included as well, this would mean an increase to 89% [8].

The increase in the Cost per PHC headcount is directly attributed to the drop in PHC headcount and an increase above the Consuer Prince index for expenditure, both due to COVID-19. The increase in the expenditure is directly attributed to the increase in Personal Protective Equipment and the increase in drug prices relating to the pandemic.

Compensation of Employees (CoE) remains the cost driver at a PHC level with approximately 65% of all current costs attributed to CoE. It is therefore essential that the skills mix at this level is correct, and that nurses function within their scope of practice.

uMkhanyakude continues to exhibit strong PHC health seeking behaviour with a PHC utilisation rate of 3, and an under 5 PHC utilisation rate of 4.3 vists per annum. When viewed in conjunction with COS, this is further enhanced.

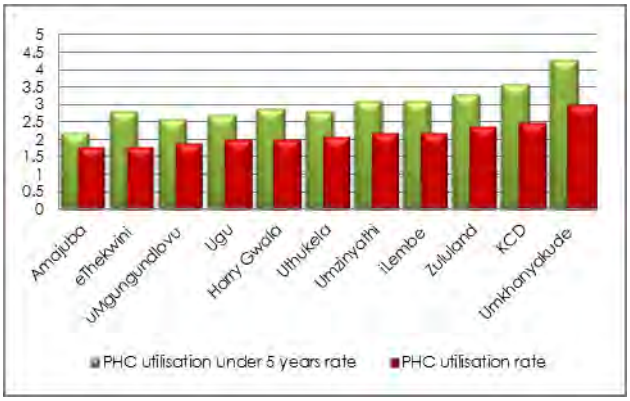
Graph 7: Expenditure per PHC Headcount – 21/22



Source: DHIS

This positive PHC health seeking behaviour could be attributed to the topography in the district (very flat sandy coastal belt interspersed with lagoons and other large bodies of water, with a mountainous interior climbing towards the Highveld), poor condition of the roads, the high socio-economic poverty in the district and the distance between facilities. The indigent population does not have the disposable income, nor transport means to travel the vast distances to the nearest hospital.

Graph 8: PHC utilisation rate and PHC utilisation rate under 5 years per district – 21/22



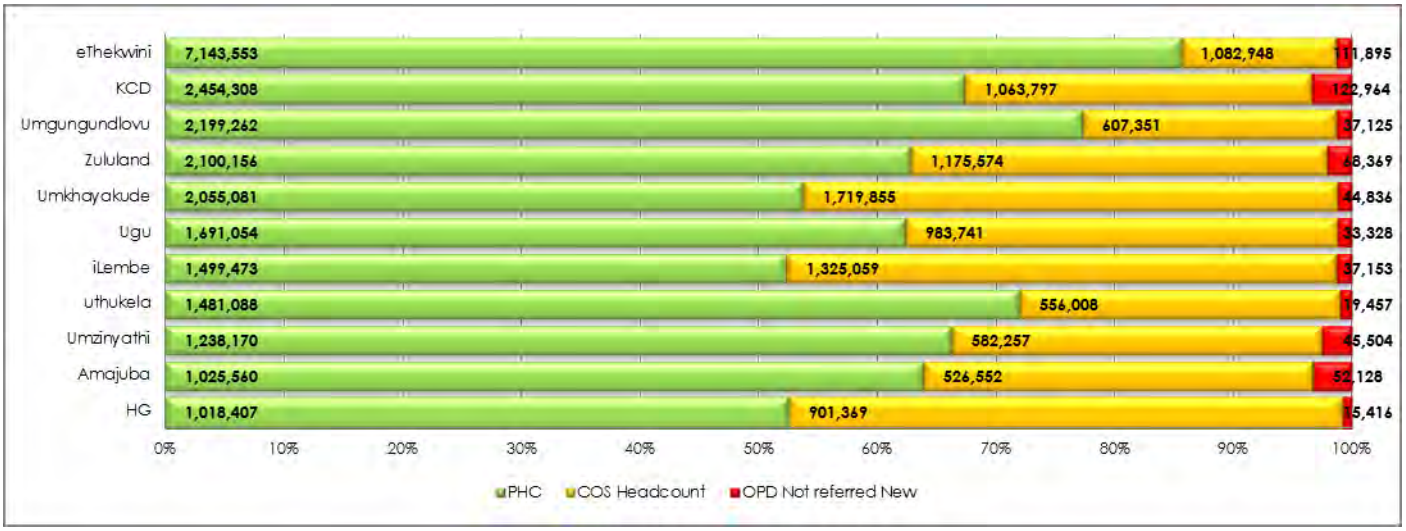
Source: DHIS

In the more remote districts such as Amajuba and KCD, OPD Headcount not referred new (Clients that have bypassed traditional PHC facilities) contributes a significant portion towards PHC Client contacts. iLembe, Harry Gwala and uMkhanyakude have a strong Community Outreach Services (COS). iLembe has 32 Ward Based Outreach Teams (WBOT's), uMkhanyakude has 29 WBOT's and Harry Gwala has 57 WBOT's which allows these districts to have a higher COS headcount.

[7] 3,743,054 / 6,240,480

[8] 5 ,557,149 / 6,240,480

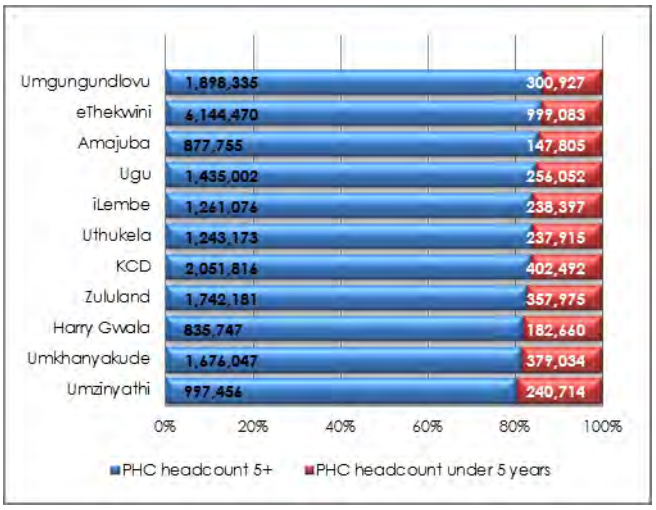
Graph 9: Proportion of PHC Client contact per district – 21/22



Source: DHIS

Districts with a higher population density with vast urban areas show a trend of higher PHC headcounts at fixed facilities. eThekwini has a population density of 1,741 people / km² (eThekwini DHP 20/21) and Msunduzi Sub-District 928 people / km² (uMgungundlovu DHP 20/21).

Graph 10: PHC Headcount and PHC headcount under 5 years per district – 21/22

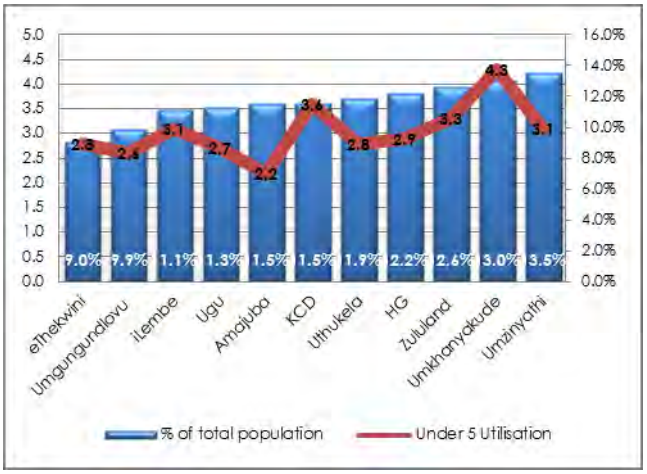


Source: DHIS

The under 5 headcount in uMgungundlovu makes up 13.7% of the total headcount. The same is true in eThekwini at 14%. The under 5 headcount makes up a bigger proportion of the headcount in Zululand (17%), Harry Gwala (17.9%), uMkhanyakude (18.4%) and uMzinyathi (19.4%), which is to be expected given their demographics. In these 4 rural districts, there is no big economic town with any significant industry, to hold the working age population (20 – 65 years) within the district.

The towns of Ladysmith in uThukela, Port Shepstone in Ugu, Stanger / Ballito in iLembe and Newcastle in Amajuba all attract the working population within their district therefore the balance between the under 5 years and working population, is not as skewed.

Graph 11: Under 5 Population Proportion vs Under 5 Utilisation Rate – per district 21/22

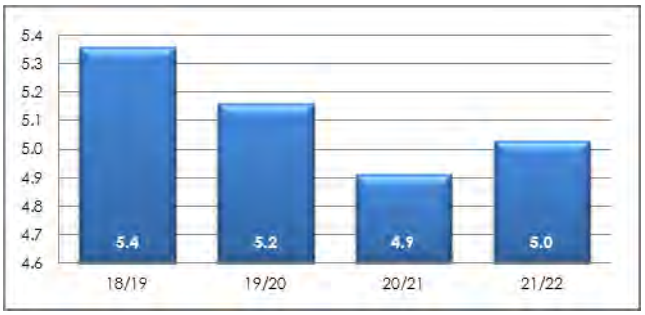


Source: DHIS

eThekwini and uMgungundlovu have the smallest proportion of under 5 population, as they are the economic hubs of KZN and therefore have a larger working population. Younger children, often live with grandparents in the more rural areas, until reaching school going age. This is reflected in the high proportion of under 5 population in Harry Gwala (12.2%), Zululand (12.6%), uMkhanyakude (13%) and uMzinyathi (13.5%).

The Average Length of Stay (ALOS) is affected by the number of days each patient spends in hospital. The COVID-19 pandemic meant that patient numbers declined in 20/21 (IPD 1,420,412) and 21/22 (IPD's 1, 509, 640) which is reflected in the lower ALOS of 4.9 days and 5.0 days respectively.

Graph 12: Average length of stay – District Hospitals



Source: DHIS

The implementation of admission criteria, as well as discharge criteria are factors that influence the ALOS at a district level. The shortage of diagnostic equipment at some district hospitals, also plays a significant role, as patients have to stay longer to access x-rays etc. The variants range from Nkonjeni Hospital (Zululand) with 3.4 days, to Niemeyer Memorial Hospital (Amajuba) at 8.6 days, with a provincial average of 5.1 days for ALOS.

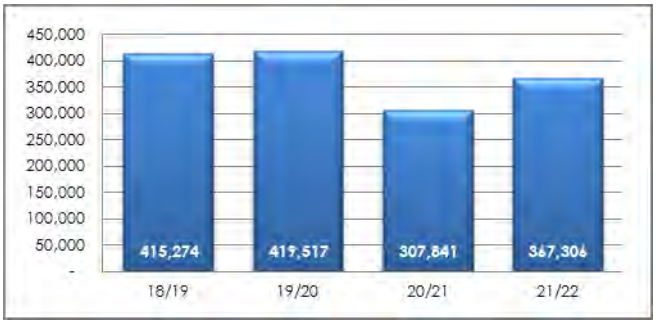
Graph 13: Inpatient bed utilisation rate – District Hospitals

Source: DHIS

The decline in the number of inpatient days (IPD) also impacts on the Bed Utilisation Rate (BUR). There has been a 15.6% decrease from the baseline[9] to 50.2% in 21/22.

Niemeyer Memorial Hospital (Amajuba) has the lowest BUR at 16.1%. This hospital is a small mining hospital in Utrecht that the Department inherited when the mines closed. St Mary's, Marianhill in eThekwini, a missionary hospital that the Department took over on 1st October 2017, has the highest BUR provincially at 78.2%. Combined with the ALOS of 4.5 days, this could indicate that the hospital is being over-utilised. It should be noted that there is no public health hospital between St Mary's, Marianhill and Northdale Hospital, Pietermartizburg meaning that the densely populated and well-travelled N3 corridor between Pinetown and Pietermaritzburg has a lack of district hospital facilities. Northdale Hospital (Pietermaritzburg) has a BUR of 76.7% and an ALOS of 5.3 days,, and as with St Mary's Marianhill, indicates that there is pressure being placed on this facility with over-utilisation.

Graph 14: OPD headcount new cases not referred – District Hospitals



Source: DHIS

The limited funding envelope means that the budget has to stretch further. One of the methods employed to curtail expenditure is to ensure that services are rendered at the correct level. PHC patients therefore need to enter the system and be treated at a PHC level, as this reduces the cost to the Department. The PHC cost per headcount is R 756 per PHC visit compared with R 3 498 per Patient Day Equivalent (PDE) at district hospital meaning that it is 4.6 times cheaper to treat a patient at PHC level rather than at district hospital level. The indicator OPD Headcount New Not Referred takes on significance within this context, as these are patients that can be treated at a PHC level, but are accessing services at a District Hospital level.

COVID-19 had an impact on 20/21 data for patients accessing PHC services from district hospitals. There has been an increase of 59 465 year-on-year within this category. This indicator is also heavily influenced by the communities' attitude towards PHC services. If PHC services are sparsely distributed, not well managed, or difficult to access this could lead to the community choosing to access services at hospital level therefore bypassing PHC services.

Provincially, eThekwini has the lowest OPD Not Referred Rate at 31.2% for district hospitals. Cognizance should be given to the fact that eThekwini has 16 hospitals of which 4 are district hospitals, and 7 are regional hospitals, which does skew the bigger picture.

The 5 district hospitals with a highest OPD Not referred headcount are Dundee Hospital (14,305) in uMzinyathi District, Mbongolwane Hospital (13,889), Catherine Booth Hospital (8,872), Eshowe Hospital (53,684) and Nkandla Hospital (23,364) in KCD. The district hospitals with the lowest OPD Not referred Headcount are St Appollinaris Hospital (410) and

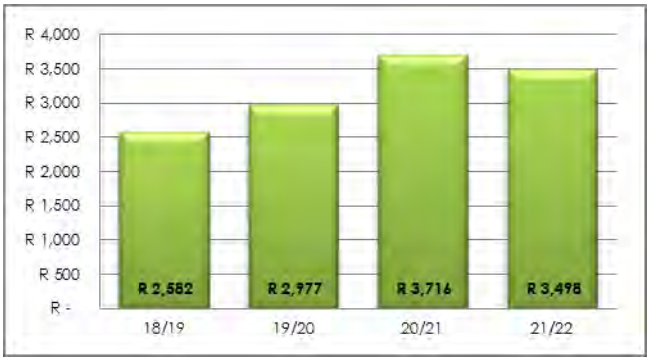
[9] 59.5% BUR for District Hospitals 18/19

Christ the King Hospital (733) in Harry Gwala District and St Mary's Marianhill (6,475) in eThekwini.

Gateway Clinics, positioned at the entrance of the hospital to "attract PHC patients bypassing clinics" make a significant contribution to ensuring that PHC patients are treated at a PHC level. Three hospitals (Mbongolwane, Catherine Booth and Nkandla Hospitals) in the top 5 hospitals with the highest OPD Not Referred Rate, do not have Gateway Clinics. Eshowe Gateway clinic treated 63,473 PHC patients, and Dundee Gateway Clinic treated 21,679 PHC patients. Provincially, Gateway Clinics account for 5.6% (1,341,076) of the total PHC headcount.

The expenditure per PDE is influenced by the operational costs of the facility combined with the patient load. During COVID-19, facilities had a lower patient load, with higher expenses for Personal Protective Equipment (PPE) thereby escalating the cost.

Graph 15: Expenditure per PDE – District Hospitals



Source: DHIS

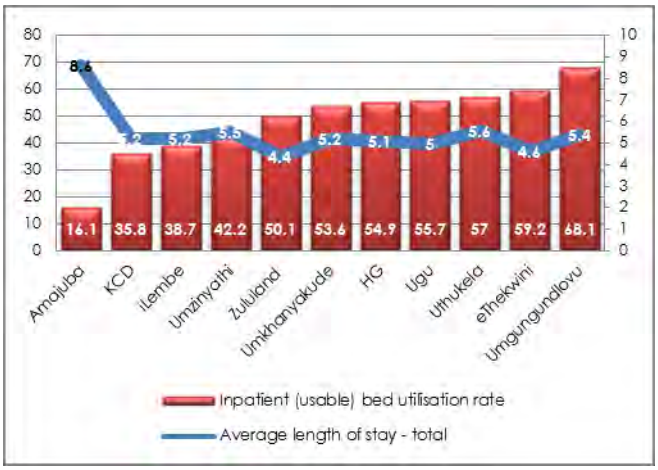
Expenditure has increased by 16% from R 6,649,557 (18/19) to R 7,914,895 (21/22). This is despite the cost containments implemented and the moratorium on the filling of posts. PPE and Cost of Employment (CoE) remain the biggest cost drivers at this level of service. The decrease of R218 per PDE in 21/22, is due to the increase in patient activity with the PDE increasing by 170,779 PDE from 21/22 figures.

Niemeyer Memorial Hospital, had the highest Cost per PDE at R 22,953 (DPQR 21/22) due to their low BUR (16.1%) and high ALOS (8.6 Days). This hospital has a full complement of staff and experienced a drastic reduction in the number of patients admitted when the hospital was repurposed as a COVID-19 hospital.

The relationship between ALOS and the BUR is a complexed one. In practice, often hospitals keep patients longer thus increasing both the BUR and the ALOS. In theory, an efficiently managed hospital will have a lower ALOS (3.5 days and below) and a higher BUR (75% and above).

uMgungundlovu has 2 District Hospitals; Northdale and Appelsbosch Hospitals. Northdale Hospital has a higher BUR at 76.2% (DPQR Q4 Report), due to the transport drainage system around Northern Msunduzi and southern uMshwathi Sub-Districts. In Msuduzi Sub-District, the community around Edendale and Imbali routinely use Harry Gwala Regional Hospital for district health services, as it is easily accessible although classified as a Regional Hospital. By contrast, Appelsbosch Hospital is under utilised at 42%, as it is far from the transport links, taxi fares from the community to the hospital are expensive and Montebello Hospital (iLembe District) is close by, at less than 5kms further down the same road.

Graph 16: BUR vs ALOS per district – 21/22



Source: DHIS

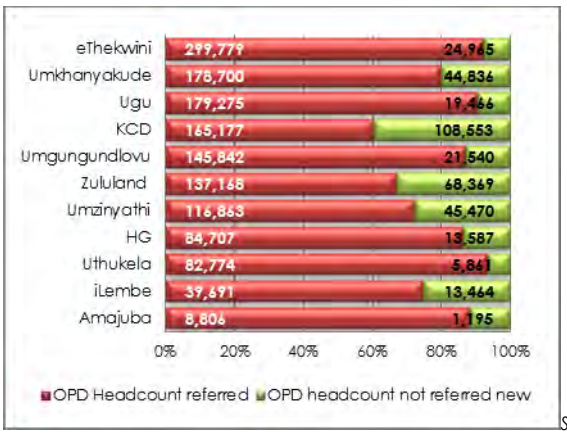
Amajuba District has one district hospital:- Niemeyer Memorial Hospital, which has been repurposed as a COVID-19 specialised hospital. The low admission rate for COVID-19, has meant that the hospital has a BUR of 16.1%, which is substantially lower than the national accepted norm of 75%. The ALOS is also above the accepted average (3 days), at 8.6 days due to the COVID-19 protocols and clinical management.

In eThekwini, a quarter of the hospitals in the district, are classified as district hospitals, which places pressure on the regional hospitals to provide level 1 hospital services. The District hospitals therefore reflect a varied BUR depending on services provides and accessibility to the community. The District hospitals are King Dinuzulu Hospital (52.2%) which also provides specialised TB and Psychiatric hospital services, St Mary's Marianhill (80.3%) which shows a high utilization rate, Wentworth (64.7%) which is providing some level 2 hospital services and Osindisweni Hospitals (46.1%). (DQPR Q4)

Zululand hospitals have improved efficiencies reflected in their lower average length of stay (4.4 days) in conjunction with their BUR (50.1%). This is in part due to Itshelejuba Hospital

(ALOS 3.9 days) and Nkonjeni Hospital (3.9 days) that both displayed lower than average ALOS's.

Graph 17: OPD Headcount in relation to OPD Headcount not referred new – 21/22



Source: DHIS

KCD, Zululand and uMzinaythi have the highest proportion of OPD Not referred clients in relation to the Total OPD headcount. This is consistent with the lack of Gateway Clinics in KCD District hospitals and the strategic placement of the hospitals in relation to the communities they serve. Many of the hospitals in these 3 districts were previous missionary hospitals which influenced their location.

Although both uMzinyathi and Zululand have the lowest average catchment population per clinic with uMzinyathi at 10,545 capita per clinic, and Zululand at 11,563 capita per clinic, population distribution patterns are similar in these 2 districts. Both districts have a strong traditional social element entrenched in the Tribal Land Authority structures with subsistence farming contributing significantly to the local economy. The population is therefore widely dispersed amongst family homesteads that have little disposal income. These communities therefore tend to access health care at their closest facility.

eThekwini in contrast, has an average catchment of 35,249 capita per clinic which is the highest provincially. Due to the high population density in this metropolitan, health services are possibly easier to access hence the OPD Not referred contributes only 7.7% of the total OPD Headcount.

The Regional hospital ALOS increased from 6 days (20/21) to 6.3 days (21/22) due to longer stays for mental health care users and orthopaedic patients. The BUR target of 73.5% was not met even though there was an increase from the 20/21 baseline of 60.3%, illustrating the effect of progressive restoration of services and implementation of resurgence recovery plan in 21/22. COVID-19 consumables and equipment kept the expenditure per PDE higher at R 3,938 / PDE.

The current TB regimen is the main reason for the decrease in the ALOS as it promotes community based care, thereby reducing the number of days patients needing to be hospitals. The same regimen also led to the decline in the BUR from 36.5% (18/19) to 12.8% (21/22).

The number of Health Care Associated Infections in psychiatric hospitals increased by 837 year-on-year due to sharing of facilities and as a result of the patient's condition i.e. their redcued ability to comply with infection prevention measures.

The ALOS increased from 43.2 days (20/21) to 49 days (21/22) as a result of increased hospital admissions at Hillcrest hospital which provides long term chronic care. The inpatient BUR decreased from 36.1% (20/21) to 35.6% (21/22). These changes are attributed to the repurposing of Clairwood hospital for COVID-19. The expenditure per PDE decreased slightly from R 4,905 to R 4,784 but remained higher than expected due to the low BUR at Clairwood hospital and high cost linked to utilization of Personal Protective Equipment (PPE) .

The ALOS decreased from 7.4 days in (20/21) to 6.9 days (21/22) with a steady decline from 7.9 days (18/19). Clinical governance roadshows, revitalization of clinical governance structures, and facility based support resulted in the implementation of quality improvement projects. The BUR increased from 59.9% (20/21) to 71.3% (21/22), attributed to progressive implementation of the COVID-19 recovery plan. The review of PPE utilization policy which reduced PPE utilization led to the expenditure per Patient Day Equivalent (PDE) decreasing to R 4,911. The provision of district level services in tertiary hospitals is one of the main causes of the increase in OPD headcount new cases not referred with specific reference to Ngwelezana Hospital. This is the only hospital in the Umhlathuze sub-district, the most populous sub-district in KCD where the communities of Richard's Bay, Empangeni and Ngwelezana are situated.

The 8.5 days Central hospital target for ALOS was not met, even though there was a decrease from 10.5 days (20/21) to 10.2 days (21/22). Some clinical disciplines are dependent on the support of specialized clinical technologists which are in short supply, thereby negatively impacting on treatment times. Additionally, there has been a reduction of theatre time due to staff shortages, and the long length of stay of orthopaedic and neurosurgical cases.

The BUR improved by 27% to 55.5%, despite the staff resignations and repurposing of beds as a result of COVID-19. The expenditure per PDE for Central hospital decreased from R

14,487 (20/21) to R12,108 (21/22), as a result of reduction in PPE use following the PPE policy review. The cancellation of some OPD Specialised clinics due to COVID-19 contributed to the cohort of Inkosi Albert Luthuli Hospital patients presenting themselves without an appointment as they experienced clinical problems requiring urgent attention.

Patients are encouraged to enter the health system through the PHC level of clinics and Community Health Centres (CHC's). There would then be an upward referral to district hospitals for basic hospital services. From here the referral upwards is to Regional Hospitals, Tertiary Hospitals and then to the Central Hospital depending on their disease pattern, and the package of services provided by the hospitals.

The Patient Transport System, housed in EMS, transports patients between the different levels of care, however this does not take into account the personal circumstances of the individual concerned. In many instances, it is not always practical to access tertiary and central health services so far away from the original point of contact, hence there are gaps in service delivery with the main challenge being the provision of tertiary services in the far north of the Province.

A number of challenges confront the Department in the provision of Forensic Pathology Services. The root cause of these challenges emanate from delays in the finalisation of the organisational structure for Forensic Services which impacts on the recruitment of appropriately skilled Supervisors to improve the Turn Around time for post –mortems, DNA testing and results. A revised structure for Forensic Pathology Services is being developed and a multi-stakeholder forum for both Forensic Medicine and Forensic Pathology is being set up.

OUTCOME: REDUCED MORBIDITY AND MORTALITY

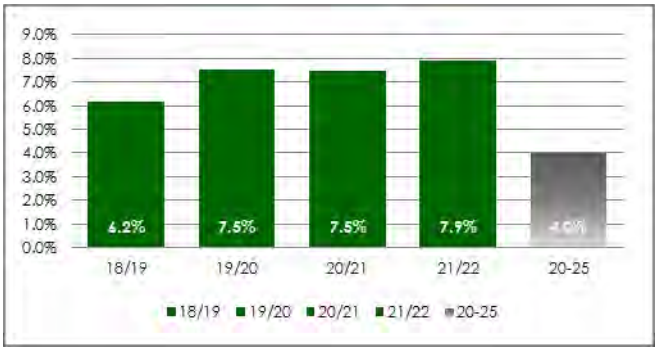
The Strategic Health Programme (SHP) Recovery Plan was implemented with enhanced focus on paediatric / adolescent matrix with interventions at a high-level across the cascade. Facility buy-in is still needed for universal application of the strategy, as attrition remains high. Lost to follow up, is one of the main contributors, to the Province not achieving the desired ART (Antiretrovial Therapy) coverage. The largest gap is noted amongst male children in the age group of 10-14 years followed by females in the same age band.

A slight increase of clients remaining in care is noted for the 21/22 period. In 2021/22, 27 percent of the adults in care were classified as lost to follow up. There is sub-optimal implementation of Adherence Guidelines (AGL) Standard Operating Procedures (SOPs) as evidenced by consistent loss to follow up. This is a generalised challenge in the Province.

There has been a decline of 11.7%, in the number of patients screened for TB from 28,212,190 (19/20) to 24,920,321 (21/22). This decrease is associated with the reduction in PHC Headcount from 33,771,340 (19/20) to 28,366,435 (21/22) due to reduced number of patients visiting facilities and expansion of Community based services. Quality screening of patients for TB remains a priority as missed opportunities and late presentation at facilities, contributes towards the death rate.

The annual target (21/22) was met due to community testing and the integration of health services. Partners' HIV testing contributed to improved outcomes in seven districts. The Department will monitor implementation of HIV testing modalities in all districts to sustain testing trends and integrate it with other health services.

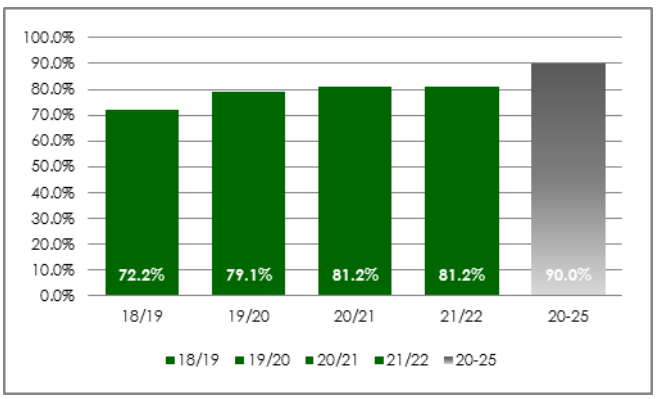
Graph 18: All DS-TB client death rate



Source: DHIS

The TB death rate increased to 7.9% (21/22) due to late presentation i.e. patients seeking health care when they are critically ill and die soon after treatment initiation. The death rate is highest amongst the HIV/Aids co-infected patients who are virally unsuppressed

Graph 19: All DS-TB client treatment success rate



Source: DHIS

There was no improvement on the TB Treatment success rate of 81.2% reported in 20/21. The success rate is affected by

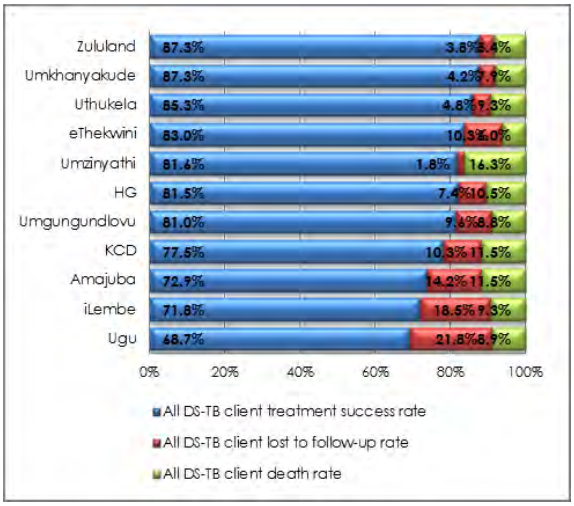
negative outcomes i.e. high loss to follow up (LTF) of 10.3% and TB death rate of 7.9%. The high loss to follow is due to poor updating of outcomes on Tier.net especially in high volume facilities and limited physical tracing and tracking of patients who have missed appointments.

The TB notification rate (reported as TB incidence) has declined from 507.3/10,000 population (18/19) to 364/100,000 (21/22). The increase in notification is attributed to positive yields on the implementation of "Finding TB Missing Cases" strategies targeting populations at risk as well as the introduction of the urine test to screen for TB in HIV positive clients.

The 21/22 target was missed by 8% mainly due to high loss to follow up (12.5%) as a result of limited resources to track, trace and monitor patients in the community. Deaths are highest in HIV/TB co-infected patients who are previous TB and ART Loss to follow up clients.

There has been a 2.5 % decrease to 67.5%, for long treatment regimen treatment success rate due to high loss to follow up which increased from 12.3% (20/21) to 14.3% (21/22) and high death rate of 11.9% (21/22). The loss to follow up is high due to limited resources to track, trace and monitor patients in the community. The high death rate is because of late presentation more noticeable in co-infected HIV patients who are previous TB and ART loss to follow up.

Graph 20: Proportion of TB client treatment success rate, TB client lost to follow up rate and TB client death rate for April 2020 – March 2021 Cohort

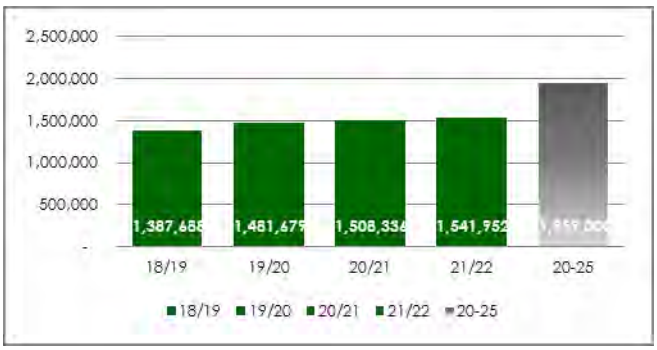


Source: DHIS

Districts that have the lowest TB treatment success rate invariably have the highest TB lost to follow up and TB death rates. This is evident in Ugu which has a lowest success rate of 68.7% combined with a TB lost to follow up rate of 21.8% and a TB death rate of 8.9%.

By contrast Zululand and uMkhanyakude , both with good PHC structures and processes in place, have a higher TB success rate.

Graph 21: ART client remain on ART end of month – total

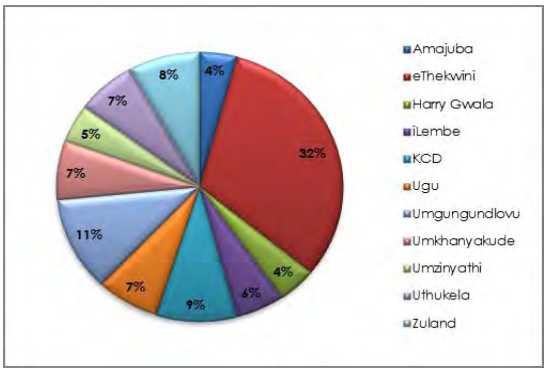


Source: DHIS

Steady improvement is noted year-on-year with a net gain on Total Patients remaining on ART (TROA) of 33,616. Net gain remains below input areas on TROA which resulted in disproportionate gains. Loss to Follow Up contributes mainly to failure to achieve TROA targets as it remains at 29% at 12 months. Adherence guidelines and / or literacy classes are not optimally rolled out. Positivity yield remains significantly low at 3% against a target of 6% which makes new initiations low despite some district efforts of targeted testing and index testing.

During 22/23, implemented strategies are continuing unhindered, including community awareness campaigns and the implementtion of the AGL's to ensure compliance.

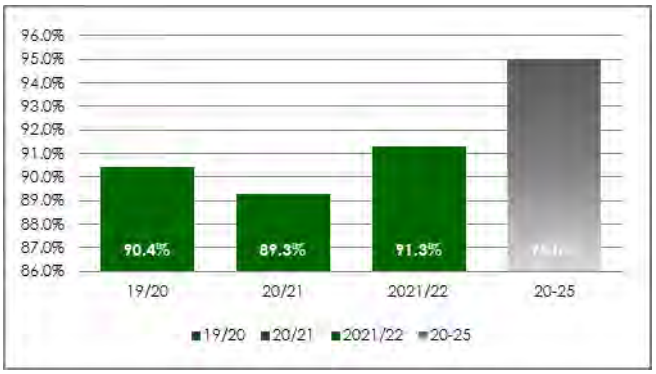
Graph 22: TROA per district – March 22



Source: DHIS

As expected, 32% of persons on ART's reside in eThekwini, followed by uMgungundlovu (11%) and KCD (9%) as these are the economic hubs.

Graph 23: ART adult viral load suppressed rate - (12 months)



Source: DHIS

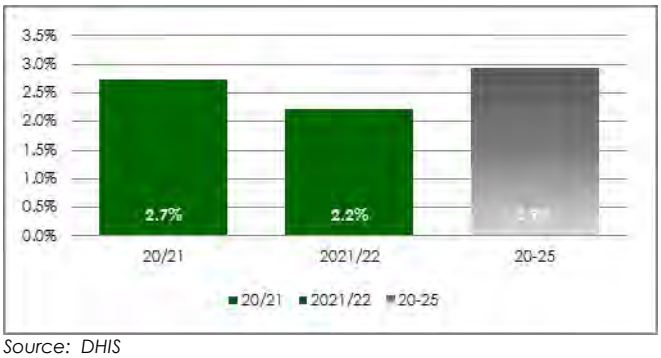
There has been significant improvement in adult viral load suppression, especially among women which is consistently above 90%. The percentage of men who have a suppressed viral load remain below target, at about 80%. Efforts are in place to target men across treatment cascades in the form of Isibaya Samadoda/iKhosomba lamajita/ men's friendly services community programmes. Tenofovir Disoproxil, Lamivudine, Dolutegravir (TLD), an ART drug used in 1st line treatment regime (which combines different types of drugs into one capsule), transition has registered benefits in terms of suppression goals.

Graph 24: ART child viral load suppressed rate - (12 months)

Source: DHIS

HIV positive children under 15 years exhibit challenges with ART treatment outcomes. Challenges with ART adherence result in paediatric HIV treatment failure (>1,000 copies), combined with ineffective management of ART side-effects and dosing complexities for children. Disclosure issues negatively impact on treatment success as the sub-poplation relies on consent and information from adults/guardians. The Results for Action (RFA) Dashboard is still not utilised effectively. The implementation of the Comprehensive Paediatric / adolescent Matrix of Interventions strategy attempts to improve health outsmes in this particular sub-population.

Graph 25: HIV positive 15-24 year olds (excl ANC) rate



Source: DHIS

A general decline in the positivity rate has been noted even though the facilities are prioritizing index testing during Operation Phuthuma. Districts are encouraged to focus on Index testing modality in order to identify positive people, who do not know their HIV status. The strategy going forward, would be to decrease testing target to focus on targeted testing in the high-risk communities.

Graph 26: ART death rate (6 months)

Source: DHIS

The ART death rate at six months has increased because of late presentation by patients to health facilities and irregular reviews of mortality audits to analyse causes of death amongst clients on antiretroviral treatment. The programme will conduct quarterly meetings in order to analyse the causes of death amongst People living with HIV.

Graph 27: ART adult death rate (6 months)

Source: DHIS

The ART death rate seems to have stabilized over the years. There is a noted challenge with linking HIV deaths to other causes of death as available clinical governance structures do not deal specifically with HIV. Late presentation by clients at facilities, has improved as more clients are identified earlier. Efforts to elevate Advanced Clinical Care are underway to identify clinical issues in this regard.

Graph 28: ART child death rate (6 months)

Source: DHIS

As per earlier analysis, paediatric HIV care needs special attention in the form of matrix interventions. Sub-optimal clinical management including linkage to care, dosage adjustment and unsuppressed viral loads all contribute adversely to care in this age group.

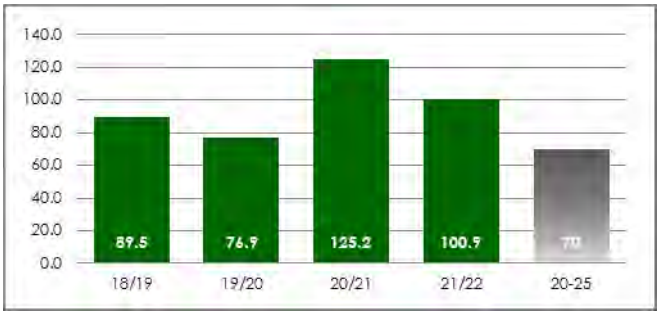
As at 2021/22, KZN is at 94-86-90 in terms of overall performance against the 90-90-90 Strategy. Performance analysis by gender indicates that males are at 93-80-75 and females at 95-90-75 against the targets. To achieve the 90-90-90 targets, KZN must increase the number of clients on ART by 3,101 patients. The gap is higher in the males and children.

HIV positive clients that are virally suppressed are at 90%, which is the target for the adult population. However, improvement is warranted for viral load completion as it remains low at 75% across the adult population and at 71% for children under 15 years. Viral Load Results For Action (RFA) training and eLabs project expansion coupled with their implementation plans took place concurrently to improve suppression. There has been a noticed improvement in suppression, since this initiation was implemented. The Viral Load Champions Model implemented in KZN, appears to be improving viral load suppression.

The Province is still experiencing inconsistencies in the standard of care for children and adolescent with HIV. This has resulted in a testing and treatment gap within the paediatric and adolescents sub-populations. Provincially, the current performance is at 80-65-71 in children under 15. To achieve 90-90-90 targets, KZN must increase the number of children on ART by 20,137.

The steady decline in Maternal Mortality ratio (MMR) was reversed in 20/21 because of the COVID-19 pandemic. COVID-19 was a new cause of maternal death for which there was no effective treatment, thus an increase in maternal deaths was inevitable and unavoidable. Most of the increase was due to direct complications of COVID-19 infections, but there was also an increase in deaths due to indirect adverse effects of the COVID-19 pandemic on the maternity health service (e.g. increased absenteeism due to staff infected with and affected by COVID-19)). In 21/22, there was a decline in the MMR because the COVID-19 pandemic waves were less severe than in 20/21.

Graph 29: Maternal Mortality in facility ratio – Total



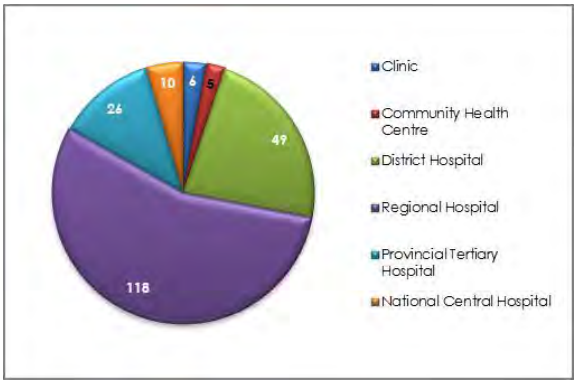
Source: DHIS

The Omicron variant wave, in particular, did not affect pregnant women as severely despite the fact that only a small minority of pregnant women had been vaccinated against COVID-19. A further decline in MMR is expected in 22/23 if further COVID-19 waves remain mild as with Omicron. This will allow health services to turn their attention to reducing maternal mortality from the common causes that pre-dated the COVID-19 pandemic.

The bulk of maternal deaths occur at a Regional Hospital level, as this is the "*in between*" level. District Hospitals refer maternal complications and high risk pregnancies upwards as Regional hospitals have more capacity and skills to deal with obstetric complications. In comparison, there are only 3 tertiary hospitals, of which Ngwelezana Hospital is a developing Tertiary Hospital and has a challenge with staff retention of specialists.

There are 2 regional hospitals that are classified as specialized Mother and Child Hospitals:- Queen Nandi Memorial Hospital (KCD) and Newcastle Hospital (Amajuba) thus adding to the maternal deaths in these Districts as complicated cases are referred here. Eleven (11) maternal deaths occurred at PHC level, which is higher than previous years, and could be due to accessibility of services due to COVID-19.

Graph 30: Maternal deaths per level of care – Public Sector 21/22

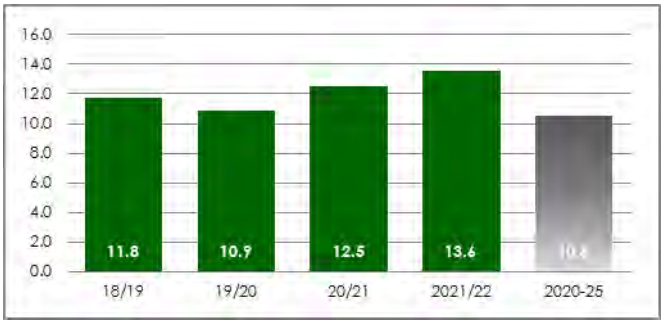


Source: DHIS

Neonatal deaths increased from 2,487 (20/21) 2,825 (21/22). In by contrast live births increased by 9.1% resulting in an increased mortality rate. Neonatal deaths have increased by 18.9% (2,375 in 19/20 to 2,825 in 21/22) since the start of the COVID-19 pandemic.

COVID-19 negatively impacted on neonatal outcomes due to reduction in staff patient ratios and separation of mothers and babies (causing reduced access to breast feeding and skin to skin contact resulting in increased health care associated infections).

Graph 31: Neonatal death in facility rate – Total



Source: DHIS

Prematurity caused 47.5% of neonatal deaths with a case fatality rate of 13.9%. Preterm admissions increased t0 8,923 (21/22). The greatest mortality of 54% (712/1,316) was in babies born weighing under 1000g accounting for 25% of all neonatal deaths. Factors contributing to prematue deaths, are low birth weight (12.3% in 21/22); teenage pregnancy; (994 babies were born to mothers younger than 14 in 21/22); inadequate coverage of antenatal steroids and inadequate respiratory support. After antenatal steroids (which help mature the premature baby's lungs), respiratory support is the most impactful intervention in reducing premature deaths. Only 41.3% (3,436 / 8,923) of preterm babies received nasal Continuous Positive Airways Pressure (nCPAP). However this has increased by 10% from 20/21. Challenges in providing respiratory support relate to inadequate infrastructure (particularly lack of medical air in many facilities), inadequate oxygen pressure (due to increased demand for the COVID-19 patients) and procurement challenges with equipment consumables.

Timing of deaths: 73.3% of neonatal deaths occurred within the 1st week of admission. These are primarily due to birth complications and inadequate access to respiratory support. However, in 21/22, there was a 31% increase in late deaths related to high bed utilisation & high staff patient ratios resulting in infection outbreaks.

Location of deaths: 48% of deaths occur at Regional Hospitals due to high bed utilisation & staff patient ratios. There are only 46% of the required high care and Intensive Care Unit (ICU) beds (275/600), available for use.

Key interventions include the upgrading of infrastructure, equipment and strengthening administrative processes.

Graph 32: Live in birth under 2 500 g in facility rate

Source: DHIS

Basic Antenatal Care Plus (BANC+) was implemented in 18/19. BANC+ advocated for more antenatal visits, improvement of antenatal care and auditing of antenatal care. Auditing of antenatal care is done as a peer review, with districts auditing another. A decline in low birth weight was noticed around 2019 – 2021. Peer review stopped in 2020 and training on BANC+ was transferred to district level. Auditing of antenatal care stopped due to a shortage of midwives at PHC. At the onset of COVID-19, the shortage of nurses, including midwives, meant that the quality of antenatal care deteriorated. This is seen in the 21/22 performance, which was very slow to improve, in spite the implementation of the recovery plan.

Further to the above, there is high rate of continuous maternal infections that are missed at antenatal clinics and pre-existing maternal medical conditions that are poorly managed which contributed to the high percentage of babies born with a low birth weight.

The positive caseload was reduced to 209 (21/22). Identification of risks in mother to child transmission of HIV at

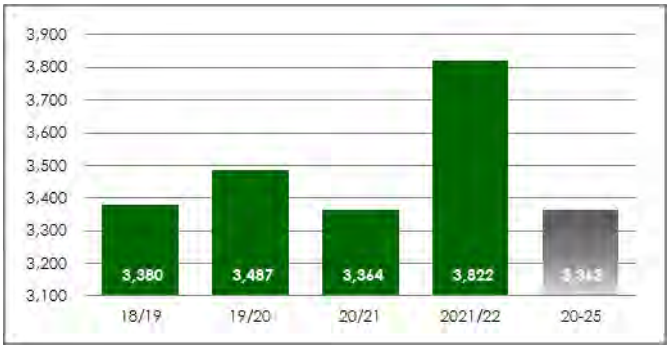
Facility level, through Facility Polymerase Chain Reaction (PCR) meetings and visits, is assisting in closing the gaps thereby reducing new HIV infections amongst children.

Graph 33: Infant PCR positive around 10 weeks rate

Source: DHIS

The number of deaths in children under-5 years has increased by 16.3% over the four year period from 18/19 to 21/22. The majority of these deaths occurred in the newborn period which accounted for 66.7% of under-5 deaths in 18/19 and 71.8% in 21/22. Over this four year period the proportion of under-5 deaths due to diarrhoea dropped from 5.1% to 3.7%; acute respiratory infections dropped from 8.2% to 5.0%; and severe acute malnutrition dropped from 5.3% to 4.8%.

Graph 34: Number of Inpatient deaths under 5 years



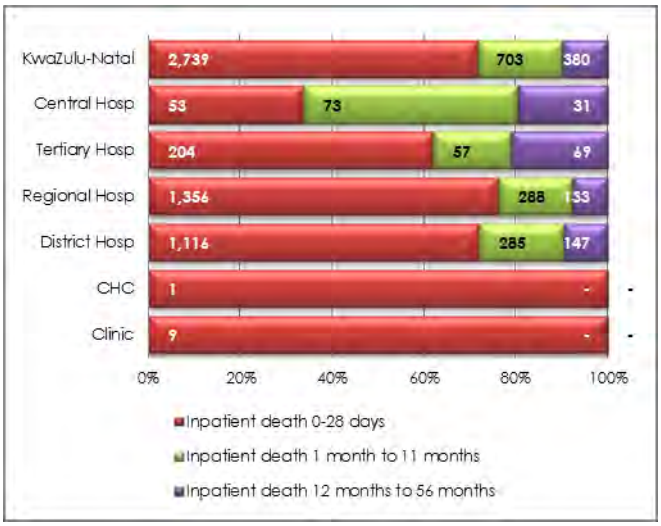
Source: DHIS

The proportion of under-5 deaths occurring between 1 and 4 years of age was 389 in both 18/19 and 21/22 although it dropped to 308 in 20/21, during the COVID-19 lockdown. This means that the increase in under-5 deaths is due to an increase in neonatal deaths and unless this is addressed it is unlikely that the 2025 target for under-5 deaths will be achieved.

The Essential Packages of Care for both Paediatrics and Child Health will be introduced to improve outcomes.

The majority of the under 5 deaths (71.7%) occurs in the Neonatal category (0 – 28 days) and this drives the under 5 death rate.

Graph 35: Under 5 deaths, per level of care – 21/22



Source: DHIS

The number of deaths between 1 and 5 years has dropped significantly over the previous 10 years, with this age category contributing 11% to the total deaths under-5.

Strategies and interventions are therefore focused on improving both maternal health and neonatal survival rates to improve the under 5 death rate.

In 21/22 there was a 16.3% increase in under-5 deaths and a slightly smaller, 13.4% increase in births, compared to the previous year resulting in a sustained increase in this indicator over the past three years.

The major contribution to under-5 deaths is deaths in the neonatal period where the need for service exceeds the current capacity of the provincial neonatal services, especially at regional and tertiary level.

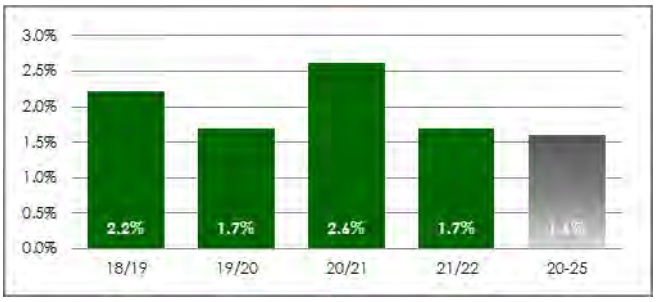
Graph 36: Death under 5 years against live birth rate

Source: DHIS

Whilst the role of improved neonatal care at district hospitals is an important element in addressing under-5 deaths, this needs to be complemented by an increase in access to regional and tertiary level neonatal beds. Various strategies are being undertaken to commission more regional and Kangaroo

Mother Care (KMC) beds, to strengthen the delivery of respiratory support in district hospitals and optimize use of the available beds. Unless the Department is able to increase the capacity of the neonatal services it is unlikely that the 2025 target will be met.

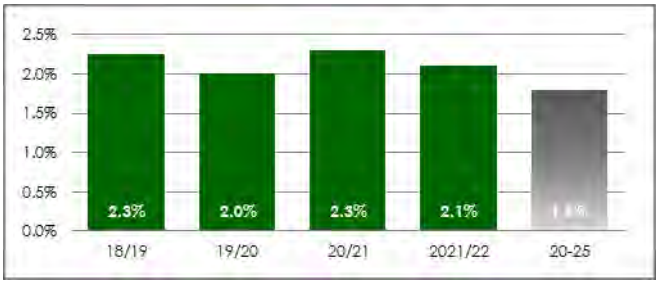
Graph 37: Child under 5 years diarrhoea case fatality rate



Source: DHIS

The child under-5 years diarrhoeal disease case fatality rate (CFR) has decreased by 18.0% since 18/19 although there have been fluctuations from year to year. This is due largely to a decline in the incidence of diarrhoeal disease associated with improved hand hygiene strengthened during the COVID-19 response. With the easing of lockdown restrictions there was a 78.4% increase in the incidence of diarrhoea and a 63.0% increase in admissions for diarrhoeal disease between 20/21 and 21/22 but only a 10.5% increase in deaths resulting in an improved case fatality rate. The lower number of deaths was associated with earlier presentation to the health service and improved assessment and treatment on admission. The Department is on track to meet the 2025 target for this indicator.

