KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

ANNUAL PERFORMANCE PLAN

2024/25 - 2026/27

GROWING KWAZULU-NATAL TOGETHER

2030 NDP

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FOREWORD BY THE EXECUTIVE AUTHORITY

It is with great pleasure and a profound sense of responsibility that I endorse the Annual Performance Plan (APP) for the KwaZulu-Natal Department of Health. As the Executive Authority, I am fully committed to ensuring the successful implementation of this plan, which serves as our roadmap for the year ahead.

This APP carries special significance, as it coincides with the 30th anniversary of our democracy.

This should encourage us to further consolidate the many significant gains that the ANC-led Government has already achieved.

These include the building of clinics and hospitals, training and deployment of more healthcare staff, improving public health literacy, expanding HIV/AIDS awareness, prevention and treatment, while improving not only general life expectancy, but also the quality of life for many.

As we continue to build a better province and country, our approach to healthcare planning is rooted in the Medium Term Strategic Framework, the Department's Strategic Plan, as well as the broader priorities set by Government.

The policy priorities outlined in this plan reflect our dedication to meeting the healthcare needs of the people of KwaZulu-Natal, guided by the resolutions of the African National Congress.

The Freedom Charter, as adopted by the Congress of the People in Kliptown, in 1955, envisioned that South Africa should have "a preventive health scheme that is be run by the state; and that free medical care and hospitalisation shall be provided for all, with special care for mothers and young children."

In democratic South Africa, healthcare, as enshrined in the Freedom Charter, is a fundamental right. And the National Health Insurance (NHI) is a crucial step towards realising this right.

We must ensure that the time honoured principles of the Freedom Charter are embedded in the implementation of this APP, and that the National Health Insurance becomes a reality, and the vehicle for the provision of accessible and quality healthcare to all.

One of our flagship programmes, "Isibhedlela Kubantu," continues to give meaning, on a regular basis, to the immense benefits of a community-based Primary Health Care approach.

Through this programme, scores of ordinary people – especially those in far-flung, rural areas, who are mostly impoverished – benefitting, at their doorstep, from the expertise of top medical personnel and a ranger of healthcare services that are ordinarily located far from them.

In many ways, it is a shining example NHI in action.

Looking at our performance indicators for the 2022/23 financial year, there are a lot of positive outcomes from which to build and further consolidate, including:

- Receiving an unqualified audit, which bears testimony to our improving financial management;
- A decline of the neonatal death in-facility rate from 13.6 / 1 000 live births to 12.9 / 1 000 live births, with a decrease in the actual number of deaths from 2 739 to 2 558;
- Maintaining a high Mental Health Screening Rate, at 56.5% (13 964 514 / 24 714 031) compared to the previous 54.9% (13 126 378 / 23 906 116);
- Achieving a reduced mother-to-child HIV transmission rate of 0.35% against the target of 5% 1;
- Testing a total of 4 027 596 people for HIV; while a total of 1 561 281 patients remained on Anti-Retroviral Treatment, at the end of March 2023;
- Reducing the maternal mortality in-facility rate from 100.6 per 100 000 live births to 81.5 per 100 000 live births;
- Increasing the Ideal Clinic status rate from 84.2% (511 / 607) to 93.4% (565 / 605);
- Increasing the number of clients accessing rehabilitation services from 756 793 in the previous financial year to 823 418.

In line with our commitment to transformation and innovation, the Annual Performance Plan places the spotlight on key programmatic areas.

Our recent establishment of On-site Midwife-led Birthing Units (OMBU), as well as plans to spread this service, underscores our determination to continue reducing maternal and child mortality rates in the Province.

We will also be continuing with our focus on strengthening nursing ethics and professionalism, in order to uphold the highest standards of care.

We will continue to prioritise E-health, in order to enhance healthcare delivery and reduce waiting times. This will ultimately do away with the loss of medical files, which compromises our ability to defend litigation.

We will further accelerate the decentralisation of the collection of chronic medicine, through "Ikhemisi Eduze Nawe," which improves its accessibility to patients, by bringing it to pick-up points closer to where they stay.

These initiatives reflect our dedication to improving the health outcomes of our communities. These are but a few of the many areas in which we intend to improve service delivery.

We have a responsibility to ensure that all our efforts – from our polices to the programmes we implement –translate into an improved lived experience for our patients, while improving our health outcomes.

Our work must be in line with the Department's mission statement, which is to "develop and implement a sustainable, co-ordinated, 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."

I call upon all health facility managers to take up their roles with diligence, and address challenges such as long waiting queues and medicine shortages.

We have put in place a complaints and compliments mechanism which entails the prominent display of the faces, names and contact details of public relations officers, healthcare facility managers, and district managers at our healthcare institutions.