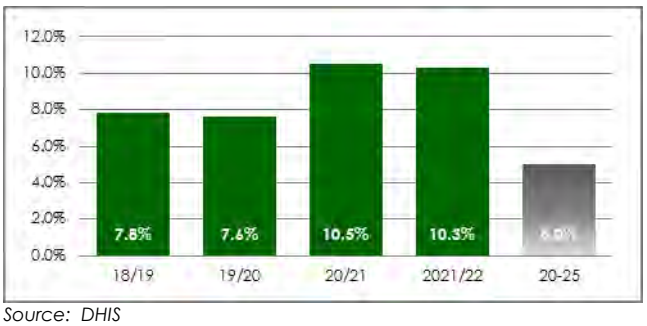
Graph 38: Child under 5 years Pneumonia case fatality rate



Source: DHIS

Since 18/19 there has been a 4.4% decline in the child under-5 years pneumonia case fatality rate associated with a reduction in the incidence of pneumonia and well as the number of admissions and deaths due to pneumonia. This was in part due to COVID-19 control measures with reduced mobility, the wearing of masks and the use of hand sanitiser.

Graph 39: Child under 5 years severe acute malnutrition case fatality rate

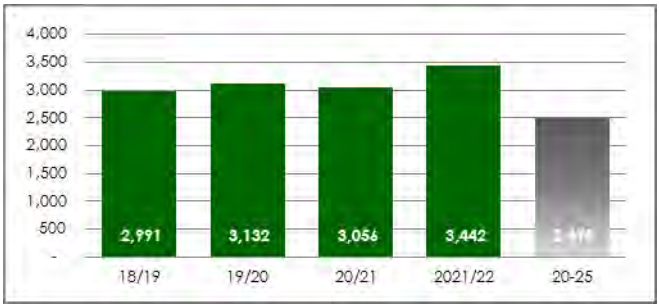


Source: DHIS

With the relaxation of these measures in 21/22 there was an associated 53.0% increase in the incidence of pneumonia, a 44.9% increase in the number of admission and a 32.4% increase in the number of deaths due to pneumonia. The smaller increase in deaths was associated with a reduction in the case fatality rate and was due to earlier presentation to the health service and easier access to respiratory support. If these improvements are maintained the Department may achieve the 2025 target for this indicator.

There has been an increase in the child under 5 severe acute malnutrition (SAM) case fatality rate, which coincided with the onset of COVID-19, which resulted in poor PHC utilisation rates, decreased headcount amongst children under 5, and poor supplementation coverage. These impacted on the malnutrition case detection negatively for early initiation of treatment. In addition, a decline in exclusive breastfeeding rates during this period contributed to an increase in SAM. The resultant food and nutrition security challenges experienced in all districts were exacerbated in eThekwini and uMgungundlovu, which were more adversely affected by the July 2021 riots. The major contributing factors to SAM deaths included poor and infant young child feeding history, social ills and co-morbid conditions like HIV, TB, cardiac illness, disabilities and neurodevelopment conditions.

Graph 40: Number of Inpatient deaths under 1 year – Public Sector



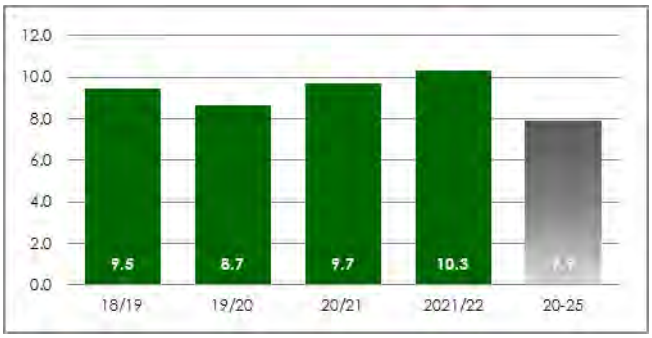
Source: DHIS

Although the number of inpatient deaths under-1 year increased, this increase occurred in the newborn period and there was an actual 2.4% decline in deaths from 1 to 11

months of age between 18/19 and 21/22. In 21/22 newborn deaths accounted for 79.8% of all under-1 deaths and if the 2025 target for this indicator is to be met then the number of neonatal deaths needs to be reduced. The roll out of the Essential Packages of Care for Paediatrics and Child Health are important interventions to strengthen health services for children beyond the neonatal period.

Compared with 20/21 early neonatal deaths increased by 2.2% (1,890-1,932) despite an increase in live births of 9.1%. However this still accounts for 73.3% of all neonatal deaths.

Graph 41: Early neonatal death rate

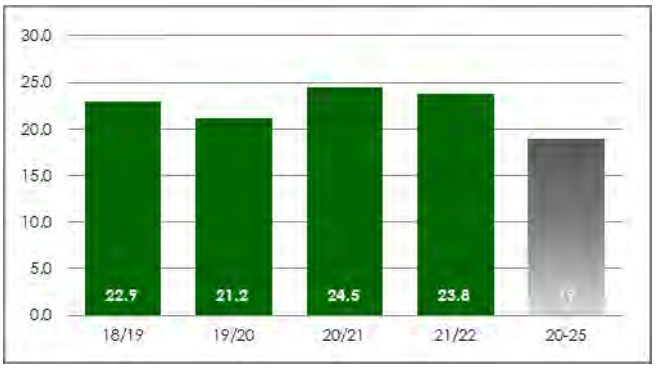


Source: DHIS

Cause of deaths: Early neonatal deaths are primarily due to birth complications, hypothermia, delays in transferring to (particularly due to the lack of Advanced Life Support Paramedics required to transport neonates), or unavailability of beds at, higher levels of care & inadequate access to respiratory support.

Location of deaths: 51% of deaths occurred at Regional Hospitals due to inadequate bed numbers and high staff patient ratios. There are only 46% of the required high care and ICU beds (275/600) available at this level.

Graph 42: Still birth in facility rate – Total

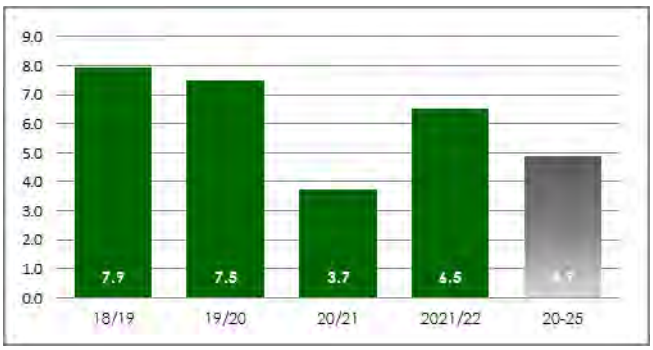


Source: DHIS

The Province has never managed to drop the Still Birth Rate (SBR) to below 20% due to various factors. Continuous infections during pregnancy that are poorly managed in antenatal care; coupled with existing maternal medical conditions that women present with when they become pregnant are regarded as major contributors of still birth.

Infections including syphilis, if not adequately screened in Antenatal Care (ANC) clinics results in poor management and subsequently affects foetal wellbeing. Prompt treatment of positive syphilis test is mandatory to reduce foetal infections and other negative outcomes. Syphilis testing and treatment is now being monitored at local and provincial level, added onto wellness dashboard indicators to re-enforce monitoring. BANC+ trainings are continuous at district level to skill new midwives so that the quality of antenatal care is improved.

Graph 43: Child under 5 years diarrhoea incidence

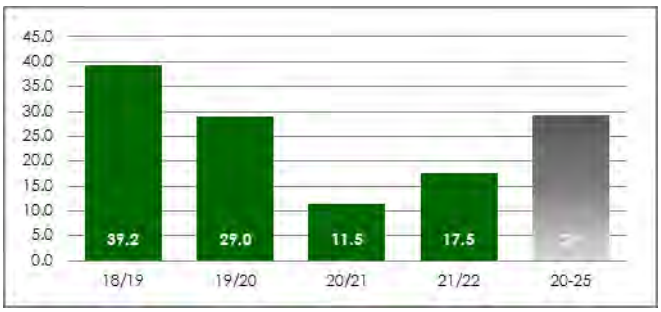


Source: DHIS

Though the diarrhoea incidence in children declining during the trend period, there has been a slight increase in 21/22 in those districts that have been affected by floods and are short of clean water supply i.e. eThekwini, Ugu, iLembe and King Cetshwayo.

The remedial action is to accelerate the activities that have been effective before.

Graph 44: Child under 5 years Pneumonia incidence



Source: DHIS

The pneumonia Incidence during the previous 2 years (particularly during COVID-19) declined because of reduced mobility of children during lockdown which resulted in reduced exposure to the viral and respiratory tract infections. Now that the accessibility to services is increasing again, and the Early Childhood Development (ECD) Sites are re-opened, most children have low immunity against viral and bacterial respiratory tract infections resulting in increased infections like

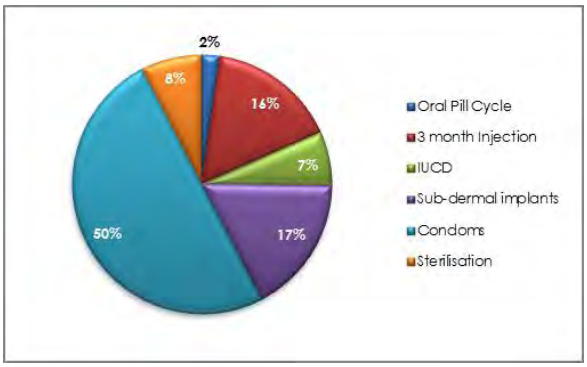
Pneumonia. The strengthening of the IMCI (Integrated Management of Childhood Illnesses) programme will be part of the remedial action.

Graph 45: Child under 5 years SAM incidence

Source: DHIS

There was in improvement in the SAM incidence in 20/21 as community health workers resumed household visits with child health services and PHC utilization rates improved. uMzinyathi and Zululand districts implemented the Family mid-upper arm circumference (MUAC) project, which assisted in advocating for nutritional screening at community level.

Graph 46: Couple year protection rate

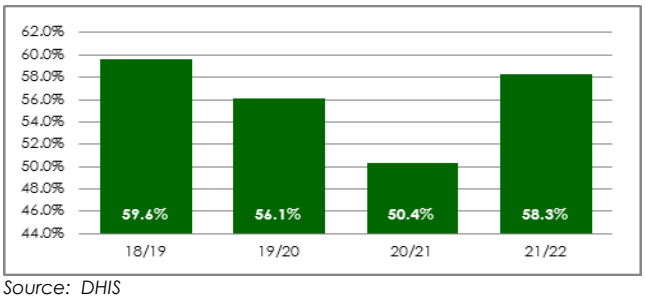


Source: DHIS

In 20/21 there was a reduction in the Couple Year Protection Rate (CYPR) to 50.4%, because of the COVID-19 pandemic. During the initial lock-down period of COVID-19, non-essential services including family planning were less accessible for the community, who were generally advised to stay at home. Additionally, there were intermittent stock-outs of contraceptive methods including injectable progesterone and implants. With the strict lock-down over, the CYPR improved in 21/22, despite ongoing intermittent stock-outs of certain contraceptives.

uMkhanyakhude, uThukela, iLembe, and Harry Gwala exceeded the Provincial target due to increase an use of long-acting reversible contraception methods.

Graph 47: Composition of Couple Year Protection Rate



Source: DHIS

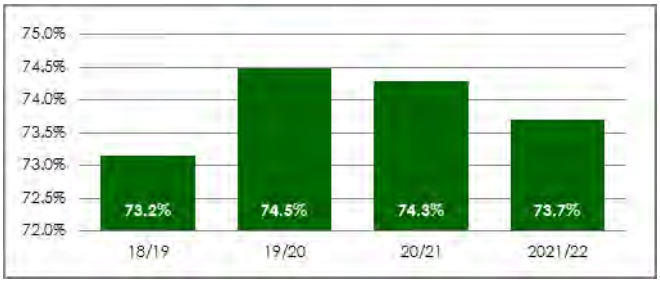
When discussing the CYPR, cognizance should be given to the fact that 50% of the CYPR comes from the vast amount of condoms (both male and female distributed). However, not all distributed condoms are correctly utilized. Dual protection needs to be emphasized with both Long acting reversible contraceptives (LARC's) employed or sterilisation combined with the use of condoms to protect against sexually transmitted diseases.

Graph 48: Delivery 10 to 19 years in facility rate

Source: DHIS

Generally teenage delivery rates are higher in rural districts: Harry Gwala, iLembe, uMkhanyakude , uMzinyathi, uThukela and Zululand, ranging from 17.8% in iLembe to 22% in Harry Gwala in 21/22. There are areas in these districts that still practice child marriages and "Ukuthwala". Parents especially mothers encourage young girls to fall pregnant for reasons like: obtaining "amalobolo" for her or socio/economic support as there is also poverty. There were also infrequent stock outs of Long Acting Reversible Contraceptives (LARC's). Workshops for other departments and community stakeholders are being done.

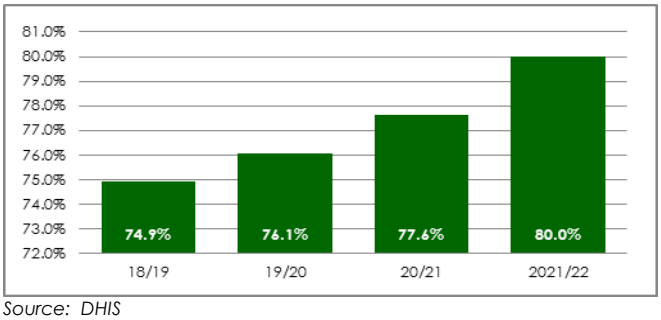
Graph 49: Antenatal 1st visit before 20 weeks rate



Source: DHIS

ANC early booking improved following the introduction of household pregnancy testing done by Community Care Giverse (CCGs), but started to drop following COVID-19 pandemic. Improvement remained stagnant in spite of good numbers for testing at household. There are multiple reasons for the poor performance including poor referrals to ANC clinics for all the positive tests, incorrect registering or use of registers in clinics.

Graph 50: Mother postnatal visit within 6 days rate

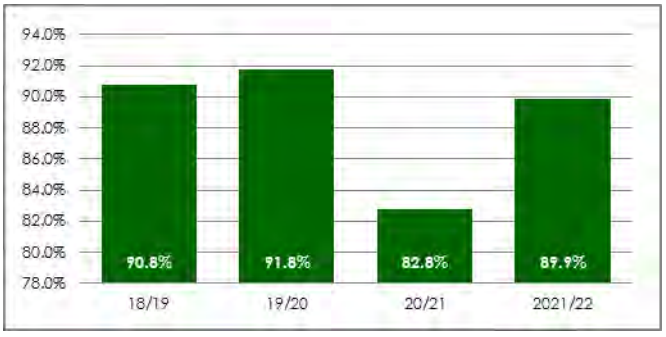


Source: DHIS

Mobiles do not offer antenatal care services due to the length of the consultation and tests required, so pregnant women have to access these services at a fixed facility. While a Recovery Plan for this activity, was shared with districts, implementation has been much slower. A shortages of midwifes has affected service delivery in maternity units throughout KZN and is the cause of adverse events in most cases.

There is acceptable performance with this indicator. This is because linkage of women with CHW's is done in antenatal care clinic whilst the women is pregnant and they are given a chance to accept CHW's allocated to them. CHW's are informed of the importance of visiting these women whilst pregnant and immediately post-delivery, to ensure that they do not miss the post-natal visit within 6 days. Delivery in hospitals also ensures that women who are still in hospital within that period are seen for post-natal care.

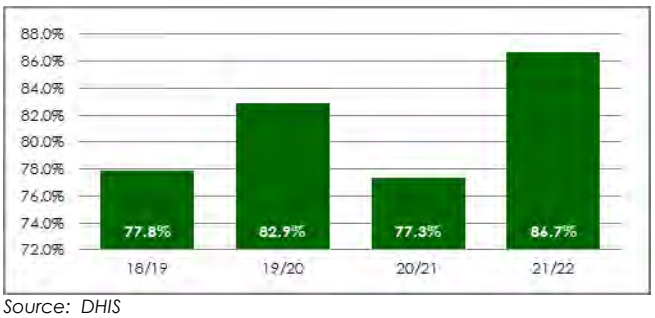
Graph 51: Immunisation under 1 year coverage



Source: DHIS

The Covid -19 pandemic meant that staff were repurposed to focus on the COVID-19 response which has disrupted the provision of routine immunisation services and worsened existing sub-optimal immunisation coverage rate in the Province.

Graph 52: Measles 2nd close coverage



Source: DHIS

The performance was achieved due to the implementation of EPI catch up drive campaigns, by the districts, to reach every child in the community who had missed their vaccines, and were due for immunization.

Some districts showed a decline in measles immunisation coverage during the surge of the Covid -19 pandemic combined with the lockdown restrictions.

The incorrect recording of the indicator in the source register occurred in the first and second quarters, was corrected through facility onsite trainings. Various remedial actions have been prioritised for 23/24 and appear under Part C of the APP.

Graph 53: Vitamin A dose 12-59 months coverage

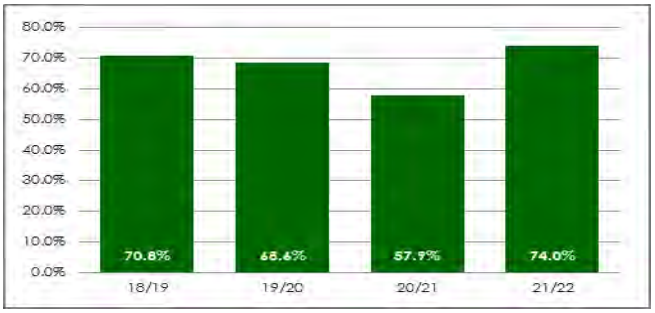
Source: DHIS

There is an upward trend depicting recovery from the effects of the COVID-19 pandemic on access to Vitamin A supplementation services. The 78.2% Vitamin A coverage (public and private data) achieved in 21/22 is due to the contribution made by CWH's in issuing supplements at the community level. Active monitoring of Vitamin A at Facility Nerve Centres Meetings also improved performance. Despite surpassing the target of 74% provicially, Ugu district remains low (62.7% coverage). Targeted outreach services as part of EPI catch-up drives to be strengthened to improve coverage.

Exclusive breastfeeding rates have stagnated since 2019 at around 56%. The most significant decrease was during the COVID-19 hard lockdown (level 5) in 2020 and the riots in July

2021, further influencing infant feeding practices. The hard lockdown and the continued COVID-19 prioritisation decreased opportunities for infant feeding counselling in support in the antenatal and postnatal period, which coincided with initial misinformation about breastfeeding and COVID-19 transmission risk.

Graph 54: Infant exclusively breastfed at DTaP-IPV-Hib HBV 3rd close rate

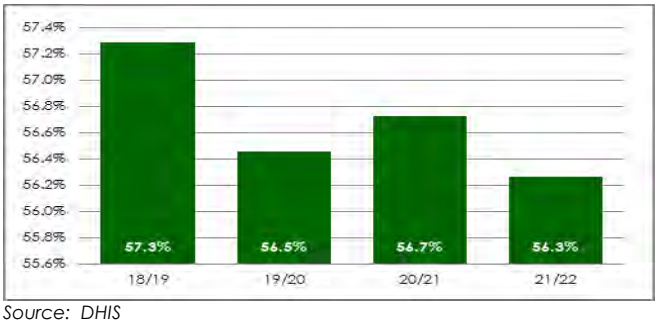


Source: DHIS

The July 2021 riots exacerbated inappropriate advertising and promotion of infant formula due to the unavailability thereof in the eThekwini region due to looting and accessibility to stock on social media platforms. These incidences have eroded a breastfeeding culture within the province. To address this within the KZN Department of Health, the Mother-baby Friendly Initiative is being revitalised to improve the facility and postnatal support as delivery is returning to normality. This includes advocacy to support implementation and build capacity on all service delivery platforms.

Capacity building undertaken by the Mental Health Co-ordinators on the Basic Mental Health screening tool, and the recording of the screenings and referrals for further assessment resulted in an increase on mental disorders screening rate by 9.4%.

Graph 55: Mental Health screening rate



Source: DHIS

Mental health screening has increased despite the COVID-19 pandemic. In 18/19, 11,621,594 patients were screened for mental health compared with 13,835,617 – a 19.1% increase. This coupled with the lower headcount has meant that the screening rate has improved significantly from 41% to 54.9%.

The mental health screening rate provincially is 57.9% provincially, with Ugu having the highest screening rate at 77.1% (screening 1,304,520 patients at PHC level). Apart from eThekwini, Ugu also has the highest number of patients on treatment at 31,943, with 4,044 placed on treatment during 21/22, which equates to 12.7% of provincial cohort.

Mental health in Ugu at a PHC level has been prioritised and this is reflected in the data. Within Ugu District, Ray Nkonjeni Sub-District has 2,392 (59.1%) of the district patients with the Port Shepstone Hospital 861 patients on treatment new, Bhomela Clinic 194 patients, Port Shepstone mobile 271 and Turton mobile 514.

Zululand also has a high initiated on treatment rate coupled with a high screening rate. As anticipated, eThekwini has the highest burden of patients on treatment (203,703) with an initiated on treatment rate of 1.4% (2,854 patients initiated on treatment in 21/22). uMzinyathi has a lower screening rate 44.1% and a low initiated on treatment rate at 0.3% (54 patients initiated on treatment).

The Department has continued to improve access of disability and rehabilitation services to persons with disabilities and those at risk of becoming disabled. During 21/22, more than 757,323 persons with disabilities received rehabilitation services. During the same period 4,537 wheelchairs, 4,374 hearing aids and 1,889 other assistive devices such as white canes were issued to persons with disabilities. In the same period, a total of 6,582 wheelchairs and other mobility devices were repaired and serviced at wheelchair repair wheelchair workshops that have been established at provincial health facilities in all Districts.

Persons with disabilities received Community Based Rehabilitation while 2,462 persons with visual impairments received independent living, orientation and mobility services in KZN in the 21/22 financial year.

Going forward into the new financial year 23/24, the Department will continue to render disability and rehabilitation services to persons with disabilities. The Department will focus on monitoring the implementation at the Centres of Excellence that have been established at provincial health facilities for management of person with disabilities as well as monitoring the implementation of expanded Community Based Rehabilitation and wheelchair repair services in the Province.

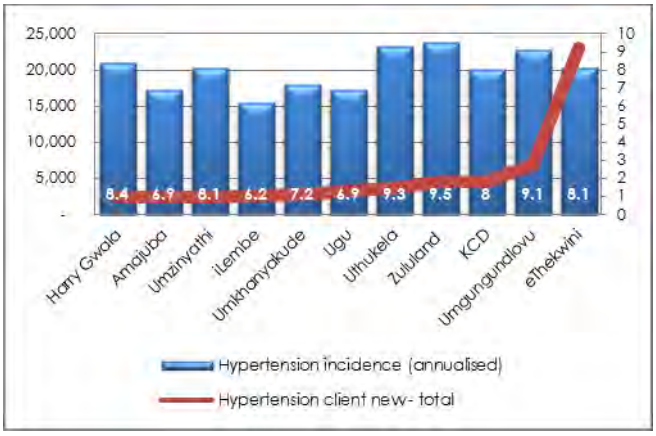
Graph 56: Number of clients accessing rehab services

Source: DHIS

Although there seemed to be an increased demand for rehabilitation services in the province, Harry Gwala and uMzinyathi districts performed poorly compared to other districts. This is due to a shortage of therapists and other resources e.g. equipment. Districts such as eThekwini, uMgungundlovu and iLembe performed better on average, when compared rural districts. The establishment of Centres of Excellence for management of disabled people in eThekwini, uMgungundlovu and King Cetshwayo districts has contributed to the increased number clients accessing rehabilitation services in the Department, thus the increase from pre-Covid times by 3.4%.[10]

Chronic conditions such as hypertension and diabetes, are also referred to as lifestyle conditions, as changes in lifestyle can have a huge impact on the progression and onset of these conditions. Chronic conditions are often the underlying cause of many an acute hospital admission, especially when undiagnosed or when the condition is uncontrolled. This has been especially true for the recent pandemic whereby uncontrolled hypertensions is a co-morbidity of COVID-19.

Graph 57: District hypertension incidence vs new patients placed on treatment – 21/22



Source: DHIS

Hypertension is the silent killer, creating awareness, screening, early detection and initiation of clients to treatment is the key to reducing the burden of hypertension.

Hypertension is a lifestyle disease and is often more prevalent in older people, although younger people on ART's are also started to develop hypertension earlier.

Fifty-three point nine percent (53.9%) of the total PHC headcount was screened for hypertension, with the 18 – 44 years accounting for 68.1% (8,766,487) of the patients screened. The 45 years and older age group accounted for 31.9% (4,108,056). In the 18 – 44 year age group, 0.4% of patients screened were placed on treatment, and in the 45 years and older age group, it climbed to 0.6% of patients screened, were placed on treatment.

Zululand has the highest hypertension incidence (9.5 / 1,000), which could be due to strong screening practices. Apart from eThekwini, Zululand screened more patients than any other district at 1,170,321, (55.7% of their total PHC headcount). This equated to 4,551 patients being placed on treatment during the reporting cycle. uThukela had the second highest incidence at 9.3 / 1,000 and 3,773 new patients placed on treatment.

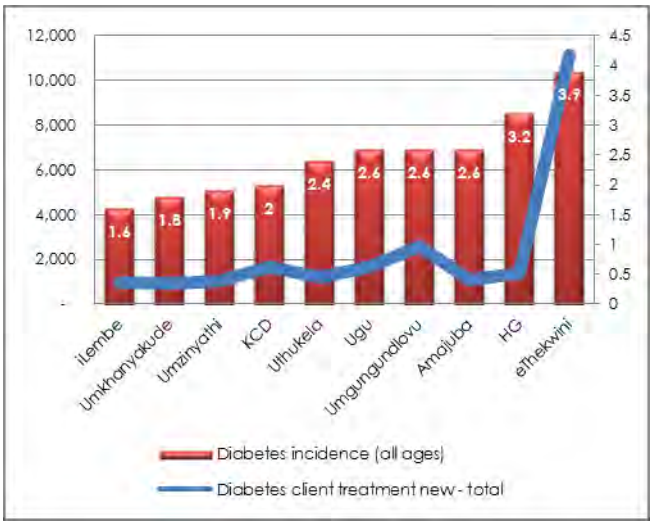
In contrast, iLembe screened 56.9% (853,909) of their PHC headcount and placed 2,648 new patients on treatment (0.3% of the patients screened were placed on treatment) resulting in the lowest hypertension incidence of 6.2 / 1,000. Focus need to be given to lowest performing district such as iLembe, Amajuba and Ugu through capacity building as well as awareness campaign at community level.

The burden of disease and high mortality rate associated with diabetes is due to complications of uncontrolled diabetes mellitus. Early diagnosis and initiation of client on treatment reduces the burden of disease and associated mortality. Most clients who know their diabetes status, adhere to the treatment regimen and make the necessary lifestyle changes are able to live full and active lives.

Case finding was low in iLembe, uMkhanyakude and uMzinyathi due to lack of resources for community based awareness campaigns. More interventions and support will be allocated to these districts to improve case detection. iLembe, as with hypertension, has the lowest diabetes incidence provincially at 1.6%, across all ages. This could be due to the fact that screening numbers were low (576,168) with only 38.4% of the PHC headcount being screened.

[10] 731,933 in 19/20 to 756,793 in 21/22

Graph 58: District diabetes incidence vs new patients placed on treatment – 21/22



Source: DHIS

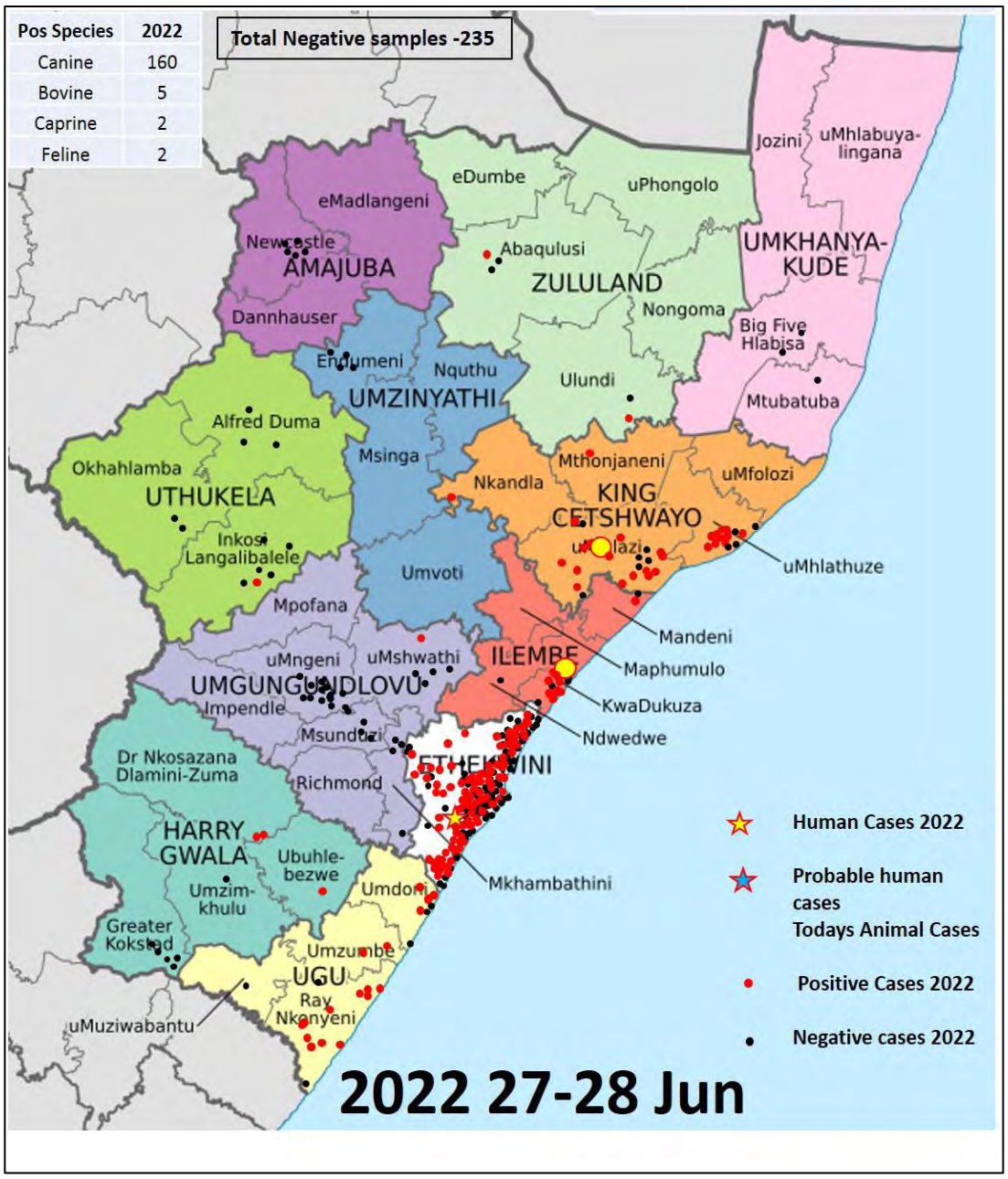
As with hypertension, Zululand has the highest incidence at 4.4 / 1,000 with 59% (1,239,796) of the PHC headcount screened for diabetes. There is a strong correlation between hypertension and diabetes and this can be found in the data quoted above.

In South Africa there were 9 laboratory confirmed human rabies deaths reported for 2022 as at June 2022, with 2 confirmed rabies cases in KwaZulu-Natal for this period. The last case was in June 2022 involving a 9 year old boy from iLembe. Community awareness has been done in the area. Rabies is 100% preventable with the correct treatment with community education playing a huge part in the success of rabies prevention.

Stock of the Equine Immunoglobulin (ERIG) & Human Immunoglobulin (HRIG) continues to be erratic. There is stock of HRIG with 2,642 doses for the management of category 3 bites, however there is a shortage of stock of ERIG for the management of category 1 and 2 exposure. Proper risk assessments must be done to ensure availability of stock.

Key messages include that educating the community that rabies is 100% fatal upon onset of clinical symptoms (disease), however rabies is 100% preventable.

Map 7: KZN Rabies Map for Quarter 2 2022



Source: Communicble Diease Control Website

Malaria is endemic to northern KwaZulu-Natal and affects uMkhanyakude, and the north eastern Zululand. The programme headquarters are based at Jozini, uMkhanyakude. The number of deaths occurred mostly in non-endemic districts due to a variety of factors including late presentation to health facilities. A range of interventions have been put in place to address the challenges. Case management training to strengthen health care worker knowledge was conducted in line with the new treatment guidelines.

Graph 59: Malaria case fatality rate

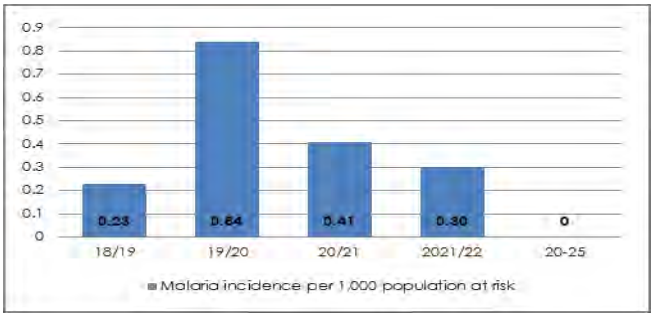
Source: DHIS

The number of deaths per annum, were 7 (18/19) pre-Covid, going up to 14 (21/22). This disease is preventable and therefore the malaria case fatality rate target for 2024/25 has

been set at 0%. This is achievable through spraying, community education and improved screening.

Malaria case fatality rate during 21/22 has 14 deaths and mostly occurred in malaria non-endemic districts. Mortality Audits were conducted and revealed the following challenges: delayed treatment initiation, laboratory analyses of samples, unavailability of treatment and unavailability of rapid diagnostic test kits. Delayed health seeking behavior/late presentation and mixed diagnosis of malaria with COVID-19 contributed to these deaths. Case management training was done in facilities that were identified as experiencing challenges. Health education was intensified to encourage health seeking behavior.

Graph 60: Malaria incidence per 1,000 population



Source: DHIS

The malaria incidence is measured against the uMkhanyakude population, as this is where it is most prevalent.

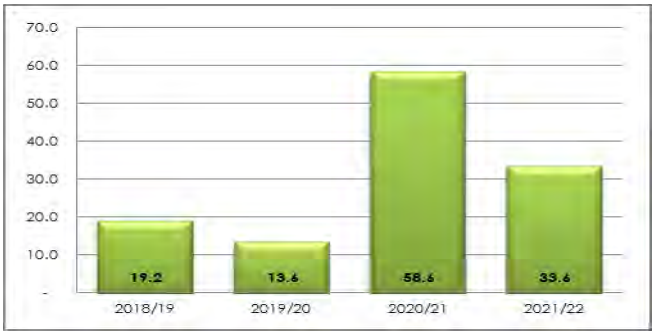
The lower malaria incidence for 20/21 (0.41 / 1,000) and 21/22 (0.3 / 1,000) was due to a drop in patients attending PHC, so screening was not as vigilant as in 19/20.

The KZN malaria incidence rate decreased from 0.84 / 1,000 (19/20) to 0.3 / 1,000 (21/22). Malaria importation remains a challenge, especially in endemic districts such as uMkhanyakude and Zululand where malaria vectors have been confirmed present. About 90% of the cases are imported and 10% are local cases reported by endemic districts.

There is mobile surveillance screening at the Border between Mozambique and South Africa by Humana people to people (partner) to screen, test and treat all mobile migrant populations. Another strategy is the implementation of focus clearing programmes focusing on local transition with the endemic district.

The dental extraction to restoration ratio measures the effectiveness and end result of dental services. The aim ultimately, is to conserve as many teeth as possible, as this has an impact on health including digestive health. The Province has seen an improving ratio in the past 5 years, although some districts are still under-performing.

Graph 61: Dental extraction to restoration ratio



Source: DHIS

Community awareness through health promotion especially with tooth brushing initiatives at school level, is yielding a positive impact. The partnership with Colgate includes the use of their mobile truck and has increased the number of restorations done.

COVID-19 had a negative impact on dental services in 20/21, as it is was not considered an essential life service and hence the ratio of extractions to restorations increased to 58.6% from 13.6% (19/20). This coupled with the shortage of dentists in some districts resulted in more extractions being done instead of restorations. The ratio is slowly starting to improve again and will hopefully return to pre-Covid values in 22/23.

The shortage of staff, combined with a lack of dedicated, ring fenced oral health budget in Programme 2 for staff, equipment and facility upgrades also impacts negatively on service delivery. The employment of a trained dental equipment repair technicians in Health Technology Services (HTS) would impact positively on the turnaround time of equipment repair.

The priorities for the programme going forward are to improve access to oral health services. This includes services in mobiles, clinics, CHC's and the hospital platforms. The access will also be improved by, increasing the Dental Therapist and Oral Hygienists coverage for the School Oral Health Programme and at facility level as part of Essential Post list Project, increase oral health education, awareness, early detection and treatment to positively impact on the extraction to Restoration ratio, and lastly the appointment of trained dental equipment repair Technicians at all HTS regions.

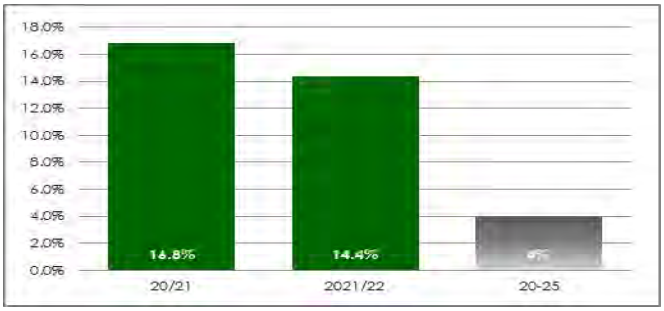
COVID-19 testing at the initial stages of the pandemic was high due to the demand for testing. COVID-19 protocols were also driving the demand for testing as all contacts of confirmed cases were tested irrespective of being symptomatic or asymptomatic. In 2020/2021, the number of

clients tested was higher than 21/22 due to the 2nd wave that hit KwaZulu-Natal hard. Testing coverage has since declined due to the vaccination programme, which is yielding positive results in terms of protecting the community. Integration of services has had positive spin offs in accessibility of testing at all levels of care.

The demand for testing continued through public and private laboratories. The number of tests increased during the peaks/ waves and majority of tests were conducted in eThekwini District. Community testing centres were established in hot spot areas during the peaks.

Positivity rate was high, partly due to the Omicron variant that was driving the 4th wave as the variant was very transmissible. Poor compliance with COVID-19 protocols contributed to the rise in numbers.

Graph 62: COVID-19 Positivity rate



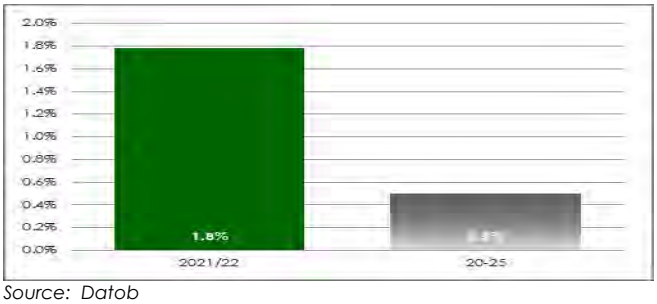
Source: Datcov

The COVID-19 positivity rate has remained constant in both reporting periods, partly due to poor compliance with COVID-19 interventions i.e. social distancing and wearing of masks. The Province was hit hardest by the two waves (2nd and 4th waves). The Province provided facilities for quarantine and isolation facilities to accommodate affected people that were unable to either self-quarantine/ self-isolate and refused to be isolated in government facilities. Community testing centres were established to improve access to testing in hot spot areas. Refusal to be tested was challenging and that contributed to the high transmission at a community level.

Case fatality rate was below 2% and this was due to late presentation to health facilities, vaccine hesitancy also contributed as most deaths occurred amongst unvaccinated population with comorbidities.

COVID-19 case fatality rate was more than 1% and this is attributed to late presentation to health facilities and vaccine hesitancy which is high in the Province. There were also a number of deaths that occurred at home and elderly people were mostly affected. Risk communication and community engagement using both print and social media were intensified in order to create awareness.

Graph 63: COVID-19 Case fatality rate: Total



Source: Datob

COVID-19 case fatality rate among persons aged 5 - 60 years was higher in the 20/21 financial year as the Province was hardest hit by the 2nd wave and there were many deaths amongst this age group. Late presentation, and use of home remedies contributed to the high number of deaths. Deaths amongst this age group were lower but the majority of deaths were of unvaccinated persons between the age 20-24 years. Many initiatives were implemented to encourage vaccination in all Districts. Training of health workers on case management was rolled out with assistance of the World Health Organisation (WHO) to enhance health care worker skills and knowledge. Vaccination access was improved.

COVID-19 Case Fatality Rate: under 5 years in 21/22 financial year was 0,5% (46 deaths). This was due to the late health seeking practices. Risk communication and community engagement was rolled out amongst mothers.

COVID-19 Case Fatality Rate 60 years and older was high amongst this age group due to late reporting to health facilities and vaccine hesitancy with some who dided at home only being confirmed positive at the mortuaries. New variants also contributed to the high number of deaths while, most deaths occurred among people with comorbidities. Interventions that including implemented to address these challenges such as vaccination drives and the establishment of vaccination centres at community level to improve access

OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE

Adherence to the national reporting guidelines led to the increase in the rate of severity assessment code (SAC) 1 incident reported within 24 hours rate at a PHC level, from 55.7% to 64.6%. However, there was an increase in the complaints on patient care, staff attitudes and waiting times mainly due to staff shortages.

The rate of SAC 1 incidents reported within 24 hours at Regional Hospitals, decreased from 83.3% (20/21) to 79.5% (21/22) due to guidelines not being adhered to. The percentages of complaints on patient care and staff attitudes

increased while the percentage of complaints on waiting times decreased.

TB hospitals had 31 SAC 1 incidents reported, compared to zero in 20/21 and 93.5% of them were reported within 24 hours. The number of complaints increased to 113 (21/22) due to TB patients being unhappy with being housed in-facility with COVID-19 patients and increased workloads of staff as a result of staff shortages.

The rate of SAC 1 incident reported within 24 hours for Psychiatric hospitals increased. Clinical Governance roadshows and revitalization of clinical governance structures contributed to this increase. Only the percentage of complaints on patient care decreased from the 20/21 baseline.

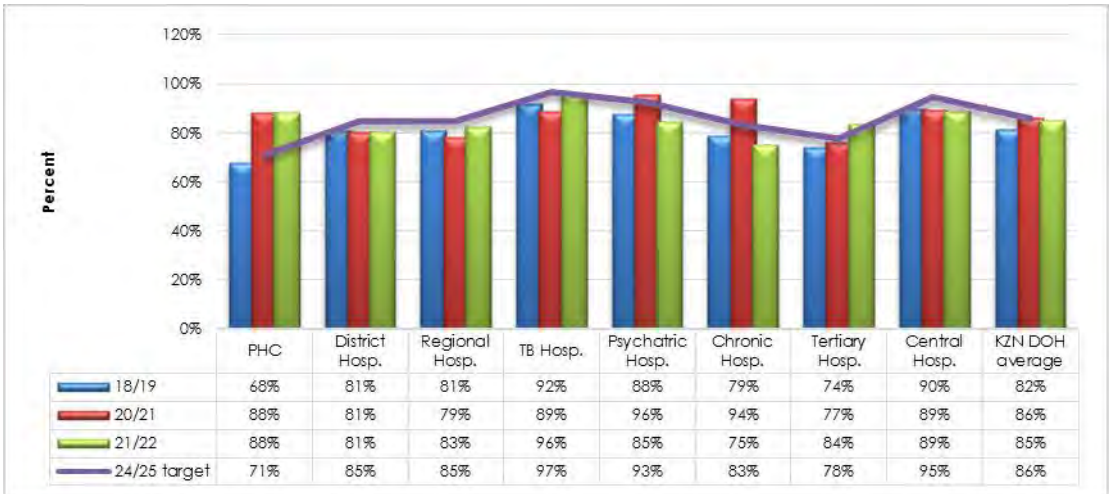
There were no SAC 1 incidents reported within 24 hours in 21/22 at Chronic Hospitals, although there was an increase in the percentage of complaints on patient care, waiting times and staff attitudes.

Tertiary Hospitals saw a decrease in the SAC 1 incident reported within 24 hours rate between 20/21 and 21/22, as a result of facilities' non-compliance with the policy. For some cases, facilities started with investigations before reporting to head office. The decrease in complaints is attributed to the decrease in the number of patients seen due to the limiting of numbers to curb the spread of COVID-19.

At a Central Hospital level, the 18% increase in SAC 1 incident reported within 24 hours rate is attributed to improved clinical governance roadshows and revitalization of clinical governance structures. There was an increase in complaints on staff attitudes, decrease on complaints on patient care and no complaint on waiting time for central hospital.

The Patient Experience of Care Satisfaction rate refers to the total number of satisfied responses as a proportion of all responses from the patient experience of care surveys. This indicator is monitored for all levels of care, i.e. from Primary health care level up to Central hospital level of care. Generally the provincial average has moved from the baseline of 82% (18/19) to 85% (21/22) and short 1% percent to reach the 2024/25 target. Primary health care and tertiary hospital are the two levels that have already exceeded their 2024/25 targets, but need to maintain the performance. Psychiatric, Chronic and Central hospitals are the three levels of service that have an achievement that is lower than the baseline. The challenges include lack of medication, long waiting times, and lack of clean linen, among others.

Graph 64: Patient Experience of Care Satisfaction rate Trend Analysis – 21/22

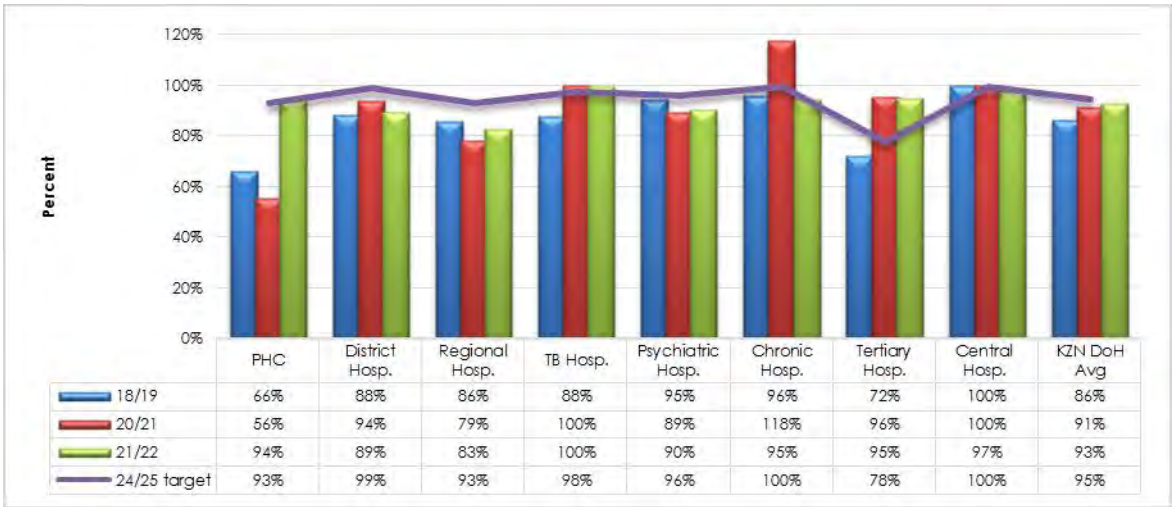


	PHC	District Hosp.	Regional Hosp.	TB Hosp.	Psychatric Hosp.	Chronic Hosp.	Tertiary Hosp.	Central Hosp.	KZN DOH average
18/19	68%	81%	81%	92%	88%	79%	74%	90%	82%
20/21	88%	81%	79%	89%	96%	94%	77%	89%	86%
21/22	88%	81%	83%	96%	85%	75%	84%	89%	85%
24/25 target	71%	85%	85%	97%	93%	83%	78%	95%	86%

Source: Complaints Information System

Patient Safety Incident Case Closure rate refers to patient safety incident cases closed in the reporting month as a proportion of the patient safety incident cases reported in the reporting month. There has been a steady increase in the provincial Patient Safety Incident Case Closure rate average. Primary health care, Tertiary hospital and Tuberculosis hospital have, in the 21/22 financial year, exceeded the 2024/25 targets. The main challenge reported is the issue of lengthy investigations that are required in some incidents.

Graph 65: Patient Safety Incident Case Closure rate Trend Analysis – 21/22



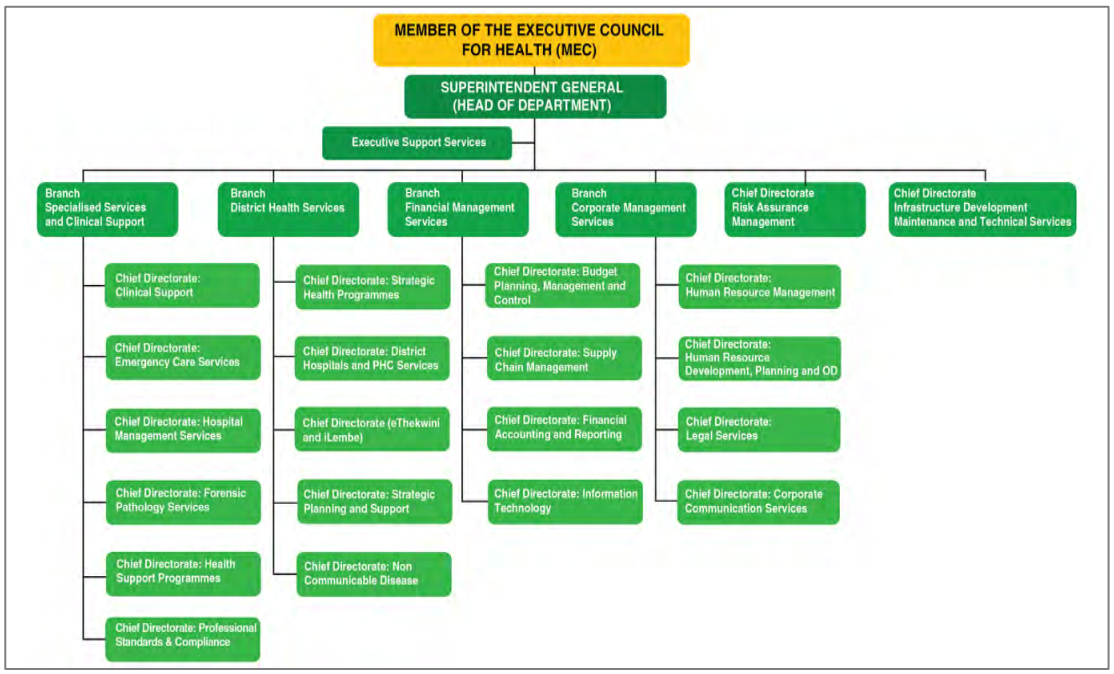
	PHC	District Hosp.	Regional Hosp.	TB Hosp.	Psychiatric Hosp.	Chronic Hosp.	Tertiary Hosp.	Central Hosp.	KZN DoH Avg
18/19	66%	88%	86%	88%	95%	96%	72%	100%	86%
20/21	56%	94%	79%	100%	89%	118%	96%	100%	91%
21/22	94%	89%	83%	100%	90%	95%	95%	97%	93%
24/25 target	93%	99%	93%	98%	96%	100%	78%	100%	95%

Source: Patient Safety Incident Software

ORGANISATIONAL STRUCTURE AND ORGANISATIONAL DESIGN

The Figure below is the approved MACRO structure by Department of Public Service Administration (DPSA) / Office of the Premier (OTP which was done in 2017). A review of the Head Office and Office Macro structures is underway to improve the cohesiveness and alignment of the structure to better respond to the interventions. .

Figure 5: KZN DOH Macro Structure as at March 2022



Source: Source: Approved Head Office Structure provided by Organisational Effeciency Services (OES) on the 16th May 2022

The vacancy rate for 21/22 is at 15.4% for the Department with Central Hospital Services having the highest vacancy rate at 16.3%. Although this programme has the highest vacancy rate, they have fewer employees with 1,101 vacant posts. In contrast, District Health Services with a 15.1% vacancy rate has approximately 7,414 vacant posts. District Health Services, is the main service delivery platform for the Department incorporating PHC services and District Hospitals. Provincial hospital services follow a similar trend with a 16.8% vacancy rate and 3,203 vacant posts.

Administration has a lower vacancy rate at 13.7% however, traditionally this programme also has the lowest turn-over rate compared to the bigger programmes such as District Health Services and Provincial Hospital Services due to the smaller number of staff. Support services are core to the functionality of the service delivery programmes.

The **Department of Health reporting lines structure** is below. A review of the Head Office and Office Macro structures is underway to improve the cohesiveness and alignment of the structure to better respond to the interventions.

Figure 6: KZN DOH Reporting Lines, as at March 2022

Table 17: Employment and vacancies by programme as on 31 March 2022

Programme	Number of posts on approved establishment [11]	Number of posts filled [12]	Vacancy rate %	Number of employees additional to the establishment [13]
Administration	1 120	967	13,7%	165
Central Hospital Services	6 761	5 660	16,3%	12
District Health Services	48 980	41 566	15,1%	9 802
Emergency Medical Services	3 340	3 053	8,6%	153
Health Care Support Services	582	479	17,7%	2
Health Facilities Management	4	4	0%	0
Health Sciences & Training	3 121	2 579	17,4%	1 999
Provincial Hospital Services	19 096	15 893	16,8%	12
TOTAL	**83 004**	**70 201**	**15,4%**	**12 145**

Source: Vulindlela HR Oversight Report extracted on 03/05/2022

The majority of the workforce falls within the Skilled, Highly Skilled Production and Highly Skilled Supervision levels reflecting vacancy rates from 17.6% to 19.2% respectively. Senior management has a higher vacancy rate of 28.3%.

Table 18: Employment and vacancies by salary band as at 31 March 2022

Salary band	Number of posts on approved establishment	Number of posts filled [14]	Vacancy rate %	Number of employees additional to establishment [15]
Lower Skilled (Levels 1-2)	3 571	2 985	16 4%	2
Skilled (Levels 3-5)	30 741	25 318	17 6%	29
Highly Skilled Production (Levels 6-8)	18 178	14 924	17 9%	56
Highly Skilled Supervision (Levels 9-12)	18 319	14 810	19 2%	2
Senior Management (Levels >= 13)	106	76	28 3%	0
Other	1 327	1 327	0%	586
Contract (Levels 1-2), Permanent	1 023	1 023	0%	1 530
Contract (Levels 3-5)	5 082	5 082	0%	5 333
Contract (Levels 6-8)	2 185	2 185	0%	2 546
Contract (Levels 9-12)	2 466	2 466	0%	2061
Contract (Levels >= 13	5	5	0%	0
TOTAL	**83 003**	**70 201**	**15 4%**	**12 145**

Source: Vulindlela HR Oversight Report extracted on 03/05/2022

[11] These are actual Posts on Persal. Organograms are not captured to ensure compliance with Cabinet Resolution to keep vacancy rates below 10%.

[12] This refers to filled **posts.** Please note that more than one sessional employee may occupy a post.

[13] Please note that as per a DPSA Directive, employees in training ranks e.g. Medical Interns and Community Service ranks e.g. Community Service Pharmacists are employed on contract and their posts are created as additional to the establishment in addition to additional to employment posts.

[14] This refers to filled **posts.** Please note that more than one sessional employee may occupy a post.

[15] Please note that as per a DPSA Directive, employees in training ranks e.g. Medical Interns and Community Service ranks e.g. Community Service Pharmacists are employed on contract and their posts are created as additional to the establishment.

The main categories of the Department of Health staff to render services are Medical Practitioners and Professional Nurses, with other staff playing a supportive role. From this perspective, Medical Practionerse have a 10.4% vacancy rate equating to 509 vacant posts, with 1,605 additional to establishment employees offsetting the vacancy rate. Professional Nurses have a 14.2% vacancy rate with 3,206 vacant posts and 2,182 additional to establishment nurses again offsetting the vacancy rate. Ambulance and Related Workers have a lower vacancy rate, but the service is restricted by the number of operational vehicles available.

Cognisance should be taken of 2 factors when reviewing the critical post establishment, The Workplace Skills mix is a concept that speaks to ensuring that the right qualifiied personel are employed at the right level, and that more "expensive" staff are not employed to do more "routine menial work" that is a nurse should not be employed to perform the functions of a data capturer or a general worker, as this adds to the CoE overhead. Secondly, staff should be equitably deployed within the Department / District, and should not be concentrated in one centre causing other services to collapse.

Table 19: Employment and vacancies by critical occupation as on 31 March 2022

Critical occupations	Number of posts on approved establishment	Number of posts filled	Vacancy rate %	Number of employees additional to establishment
All Artisans In The Building Metal Machinery Etc.	510	374	26,7%	1
Ambulance And Related Workers	3 204	2 928	8,6%	178
Dental Practitioners	169	145	14,2%	36
Dieticians And Nutritionists	246	198	19,5%	38
Emergency Services Related	44	42	4,5%	0
Engineering Sciences Related	48	35	27,1%	2
Environmental Health	100	80	20,0%	7
Head Of Department	1	1	0%	0
Medical Practitioners	4 917	4 408	10,4%	1,605
Medical Research And Related Professionals	142	90	36,6%	0
Medical Specialists	1 188	816	31,3%	0
Medical Technicians/Technologists	208	169	18,8%	0
Occupational Therapy	303	218	28,1%	69
Optometrists And Opticians	73	63	13,7%	6
Oral Hygiene	38	30	21,1%	1
Pharmacists	1 480	1 384	6,5%	316
Physicists	4	2	50%	0
Physiotherapy	445	363	18,4%	118
Professional Nurse	22 532	19 326	14,2%	2 182
Psychologists And Vocational Counsellors	146	108	26,0%	42
Radiography	802	683	14,8%	91
Social Work And Related Professionals	334	279	16,5%	23
Speech Therapy And Audiology	278	226	18,7%	113
TOTAL	**37 212**	**31 968**	**14,1%**	**4 828**

Source: Vulindlela HR Oversight Report extracted on 03/05/2022

There is a total of 102 senior managers within the Department of Health, of which 48% (49) are female. Overall, the majority of the workforce is female at 50,027 women equating to 72.4% of the workforce.

Employees with disabilities are under-represented against the 2% target, with 435 employees with disabilities (0.6%) employed. One hundred and ninety-six women make up 45% of employees with disabilities.

Table 20: Total number of employees (including employees with disabilities) in each of the following occupational categories as at 31 March 2022

Occupational categories (SASCO)	Male				Female				Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	
Senior Officials And Managers	38	1	8	1	33	3	7	6	97
Professionals	2 605	66	920	302	2 779	98	1 292	378	8 440
Technicians And Associate Professionals	4 214	48	328	21	18 826	468	1 820	255	25 980
Clerks	2 767	41	278	19	4 830	108	379	66	8 488
Service Shop And Market Sales Workers	3 934	33	406	13	14 507	95	261	26	19 275
Craft And Related Trade Workers	278	13	41	24	19	0	0	0	375
Plant And Machine Operators And Assemblers	435	8	44	2	166	5	7	1	668
Labourers And Related Workers	2 248	31	160	17	4 276	36	100	10	6 878
Total	**16 519**	**241**	**2 185**	**399**	**45 436**	**813**	**3 866**	**742**	**70 201**
Employees with disabilities	**187**	**3**	**41**	**8**	**162**	**3**	**23**	**8**	**435**

Source: Employment Equity

AUDIT OUTCOMES AND AUDIT IMPROVEMENT PLAN

MAJOR AUDIT FINDINGS FOR PERFORMANCE DATA

- Discrepancies between reported indicators and supporting documents
- Information not submitted for audit purposes
- Evidence in support of the reported achievements not available
- Relevant and reliable evidence in support of the reported achievements not available
- Inaccurate condoms distributed reported on DHIS
- Systems not effectively implemented to ensure accurate reporting of data in the Annual Performance Plan

Table 21: Primary Findings from the Auditor-General South Africa

Facilities Associated with Finding	Action plan
Primary Finding: Discrepancies between source documents and reported indicators	
Inkosi Albert Luthuli Central Hospital Port Shepstone Regional Hospital Estcourt District Hospital Eshowe District Hospital Hlabisa District Hospital Cato Manor CHC Nseleni CHC	The Department has started conducting comprehensive trainings/orientation on all M&E, Data Management and Planning activities. These training sessions cover all audit findings, gaps identified and highlight critical expectations from the facilities. To date the Department has completed 9/11 districts and aims to complete the remaining 2 by November 2022.
	A series of roadshows were conducted in June and July 2022 which covered all audit findings and actions to be taken. District, Hospital and Programme Management were invited and participated in these workshops.
	All information staff have been trained on data quality functionalities on the webDHIS. These reports will be mandatory to be run prior to submission of data (August 2022).
	The Department will continue monitoring their Audit Improvement Plan on a monthly basis.
	Verification, Reconciliation and internal audit tools have been revised to ensure that they are directly linked to an accountability at each level. This initiative will force compliance to the SOP's as well as ensure sign off by the Accounting Officer based on reliable data.
	Facility management and the data management team will conduct regular test checks to confirm the adequate implementation and operational effectiveness of the SOP's.
	The Department commits to visiting all CHC's prior to the next audit, providing support and mentoring. Cato Manor and Nseleni CHC will be prioritized.
	Feedback will be provided to all officials who are found to have been non-compliant to the policies and SOP's and the overall mismanagement of data, as well as management and safekeeping of patient records.
Primary Finding: Information not submitted for audit purposes	
Estcourt District Hospital	Management of the institution will undertake to ensure that a proper filing system is implemented for prompt and

Facilities Associated with Finding	Action plan
Eshowe District Hospital Hlabisa District Hospital King Dinuzulu Hospital Cato Manor CHC Nseleni CHC	efficient retrieval of records upon request.
	Acquire additional storage space for the safeguarding and storage of records.
	The Departments Records and Document Management Services will be contacted for assistance regarding the implementation of the SOP's and best practices as well to assist the institution to benchmark against another hospital. (benchmark Port Shepstone Hospital)
	Management will ensure that proper record keeping processes are implemented to ensure that all patient files and supporting documents are filed accordingly to ensure that such are easily retrieved when requested.
Primary Finding: Evidence in support of the reported achievement not available	
Estcourt District Hospital Eshowe District Hospital Hlabisa District Hospital Cato Manor CHC	Appoint a Clinic Records audit team with specific Terms Of Reference where applicable.
	Clinic Audits will be included as a KRA in each manager's Performance Agreement.
	Clinic audits will be undertaken monthly.
	In-service training on DHMIS Policy will be conducted.
	Clinical personnel to be subjected to records and document management training
Primary Finding: Relevant and reliable evidence in support of the reported achievement not available	
Cato Manor CHC Nseleni CHC	Training held in August 2022 with all QA co-ordinators to discuss strategy to correct the finding.
	The surveys, questionnaires as well as the assessment checklists are pre-numbered with signed consent forms or includes a unique identifier.
	Where necessary, the use of pictures will be considered for the observations conducted on the day of the assessment.
	The surveys / questionnaire checklists will be pre-numbered which will ensure that all completed forms are accounted for and reported accordingly.
Primary Finding: Inaccurate condoms distributed reported on DHIS	
King Cetshwayo Primary Condom Distribution Site SHP – Head office	Checking of correct and accurate recording of information on the bin cards.
	The HAST coordinator and the Facility Information Officer (FIO) will verify the data for accuracy and completeness before it is captured on the WebDHIS.
	The PPSD data will be split and emailed to all Districts by the 10th of every month. All districts (Condom LMIS Officers/ HAST FIO's/ HAST Coordinators) would be expected to verify if the data captured on the webDHIS corresponds with the figures on the PPSD report.
	On the 15th of every month, each district will be required to submit screenshots of male and female condom data captured on the webDHIS as well as provide scanned copies of their Condom PDS monthly summary report.
	The Provincial Strategic Information Management Unit Data Administrators would then verify figures captured on the webDHIS against the PPSD report as well as to the PDS Monthly Summary Report from each district. Should there be any discrepancies, feedback would be provided to the relevant district(s) by the 20th of every month. This would be followed up until all data discrepancies are resolved.
Primary Finding: Systems not effectively implemented to ensure accurate reporting of data on the annual performance report	
Province	The Department has started conducting comprehensive trainings/orientation on all M&E, Data Management and Planning activities. These training sessions cover all audit findings, gaps identified and highlight critical expectations from the facilities. To date the Department has completed 9/11 districts.
	A series of roadshows were conducted in June and July 2022 which covered all audit findings and actions to be taken
	All information staff have been trained on data quality functionalities on the webDHIS. These reports will be mandatory to be run prior to submission of data (August 2022).
	Verification, Reconciliation and internal audit tools have been revised to ensure that they are directly linked to an accountability at each level. This initiative will force compliance to the SOP's as well as ensure sign off by the Accounting Officer based on reliable data.

Challenges experienced in 20221/22

- Data verification- processes not followed. Lack of evidence.
- Data signoff – Poor sign off processes, verification processes do not take place prior to data sign-off.
- Non Functional Facility Information Committees – to be led by Senior Manager
- Records Management Intervention
- Blatant non-compliance to current SOP's

Non-Negotiable Activities for Districts and Facilities

- Districts to adopt Provincial Audit Improvement Plan (AIP) and commit to action plans/remedial actions.
- Each Facility to develop internal audit improvement plan and monitor monthly.
- Districts to conclude the roll out of patient folders as per DHS commitment.
- Ensure information committee meetings are scheduled and held for the year.
- Orientation/refresher training sessions to be completed for the 4 districts.
- Ideal clinic team to ensure correct guidelines are in place/adhered to.
- Fill vacant information posts at facility level, where possible
- Regular audit of facility information to occur – tools to be used
- Records Management intervention plan required

UPDATED KEY RISKS & MITIGATION STRATEGIES

Table 22: Key Risks and Mitigation Strategies

KEY RISKS	RISK MITIGATION
OUTCOME: UNIVERSAL HEALTH COVERAGE	
Escalating Medico Legal Litigation claims against the Department	• Implement Patients Records Management Plan — roll out best practices in records management.
	• Roll out of the approved Clinical Governance and Quality Improvement Policy in order to standardize structures, management approach and activities at all levels.
	• Appointment of clinical committee to review the controls
High staff vacancy rate	• Implement approved Essential Post List (Minimum Posts) for all Health Establishments.
National Health Insurance, Facility Accreditation and Compliance: Licensing of Private Health Establishments	• Develop the Provincial Private Licensing Regulations.
	• Revise bed norms for all categories of beds
	• Motivate for amendment of regulations to make a provision for revoking approvals of undeveloped establishment that exceed 5 years, of licenses for establishments not build within 5 years
Network Connectivity issues in all institutions	• Engage the Departmental ICT Unit for the installation of broadband connectivity in all facilities
Inability to manage Data effectively and efficiently	• Engage the Departmental ICT Unit to explore a systems that records data at point of service
	• Engage with NHI Policy Planning to request the intervention of NDOH for support on revival of the HPRS system
The Departmental Organisational Structures is not aligned to the Departmental Strategic Objectives and the Prescribed Legislative mandates	• Follow-up with the Principals on the finalisation of the Departmental organisational Structures for all levels
	• Motivate for the finalisation of Service delivery platform documents
Delays in finalisation of disciplinary cases	• Motivate for the filling of posts on contract basis : Investigating Officers and Presiding Officers
	• Engage Security Management Services to intervene for protection of Managers , witnesses who are threatened and intimidated .
Lack of synergy between conventional Health Workers and Traditional Health Practitioners (THP's)	• Develop policy on integration
	• Establish and formalise referral pathway
Increase in demand of health services	• Establish MOU for cross-boundaries and cross-border
	• To implement Preventive and promotive programmes
	• Integrate traditional medicine in Health Promotion Strategy
	• To implement Health Patient Registration System (HPRS)
Non finalisation of Primary Health Care (PHC) Provincialisation	• Finalise decision on Provincialisation process
Non accreditation of Health Establishments	• Develop a Provincial PSI Guideline
	• Re-enforce compliance with Non-negotiables
	• Develop the strategy to implement Peer Assessments on IHRM
Funding pressures threaten the achievement of service delivery objectives.	• Implement hospital rationalisation plan in order to improve efficiencies.
Inadequate storage for clinical records	• Engage with the Departments ICT Unit on the roll-out of the e-Health system and proposal for other

KEY RISKS	RISK MITIGATION
	electronical storage systems.
	• Follow-up with the Infrastructure Development Unit for a consideration of an offsite storage
High turnover of medical and nursing specialists	• Revive clinical outreach and in-reach programme.
	• Improve accessibility of specialists through Telemedicine and other E-Health platforms. (HMS, DHS and IT)
Inadequate administration and management of Pharmaceutical Stock	• Implement Rx Solution Stock Management System at PHC Clinics
	• Replace MEDSAS with a suitable warehouse management system.
Delayed completion of infrastructure projects	• Ongoing monitoring of the Infrastructure Supply Chain Management (SCM) Model
	• Development of the Standardised Tender Documents
Poor EMS response times due to a shortage of vehicles (put under Universal health Coverage and not Improved Client Experience of care)	• Update vehicle replacement plan
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE	
Lack of a Provincial Complaints Management Strategy	• Revive the Complaints Mechanism Committee
	• Develop and adopt the Provincial Complaints Management Strategy
OUTCOME: REDUCED MORBIDITY AND MORTALITY	
Inherent Risk of Health Care Associated Infections	• Adopt a multi-modal improvement strategies
	• Optimise the built environment to ensure compliance to IPC Principles
Inability to reduce the burden of disease from HIV	• Targeted testing for HIV
	• Provider Initiated counselling , testing and treatment adherence strategies through differentiated care
Inability to reduce the burden of disease from TB	• Targeted testing for TB
	• Treatment adherence strategies through patient treatment support
Inadequate treatment/ rehabilitation of children with cerebral palsy	• Improvement of infrastructure through the 10 year infrastructure Program/Plan
	• Development of an SOP on Referrals and other Treatment Protocols
Inability to timeously identify outbreaks	• Revival of the CDC (Ommunicable Disease Control) Organisational Structure
	• Orientation and Re-orientation on Outbreak Response Team
Improper management of HCRW	• Enforce compliance to the legislation and HCRW policy

THE PLANNING PROCESS

PESTLE ANALYSIS INTEGRATED WITH THE SWOT OVERVIEW

Table 23: Pestle / SWOT Combination Summary Analysis for external factors

Pestle Category	Opportunities	Threats
Political	The ruling party manifesto of 2017 and the implementation of NHI	
Economical	KZN is the 2nd largest population which determines budget allocation	KZN has a large uninsured medical population with approximately 10 326 801 people relying on public health facilities.
		28.7% of the population younger than 15 years 9.2% of the population older than 60 years, which in effect means 37.9% of the population is not economically active and is reliant on remaining population economically which can have an effect on health seeking behaviour and how health services are accessed.
	SA is classified as an upper-middle income country with a per capita income of R 55 258.	This perceived wealth does not percolate downwards as in KZN 51.7% of the population was classified as living in poverty.
	80.6% of learners at public schools are benefitting from the School Nutrition Programme	In KZN, there is an above average number of children under 5 years with severe acute malnutrition incidence and HIV prevalence.

Pestle Category	Opportunities	Threats
Socio-Demographic	Health Promotion is a priority of the MTSF and the DoH, KZN.	KZN has more children under 5 years of age than any other Province, meaning that health services for this age group can become overburdened.
	Community Health Workers and Ward Based Outreach Teams have a key role to play in the addressing social determinants through health education and prompt referrals. This includes the Traditional Health Practitioners (THP).	High proportion of deaths in the 35 – 59 years age group due to both NCD's and CD's, placing a burden on the economically active population.
	More females access health services early due to the increased focus on women's health.	There is a smaller male population in the older age groups due to poor health seeking behaviour and an increase in risky behaviour, again placing a burden on the higher end curative health services provided.
		5.5% of the KZN population is categorised as disabled at 583 000 people.
Technological	The 4th Industrial Revolution has begun which impacts on medical technology, the collection and collation of data and a Patient Management System	The KZN DoH is still largely paper based with regards to the collection and collation of data and Patient Management Systems.
		Challenges with the broadband network including both coverage in rural areas and the amount of "down time" experienced due to cable theft.
Legal		The increase in the number of litigation cases lodged against the KZN DoH threatens the amount of available budget and impacts on service delivery
Environmental	Decline in people living in informal dwellings	
	Gains made in access to piped water, and electricity.	
	Large proportion of subsistence farmers up north with access to food resources in KZN similar to the national averages.	

Table 24: Pestle / SWOT Combination Summary Analysis for internal factors

Pestle Category	Strengths	Weaknesses
Political	Good political will and leadership	
Economical	Budget cut and cost constraints impact on services provided	Staff shortage in both critical and non-critical posts
		Distribution of resources is skewed towards a hospi-centric approach.
Socio-Demographic	COVID-19 measures implemented improved the performance of some of the child health indicators were hand washing and improved health hygiene contributed to improvement in indicators.	There is a need to address the neonatal death rate should the under 5 death rate target for 2024/25 be achieved
		The management of HAST Patients including the disclosure and management of children and the implementation of literacy classes needs to be improved.
Technological	Patient information systems already in place in 5 hospitals	Computer literacy is still a challenge at PHC level in clinics for supervisions purposes
Legal	There is a Medico-Legal Component in place within the Department to assist with the Medico-Legal claims	Poor record keeping and poor implementation of SoP's allows for the increase in medico-legal cases
Environmental	Administrative and systemic processes in place	Poor implementation and compliance to AGL's and SoP's.

Table 25: Planning Processes for the 2023/ 24 planning cycle

No.	Activity	Description	Responsibility	Estimated timeframe[16]	Output
1.	Develop the Planning Guide for Department planning processes outlining high level dates and activities related to APP deliverables	a) Strategic Provincial Planning Guide developed, breaking down activities and due dates b) Draft list of indicators made available to DD(Provincial planning) to commence template and guide Prep c) Draft list of National, Provincial, Departmental priorities sent to DD(Provincial Planning) to commence template and planning guide d) Submit SOP, draft indicators and priorities to Deputy Director: Strategic provincial planning	Director: Strategic Planning	By 1 June	Strategic Planning Guide List of draft indicators List of draft National, Provincial and Departmental priorities
2.	Customise APP template and Excel Indicator templates	a) Draft template developed with draft indicators, draft TIDS, historic data, narrative from the latest draft annual report (To inform the situational analysis) and other draft available information b) Narrative guide developed[17]: c) Submit (a) and (b) to Director for circulation to/presentation to the HSDPM&E unit for input on template and processes	DD: Strategic Planning (Provincial planning)	By 15 June	Draft Template, Narrative Guide & excel indicator tables
3.	Initiate the planning process by issuing notice of the commencement of the new planning cycle	a) Templates and guiding documents forwarded/presented to the HSDPM&E unit for input on template and processes b) Templates and guiding documents sent electronically to Cluster Heads for dissemination to and discussion with their respective business units(BUs)	Director: Strategic Planning	By 30 June	Evidence of unit engagement on the Annual plan template and process Evidence of templates and guiding documents sent to clusters
4.	Programmes planning	a) Clusters to analyse policy priorities/mandate/challenges and commence planning for priority areas/mandate Clusters to peruse APP template and guide an provide the relevant information b) Hold strategic planning sessions with key stakeholders at cluster level and invite strategic planning to provide technical support c) Submit populated template and address all items required in the guide to strategic.planning@kznhealth.gov.za	All Business Unit Heads (All DDs: Strategic planning available for technical support to clusters)	11 July to – 31 August	Completed draft template, and information as specified in the guide available from all clusters
5.	Consult to obtain approval for hosting the strategic planning session[18]	Office of the HOD to request Executive Authority to approve the date and draft programme for the proposed strategic planning session	Office of the Head of Department	1 – 7 August	Approved date and programme
6.	Hold strategic planning session[19]	Departmental Extended MANCO invited to participate and engage on inputs into draft APP and any amendments to Strategic Plan (if applicable)	Director Strategic Planning	August (exact date to be confirmed by HOD's Office	Departmental Strategic Planning Session Report

[16] Subject to change based on annual calendar differences

[18] *For 5 year strategic planning cycle only (Next session to take place in 2022)*

[19] For 5 year strategic planning cycle

No.	Activity	Description	Responsibility	Estimated timeframe[16]	Output
7.	Consolidate draft APP inputs received from Programmes/business unit	a) Peruse revised inputs emanating from the programme planning sessions submitted by clusters and update draft APP b) Analysis, including consultation with programmes, of data regarding performance trends provincially. c) Attend district performance reviews for current trends at a district level d) Update the APP Excel templates with AR 21/22 audited data e) Incorporate the narrative from the AR into the Situational Analysis f) Liaise with Research for updated analysis on External Environment g) Submit APP consolidated 1st draft with emphasis on Part B Situational Analysis and the completion of historical data in Part C to Director	DD: SP (Provincial Planning)	1- 12 September	Evidence of submission of edited and consolidated 1st draft APP (with: Updated Parts A and B; Part C: National and Provincial priority indicators with Historic Data; Draft TIDS for National and Provincial Priority indicators) to Director
8.	Updated Risks available	Request Risks from the Business Unit responsible for Risk Assurance Management	Director: Strategic Planning	By 12 September	Evidence of engagements with RAM
9.	Amend and validate draft APP	Review the Draft APP and consider recommendations: a) Amendments needed: Recommend amendments to DD b) No internal amendments needed: Draft APP circulated departmentally for amendment and validation by clusters	Director Strategic Planning	13 – 18 September	1st draft APP amended and validated
10.	Review Cluster input	Receive Cluster inputs, note and send to DD: Strat Planning for amending	Director: Strategic Planning	19-20 September	Inputs acknowledged and forwarded to DD
11.	Incorporate comments and finalise draft APP	Incorporate comments/inputs received into draft APP and submit to Director for quality assurance and endorsement	DD: Strategic Planning	21 – 24 September	Quality assured and endorsed draft APP (component level)
12.	Unit Endorsement	Submit draft APP to Unit for review and comment	Director: Planning	25-28 September	Quality assured and endorsed draft APP (Unit level)
13.	Presentation of draft 1 APP to oversight bodies and MANCO	Present the Draft 1 APP to MANCO and/or Health Portfolio Committee (HPC) and incorporate feedback into the draft APP	Director: Strategic Planning	By 29 Sept	Evidence of circulation to or presentation to the MANCO and/or Health Portfolio Committee (HPC)
14.	Submit draft 1 APP to HOD for approval	Submission to HOD for approval of draft 1 of the APP and incorporate feedback into the draft APP	CD: HSDPM&E	29 Sept -7 October	Approved draft APP
15.	Submit draft 1 APP to OTP	Draft APP submitted to oversight bodies including OTP, NDoH, Provincial Treasury, AGSA	Director: Strategic Planning	15 October	OTP assessment of draft APP
16.	Obtain inputs for printing of the APP	a) Liaise with Govt Printers to obtain ISBN and PR numbers b) APP Book and CD Covers font updated	DD: T. Hattingh	By Nov	ISBN and PR numbers received Updated covers received

No.	Activity	Description	Responsibility	Estimated timeframe[16]	Output
17.	2nd Draft APP and Draft AOP sent to Cluster	To request input on 2nd Draft APP and Draft AOP: • Confirmation of targets by clusters • Mid-year data from data management • Narrative/other input from clusters	Director: Planning	1 Nov - 14 December	2nd Draft Templates emailed to all clusters
18.	Cluster Consultations on draft APP and AOP	Provision of Technical Planning Support	Clusters	14 December – 4 Jan	Evidence of Technical support provided/offered to all programmes/business units towards finalisation of APP /AOP input
19.	Report Non submission and follow up		DD: Planning Director: Planning	7 Jan	
20.	Submission of Final APP/AOP inputs (Inc targets) to Provincial Planning	Clusters to send all APP and AOP input to Strategic Planning (Narratives, Baselines, Targets, Activities, Budget)	Clusters	5 Jan	Evidence of submission
21.	Submission of Final APP/AOP inputs (Inc targets) to DD responsible for Provincial Planning	Consolidation of cluster inputs into the Final Draft APP and AOP	DDs (Planning)	By 14 Jan	Evidence of submission
22.	Final draft consolidated APP and AOP submission to Director: Planning	For assessment / quality checking	DD: Provincial Planning	31 January	Evidence of submission
23.	Circulate OTP/DPME feedback on draft APP assessment for cluster input/comment	Comments from DPME on assessed draft APP circulated electronically to all Cluster Heads for consideration and amendment of their inputs	Director: Strategic Planning	1 Feb	OTP assessment report on draft APP
24.	Proof reading and finalising draft APP and AOP	Draft APP finalised and consolidated as per comments received on the DPME input Submit Final Draft APP and AOP to Director for quality checking	DD: Strategic planning	4 Feb	APP Finalised Update available to be sent to Treasury/AGSA
25.	Submit final APP and AOP for quality assurance	Final APP and AOP submitted to CD: HSDPM&E and unit for quality assurance and endorsement	Director: Strategic Planning	7-8 Feb	Quality assured and endorsed final draft APP
26.	Present draft APP and AOP to Oversight bodies MANCO/HPC	For MANCO assessment and inputs	Director: Planning	9-11 Feb	MANCO Report
27.	Presentation of APP to oversight bodies for input	Present APP to HPC	Director: Strategic Planning	HPC timelines (Q4)	Presentation of APP given at HPC
28.	Submit final APP and AOP for approval	Final APP accompanied by a covering memo submitted to Cluster Heads for approval	Director: Strategic planning with support from CD: HSDPM&E	14-18 Feb	Signed-off/approved APP
		Final APP accompanied by a covering memo submitted to HOD for approval and onward submission to office of the MEC for approval	Director: Strategic planning with support from CD: HSDPM&E	21 Feb - 4 March	

No.	Activity	Description	Responsibility	Estimated timeframe[16]	Output
29.	Format and Print APP	Submit to Corporate communications for format support Print APP and prepare for tabling by end of March Submit to Director for onward submission for tabling	DD: Strategic Planning	7-14 March	Formatted Document sent to communications Printed APP
30.	Submission of approved APP for tabling in Legislature	APP forwarded to Speaker at Legislature ten days before tabling. Tabled in Legislature by the Executive Authority	Strategic Planning/ Executive Authority	Mid- March	Approved APP submitted for tabling in Legislature
	Submission of AOP to OTP	Submission of signed off AOP to OTP planning	Director	31 March	Approved AOP submitted to OTP
31.	Publish KZN DoH APP and AOP	Tabled APP And Approved AOP uploaded onto the departmental intranet and website and printed copies of APP for distribution	Provincial Planning DD	Within a week of tabling	Tabled APP Published APP
32.	Submit final APP to relevant Bodies	Submission of the final APP for the upcoming financial year to OTP, NDoH, PT, AGSA for information.	Director: Strategic Planning	End May	Final and tabled KZN DoH APP submitted to DPME

NOTES

PART C: MEASURING OUR PERFORMANCE

8. PROGRAMME 1: ADMINISTRATION

Programme Purpose

Conduct the strategic management and overall administration of the Department of Health. There are no changes to the Programme 1 structure.

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

Render advisory, secretarial and administrative support, and public relations, communication and parliamentary support.

Sub-Programme 1.2: Management

Policy formulation, overall leadership, management and administration support of the Department and the respective districts and institutions

Table 26: Programme 1 Outcome Indicators and Targets

Indicator Name		Data Source	South Africa		Provincial		Medium Term Targets		
			Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2023/24	2024/25	2025/26
OUTCOME: UNIVERSAL HEALTH COVERAGE									
I	**Audit opinion of Provincial DoH**	**Annual Reports**	**Unqualified**	**Unqualified**	**Qualified**	**Unqualified**	**Unqualified**	**Unqualified**	**Unqualified**
II	**Contingent liability of medico-legal cases**	**Medico-legal case management system**	**R 90 Bn**	**R18 Bn**	**R 20 Bn**	**R32 bn**	**R 31 Bn**	**R 32 Bn**	**R 33 Bn**
III	**UHC Service Index**	**SAHR**	**68%**	**75%**	**71.7%**	**73.5%**	**73.5%**	**73.5%**	**73.5%**
IV	**Professional nurses per 100 000 population**	**Manual calculation**	**Not available**	**Not available**	**153 / 100 000**	**152.5 / 100 000**	**152.5 / 100 000**	**152.5 / 100 000**	**152.5 / 100 000**
	Professional Nurses	*Persal*			*17 444*	*18 177*	*17 997*	*18 177*	*18 360*
	Population	*Stats SA*			*11 417 126*	*11 919 339*	*11 801 473*	*11 919 339*	*12 037 206*
V	**Medical officers per 100 000 population**	**Manual calculation**	**Not available**	**Not available**	**34 / 100 000**	**27.4 / 100 000**	**27.4 / 100 000**	**27.4 / 100 000**	**27.4 / 100 000**
	Medical Officers	*Persal*			*3 879*	*3 260*	*3 234*	*3 260*	*3 260*
	Population	*Stats SA*			*11 417 126*	*11 919 339*	*11 801 473*	*11 919 339*	*11 919 339*

Table 27: Programme 1 Output Indicators and Targets

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
OUTCOME: UNIVERSAL HEALTH COVERAGE								
CHW's contracted into the Health system as part of the Community Based Model	**1. Number of CHW's contracted into the Health System**	**10 080**	**10 350**	**10 245**	**10 173**	**10 350**	**10 350**	**10 350**
Supplier invoices paid within 30 days	**2. Percentage of supplier invoices paid within 30 Days**	**95.7%**	**96.3%**	**95%**	**95.5%**	**95%**	**95%**	**95%**
	Supplier invoices paid within 30 Days	*294 852*	*300 497*	*294 166*	*151 396*	*237 500*	*237 500*	*237 500*
	Supplier invoices paid	*308 098*	*311 902*	*308 084*	*158 610*	*250 000*	*250 000*	*250 000*
Hospitals implementing the e-Health System	**3. Percentage of hospitals using the E-Health System**	**New indicator**	**3%**	**2.8%**	**2.9%**	**67.1%**	**100%**	**100%**

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
	Total number of hospitals with an electronic system to record clinical codes		*2*	*2*	*2*	*47*	*70*	*70*
	Total number of hospitals		*72*	*72*	*70*	*70*	*70*	*70*

Table 28: Programme 1 Output Indicators Quarterly and Annual Targets

Indicator Name	Targets				
	2023/24	Q1	Q2	Q3	Q4
OUTCOME: UNIVERSAL HEALTH COVERAGE					
1. Number of CHW's contracted into the Health System	**10 350**	**10 350**	**10 350**	**10 350**	**10 350**
2. Percentage of supplier invoices paid within 30 Days	**95%**	**95%**	**95%**	**95%**	**95%**
Supplier invoices paid within 30 Days	*237 500*	*59 375*	*59 375*	*59 375*	*59 375*
Supplier invoices paid	*250 000*	*62 500*	*62 500*	*62 500*	*62 500*
3. Percentage of hospitals using the E-Health System	**67.1%**	**4.3%**	**60%**	**60%**	**67%**
Total number of hospitals with an electronic system to record clinical codes	*47*	*3*	*42*	*42*	*47*
Total number of hospitals	*70*	*70*	*70*	*70*	*70*

Explanation of Planned Performance over the Medium Term Period

OUTCOME: UNIVERSAL HEALTH COVERAGE

Corporate Services : An HR Resource Strategy will be developed in conjunction with the Service Delivery Cluster including an organisational review of structures to ensure that form and function are aligned. The strengthening of all Employee Health Wellness programmes at all levels of service to promote employee wellness. Achievement towards a clean audit for human resource outcomes including HR functions.

Finance: The Preferential Procurement Framework will be reviewed to towards the empowerment of vulnerable groups, including women, the youth, persons living with disabilitiy and military veterans. Revenue enhancement and cost management will be strengthened. Filling of key posts, talent identification, and capacitation of staff. Improvement of audit outcomes and support will be through the implementation of the Logis System.

Community Health Workers: Ensure Community Health Workers are in place for access to health services.

Minimum Staff Establishment: The Department is reviewing the minimum staff establishment aimed at addressing critical staff shortages at identified facilities. The implementation is a

challenge as the Department has insufficient funding at this stage to implement the finalised plan. Filling of posts will be done on a phased-in basis as funding becomes available.

National Health Insurance: The Department plans to increase general practitioners (GP) contracted in the province *via* the National Health Insurance (NHI) grant from 119 in 22/23 to 130 in 23/24. The increase in GPs contracted assists to reduce the relative cost of health care and increase access to medical professional in needy communities.

Medico-Legal: A reassessment and adjustment of staffing & structure will be conducted to facilitate a model that appropriately & adequately deals with the growing challenge of medico legal claims with the express goal of establishing and facilitating workable and practical strategies to reduce contingent liabilities. The department will continue with implementation of the Mediation Policy, will pursue the review of unsettled claims in eThekwini for closure, improve relations with the State Attorney's office to assist with the more basic cases that can be concluded quickly, work towards implementation of an effective collection strategy through private attorneys and improvement of internal communication with information being disseminated via district workshops and improved relations for fleet management regarding legal prescripts.

eHealth System: In 2023/24, the Department will procure equipment to commence the implementation of the KZN eHealth system in additional hospitals. The Department plans to roll out the eHealth system in 67.1% (47/70 including PKISMH) of hospitals in 2023/24. The E-Health implementation improves records management as well as client waiting times.

Payment of Supplier Invoices within 30 Days of receipt: The payment of suppliers is an important aspect of NHI to ensure services are paid for timeously, and do not negatively affect the supplier's cash flow. The departmental systems and processes are geared towards improving the timeous payment to suppliers.

Programme Resource Considerations

Table 29: Budget allocation Estimates (R'000) (Programme 1)

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
Office of the MEC	21 864	19 676	21 243	26 669	26 669	27 278	24 890	25 636	26 981
Management	774 333	1 287 385	1 018 758	1 034 358	1 135 608	1 172 175	1 241 593	1 342 194	1 402 321
Sub-Total	**796 197**	**1 307 061**	**1 040 001**	**1 061 027**	**1 162 277**	**1 199 453**	**1 266 483**	**1 367 830**	**1 429 302**
Unauthorized expenditure (1st charge) not available for spending	-		-	-	-	-	-	-	-
Baseline available for spending after 1st charge	**796 197**	**1 307 061**	**1 040 001**	**1 061 027**	**1 162 277**	**1 199 453**	**1 266 483**	**1 367 830**	**1 429 302**

Table 30: Summary of Budget Allocations and Estimates by Economic Classification (R'000) (Programme 1)

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
Current payments	**750 020**	**1 269 315**	**924 989**	**1 006 254**	**1 101 609**	**1 095 906**	**1 202 147**	**1 290 100**	**1 339 329**

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
Compensation of employees	423 890	429 698	476 820	523 425	517 943	503 896	536 262	563 281	579 944
Goods and services	**325 600**	**839 245**	**447 671**	**482 829**	**583 666**	**591 421**	**665 885**	**726 819**	**759 385**
Communication	15 216	27 030	36 345	18 299	54 528	56 018	57 145	59 716	62 391
Computer Services	99 851	121 700	123 304	93 500	99 471	111 797	177 713	218 662	228 458
Consultants, Contractors and special services	56 010	38 271	47 119	63 713	53 422	52 354	55 929	59 445	62 108
Inventory	3 365	349 996	37 491	8 205	8 205	6 601	7 949	8 308	8 680
Operating leases	8 671	8 476	7 828	9 698	9 698	10 270	10 981	11 475	11 989
Travel and subsistence	21 900	64 291	16 579	39 214	22 801	21 742	53 895	54 971	57 433
Maintenance, repair and running costs	7 950	32 333	6 996	50 292	21 490	24 699	29 140	27 697	28 938
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	112 637	197 148	172 009	199 908	314 051	307 940	273 133	286 545	299 388
Interest and rent on land	530	372	498	-	-	589	-	-	-
Transfers and subsidies to	**24 812**	**11 076**	**23 049**	**9 491**	**9 491**	**27 809**	**9 908**	**10 354**	**10 817**
Provinces and municipalities	3 564	3 243	6 426	4 551	4 551	4 172	4 751	4 965	5 187
Departmental agencies and accounts	7	4	-	1	1	1	1	1	1
Higher education institutions	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	21 241	7 829	16 623	4 939	4 939	23 636	5 156	5 388	5 629
Payments for capital assets	**21 276**	**22 631**	**91 840**	**45 282**	**45 282**	**69 843**	**54 428**	**67 376**	**79 156**
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Machinery and equipment	21 276	22 631	91 840	45 282	45 282	69 843	54 428	67 376	79 156
Payment for financial assets	89	4 039	123	-	5 895	5 895	-	-	-
Total economic classification	**796 197**	**1 307 061**	**1 040 001**	**1 061 027**	**1 162 277**	**1 199 453**	**1 266 483**	**1 367 830**	**1 429 302**
Unauthorised expenditure (1st charge) not available for spending	-								
Total economic classification	**796 197**	**1 307 061**	**1 040 001**	**1 061 027**	**1 162 277**	**1 199 453**	**1 266 483**	**1 367 830**	**1 429 302**

PERFORMANCE AND EXPENDITURE TRENDS

Programme 1 is allocated 2.5% of the Vote 7 budget, up from 2.3% in the 22/23 revised estimated. This amounts to an increase of R 67 030 000.

UPDATED KEY RISKS AND MITIGATION

Table 31: Key Risks and Mitigation Strategies (Programme 1)

Key Risks	*Risk Mitigation*
Outcome: Universal Health Coverage	
Escalating Medico Legal Litigation claims against the Department	Improve PSI awareness program
	Prioritise existing facilities rather than building new (Department's IPMP)
	Implement Patients Records Management Plan — roll out best practices in records management.
	Monitor compliance of facilities with the Clinical Governance policy and provide facility based support by finalising facility based support programme
	Roll out of the approved clinical governance and quality improvement policy in order to standardize structures, management approach and activities at all levels.
	Implement approved Essential Post List (Minimum Posts) for all Health Establishments.
Poor food services management systems	Fast tracking the process of tender revisions for Outsourced Catering and Insourced food procurement, and transfer all small hospital Food from outsourced to In-house
	Install Food Conveyor system for portioning meals correctly in big hospitals
Escalating Medico Legal Litigation claims against the Department	Improve PSI awareness program
National Health Insurance, Facility Accreditation and Compliance: Licensing of Private Health Establishments	Develop the Provincial Private Licensing Regulations.
	Review licensing fees.
	Revise bed norms for all categories of beds
	Motivate for amendment of regulations to make a provision for revoking approvals of undeveloped establishment that exceed 5 years, of licenses for establishments not build within 5 years
Inequitable health care financing	Change Medical Schemes Act
	Regulate private health industry
	Improve financial management by Managers
Network Connectivity issues in all institutions	Engage the Departmental ICT Unit for the installation of broadband connectivity in all facilities
Inability to manage Data effectively and efficiently	Engage the Departmental ICT Unit to explore a systems that records data at point of service
	Engage with NHI Policy Planning to request the intervention of NDOH for support on revival of the HPRS system
Poor quality of data produced for spatial mapping.	Make representations for the revival of the GIS Forum that will provide a platform to allow for issues and challenges to be addressed at a Provincial Level.
Poor Persal data integrity	Implementation of PERSAL clean-up strategy (PERSAL Info Improvement Plan)
Delayed compilation of documents produced by Strategic Planning component	Report progress on cluster participation in strategic planning documents to MANCO
	Engage with SHP to discuss Integrated District Planning processes
Fire incident	Review the emergency preparedness guideline
	Develop Monitoring tools

Key Risks	*Risk Mitigation*
Outcome: Universal Health Coverage	
Occupational Stress	Raise awareness on impact of poor communication in the Department
	Review and Train on Wellness Policies
High staff vacancy rate	Motivate for funding of posts as per approved organisational structure
Inadequate IT Infrastructure	Motivate for WiFi connectivity/ DSTV subscription & License on the 2023/24 Procurement Plan
The Departmental Organisational Structures is not aligned to the Departmental Strategic Objectives and the Prescribed Legislative mandates	Follow-up with the Principals on the finalisation of the Departmental organisational Structures for all levels
	Motivate for the finalisation of Service delivery platform documents
Delays in finalisation of disciplinary cases	Motivate for the filling of posts on contract basis : Investigating Officers and Presiding Officers
	Engage Security Management Services to intervene for protection of Managers , witnesses who are threatened and intimidated .
Increase in Medico-Legal Contingent Liability	Appointment of clinical committee to review the controls
Poor medical records management	Heads of facilities to get clinicians to record and keep appropriate clinical information.
Performance indicators that are not funded	To motivate for the alignment of Strategic Planning and Budget planning calendars/processes.
	Quarterly reviews of the budget against the performance indicators
Attack on Departmental employees	Invest in the installation of a technology system (CCTV, Biometrics, panic buttons) at strategic areas
	Identify a task team headed by security service to conduct security risk assessment on the issues faced by the Department and make necessary recommendations
	Conduct an awareness to all Districts

NOTES

9. PROGRAMME 2: DISTRICT HEALTH SERVICES

Programme Purpose

To render Primary Health Care and District Hospital Services. There are no changes to the Programme 2 structure.