We urge the public to make use of these, in order to have recourse where they may feel aggrieved.

We must create a conducive environment, where every staff member is dedicated to the well-being of our patients.

Consequence management mechanisms must be rigorously enforced to deal with errant staff, ensuring accountability, corrections, and maintaining the highest standards of service delivery.

As we begin the new financial year, let us remain steadfast in our commitment to delivering quality healthcare services.

Together, let us continue to make a significant impact on the health and well-being of the people we serve, translating policies into tangible improvements in the lived experience of our communities.

Ms. Nomagugu Simelane

Executive Authority: KwaZulu-Natal Department of Health

Date: 27th March 2024

STATEMENT BY THE ACCOUNTING OFFICER

I would like to take this opportunity to express my deepest gratitude to our Hon. MEC Ms. Nomagugu Simelane for her political oversight, leadership and guidance.

I would also like to convey a word of thanks to all the dedicated healthcare workers who have tirelessly put the needs of our patients first.

Your hard work and compassion are the pillars upon which our healthcare system stands. And your commitment ensures that the well-being of our communities remains at the forefront of our mission.

In our ongoing pursuit of excellence, it is essential for all of us to recognise that without our patients, we would have no purpose.

As healthcare professionals, let us be reminded, at all times, of the profound impact that we have on the lives of those we serve.

Let us be reminded that we hold the responsibility to treat every patient with the utmost care and empathy, as we would wish for our own loved ones.

This ought to be an over-arching sentiment that guides our actions and decisions at every turn. It should help us foster an environment where care, patience, compassion and understanding prevail.

Coupled with our commitment to providing high-quality healthcare, we must acknowledge the challenging economic landscape in our country and province, and the necessity to exercise fiscal responsibility at all material times.

As we chart our course for the upcoming year, we must be mindful that Government faces numerous constraints with limited resources.

The demand for healthcare services is ever-growing, and yet, fiscal constraints necessitate that we do more with less.

It thus becomes incumbent upon those of us who are tasked with managing public funds, to optimise the allocation of resources.

This means we must always be seeking innovative and efficient ways to deliver healthcare without compromising on its quality.

By exercising fiscal responsibility, we can ensure the sustainability of our healthcare initiatives, and maximise the impact of our interventions.

Through prudent financial management, we can navigate these challenges and uphold our commitment to delivering accessible and effective healthcare services to all.

Preventive healthcare and early diagnosis are vital elements towards achieving these goals, and in promoting a healthier community. I urge each healthcare worker to take the lead in advocating for a healthy way of life.

Through disease prevention and regular screening and testing, we can contribute to the early detection and effective management of diseases, while improving the overall health outcomes for our patients – at the same time making savings so as to channel our limited resources where they are needed most.

Healthcare workers, as ambassadors of our noble profession, also play a pivotal role in shaping public perception.

Therefore, we have a responsibility to conduct ourselves with the highest level of professionalism, not only in the workplace, but in every aspect of our lives.

From dietary choices to regular exercise, and by abstaining from detrimental habits such as smoking, drinking and drug abuse. We should exemplify the values we hold as healthcare professionals.

This should be demonstrated in every facet of our lives, even the material that we post on our social media platforms as it tends to become a reflection not only of ourselves, but also on the healthcare profession, the families and communities that have produced us.

Social media presents us with a potentially powerful platform from which to advance the cause of public health promotion, instead of posting material that is arbitrary, or – as we've seen in some cases – inflammatory to the point of subjecting people to discipline.

It's an area in which we need to be circumspect and should be treated with caution.

Furthermore, I encourage all healthcare workers to prioritise their own health and well-being.

As human beings, we go through many of life's tough challenges. And not all of us are able to cope.

Exposure to the realities of the healthcare sector, such as heavy workload, and incidents that involve trauma and injury as well as other forms of distress, might trigger or exacerbate health challenges.

Coupled with other forms of turmoil, this might make it difficult for a healthcare worker to be productive in the workplace or discharge their duties effectively.

I therefore implore all our staff across the board to utilise the occupational health services and employee assistance programmes that we have made available.

A healthy workforce within the healthcare environment is essential to delivering optimal patient care. So, by taking care of ourselves, we can strengthen our ability to care for others.

Working together, let us continue to strive for excellence, placing the needs of our patients at the forefront of all our endeavors.

Thank you, once again, for your commitment to the health and well-being of the people of KwaZulu-Natal.

Dr. SC Tshabalala

Accounting Officer: KwaZulu-Natal Department of Health

Date: 3rd March 2024

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 2024-2027.