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, 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 nutrition specific and nutrition sensitive 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

Table 32: PHC Outcome Indicators and Targets

Indicator Name	Data Source	South Africa		Provincial		Medium Term Targets		
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2023/24	2024/25	2025/26
OUTCOME: UNIVERSAL HEALTH COVERAGE								
VI Ideal clinic status obtained rate	**Ideal Health Facility Software**	**56%**	**100% PHC**	**75.6%**	**100%**	**85.1%**	**100%**	**100%**
Fixed PHC health facilities have obtained Ideal Clinic status	*Ideal clinic report*	*Not available*	*Not available*	*461*	*610*	*519*	*610*	*610*
Fixed PHC clinics or fixed CHCs and or CDCs		*Not available*	*Not available*	*610*	*610*	*610*	*610*	*610*
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE								
VII Patient Safety Incident (PSI) case closure rate –PHC facility	**Patient Safety Incidence Software**	**Not available**	**Not available**	**65.9%**	**95%**	**95%**	**95%**	**95%**
Patient Safety Incident (PSI)case closed – PHC facility	*Patient Safety Incidence Reports*			*270*	*684*	*665*	*684*	*690*
Patient Safety Incident (PSI) case Reported – PHC facility				*410*	*720*	*700*	*720*	*726*
VIII Patient Experience of Care satisfaction rate – PHC	**webDHIS PEC**	**Not available**	**Not available**	**68%**	**90%**	**88%**	**90%**	**90%**
Patient Experience of Care survey satisfied responses - PHC	*Patient Surveys*			*31 326*	*1 935 000*	*945 751*	*1 935 000*	*1 935 000*
Patient Experience of Care survey total responses - PHC				*46 068*	*2 150 000*	*1 074 718*	*2 150 000*	*2 150 000*

Table 33: PHC Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE								
Severity Assessment Code (SAC) incidence reported within 24 hours rate at PHC level	**4. Severity assessment code (SAC) 1 incident reported within 24 hours rate – PHC**	**54.3%**	**55.7%**	**64.6%**	**78.8%**	**85%**	**85%**	**85%**
	Severity assessment code (SAC) 1 incidents reported within 24 hours – PHC facility	*57*	*122*	*133*	*164*	*187*	*187*	*187*
	Severity assessment code (SAC) 1 incident reported – PHC facility	*105*	*219*	*206*	*208*	*220*	*220*	*220*

Table 34: PHC Output Indicators Quarterly and Annual Targets

Indicator Name	Targets				
	2023/24	Q1	Q2	Q3	Q4
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE					
4. Severity assessment code (SAC) 1 incident reported within 24 hours rate – PHC	**85%**	**85%**	**84%**	**85%**	**85%**
Severity assessment code (SAC) 1 incidents reported within 24 hours – PHC facility	*187*	*47*	*46*	*47*	*47*
Severity assessment code (SAC) 1 incident reported – PHC facility	*220*	*55*	*55*	*55*	*55*

DISTRICT HOSPITALS

Table 35: District Hospitals Outcome Indicators and Targets

Indicator Name	Data Source	South Africa		Provincial		Medium Term Targets		
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2023/24	2024/25	2025/26
OUTCOME: IMPROVED EXPERIENCE OF CARE								
IX Patient Safety Incident (PSI) case closure rate – District Hospital	**Patient Safety Incidence Software**	**Not available**	**Not available**	**93.1%**	**99%**	**90%**	**99%**	**99.2%**
Patient Safety Incident (PSI)case closed - District Hospital	*Patient Safety Incidence Reports*			*1 166*	*1 757*	*1 620*	*1 757*	*1 736*
Patient Safety Incident (PSI) case Reported – District Hospital				*1 252*	*1 775*	*1 800*	*1 775*	*1 750*
X Patient Experience of Care satisfaction rate – District Hospitals	**WebDHIS PEC Module**	**Not available**	**Not available**	**81%**	**85.1%**	**81%**	**85.1%**	**86%**
Patient Experience of Care survey satisfied responses – District Hospitals	*Patient surveys*			*2 923*	*170 200*	*162 000*	*170 200*	*172 000*
Patient Experience of Care survey total responses – District Hospitals				*3 609*	*200 000*	*200 000*	*200 000*	*200 000*
OUTCOME: REDUCED MORBIDITY AND MORTALITY								
XI [Number of] Maternal death in facility – District hospitals	**Maternal death register**	**275**	**N/A**	**51**	**48**	**49**	**48**	**47**
XII [Number of] Death in facility under 5 years – District Hospital	**Midnight report**	**5 604**	**5 044**	**1 334**	**1 439**	**1 476**	**1 439**	**1 403**
XIII Child under 5 years diarrhoea case fatality rate –District Hospital	**DHIS**	**1.7%**	**1.3%**	**2.2%**	**1.5%**	**1.6%**	**1.5%**	**1.4%**
Diarrhoea death under 5 years – District hospital	*Midnight report*	*353*	*212*	*94*	*65*	*70*	*65*	*61*

Indicator Name	Data Source	South Africa		Provincial		Medium Term Targets		
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2023/24	2024/25	2025/26
Diarrhoea separation under 5 years – district hospital	*Ward register*	*21 030*	*16 824*	*4 360*	*4 212*	*4 268*	*4 212*	*4 212*
XIV Child under 5 years pneumonia case fatality rate –District Hospital	**DHIS**	**1.5%**	**1.3%**	**1.8%**	**1.3%**	**1.4%**	**1.3%**	**1.2%**
Pneumonia death under 5 years – District Hospital	*Midnight report*	*420*	*294*	*128*	*80*	*93*	*80*	*75*
Pneumonia separation under 5 years – District Hospital	*Ward register*	*27 446*	*21 957*	*6 938*	*6 243*	*6 419*	*6 243*	*6 243*
XV Child under 5 years Severe Acute Malnutrition case fatality rate –District Hospital	**DHIS**	**6.3%**	**5.9%**	**7%**	**7.6%**	**8.5%**	**7.6%**	**7.5%**
Severe acute malnutrition death under 5 years - District Hospitals	*Midnight report*	*425*	*361*	*94*	*82*	*94*	*82*	*79*
Severe acute malnutrition inpatient separation under 5 years - District Hospitals	*Ward register*	*6 771*	*6 094*	*1 336*	*1 075*	*1 100*	*1 075*	*1 050*

Table 36: District Hospitals Output Indicators and Targets

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
OUTCOME: IMPROVED EXPERIENCE OF CARE								
Severity Assessment Code (SAC) incidence reported within 24 hours rate at District Hospital level	**5. Severity assessment code (SAC) 1 incident reported within 24 hours rate – District Hospital**	**65.3%**	**75.1%**	**72.2%**	**83.8%**	**83%**	**85%**	**90%**
	Severity assessment code (SAC) 1 incidents reported within 24 hours – District Hospital	*235*	*220*	*459*	*506*	*498*	*510*	*540*
	Severity assessment code (SAC) 1 incident reported – District Hospital	*360*	*293*	*636*	*604*	*600*	*600*	*600*

Table 37: District Hospitals Output Indicators Quarterly and Annual Targets

Indicator Name	Targets				
	2023/24	Q1	Q2	Q3	Q4
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE					
5. Severity assessment code (SAC) 1 incident reported within 24 hours rate – District Hospital	**83%**	**82.7%**	**83.3%**	**82.7%**	**83.3%**
Severity assessment code (SAC) 1 incidents reported within 24 hours – District Hospital	*498*	*124*	*125*	*124*	*125*
Severity assessment code (SAC) 1 incident reported – District Hospital	*600*	*150*	*150*	*150*	*150*

HIV / TB AND SEXUALLY TRANSMITTED INFECTIONS (HAST)

Table 38: HAST Outcome Indicators and Targets

Indicator Name		Data Source	South Africa		Provincial		Medium Term Targets		
			Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2023/24	2024/25	2025/26
OUTCOME: REDUCED MORBIDITY AND MORTALITY									
XVI	**[Number of] All DS-TB Deaths**	**TB clinical stationary**	**New indicator**	**Not available**	**3 593**	**2 840**	**3 000**	**2 840**	**2 500**
XVII	**All DS-TB client treatment success rate**	**DHIS**	**80%**	**Not available**	**72.2%**	**86%**	**85%**	**86%**	**88%**
	All DS- TB client successfully completed treatment	*DS clinical stationary*	*182,084*		*42 178*	*40 703*	*36 573*	*40 703*	*42 240*
	All DS-TB treatment start		*227,547*		*58 411*	*47 329*	*43 027*	*47 329*	*48 000*
XVIII	**TB Rifampicin Resistant / Multidrug resistant treatment success rate**	**EDR.web**	**New indicator**	**Not available**	**63.5%**	**72%**	**70%**	**72%**	**74%**
	All Rifampicin resistant / Multidrug resistant clients successfully completed treatment	*TB clinical stationary*			*2 850*	*1 133*	*965*	*1 133*	*1 242*
	All Rifampicin resistant / Multidrug resistant client started on treatment				*4 491*	*1 574*	*1 378*	*1 574*	*1 678*
XIX	**TB Pre-XDR treatment success rate**	**EDR.web**	**New indicator**	**Not available**	**New indicator**	**68.3%**	**65.9%**	**68.3%**	**70%**
	TB Pre-XDR client who successfully completed treatment	*TB clinical stationary*				*41*	*29*	*41*	*49*
	TB Pre-XDR client started on treatment					*60*	*44*	*60*	*70*
XX	**ART client remain on ART end of month – sum**	**ART register**	**4 629 831**	**5 271 837**	**1 387 688**	**1 701 031**	**1 622 676**	**1 701 031**	**1 817 137**
XXI	**ART Adult Viral load suppressed rate (Below 50) [12 months]**	**DHIS**	**79.2%**	**89.1%**	**90.6%**	**95%**	**95%**	**95%**	**95%**
	ART adult viral load under 50	*ART paper register*	*-*	*-*	*38 371*	*90 866*	*90 866*	*90 866*	*90 866*
	ART adult viral load done		*-*	*-*	*42 374*	*95 648*	*95 648*	*95 648*	*95 648*
XXII	**ART Child viral load suppressed rate (Below 50) [12 months]**	**DHIS**	**74.8%**	**81.5%**	**68.7%**	**90%**	**70%**	**90%**	**90%**
	ART child viral load under 50	*ART paper register*	*-*	*-*	*826*	*2 250*	*1 750*	*2 250*	*2 250*
	ART child viral load done		*-*	*-*	*1 203*	*2 500*	*2 500*	*2 500*	*2 500*
XXIII	**HIV positive 15-24 years (excl ANC) rate**	**DHIS**	**New indicator**	**3.5%**	**New indicator**	**1.8%**	**1.8%**	**1.8%**	**1.8%**
	HIV positive 15 – 24 years (excl ANC)	*PHC tick register, HTS register*		*-*		*14 058*	*14 058*	*14 058*	*14 058*
	HIV test 15 – 24 years (excl ANC)			*-*		*781 000*	*781 000*	*781 000*	*781 000*

Table 39: HAST Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
OUTCOME: REDUCED MORBIDITY AND MORTALITY								
Reduce TB clients lost to follow up	**6. All DS-TB client lost to follow up rate**	**10.5%**	**10.7%**	**10.3%**	**9.2%**	**7%**	**6%**	**5%**
	All DS-TB client loss to follow-up	*5 499*	*5 495*	*3 826*	*3 580*	*3 012*	*2 839*	*2 400*
	All DS-TB treatment start	*52 423*	*51 150*	*37 312*	*38 992*	*43 027*	*47 329*	*48 000*
	7. TB Rifampicin resistant / Multidrug – Resistant lost to follow up rate	**New indicator**	**New indicator**	**New indicator**	**New indicator**	**15%**	**13%**	**10%**
	TB Rifampicin resistance / multi-drug resistant client loss to follow-up					*207*	*205*	*167*
	TB Rifampicin Resistant / Multi-drug resistant client started on treatment					*1 378*	*1 574*	*1 678*
	8. TB Pre-XDR Loss to Follow-up Rate	**New indicator**	**New indicator**	**New indicator**	**New indicator**	**15.9%**	**13.3%**	**10%**
	TB Pre-XDR clients who are loss to follow-up					*7*	*8*	*7*
	TB Pre-XDR clients started on treatment					*44*	*60*	*70*
Adults on ART remaining in care at 12 months	**9. ART adult remain in care rate (12 months)**	**66%**	**52.6%**	**68.4%**	**76.3%**	**75%**	**80%**	**85%**
	ART adult remain in care – total	*113 832*	*390 644*	*78 003*	*104 950*	*129 544*	*152 000*	*161 500*
	ART adult start minus cumulative transfer out	*172 421*	*741 997*	*113 994*	*137 554*	*172 726*	*190 000*	*190 000*
Children on ART remaining in care at 12 months	**10. ART child remain in care rate (12 months)**	**74.4%**	**57.6%**	**76.6%**	**79.5%**	**75%**	**80%**	**85%**
	ART child remain in care – total	*3 354*	*9 898*	*1 799*	*2 654*	*3 376*	*4 000*	*4 250*
	ART child start minus cumulative transfer out	*4 506*	*17 177*	*2 349*	*3 340*	*4 500*	*5 000*	*5 000*

Table 40: HAST Output Indicators Quarterly and Annual Targets

Indicator Name	Targets				
	2023/24	Q1	Q2	Q3	Q4
OUTCOME: REDUCED MORBIDITY AND MORTALITY					
6. All DS-TB client lost to follow up rate	**7%**	**7%**	**7%**	**7%**	**7%**
All DS-TB client loss to follow-up	*3 012*	*753*	*753*	*753*	*753*
All DS-TB patients in treatment outcome cohort	*43 027*	*10 757*	*10 757*	*10 757*	*10 756*
7. TB Rifampicin resistant / Multidrug - Resistant lost to follow up rate	**15%**	**15.1%**	**15.1%**	**15.1%**	**14.8%**

Indicator Name		Targets				
		2023/24	Q1	Q2	Q3	Q4
	TB Rifampicin resistance / multi-drug resistant client loss to follow-up	*207*	*52*	*52*	*52*	*51*
	TB Rifampicin Resistant / Multi-drug client started on treatment	*1 378*	*345*	*345*	*344*	*344*
8.	**TB Pre-XDR Loss to Follow-up Rate**	**16%**	**18.2%**	**18.2%**	**18.2%**	**9.1%**
	TB Pre-XDR clients who are lost to follow-up	*7*	*2*	*2*	*2*	*1*
	TB Pre-XDR clients started on treatment	*44*	*11*	*11*	*11*	*11*
9.	**ART adult remain in care rate (12 months)**	**75%**	**75%**	**75%**	**75%**	**75%**
	ART adult remain in care – total	*129 544*	*32 386*	*32 386*	*32 386*	*32 386*
	ART adult start minus cumulative transfer out	*172 726*	*43 181*	*43 181*	*43 182*	*43 182*
10.	**ART child remain in care rate (12 months)**	**75%**	**75%**	**75%**	**75%**	**75%**
	ART child remain in care – total	*3 376*	*844*	*844*	*844*	*844*
	ART child start minus cumulative transfer out	*4 500*	*1 125*	*1 125*	*1 125*	*1 125*

MATERNAL, WOMAN AND CHILD HEALTH INCLUDING NUTRITION (MCWHN)

Table 41: MCWHN Outcome Indicators and Targets

Indicator Name		Data Source	South Africa		Provincial		Medium Term Targets		
			Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2023/24	2024/25	2025/26
OUTCOME: REDUCED MORBIDITY AND MORTALITY									
XXIV	**Maternal Mortality in facility Ratio - Total**	**DHIS**	**105.9 / 100 000**	**100 / 100 000**	**88.4 / 100 000**	**85.3 / 100 000**	**90.5 / 100 000**	**85.3 / 100 000**	**80.2 / 100 000**
	Maternal death in facility - Total	*Maternal death register*	*1 065*	*-*	*188*	*180*	*190*	*180*	*170*
	Live births known to facility - Total	*Delivery register*	*1 005 398*	*-*	*12 723*	*211 000*	*210 000*	*211 000*	*212 000*
XXV	**Neonatal death in facility rate – Total**	**DHIS**	**12 / 1000**	**< 10 / 1000**	**11.5 / 1 000**	**13.1 / 1 000**	**13.3 / 1 000**	**13.1 / 1 000**	**13 / 1 000**
	Inpatient death neonatal - total	*Midnight report*	*11 642*	*-*	*2 315*	*2 629*	*2 655*	*2 629*	*2 603*
	Live birth in facility - Total	*Delivery register*	*959 533*	*-*	*201 947*	*200 000*	*200 000*	*200 000*	*200 000*
XXVI	**Live Birth under 2 500 g in facility rate - Total**	**DHIS**	**12.8%**	**Not available**	**11.9%**	**11.3%**	**11.8%**	**11.3%**	**11.3%**
	Live birth under 2500g in facility - Total	*Delivery register*	*123 288*		*24 035*	*22 665*	*23 500*	*22 665*	*22 665*
	Live birth in facility - Total		*959 533*		*201 947*	*200 000*	*200 000*	*200 000*	*200 000*

Indicator Name		Data Source	South Africa		Provincial		Medium Term Targets		
			Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2023/24	2024/25	2025/26
XXVII	**Death under 5 years against live birth rate - Total**	**DHIS**	**4.8%**	**4.3%**	**1.7%**	**1.8%**	**1.9%**	**1.8%**	**1.8%**
	Death in facility under 5 years - total	*Midnight report*	*16 843*	*-*	*3 380*	*3 607*	*3 700*	*3 607*	*3 517*
	Live birth in facility - total	*Ward register*	*959 533*	*-*	*201 947*	*200 000*	*200 000*	*200 000*	*200 000*
XXVIII	**Death in facility under 5 years rate - total**	**DHIS**	**Not available**	**Not available**	**3.8%**	**5.9%**	**6.1%**	**5.9%**	**5.8%**
	Death in facility under 5 years - total	*Midnight report*			*3 380*	*3 607*	*3 700*	*3 607*	*3 517*
	Inpatient separations under 5 years – total	*DHIS*			*88 844*	*60 750*	*60 656*	*60 750*	*60 750*
XXIX	**Death in facility under 1 year rate - Total**	**DHIS**	**Not available**	**Not available**	**5.4%**	**8%**	**8.2%**	**8%**	**7.8%**
	Death in facility under 1 years - total	*Midnight report*			*3 055*	*3 266*	*3 350*	*3 266*	*3 185*
	Inpatient separations under 1 year - Total	*DHIS*			*57 009*	*40 750*	*40 750*	*40 750*	*41 000*
XXX	**Child under 5 years diarrhoea case fatality rate – total**	**DHIS**	**1.9%**	**1.4%**	**2.2%**	**1.6%**	**1.7%**	**1.6%**	**1.5%**
	Diarrhoea death under 5 years - total	*Midnight report*	*679*	*407*	*171*	*117*	*124*	*117*	*111*
	Diarrhoea separation under 5 years - total	*Ward register*	*36 009*	*28 807*	*7 702*	*7 403*	*7 500*	*7 403*	*7 403*
XXXI	**Child under 5 years Pneumonia case fatality rate – total**	**DHIS**	**1.9%**	**1.7%**	**2.2%**	**1.8%**	**1.9%**	**1.8%**	**1.7%**
	Pneumonia death under 5 years - total	*Midnight report*	*962*	*673*	*279*	*217*	*239*	*217*	*201*
	Pneumonia separation under 5 years - total	*Ward Register*	*50 212*	*40 170*	*12 370*	*11 914*	*12 450*	*11 914*	*11 914*
XXXII	**Child under 5 years Severe acute malnutrition case fatality rate – total**	**DHIS**	**7.1%**	**6.7%**	**7.8%**	**7.1%**	**8%**	**7.1%**	**6.5%**
	Severe acute malnutrition death under 5 years	*Midnight report*	*806*	*685*	*179*	*139*	*160*	*139*	*127*
	Severe acute malnutrition inpatient under 5 years	*Ward register*	*11 280*	*10 152*	*2 289*	*1 965*	*1 995*	*1 965*	*1 944*
XXXIII	**Still Birth in Facility Rate – total**	**DHIS**	**Not available**	**Not available**	**21.8 / 1 000**	**22.3 / 1 000**	**23.2 / 1 000**	**22.3 /1 000**	**21.2 /1 000**
	Still birth in facility- total	*Midnight report*			*4 500*	*4 562*	*4 750*	*4 562*	*4 334*
	Total births in facility – Total	*Delivery register*			*206 438*	*204 562*	*204 750*	*204 562*	*204 334*

Note: The national indicator worded" **Neonatal death in facility per 1,000 live births"** uses the same data elements and methodology as the indicator "**Neonatal death in facility rate".** This indicator therefore has not been repeated in the table above

Table 42: MCWHN Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
OUTCOME: REDUCED MORBIDITY AND MORTALITY								
Couple year protection years dispensed	**11. Couple year protection rate**	**56.1%**	**50.4%**	**58.3%**	**49.2%**	**63%**	**67.5%**	**68%**
	Couple year protection	*1 767 547*	*1 599 597*	*1 817 725*	*1 549 746*	*2 003 624*	*2 169 642*	*2 209 626*
	Population 15-49 years female	*3 125 661*	*3 175 848*	*3 115 857*	*3 148 064*	*3 180 357*	*3 214 285*	*3 249 450*
Deliveries in age group 10 to 19 years	**12. Delivery 10 - 19 years in facility rate**	**16.3%**	**17.1%**	**17.1%**	**17.4%**	**15.3%**	**15%**	**15%**
	Delivery 10 – 19 years in facility	*36 171*	*34 572*	*35 018*	*36 198*	*32 130*	*31 693*	*31 693*
	Delivery in facility – total	*221 507*	*201 783*	*204 450*	*208 236*	*210 000*	*211 291*	*211 291*
Antenatal 1st visits before 20 weeks	**13. Antenatal 1st visit before 20 weeks rate**	**74.5%**	**74.3%**	**73.7%**	**73.9%**	**75%**	**77%**	**77%**
	Antenatal 1st visit before 20 weeks	*168 237*	*163 505*	*159 161*	*164 592*	*168 752*	*173 250*	*173 250*
	Antenatal 1st visit – total	*225 846*	*220 105*	*215 821*	*222 634*	*225 000*	*225 000*	*225 000*
Postnatal visits for mother within 6 days of delivery	**14. Mother postnatal visit within 6 days rate**	**76.1%**	**77.6%**	**80%**	**82.9%**	**80%**	**85%**	**90%**
	Mother postnatal visit within 6 days after delivery	*168 515*	*156 605*	*163 512*	*172 622*	*168 000*	*179 597*	*190 162*
	Delivery in facility - total	*221 507*	*201 783*	*204 450*	*208 236*	*210 000*	*211 291*	*211 291*
Reduce infant PCR test positive under 5 years	**15. Infant PCR test positive around 6 months rate**	**New indicator**	**New indicator**	**New indicator**	**New indicator**	**1%**	**1%**	**1%**
	Infant PCR test positive around 6 months rate					-	-	-
	Infant HIV PCR test around 6 months					-	-	-
	16. HIV Test positive around 18 months rate	**New indicator**	**New indicator**	**New indicator**	**New indicator**	**1.5%**	**1.5%**	**1.5%**
	HIV Test positive around 18 months					-	-	-
	HIV tests done around 18 months					-	-	-
Fully immunised childre under 1 years coverage	**17. Immunisation under 1 year coverage**	**91.8%**	**82.8%**	**89.9%**	**95.9%**	**90%**	**90%**	**90.2%**
	Immunised fully under 1 year new	*239 295*	*217 217*	*229 899*	*243 634*	*227 245*	*226 360*	*226 360*
	Population under 1 year	*260 734*	*262 488*	*255 744*	*254 035*	*252 494*	*251 511*	*251 052*
Measles 2nd dose coverage in children 1 years old	**18. Measles 2nd dose 1 year coverage**	**82.9%**	**77.3%**	**86.7%**	**96.7%**	**95%**	**95%**	**95.3%**
	Measles 2nd dose	*217 727*	*202 795*	*218 837*	*245 390*	*239 926*	*238 969*	*238 969*
	Target population 1 year	*262 526*	*262 205*	*252 321*	*253 879*	*252 554*	*251 547*	*250 878*

Table 43: MCWHN Output Indicators Quarterly and Annual Targets

Indicator Name	Targets				
	2023/24	Q1	Q2	Q3	Q4
OUTCOME: REDUCED MORBIDITY AND MORTALITY					
11. Couple year protection rate	**63%**	**63%**	**63%**	**63%**	**63%**
Couple year protection	*2 003 624*	*500 906*	*500 906*	*500 906*	*500 906*
Population 15-49 years female	*3 180 357*	*795 089*	*795 089*	*795 089*	*795 089*
12. Delivery 10 to 19 years in facility rate	**15.3%**	**15.3%**	**15.3%**	**15.3%**	**15.3%**
[Delivery 10-14 years in facility] + [Delivery 15-19 years in facility]	*32 130*	*8 032*	*8 033*	*8 032*	*8 033*
Delivery in facility – total	*210 000*	*52 500*	*52 500*	*52 500*	*52 500*
13. Antenatal 1st visit before 20 weeks rate	**75%**	**75%**	**75%**	**75%**	**75%**
Antenatal 1st visit before 20 weeks	*168 752*	*42 188*	*42 188*	*42 188*	*42 188*
Antenatal 1st visit – total	*225 000*	*56 250*	*56 250*	*56 250*	*56 250*
14. Mother postnatal visit within 6 days rate	**80%**	**80%**	**80%**	**80%**	**80%**
Mother postnatal visit within 6 days after delivery	*168 000*	*42 000*	*42 000*	*42 000*	*42 000*
Delivery in facility - total	*210 000*	*52 500*	*52 500*	*52 500*	*52 500*
15. Infant PCR test positive around 6 months rate	**1%**	**1%**	**1%**	**1%**	**1%**
Infant PCR test positive around 6 months rate	-	-	-	-	-
Infant PCR test around 6 months	-	-	-	-	-
16. HIV Test positive around 18 months rate	**1.5%**	**1.5%**	**1.5%**	**1.5%**	**1.5%**
HIV Test positive around 18 months	-	-	-	-	-
HIV tests done around 18 months	-	-	-	-	-
17. Immunisation under 1 year coverage	**90%**	**90%**	**90%**	**90%**	**90%**
Immunised fully under 1 year	*227 245*	*56 811*	*56 811*	*56 811*	*56 812*
Population under 1 year	*252 494*	*63 124*	*63 123*	*63 123*	*63 124*
18. Measles 2nd dose coverage	**95%**	**95%**	**95%**	**95%**	**95%**
Measles 2nd dose	*239 926*	*59 981*	*59 981*	*59 982*	*59 982*
Population aged 1 year	*252 554*	*63 138*	*63 138*	*63 139*	*63 139*

DISEASE PREVENTION AND CARE (DPC)

Table 44: DPC Outcome Indicators and Targets

Indicator Name		Data Source	South Africa		Provincial		Medium Term Targets		
			Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2023/24	2024/25	2025/26
OUTCOME: REDUCED MORBIDITY AND MORTALITY									
XXXIV	**Malaria case fatality rate**	**Manual calculation**	**0.64%**	**N/A**	**0.5%**	**0%**	**0.0%**	**0%**	**0%**
	Malaria deaths reported	*PHC tick register; Malaria Register*	*-*		*7*	*0*	*0*	*0*	*0*
	Malaria cases reported		*-*		*1 493*	*600*	*600*	*600*	*600*
XXXV	**Malaria incidence per 1,000 population at risk**	**Manual Calculation**	**N/A**	**N/A**	**0.23 / 1,000**	**0 / 1,000**	**0 / 1,000**	**0 / 1,000**	**0 / 1,000**
	Number of malaria cases (new)	*PHC tick register; Malaria Register*			*162*	*0*	*0*	*0*	*0*
	Population uMkhanyakude	Stats SA			*696 042*	*694 485*	*690 193*	*694 485*	*694 485*
XXXVI	**Covid-19 Case Fatality Rate: Total**	**Datcov**	**N/A**	**N/A**	**New indicator**	**0.7%**	**1.2%**	**0.7%**	**0.7%**
	Number of deaths in positive covid-19 cases: Total					*800*	*2 064*	*800*	*800*
	Separations Covid-19 cases: Total					*111 000*	*172 000*	*111 000*	*111 000*

EXPLANATION OF PLANNED PERFORMANCE OVER THE MEDIUM TERM PERIOD:

This programme exists to render PHC and District Hospital Services. Community services and outreach community services are included in level 1 health services. Vertical programmes rendering services across the service delivery platform including nutrition, maternal child and woman's health, TB/HIV and AIDS, as well as district coronary services. The service delivery platform consists of 170 mobile clinics, 590 fixed clinics, 22 CHCs and 37 District Hospitals.

OUTCOME: UNIVERSAL HEALTH COVERAGE

Access to health services will be improved through the following interventions.

- Through determining and clearing backlogs in elective surgeries and orthopaedics, as well as other services that were negatively impacted by COVID-19.
- Provinicalisation of eThekwini municipal clinics.
- Expansion of outreach services through the implementation of the Sub-District Model / Community Based Model
- the Department has committed to the building of 11 new clinics in 23/24 to further expand outreach services.
- The referral pathway will be reviewed as an integrated part of the service delivery platform, taking into account the rationalisation of facilities.
- Document and records management policy to be strengthened and improved at all levels of care.

The package of service will be reviewed for all levels in an integrated approach to ensure efficient usage of resources.

- Richmond Hospital is being repurposed as a district hospital to cater for the growing community in Richmond / Hopewell.
- Clairwood Hospital is also being repurposed as a district hospital. The implementation will take a phased in approach over time due to budget constraints.
- The package of service for St Margaret's and Niemeyer Memorial Hospital will be reviewed

Accelerating EMS, FP, and Forensic medicine with human capital, resource availability and service expansion will also contribute towards Universal Health coverage.

OUTCOME: REDUCED MORBIDITY AND MORTALITY

Primary Health Care: The Department will continue to focus on PHC re-engineering through Community Based Services, WBOT teams, School health Teams, and CHW's. The scale-up plan to increase the number of PHC facilities that obtain Ideal Clinic will be implemented in 23/24 to ensure 100% of clinics are Ideal by 2024/25. This will have implications for both accessibility, efficiency and effectiveness.

Integrated Health Promotion Strategy: this will be implemented across all levels of care with the focus on the following social issues:-

- Health literacy and understanding personal health and hygiene
- Teenage pregnancy
- Severe Acute Malnutrition, in all areas. An increase has been noticed in urban areas after the COVID-19 pandemic.
- Gender Based Violence and Femicide

District Hospital: District hospitals are the first line in hospital services and as such have the bulk of the facilities with 37 district hospitals provincially. Mortalities within the hospital form an important indicator for the level of care provided, and give a reflection on the disease burden for that catchment population. Therefore, at an outcome level, mortality indicators for maternal and child health are monitored for district hospitals as a whole, combined with Patient Experience of Care and Patient Safety Incidents contributing towards the improvement in health outcomes, patient care and the experience of the patient travelling through the public health system.

HIV / AIDS, TB and Sexually Transmitted Infections: The number of clients remaining on ART is an output that requires constant monitoring as research has shown that a person who is virally suppressed, is less likely to transmit HIV / AIDS. The increase in the number of clients on ARV treatment from 1 564 327 (December 2022) to 1 622 676 will impact on the 95-95-95 strategy. The Department has made progress in achieving this strategy, and is currently at 96-83-93 for the total population serviced. The Department is lagging behind in initiating men, children and key populations on ART. The expansion and establishment of men's and key population health services to improve HIV screening, testing, and treatment should improve adherence. The Department will also enable accessibility, acceptability and integrated child, adolescent and youth HIV services. Improvement in psycho-social support for children, adolescent and youth to cope with HIV management will also impact on adherence. Efforts to elevate Advanced Clinical Care are underway to identify clinical issues with regards to the ART death rate.

TB treatment outcomes are a major contributor to this programme and as such the program will engage districts to verify the alignment of Linkage Officers to TB outreach teams, identify vacant posts, recruit and assign personnel to improve tracking, tracing and retention to care. Community awareness campaigns will continue, on the importance of adherence to treatment.

The strategy to screen at least 90% of the clients attending health care facilities will continue. During Q2 of 2022/23, 88% (25 257 387 / 28 724 954) of the headcount was screened. This drop was expected as the province implemented universal testing for TB to targeted populations such as HIV positive patients, index patient contacts and patients who have had previous episodes of TB. KZN has a high burden of HIV and TB hence the high proportion of clients who are universally tested for TB. The Department will continue to implement the rationalisation of TB services in district and specialised hospitals across the Province, particularly where there is a trend of low bed-occupancy rates and low demand for services.

Maternal and Child Health: Child health continues to be a focus for Programme 2 especially with regards to diarrhoea, pneumonia and severe acute malnutrition. The implementation of the immunisation programme for under 1 years includes the vaccinations for common

childhood illnesses, Rotavirus (diarrhoea), PCV (pneumonia) and allows for growth weight monitoring of children.

To improve the immunisation coverage under 1 year, districts are implementing a specific catch-up plan running parallel to with ongoing routine services. Programme managers will continue with ongoing technical support at facility level, combined with onsite training, programme supervision and monitoring of data collection processes.

Measles coverage at 1 year is also an important indicator in the child health provision of services, as measles outbreaks have been reported nationally since 2020. Disruption of routine of immunisation services worsened the longstanding challenges in immunisation and existing sub-optimal immunisation coverage which could result in secondary outbreaks of vaccine preventable diseases. There is active monitoring of the implementation of the catch-up drive running parallel to routine services thus ensuring that communities remain protected from Vaccine Preventable Diseases (VPD). Stock availability of all antigens is being monitored at the pharmaceutical depot, districts and facilities with technical onsite support and training provided concentrating on the districts that have poor performance.

Education on hand washing plays an important part in reducing bacterial diseases resulting in diarrhoea. Combined with education on house and food hygiene and water sterilization, in light of the recent floods, will be prioritised going forwards. Strengthening of community based child health Programs at the Phila Mntwana Sites, households and Early Childhood Development (ECD) Sites will continue to be the focus for MTEF period.

Remedial actions for combating pneumonia in children, includes the strengthening of the integrated Management of Childhood illnesses, the issuing of antibiotics to treat infections, increasing the rate of pneumococcal vaccination of children against pneumonia and promote good nutrition programmes for children to reduce malnutrition and increase immunity. Improve capacity at District Hospital level for respiratory support.

As mentioned in Part B, in order to achieve the 2024/25 Under 5 mortality target, emphasis needs to be placed on the improvement of early neonatal (0 – 7 days) and neonatal services (8 – 28 days). Early neonatal survival rates are strongly linked to the quality of maternal care provided during the pregnancy hence the need to monitor the ANC before 20 weeks rate. This allows high risk pregnancies to be diagnosed early and for a safe birthing plan to be put in place. Additional interventions to reduce the early neonatal death rate is the introduction of an Essential Page of Care for Paediatrics and Child Health with the aim to strengthen health services for children in an effort to facilitate early entry into the health service, more effective assessments on entry and better care of children who require admission.

Sensitize districts to revive multi sector child health forums which will assist at facility level and engagement with DSD locally.

Key neonatal interventions planned to address these challenges are the upgrading of all neonatal units to ensure provision of medical air and adequate electrical points, procurement of respiratory support equipment, increased monitoring and strengthening of administration of antenatal steroids and reintroduction of basic neonatal training which had to be stopped during the pandemic.

Facilitate that pregnant women presenting with infections in antenatal care are treated adequately;

Disease Prevention and Control: It has been noted in Part B that one of the major challenges affecting the outcomes of these preventative programmes is accessing of services by children under 15 years and men. Women access health services more frequently than men, and in general, have better health outcomes because of it. Men tend to access health services infrequently, and present late to facilities with a reduced prognosis. Efforts are in place to target men across treatment cascades in the form of Isibaya Samadoda / iKhosomba lamajita/ men's friendly services. The implementation of the Integrated Non-Communicable Disease Strategy will also assist.

COVID-19 has had a significant impact on health outcomes and with the roll-out of the vaccination programme, it is envisaged that this will reduce the morbidity and mortality at a community level. Malaria, endemic to the north of KZN, is monitored for elimination of this disease by 2025.

The Forensic services at a district level are to be strengthened during afterhours. This will form part of an integrated approach with Clinical Support Services.

Stakeholder engagements and relations will be strengthened .

OUTCOME: CLIENT EXPERIENCE OF CARE

The rofessionalising EMS and FPS and strengthening employee wellness will improve the client experience of care. Health establishments will be prepared for certification by the Office of Health Standard Compliance (OHSC). The "Make me Look like a Hospital" programme will be strengthened. The Ideal Clinic programme should find expression and be realised in the MTEF. Capacity building for clinical managers on management functions will further strengthen health processes and improve the clients experience of care.

PROGRAMME RESOURCE CONSIDERATIONS

Table 45: Budget allocation Estimates (R'000) (Programme 2)

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
District Management	314 889	312 661	345 336	320 580	333 357	358 122	351 098	359 907	376 032
Community Health Clinics	4 697 761	4 794 183	4 602 318	5 073 506	5 235 639	5 231 696	5 376 496	5 772 808	6 031 429
Community Health Centres	1 919 490	1 943 766	2 029 292	2 040 938	2 131 284	2 119 940	2 201 253	2 304 569	2 407 812
Community Based Services	853 205	875 248	333 169	971 484	1 051 496	975 819	1 116 390	1 134 736	1 185 575
Other Community Services	1 222 068	3 276 155	4 754 847	3 958 699	3 887 484	4 281 151	2 565 015	2 778 645	2 903 128
HIV and AIDS	5 503 831	5 710 861	6 817 236	6 482 620	6 512 062	6 512 062	6 448 252	6 737 779	7 039 695
Nutrition	32 705	28 927	32 175	33 230	33 230	33 230	35 812	37 424	39 099
Coroner Services	241 424	251 335	272 956	283 479	292 115	294 291	286 304	304 071	317 695
District Hospitals	7 941 490	7 744 116	8 082 542	7 350 120	7 990 017	8 195 877	7 929 954	7 955 181	8 311 592
Sub-Total	**22 726 863**	**24 937 252**	**27 269 871**	**26 514 656**	**27 466 684**	**28 002 188**	**26 310 574**	**27 385 120**	**28 612 057**
Unauthorized expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Baseline available for spending after 1st charge	**22 726 863**	**24 937 252**	**27 269 871**	**26 514 656**	**27 466 684**	**28 002 188**	**26 310 574**	**27 385 120**	**28 612 057**

Table 46: Summary of Budget Allocations and Estimates by Economic Classification (R'000) (Programme 2)

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
Current payments	**22 086 850**	**24 341 051**	**26 455 979**	**25 813 621**	**26 807 329**	**27 285 195**	**25 576 984**	**26 588 345**	**27 783 241**

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
Compensation of employees	14 099 897	15 353 786	17 102 838	16 358 631	16 881 633	17 600 289	15 939 732	16 177 346	16 820 398
Goods and services	**7 986 516**	**8 986 965**	**9 352 549**	**9 454 505**	**9 925 211**	**9 684 232**	**9 636 785**	**10 410 469**	**10 962 289**
Communication	52 688	57 661	68 989	66 695	73 143	94 243	66 489	71 094	74 279
Computer Services	867	-	-	-	-	-	14	14	14
Consultants, Contractors and special services	212 633	210 679	270 516	309 014	401 680	400 666	351 689	362 985	379 245
Inventory	4 518 193	5 189 876	4 819 129	5 160 501	5 070 395	4 885 760	5 215 049	5 698 315	5 737 086
Operating leases	36 029	38 375	41 119	45 832	45 631	49 654	51 491	52 675	55 035
Travel and subsistence	42 711	26 617	31 376	44 351	48 048	51 968	65 069	59 265	61 952
Maintenance, repair and running costs	115 765	95 250	130 877	102 996	113 854	184 252	159 529	168 052	175 580
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	3 007 630	3 368 507	3 990 543	3 725 116	4 172 460	4 017 689	3 727 455	3 998 069	4 479 098
Interest and rent on land	437	300	592	485	485	674	467	530	554
Transfers and subsidies to	**413 515**	**364 206**	**469 946**	**440 661**	**455 819**	**501 541**	**473 672**	**495 220**	**517 404**
Provinces and municipalities	222 893	199 352	249 303	256 596	264 083	264 083	275 373	286 945	299 800
Departmental agencies and accounts	174	154	80	53	53	53	58	61	63
Higher education institutions	-	-	-	-	-	-	-	-	-
Non-profit institutions	47 948	51 651	53 489	56 134	63 440	63 440	64 778	67 693	70 726
Households	142 500	113 049	167 074	127 878	128 243	173 965	133 463	140 521	146 815
Payments for capital assets	**226 476**	**231 896**	**343 434**	**260 374**	**203 536**	**215 239**	**259 918**	**301 555**	**311 412**
Buildings and other fixed structures	-	-	26	-	-	-	-	-	-
Machinery and equipment	226 476	231 896	343 408	260 374	203 536	215 239	259 918	301 555	311 412
Payment for financial assets	22	99	512	-	-	213	-	-	-
Total economic classification	**22 726 863**	**24 937 252**	**27 269 871**	**26 514 656**	**27 466 684**	**28 002 188**	**26 310 574**	**27 385 120**	**28 612 057**
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	**22 726 863**	**24 937 252**	**27 269 871**	**26 514 656**	**27 466 684**	**28 002 188**	**26 310 574**	**27 385 120**	**28 612 057**

PERFORMANCE AND EXPENDITURE TRENDS

Programme 2 is allocated 51.9% of the Vote 7 budget, down from 53.2% in the 22/23 revised estimates. This amounts to a decrease of R 1 691 614 000, due to the overall decrease in budget.

UPDATED KEY RISKS AND MITIGATION

Table 47: Updated key risks and mitigation (Programme 2)

Key Risks	Risk Mitigation
Outcome: Universal Health Coverage	
Lack of synergy between conventional Health Workers and Traditional Health Practitioners (THP's)	Develop policy on integration
	Establish and formalise referral pathway
Increase in demand of health services	To establish MOU for cross-boundaries and cross-border
	To implement Preventive and promotive programmes
	Integrate traditional medicine in Health Promotion Strategy
	To implement Health Patient Registration System (HPRS)
Inadequate/ Poor Clinical Governance	Monitor functionality of Governance Structures.
	Monitor essential basic equipment required and provide training
	To request SCM to develop Departmental catalogue and Review catalogue annually
Non finalisation of Primary Health Care (PHC) Provincialisation	Finalise decision on Provincialisation process
Non accreditation of Health Establishments	Develop a Provincial PSI Guideline
	Re-enforce compliance with Non-negotiables
	Develop the strategy to implement Peer Assessments on IHRM
Outcome: Reduced morbidity and mortality	
Inherent Risk of Health Care Associated Infections	Adopt a multi-modal improvement strategies
	Monitor & evaluate the implementation of the IPC Strategy Framework annually
	Optimise the built environment to ensure compliance to IPC Principles
Inability to reduce the burden of disease from HIV	Targeted testing for HIV
	Provider Initiated counselling , testing and treatment adherence strategies through differentiated care
Inability to reduce the burden of disease from TB	Targeted testing for TB
	Treatment adherence strategies through patient treatment support
Inadequate treatment/ rehabilitation of children with celebral palsy	Improvement of infrastructure through the 10 year infrastructure Program/Plan
	Development of an SOP on Referrals and other Treatment Protocols
Inability to timeously identify outbreaks	Revival of the CDC Organisational Structure
	Orientation and Re-orientation on Outbreak Response Team
Improper management of HCRW	Enforce compliance to the legislation and HCRW policy
Outcome: Improved Patient Experience of Care	
Lack of a Provincial Complaints Management Strategy	Revive the Complaints Mechanism Committee
	Develop and adopt the Provincial Complaints Management Strategy

10. PROGRAMME 3: EMERGENCY MEDICAL SERVICES

Programme Purpose

Rendering pre-hospital Emergency Medical Services, including Inter-hospital Transfers and Planned Patient Transport - The previous structure included Sub-Programme 3.3: Disaster Management which is a Municipal function.

Sub-Programme 3.1: Emergency Services

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

Sub-Programme 3.2: Planned Patient Transport

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).

Table 48: EMS Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
OUTCOME: UNIVERSAL HEALTH COVERAGE								
EMS P1 response in urban areas under 30 minutes	**19. EMS P1 urban response under 30 minutes rate**	**New indicator**	**New indicator**	**50.9%**	**42.9%**	**50%**	**50%**	**50%**
	EMS P1 urban response under 30 minutes			*62 018*	*44 726*	*78 112*	*78 111*	*78 111*
	EMS P1 urban responses			*121 770*	*104 286*	*156 222*	*156 222*	*156 222*
EMS P1 response in rural areas under 60 minutes	**20. EMS P1 rural response under 60 minutes rate**	**New indicator**	**New indicator**	**52.4%**	**51.1%**	**55%**	**55%**	**55%**
	EMS P1 rural response under 60 minutes			*82 307*	*74 251*	*111 240*	*111 242*	*111 242*
	EMS P1 rural responses			*157 011*	*145 328*	*202 258*	*202 258*	*202 258*

Table 49: EMS Output Indicators Quarterly and Annual Targets

Indicator Name	Targets				
	2023/24	Q1	Q2	Q3	Q4
OUTCOME: UNIVERSAL HEALTH COVERAGE					
19. EMS P1 urban response under 30 minutes rate	**50%**	**50%**	**50%**	**50%**	**50%**
EMS P1 urban response under 30 minutes	*78 112*	*19 528*	*19 528*	*19 528*	*19 528*
EMS P1 urban responses	*156 222*	*39 056*	*39 056*	*39 055*	*39 055*
20. EMS P1 rural response under 60 minutes rate	**55%**	**55%**	**55%**	**55%**	**55%**
EMS P1 rural response under 60 minutes	*111 240*	*27 810*	*27 810*	*27 810*	*27 810*
EMS P1 rural responses	*202 258*	*50 564*	*50 564*	*50 565*	*50 565*

EXPLANATION OF PLANNED PERFORMANCE OVER THE MEDIUM TERM PERIOD:

Programme 3 outputs of ensuring improved access to specialised services and emergency services, is largely focused towards the outcome of Universal Health Coverage. It indirectly influences Improved Patient Experience of Care, and impacts on Reduced Morbidity and Mortality.

OUTCOME: UNIVERSAL HEALTH COVERAGE

Improved response times require an increase in the number of customised built EMS bases combined with strategically located satellite bases to reduce training times to hot spots and putting EMS closer to the community.

Provincial Vehicle Management has been engaged to increase the pool of service providers and improve supervision of fleet matters leading to an increase in the number of ambulances available at any given time. District Fleet Officers will engage with service providers regularly, to limit ambulance down time and ensure better management of services.

Operational ambulances are dependent on staffing and equipment/fleet. Overtime restrictions are still in place currently. The Department is exploring different shift systems in order to reduce the compulsory overtime which will in turn increase available budget for actual overtime. The Department plans to increase the average number of daily operational ambulances from 179 in Q2 of 22/23 to 200 by 31 March 2024.

PROGRAMME RESOURCE CONSIDERATIONS

Table 50: Budget allocation Estimates (R'000) (Programme 3)

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
Emergency Services	1 460 183	1 478 434	1 434 921	1 442 779	1 548 023	1 548 023	1 473 709	1 527 999	1 596 455
Planned Patient Transport	142 703	127 493	161 845	174 400	159 328	178 687	181 806	194 166	202 865
Sub-Total	**1 602 886**	**1 605 927**	**1 596 766**	1 617 179	**1 707 351**	**1 726 710**	**1 655 515**	**1 722 165**	**1 799 320**
Unauthorized expenditure (1st charge) not available for spending	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Baseline available for spending after 1st charge	**1 602 886**	**1 605 927**	**1 596 766**	**1 617 179**	**1 707 351**	**1 726 710**	**1 655 515**	**1 722 165**	**1 799 320**

Table 51: Summary of Budget Allocations and Estimates by Economic Classification (R'000) (Programme 3)

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
Current payments	**1 426 505**	**1 429 072**	**1 512 031**	**1 501 673**	**1 593 453**	**1 612 200**	**1 558 285**	**1 621 459**	**1 694 104**
Compensation of employees	1 031 514	1 074 827	1 189 352	1 102 953	1 238 165	1 239 159	1 217 755	1 243 396	1 299 100
Goods and services	**394 990**	**354 242**	**322 675**	**398 720**	**355 231**	**372 593**	**340 530**	**378 063**	**395 004**
Communication	8 964	9 246	9 577	10 152	9 400	9 408	10 081	10 769	11 252
Computer Services	-	-	-	-	-	-	-	-	-

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	**2019/20**	**2020/21**	**2021/22**	**2022/23**			**2023/24**	**2024/25**	**2025/26**
Consultants, Contractors and special services	2 686	2 707	2 754	2 694	2 725	2 790	2 261	2 520	2 633
Inventory	28 659	35 669	23 552	33 147	23 676	23 866	25 482	35 965	37 577
Operating leases	2 516	2 581	2 301	2 405	2 712	2 799	3 003	2 981	3 115
Travel and subsistence	3 937	649	2 089	2 722	1 543	1 326	2 851	2 982	3 116
Maintenance, repair and running costs	258 166	215 611	218 225	263 827	251 245	265 383	225 516	237 677	248 325
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	90 062	87 779	64 177	83 773	63 930	67 021	71 336	85 169	88 986
Interest and rent on land	**1**	**3**	**4**	**-**	**57**	**448**	**-**	**-**	**-**
Transfers and subsidies to	**4 274**	**5 818**	**13 920**	**6 823**	**14 711**	**15 311**	**6 830**	**7 137**	**7 456**
Provinces and municipalities	2 680	2 030	1 873	3 401	3 186	2 503	3 401	3 554	3 713
Departmental agencies and accounts	-	-	-	2	-	-	2	2	2
Higher education institutions	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	1 594	3 788	12 047	3 420	11 525	12 808	3 427	3 581	3 741
Payments for capital assets	**172 107**	**171 037**	**70 815**	**108 683**	**99 187**	**99 187**	**90 400**	**93 569**	**97 760**
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Machinery and equipment	172 107	171 037	70 815	108 683	99 187	99 187	90 400	93 569	97 760
Payment for financial assets	-	-	-	-	-	12	-	-	-
Total economic classification	**1 602 886**	**1 605 927**	**1 596 766**	**1 617 179**	**1 707 351**	**1 726 710**	**1 655 515**	**1 722 165**	**1 799 320**
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	**1 602 886**	**1 605 927**	**1 596 766**	**1 617 179**	**1 707 351**	**1 726 710**	**1 655 515**	**1 722 165**	**1 799 320**

PERFORMANCE AND EXPENDITURE TRENDS

Programme 3 is allocated 3.3% of the Vote 7 budget, maintaining the same allocation as the 22/23 revised estimates. This amounts to an actual rand value decrease of R 71 195 000.

UPDATED KEY RISKS AND MITIGATION

Table 52: Updated key risks and mitigation (EMS)

Key Risks	Risk Mitigation
Outcome: Improved patient experience of care	
Unable to improve on response time	Update vehicle replacement plan

NOTES

11. PROGRAMME 4: PROVINCIAL HOSPITALS SERVICES (REGIONAL AND SPECIALISED)

Programme Purpose

Deliver hospital services, which are accessible, appropriate, and effective and provide general specialist services, including specialized rehabilitation services, as well as a platform for training health professionals and research. There are no changes to the Programme 4 structure.

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: Tuberculosis Hospitals

Convert present Tuberculosis hospitals into strategically placed centres of excellence. TB centres of excellence will admit patients with complicated TB requiring isolation for public protection and specialised clinical management in the intensive phase of treatment to improve clinical outcomes. This strategy will reduce operational costs in the long term.

Sub-Programme 4.3: Psychiatric- Mental Hospitals

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

Sub-Programme 4.4: Sub-acute, Step down and 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: Dental Training Hospital

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

REGIONAL HOSPITALS

Table 53: Regional Hospitals Outcome Indicators and Targets

Indicator Name		Data Source	South Africa		Provincial		Medium Term Targets		
			Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2023/24	2024/25	2025/26
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE									
XXXVII	**Patient Experience of Care satisfaction rate – Regional Hospitals**	**WebDHIS PEC**	**Not available**	**Not available**	**81%**	**85.1%**	**83%**	**85.1%**	**85.1%**
	Patient experience of care survey satisfied responses - Regional Hospitals	Patient Surveys	-	-	*4 547*	*85 100*	*83 000*	*85 100*	*85 100*
	Patient experience of care survey total responses - Regional Hospitals		-	-	*5 613*	*100 000*	*100 000*	*100 000*	*100 000*
XXXVIII	**Patient Safety Incident (PSI) case closure rate - Regional Hospital**	**Patient Safety Incidence Software**	**Not available**	**Not available**	**86%**	**98%**	**97%**	**98%**	**99%**
	Patient Safety Incident (PSI) case closed - Regional Hospitals	Patient Safety Incidence Report	-	-	*240*	*2 205*	*2 134*	*2 205*	*2 208*
	Patient Safety Incident (PSI) case reported - Regional Hospitals		-	-	*279*	*2 250*	*2 200*	*2 250*	*2 230*
OUTCOME: REDUCED MORBIDITY AND MORTALITY									
XXXIX	**[Number of] Maternal deaths in facility - Regional Hospitals**	**Maternal register**	**374**	**Not Available**	**82**	**102**	**109**	**102**	**95**
XL	**[Number of] Deaths in facility under 5 years - Regional Hospitals**	**Midnight report**	**5 518**	**4 966**	**1 703**	**1 710**	**1 754**	**1 710**	**1 667**
XLI	**Child under 5 years diarrhoea case fatality rate – Regional Hospital**	**DHIS**	**2.3%**	**1.7%**	**2.4%**	**1.7%**	**1.7%**	**1.7%**	**1.7%**
	Diarrhoea death under 5 years – Regional hospital	*Midnight report*	*199*	*119*	*68*	*48*	*49*	*48*	*46*
	Diarrhoea separation under 5 years – Regional hospital	*Ward register*	*8 547*	*6 838*	*2 874*	*2 784*	*2 820*	*2 784*	*2 784*
XLII	**Child under 5 years pneumonia case fatality rate –Regional Hospital**	**DHIS**	**2.3%**	**2.1%**	**2.4%**	**2.2%**	**2.2%**	**2.2%**	**2.0%**
	Pneumonia death under 5 years – Regional Hospital	*Midnight report*	*296*	*207*	*100*	*103*	*105*	*103*	*96*
	Pneumonia separation under 5 years – Regional Hospital	*Ward register*	*12 662*	*10 098*	*4 241*	*4 718*	*4 851*	*4 718*	*4 718*
XLIII	**Child under 5 years Severe Acute Malnutrition case fatality rate – Regional Hospital**	**DHIS**	**8.7%**	**8.3%**	**9%**	**6.5%**	**7.6%**	**6.5%**	**5.5%**
	Severe acute malnutrition death under 5 years - Regional Hospitals	*Midnight report*	*249*	*212*	*76*	*49*	*57*	*49*	*41*
	Severe acute malnutrition inpatient under 5 years - Regional Hospital	*Ward register*	*2 848*	*2 563*	*839*	*750*	*750*	*750*	*750*

Table 54: Regional Hospitals Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE								
Severity Assessment Code (SAC) 1 incidence reported within 24 hrs rate - Regional Hospitals	**21. Severity assessment code (SAC) 1 incident reported within 24 hours rate – Regional Hospital**	**81.9%**	**83.3%**	**79.5%**	**88.7%**	**90.2%**	**92.1%**	**95.1%**
	Severity assessment code (SAC) 1 incidents reported within 24 hours – Regional Hospital	*158*	*305*	*290*	*298*	*331*	*339*	*350*
	Severity assessment code (SAC) 1 incident reported – Regional Hospital	*193*	*366*	*365*	*336*	*367*	*368*	*368*

Table 55: Regional Hospitals Output Indicators Quarterly and Annual Targets

Indicator Name	Targets				
	2023/24	Q1	Q2	Q3	Q4
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE					
21. Severity assessment code (SAC) 1 incident reported within 24 hours rate – Regional Hospital	**90.2%**	**91.2%**	**90.2%**	**90.2%**	**89.1%**
Severity assessment code (SAC) 1 incidents reported within 24 hours – Regional Hospital	*331*	*83*	*83*	*83*	*82*
Severity assessment code (SAC) 1 incident reported – Regional Hospital	*367*	*91*	*92*	*92*	*92*

TB HOSPITALS

Table 56: TB Hospitals Outcome Indicators and Targets

Indicator Name	Data Source	South Africa		Provincial		Medium Term Targets		
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2023/24	2024/25	2025/26
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE								
XLIV Patient Experience of Care satisfaction rate – TB Hospital	**WebDHIS PEC Module**	**Not available**	**Not available**	**92.3%**	**97.3%**	**97.3%**	**97.3%**	**97.5%**
Patient experience of care survey satisfied responses – TB Hospital	Patient Surveys	-	-	*131*	*1 654*	*1 654*	*1 654*	*1 657*
Patient experience of care survey total responses – TB Hospital		-	-	*142*	*1 700*	*1 700*	*1 700*	*1 700*

Indicator Name	Data Source	South Africa		Provincial		Medium Term Targets		
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2023/24	2024/25	2025/26
XLV Patient Safety Incident (PSI) case closure rate – TB Hospital	**Patient Safety Incidence Software**	**Not available**	**Not available**	**88%**	**100%**	**100%**	**100%**	**100%**
Patient Safety Incident (PSI) case closed – TB Hospital	Patient Safety Incidence Reports	-	-	*44*	*250*	*250*	*250*	*250*
Patient Safety Incident (PSI) case reported – TB Hospital		-	-	*50*	*250*	*250*	*250*	*250*

Table 57: TB Hospitals Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE								
Severity Assessment Code (SAC) 1 incidence reported within 24 hrs rate - TB Hospitals	**22. Severity assessment code (SAC) 1 incident reported within 24 hours rate – TB Hospital**	**98.4%**	**0.0%**	**93.5%**	**100%**	**95%**	**96.2%**	**97.0%**
	Severity assessment code (SAC) 1 incidents reported within 24 hours – TB Hospital	*123*	*0*	*29*	*26*	*31*	*25*	*25*
	Severity assessment code (SAC) 1 incident reported – TB Hospital	*125*	*0*	*31*	*26*	*32*	*26*	*26*

Table 58: TB Hospitals Output Indicators Quarterly and Annual Targets

Indicator Name	Targets				
	2023/24	Q1	Q2	Q3	Q4
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE					
22. Severity assessment code (SAC) 1 incident reported within 24 hours rate – TB Hospital	**95%**	**100%**	**100%**	**100%**	**87.5%**
Severity assessment code (SAC) 1 incidents reported within 24 hours – TB Hospital	*31*	*8*	*8*	*8*	*7*
Severity assessment code (SAC) 1 incident reported – TB Hospital	*32*	*8*	*8*	*8*	*8*

PSYCHIATRIC HOSPITALS

Table 59: Psychiatric Hospitals Outcome Indicators and Targets

Indicator Name	Data Source	South Africa		Provincial		Medium Term Targets		
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2023/24	2024/25	2025/26
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE								
XLVI Patient Experience of Care satisfaction rate – Psychiatric Hospital	**WebDHIS PEC**	**Not Available**	**Not Available**	**88%**	**92.6%**	**90%**	**92.6%**	**94%**
Patient experience of care survey satisfied responses – Psychiatric Hospital	Patient surveys	-	-	*169*	*13 890*	*13 500*	*13 890*	*14 100*
Patient experience of care survey total responses – Psychiatric Hospital		-	-	*192*	*15 000*	*15 000*	*15 000*	*15 000*
XLVII Patient Safety Incident (PSI) case closure rate – Psychiatric Hospital	**Patient Safety Incidence Software**	**Not Available**	**Not Available**	**94.6%**	**96%**	**92%**	**96%**	**97%**
Patient Safety Incident (PSI) case closed – Psychiatric Hospital	Patient Safety Incidence Reports	-	-	*192*	*192*	*184*	*192*	*194*
Patient Safety Incident (PSI) case reported – Psychiatric Hospital		-	-	*203*	*200*	*200*	*200*	*200*

Table 60: Psychiatric Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE								
Severity Assessment Code (SAC) 1 incidence reported within 24 hrs rate - Psychiatric Hospital	**23. Severity assessment code (SAC) 1 incident reported within 24 hours rate – Psychiatric Hospital**	**86.7%**	**28.6%**	**85%**	**87.5%**	**95%**	**95%**	**96%**
	Severity assessment code (SAC) 1 incidents reported within 24 hours – Psychiatric Hospital	*26*	*16*	*34*	*14*	*38*	*38*	*38*
	Severity assessment code (SAC) 1 incident reported – Psychiatric Hospital	*30*	*56*	*40*	*16*	*40*	*40*	*40*

Table 61: Psychiatric Hospitals Output Indicators Quarterly and Annual Targets

Indicator Name	Targets				
	2023/24	Q1	Q2	Q3	Q4
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE					
23. Severity assessment code (SAC) 1 incident reported within 24 hours rate – Psychiatric Hospital	**95%**	**90%**	**90%**	**100%**	**100%**
Severity assessment code (SAC) 1 incidents reported within 24 hours – Psychiatric Hospital	*38*	*9*	*9*	*10*	*10*
Severity assessment code (SAC) 1 incident reported – Psychiatric Hospital	*40*	*10*	*10*	*10*	*10*

CHRONIC HOSPITALS

Table 62: Chronic Hospitals Outcome Indicators and Targets

Indicator Name	Data Source	South Africa		Provincial		Medium Term Targets		
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2023/24	2024/25	2025/26
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE								
XLVIII Patient Experience of Care satisfaction rate – Chronic/Sub-acute Hospital	**WebDHIS PEC**	**Not available**	**Not available**	**79%**	**83.3%**	**80%**	**83.3%**	**85%**
Patient experience of care survey satisfied responses – Chronic/Sub-acute Hospital	Patient Surveys	-	-	*122*	*6 664*	*6 400*	*6 664*	*6 800*
Patient experience of care survey total responses – Chronic/Sub-acute Hospital		-	-	*154*	*8 000*	*8 000*	*8 000*	*8 000*
XLIX Patient Safety Incident (PSI) case closure rate – Chronic/Sub-acute Hospital	**Patient Safety Incidence Software**	**Not available**	**Not available**	**95.8%**	**100%**	**100%**	**100%**	**100%**
Patient Safety Incident (PSI) case closed – Chronic/Sub-acute Hospital	Patient Safety Incidence Reports		-	*136*	*60*	*60*	*60*	*60*
Patient Safety Incident (PSI) case reported – Chronic/Sub-acute Hospital		-	-	*142*	*60*	*60*	*60*	*60*

Table 63: Chronic Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE								
Severity Assessment Code (SAC) 1 incidence reported within 24 hrs rate - Chronic Hospitals	**24. Severity assessment code (SAC) 1 incident reported within 24 hours rate – Chronic/Sub-acute Hospital**	**100%**	**100%**	**0%**	**0%**	**100%**	**100%**	**100%**
	Severity assessment code (SAC) 1 incidents reported within 24 hours – Chronic/Sub-acute Hospital	*2*	*12*	*-*	*-*	*12*	*12*	*12*
	Severity assessment code (SAC) 1 incident reported – Chronic/Sub-acute Hospital	*2*	*12*	*-*	*-*	*12*	*12*	*12*

Table 64: Chronic Hospitals Output Indicators Quarterly and Annual Targets

Indicator Name	Targets				
	2023/24	Q1	Q2	Q3	Q4
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE					
24. Severity assessment code (SAC) 1 incident reported within 24 hours rate – Chronic/Sub-acute Hospital	**100%**	**100%**	**100%**	**100%**	**100%**
Severity assessment code (SAC) 1 incidents reported within 24 hours – Chronic/Sub-acute Hospital	*12*	*3*	*3*	*3*	*3*
Severity assessment code (SAC) 1 incident reported – Chronic/Sub-acute Hospital	*12*	*3*	*3*	*3*	*3*

EXPLANATION OF PLANNED PERFORMANCE OVER THE MEDIUM TERM PERIOD

Programme 4 outputs are geared towards achieving all 3 of the Departments Outcomes namely Universal Health Coverage, Improved Client Experience of Care and Reduced Morbidity and Mortality. This programme delivers hospital services at general specialist level, including specialised rehabilitation services, as well as a platform for training health professionals and research.

OUTCOME: UNIVERSAL HEALTH COVERAGE

The Department will continue to implement the rationalisation of services in district and specialised hospitals across the province, particularly where there is a trend of low bed-occupancy rates and low demand for services. The Department will oversee the complete commissioning of PKISMH including Paediatric Services, O&G services and Thuthuzela Centre. The official opening of PKISMH will be in 23/24.

Repurpose Clairwood Hospital and Richmond Hospital previously a specialised Chronic and specialised TB hospital respectively, to provide district level services.

Develop Hillcrest Hospital 10-year Infrastructure Plan. Implementation will be through the increase in the number of beds dedicated to rehabilitation services

Regional hospitals

- Review neonatal services and build up subspecialty outreach support.
- Enforce participation in Integrated Moderate Acute Malnutrion training, especially for to establish models for nutritional surveillance and support amongst children with long term health conditions
- Address challenges impacting on theatre waiting time.
- Facilities to implement a multi-disciplinary approach in managing Mental Health Users.
- Re-purpose TB beds for use as Mental Health beds.
- Adherence to Infection Prevention and Control (IPC) and the revised COVID-19 guidelines on quarantine and isolation of staff.
- Finalize the Clinical Outreach Policy
- Expand Oncology Services and reduce the backlog in services
- Continue with the process of regionalisation of 4 district hospitals
- Merge Doris Goodwin Hospital to Edendale Hospital to improve effeciencies.

TB hospitals: Review TB management platform in line with the hospital rationalization programme.

Psychiatric hospitals: Facilitate training specific to Psychiatric facilities on surveillance and prevention strategies for Hospital Acquired Infections (HAI).

Sub-Acute, Step Down and Chronic Medical Hospitals: Support implementation of COVID-19 guidelines for long-term facilities.

PROGRAMME RESOURCE CONSIDERATIONS

Table 65: Budget allocation Estimates (R'000) (Programme 4)

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
General (Regional) Hospitals	9 366 407	9 376 385	9 916 354	9 543 180	10 110 325	10 284 555	10 202 275	10 760 684	11 104 303
Tuberculosis Hospitals	711 352	635 243	481 509	496 351	505 805	513 162	500 580	534 315	558 252
Psychiatric-Mental Hospitals	979 725	975 904	1 004 378	985 107	1 030 031	1 037 498	1 062 658	1 067 007	1 114 809
Sub-acute, Step-down and Chronic Medical Hospitals	443 945	317 902	322 245	385 399	352 058	333 848	379 146	389 460	406 908
Dental Training Hospital	19 785	20 205	21 270	22 208	20 735	20 078	20 090	20 500	21 419
Sub-Total	**11 521 214**	**11 325 639**	**11 745 756**	**11 432 245**	**12 018 954**	**12 189 141**	**12 164 749**	**12 771 966**	**13 205 691**
Unauthorized expenditure (1st charge) not available for spending	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Baseline available for spending after 1st charge	**11 521 214**	**11 325 639**	**11 745 756**	**11 432 245**	**12 018 954**	**12 189 141**	**12 164 749**	**12 771 966**	**13 205 691**

Table 66: Summary of Budget Allocations and Estimates by Economic Classification (R'000) (Programme 4)

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
Current payments	**11 198 706**	**11 102 742**	**11 386 381**	**11 131 277**	**11 840 476**	**11 868 958**	**11 859 406**	**12 440 325**	**12 859 195**
Compensation of employees	8 354 915	8 269 554	8 549 370	8 206 198	8 836 562	8 958 981	9 073 954	9 208 059	9 587 079
Goods and services	**2 843 410**	**2 833 149**	**2 836 657**	**2 925 075**	**3 003 910**	**2 909 821**	**2 785 448**	**3 232 262**	**3 272 112**
Communication	17 490	17 128	17 148	20 913	19 053	17 197	20 990	22 435	23 441
Computer Services	126	158	137	150	150	133	176	184	192
Consultants, Contractors and special services	382 255	418 872	321 567	352 031	291 735	323 553	372 394	386 145	403 445
Inventory	1 277 901	1 324 645	1 371 991	1 264 286	1 382 494	1 458 470	1 068 083	1 297 606	1 285 770
Operating leases	15 529	15 775	16 741	40 388	40 240	20 444	32 270	43 037	44 965
Travel and subsistence	3 890	1 934	1 626	3 285	3 260	1 447	3 233	3 579	3 739
Maintenance, repair and running costs	15 528	12 580	20 762	15 149	15 104	26 540	16 042	16 764	17 515
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	1 130 691	1 042 057	1 086 685	1 228 873	1 251 874	1 062 037	1 272 260	1 462 512	1 493 045
Interest and rent on land	381	39	354	4	4	156	4	4	4
Transfers and subsidies to	**114 731**	**98 425**	**211 951**	**92 317**	**86 403**	**233 423**	**90 205**	**94 265**	**98 488**
Provinces and municipalities	-	-	-	-	-	-	-	-	-
Departmental agencies and accounts	116	68	87	108	108	86	113	118	123
Higher education institutions	-	-	-	-	-	-	-	-	-
Non-profit institutions	5 479	5 643	3 989	5 914	-	-	-	-	-
Households	109 136	92 714	207 875	86 295	86 295	233 337	90 092	94 147	98 365
Payments for capital assets	**207 496**	**124 438**	**147 400**	**208 651**	**92 075**	**86 345**	**215 138**	**237 376**	**248 008**
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Machinery and equipment	207 496	124 438	147 400	208 651	92 075	86 345	215 138	237 376	248 008
Payment for financial assets	281	34	24	-	-	415	-	-	-
Total economic classification	**11 521 214**	**11 325 639**	**11 745 756**	**11 432 245**	**12 018 954**	**12 189 141**	**12 164 749**	**12 771 966**	**13 205 691**
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	**11 521 214**	**11 325 639**	**11 745 756**	**11 432 245**	**12 018 954**	**12 189 141**	**12 164 749**	**12 771 966**	**13 205 691**

PERFORMANCE AND EXPENDITURE TRENDS

Programme 4 is allocated 24% of the Vote 7 budget, an increase from 23.2% allocation in the 22/23 revised estimates. This increase in allocation amounts to an actual rand value decrease of R 24 392 000.

UPDATED KEY RISKS AND MITIGATION

Table 67: Updated key risks and mitigation (Programme 4)

Key Risks	Risk Mitigation
Outcome: Universal health coverage	
Funding pressures threaten the achievement of service delivery objectives.	Implement hospital rationalisation plan in order to improve efficiencies.
	Strengthen the functionality of cash flow committees to monitor costs across all units and institutions.
Inadequate storage for clinical records	Engage with the Departments ICT Unit on the roll-out of the e-Health system and proposal for other electronical storage systems.
	Follow-up with the Infrastructure Development Unit for a consideration of an offsite storage

12. PROGRAMME 5: CENTRAL AND TERTIARY HOSPITALS

Programme Purpose

To provide tertiary services and create a platform for training of health professionals - there are no changes to the Programme 5 structure.

Sub-Programme 5.1: Central Hospital Services

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

Sub-Programme 5.2: Provincial Tertiary Hospital Services

To provide tertiary health services and create a platform for the training of Specialist health professionals.

TERTIARY HOSPITALS

Table 68: Tertiary Hospitals Outcome Indicators and Targets

Indicator Name		Data Source	South Africa		Provincial		Medium Term Targets		
			Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2023/24	2024/25	2025/26
OUTCOME: IMROVED CLIENT EXPERIENCE OF CARE									
L	**Patient Experience of Care satisfaction rate – Tertiary Hospitals**	**WebDHIS PEC**	**Not Available**	**Not Available**	**74%**	**86%**	**85%**	**86%**	**87%**
	Patient experience of care survey satisfied responses - Tertiary Hospitals	Patient Surveys			*585*	*38 700*	*34 000*	*38 700*	*43 500*
	Patient experience of care survey total responses - Tertiary Hospitals				*790*	*45 000*	*40 000*	*45 000*	*50 000*
LI	**Patient Safety Incident (PSI) case closure rate – Tertiary Hospital**	**Patient Safety Incidence Software**	**Not Available**	**Not Available**	**72.1%**	**97%**	**96.4%**	**97%**	**97%**
	Patient Safety Incident (PSI) case closed - Tertiary Hospitals	Patient Safety Incidence Reports			*310*	*1 867*	*1 880*	*1 867*	*1 843*
	Patient Safety Incident (PSI) case reported - Tertiary Hospitals				*430*	*1 925*	*1 950*	*1 925*	*1 900*
OUTCOME: REDUCED MORBIDITY AND MORTALITY									
LII	**[Number of] maternal deaths in facility - Tertiary Hospital**	**Maternal register**	**192**	**Not available**	**29**	**22**	**23**	**22**	**21**
LIII	**[Number of] Death in facility under 5 years - Tertiary Hospital**	**Midnight Report**	**2 499**	**2 249**	**229**	**278**	**285**	**278**	**271**
LIV	**Child under 5 years diarrhoea case fatality rate –Tertiary Hospital**	**DHIS**	**2.1%**	**1.6%**	**1.8%**	**1%**	**1.2%**	**1%**	**1%**
	Diarrhoea death under 5 years – Tertiary Hospital	*Midnight Report*	*77*	*46*	*8*	*4*	*5*	*4*	*4*
	Diarrhoea separation under 5 years – Tertiary Hospital	*Ward register*	*3 693*	*2 954*	*440*	*407*	*412*	*407*	*407*
LV	**Child under 5 years pneumonia case fatality rate –Tertiary Hospital**	**DHIS**	**1.9%**	**1.7%**	**0.7%**	**2.5%**	**2.5%**	**2.5%**	**2.1%**
	Pneumonia death under 5 years – Tertiary Hospital	*Midnight Report*	*112*	*78*	*6*	*19*	*25*	*19*	*16*
	Pneumonia separation under 5 years – Tertiary Hospital	*Ward register*	*5 751*	*4 601*	*892*	*774*	*990*	*774*	*774*
LVI	**Child under 5 years Severe acute malnutrition case fatality rate – Tertiary Hospital**	**DHIS**	**8%**	**7.9%**	**4.3%**	**5.5%**	**6%**	**5.5%**	**4.6%**
	Severe acute malnutrition death under 5 years - Tertiary Hospitals	*Midnight Report*	*81*	*69*	*5*	*7*	*8*	*7*	*6*
	Severe acute malnutrition inpatient under 5 years - Tertiary Hospital	*Ward register*	*969*	*872*	*116*	*127*	*133*	*127*	*130*

Table 69: Tertiary Hospitals Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE								
Severity Assessment Code (SAC) 1 incidence reported within 24 hrs rate - Tertiary Hospital	**25. Severity assessment code (SAC) 1 incident reported within 24 hours rate – Tertiary Hospital**	**84.6%**	**92.3%**	**85.1%**	**93.7%**	**100%**	**100%**	**100%**
	Severity assessment code (SAC) 1 incidents reported within 24 hours – Tertiary Hospital	*22*	*84*	*86*	*268*	*200*	*92*	*92*
	Severity assessment code (SAC) 1 incident reported – Tertiary Hospital	*26*	*91*	*101*	*286*	*200*	*92*	*92*

Table 70: Tertiary Hospitals: Output Indicators Quarterly and Annual Targets

Indicator Name	Targets				
	2023/24	Q1	Q2	Q3	Q4
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE					
25. Severity assessment code (SAC) 1 incident reported within 24 hours rate – Tertiary Hospital	**100%**	**100%**	**100%**	**100%**	**100%**
Severity assessment code (SAC) 1 incidents reported within 24 hours – Tertiary Hospital	*200*	*50*	*50*	*50*	*50*
Severity assessment code (SAC) 1 incident reported – Tertiary Hospital	*200*	*50*	*50*	*50*	*50*

CENTRAL HOSPITALS

Table 71: Central Hospitals Outcome Indicators and Targets

Indicator Name	Data Source	South Africa		Provincial		Medium Term Targets		
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2023/24	2024/25	2025/26
OUTCOME: IMROVED CLIENT EXPERIENCE OF CARE								
LVII Patient Experience of Care satisfaction rate – Central Hospitals	**WebDHIS PEC**	**Not Available**	**Not Available**	**90%**	**94.8%**	**93.7%**	**94.8%**	**94.8%**
Patient experience of care survey satisfied responses - Central Hospitals	Patient Surveys			*343*	*14 220*	*14 055*	*14 220*	*14 220*

Indicator Name	Data Source	South Africa		Provincial		Medium Term Targets		
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2023/24	2024/25	2025/26
Patient experience of care survey total responses - Central Hospitals				*381*	*15 000*	*15 000*	*15 000*	*15 000*
LVIII Patient Safety Incident (PSI) case closure rate – Central Hospital	**Patient Safety Incidence Software**	**Not Available**	**Not Available**	**100%**	**100%**	**100%**	**100%**	**100%**
Patient Safety Incident (PSI) case closed - Central Hospitals	Patient Safety Incidence Reports			*38*	*325*	*350*	*325*	*300*
Patient Safety Incident (PSI) case reported - Central Hospitals				*38*	*325*	*350*	*325*	*300*
OUTCOME: REDUCED MORBIDITY AND MORTALITY								
LIX [Number of] maternal deaths in facility - Central Hospital	**Maternal register**	**188**	**Not Available**	**7**	**8**	**9**	**8**	**7**
LX [Number of] Death in facility under 5 years - Central Hospital	**Midnight Report**	**2 920**	**2 628**	**213**	**180**	**185**	**180**	**176**
LXI Child under 5 years pneumonia case fatality rate – Central Hospital	**DHIS**	**3.6%**	**3.2%**	**15.6%**	**8.4%**	**8.4%**	**8.4%**	**7.8%**
Pneumonia death under 5 years – Central Hospital	*Midnight Report*	*130*	*91*	*45*	*15*	*16*	*15*	*14*
Pneumonia separation under 5 years – Central Hospital	*Ward register*	*3 569*	*2 855*	*289*	*179*	*190*	*179*	*179*
LXII Child under 5 years Severe acute malnutrition case fatality rate –Central Hospital	**DHIS**	**7.6%**	**7.2%**	**23.5%**	**7.7%**	**8.3%**	**7.7%**	**7.1%**
Severe acute malnutrition death under 5 years - Central Hospital	*Midnight Report*	*50*	*43*	*4*	*1*	*1*	*1*	*1*
Severe acute malnutrition inpatient separation under 5 years - Central Hospital	*Ward register*	*656*	*590*	*17*	*13*	*12*	*13*	*14*

Table 72: Central Hospitals Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE								
Severity Assessment Code (SAC) 1 incidence reported within 24 hrs rate - Central Hospital	**26. Severity assessment code (SAC) 1 incident reported within 24 hours rate – Central Hospital**	**21.1%**	**75.9%**	**89.4%**	**100%**	**95%**	**95%**	**100%**
	Severity assessment code (SAC) 1 incidents reported	*4*	*44*	*42*	*6*	*19*	*19*	*20*

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
	within 24 hours – Central Hospital							
	Severity assessment code (SAC) 1 incident reported – Central Hospital	*19*	*58*	*47*	*6*	*20*	*20*	*20*

Table 73: Central Hospitals Output Indicators Quarterly and Annual Targets

Indicator Name	Targets				
	2023/24	Q1	Q2	Q3	Q4
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE					
26. Severity assessment code (SAC) 1 incident reported within 24 hours rate – Central Hospital	**95%**	**100%**	**100%**	**100%**	**80%**
Severity assessment code (SAC) 1 incidents reported within 24 hours – Central Hospital	*19*	*5*	*5*	*5*	*4*
Severity assessment code (SAC) 1 incident reported – Central Hospital	*20*	*5*	*5*	*5*	*5*

EXPLANATION OF PLANNED PERFORMANCE OVER THE MEDIUM TERM PERIOD

Programme 5 outputs are geared towards achieving all 3 of the Departments Outcomes namely *Universal Health Coverage*, *Improved Client Experience of Care* and *Reduced Morbidity and Mortality*.

OUTCOME: REDUCED MORBIDITY AND MORTALITY

This programme provides tertiary and highly specialised medical health and quaternary services on a national basis and serves as a platform for the training of health workers and research. There are three tertiary hospitals (Greys, King Edward VIII and Ngwelezane Hospitals) and one central hospital in KZN, namely the IALCH. As part of the rationalisation plan to improve efficiencies, a decision was taken to merge St. Aidan's Regional Hospital with King Edward VIII Tertiary Hospital. The merger of St Aiden's and KEH has been completed.

The Public Private Partnership (PPP) agreement with Impilo Consortium (RF) (Pty) Ltd at IALCH was extended from 1 August 2021 for a further 18 months and will terminate on 28 February 2023 and immediately move into a six (6) months transition and/or handover period as per clause 3.2 of the main agreement, which will see the agreement officially coming to an end and/or expiring on the 31 July 2023. The Department is in the process of evaluating the RFP documents to appoint the new private partner for a 12-year PPP contract period from 1 August 2023. However, the Department is experiencing delays in the finalisation of the procurement process of appointing a new private partner, therefore the Department is exploring other means of expediting the procurement process and/or including requesting for a further 12 months agreement extension with Provincial and National Treasury respectively.

Tertiary hospitals

- Facilitate commissioning of Neonatal nursery, development of paediatric ICU and expansion of respiratory support to include high flow heated humidified oxygen.
- Support implementation of early warning scoring systems in children's wards
- Explore role of high flow heated humidified oxygen for respiratory support.

- Explore models to improve nutritional surveillance and support to children with long term health conditions.
- Commission new nursery at King Edward VIII to increase number of tertiary ICU and high care beds.
- Liaise with Emergency Medical Services to explore better mechanisms for down referral of stable babies who no longer require tertiary services.
- Contingency plans to be developed for Hospital theatres.
- Phase out district level services whilst increasing tertiary level package of services in King Edward VIII Hospital.

Central hospital

- Protocols will be developed to facilitate early referral and for higher levels to accept patients that are referred.
- Sustain existing programmes across the health service and improve referral pathways and systems.
- Support the implementation of the multimodal strategy and IPC bundles to reduce device related HAIs in a Central hospital.

PROGRAMME RESOURCE CONSIDERATIONS

Table 74: Budget allocation Estimates (R'000) (Programme 5)

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
Central Hospital Services	2 389 393	2 653 569	2 540 207	2 650 370	2 672 261	2 811 537	2 648 394	2 745 520	2 770 230
Provincial Tertiary Hospital Services	2 779 776	2 731 891	2 814 948	2 717 808	2 840 634	3 061 957	2 843 751	2 939 131	3 084 071
Sub-Total	**5 169 169**	**5 385 460**	**5 355 155**	**5 368 178**	**5 512 895**	**5 873 494**	**5 492 145**	**5 684 651**	**5 854 301**
Unauthorized expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Baseline available for spending after 1st charge	**5 169 169**	**5 385 460**	**5 355 155**	**5 368 178**	**5 512 895**	**5 873 494**	**5 492 145**	**5 684 651**	**5 854 301**

Table 75: Summary of Budget Allocations and Estimates by Economic Classification (R'000) (Programme 5)

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2018/19	2019/20	2020/21	2021/22			2022/23	2023/24	2024/25
Current payments	**4 975 407**	**5 270 488**	**5 283 641**	**5 258 423**	**5 406 178**	**5 768 748**	**5 381 602**	**5 569 135**	**5 639 972**
Compensation of employees	3 032 929	3 075 647	3 175 808	3 022 384	3 193 898	3 315 792	3 199 711	3 254 538	3 217 841
Goods and services	**1 942 406**	**2 194 842**	**2 107 833**	**2 236 039**	**2 212 280**	**2 452 927**	**2 181 891**	**2 314 597**	**2 422 131**

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	**2018/19**	**2019/20**	**2020/21**	**2021/22**			**2022/23**	**2023/24**	**2024/25**
Communication	5 986	7 100	6 482	8 105	7 147	6 512	8 447	8 827	9 222
Computer Services	7 413	5 999	6 077	5 620	5 620	5 943	5 994	6 264	6 545
Consultants, Contractors and special services	666 156	962 870	825 725	973 942	962 397	960 138	1 042 555	1 068 655	1 120 371
Inventory	878 015	865 839	886 580	821 110	850 412	1 078 067	713 266	779 267	814 178
Operating leases	2 101	2 321	2 143	2 776	2 700	2 587	2 899	3 030	3 166
Travel and subsistence	977	369	428	1 897	897	1 090	1 980	2 069	2 162
Maintenance, repair and running costs	807	478	825	839	1 194	1 409	876	916	957
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	380 951	349 866	379 573	421 750	381 913	397 181	405 874	445 569	465 530
Interest and rent on land	72	-1	-	-	-	29	-	-	-
Transfers and subsidies to	**22 593**	**27 104**	**27 517**	**44 157**	**44 157**	**46 986**	**45 687**	**47 743**	**49 882**
Provinces and municipalities	-	-	-	-	-	-	-	-	-
Departmental agencies and accounts	109	77	63	79	79	101	82	86	90
Higher education institutions	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	22 484	27 027	27 454	44 078	44 078	46 885	45 605	47 657	49 792
Payments for capital assets	171 169	87 868	43 997	65 598	62 560	57 760	64 856	67 773	164 447
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Machinery and equipment	171 169	87 868	43 997	65 598	62 560	57 760	64 856	67 773	164 447
Payment for financial assets	-	-	-	-	-	-	-	-	-
Total economic classification	**5 169 169**	**5 385 460**	**5 355 155**	**5 368 178**	**5 512 895**	**5 873 494**	**5 492 145**	**5 684 651**	**5 854 301**
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	**5 169 169**	**5 385 460**	**5 355 155**	**5 368 178**	**5 512 895**	**5 873 494**	**5 492 145**	**5 684 651**	**5 854 301**

PERFORMANCE AND EXPENDITURE TRENDS

Programme 5 is allocated 10.8% of the Vote 7 budget allocation, down from the 11.2% allocation in the 22/23 revised estimates. This is a decrease of R 381 349 000.

UPDATED KEY RISKS AND MITIGATION

Table 76: Updated key risks and mitigation (Programme 5)

Key Risks	Risk Mitigation
Outcome: Universal health coverage	
Funding pressures threaten the achievement of service delivery objectives.	Strengthen the functionality of cash flow committees to monitor costs across all units and institutions.
Inadequate storage for clinical records	Engage with the Departments ICT Unit on the roll-out of the e-Health system and proposal for other electronical storage systems.
	Follow-up with the Infrastructure Development Unit for a consideration of an offsite storage

13. PROGRAMME 6: HEALTH SCIENCES AND TRAINING

Programme Purpose

Render training and development opportunities for actual and potential employees of the Department of Health - There are no changes to the Programme 6 structure.

Sub-Programme 6.1: Nursing Training Colleges

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

Sub-Programme 6.2: EMS Training Colleges

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: Primary Health Care Training

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

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.

Table 77: Programme 6 Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
OUTCOME: UNIVERSAL HEALTH COVERAGE								
First Year Nursing Students awarded bursaries	**27. Number of Bursaries awarded to first year nursing students**	**178**	**101**	**160**	**Annual**	**120**	**120**	**120**
Bursaries awarded to internal employees	**28. Number of internal employees awarded bursaries**	**New indicator**	**369**	**360**	**Annual**	**480**	**600**	**600**

Table 78: Programme 6: Output Indicators Quarterly and Annual Targets

Indicator Name	Targets				
	2023/24	Q1	Q2	Q3	Q4
OUTCOME: UNIVERSAL HEALTH COVERAGE					
27. Number of Bursaries awarded to first year nursing students	**120**	0	0	0	120
28. Number of internal employees awarded bursaries	**480**	0	0	0	480

EXPLANATION OF PLANNED PERFORMANCE OVER THE MEDIUM TERM PERIOD

Programme 6 renders training and development opportunities for actual and potential employees of the department. This pertains to the outcome of Universal Health Coverage.

OUTCOME: UNIVERSAL HEALTH COVERAGE

Strengthening of the training programmes for skills transfer and development. The support for training of nursing specialists to support the process of regionalisation of the 4 hospitals and the tertiary hospital in the North. Strengthen registrar training to support the change in the service delivery platform with the regionalisation of the 4 district hospitals. The strengthening of training of allied professionals including EMS to support the referral pathway of the Department

The Department will seek accreditation with South African Nursing Council (SANC) and Council for Higher Education (CHE) for Post Graduate Diplomas in Nursing). (The KZNCN is continuing with plans to offer the new Post Graduate Diplomas to in-service Professional nurses of the KZNDOH. The programmes can however only be offered once accreditation has been received from the South African Nursing Council and the Council on Higher Education. The KZNCN has to date submitted 9 Post Graduate Diploma programmes for accreditation, and the outcome is awaited).

Officials will be trained through the EMS College based at McCord Hospital. This training is for existing EMS personnel and the training programmes are courses linked to EMS specific continuous professional development programmes.

The Department will award 480 bursaries in the 2023 academic year to internal employees to study various qualifications. This is in line with the departmental bursary policy for part-time studies, that afford internal employees an opportunity for skills development in order to enhance career pathing through the improvement of their current qualifications and to improve employee performance.

The Department is accredited by the HPCSA for 1 170 medical intern posts and these posts are funded though voted funds (570 posts) and through the Human Resources (HR) and Training grant (600 posts). The Department has been allocated 1 270 Community Service personnel in the various categories. Currently, there are 12 students who are studying in Cuba as part of the Nelson Mandela Fidel Castro Medical Programme Collaboration.

PROGRAMME RESOURCE CONSIDERATIONS

Table 79: Budget allocation Estimates (R'000) (Programme 6)

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
Nursing Training Colleges	241 488	220 796	212 037	221 447	221 447	221 243	222 764	234 634	245 147
EMS Training Colleges	21 564	19 568	22 326	37 927	37 927	36 399	31 082	36 788	38 437
Bursaries	217 510	109 494	74 129	148 818	120 369	120 369	138 610	145 354	151 866
Primary Health Care Training	44 430	37 753	33 505	47 134	43 646	35 931	48 295	53 362	55 753
Training Other	779 581	877 586	1 020 190	934 909	1 009 621	1 060 899	1 040 258	1 079 335	1 161 193
Sub-Total	**1 304 573**	**1 265 197**	**1 362 187**	**1 390 235**	**1 433 010**	**1 474 841**	**1 481 009**	**1 549 473**	**1 652 396**
Unauthorized expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Baseline available for spending after 1st charge	**1 304 573**	**1 265 197**	**1 362 187**	**1 390 235**	**1 433 010**	**1 474 841**	**1 481 009**	**1 549 473**	**1 652 396**

Table 80: Summary of Budget Allocations and Estimates by Economic Classification (R'000) (Programme 6)

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
Current payments	**1 067 189**	**1 137 118**	**1 267 526**	**1 211 585**	**1 280 190**	**1 321 867**	**1 318 406**	**1 376 762**	**1 471 948**
Compensation of employees	1 013 485	1 103 769	1 230 693	1 144 630	1 207 280	1 249 234	1 239 511	1 294 407	1 385 902
Goods and services	**53 317**	**33 347**	**36 833**	**66 955**	**72 910**	**72 633**	**78 895**	**82 355**	**86 046**
Communication	886	827	861	743	813	843	875	914	956

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
Computer Services	215	202	-	242	-	-	-	-	-
Consultants, Contractors and special services	74	171	101	69	74	84	97	102	107
Inventory	3 878	2 300	3 449	5 433	4 401	5 266	4 882	5 102	5 331
Operating leases	1 315	1 247	1 009	1 522	2 080	2 043	2 138	2 234	2 334
Travel and subsistence	17 376	5 341	4 266	22 458	12 293	11 986	12 875	13 455	14 058
Maintenance, repair and running costs	2 450	1 784	1 129	2 781	3 405	2 058	3 562	3 722	3 889
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	27 123	21 475	26 018	33 707	49 844	50 353	54 466	56 826	59 371
Interest and rent on land	387	2	-	-	-	-	-	-	-
Transfers and subsidies to	**228 430**	**126 123**	**92 096**	**154 933**	**130 700**	**133 619**	**150 499**	**157 779**	**164 847**
Provinces and municipalities	-	-	-	-	-	-	-	-	-
Departmental agencies and accounts	22 036	23 248	23 248	24 364	23 248	23 248	25 436	26 581	27 772
Higher education institutions	-	-	-	-	-	-	-	-	-
Non-profit institutions	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Households	**206 394**	**102 875**	**68 848**	**130 569**	**107 452**	**110 371**	**125 063**	**131 198**	**137 075**
Payments for capital assets	8 954	1 956	2 564	23 717	22 120	19 355	12 104	14 932	15 601
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Machinery and equipment	8 954	1 956	2 564	23 717	22 120	19 355	12 104	14 932	15 601
Payment for financial assets	-	-	1	-	-	-	-	-	-
Total economic classification	**1 304 573**	**1 265 197**	**1 362 187**	**1 390 235**	**1 433 010**	**1 474 841**	**1 481 009**	**1 549 473**	**1 652 396**
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	**1 304 573**	**1 265 197**	**1 362 187**	**1 390 235**	**1 433 010**	**1 474 841**	**1 481 009**	**1 549 473**	**1 652 396**

PERFORMANCE AND EXPENDITURE TRENDS

Programme 6 is allocated 2.9% of the Vote 7 budget allocation, up from the 2.8% allocated in the 22/23 revised estimates. This equates to an increase of R 6 168 000.

UPDATED KEY RISKS AND MITIGATION

Table 81: Updated key risks and mitigation (Programme 6)

Key Risks	Risk Mitigation
Outcome: Universal Health Coverage	
High turnover of medical and nursing specialists	Revive clinical outreach and in-reach programme.
	Improve accessibility of specialists through Telemedicine and other E-Health platforms. (HMS, DHS and IT)
	Encourage institutions to build capacity by reviewing the rotation system and pairing

It should be noted that the above key risks relate to service delivery and not to the HRMS Unit.

NOTES

14. PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

Programme Purpose

To render support services required by the Department to realise its aims. There are no changes to the Programme 7 structure.

Sub-Programme 7.1: Medicine Trading Account

Render Pharmaceutical services to the Department. Manage the supply of pharmaceuticals and medical sundries to hospitals, Community Health Centres and local authorities via the Medicine Trading Account.

Sub-Programme 7.2: Laundry Services

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

Sub-Programme 7.3: Orthotic and Prosthetic Services

Render specialised orthotic and prosthetic services.

Table 82: Programme 7: Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
OUTCOME: UNIVERSAL HEALTH COVERAGE								
Tracer medicine stock out rate - PPSD	**29. Tracer Medicine Stock-Out Rate at the Provincial Pharmaceutical Supply Depot (PPSD)**	**8.9%**	**9.1%**	**6.8%**	**1.9%**	**≤ 5%**	**≤ 5%**	**≤ 5%**
	Number of medicine out of stock	*82*	*84*	*63*	*9*	*Varies*	*Varies*	*Varies*
	Total number of tracer medicine expected to be in stock	*924*	*924*	*924*	*462*	*Varies*	*Varies*	*Varies*
Tracer medicine stock out rate at facilities	**30. Tracer Medicine Stock-Out Rate at facilities (hospitals, community health centres and clinics)**	**3%**	**0.2%**	**1.7%**	**1.6%**	**≤ 5%**	**≤ 5%**	**Varies**
	Number of Tracer medicines stock out in bulk store	*13 045*	*1 198*	*10 709*	*4 323*	*Varies*	*Varies*	*Varies*
	Number of tracer medicines expected to be stocked in the bulk store	*433 390*	*581 666*	*616 162*	*271 370*	*Varies*	*Varies*	*Varies*

Table 83: Programme 7: Output Indicators Quarterly and Annual Targets

Indicator Name	Targets				
	2023/24	Q1	Q2	Q3	Q4
OUTCOME: UNIVERSAL HEALTH COVERAGE					
29. Tracer Medicine Stock-Out Rate at the Provincial Pharmaceutical Supply Depot (PPSD)	**≤ 5%**	**≤ 5%**	**≤ 5%**	**≤ 5%**	**≤ 5%**
Number of medicine out of stock	*Varies*	*Varies*	*Varies*	*Varies*	*Varies*
Total number of tracer medicine expected to be in stock	*Varies*	*Varies*	*Varies*	*Varies*	*Varies*
30. Tracer Medicine Stock-Out Rate at facilities (hospitals, community health centres and clinics)	**≤ 5%**	**≤ 5%**	**≤ 5%**	**≤ 5%**	**≤ 5%**
Number of Tracer medicines stock out in bulk store	*Varies*	*Varies*	*Varies*	*Varies*	*Varies*
Number of tracer medicines expected to be stocked in the bulk store	*Varies*	*Varies*	*Varies*	*Varies*	*Varies*

EXPLANATION OF PLANNED PERFORMANCE OVER THE MEDIUM TERM PERIOD

Programme 7 outputs are geared towards the outcome of *Universal Health Coverage*.

OUTCOME: UNIVERSAL HEALTH COVERAGE

This programme houses a number of centralised services, including the PPSD which manages the supply of pharmaceuticals and medical sundries, the provision of laundry services, as well

as the provision of specialised orthotic and prosthetic services. Although the Department aims to fit 80%of clients needing orthotics and prosthetics, this may not be met with the current budget. The target of 60% is a more realistic target. The Department (Orthotics and Prosthetics programme) will continue to conduct 32 outreach clinics per month. The services will be rationalized to once every 2 months in certain clinics where there is a low demand for services.

The COVID 19 vaccination programme will continue in 2023/24. All fixed facilities in all Districts will continue to provide COVID-19 vaccinations on daily basis. This includes weekends for facilities that are operating for 7 days a week. The number of outreach sites have reduced due to poor uptake by the public. Hot spots are still being targeted. There are no outreach sites opened on weekends. Demand creation is on-going. COVID-19 vaccination will be integrated into the mainstream vaccination programme in PHC facilities.

The optimisation of existing laundry services through remunerated overtime, to reduce the soiled linen backlog has been introduced and will continue. SCM have secured a 3 year contract with strategic partners to allow for the purchasing of linen "as and when required".

Pharmaceutical services will monitor the implementation of the Improvement Plans for Grade C Pharmacies, including the infrastructure interventions that were recommended to ensure all Grade C pharmacies, can be reassessed and upgrade accordingly.

Improving efficiencies in pharmaceutical and laboratory services will be a priority for this MTEF.

PROGRAMME RESOURCE CONSIDERATIONS

Table 84: Budget allocation Estimates (R'000) (Programme 7)

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
Medicine Trading Account	25 325	200 379	70 219	77 193	78 446	74 610	78 430	80 882	85 592
Laundry Services	171 809	182 588	188 976	204 746	202 974	171 769	206 864	217 900	229 468
Orthotic and Prosthetic Services	54 232	47 547	58 964	80 092	67 579	66 843	66 598	68 382	72 723
Sub-Total	**251 366**	**430 514**	**318 159**	362 031	**348 999**	**313 222**	**351 892**	**367 164**	**387 783**
Unauthorized expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Baseline available for spending after 1st charge	**251 366**	**430 514**	**318 159**	**362 031**	**348 999**	**313 222**	**351 892**	**367 164**	**387 783**

Table 85: Summary of Budget Allocations and Estimates by Economic Classification (R'000) (Programme 7)

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2018/19	2019/20	2020/21	2021/22			2022/23	2023/24	2024/25
Current payments	**249 044**	**423 608**	**309 839**	**351 176**	**338 144**	**304 751**	**339 483**	**353 572**	**373 583**
Compensation of employees	154 467	151 147	161 735	187 217	173 040	165 388	173 349	179 964	192 199

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2018/19	2019/20	2020/21	2021/22			2022/23	2023/24	2024/25
Goods and services	**94 577**	**272 461**	**148 104**	**163 959**	**165 104**	**139 363**	**166 134**	**173 608**	**181 384**
Communication	1 079	969	1 079	1 302	1 302	1 116	1 192	1 247	1 303
Computer Services	2 605	2 754	2 461	2 989	2 989	2 861	3 291	3 439	3 593
Consultants, Contractors and special services	591	196	3 062	256	2 756	3 034	3 099	3 239	3 384
Inventory	35 671	214 064	79 899	106 892	99 392	73 936	93 889	98 112	102 505
Operating leases	499	470	503	545	545	356	453	473	494
Travel and subsistence	536	456	464	400	400	523	531	555	581
Maintenance, repair and running costs	4 975	4 025	5 363	5 357	5 357	7 409	7 374	7 706	8 052
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	48 621	49 527	55 273	46 218	52 363	50 128	56 305	58 837	61 472
Interest and rent on land	-	-	-	-	-	-	-	-	-
Transfers and subsidies to	**1 493**	**1 001**	**803**	**908**	**908**	**539**	**948**	**991**	**1 035**
Provinces and municipalities	-	-	-	-	-	-	-	-	-
Departmental agencies and accounts	-	-	-	-	-	-	-	-	-
Higher education institutions	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	1 493	1 001	803	908	908	539	948	991	1 035
Payments for capital assets	**829**	**5 905**	**7 516**	**9 947**	**9 947**	**7 932**	**11 461**	**12 601**	13 165
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Machinery and equipment	829	5 905	7 516	9 947	9 947	7 932	11 461	12 601	13 165
Payment for financial assets	-	-	1	-	-	-	-	-	-
Total economic classification	**251 366**	**430 514**	**318 159**	**362 031**	**348 999**	**313 222**	**351 892**	**367 164**	**387 783**
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	**251 366**	**430 514**	**318 159**	**362 031**	**348 999**	**313 222**	**351 892**	**367 164**	**387 783**

PERFORMANCE AND EXPENDITURE TRENDS

Programme 7 is allocated 0.7% of the Vote 7 budget allocation, an increase from 0.6% allocated in the 22/23 revised estimates. This equates to a rand value increase of R 38 670 000.

UPDATED KEY RISKS AND MITIGATION

Table 86: Updated key risks and mitigation (Programme 7)

Key Risks	Risk Mitigation
Outcome: Universal Health Coverage	
Inadequate administration and management of Pharmaceutical Stock	Implement Rx Solution Stock Management System at PHC Clinics
	Replace MEDSAS with a suitable warehouse management system.

NOTES

15. PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

Programme Purpose

Provision of new health facilities and the refurbishment, upgrading and maintenance of existing health facilities - there are no changes to the structure of Programme 8.

Sub-Programme 8.1: Community Health Facilities

Construction of new facilities and refurbishment, upgrading and maintenance of existing Community Health Centres and Primary Health Care clinics and facilities

Sub-Programme 8.2: District Hospital Services

Construction of new facilities and refurbishment, upgrading and maintenance of existing EMS facilities

Sub-Programme 8.3: Emergency Medical Services

Construction of new facilities and refurbishment, upgrading and maintenance of existing District Hospitals

Sub-Programme 8.4: Provincial 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

Table 87: Programme 8 Outcome Indicators and Targets

Indicator Name	Data Source	South Africa		Provincial		Medium Term Targets		
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2023/24	2024/25	2025/26
OUTCOME: UNIVERSAL HEALTH COVERAGE								
LXIII Percentage of public health facilities refurbished, repaired and maintained	**Infrastructure** Management System	**New indicator**	**New indicator**	**New indicator**	**New indicator**	**100%**	**100%**	**100%**
Total number of health facilities completed capital infrastructure projects (i.e. Practical Completion or equivalent achieved for projects categorised as New & Replacement, Upgrades & Additions or Rehabilitation, Renovations & Refurbishment's						-	-	-
Total number of health facilities planned to have completed capital infrastructure projects (i.e. Practical Completion or equivalent achieved for projects categorised as New & Replacement, Upgrades & Additions or Rehabilitation, Renovations & Refurbishment's						-	-	-

Table 88: Programme 8: Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
OUTCOME: UNIVERSAL HEALTH COVERAGE								
Health facilities with completed capital infrastructure projects	**31. Percentage of health facilities with completed capital infrastructure projects (Programme 8)**	**New indicator**	**New indicator**	**New indicator**	**22%**	**100%**	**100%**	**100%**
	Total number of health facilities with completed refurbishment Capital infrastructure projects i.e. Practical completion certificate (or equivalent issued)				*23*	*41*	*105*	*105*
	Total number of health facilities on the 10 year infrastructure plan that needed major planned to have completed Capital infrastructure projects i.e. Practical completion certificate (or equivalent				*105*	*41*	*105*	*105*
Jobs created through the Expanded Public Works Programme (EPWP)	**32. Number of jobs created through the EPWP**	**3 992**	**3 811**	**3 148**	**2 563**	**2 500**	**2 500**	**2 500**

Table 89: Programme 8: Output Indicators Quarterly and Annual Targets

Indicator Name	Targets				
	2023/24	Q1	Q2	Q3	Q4
OUTCOME: UNIVERSAL HEALTH COVERAGE					
31. Percentage of health facilities with completed capital infrastructure projects (Programme 8)	**100%**	**0%**	**0%**	**0%**	**100%**
Total number of health facilities with completed refurbishment Capital infrastructure projects i.e. Practical completion certificate (or equivalent issued)	*41*	*0*	*0*	*0*	*41*
Total number of health facilities on the 10 year infrastructure plan that needed major planned to have completed Capital infrastructure projects i.e. Practical completion certificate (or equivalent	*41*	*0*	*0*	*0*	*41*
32. Number of jobs created through the EPWP	**2 500**	**625**	**625**	**625**	**625**

EXPLANATION OF PLANNED PERFORMANCE OVER THE MEDIUM TERM PERIOD

The programme 8 outputs are geared towards the outcome of *Universal Health Coverage*. This programme performs facilities management of CHCs, district hospitals, emergency medical services facilities, provincial hospitals, central and tertiary hospitals, as well as all other buildings and structures.

OUTCOME: UNIVERSAL HEALTH COVERAGE

In the next MTEF period the Department will continue to improve availability, reliability and maintainability of the existing infrastructure assets. To this regard the Department is committed to the following:

- Complete installation of Replacement Perimeter fences
- Complete the installation of Elevated Water Tanks Installation Programmes
- Complete installation of the New / Replacement Standby Generators sets
- Asbestos and other Dilapidated Roof Replacement Programme

The programme for the Implementation of 20 new clinics each estimated at an average of R 80 Million has also started with planning and design for most of them underway. Construction is expected to begin in 2024/25 and beyond.

Tender documents for a project to renovate and upgrade the Midlands Laundry at Fort Napier has been completed

Tender document to equip Cato Manor Laundry with additional tunnel washer has also been completed the project is to be advertised before end of January 2023,

The design work on the upgrading of four hospitals from district to regional level of care will also gain momentum within the next MTEF. The master plans are being developed and will be presented in February 2023. The hospitals are Vryheid, Bethesda, Dundee and Christ the King Hospital.