Mrs P. Msimango

Acting DDG: Clinical Support Services

Dr T.D. Moji

Acting DDG: Clinical Services

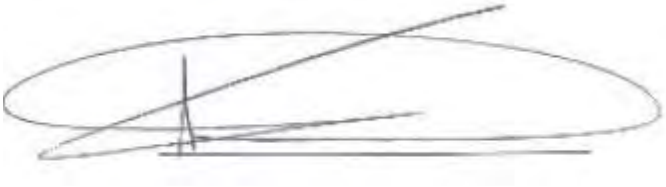
Mr M. Zungu

DDG: National Health Insurance (NHI)

Mr K. Vilakazi

Chief Financial Officer

Dr N. Mthembu
Acting Deputy Director General: Corporate Services Management



Mr. S Mhlongo
Acting Chief Director: Infrastructure Development

Ms. 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

Dr SC Tshabalala Date: 3rd March 2024

Accounting Officer: KwaZulu-Natal Department of Health

Approved by:

Ms. Nomagugu Simelane Date: 27th March 2024

Executive Authority: KwaZulu-Natal Department of Health

ABBREVIATIONS

Abbreviation	Description
AGL	Adherence of Guidelines
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APP	Annual Performance Plan
ART	Anti-Retroviral Therapy
AWG	Action Work Group
BAS	Basic Accounting System
BUR	Bed Utilisation Rate
CCG(s)	Community Care Giver(s)
CCMDD	Centralised Chronic Medicine Dispensing and Distribution
CDC	Communicable Disease Control
CHC(s)	Community Health Centre(s)
COGTA	Cooperative Government and Traditional Affairs Department
CHW	Community Health Worker
COVID-19	Coronavirus Disease first identified in 2019
CPAP	Continuous Positive Airway Pressure
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
EMS	Emergency Medical Services
FIO	Facility Information Officer
GBVF	Gender Based Violence and Femicide
GRPBMEAF	Gender Based Response Planning Budgeting Monitoring and Evaluation and Audit Framework
GDP	Gross Domestic Product
HAST	HIV / AIDS, Sexually Transmitted Diseases and Tuberculosis
HIV	Human Immunodeficiency Virus
HOD	Head of Department
HPC	Health Portfolio Committee
HPRS	Health Patient Registration System
HRD	Human Resource Development
HVAC	Heating, ventilation, and air-conditioning
IALCH	Inkosi Albert Luthuli Central Hospital
ICT	Information Communication Technology

Abbreviation	Description
IHRM	Ideal Hospital Realisation and Maintenance Programme
IMCI	Integrated Management of Child Illnesses
IMHPWS	Integrated Multi-stakeholder Health Promotion and Wellbeing
KMC	Kangaroo Mother Care
KZN	KwaZulu-Natal
KZNCN	KwaZulu-Natal College of Nursing
LARC	Long-Acting Reversible Contraceptive
LCD	Leading Cause of Death
MCWH	Maternal Child and Women's Health
MDR-TB	Multi Drug Resistant Tuberculosis
MEC	Member of the Executive Council
M&E	Monitoring and Evaluation
MHS	Military Health System
MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework
NCD(s)	Non-Communicable Disease(s)
NDP	National Development Plan
NGO(s)	Non-Governmental Organisation(s)
NHI	National Health Insurance
OHSC	Office of the Health Standards Compliance
OMBU's	Obstetric Maternity Birth Units
OPD	Out-Patient Department
OTP	Office of the Premier
PCR	Polymerase Chain Reaction
PGDP	Provincial Growth and Development Plan
PHC	Primary Health Care
PPSD	Provincial Pharmaceutical Supply Depot
RMS	Rapid Mortality Survey conducted by Health Systems Trust
RMTC	Road Traffic Management Centre
SAC	Severity Assessment Code
SAHPRA	South African Health Product Regulatory Authority
SALGA	South African Local Government Association
SAM	Severe Acute Malnutrition
SANC	South African Nursing Council
SCM	Supply Chain Management
SDIP	Service Delivery Improvement Plan
SITA	State Information Technology Agency

Abbreviation	Description
SHP	Strategic Health Programmes
SOP's	Standard Operating Procedures
Stats SA	Statistics South Africa
TB	Tuberculosis
TCC	Thuthuzela care centres
TLD	Tenofovir disoproxil, lamivudine, dolutegravir
TROA	Total Patients Remaining on ART
UHC	Universal Health Coverage
WBOT(s)	Ward Based Outreach Team(s)
WHO	World Health Organisation

PART A: OUR MANDATE

1. CONSTITUTIONAL MANDATE

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

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

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

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

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

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

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

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

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

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

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

2.1 LEGISLATION FALLING UNDER THE DEPARTMENT OF HEALTH'S PORTFOLIO

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

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;

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 INCLUDING POLICIES AND STRATEGIES

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) - Skills Development Framework was developed with the purpose to make provision for education, training and development activities designed to help employees gain knowledge, skills and attitudes that would improve their performance in the respective portfolios/ positions/area of operation.