The commitment to build a New Tertiary Hospital in the North of the Province is also being honoured and the draft Business Case for this project is being circulated for comments.

In a bid to improve the management of health infrastructure in the Province, the 'hub and spoke" model has been adopted, entailing decentralisation of head-office personnel to the three Infrastructure Management Hubs, which are being established in the Province. It is anticipated that these hubs will bring about improved turnaround times on infrastructure-related matters that require specialised skill, as well as proactive maintenance. eThekwini and uMgungundlovu Infrastructure Management Hubs are now sufficiently operational whilst resourcing of Empangeni Hub is currently underway.

Revision of Disaster management and business continuity plans are underway to mitigate against load shedding and load reduction. Load shedding impacts on critical engineering equipment, thereby resulting in diesel cost and costly breakdowns.

Complete the planning and design of mental health facilities.

Complete the implementation for the short term maintenance project at Ngwelezana in respect of the flood damage.

PROGRAMME RESOURCE CONSIDERATIONS

Table 90: Budget allocation Estimates (R'000) (Programme 8)

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
Community Health Facilities	196 015	209 326	294 055	379 167	435 351	401 227	285 449	403 911	388 208
District Hospital Services	342 018	808 108	465 265	403 823	503 233	541 342	534 341	506 055	573 100
Emergency Medical Services	-	-	-	22 570	16 000	4 500	55 345	26 923	14 274
Provincial Hospital Services	1 010 015	1 723 875	901 083	579 194	521 467	556 077	451 807	431 660	455 863
Central Hospital Services	82 492	76 072	35 616	74 677	57 877	65 893	153 816	138 127	142 012
Other Facilities	223 768	295 814	246 063	404 788	330 291	295 180	484 387	427 270	447 231
Sub-Total	**1 854 308**	**3 113 195**	**1 942 082**	1 864 219	**1 864 219**	**1 864 219**	**1 965 145**	**1 933 946**	**2 020 688**
Unauthorized expenditure (1st charge) not available for spending	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Baseline available for spending after 1st charge	**1 854 308**	**3 113 195**	**1 942 082**	**1 864 219**	**1 864 219**	**1 864 219**	**1 965 145**	**1 933 946**	**2 020 688**

Table 91: Summary of Budget Allocations and Estimates by Economic Classification (R'000) (Programme 8)

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
Current payments	**630 496**	**712 973**	**753 619**	**628 321**	**794 467**	**755 907**	**670 766**	**583 673**	**527 540**
Compensation of employees	79 675	78 563	96 731	95 736	97 394	93 770	109 614	102 000	83 479
Goods and services	**550 821**	**634 410**	**656 888**	**532 585**	**697 073**	**662 137**	**561 152**	**481 673**	**444 061**
Communication	-	-	21	-	-	-	-	-	-

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
Computer Services	100	-	970	-	80	80	-	-	-
Consultants, Contractors and special services	4 661	2 904	286	-	375	546	-	-	-
Inventory	35 756	39 841	23 660	13 415	19 104	23 912	19 493	19 505	20 379
Operating leases	79 131	169 469	236 800	125 100	166 100	149 129	130 679	40 138	43 129
Travel and subsistence	2 138	1 172	1 951	-	180	175	-	-	-
Maintenance, repair and running costs	-	-	-	-	-	75	-	-	-
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	429 035	421 024	393 200	394 070	511 234	488 220	410 980	422 030	380 553
Interest and rent on land	-	-	-	-	-	-	-	-	-
Transfers and subsidies to	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Provinces and municipalities	-	-	-	-	-	-	-	-	-
Departmental agencies and accounts	-	-	-	-	-	-	-	-	-
Higher education institutions	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	-	-	-	-	-	-	-	-	-
Payments for capital assets	**1 223 812**	**2 400 222**	**1 188 463**	**1 235 898**	**1 069 752**	**1 108 312**	**1 294 379**	**1 350 273**	**1 493 148**
Buildings and other fixed structures	928 325	2 218 868	1 008 097	1 196 960	776 753	809 205	1 252 318	1 329 493	1 457 048
Machinery and equipment	295 487	181 354	180 366	38 938	292 999	299 107	42 061	20 780	36 100
Payment for financial assets	-	-	-	-	-	-	-	-	-
Total economic classification	**1 854 308**	**3 113 195**	**1 942 082**	**1 864 219**	**1 864 219**	**1 864 219**	**1 965 145**	**1 933 946**	**2 020 688**
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	**1 854 308**	**3 113 195**	**1 942 082**	**1 864 219**	**1 864 219**	**1 864 219**	**1 965 145**	**1 933 946**	**2 020 688**

PERFORMANCE AND EXPENDITURE TRENDS

Programme 8 is allocated 3.9% of the Vote 7 budget, an increase from 3.5% in the 22/23 revised estimates. This equates to a Rand value increase of R 100 926 000.

UPDATED KEY RISKS AND MITIGATION

Table 92: Updated key risks and mitigation (Programme 8)

Key Risks	Risk Mitigation
Outcome: Universal Health Coverage	
Delayed completion of infrastructure projects	Ongoing monitoring of the Infrastructure SCM Model
	Development of the Standardised Tender Documents
Disasters (Natural and Man-made)	Revised disaster management business continuity plans

16. INFRASTRUCTURE PROJECTS

Table 93: Infrastructure Projects

Project Name	Budget Programme	Sub Programme	Milestone Reached (IRM)	Construction Start Date	Estimated Construction End Date	Total Project Cost as captured on project page	Current Year Expenditure
Addington Hospital - Restoration Of Fire Services	Health Facilities Management	Provincial Hospital Services	Construction 76% - 99%	04 December 2020	31 March 2023	34,591,470.00	1,729,574.00
Flood Damage Recovery 2022 programme	Health Facilities Management	Provincial Hospital Services	Tender	30 June 2023	30 November 2023	170,307,583.00	128,736,917.00
Benedictine Hospital - Construction of new staff accommodation - Phase 2	Health Facilities Management	District Hospital Services	Pre-feasibility	30 June 2023	30 June 2025	49,500,000.00	R20,308,606
Bruntville CHC-Construction of a New Pharmacy,Dispensary area,walkways,parking and relocation of Par	Health Facilities Management	Community Health Facilities	Construction 51% - 75%	15 October 2021	31 March 2023	25,545,972.00	R6,278,617
Cato Manor Regional Laundry - Installation of Laundry Equipment	Health Facilities Management	Other Facilities	Tender	01 June 2023	29 December 2023	110,000,000.00	R3,600,000
Ekhombe Hospital - Staff Accommodation Renovation	Health Facilities Management	District Hospital Services	Construction 1% - 25%	12 November 2021	10 November 2023	70,000,000.00	R31,500,000
Grey's Hospital - Upgrade and renovation to Nurse's and Doctor's accommodation	Health Facilities Management	Central Hospital Services	Construction 26% - 50%	17 June 2022	12 June 2024	40,562,964.22	R20,000,000
KwaMagwaza Hospital: Repair and Water proof roofs at OPD; Female and Male Ward and Theatres	Health Facilities Management	District Hospital Services	Construction 51% - 75%	09 February 2022	08 August 2023	15,400,000.00	R4,000,000
Ladysmith Hospital - 72 hr Water and Fire Storage Upgrade	Health Facilities Management	Provincial Hospital Services	Construction 1% - 25%	28 October 2022	30 November 2023	15,530,022.21	R10,557,493
Madadeni Hospital : Upgrades to the Student Accommodation	Health Facilities Management	Provincial Hospital Services	Tender	12 May 2023	30 April 2024	67,461,225.00	R25,000,000
Madadeni Hospital- Replacement of Reservoir tank	Health Facilities Management	Provincial Hospital Services	Construction 51% - 75%	21 January 2022	30 June 2023	27,585,004.00	R9,000,000
Murchison Hospital- Alterations and Renovations to Staff Accommodation	Health Facilities Management	District Hospital Services	Construction 1% - 25%	14 September 2022	14 December 2023	34,649,213.00	R21,500,000
Natalia Building: Replacement of 4 x Generator Sets	Health Facilities Management	Other Facilities	Tender	01 March 2023	31 August 2023	14,076,794.00	R10,000,000
Newcastle Hospital -Installation of packaged HVAC units to Theatres 1, 2, 3 and 4	Health Facilities Management	Provincial Hospital Services	Construction 51% - 75%	03 November 2021	28 February 2023	16,681,186.00	R1,783,813
Newcastle Hospital -Package D-CCTV cameras and access control, heat pumps ,fire detection	Health Facilities Management	Provincial Hospital Services	Construction 1% - 25%	01 June 2022	31 August 2024	194,034,844.00	R27,300,000

Project Name	Budget Programme	Sub Programme	Milestone Reached (IRM)	Construction Start Date	Estimated Construction End Date	Total Project Cost as captured on project page	Current Year Expenditure
Nkonjeni Hospital - Build a new Neonatal facility & renovate existing	Health Facilities Management	District Hospital Services	Construction 51% - 75%	03 July 2020	31 March 2023	77,112,606.00	R32,000,000
Northdale Hospital - Renovate Existing Nurses Home and Construct new 28 Uni	Health Facilities Management	District Hospital Services	Tender	08 November 2022	08 November 2024	69,272,578.00	R21,700,000
Northdale Hospital - Replacement of Roofs	Health Facilities Management	District Hospital Services	Construction 76% - 99%	02 August 2021	31 March 2023	40,365,000.00	R2,000,000
Osindisweni Hospital - New Decentralized MDR Unit	Health Facilities Management	District Hospital Services	Construction 26% - 50%	12 April 2021	17 May 2023	127,166,089.00	R4,127,402
Prince Mshiyeni Hospital - Replace 7 standby generators	Health Facilities Management	Provincial Hospital Services	Tender	01 March 2023	29 September 2023	20,508,662.00	R3,550,000
Wentworth Hospital - Replacement of Existing Security Fence	Health Facilities Management	District Hospital Services	Construction 1% - 25%	16 January 2023	15 December 2023	12,000,000.00	R10,000,000

17. PUBLIC-PRIVATE PARTNERSHIPS (PPPS)

Table 94: Public Private Partnerships (PPPs)

Name of PPP	Purpose	Output	Current Annual Budget for 23/24	Date of Termination
Inkosi Albert Luthuli Central Hospital The Department is in a partnership agreement with Impilo Consortium (RF) (PTY) Ltd and Cowslip Investments (SOE) Ltd	• Supply of Equipment and Information Management and Technology Systems and Replace the Equipment	Delivery of non-clinical services to IALCH	To be Confirmed	31 July 2023
	• Systems to ensure that they remain state of the art.			
	• Supply and Replace Non-Medical Equipment.			
	• Provide the services necessary to manage project assets in accordance with best industry practice.			
	• Maintain and Replace Departmental assets in terms of replacement schedules.			
	• Provide and or Procure Utilities, Consumables and Surgical Instruments.			
	• Provide facility management services			

18. STATE AIDED FACILITIES

Table 95: State Aided Facilities

Number	Organisation	District	2022/23 Allocation	2023/24 Allocation
Disability and Rehabilitation				
1	Disabled People South Africa KZN (CBR)	All	1 126 000	1 176 000
2	Disabled People South Africa KZN (WCR)	All	1 034 000	1 064 000
3	CBR Education & Training for Empowerment (CREATE)	uMgungundlovu	524 000	800 000
4	I–Matter Foundation	Amajuba	0	600 000
5	Ikhayalethu Health & Education Centre	uMkhanyakude	524 000	1 749 000
6	KZN Blind & Deaf Society	Zululand	1 001 000	1 045 000
7	Magaye Visually Impaired People's Association	uMgungundlovu	626 000	800 000
8	Nominated Disability Organisation	Ugu	0	360 000
9	Rachel Swart Fund	All	0	800 000
10	South African Mobility for the Blind Trust	All	0	800 000
Mental Health				
11	Akehlulwa Lutho	uMkhanyakude	0	680 000
12	Clermont Day Care Centre	eThekwini	468 000	487 000
13	DCMH - Austerville Halfway House	eThekwini	655 000	682 000
14	DCMH - Azalea House	eThekwini	604 000	628 000
15	DCMH - Happy Hours Amaoti	eThekwini	655 000	682 000
16	DCMH - Happy Hours Durban North	eThekwini	546 000	568 000
17	DCMH - Happy Hours KwaXimba	eThekwini	468 000	487 000
18	DCMH - Happy Hours Ninikhona	iLembe	327 000	340 000
19	DCMH - Happy Hours Phoenix	eThekwini	312 000	324 000
20	DCMH - Jona Vaughn Centre	eThekwini	4 268 000	4 396 000
21	DCMH - Madeline Manor	eThekwini	1 058 000	1 090 000
22	DCMH - Umlazi Halfway House	eThekwini	432 000	449 000
23	Hlanganani Ngothando Organisation	Harry Gwala	441 000	459 000
24	Indlu Youkuphephela Skills Training	Ugu	630 000	655 000
25	Ikhwezi Welfare Organisation	iLembe	1 911 000	1 968 000
26	Inqolobane Home for Children with Physical Disabilities	iLembe	0	380 000
27	John Paetie House	uMgungundlovu	2 450 000	2 450 000
28	Lynn & Imbali House	uMgungundlovu	1 404 000	1 446 000
29	Othandweni Cerebral Palsy Organisation	Ugu	409 000	425 000
30	Rainbow Haven	uMgungundlovu	633 000	658 000
31	Ramakrishna Umzamo Home	eThekwini	729 000	758 000
32	SCDIFA Centre	eThekwini	2 041 000	2 102 000
33	Sparkes Estate	eThekwini	2 348 000	2 418 000
34	Solid Foundation for Rural Development (SORD)	uMkhanyakude	745 000	775 000
35	South Coast Hospice	Ugu	1 836 000	1 891 000
36	St Luke Home for Healing	iLembe	633 000	658 000
37	Still A Time	eThekwini	206 000	214 000

Number	Organisation	District	2022/23 Allocation	2023/24 Allocation
38	Sunfield Home	uMgungundlovu	290 000	302 000
39	Talitha Cumi Special Needs & Development Care Centre	uMgungundlovu	0	680 000
40	The Word of God	Ugu	0	192 000
Palliative, Hospice & Step Down Care				
41	Blessed Gerard Care Centre	iLembe	418 000	437 000
42	Chatsworth Regional Hospice	eThekwini	350 000	366 000
43	Duduza Care Centre	uMzinyathi i	880 000	920 000
44	Estcourt Hospice	uThukela	660 000	690 000
45	Ekukhanyeni Clinic	eThekwini	1 242 000	1 304 000
46	Ethembeni Care Centre	King Cetshwayo	5 590 000	5 870 000
47	Highway Hospice	eThekwini	860 000	860 000
48	Hillcrest Aids Centre Trust	eThekwini	880 000	920 000
49	Howick Hospice	uMgungundlovu	748 000	782 000
50	KwaHilda Ongcwele	Amajuba	300 000	315 000
51	Ladysmith Hospice	uThukela	560 000	585 000
52	Msunduzi Hospice	uMgungundlovu	1 100 000	1 100 000
53	Ntokozweni Village for the Vulnerable	Ugu	180 000	188 000
54	Philanjalo Hospice	uMzinyathi i	2 958 000	3 106 000
55	South Coast Hospice	Ugu	560 000	585 000
56	Thembalethu Care Association	uThukela	300 000	314 000
57	TLC Hospice	Harry Gwala	350 000	366 000
58	Woza Moya Organisation	Harry Gwala	369 000	386 000
Primary Health Care				
59	Bekimpelo Trust	eThekwini	5 662 000	3 662 000
60	Enkumane Clinic	uMgungundlovu	329 000	329 000
61	Matikwe Clinic	eThekwini	585 000	611 000
62	Mountain View	Zululand	3 989 000	1 995 000
63	Philakade TLC	eThekwini	1 377 000	1 438 000
	TOTAL		**64 778 000**	**63 851 000**

NOTES

PART D: TECHNICAL INDICATOR DESCRIPTION (TID) FOR APP

19. STRATEGIC PLAN / OUTCOME INDICATORS

Table 96: Strategic Plan / Outcome Indicator Definitions

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
PROGRAMME 1													
i.	**Audit opinion of Provincial DoH**	Audit opinion for Provincial Departments of Health for financial and performance information	AGSA Findings	N/A	N/A	AGSA Findings	None	None	None	Categorical	Annual	Unqualified audit opinion	Office of the HoD
ii.	**Contingent liability of medico-legal cases**	Contingent liability for the total rand value of the medico legal claims for all backlog cases that were on the case register as at 31 March	Medico-legal case management system	Total rand value of the medico legal claims for all backlog cases that were on the case register as at 31 March	Not Applicable	Medico-legal cases	Accuracy dependent of reporting of data into the system	None	None	Sum	Annual, as at that point in time	Equal or lower than target	Legal Services
iii.	**UHC service Index**	UHC Service Coverage Index is a measurement of coverage of essential health services and is calculated as the product of Reproductive, maternal, new born and child health coverage; Infectious disease control; Non-communicable diseases and Service capacity and access.	South African Health Review	N/A	N/A	South African Health Review	None	None	None	Index	Annual	Higher or equal to target	NHI
iv.	**Professional nurses per 100 000 population**	The number of Professional Nurses in posts on the last day of March of the reporting year per 100 000 population.	Persal (Professional Nurses)	Number of occupied Professional Nurse posts in the reporting cycle	Total population	Persal (Professional Nurses) DHIS (Stats SA population)	Employees are productive	None	None	Ratio	Annual	Equal or higher than target	HRMS
v.	**Medical officers per 100 000 population**	The number of Medical Officers in posts on the last day of March of the reporting year per 100 000 population.	Persal (Medical Officers)	Number of occupied Medical Officer posts inreporting year	Total population	Persal (Medical Officers) DHIS (Stats SA population	Employees are productive	None	None	Ratio	Annual	Equal or higher than target	HRMS
PROGRAMME 2: PRIMARY HEALTH CARE													
vi.	**Ideal clinic status obtained rate**	Fixed PHC health facilities that obtained Ideal Clinic status (bronze, silver, gold) as a proportion of fixed PHC clinics and CHCs/CDCs	Ideal Health Facility software	Fixed PHC health facilities have obtained Ideal Clinic status	Fixed PHC clinics or fixed CHCs and or CDCs	Ideal Health Facility assessments	Accurate data submitted by health facilities	None	None	Rate	Annual [Non-cumulative]	Equal or higher than target	DHS

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transform-ation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
vii.	**Patient Safety Incident (PSI) case closure rate - PHC**	Patient Safety Incident case closed in the reporting month as a proportion of Patient Safety Incident cases reported in the reporting month	Ideal Health Facility Software	Number of Patient Safety Incident (PSI) case closed in the reporting month	Number of Patient Safety Incident (PSI) case reported in the reporting month	Patient Safety Incidence Reports	Accurate data submitted by health facilities	None	None	Rate	Annual	Equal or higher than the target	NHI
viii.	**Patient Experience of Care satisfaction rate - PHC**	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	webDHIS PEC Module	Number of Patient Experience of Care survey "satisfied" responses	Number of Patient Experience of Care survey total responses	Patient Surveys	Accurate data submitted by health facilities	None	None	Rate	Annual	Equal or higher than the target	NHI
PROGRAMME 2: DISTRICT HOSPITALS													
ix.	**Patient Safety Incident (PSI) case closure rate – District Hospital**	Patient Safety Incident case closed in the reporting month as a proportion of Patient Safety Incident cases reported in the reporting month	Ideal Health Facility Software	Number of Patient Safety Incident (PSI) case closed in the reporting month	Number of Patient Safety Incident (PSI) case reported in the reporting month	Patient Safety Incidence Reports	Accurate data submitted by health facilities	None	None	Rate	Annual	Equal or higher than the target	NHI
x.	**Patient Experience of Care satisfaction rate – District Hospital**	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	webDHIS PEC Module	Number of Patient Experience of Care survey "satisfied" responses	Number of Patient Experience of Care survey total responses	Patient Surveys	Accurate data submitted by health facilities	None	None	Rate	Annual	Equal or higher than the target	NHI
xi.	**[Number of] maternal death in facility – District Hospital**	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric)	DHIS	[Number of] maternal death in facility	Not applicable	Maternal death register,	Accurate data submitted by health facilities	Women	None	Number	Annual	Lower or equal to the target	SHP
xii.	**[Number of] Death in facility under 5 years – District Hospital**	Children under 5 years who died during their stay in the facility	DHIS	[Number of] Death in facility under 5 years	Not applicable	Midnight census;	Accurate data submitted by health facilities	Children under 5 years	None	Number	Annual	Lower or equal to target	SHP
xiii.	**Child under 5 years diarrhoea case fatality rate – District Hospital**	Diarrhoea deaths in children under 5 years as a proportion of diarrhoea separations under 5 years in health facilities	DHIS	Diarrhoea death under 5 years	Diarrhoea separation under 5 years	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Rate	Annual	Lower or equal to target	SHP
xiv.	**Child under 5 years pneumonia case**	Pneumonia deaths in children under 5 years as a proportion of	DHIS	Pneumonia death under 5	Pneumonia separation under 5	Ward register	Accurate data	Children	None	Rate	Annual	Lower or equal to	SHP

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transform-ation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
	fatality rate – District Hospital	pneumonia separations under 5 years in health facilities		years	years		submitted by health facilities	under 5 years				target	
xv.	**Child under 5 years severe acute malnutrition case fatality rate – District Hospital**	Severe acute malnutrition deaths in children under 5 years as a proportion of total deaths in facility under 5 years	DHIS	Severe acute malnutrition death under 5 years	Severe acute malnutrition inpatient under 5 years	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Rate	Annual	Lower or equal to target	SHP
PROGRAMME 2: HIV / AIDS, TB AND SEXUALLY TRANSMITTED INFECTIONS													
xvi.	**[Number of] All DS-TB Deaths**	TB clients who started drug-susceptible tuberculosis (DS-TB) treatment and who subsequently died	DHIS	All DS-TB deaths	None	TB Clinical stationery	Accurate data submitted by health facilities	Cohort	None	Number	Annual	Lower or equal to target	SHP
xvii.	**All DS-TB client treatment success rate**	TB clients who started drug-susceptible tuberculosis (DS-TB) treatment and who subsequently successfully completed treatment as a proportion of all those in the treatment outcome cohort	DHIS	All DS-TB client successfully completed treatment	All DS-TB treatment start	TB Clinical Stationery;	Accurate data submitted by health facilities	Cohort	None	Rate	Annual	Higher or equal to target	SHP
xviii.	**Rifampicin Resistant / Multidrug resistant treatment success rate**	TB Rifampicin Resistant / Multidrug Resistant clients who started treatment and who subsequently successfully completed treatment as a proportion of all those in the treatment outcome cohort	EDR.Web	All Rifampicin resistant / Multidrug resistant clients successfully completed treatment	All Rifampicin resistant / Multidrug resistant client started on treatment	TB Clinical Stationery;	Accurate data submitted by health facilities	Cohort	None	Rate	Annual	Higher or equal to target	SHP
xix.	**TB Pre-XDR treatment success rate**	TB Pre-XDR clients who started treatment and who subsequently successfully completed treatment as a proportion of all those in the treatment outcome cohort	EDR.Web	TB Pre-XDR client who successfully completed treatment	TB Pre-XDR client started on treatment	TB Clinical Stationery;	Accurate data submitted by health facilities	Cohort	None	Rate	Annual	Higher or equal to target	SHP
xx.	**ART client remain on ART end of month – sum**	Total clients remaining on ART (TROA) are the sum of the following: - Any client on treatment in the reporting month - Any client without an outcome reported in the reporting month	DHIS	ART adult and child under 15 years remaining on ART end of month	None	ART Register;	Accurate data submitted by health facilities	None	None	Number	Quarter Specific	Higher or equal to target	SHP
xxi.	**ART Adult Viral load**	ART adult viral load under 50 as	TIER.Net	ART adult viral load under	ART adult viral load	ART paper	Accurate	Cohort	None	Rate	Annual	Higher or	SHP

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
	suppressed rate (below 50) [12 months]	a proportion of ART adult viral load done		50	done	Register;	data submitted by health facilities					equal to target	
xxii.	**ART Child viral load suppressed rate (below 50) [12 months]**	ART child viral load under 50 as a proportion of ART child viral load done	TIER.Net	ART child viral load under 50	ART child viral load done	ART paper Register;	Accurate data submitted by health facilities	Children under 15 years cohort	None	Rate	Annual	Higher or equal to target	SHP
xxiii.	**HIV positive 15-24 year olds (excl ANC) Rate**	Adolescents and youth 15 to 24 years who tested HIV positive as a proportion of youth who were tested for HIV in this age group	DHIS	HIV positive 15-24 years (excl ANC)	HIV test 15-24 years (excl ANC)	PHC Comprehensive Tick Register;	Accuracy dependant on Accurate data submitted by health facilities	Youth	None	Rate	Annual	Lower or equal to target	SHP
PROGRAMME 2: MATERNAL, CHILD AND WOMAN'S HEALTH INCLUDING NUTRTION													
xxiv.	**Maternal Mortality in facility Ratio - Total**	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100,000 live births in facility	DHIS	Maternal death in facility	Live births known to facility	Maternal death register, Delivery register	Accurate data submitted by health facilities	Women	None	Ratio;	Annual	Equal or lower than target	SHP
xxv.	**Neonatal death in facility rate - Total**	Infants 0-28 days who died during their stay in the facility live births in facility expressed as a ratio per 1 000	DHIS	Inpatient death neonatal	Live birth in facility	Delivery register, Midnight report	Accurate data submitted by health facilities	Neonates	None	Ratio	Annual	Equal or lower then target	SHP
xxvi.	**Live Birth under 2 500 g in facility rate - Total**	Infants born alive weighing less than 2 500g as proportion of total Infants born alive in health facilities (Low birth weight)	DHIS	Live birth under 2500g in facility	Live birth in facility	Delivery register, Midnight report	Accurate data submitted by health facilities	Neonates	None	Rate	Annual	Equal or lower then target	SHP
xxvii.	**Death under 5 years against live birth rate - Total**	Children under 5 years who died during their stay in the facility as a proportion of all live births	DHIS	Death in facility under 5 years total	Live birth in facility	Midnight report	Accurate data submitted by health facilities	Children under 5 years	None	Rate	Annual	Equal or lower then target	SHP

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transform-ation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
xxviii.	**Death in facility under 5 years rate - total**	Children under 5 years who died during their stay in the facility as a proportion of inpatient separations under 5 years. Inpatient separations under 5 years is the total of inpatient discharges, inpatient deaths and inpatient transfers out.	Midnight census; Admission, Discharge & Death registers	Death in facility under 5 years total	Inpatient separations under 5 years	Midnight census; Admission, Discharge & Death registers	Accurate data submitted by health facilities	Children under 5 years	None	Rate	Annual	Equal or lower than target	SHP
xxix.	**Death in facility under 1 year rate - Total**	Children under 1 year who died during their stay in the facility as a proportion of inpatient separations under 1 year. Inpatient separations under-year is the total of inpatient discharges, inpatient deaths and inpatient transfers out.	Midnight census; Admission, Discharge & Death registers	Death in facility under 1 years	Inpatient separations under 1 year	Midnight census; Admission, Discharge & Death registers	Accurate data submitted by health facilities	Children under 1 years	None	Rate	Annual	Equal or lower than target	SHP
xxx.	**Child under 5 years diarrhoea case fatality rate - total**	Diarrhoea deaths in children under 5 years as a proportion of diarrhoea separations under 5 years in health facilities	DHIS	Diarrhoea death under 5 years	Diarrhoea separation under 5 years	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Rate	Annual	Equal or lower then target	SHP
xxxi.	**Child under 5 years pneumonia case fatality rate - total**	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	DHIS	Pneumonia death under 5 years	Pneumonia separation under 5 years	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Rate	Annual	Equal or lower then target	SHP
xxxii.	**Child under 5 years Severe acute malnutrition case fatality rate - total**	Severe acute malnutrition deaths in children under 5 years as a proportion of total deaths in facility under 5 years	DHS	Severe acute malnutrition death under 5 years	Severe acute malnutrition inpatient under 5 years	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Rate	Annual	Equal or lower then target	SHP
xxxiii.	**Still Birth in Facility Rate – total**	Infants born still as proportion of total infants born in health facilities	DHIS	Still birth in facility	Total births in facility	Ward register, Midnight census	Accurate data submitted by health facilities	All births	None	Ratio per 1 000	Quarterly	Equal or lower incidence	SHP
PROGRAMME 2: DISEASE PREVENTION AND CONTROL													
xxxiv.	**Malaria case fatality rate (Indicator applicable to endemic provinces)**	Malaria deaths reported in South Africa. The death resulting from primary malaria diagnosis at the time of death	Malaria Information System	Malaria deaths reported	Malaria cases reported	Malaria Information System	Accurate data submitted by health facilities	None	None	Rate	Annual	Equal or lower then target	Environmental Health & CDC

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
xxxv.	**Malaria incidence per 1 000 population at risk**	New malaria cases as proportion of 1 000 population at risk (high-risk malaria areas (uMkhanyakude) based on malaria cases per 1 000	PHC register; CDC Surveillance database; Malaria database; Stats SA;	Number of malaria cases (new)	Population uMkhanyakude	Malaria database	Accurate data submitted by health facilities	None	uMkhanyakude	Ratio	Annual	Lower incidence	Environmental Health & CDC
xxxvi.	**Covid-19 Case Fatality Rate: Total**	Percentage of clients who died as a result of COVID-19	Datcov	Number of deaths in positive Covid-19 cases : Total	Separations Covid-19 cases Total	Ward registers	Accurate data submitted by health facilities	None	None	Rate	Annual	Equal or lower than target	Environmental Health & CDC
PROGRAMME 4: REGIONAL HOSPITAL													
xxxvii.	**Patient Experience of Care satisfaction rate - Regional Hospital**	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	webDHIS PEC Module	Patient Experience of Care survey "satisfied" responses	Patient Experience of Care survey total responses	Patient Surveys	Accurate data submitted by health facilities	None	None	Rate	Annual	Equal or higher than the target	QA
xxviii.	**Patient Safety Incident (PSI) case closure rate - Regional Hospital**	Patient Safety Incident case closed in the reporting month as a proportion of Patient Safety Incident cases reported in the reporting month	Ideal Health Facility Software	Patient Safety Incident (PSI) case closed in the reporting month	Patient Safety Incident (PSI) case reported in the reporting month	Patient Safety Incidence Reports	Accurate data submitted by health facilities	None	None	Rate	Annual	Equal or higher than the target	QA
xxxix.	**[Number of] Maternal deaths in facility - Regional Hospital**	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric)	DHIS	[Number of] Maternal deaths in facility	Not applicable	Maternal death register,	Accurate data submitted by health facilities	Pregnant women	None	Number	Annual	Lower or equal to the target	SHP
xl.	**[Number of] Deaths in facility under 5 years - Regional Hospital**	Children under 5 years who died during their stay in the facility	DHIS	[Number of] Deaths in facility under 5 years	Not applicable	Midnight census;	Accurate data submitted by health facilities	Children under 5 years	None	Number	Annual	Lower or equal to target	SHP
xli.	**Child under 5 years diarrhoea case fatality rate - Regional Hospital**	Diarrhoea deaths in children under 5 years as a proportion of diarrhoea separations under 5 years in health facilities	DHIS	Diarrhoea death under 5 years	Diarrhoea separation under 5 years	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Rate	Annual	Lower or equal to target	SHP

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
xlii.	**Child under 5 years pneumonia case fatality rate - Regional Hospital**	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	DHIS	Pneumonia death under 5 years	Pneumonia separation under 5 years	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Rate	Annual	Lower or equal to target	SHP
xliii.	**Child under 5 years severe acute malnutrition case fatality rate - Regional Hospital**	Severe acute malnutrition deaths in children under 5 years as a proportion of total deaths in facility under 5 years	DHIS	Severe acute malnutrition death under 5 years	Severe acute malnutrition inpatient under 5 years	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Rate	Annual	Lower or equal to target	SHP
PROGRAMME 4: TB HOSPITALS													
xliv.	**Patient Experience of Care satisfaction rate – TB Hospital**	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	webDHIS PEC Module	Patient Experience of Care survey "satisfied" responses	Patient Experience of Care survey total responses	Patient Surveys	Accurate data submitted by health facilities	None	None	Rate	Annual	Equal or higher than the target	NHI
xlv.	**Patient Safety Incident (PSI) case closure rate – TB Hospital**	Patient Safety Incident case closed in the reporting month as a proportion of Patient Safety Incident cases reported in the reporting month	Ideal Health Facility Software	Patient Safety Incident (PSI) case closed in the reporting month	Patient Safety Incident (PSI) case reported in the reporting month	Patient Safety Incidence Reports	Accurate data submitted by health facilities	None	None	Rate	Annual	Equal or higher than the target	NHI
PROGRAMME 4: PSYCHIATRIC HOSPITALS													
xlvi.	**Patient Experience of Care satisfaction rate - Psychiatric Hospital**	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Ideal Health Facility Software	Patient Experience of Care survey "satisfied" responses	Patient Experience of Care survey total responses	Patient Surveys	Accurate data submitted by health facilities	None	None	Rate	Annual	Equal or higher than the target	NHI
xlvii.	**Patient Safety Incident (PSI) case closure rate - Psychiatric Hospital**	Patient Safety Incident case closed in the reporting month as a proportion of Patient Safety Incident cases reported in the reporting month	Ideal Health Facility Software	Patient Safety Incident (PSI) case closed in the reporting month	Patient Safety Incident (PSI) case reported in the reporting month	Patient Safety Incidence Reports	Accurate data submitted by health facilities	None	None	Rate	Annual	Equal or higher than the target	NHI
PROGRAMME 4: CHRONIC HOSPITALS													
xlviii.	**Patient Experience of Care satisfaction rate – Chronic Hospitals**	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	webDHIS PEC Module	Patient Experience of Care survey "satisfied" responses	Patient Experience of Care survey total responses	Patient Surveys	Accurate data submitted by health facilities	None	None	Rate	Annual	Equal or higher than the target	NHI
xlix.	**Patient Safety Incident (PSI) case**	Patient Safety Incident case closed in the reporting month as	Ideal Health Facility	Patient Safety Incident (PSI) case closed in the reporting	Patient Safety Incident (PSI) case	Patient Safety Incidence	Accurate data	None	None	Rate	Annual	Equal or higher than	NHI

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
	closure rate – Chronic Hospitals	a proportion of Patient Safety Incident cases reported in the reporting month	Software	month	reported in the reporting month	Reports	submitted by health facilities					the target	
PROGRAMME 5: TERTIARY HOSPITALS													
I.	**Patient Experience of Care satisfaction rate – Tertiary Hospitals**	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	webDHIS PEC Module	Patient Experience of Care survey "satisfied" responses	Patient Experience of Care survey total responses	Patient Surveys	Accurate data submitted by health facilities	None	None	Rate	Annual	Equal or higher than the target	NHI
Ii.	**Patient Safety Incident (PSI) case closure rate – Tertiary Hospitals**	Patient Safety Incident case closed in the reporting month as a proportion of Patient Safety Incident cases reported in the reporting month	Ideal Health Facility Software	Patient Safety Incident (PSI) case closed in the reporting month	Patient Safety Incident (PSI) case reported in the reporting month	Patient Safety Incidence Reports	Accurate data submitted by health facilities	None	None	Rate	Annual	Equal or higher than the target	NHI
Iii.	**[Number of] Maternal deaths in facility – Tertiary Hospitals**	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric)	DHIS	[Number of] Maternal deaths in facility	Not applicable	Maternal death register,	Accurate data submitted by health facilities	Women	None	Number [Cumulative]	Annual	Lower or equal to the target	SHP
Iiii.	**[Number of] Deaths in facility under 5 years – Tertiary Hospitals**	Children under 5 years who died during their stay in the facility	DHIS	[Number of] Deaths in facility under 5 years	Not applicable	Midnight census;	Accurate data submitted by health facilities	Children under 5 years	None	Number [Cumulative]	Annual	Lower or equal to target	SHP
Iiv.	**Child under 5 years diarrhoea case fatality rate– Tertiary Hospitals**	Diarrhoea deaths in children under 5 years as a proportion of diarrhoea separations under 5 years in health facilities	DHIS	Diarrhoea death under 5 years	Diarrhoea separation under 5 years	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Rate	Annual	Lower or equal to target	SHP
Iv.	**Child under 5 years pneumonia case fatality rate – Tertiary Hospitals**	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	DHIS	Pneumonia death under 5 years	Pneumonia separation under 5 years	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Rate	Annual	Lower or equal to target	SHP
Ivi.	**Child under 5 years severe acute malnutrition case fatality rate – Tertiary**	Severe acute malnutrition deaths in children under 5 years as a proportion of total deaths in facility under 5 years	DHIS	Severe acute malnutrition death under 5 years	Severe acute malnutrition inpatient under 5 years	Ward register	Accurate data submitted by health	Children under 5 years	None	Rate	Annual	Lower or equal to target	SHP

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transform-ation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
	Hospitals						facilities						
PROGRAMME 5: CENTAL HOSPITALS													
lvii.	**Patient Experience of Care satisfaction rate – Central Hospital**	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	webDHIS PEC Module	Patient Experience of Care survey "satisfied" responses	Patient Experience of Care survey total responses	Patient Surveys	Accurate data submitted by health facilities	None	None	Rate	Annual	Equal or higher than the target	QA
lviii.	**Patient Safety Incident (PSI) case closure rate – Central Hospital**	Patient Safety Incident case closed in the reporting month as a proportion of Patient Safety Incident cases reported in the reporting month	Ideal Health Facility Software	Patient Safety Incident (PSI) case closed in the reporting month	Patient Safety Incident (PSI) case reported in the reporting month	Patient Safety Incidence Reports	Accurate data submitted by health facilities	None	None	Rate	Annual	Equal or higher than the target	QA
lix.	**[Number of] Maternal deaths in facility – Central Hospital**	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric)	DHIS	[Number of] Maternal deaths in facility [District, Regional, Tertiary and Central]	Not applicable	Maternal death register,	Accurate data submitted by health facilities	Women	None	Number	Annual	Lower or equal to the target	SHP
lx.	**[Number of] Deaths in facility under 5 years – Central Hospital**	Children under 5 years who died during their stay in the facility	DHIS	[Number of] Deaths in facility under 5 years	Not applicable	Midnight census;	Accurate data submitted by health facilities	Children under 5 years	None	Number	Annual	Lower or equal to target	SHP
lxi.	**Child under 5 years pneumonia case fatality rate – Central Hospital**	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	DHIS	Pneumonia death under 5 years	Pneumonia separation under 5 years	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Rate	Annual	Lower or equal to target	SHP
lxii.	**Child under 5 years severe acute malnutrition case fatality rate – Central Hospital**	Severe acute malnutrition deaths in children under 5 years as a proportion of total deaths in facility under 5 years	DHIS	Severe acute malnutrition death under 5 years	Severe acute malnutrition inpatient under 5 years	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Rate	Annual	Lower or equal to target	SHP
PROGRAMME 8: INFRASTRUCTURE													
lxiii.	**Percentage of public health facilities refurbished, repaired**	Number of health facilities with completed capital infrastructure projects (i.e. Practical Completion or equivalent	Project Management Information	Total number of health facilities completed capital infrastructure projects (i.e. Practical Completion or	Total number of health facilities planned to have completed capital	Project List (B5) and Practical Completion Certificates or	Accurate data submitted by health	None	None	Rate	Annual	Higher or equal to target	Infrastructure

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transform-ation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
	and maintained	achieved for projects categorised as New & Replacement, Upgrades & Additions or Rehabilitation, Renovations & Refurbishment's) expressed as a percentage of the number of health facilities planned to have completed capital infrastructure projects	System	equivalent achieved for projects categorised as New & Replacement, Upgrades & Additions or Rehabilitation, Renovations & Refurbishment's	infrastructure projects (i.e. Practical Completion or equivalent achieved for projects categorised as New & Replacement, Upgrades & Additions or Rehabilitation, Renovations & Refurbishment's	equivalent	facilities						

20. APP OUTPUT INDICATORS

Table 97: APP Output Indicator Definitions

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired perform-ance	Indicator Responsibility
				Number / Numerator	Denominator								
PROGRAMME 1: ADMINISTRATION													
1.	**Number of CHW's contracted into the Health System**	The number of CHWs appointed on contract during year of reporting.	CHW database/ Persal	Number of CHW's on contract in the Public Health system	N/A	CHW database/ Persal	None	None	None	Number –	Quarter specific	Equal or higher than target	ESS
2.	**Percentage of supplier invoices paid within 30 Days**	The number of payments processed within 30 days of receipt of the invoice in the month over the total number of payments that were processed in the month.	Cognos	Suppliers paid within 30 days	Suppliers paid within the given month (period)	BAS	None	None	None	Rate	Quarter specific	Equal or higher than target	CFO
3.	**Percentage of Hospitals using the E-health system**	Hospitals that use an electronic system to capture clinical codes for each and every patient visit	Hospitals that have access to and use an electronic system for patient records	Total number of hospitals with an electronic system to record clinical codes	Total number of hospitals	Hospitals that use an electronic system to capture clinical codes for each and every patient visit	None	None	None	Rate ()	Quarter specific	Equal or higher than target	ICT
PROGRAMME 2: PRIMARY HEALTH CARE													

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired perform-ance	Indicator Responsibility
				Number / Numerator	Denominator								
4.	**Severity assessment code (SAC) 1 incident reported within 24 hours rate – PHC**	Severity assessment code (SAC) 1 incidents reported within 24 hours as a proportion of Severity assessment code (SAC) 1 incident reported	Ideal Health Facility Software	Severity assessment code (SAC) 1 incidents reported within 24 hours	Severity assessment code (SAC) 1 incident reported	Patient Safety Incident Reports	Accurate data submitted by health facilities	None	None	Rate)	Quarter specific	Equal or higher than target	NHI
PROGRAMME 2: DISTRICT HOSPITALS													
5.	**Severity assessment code (SAC) 1 incident reported within 24 hours rate - District Hospital**	Severity assessment code (SAC) 1 incidents reported within 24 hours as a proportion of Severity assessment code (SAC) 1 incident reported	Ideal Health Facility Software	Severity assessment code (SAC) 1 incidents reported within 24 hours	Severity assessment code (SAC) 1 incident reported	Patient Safety Incident Reports	Accurate data submitted by health facilities	None	None	Rate	Quarter specific	Equal or higher than target	NHI
PROGRAMME 2: HIV / AIDS, TB AND SEXUALLY TRANSMITTED INFECTIONS													
6.	**All DS-TB Lost to follow-up rate**	ALL TB clients who started drug-susceptible tuberculosis (DS-TB) treatment and who were subsequently lost to follow-up as a proportion of all those who started DS TB treatment	DHIS	All DS-TB client loss to follow-up	All DS-TB treatment start	DS-TB Clinical Stationery;TIER.Net	Accurate data submitted by health facilities	Cohort	None	Rate	Quarter specific	Lower or equal to target	SHP
7.	**TB Rifampicin resistant / Multidrug - Resistant lost to follow up rate**	TB Rifampicin Resistant/Multidrug Resistant clients loss to follow-up as a proportion of TB Rifampicin Resistant/Multidrug Resistant clients started on treatment	DHIS	TB Rifampicin resistance / multi-drug resistant client loss to follow-up	TB Rifampicin Resistant / Multi-drug client started on treatment	DS-TB Clinical Stationery;TIER.Net	Accurate data submitted by health facilities	Cohort	None	Rate	Quarter specific	Lower or equal to target	SHP
8.	**TB Pre-XDR Loss to Follow-up Rate**	TB Pre-XDR clients who are loss to follow up as a proportion of TB Pre-XDR clients started on treatment	DHIS	TB Pre-XDR clients who are lost to follow-up	TB Pre-XDR clients started on treatment	DS-TB Clinical Stationery;TIER.Net	Accurate data submitted by health facilities	Cohort	None	Rate	Quarter specific	Lower or equal to target	SHP
9.	**ART adult remain in care rate [12 months]**	ART adult remain in care - total as a proportion of ART adult start minus cumulative transfer out	TIER.Net	ART adult remain in care at 12 months - total	ART adult start minus cumulative transfer out	ART paper Register;; DHIS	Accurate data submitted by health facilities	Cohort	None	Rate	Quarter specific	Higher or equal to target	SHP
10.	**ART child remain in care rate [12 months]**	ART child remain in care - total as a proportion of ART child start minus cumulative transfer out	TIER.Net;	ART child remain in care at 12 months - total	ART child start minus cumulative transfer out	ART paper Register; DHIS	Accurate data submitted by health facilities	Children and youth cohort	None	Rate	Quarter specific	Higher or equal to target	SHP

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired perform-ance	Indicator Responsibility
				Number / Numerator	Denominator								
PROGRAMME 2: MATERNAL, CHILD AND WOMAN'S HEALTH INCLUDING NUTRTION													
11.	**Couple year protection rate**	Women protected against pregnancy by using modern contraceptive methods, including sterilisations, as proportion of female population 15-49 year.	DHIS	Couple year protection	Population 15-49 years female	PHC Comprehensive Tick Register StatsSA	Accurate data submitted by health facilities	Women	None	Rate	Quarter specific	Equal or higher than target	SHP
12.	**Delivery 10 -19 years in facility rate**	Deliveries to women under the age of 20 years as proportion of total deliveries in health facilities	DHIS	Delivery 10-19 years in facility	Delivery in facility - total	Health Facility Register, Delivery/Maternity register, DHIS	Accurate data submitted by health facilities	Women	None	Rate	Quarter specific	Equal or lower then target	SHP
13.	**Antenatal 1st visit before 20 weeks rate**	Women who have a first visit before they are 20 weeks into their pregnancy as proportion of all antenatal 1st visits	DHIS	Antenatal 1st visit before 20 weeks	Antenatal 1st visit - total	PHC Comprehensive Tick Register	Accurate data submitted by health facilities	Women	None	Rate	Quarter specific	Higher or equal to target	SHP
14.	**Mother postnatal visit within 6 days rate**	Mothers who received postnatal care within 6 days after delivery as proportion of deliveries in health facilities	DHIS	Mother postnatal visit within 6 days after delivery	Delivery in facility total	PHC Comprehensive Tick Register	Accurate data submitted by health facilities	Females	None	Rate	Quarter specific	Higher or equal to target	SHP
15.	**Infant PCR test positive around 6 months rate**	Infant PCR test positivity around 6months among infants born to HIV positive mothers	DHS	Infant PCR test positive around 6 months rate	Infant HIV PCR test around 6 months	PHC Comprehensive Tick Register	Accurate data submitted by health facilities	Children under 5 years	None	Rate	Quarter specific	Equal or lower then target	SHP
16.	**HIV Test positive around 18 months rate**	HIV test positive at 18 months (18-24) as a proportion of the total deliveries	DHS	HIV Test positive around 18 months	HIV tests done around 18 months	PHC Comprehensive Tick Register	Accurate data submitted by health facilities	Children under 5 years	None	Rate	Quarter specific	Equal or lower then target	SHP
17.	**Immunisation under 1 year coverage**	Children under 1 year who completed their primary course of immunisation as a proportion of population under 1 year	DHIS	Immunised fully under 1 year new	Population under 1 year	PHC Comprehensive Tick Register StatsSA	Accurate data submitted by health facilities	Children under 1 years	None	Rate)	Quarter specific	Higher or equal to target	SHP
18.	**Measles 2nd dose 1 year coverage**	Children 1 year (12 months) who received measles 2nd dose, as a proportion of the 1 year population.	DHIS	Measles 2nd dose	Target population 1 year	PHC Comprehensive Tick Register StatsSA	Accurate data submitted by health facilities	Children 1 years and under	None	Rate	Quarter specific	Higher or equal to target	SHP

	Indicator Title	Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired perform-ance	Indicator Responsibility
				Number / Numerator	Denominator								
	PROGRAMME 3: EMERGENCY MEDICAL CARE												
19.	**EMS P1 urban response under 30 minutes rate**	Proportion P1 calls in urban locations with response times under 30 minutes. Response time is calculated from the time the call is received to the time of the first dispatched medical resource arrival on scene.	EMS database	EMS P1 urban response under 30 minutes	EMS P1 urban responses	EMS Registers	Accurate data submitted	None	None	Rate	Quarter specific	Higher or equal to target	EMS
20.	**EMS P1 rural response under 60 minutes rate**	Proportion P1 calls in rural locations with response times under 60 minutes. Response time is calculated from the time the call is received to the time of the first dispatched medical resource arrival on scene	EMS database	EMS P1 rural response under 60 minutes	EMS P1 rural responses	EMS Registers	Accurate data submitted	None	None	Rate	Quarter specific	Higher or equal to target	EMS
	PROGAMME 4: REGIONAL HOSPITALS, TB HOSPITALS, PSYCHIATRIC HOSPITALS AND CHRONIC HOSPITALS												
21.	**Severity assessment code (SAC) 1 incident reported within 24 hours rate - Regional Hospital**	Severity assessment code (SAC) 1 incidents reported within 24 hours as a proportion of Severity assessment code (SAC) 1 incident reported	Ideal Health Facility Software	Severity assessment code (SAC) 1 incidents reported within 24 hours	Severity assessment code (SAC) 1 incident reported	Patient Safety Incident Reports	Accurate data submitted by health facilities	None	None	Rate ()	Quarter specific	Equal or higher than target	NHI
	PROGRAMME 5: TERTIARY HOSPITALS AND CENTRAL HOSPITALS												
22.	**Severity assessment code (SAC) 1 incident reported within 24 hours rate – Tertiary Hospitals**	Severity assessment code (SAC) 1 incidents reported within 24 hours as a proportion of Severity assessment code (SAC) 1 incident reported	Ideal Health Facility Software	Severity assessment code (SAC) 1 incidents reported within 24 hours	Severity assessment code (SAC) 1 incident reported	Patient Safety Incident Reports	Accurate data submitted by health facilities	None	None	Rate	Quarter specific	Equal or higher than target	NHI
	PROGRAMME 6: HEALTH SCIENCES												
23.	**Number of Bursaries awarded to first year nursing students**	Number of bursaries awarded for first year nursing students.	Bursary records	Number of bursaries awarded for first year nursing students.	Not applicable	Bursary records	Accurate data	None	None	Number	Annual	Higher or equal to target	HRMS
24.	**Number of internal employees awarded bursaries**	Number of internal employees awarded bursaries	Bursary records	Number of internal employees awarded bursaries	Not applicable	Bursary records	Accurate data	None	None	Number	Annual	Higher or equal to target	HRMS
	PROGRAMME 7: CLINICAL SUPPORT												
25.	**Tracer Medicine**	Number of tracer medicines	Pharmacy	Number of tracer	Total number of	Pharmacy records	Accurate	None	None	Rate	Quarter	Lower or	Pharmacy

	Indicator Title	Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired perform-ance	Indicator Responsibility
				Number / Numerator	Denominator								
	Stock-Out Rate at the Provincial Pharmaceutical Supply Depot (PPSD)	out of stock as proportion of medicines expected to be in stock (any item on the Tracer Medicine List that had a zero balance in the Bulk Store on a Stock Control System.	records	medicines out of stock	medicines expected to be in stock		data				specific	equal to target	
26.	**Tracer Medicine Stock-Out Rate at facilities (hospitals, community health centres and clinics)**	Number of tracer medicines out of stock as proportion of medicines expected to be in stock (any item on Tracer Medicine List that had a zero balance in Bulk Store (facilities) on the Stock Control System).	Pharmacy records	Number of tracer medicines stock out in bulk store	Number of tracer medicines expected to be stocked in the bulk store	Pharmacy records	Accurate data submitted by health facilities	None	None	Rate	Quarter specific	Lower or equal to target	Pharmacy
	PROGRAMME 8: INFRASTRUCTURE												
27.	**Percentage of health facilities with completed capital infrastructure projects (Programme 8)**	Percentage of existing health facilities where Capital, Scheduled Maintenance, or Professional Day-to-day Maintenance projects (Management Contract projects only) have been completed (excluding new and replacement facilities).	Project management Information Systems (PMIS)	Total number of health facilities with completed Capital infrastructure projects i.e. Practical completion certificate (or equivalent issued)	Total number of health facilities planned to have completed Capital infrastructure projects i.e. Practical completion certificate (or equivalent issued)	Project management Information Systems (PMIS)	PMIS is updated frequently and accurately	None	None	Rate	Quarter specific	Higher or equal to target	Infrastructure
28.	**Number of jobs created through the EPWP**	The number of jobs created through EPWP.	EPWP Integrated Reporting System	Number of persons employed	None	Employment contracts	Accurate data submitted by health facilities	None	None	Number	Quarter specific	Higher or equal to target	Infrastructure

ANNEXURES

21. ANNEXURE A: AMENDMENTS TO THE STRATEGIC PLAN

STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 20/21 to 24/25

The table below: "*Universal Health Coverage*" below is reflected on page 55 of the Revised Strategic Plan 20/21 to 24/25 as Table 14. The Outcome Indicators/Targets that are being updated are in italic and strikethrough font. The changes are highlighted in yellow. The Revised Table 14 is subsequently reflected.

Table 98: Outcome Indicators for Universal health Coverage as at March 2023

Outcome Indicator	Data Source	South Africa		Provincial		Changes made in 2023/24
		Baseline (18/19)	Five Year Target (24/25)	Baseline (18/19)	Five Year Target (24/25)	
UHC service Index	SAHR	68%	75%	71.7%	73.5%	
Audit opinion of Provincial DoH	Annual Reports	Unqualified	Clean Audit	Qualified	Unqualified	
Contingent liability of medico-legal cases	Medico-legal case management system	R 90 Bn	R 18 Bn	R 20 Bn	~~R 18 Bn~~ R 32 bn	The Contingent liability has been increasing of the MTEF. The target of R 18 billion was unrealistic given the resource constraints. Adopted at the 2023 Strategic Plan (Source: Draft report from Feb 2023 Strategic Planning session)
~~Percentage of facilities certified by OHSC~~	~~To be determined~~	~~NA~~	~~NA~~	~~New~~	~~71.4%~~	Removed from the National List of Indicators. (Source: SI Shared Planners V2 Oct 2022)
~~Number of districts with Quality Improvement; monitoring and response forums formalized and convened quarterly~~	~~Terms of reference for response forums~~	~~Baseline to be determined~~	~~52~~	~~New~~	~~11~~	Removed from the National List of Indicators. (Source: SI Shared Planners V2 Oct 2022)
Ideal clinic status obtained rate	Ideal Health Facility Software	56% (19/3400)	100%	75.6%	100% (610 / 610)	
Percentage of PHC facilities with functional clinic committees	Attendance registers of meetings of clinic committees	Baseline to be determined	Not available	New	100% (610/ 610)	Remains in Strategic Plan only- not monitored annually in APP Monitored in AOP
Percentage of hospitals with functional hospital boards	Attendance registers of meetings of hospital board meetings	Baseline to be determined	Not available	New	100% (72/72)	Remains in Strategic Plan only- not monitored annually in APP Monitored in AOP

Outcome Indicator	Data Source	South Africa		Provincial		Changes made in 2023/24
		Baseline (18/19)	Five Year Target (24/25)	Baseline (18/19)	Five Year Target (24/25)	
Professional nurses per 100 000 population	Persal/ StatsSA	Not available	Not available	153 / 100k (17 444/11 417 126)	152.5 / 100k ~~(18 421/12 079 648)~~ (18 177 / 11 919 939)	Updated population estimates
Medical officers per 100 000 population	Persal/ StatsSA	NA	NA	34 / 100k (3 879 / 11 417 126)	27.4 / 100k ~~(3 310 /12 079 648)~~ (3 260 / 11 919 339)	Updated population estimates
Percentage of the population within a 5 km radius of a health service	DHIS/GCIS	Not available	Not available	77%	≥ 84%	Mapping was done. Target revised accordingly.
EMS P1 urban response under 30 minutes rate	EMS DataBase	Not available	Not available	New indicator	50%	Added in 2023/24 as this was previously not on the standardised outcome list from NDOH
EMS P1 rural response under 60 minutes rate	EMS DataBase	Not available	Not available	New Indicator	55%	Added in 2023/24 as this was previously not on the standardised outcome list from NDOH

The table below: "*Outcome: Improved Client Experience of Care*" below is reflected on page 59 of the Revised Strategic Plan /21 to 24/25 as Table 16. The Indicators and Targets that are being updated are in italic and strikethrough font. The changes are highlighted in yellow. The revised Table 16 is subsequently reflected.

Table 99: Revised Outcome Indicators for Improved Client Experience of Care as at March 2023

Outcome Indicator	Data Source	South Africa		Provincial		Comment
		Baseline (18/19)	Five Year Target (24/25)	Baseline (18/19)	Five Year Target (24/25)	
Patient Experience of Care satisfaction rate – PHC	Patient surveys	76.5%	85%	68% (31 326/46 068)	~~71.4%~~ ~~(34 586/48 418)~~ 90% (1 935 000/2 150 000)	The target of 71.4% was achieved in 21/22
Patient Experience of Care satisfaction rate - District Hospitals	Patient surveys	Not available	Not available	81% (2 923/3 609)	85.1% ~~(3 227/3 793)~~ (170 200 / 200 000)	Updated raw data based on trend analysis

Outcome Indicator	Data Source	South Africa		Provincial		Comment
		Baseline (18/19)	Five Year Target (24/25)	Baseline (18/19)	Five Year Target (24/25)	
Patient Experience of Care satisfaction rate - Regional Hospitals	Patient surveys	Not available	Not available	81% (4 547/5 613)	85.1% ~~(50/5 899)~~ 85 100/100 000)	Updated raw data based on trend analysis
Patient Experience of Care satisfaction rate (TB Hospitals) – TB Hospitals	Patient surveys	Not available	Not available	92.3% (131 / 142)	97.3% ~~(145 / 149)~~ (1 654/ 1 700)	Updated raw data based on trend analysis
Patient Experience of Care satisfaction rate (Specialised Psychiatric hospitals) – Psychiatric Hospital	Patient surveys	Not available	Not available	88% (169 / 192)	92.6% ~~(187 / 2)~~ (13 890/ 15 000)	Updated raw data based on trend analysis
Patient Experience of Care satisfaction rate (Chronic/Sub-Acute Hospitals) – Chronic/Sub-acute Hospital	Patient surveys	Not available	Not available	79% (122 / 154)	83.3% ~~(135 / 162)~~ (6 664/ 8 000)	Updated raw data based on trend analysis
Patient Experience of Care satisfaction rate (Tertiary Hospitals) – Tertiary Hospitals	Patient surveys	Not available	Not available	74% (585 / 790)	~~77.8%~~ ~~(646 / 830)~~ 86% (38,700 / 45,000)	Baseline for 21/22 exceeded 5 Year Strategic Target
Patient Experience of Care satisfaction rate (Central Hospitals) - Central Hospitals	Patient surveys	Not available	Not available	90% (343 / 381)	94.8% ~~(379 / 400)~~ (14 220/15 000)	Updated raw data based on trend analysis
Patient Safety Incident (PSI) case closure rate –PHC facility	Patient safety incident software	Not available	Not available	65.9% (270/410)	~~93.%~~ ~~(198/212)~~ 95% (684 / 720)	Baseline for 21/22 exceeded the 5 year strategic plan target
Patient Safety Incident (PSI) case closure rate (District Hospital) – District Hospital	Patient safety incident software	Not available	Not available	93.1% ~~88.3%~~ (1 166/1 252)	99.0% ~~(1 013/1 023)~~ (1 757 / 1 775)	Calculation error in baseline data was identified Updated raw data based on trend analysis
Patient Safety Incident (PSI) case closure rate (Regional Hospital) – Regional Hospital	Patient safety incident software	Not available	Not available	86% (240 /279)	~~93.2%~~ ~~(247/265)~~ 98% (2 205 / 2 250)	Baseline for 21/22 exceeded the 5 year strategic plan target

Outcome Indicator	Data Source	South Africa		Provincial		Comment
		Baseline (18/19)	Five Year Target (24/25)	Baseline (18/19)	Five Year Target (24/25)	
Patient Safety Incident (PSI) case closure rate (TB Hospitals) – TB Hospital	Patient safety incident software	Not available	Not available	88% (44 / 50)	~~97.9%~~ ~~(46 / 47)~~ 100% (250 / 250)	Baseline for 21/22 exceeded the 5 year strategic plan target
Patient Safety Incident (PSI) case closure rate (Psychiatric Hospitals) – Psychiatric Hospital	Patient safety incident software	Not available	Not available	94.6% (192 / 203)	96% ~~(190 / 198)~~ (192/200)	Updated raw data based on trend analysis
Patient Safety Incident (PSI) case closure rate (Sub acute, step down and chronic medical hospitals) – Chronic/Sub-acute	Patient safety incident software	Not available	Not available	95.8% (136 / 142)	100% ~~(137 / 137)~~ (60 / 60)	Updated raw data based on trend analysis
Patient Safety Incident (PSI) case closure rate (Tertiary Hospitals) – Tertiary Hospital	Patient safety incident software	Not available	Not available	72.1% (310 / 430)	~~78%~~ ~~(319 / 409)~~ 97% (1 867 / 1 925)	Baseline for 21/22 exceeded the 5 year strategic plan target
Patient Safety Incident (PSI) case closure rate (Central Hospital) – Central Hospital	Patient safety incident software	Not available	Not available	100% (38 / 38)	100% ~~(33 / 33)~~ (325 / 325)	Updated raw data based on trend analysis

The table below: *Outcome: Reduced Morbidity and Mortality* below is reflected as table 18 on page 62 of the Revised Strategic Plan /21 to 24/25. The Indicators and Targets that are being updated are in italic and strikethrough font. The changes are highlighted in yellow. The revised Table 18 is subsequently reflected.

Table 100: Revised Outcome indicators for Reduced Morbidity and Mortality as at March 2023

Outcome Indicator	Data Source	South Africa		Provincial		Comment for 23/24 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Baseline (18/19)	Five Year Target (24/25)	
Maternal Mortality in facility Ratio (total)- Total	Maternal death register, Delivery Register	129/100 000	<100 /100 000	88.4 /100 000 (188 /212 723)	~~70/100 000~~ ~~(146 /8 003)~~ 85.3 / 100 000 (180 / 211 000)	Target amended as private data has been included in the target set, but from 2022/23 is excluded in reporting documents

Outcome Indicator	Data Source	South Africa		Provincial		Comment for 23/24 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Baseline (18/19)	Five Year Target (24/25)	
Maternal Mortality in facility ratio -District Hospitals		Not available	Not available	58.1 / 100 000 (51 / 87 811)	~~47.6/100 000~~ ~~(44 / 92 393)~~ 48.7 /100 000 (48 / 98 506)	
Maternal Mortality in facility ratio - Regional Hospitals		Not available	Not available	107.9 / 100 000 (82 / 76 025)	~~80/100 000~~ ~~(62/77 516)~~ (97.9 /100 000 (102 / 104 194)	
Maternal Mortality in facility ratio - Tertiary Hospitals		Not available	Not available	355.5 / 100 000 (29 / 8 158)	~~304.6/100 000~~ ~~(24 / 7 879)~~ 293 /100 000 (22 /7 500)	
Maternal Mortality in facility ratio - Central Hospitals		Not available	Not available	1 431.5 / 100 000 (7 / 489)	~~851.1/100 000~~ ~~(7 / 470~~) 1 000/ 100 000 (8 / 800)	
Live Birth under 2 500 g in facility rate – Total	Delivery register, Midnight report	Not available	Not available	11.9% (24 035 /201 947)	~~11%~~ ~~(25 493/ 231 759)~~ 11.3% 22 665 / 200 000)	Target amended as private data has been included in the target set, but from 2022/23 is excluded in reporting documents
Neonatal death in facility rate – total (Note – called Neonatal (under 28 days) deaths in facility rate in the National Standardised indicator list. The name above is aligned to the NIDS definition)	Delivery register, Midnight report	12/1 000	<10/1 000	11.5 /1 000 (2 315 / 201 947))	~~10.5/1 000~~ ~~(2 077/197 850)~~ 13.1 / 1,000 (2 629 / 200 000)	Target amended as private data has been included in the target set, but from 2022/23 is excluded in reporting documents
~~Neonatal death in facility rate – District Hospital~~		~~Not available~~	~~Not available~~	~~9.1/1 000~~ ~~(927 /100 973)~~	~~8.4/1 000~~ ~~(743/88 412)~~	The indicator was removed from the National List of indicators for each level of care and the consolidated indicator at a provincial level remains
~~Neonatal death in facility rate – Regional hospitals~~		~~Not available~~	~~Not available~~	~~16.4 / 1 000~~ ~~(1 157 / 70 681)~~	~~15/1 000~~ ~~(1 336 /75 725)~~	
~~Neonatal death in facility rate – Tertiary hospitals~~		~~Not available~~	~~Not available~~	~~22.9 / 1 000~~ ~~1 825 / 8 078)~~	~~21/1 000~~ ~~(164 / 7 799)~~	
~~Neonatal death in facility rate – Central hospitals~~		~~Not available~~	~~Not available~~	~~190 / 1 000~~ ~~(93 / 489)~~	~~123/1 000~~ ~~(58 / 470)~~	

Outcome Indicator	Data Source	South Africa		Provincial		Comment for 23/24 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Baseline (18/19)	Five Year Target (24/25)	
~~Infant PCR test positive around 10 weeks rate~~	~~PHC comprehensive tick register~~	~~Not Available~~	~~Not Available~~	~~0.62%~~ ~~332/53 330)~~	~~0.4%~~ ~~(213/53 330)~~	Removed from NDoH Customised Indicator list. Replaced with 2 indicators:- 1. Infant PCR test positive around 6 months rate **2.** HIV test positive around 18 months rate
Infant PCR test positive around 6 months rate	~~PHC comprehensive tick register~~	New Indicator	Not Available	New indictor	1%	Replacements for NDoH Customised Indicator Infant PCR test positive around 10 weeks rate.
HIV test positive around 18 months rate		New Indicator	Not available	New Indicator	1.5%	
~~Over-weight or obese child under 5 years incidence~~	~~SADHS 16~~	~~13%~~	~~10%~~	~~22.8~~	~~To be determined~~	Removed from the National List of indicators and subsequently removed from the Provincial Plans
~~School learner overweight rate~~	~~DHIS~~	~~Not Available~~	~~Not Available~~	~~Not monitored~~	~~To be determined~~	
Children <5 who are stunted	SADHS 16	27%	To be determined	14.3%	17%	
Death under 5 years against live birth rate – total	Deliver, Maternity register, midnight report	Not Available	Not Available	~~1.3%~~ ~~(1 334/ 100 973)~~ 1.7% (3 380 / 201 947)	~~1.3%~~ ~~(3 055 / 231 759)~~ 1.8% (3 607 / 200 000)	Target amended as private data has been excluded. Baseline data was updated as the original baseline data quoted was for District Hospitals
Death under 5 years against live births –District Hospital		Not Available	Not Available	1.3% (1 334/100 973)	~~1.17%~~ ~~(1 032 /88 412)~~ 1.5% (1 439/ 93 400)	Targets amended in alignment with the change in the number of deaths under 5 in facility
Death in facility under 5 years against live birth rate – Regional Hospital		Not available	Not available	2.4% (1 703 /70 618)	~~2.2%~~ ~~(1 710/75 725)~~ 1.7% (1 710/ 98 800)	
Death under 5 years against live birth rate – Tertiary Hospital		Not available	Not available	2.8% (229 / 8 078)	~~2.3%~~ ~~(177/7 799)~~ 3.8% (278 / 7 200)	

Outcome Indicator	Data Source	South Africa		Provincial		Comment for 23/24 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Baseline (18/19)	Five Year Target (24/25)	
Death under 5 years against live birth rate- Central Hospital		Not available	Not available	43.6% (213 / 489)	~~34.9%~~ ~~(165 / 470)~~ 30% (180 / 600)	
Child under 5 years diarrhoea case fatality rate (total) - Total	DHIS, Midnight register, Ward Register	Not available	Not available	2.2% (171 / 7 702)	1.6% (117/ 7 403)	
Child under 5 years diarrhoea case fatality rate –District Hospital		Not available	Not available	2.2% (94 /4 360)	1.5% ~~(56/3 744)~~ (65 / 4 212)	Updated raw data based on trend analysis
Child under 5 years diarrhoea case fatality rate –Regional Hospital		Not available	Not available	2.4% (68 / 2 874)	~~1.3%~~ ~~(40 / 3 173)~~ 1.7% (48 / 2 784)	Target amended as private data has been included in the target set, but from 2022/23 is excluded in reporting documents
Child under 5 years diarrhoea case fatality rate- Tertiary Hospital		Not available	Not available	1.8% (8 / 440)	~~1.2%~~ ~~(6 / 486)~~ 1% (4 / 407)	
Child under 5 years Pneumonia case fatality rate (total)	DHIS, Midnight Report, Ward Register	Not available	Not available	2.2% (279 / 12 370)	1.8% (217 / 11 914)	
Child under 5 years pneumonia case fatality rate –District Hospital		Not available	Not available	1.8% (128 / 6 938)	1.3% ~~(76 / 5 958)~~ (80 / 6, 243)	Target amended as private data has been included in the target set, but from 2022/23 is excluded in reporting documents
Child under 5 years pneumonia case fatality rate –Regional Hospital		Not available	Not available	2.4% (100 / 4 241)	~~1.3%~~ ~~(59 / 4682)~~ 2.2% (103 / 4 718)	
Child under 5 years pneumonia case fatality rate- Tertiary Hospital		Not available	Not available	0.7% (6 / 892)	~~1.5%~~ ~~(9/596)~~ 2.5% (19 / 774)	Target amended as private data has been included in the target set, but from 2022/23 is excluded in reporting documents
Child under 5 years pneumonia case fatality rate – Central Hospital		Not available	Not available	15.6% (45/ 289)	~~3.3% (16/486)~~ 8.4% (15 / 179)	

Outcome Indicator	Data Source	South Africa		Provincial		Comment for 23/24 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Baseline (18/19)	Five Year Target (24/25)	
Child under 5 years Severe acute malnutrition case fatality rate (Total)	DHIS, Midnight register, Ward Register	Not available	Not available	7.8% (179 / 2 289)	~~5%~~ ~~(90 / 1 800)~~ 7.1% (139 / 1 965)	
Child under 5 years Severe acute malnutrition case fatality rate – District Hospital		Not available	Not available	7% (94 / 1 336)	~~4.8%~~ ~~(48 / 990)~~ 7.6% (82 / 1 075)	
Child under 5 years Severe acute malnutrition case fatality rate –Regional Hospital		Not available	Not available	9% (76 / 839)	~~5.8%~~ ~~(40 / 690)~~ 6.5% (49 / 750)	
Child under 5 years Severe acute malnutrition case fatality rate- Tertiary Hospital		Not available	Not available	4.3% (5 / 116)	~~0.9%~~ ~~(1 / 110)~~ 5.5% (7 / 127)	
Child under 5 years Severe acute malnutrition case fatality rate – Central Hospital		Not available	Not available	23.5% (4 / 17)	~~10%~~ ~~(1 /10)~~ 7.7% (1 / 13)	
Death in facility under 1 year rate –total	DHIS, Midnight register, Ward Register	Not available	Not available	5.4% (3 055 / 57 009)	~~4.1%~~ ~~(2 498 / 60 8)~~ 8% (3 266/ 40 750)	Target amended as private data has been included in the target set, but from 2022/23 is excluded in reporting documents
~~Death in facility under 1 year rate – District Hospital~~		~~Not available~~	~~Not available~~	~~5.3% (1 153/21 880)~~	~~3.7% (892 / 24 157)~~	Collapsed into a consolidated provincial indicator
~~Death in facility under 1 year rate – Regional Hospital~~		~~Not Available~~	~~Not Available~~	~~5.3% (1 422 / 27 059)~~	~~4.8% (1 296 / 27 000)~~	
~~Death in facility under 1 year rate – Tertiary Hospital~~		~~Not Available~~	~~Not Available~~	~~4.4% (195 / 4 445)~~	~~3.1% (151/ 4 908)~~	
~~Death in facility under 1 year rate – Central Hospital~~		~~Not Available~~	~~Not Available~~	~~9.3% (184 / 1 977)~~	~~7.9% (142/ 1 800)~~	

Outcome Indicator	Data Source	South Africa		Provincial		Comment for 23/24 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Baseline (18/19)	Five Year Target (24/25)	
Death in facility under 5 years rate - Total	DHIS, Midnight register, Ward Register	Not Available	Not Available	~~3.9%~~ ~~(3 444 /88 844)~~ 3.8% 3 380 / 88 844)	~~3.8%~~ ~~(3 577/94 142)~~ 5.9% (3 607 / 60 750)	Target amended as private data has been included in the target set, but from 2022/23 is excluded in reporting documents Baseline data amended to be align with numerator for Death in facility under 5 years against live birth rate
Death in facility under 5 years rate –District Hospital		Not Available	Not Available	3.5% (1 334/37 674)	~~2.48%~~ ~~(1 032 /41 565)~~ 5% (1 439/ 28 856)	Target amended as private data has been included in the target set, but from 2022/23 is excluded in reporting documents
Death in facility under 5 years rate –Regional Hospital		Not Available	Not Available	4.4% (1 703 / 38 610)	~~4%~~ ~~(1 710/ 42 629)~~ 6.8% (1 710/ 24 968)	
Death in facility under 5 years rate –Tertiary Hospital		Not Available	Not Available	4% (229 / 5 777)	~~2.8%~~ ~~(177 / 6 378)~~ 6.3% (278 / 4 435)	
Death in facility under 5 years rate –Central Hospital		Not Available	Not Available	5.7% (213 / 3 754)	~~4.6%~~ ~~(165/ 3 570)~~ 7.2% (180 / 2 490)	
Still Birth in Facility Rate – total	Ward register, midnight report	Not Available	Not Available	21.8 / 1 000 (4 500 / 206 438)	~~19/1 000~~ ~~(3 840 / 2 109)~~ 22.3 / 1,000 (4 562 / 204 562)	Target amended as private data has been included in the target set, but from 2022/23 is excluded in reporting documents
~~Still Birth in Facility Rate – district hospital~~		~~Not Available~~	~~Not Available~~	~~18.9/1 000~~ ~~(1 616 / 85 322)~~	~~14/1 000~~ ~~(1 259 / 89 921)~~	Collapsed into a consolidated provincial indicator
~~Still Birth in Facility Rate – regional hospital~~		~~Not Available~~	~~Not Available~~	~~28.8/1 000~~ ~~(2 9 / 76 587)~~	~~.2/1 000~~ ~~(1 572/77 834)~~	
~~Still Birth in Facility Rate – tertiary hospital~~		~~Not Available~~	~~Not Available~~	~~31.1/1 000~~ ~~(258 / 8 306)~~	~~21.8/1000~~ ~~(177/8 131)~~	

Outcome Indicator	Data Source	South Africa		Provincial		Comment for 23/24 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Baseline (18/19)	Five Year Target (24/25)	
~~Still Birth in Facility Rate – central hospital~~		~~Not Available~~	~~Not Available~~	~~29.8/1 000 (15 / 503)~~	~~25.3/1 000 (12/475)~~	
~~Early Neonatal death Rate – Total~~	~~Ward register, midnight report~~	~~Not Available~~	~~Not Available~~	~~9/1 000 (1 818 / 1 947)~~	~~7.9/1 000 (1 628 / 6 041)~~	Removed as most of the neonatal deaths occur within the first 6 days of life therefore there is little value in having 2 indicators portraying the same scenario
~~TB Rifampicin Resistant/MDR/pre-XDR treatment success rate - Long~~	~~DR-TB Clinical Stationery; TIER.Net~~	~~Not Available~~	~~Not Available~~	~~59.7% (1 7 / 2 882)~~	~~65% (1 515 / 2 330)~~	This indicator has been combined into 1 indicator by NDoH named "*TB Rifampicin Resistant / Multidrug – Resistant treatment success rate*"
~~TB Rifampicin Resistant/MDR/pre-XDR treatment success rate - Short~~	~~DR-TB Clinical Stationery; TIER.Net~~	~~Not Available~~	~~Not Available~~	~~70.2% (1 130 / 1 609)~~	~~75% (935 / 1 250)~~	
TB Rifampicin Resistant / Multidrug – Resistant treatment success rate	DR-TB Clinical Stationery; TIER.Net	Not Available	Not Available	63.5% (2 850 / 4 491)	72% (1 133 / 1 574)	New indicator on the NDoH Customised Indicator List. Combination of the long and short Rifampicin Resistant / MDR / Pre-XDR treatment indicator
~~All DS-TB Client death rate~~	~~DR-TB Clinical Stationery; TIER.Net~~	~~Not Available~~	~~Not Available~~	~~7.4% (2854 / 38 451)~~	~~4% (1 920 / 48 000)~~	Removed from NDoH Customised indicator list and replaced with Number of TB deaths
Number of All DS-TB deaths NB: On the National Standarised Indicator List, naming convention is "*Number of TB deaths*"	DR-TB Clinical Stationery; TIER.Net	Not Available	Not Available	3 593 ~~2 854~~	~~1 920~~ 2 840	New indicator on the NDoH Customised Indicator List. Baseline data was updated in accordance with the Annual Report 18/19
All DS- TB client Treatment success Rate	DS-TB Clinical Stationery; TIER>net	Not Available	Not Available	~~79.2% (31 280 / 38 451)~~ 72.2% (42 178 / 58 411)	~~90% (43 0 / 48 000)~~ 86% (40 703 / 47 329)	Change in the TB treatment regime and decline in the social determinants of health. Baseline data was updated in accordance with the Annual Report 2018/19
TB Pre-XDR Treatment Success Rate	-TB Clinical Stationery; TIER.net	Not available	Not available	New Indicator	68.3% (41 / 60)	New indicator on the NDoH Customised Indicator list
~~ART Death rate (6 months)at 6 months~~	~~ART register; TIER.net: DHIS~~	~~Not Available~~	~~Not Available~~	~~1.2% (2 435 / 2 938)~~	~~1% (2 029 / 2 938)~~	Removed from NDoH Customised Indicator List

Outcome Indicator	Data Source	South Africa		Provincial		Comment for 23/24 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Baseline (18/19)	Five Year Target (24/25)	
~~ART adult death rate (6 months) at 6 months~~	~~ART register; TIER.net: DHIS~~	~~NA~~	~~NA~~	~~1.2%~~ ~~(2 375/ 197 918)~~	~~1%~~ ~~(1 979 / 197 918)~~	
~~ART child death rate (6 months) at 6 months~~	~~ART register; TIER.net: DHIS~~	~~NA~~	~~NA~~	~~1.4%~~ ~~(70 / 5 0)~~	~~1%~~ ~~(50 / 5 0)~~	
HIV positive 15 -24 years (Exc ANC) Rate NB, this indicator is called "HIV Incidence amongst Youth" in the Standardised Indicator list	HTS Register (HIV testing services)TIER.Net; DHIS	Not Available	Not Available	New indicator	~~2.9% (14 600/500 000)~~ 1.8% (14 058 / 781 000)	Target met and revised
HIV prevalence among 15 -24 year old pregnant women	Thembisa Model	Not Available	Not Available	Not Available	24.9%	
Adult Viral load suppressed rate (Below 50) (12 months)	ART paper register;TIER.net; DHIS	Not Available	Not Available	90.6% (38 371 / 42 374)	~~90%~~ ~~(38 136 / 42 374)~~ 95% (90 866/ 95 648)	National Department of Health revised the 90 / 90 / 90 Strategy to 95 / 95 / 95 in 2022/23
ART Child viral load suppressed rate (Below 50) [12 months)	ART paper register;TIER.net; DHIS	Not Available	Not Available	68.7% (826 / 1 203)	90% ~~(1 082 / 1 203)~~ (2 250 / 2 500)	
ART Client remain on ART end of month -sum	ART register; TIER.net: DHIS	Not Available	Not Available	1 387 688	~~1 959 000~~ 1 701 031	Alignment to DORA target
Infant Mortality Rate	ASSA 08	Not Available	Not Available	30.9/1 000	27/1 000	Monitored in the AOP as part of the rationalisation of APP indicators
Under 5 mortality rate	ASSA 08	Not Available	Not Available	41.7/1 000	38/1 000	
Child under 5 years Diarrhoea incidence	DHIS, PHC tick register, StatsSA	Not Available	Not Available	7.9 /1 000 (10 553 / 1 330 900)	5/1 000 (5 751 / 1 150 228)	Monitored in the AOP as part of the rationalisation of APP indicators
Child under 5 years pneumonia incidence	DHIS, PHC tick register, StatsSA	Not Available	Not Available	39.2 /1 000 (52 169 / 1 330 900)	29/1 000 (33 357 / 1 150 228)	
Child under 5 years severe acute malnutrition incidence	DHIS, PHC tick register, StatsSA	Not Available	Not Available	1.9 /1 000 (2 575 / 1 330 900)	1.0/1 000 (1 150 / 1 150 228)	
Diabetes Incidence	DHIS, PHC tick register, StatsSA	Not Available	Not Available	2.9/1 000 (17 616 / 11 417 132)	2.5/1 000 (30 199 / 12 079 648)	Monitored in the AOP as part of the rationalisation of APP indicators

Outcome Indicator	Data Source	South Africa		Provincial		Comment for 23/24 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Baseline (18/19)	Five Year Target (24/25)	
Hypertension Incidence	DHIS, PHC tick register, StatsSA	Not Available	Not Available	29.5/1 000 336 805 / 11 417 132)	/1 000 (241 593 / 12 079 648)	
HIV incidence	Thembisa Model	Not Available	Not Available	0.55%	<1%	Monitored in the AOP as part of the rationalisation of APP indicators
COVID-19 Testing Coverage	NOT AVAILABLE	Not Available	Not Available	New Indicator	2,070 / 100k	Monitored in the AOP as part of the rationalisation of APP indicators
COVID-19 Positivity Rate	NOT AVAILABLE	Not Available	Not Available	New Indicator	4%	
COVID-19 Case Fatality Rate: Total	NOT AVAILABLE	Not Available	Not Available	New Indicator	~~Monitor Trends~~ ~~0.5%~~ 0.7% (800 / 111 000)	Replaced COVID-19 Case Fatality Rate: 5 to 60 years
~~COVID-19 Case Fatality Rate: 5 to 60 years~~	~~NOT AVAILABLE~~	~~Not Available~~	~~Not Available~~	~~New Indicator~~	~~Monitor Trends~~ ~~0.5%~~	
~~TB Incidence~~	~~DHIS, PHC tick register, StatsSA~~	~~Not Available~~	~~Not Available~~	~~507.3 / 100 000~~ ~~(57 921 / 11 417 132)~~	~~0/100 000~~ ~~(24 159 / 12 079 648)~~	Removed and replaced with the indicator "TB Notification Rate" in the AOP
Malaria incidence per 1000 population at risk	Malaria information system	Not Available	Not Available	0.23/1 000 (162 / 696 042)	0/1 000 (0 / ~~686 893~~) (0 / 694 485)	Changes from Stats SA Mid-Year Population Estimates 2022
Malaria case fatality rate	Malaria Information system	0.01% (70 / 581 700)	Malaria eliminated by 23	0.5% (7 / 1 493)	0% (0 / 1000)	

22. ANNEXURE B: CONDITIONAL GRANTS

Table 101: Conditional Grants

Name of grant	Purpose	Outputs	Current annual budget
District Health Programmes Grant	See below	See below	R 7 087 769 000
	Comprehensive HIV/AIDS component		
	• To enable the health sector to develop and implement an effective response to HIV and IDS • Prevention and protection of health workers from exposure to hazards in the workplace	• Number of new patients started on antiretroviral therapy (ART) • Total number of patients on antiretroviral therapy remaining in care • Number of male condoms distributed • Number of female condoms distributed • Number of infants tested through the polymerase chain reaction test at 10 weeks • Number of clients tested for HIV (including antenatal) • Number of medical male circumcisions performed • Number of clients started on Pre-Exposure Prophylaxis	R 6 332 313 000
	TB Component		R 115 939 000
	• To enable the health sector to develop and implement an effective response to TB	• Number of HIV positive clients initiated on TB preventative therapy • Number of patients tested for TB using Xpert • Number of eligible HIV positive patients tested for TB using urine lipoarabinomannan assay • Drug sensitive TB treatment start rate (under 5 years and 5 years and older) • Number of rifampicin resistant / multi-drug resistant TB patients started on treatment	
	Community Outreach Services Component		R 572 741 000
	• To ensure provision of quality community outreach services through WBPHOTs by ensuring community health workers receive remuneration, tools of trade and training in line with scope of work	• Number of community health workers receiving a stipend • Number of community health workers trained • Number of HIV clients lost to follow-uptraced • Number of TB clients lost to follow traced	

Name of grant	Purpose	Outputs	Current annual budget
	• Malaria Elimination Component		R 16 055 000
	• To enable the health sector to develop and implement an effective Malaria response in support of the National Strategic Plan for Malaria Elimination	• Number of malaria-endemic municipalities with 95 per cent or more indoor residual spray (IRS) coverage • Percentage confirmed cases notified within 24 hours of diagnosis in endemic areas • Percentage of confirmed cases investigated and classified within 72 hours in endemic areas • Percentage of identified health facilities with recommended treatment in stock • Percentage of identified health workers trained on malaria elimination • Percentage of population reached through malaria information education and communication (IEC) on malaria prevention and early health-seeking behaviour interventions • Percentage of vacant funded malaria positions filled as outlined in the business plan • Number of malaria camps refurbished and/or constructed	
	HPV Component		R 50 721 000
	• To enable the health sector to prevent cervical cancer by making available HPV vaccinations from grade 5 school girls in all public and special schools and progressive integration of Human Papillomavirus into the integrated school health programme.	• Percentage of grade five school girls aged 9 years and above vaccinated for HPV first dose • Percentage of schools with grade five girls reached by the HPV vaccination team with first dose • Percentage of grade five school girls aged 9 years and above vaccinated for HPV second dose • Percentage of schools with grade five girls reached by the HPV vaccination team with second dose	
Health Facility Revitalisation Grant	• To help accelerate maintenance, renovations, upgrades, additions, and construction of infrastructure in health • To help on replacement and commissioning of health technology in existing and revitalising health facilities • To enhance capacity to deliver health infrastructure • To accelerate the fulfilment of the requirements of occupational health and safety	• Number of PHC facilities constructed or revitalised • Number of hospitals constructed or revitalised • Number of facilities maintained, repaired or refurbished	R 1 462 122 000
Human Resources and Training Grant	• To appoint statutory positions in the health sector for systematic realisation of human resources for health strategy and phased-in of National Health Insurance • Support Provinces to fund service costs associated with clinical training and supervision of health science trainees on the public service platform	• Number and percentage of statutory posts funded from this grant (per category and discipline) and other funding sources • Number and percentage of registrars posts funded from this grant (per discipline) and other funding sources • Number and percentage of specialists posts funded from this grant (per discipline) and other funding sources	R 764 447 000

Name of grant	Purpose	Outputs	Current annual budget
National Health Insurance Grant	**Health Practitioners contracts Grant**		R 52 852 000
	• Implementation of strategic purchasing platform for primary health care services	• Number of health professionals contracted (per discipline)	
	Oncology Grant		R 40 027 000
	• Enhanced access to health care services for cancer patients	• Number of patients seen per type of cancer • Percentage reduction in oncology treatment including radiation oncology backlog	
	Mental Health Grant		R 33 453 000
	• Strengthen mental healthcare service delivery in primary health care and community-based mental health services • Improved forensic mental health services	• Percentage increase in the number of clients of all ages seen at ambulatory (non-inpatient) services for mental health conditions • Percentage reduction in the backlog of forensic mental observations	
National Tertiary Services Grant	• Ensure the provision of tertiary health services in South Africa • To compensate tertiary facilities for the additional costs associated with the provision of these services	• Number of inpatient separations • Number of day patient separations • Number of outpatient first attendances • Number of outpatient follow –up attendances • Number of inpatient days • Average length of stay by facility (tertiary) • Bed utilisation rate by facility (all levels of care)	R 2 000 300
EPWP Integrated Grant for Provinces	• To incentivise provincial departments to expand work creation efforts through the use of labour, intensive delivery methods in the following identified focus areas, in compliance with the Expanded Public Works Programme (EPWP) guidelines: • road maintenance and the maintenance of buildings • low traffic volume roads and rural roads • other economic and social infrastructure • tourism and cultural industries • sustainable land based livelihoods • waste management	• Number of people employed and receiving income through the EPWP • Number of days worked per work opportunity created • Number of full-time equivalents (FTEs) to be created through the grant	R 8 614 000 Social Cluster incentive (R 21 107 000)

23. ANNEXURE D: DISTRICT DEVELOPMENT MODEL

Table 102: District Development Model

Area of Intervention	MTEF 2023/24 – 2025/26					
	Project Description	**Budget Allocation**	**District Municipality**	**Location: GPS Co-ordinates**	**Project Leader**	**Social Partners**
Electricity	Addington Gateway - Installation of Standby Generator set	800,000.00	eThekwini	Longitude 31.040 Latitude (29.861)	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
Electricity	Ethekwini District -Installation New Generator Sets in 2 Central Laundries KZN Central Laundry Cato Manor Central Laundry	14,000,000.00	eThekwini	Longitude 30.937 Latitude (29.955)	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
Electricity	King Cetshwayo District - Installation of Standby Generator Sets - DOPW	2,481,000.00	King Cetshwayo	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
Water	Ladysmith Hospital - 72 hr Water and Fire Storage Upgrade	15,530,022.21	uThukela	Longitude 29.766 Latitude (28.557)	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
Sanitation	Ladysmith Hospital - Replacement of Sewer Reticulation	11,980,671.51	uThukela	Longitude 29.766 Latitude (28.557)	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
Water	Madadeni Hospital- Replacement of Reservoir tank	27,585,004.00	Amajuba	Longitude 30.051 Latitude (27.764)	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
Electricity	Molweni Clinic- Installation of Standby Generator Set	900,000.00	eThekwini	Longitude 30.879 Latitude (29.740)	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
Electricity	Natalia Building: Replacement of 4 x Generator Sets	14,076,794.00	uMgungundlovu	Longitude 30.383 Latitude (29.601)	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
Electricity	Ngwelezane Hospital - Replacement of Backup Generator	5,852,856.00	King Cetshwayo	Longitude 31.864 Latitude (28.780)	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
Electricity	PPSD - New Generator Set	2,500,000.00	eThekwini	Longitude 30.957 Latitude (29.936)	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
Electricity	Prince Mshiyeni Hospital - Replace 7 standby generators	20,508,662.00	eThekwini	Longitude 30.937 Latitude (29.955)	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
Electricity	Purchase 14 Portable Standby Disaster Management Generators Sets	15,000,000.00	uMgungundlovu	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
Electricity	Ugu District Clinics - Installation of 14 Standby Generator Sets DoH	7,548,710.22	Ugu	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
Water	Umbumbulu Clinic-Install elevated water storage tank 87 000L	900,000.00	uMgungundlovu	Longitude 30.699 Latitude (29.981)	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts

Area of Intervention	MTEF 2023/24 – 2025/26					
	Project Description	**Budget Allocation**	**District Municipality**	**Location: GPS Co-ordinates**	**Project Leader**	**Social Partners**
Electricity	UMkhanyakude District Clinics - Installation of 23 Standby Generator Sets DoH	6,918,731.00	uMkhanyakude	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
Water	Uthukela District - Installation of 15 x 20kl elevated water tanks in 14 Clinic & 1 Mortuary	10,200,000.00	uThukela	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	Candover Clinic - Construction of New Clinic and Accommodation	50,000,000.00	Zululand	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	Cwaka Clinic - New Replacement Clinic	87,028,270.00	uMzinyathi	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	Ezwenelisha Clinic - Replacement of existing clinic with a new Clinic	50,000,000.00	uMkhanyakude	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	Hopewell Clinic - Construction of New Clinic	50,000,000.00	uMgungundlovu	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	Ikhwezi Lokusa Clinic- Construction of New Clinic	64,766,054.00	Harry Gwala	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	KwaGwebu Clinic : New Ideal Clinic and accommodation	78,000,000.00	Zululand	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	Kwampande Clinic- New Clinic	73,570,857.00	uMgungundlovu	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	Madundube Clinic - Construct New Medium Clinic	110,000,000.93	iLembe	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	Mahhehle / Ncakubana Clinic -Construction of a New Clinic with residence	55,000,000.00	Harry Gwala	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	Mahloni Clinic: Construction of a small clinic with accommodation	50,000,000.00	Zululand	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	Mambulu Clinic (Kranskop)- Construction of a New Clinic	45,000,000.00	iLembe	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	Mpaphala Clinic - Construction of New Medium Clinic	70,000,000.00	King Cetshwayo	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	Mpolweni Clinic- Construction of New Small Clinic	70,000,000.00	uMgungundlovu	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	Mpukunyoni Clinic - Replacement of Existing Clinic	50,000,000.00	uMkhanyakude	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	Ndelu Clinic - Replacement of an existing Small Clinic with a Small Ideal Clinic	53,056,126.00	Ugu	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts

Area of Intervention	MTEF 2023/24 – 2025/26					
	Project Description	**Budget Allocation**	**District Municipality**	**Location: GPS Co-ordinates**	**Project Leader**	**Social Partners**
New clinic including sevices	Nyavini Clinic - Construction Outlier Clinic	56,000,000.00	Ugu	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	Obanjeni Clinic - Construction of a new clinic with residence	78,000,000.00	King Cetshwayo	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	Ofafa/ Ntakama Clinic - Construct New Clinic	45,000,000.00	Harry Gwala	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts
New clinic including sevices	Shayamoya Clinic - Construction of a New Small Clinic	59,868,243.00	Harry Gwala	Site to be confirmed	Dept of Health	Local government, communities, other Government Departments, Hospitals Boards and Labour Unionts

24. ANNEXURE E: POPULATION

Table 103: KwaZulu-Natal Province - DHIS downloaded 2022/06/01

Data Element	21/22	22/23	23/24	24/25	25/26
Female 02-04 years	364,650	367,988	370,594	371,412	371,034
Female 05 years	119,588	120,744	121,721	122,531	123,101
Female 05-09 years	590,744	594,339	598,790	604,016	608,806
Female 06-09 years	471,156	473,595	477,066	481,483	485,709
Female 1 year	124,334	125,130	124,450	123,895	123,541
Female 10-11 years	235,760	234,105	234,063	234,731	236,108
Female 10-14 years	583,377	585,432	586,317	586,028	586,400
Female 12 years	117,828	118,167	117,034	116,615	117,028
Female 13 years	116,110	117,528	117,972	116,886	116,498
Female 14 years	113,673	115,628	117,251	117,798	116,764
Female 15 years	110,114	112,920	115,150	116,977	117,633
Female 15-19 years	509,897	523,907	539,955	554,109	566,569
Female 15-44 years	2,811,907	2,840,695	2,871,674	2,903,289	2,932,806
Female 16 years	106,559	109,146	112,214	114,710	116,750
Female 17 years	102,445	105,382	108,232	111,572	114,342
Female 18-19 years	190,776	196,457	204,362	210,853	217,845
Female 20-24 years	477,258	469,532	465,672	467,719	475,353
Female 25-29 years	509,115	501,241	490,189	478,660	466,435
Female 30-34 years	515,493	517,086	517,020	514,844	511,164
Female 35-39 years	451,461	465,896	479,156	490,875	499,066
Female 40-44 years	348,688	363,037	379,680	397,080	414,222
Female 45 years and older	1,438,605	1,460,048	1,480,741	1,502,009	1,525,656
Female 45-49 years	303,950	307,369	308,683	310,996	316,644
Female 50-54 years	256,132	259,514	265,469	271,787	277,433
Female 55-59 years	239,026	238,722	237,542	236,326	235,805
Female 60-64 years	201,243	205,714	209,580	212,993	215,849

Data Element	21/22	22/23	23/24	24/25	25/26
Female 65-69 years	161,135	163,991	167,489	170,607	173,725
Female 70-74 years	125,639	127,370	128,644	130,513	132,750
Female 75-79 years	80,071	85,159	89,878	93,655	96,370
Female 80 years and older	71,410	72,210	73,466	75,128	77,075
Female under 1 year	126,006	125,148	124,362	123,838	123,588
Female under 5 years	614,988	618,270	619,404	619,144	618,160
Male 02-04 years	375,376	378,741	381,318	382,282	382,135
Male 05 years	123,068	124,195	125,268	126,046	126,676
Male 05-09 years	608,777	611,993	616,265	621,156	625,953
Male 06-09 years	485,706	487,796	490,999	495,105	499,275
Male 1 year	127,987	128,749	128,104	127,652	127,337
Male 10-11 years	242,080	241,006	241,127	241,726	242,917
Male 10-14 years	595,611	599,333	601,917	602,822	603,223
Male 12 years	120,065	121,213	120,302	120,167	120,382
Male 13 years	117,885	119,774	121,015	120,120	119,988
Male 14 years	115,576	117,346	119,478	120,809	119,938
Male 15 years	112,016	114,619	116,747	119,131	120,575
Male 15-19 years	517,240	530,377	545,897	560,540	574,654
Male 15-44 years	2,782,738	2,815,764	2,849,827	2,884,525	2,916,615
Male 16 years	108,321	110,724	113,691	116,172	118,810
Male 17 years	103,969	106,712	109,479	112,809	115,651
Male 18-19 years	192,935	198,323	205,976	212,432	219,622
Male 20-24 years	481,955	473,222	468,544	469,837	476,846
Male 25-29 years	516,430	506,627	493,810	481,104	468,222
Male 30-34 years	518,526	520,734	519,994	515,878	509,465
Male 35-39 years	438,551	456,335	471,552	485,361	495,096
Male 40-44 years	310,034	328,472	350,034	371,804	392,328
Male 45 years and older	903,331	920,910	938,979	958,749	982,648
Male 45-49 years	244,387	249,123	253,603	259,554	269,538

Data Element	21/22	22/23	23/24	24/25	25/26
Male 50-54 years	177,137	185,100	194,171	203,071	210,942
Male 55-59 years	146,038	146,184	146,028	146,630	148,937
Male 60-64 years	115,863	117,051	118,546	119,914	120,938
Male 65-69 years	89,952	90,016	90,042	90,092	90,336
Male 70-74 years	64,231	65,430	66,120	66,488	66,562
Male 75-79 years	37,053	38,584	40,254	41,852	43,208
Male 80 years and older	28,671	29,414	30,215	31,151	32,183
Male under 1 year	129,738	128,887	128,132	127,673	127,464
Male under 5 years	633,108	636,379	637,554	637,613	636,935
Total population	11,563,185	11,683,165	11,801,473	11,919,339	12,037,206

25. ANNEXURE F: DISTRICT PROFILES

AMAJUBA DISTRICT

District Demographic

Figure 7: District percentage population by age – gender compared to South Africa (DHB 2019/20)

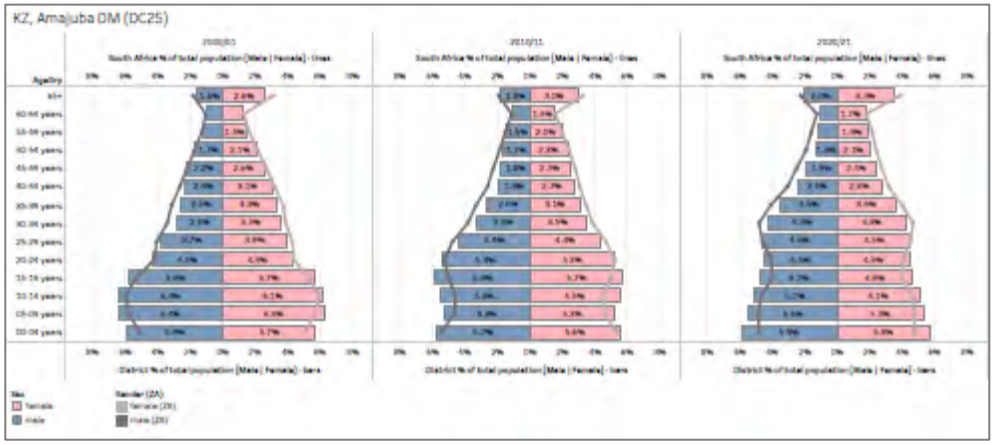
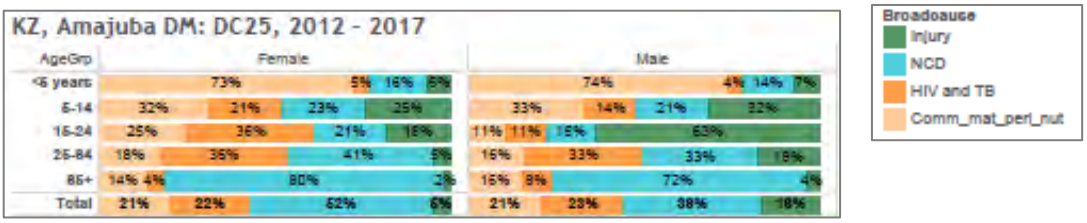


Figure 8: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)



Brief Overview of the Major Social Determinant Challenges

In Amajuba, 92.1% of the population use electricity for lighting, with only 52% having access to flush toilets and 37.3% to piped water inside the house. All three of these social determinants contribute to the standard of living and health behaviour practices prevalent in the District.

Unemployment is a major problem in Amajuba at 48.4%, the 3rd highest in the Province. Coupled with the high number of adults who do not have higher education (91%), and the 63.4% who do not have matric, means that ability to understand health concepts and IPC practices might be impaired. The macro effect is that it stifles economic growth and the micro effect is that it lowers the individual's standards of living. Education is one of the major contributing factors in the poverty and the inequality of the distribution of income.

Table 104: Amajuba Social determinants of health

	Source /Year	District
Percentage of female households (%)	2016	48.4%
Unemployment rate (%)	2011	39.1%
Youth unemployment rate (15 – 34 years) (%)	2011	50.3%
Percentage of population 20 years and older with no schooling (%)	2016	12.3%
Percentage without matric (%)	2016	63.4%
Percentage without higher education (%)	2016	91%
Formal dwellings (%)	2016	84.4%
Percentage of households using electricity for lightening (%)	2016	92.1%
Percentage of households with flush toilet connected to sewerage (%)	2016	52%
Percentage of households with weekly refusal removal (%)	2016	53.8%

	Source /Year	District
Percentage of households with piped water inside dwellings (%)	2016	37.3%
Drinking water system (Blue Drop) Performance rating (%)	2014	58.2%

Source: Stats SA, 2014 Blue Drop Report

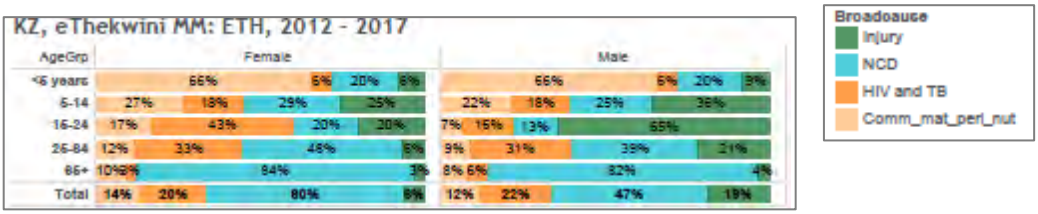
Graph 66: Amajuba HIV / AIDS Cascades as at March 2022

ETHEKWINI METROPOLITIAN

District Demographic

Figure 9: District percentage population by age – gender compared to South Africa (DHB 2019/20)

Figure 10: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)



Brief overview of the major Social Determinant Challenges

According to the Living Conditions Survey (Stats SA), approximately 60% of eThekwini households earn less than R38 400 per annum, with an estimated poverty headcount of 3.8% compared to 4.1% in other Metro's in South Africa.

The number of unemployed people increased from 233 338 in 2015 to 240 840 in 2016 (3.2%), with an unemployment rate of 27.1% in quarter two of 2018. The labour force absorption rate increase of 0.4% (from 45.8% to 43.1%) and decrease in participation rate (from 59.31% to 59.1%) is indicative of an increasing number of people looking for employment and a decreased likelihood of them finding employment.[20]

More males (41%) than females (37%) attain some secondary school education, and a higher proportion of females (14%) than males (9%) are reported as having no formal schooling. Although the highest proportion of people with no schooling resides in uMzinyathi (30%), uMkhanyakude (28%) and Zululand (20%), the highest proportion of working age population resides in eThekwini.

[20] eThekwini IDP 2019/20

Table 105: eThekwini Social determinants of health

Measures	Year	District
Percentage of female households (%)	2016	42.1%
Unemployment rate (%)	2018	27.1%
Youth unemployment rate (15 – 34 years) (%)	2011	39%
Percentage of population 20 years and older with no schooling (%)	2016	8.6%
Percentage without matric (%)	2016	56.9%
Percentage without higher education (%)	2016	89.1%
Formal dwellings (%)	2016	81.5%
Percentage of households using electricity for lightening (%)	2016	89.9%
Percentage households with flush toilet connected to sewerage (%)	2016	30.7%
Percentage of households with weekly refusal removal (%)	2016	21.9%
Percentage of households with piped water inside dwellings (%)	2016	39.2%
Drinking water system (Blue Drop) Performance rating (%)	2014	95.9%

Source: Local Government Handbook, Stats SA; 2014 Blue Drop Report

Graph 67: eThekwini HIV / AIDS Cascades as at March 2022

HARRY GWALA DISTRICT

District Demographic

Figure 11: District percentage population by age – gender compared to South Africa (DHB 2019/20)

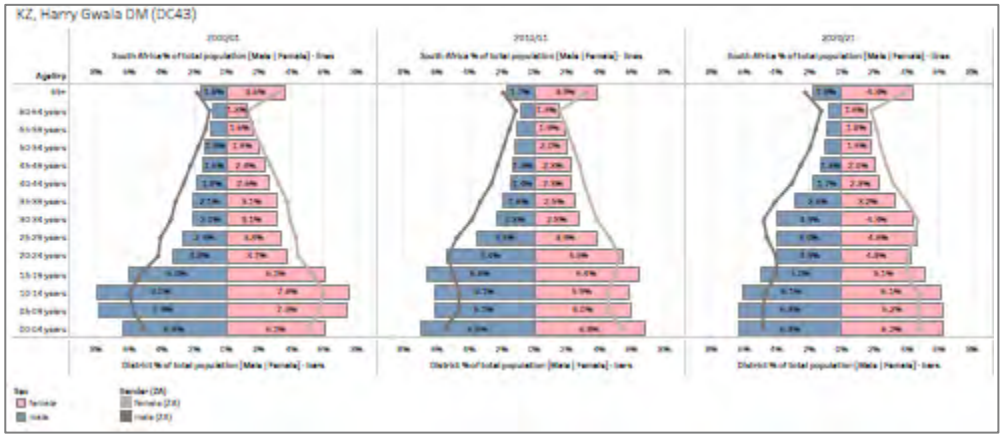
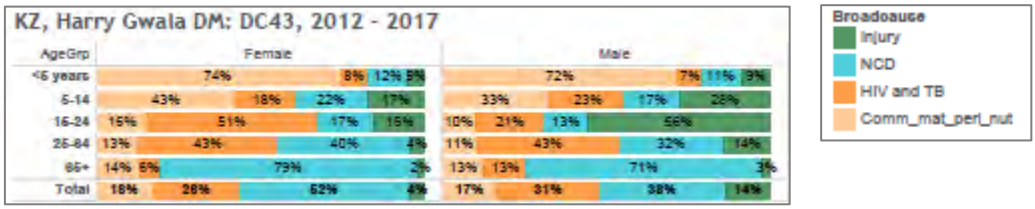


Figure 12: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)



Brief overview of the major Social Determinant Challenges

Harry Gwala District has poor social determinants due to limited infrastructure and employment opportunities. Only 18.4% of the population has access to flush toilets, 11.4% to piped water inside, with 41.7% living in formal dwellings. As Harry Gwala is a traditional and rural district, subsistence farming is prevalent.

Harry Gwala District has high unemployment rate in general at 36% and a high youth unemployment rate of 44%. This unemployment rate is driven by the fact that 93.6% of the population 20 years and older has no higher education, and 76.5% have no matric. The high unemployment rates can be linked to the high HIV infection rates and increased teenage pregnancy rates. Both these social ills can only be prevented through education.

The percentage of Female headed households (53.9%) is high. TB and HIV / AIDS death rate amongst males is high, as males general seek medical assistance only once the disease has advanced. Accidents and violence including self-inflicted injuries also contribute to the picture. (2017/18 DHB).

Table 106: Harry Gwala Social determinants of health

	Source /Year	District
Percentage of female-headed households (%)	2016	53.9%
Unemployment rate (%)	2011	36%
Youth unemployment rate (15 – 34 years) (%)	2011	44.4%
Percentage of population 20 years and older with no schooling (%)	2016	25%
Percentage without matric (%)	2016	76.5%
Percentage without higher education (%)	2016	93.6%
Formal dwellings (%)	2016	41.7%
Percentage of households using electricity for lightening (%)	2016	81.2%
Percentage of households with flush toilet connected to sewerage (%)	2016	18.4%

	Source /Year	District
Percentage of households with weekly refusal removal (%)	2016	23.1%
Percentage of households with piped water inside dwellings (%)	2016	11.4%
Drinking water system (Blue Drop) Performance rating (%)	2014	63.4%

Source: Local Government Handbook, Stats SA; 2014 Blue Drop Report

Graph 68: Harry Gwala District HIV / AIDS Cascades as at March 2022

ILEMBE DISTRICT

District Demographic

Figure 13: District percentage population by age – gender compared to South Africa (DHB 2019/20)

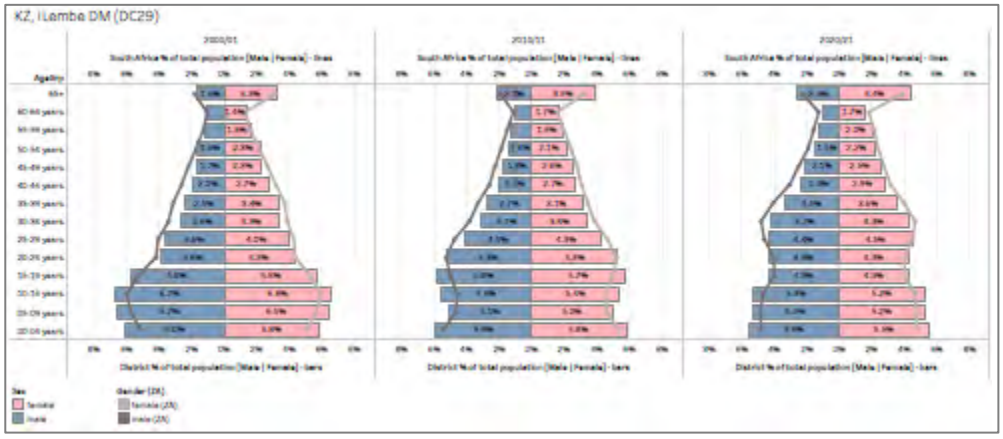
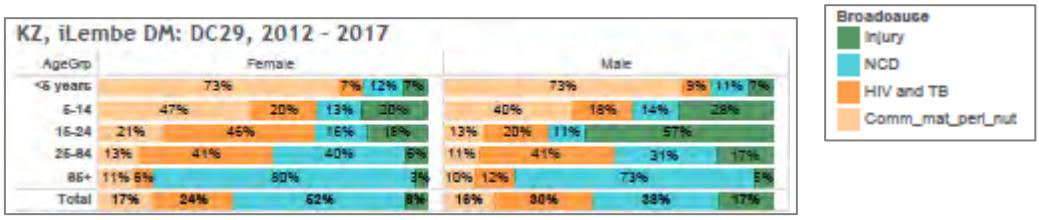


Figure 14: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)



Brief overview of the major Social Determinant Challenges

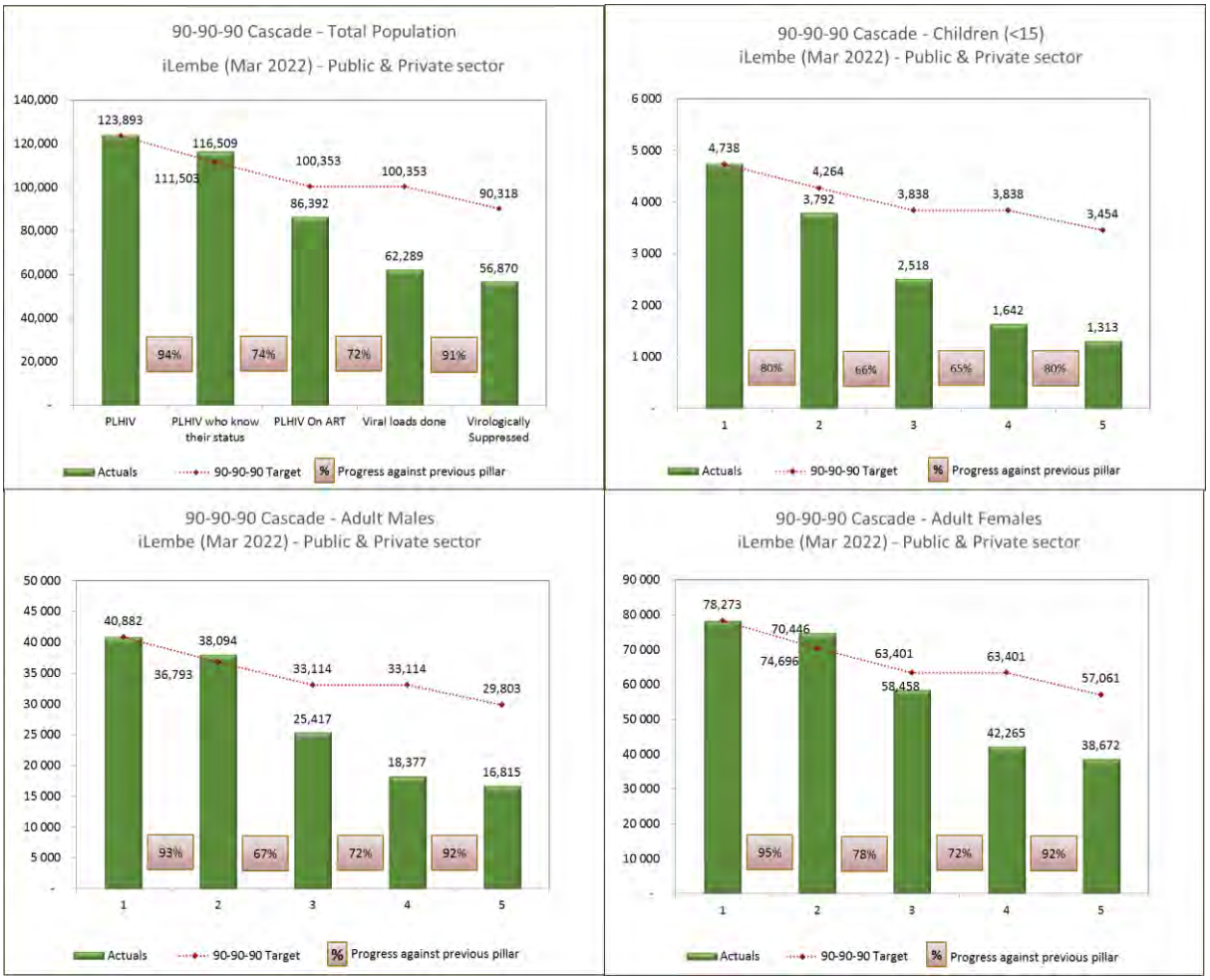
In iLembe, the unemployment rate increased to 30.6% in 2011. Youth unemployment at 37.2%, is cause for concern as some areas in the district have a high teenage pregnancy rate. Maphumulo Sub-District is the leading sub district for deliveries among females 10 – 19 years, followed by KwaDukuza Sub-District.

The District has experienced a decline in the number of people with higher education. There was a decline from 3.7% to 3.1% in 2011 pointing to a possible emigration of highly skilled- workers. The number of people with matric has however increased to 26.6% in 2011. There are some specific issues to be addressed relating to education that include the quality of education facilities, the infrastructure available at these facilities, inability to attract high quality educators and the uncoordinated and untargeted adult education and literacy programmes. The increased productivity and improvements to the skills base in the district aim to support economic and social development, with improved health outcomes.

Table 107: iLembe Social determinants of health

	StatSA	District
Percentage of female-headed households (%)	2016	47.1%
Unemployment rate (%)	2011	30.6%
Youth unemployment rate (15 – 34 years) (%)	2011	37.2%
Percentage of population 20 years and older with no schooling (%)	2016	22%
Percentage without matric (%)	2016	67.2%
Percentage without higher education (%)	2016	93.7%
Formal dwellings (%)	2016	73.9%
Percentage of households using electricity for lightening (%)	2016	85.2%
Percentage of households with flush toilet connected to sewerage (%)	2016	20.4%
Percentage of households with weekly refusal removal (%)	2016	32.5%
Percentage of households with piped water inside dwellings (%)	2016	18.3%
Drinking water system (Blue Drop) Performance rating (%)	2014	86.7%

Graph 69: iLembe District HIV / AIDS Cascades as at March 2022



KING CETSHWAYO DISTRICT

District Demographic

Figure 15: District percentage population by age – gender compared to South Africa (DHB 2019/20)

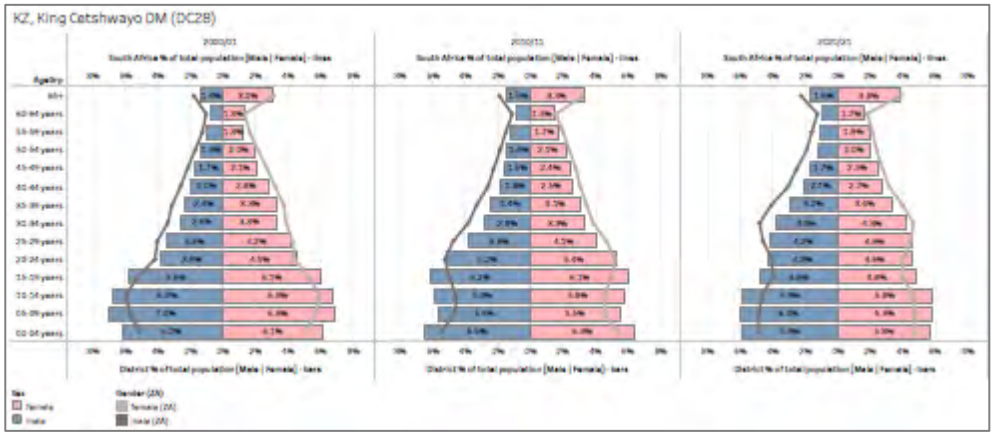
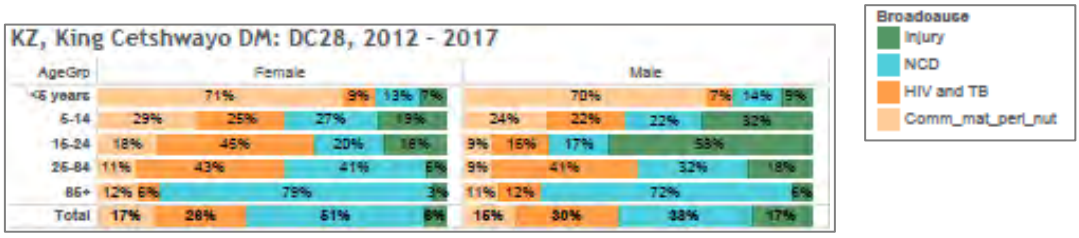


Figure 16: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)



Brief overview of the major Social Determinant Challenges

Health is determined in part by access to social and economic opportunities. The opportunities for employment in decent jobs are hampered by the low level of education to decent jobs and high number of families that are dependent on social grants and low paying jobs. The district has done well above the provincial and national figures in terms of households using electricity (91.9%); however, water supply is still a challenge and the lowest at 26.9%. This low access to piped water inside dwellings coupled with low percentage of households with flush toilets connected to sewerage (27%) could contribute to the high numbers of diarrhoeal cases in the District, which is the second leading cause of deaths among the under 5's.

The level of education is below the provincial and national figures. The percentage of people over 20 years with no schooling is 24%. The percentage of the population, without higher education is 90.8%. Information, Education and Communication (IEC) material provided to communities are translated into the communities' local languages. This is also practiced when providing health education in facilities.

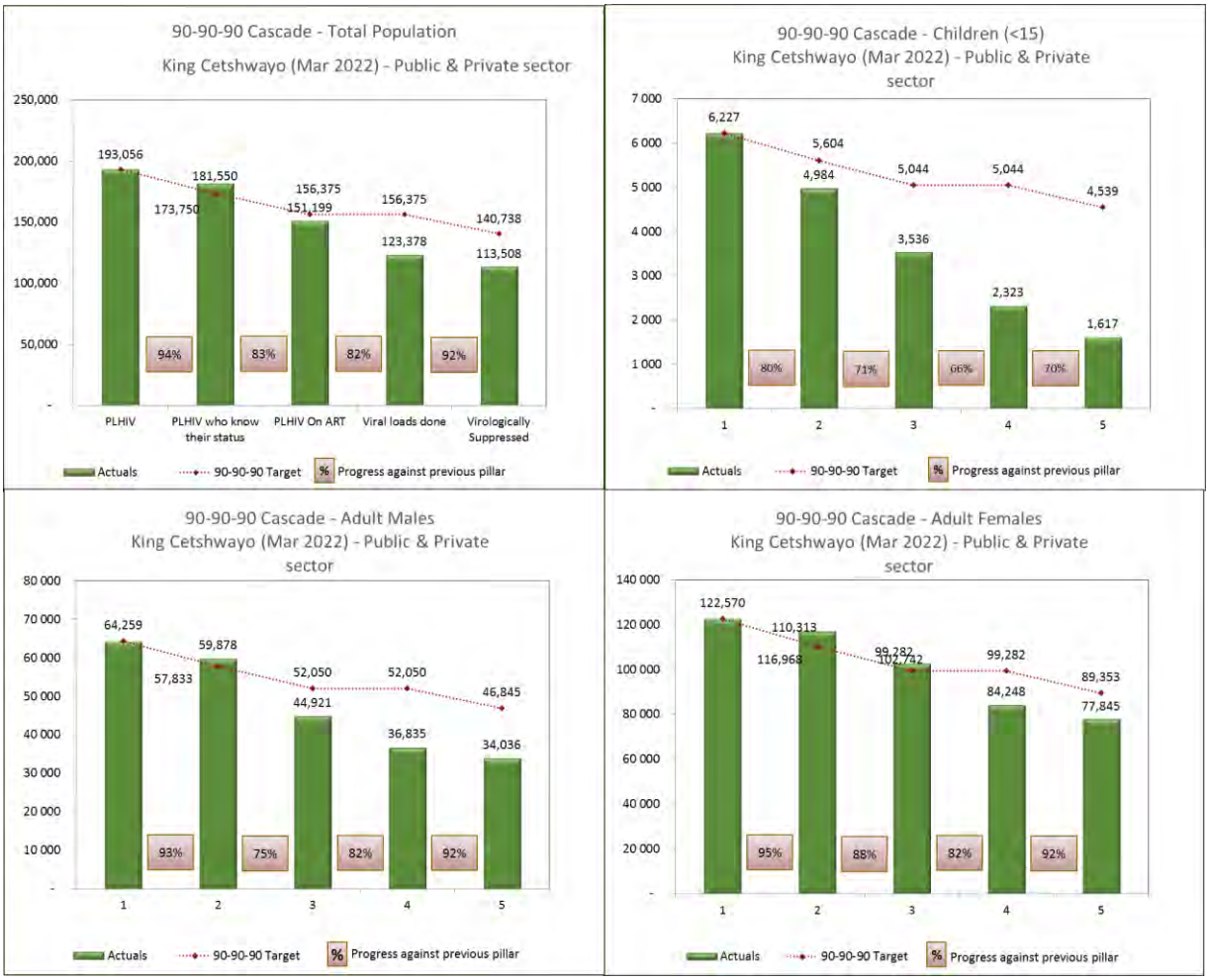
Table 108: KCD Social determinants of health

	StatSA	District
Percentage of female-headed households (%)	2016	49.8%
Unemployment rate (%)	2011	34.7%
Youth unemployment rate (15 – 34 years) (%)	2011	44.4%
Percentage of population 20 years and older with no schooling (%)	2016	24%
Percentage without matric (%)	2016	64%
Percentage without higher education (%)	2016	90.8%
Formal dwellings (%)	2016	70.6%
Percentage of households using electricity for lightening (%)	2016	91.9%
Percentage of households with flush toilet connected to sewerage (%)	2016	27.4%

	StatSA	District
Percentage of households with weekly refusal removal (%)	2016	27.3%
Percentage of households with piped water inside dwellings (%)	2016	26.9%
Drinking water system (Blue Drop) Performance rating (%)	2014	74.1%

Source: Local Government Handbook, Stats SA; 2014 Blue Drop Report

Graph 70: King Cetshwayo District HIV / AIDS Cascades as at March 2022



UGU DISTRICT

District Demographics

Figure 17: District percentage population by age – gender compared to South Africa (DHB 2019/20)

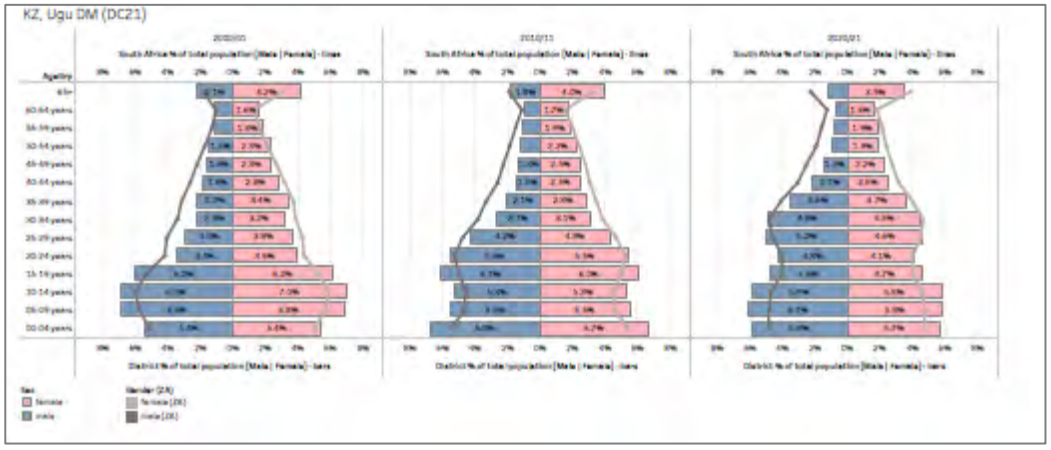


Figure 18: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)

Brief overview of the major Social Determinant Challenges

Education is an important social determinant that has a significant impact on health status over the course of a lifetime. Higher levels of educational attainment are associated with improved health outcomes due to increases in timeous health seeking behaviour. In Ugu , 68% of the population does not have a matric qualification while 91% of the population has not gone onto higher education.

The unemployment rate in Ugu is 35%, this figure. High levels of youth (15-34 years) unemployment (45%) that impacts on the rates of teenage pregnancy and substance abuse. People who have a higher income and social status have a better .

standard of living and can afford healthcare which translates to improved health outcomes. Poverty is a major contributor to ill health as it may mean poor living conditions, which lacks adequate sanitation. This predisposes the communities to waterborne diseases like diarrhoea.

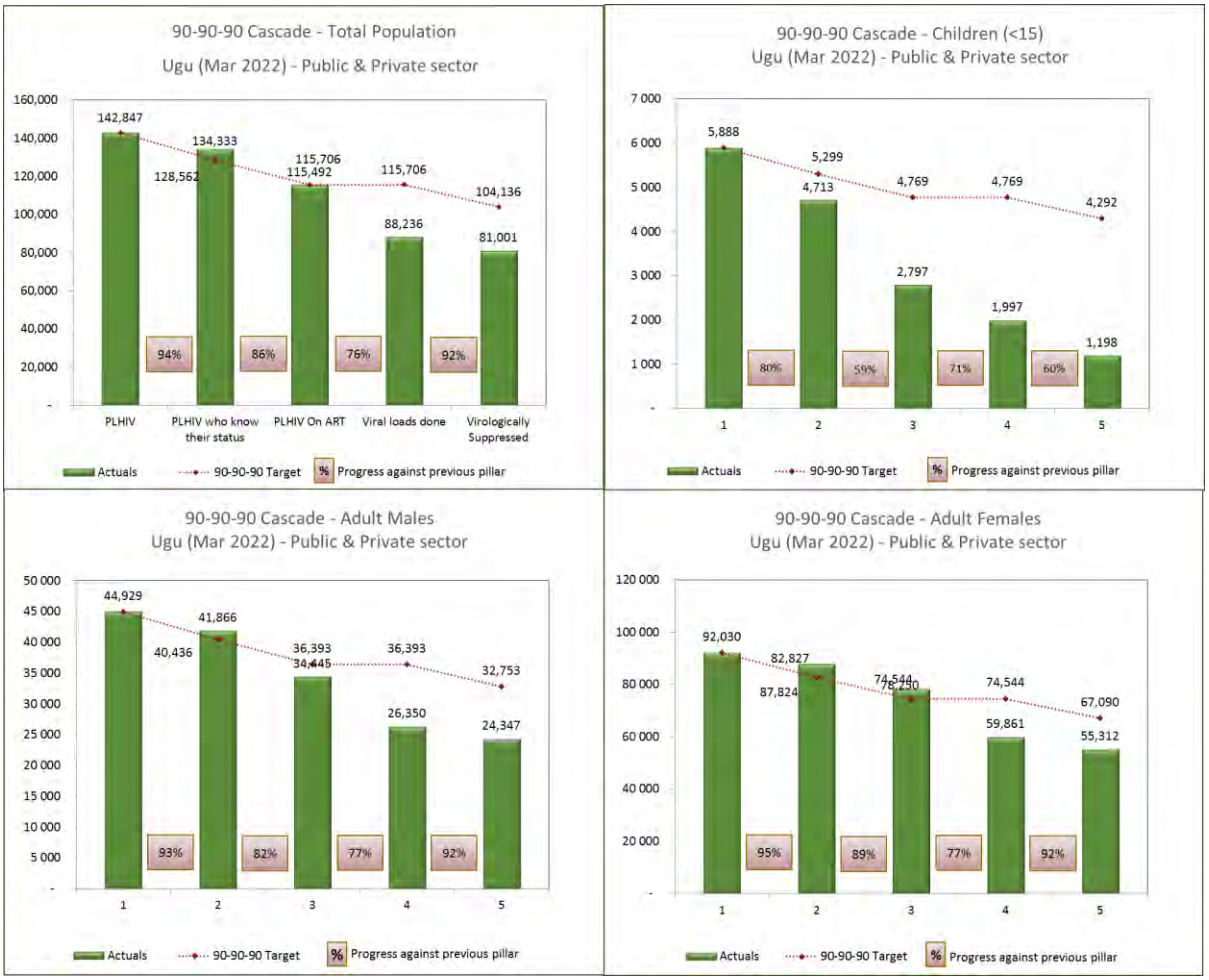
Only 58% of the Ugu population live in formal dwellings. People that live in informal settlements usually have many health problems, when compared to those with formal housing and sanitation. Access to safe water clean air, healthy workplaces, communities and roads contribute to good health, however, only 21% of the population, have piped water and 20% with access to sanitation

Table 109: Ugu Social determinants of health

	StatSA	District
Percentage of female-headed households (%)	2016	49.9%
Unemployment rate (%)	2011	35.2%
Youth unemployment rate (15 – 34 years) (%)	2011	45.1%
Percentage of population 20 years and older with no schooling (%)	2016	17.9%
Percentage without matric (%)	2016	68.1%
Percentage without higher education (%)	2016	91.9%
Formal dwellings (%)	2016	58.6%

	StatSA	District
Percentage of households using electricity for lightening (%)	2016	84.2%
Percentage of households with flush toilet connected to sewerage (%)	2016	20.8%
Percentage of households with weekly refusal removal (%)	2016	19.7%
Percentage of households with piped water inside dwellings (%)	2016	21.2%
Drinking water system (Blue Drop) Performance rating (%)	2014	66.3%

Graph 71: Ugu District HIV / AIDS Cascades as at March 2022

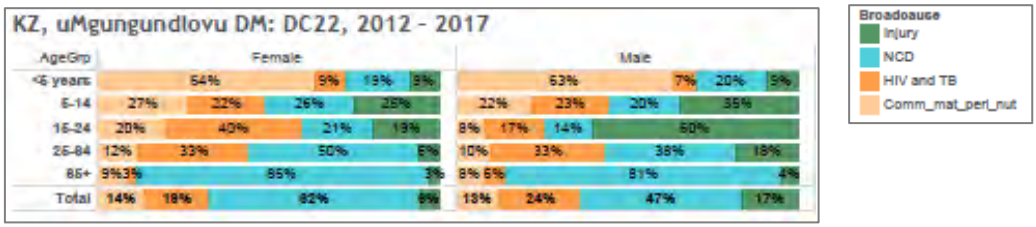


UMGUNGUNDLOVU DISTRICT

District Demographic

Figure 19: District percentage population by age – gender compared to South Africa (DHB 2019/20)

Figure 20: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)



Brief overview of the major Social Determinant Challenges

A high unemployment rate (30.4%) represents a higher demand on public health care services and contributes to higher prevalence of substance abuse and teenage pregnancies.

Formal education has a direct impact on health outcomes with 63.1% of the population have no matric and 87.2% are without higher education. Eleven point 7 percent (11.7%) of the population in the District are 20 years and older with no schooling which impacts as health outcomes as they not well equipped to make rational healthy lifestyle decisions. Teenage pregnancy is escalating in the District with a direct impact on the maternal and child mortality performance

In Umgungundlovu, 40.5% of the households have flushing toilets and 24.3% of the District lives in informal housing which also has health implications.

Table 110: uMgungundlovu Social determinants of health

	Source /Year	District
Percentage of female-headed households (%)	2016	46.4
Unemployment rate (%)	2011	30.4
Youth unemployment rate (15 – 34 years) (%)	2011	39.5
Percentage of population 20 years and older with no schooling (%)	2016	11.7
Percentage without matric (%)	2016	63.1
Percentage without higher education (%)	2016	87.2
Formal dwellings (%)	2016	76.7
Percentage of households using electricity for lightening (%)	2016	92.8
Percentage of households with flush toilet connected to sewerage (%)	2016	40.5
Percentage of households with weekly refusal removal (%)	2016	41.4
Percentage of households with piped water inside dwellings (%)	2016	37.7
Drinking water system (Blue Drop) Performance rating (%)	2014	89.5

Source: Local Government Handbook, Stats SA; 2014 Blue Drop Report

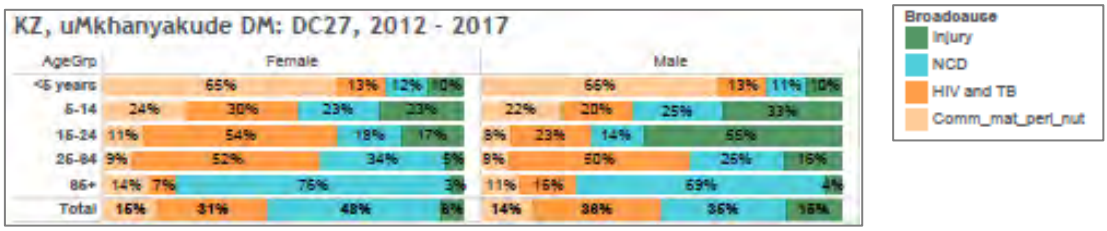
Graph 72: uMgungundlovu District HIV / AIDS Cascades as at March 2022

UMKHANYAKUDE DISTRICT

District Demographic

Figure 21: District percentage population by age – gender compared to South Africa (DHB 2019/20)

Figure 22: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)



Brief overview of the major Social Determinant Challenges

uMkhanyakude is socioeconomically deprived. The District has high unemployment, low levels of education and poor living conditions. These social determinants make the district more prone to many diseases, especially water borne diseases such as diarrhoea and bilharzia. Most diseases follow a socioeconomic gradient, being more common in the poorer strata of society.

Lower educational levels in women is associated with higher fertility rates, and the district suffers one of the highest teenage (10-19yrs) pregnancy rates (21%) in the country consistent with the poor education and employment indicators. Without improving educational outcomes, it will be difficult for the district to address high unemployment, poverty and high teenage pregnancies, which in turn feed the cycle of deprivation.

The district prone to malaria, hence the Malaria Control Programme is based in Jozini. Malaria has been kept under control in the district since the serious epidemics in the 1990s, however cases and deaths still occur, and the risk of outbreaks remains.

Table 111: uMkhanyakude Social determinants of health

	Source /Year	District
Percentage of female-headed households (%)	2016	54.2
Unemployment rate (%)	2011	42.8
Youth unemployment rate (15 – 34 years) (%)	2011	51.2
Percentage of population 20 years and older with no schooling (%)	2016	32,7
Percentage without matric (%)	2016	68.9
Percentage without higher education (%)	2016	93.6
Formal dwellings (%)	2016	70.1
Percentage of households using electricity for lightening (%)	2016	53
Percentage of households with flush toilet connected to sewerage (%)	2016	7,5

	Source /Year	District
Percentage of households with weekly refusal removal (%)	2016	4
Percentage of households with piped water inside dwellings (%)	2016	6.9
Drinking water system (Blue Drop) Performance rating (%)	2014	57.9

Source: Local Government Handbook, Stats SA; 2014 Blue Drop Report

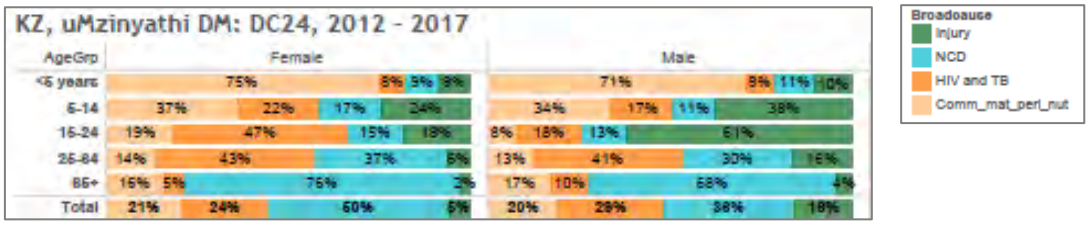
Graph 73: uMkhanyakude District HIV / AIDS Cascades as at March 2022

UMZINYATHI DISTRICT

District Demographic

Figure 23: District percentage population by age – gender compared to South Africa (DHB 2019/20)

Figure 24: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)



Brief overview of the major Social Determinant Challenges

In uMzinyathi, due to limited job opportunities within the district, many males migrate to seek employment outside the district, leaving females behind to head the households. Some migrant workers especially those on anti-retroviral medication (ARV's) do not want to be transferred out, which has implications for continuum of and provision of services.

uMzinyathi has an unemployment rate of 36.6% and youth unemployment of 45.6%. uMzinyathi is on the corridor route and has commercial sex workers. 39.9% of the district population 20 years and older have no schooling, this impacts on the understanding of health issues.

The district has a formal dwellings rate of 47%, so 53% of dwellings in the district are traditional and informal dwellings. Informal dwellings usually have a lack of piped water, lack of proper sanitation, poor drainage, stagnant water, and lack of refuse removal which creates ideal conditions for water borne microbes etc.. Hand washing may be a challenge. There is generally a lack of electricity for cooking and refrigeration which may contribute to poor food safety. The burning of wood, coal, candles, gas, and paraffin may contribute to burns, paraffin poisoning and respiratory conditions. There is lack of recreational space for child development. Informal residents tend to relocate frequently which may affect tracing of patients.

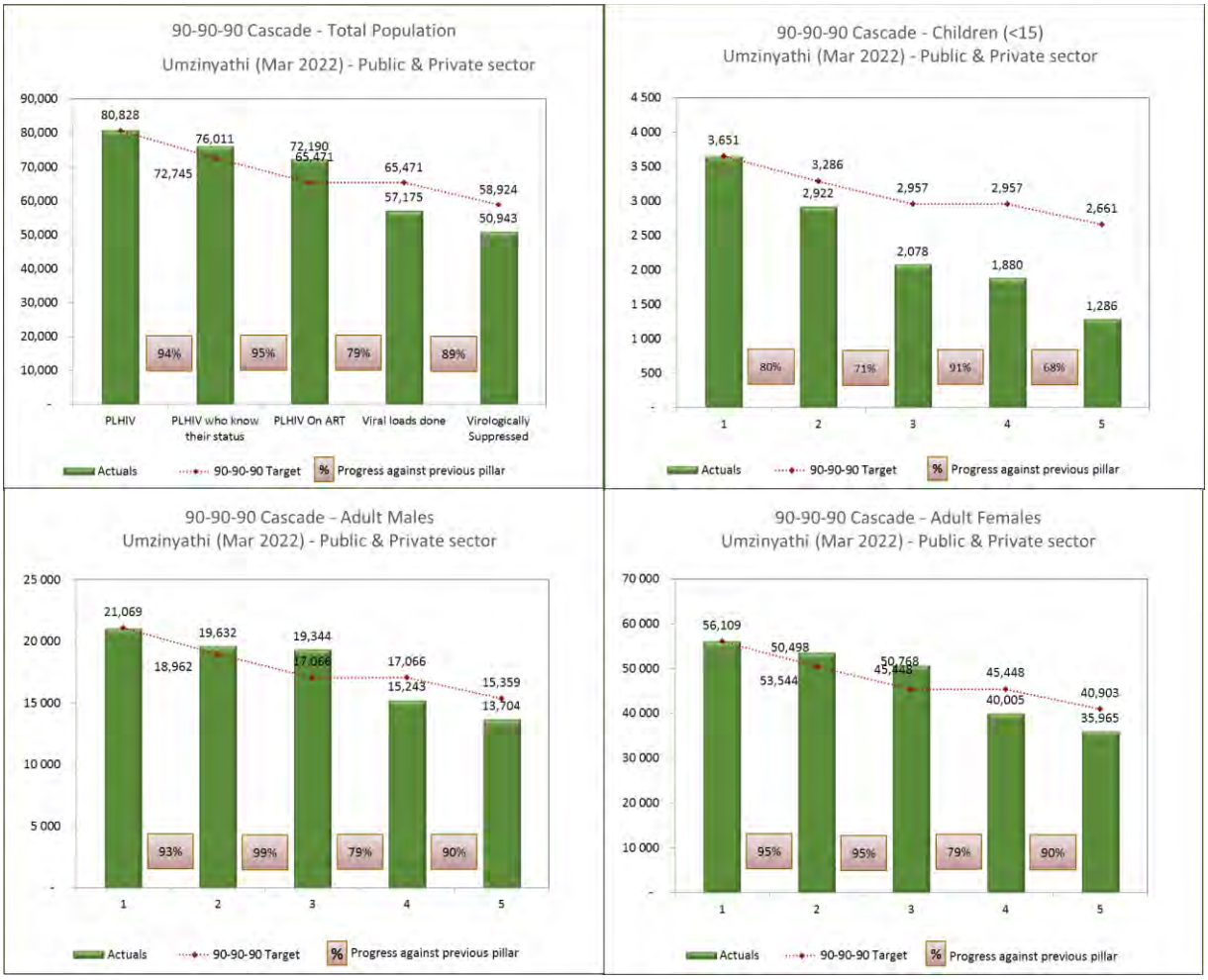
Table 112: uMzinyathi Social determinants of health

	Source /Year	District
Percentage of female-headed households (%)	Community Survey 2016	58,9%
Unemployment rate (%)	Census 2011	36,6%
Youth unemployment rate (15 – 34 years) (%)	Census 2011	45,6%
Percentage of population 20 years and older with no schooling (%)	Community Survey 2016	39,9%
Percentage without matric (%)	Community Survey 2016	73,1%
Percentage without higher education (%)	Community Survey 2016	93,6%
Formal dwellings (%)	Community Survey 2016	47%

	Source /Year	District
Percentage of households using electricity for lightening (%)	Community Survey 2016	69,8%
Percentage of households with flush toilet connected to sewerage (%)	Community Survey 2016	27,7%
Percentage of households with weekly refusal removal (%)	Community Survey 2016	15,5%
Percentage of households with piped water inside dwellings (%)	Community Survey 2016	23%
Drinking water system (Blue Drop) Performance rating (%)	Blue drop report 2014	78%

Source: Local Government Handbook, Stats SA; 2014 Blue Drop Report

Graph 74: uMzinyathi District HIV / AIDS Cascades as at March 2022



UTHUKELA DISTRICT

District Demographic

Figure 25: District percentage population by age – gender compared to South Africa (DHB 2019/20)

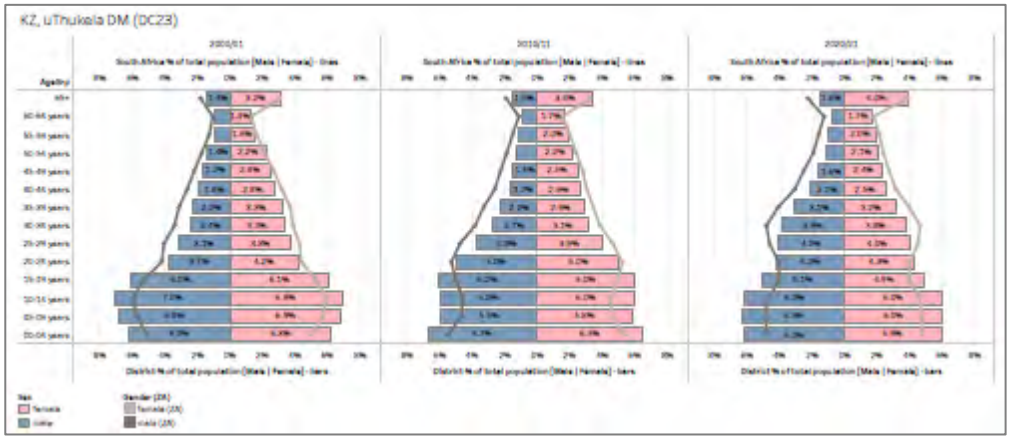
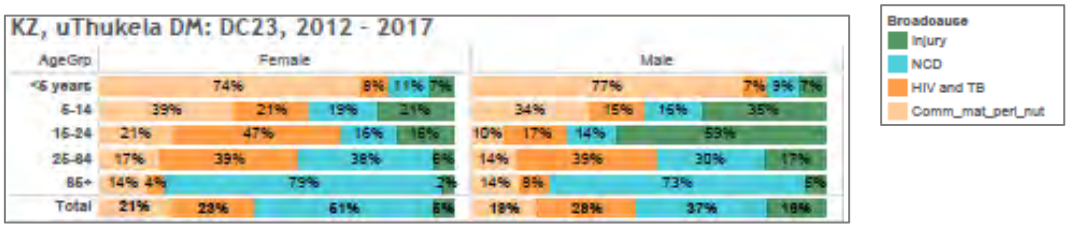


Figure 26: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)



Brief overview of the major Social Determinant Challenges

The access to water was a challenge in the 2018/19 financial year due to the drought in the District. This affected households as well as service delivery especially at St. Chads CHC due to low water pressure within the Municipality water supply; the Municipality was unable to provide St. Chads with water. Various meetings were held between the DoH and the District Municipality whereby the Municipality agreed to supply St. Chads with two tanker loads of 16000 litres capacity in a daily basis. However, this has to date not materialized. This has an impact on Infection and Prevention Control at the CHC. A borehole was donated, but the yield from the borehole is very low and cannot sustain the water demands from the CHC.

There are many rural areas within the district where accessibility to potable water is a challenge therefore service delivery for basic social determinants is not easy. The current boreholes had exceeded their life expectancy and require replacements. Unavailability of water affects prevention of communicable diseases and safety of feeding in infants who are formula fed.

Table 113: uThukela Social determinants of health

	Source /Year	District
Percentage of female-headed households (%)	2016	85.7%
Unemployment rate (%)	2011	39.6%
Youth unemployment rate (15 – 34 years) (%)	2011	49.3%
Percentage of population 20 years and older with no schooling (%)	2016	20.3%
Percentage without matric (%)	2016	66.7%
Percentage without higher education (%)	2016	93.4%
Formal dwellings (%)	2016	69.8%
Percentage of households using electricity for lightening (%)	2016	85.5%
Percentage of households with flush toilet connected to sewerage (%)	2016	29%
Percentage of households with weekly refusal removal (%)	2016	31.3%

	Source /Year	District
Percentage of households with piped water inside dwellings (%)	2016	22.3%
Drinking water system (Blue Drop) Performance rating (%)	2014	34.5%

Source: Local Government Handbook, Stats SA; 2014 Blue Drop Report

Graph 75: uThukela District HIV / AIDS Cascades as at March 2022

ZULULAND DISTRICT

District Demographic

Figure 27: District percentage population by age – gender compared to South Africa (DHB 2019/20)

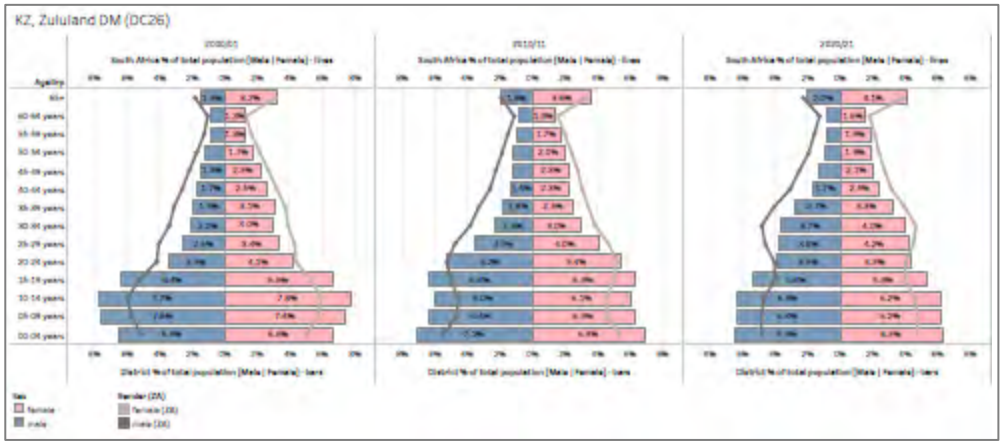
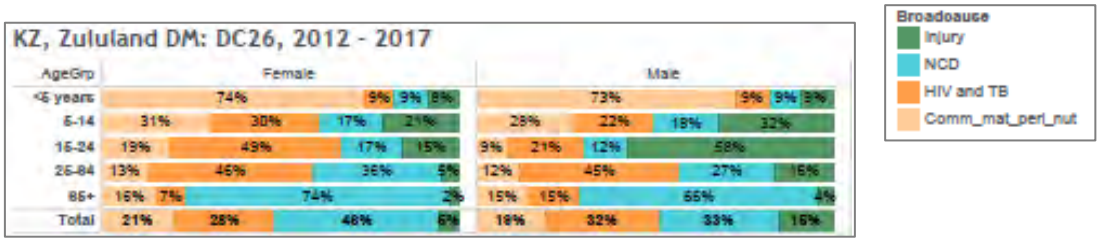


Figure 28: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)



Brief overview of the major Social Determinant Challenges

The unemployment rate is high at 51.2%. The high unemployment rate poses a high risk of social ills as is the case in issues of sexual assault which is related to high use of marijuana and other drug related substances especially at uPhongolo, Abaqulusi and Nongoma sub- districts. Unemployment contributes to low food security and subsequent malnutrition (DHB 2015), as is the situation with a high severe malnutrition incident within the district of 1.6% (189/115824) (DHIS 2018/9).

There is a high percentage of youth ages (14-24 years) unemployment rate of 41.1%. This category of the community is very active, but unemployable as they also lack skills as 72.6% of them are without higher education qualification. This also may be contributing to the high teenage pregnancy rate ages10-19 years of 23% (DHIS 2018).

Percentage of households with flush toilets connected to sewerage is only 18%, which puts more pressure to the municipality to provide with pit latrines for them to have access to safe sanitation. Only 51.2% of the population has access to drinking water, this has a contributory factor in the high diarrhoea although it has decreased. The district needs to plan for community services to improve on early identification and management through the utilisation of the Outreach Program – ward based outreach teams (WBoTs) and community education on the prevention and management of diarrhoeal diseases at a community level to reduce the incidence as well as mortality due to diarrhoea.

Table 114: Zululand Social determinants of health

	Source /Year	District
Percentage of female-headed households (%)	Stats SA (Local Government Handbook	53.8%
Unemployment rate (%)		41.1%
Youth unemployment rate (15 – 34 years) (%)		51.2%
Percentage of population 20 years and older with no schooling (%)		24%
Percentage without matric (%)		67.6%
Percentage without higher education (%)		72.6%

	Source /Year	District
Formal dwellings (%)		62.1%
Percentage of households using electricity for lightening (%)		84.9%
Percentage of households with flush toilet connected to sewerage (%)		18.7%
Percentage of households with weekly refusal removal (%)		22.3%
Percentage of households with piped water inside dwellings (%)		14.6%
Drinking water system (Blue Drop) Performance rating (%)		51.2%

Source: Local Government Handbook, Stats SA; 2014 Blue Drop Report

Graph 76: Zululand District HIV / AIDS Cascades as at March 2022

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