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.

Crime Prevention Strategy will be implemented in Health through the security awareness programmes conducted quarterly, installation of tracking devices in state vehicles, and installation of surveillance cameras in all premises. Threat and risk assessments will be conducted, when required, as will background checks for all employees for criminal convictions.

Food Security is a national challenge. KwaZulu-Natal province has several households in the poorest rural areas that are facing food insecurity. Therefore, the intervention by the Department of Agriculture & Rural Development to assist indigent families and farmers, affording them an opportunity to participate in the mainstream economy of the province is timely

Operation Clean Audit

Poverty Eradication Strategy, a framework for a provincial programme of action that targets the poorest households in the poorest wards of this Province. The Poverty Eradication programme lends technical support in the facilitation and coordination of game changing interventions as identified in the Master Plan. The Office of the Premier coordinates and monitors interventions.

Provincial Spatial Development Strategy. The envisaged spatial vision for KwaZulu-Natal could be summarised as follow: "Optimal and responsible utilisation of human and environmental resources, building on addressing need and maximising opportunities toward greater spatial equity and sustainability in development

Vulnerable Groups Strategy, The Office of the Premier is the core co-ordinator of the development of the consolidated plans for the province that focuses on the development and monitoring of the mainstreaming of human rights into government programmes and co-ordinating the establishment of the Forums and facilitating capacity building of human rights. This includes the gender-based violence strategy which is being implemented to combat the rising gender based violence and femicide (GBVF) in the province.

Operation Sukuma Sakhe / District Development Model Strategy, the District Development Model was introduced in 2019, and since its inception, the Province embraced the concept and rolled out the programme. The eThekwini Metro was identified as one of the three pilots by the National Department of Cooperative Governance (DCOG), who then appointed the Development Bank of South Africa (DBSA) to establish the hub, coordinate the three spheres of government, develop and implement the "One Plan".

The Anti-Fraud strategy (Fraud Preventions Strategy) outlines the Department's focus and commitment to the reduction and possible eradication of incidences of fraud and corruption. Fraud and corruption pose a significant potential risk to the Department which undermines the Department's mandate of delivering better Healthcare Services to the residents of the KwaZulu-Natal Province. The Department is highly committed towards the prevention and eradication of fraud and corruption through an adoption and confirmation of a culture of zero tolerance towards the activities of fraud and corruption. The Department adopts the proactive approach towards the prevention of fraud and corruption activities through a continuous process of risk management.

Energy Master Plan - The goals of the Masterplan are premised on broad government policy and objectives as presented in the 1998 Energy White Paper. The White Paper on Energy Policy also outlines the medium term objectives as far as the development of electricity is concerned. The White Paper further outlines the following objectives with regards to the governance of the sector:

White Paper on the Rights of Persons with Disabilities (2015), this document defines the right and responsibilities of disabled persons and guarantees their protection and inclusion in the workplace and within the health sector

Gender Based Response Planning, Budgeting, Monitoring, Evaluation and Audit Framework (GRPBMEAF) (Oct 2020), implemented to Institutionalize gender mainstreaming across state machinery, broader political and socio-economic transformation agenda, outcomes and results-based approach, Govt-wide policy, planning and prioritization, broader public finance and budget reforms. The implementation of the Forensic Medicine Strategy and the GBV strategy addresses the public health aspects of this Framework.

National health's 2030 Human Resource Strategy for Health - The Department is guided by the National Health's 2030 Human Resource Strategy for Health which aims at ensuring the investment in the health workforce to ensure quality universal health coverage and a long and healthy life for all people. This is implemented through skills audit, alignment of training interventions to performance gaps identified during performance assessments as well as management meeting's outcomes.

Human Resource Turnaround Strategy - is developed by Office of the Premier with predetermined Indicators and All Provincial Departments are required to provide quarterly updates to these

indicators. The Department of Health: KZN is in compliance and timeously provides updates on the indicators to OTP on a quarterly basis.

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

In early 2022, the Climate Change Bill which seeks to ensure that South Africa responds adequately to climate change, was introduced to Parliament.

In May 2023 a high court ruling was in favour of hospitals and clinics, schools and police stations being exempted from load shedding ensuring that these institutions do not have uninterrupted power supply for the efficient delivery of public services.

In June 2023 the National Health Insurance (NHI) Bill which makes provision for universal access to health care services in the country in accordance with the National Health Insurance White Paper was passed.

Whilst in the same month, the Public Procurement Bill was introduced to Parliament. The aim of this bill is to dissolve the current multilayered system found at different government spheres and to introduce a single regulatory framework for all public procurement across national, provincial, and local government. This will assist in fighting corruption and mismanagement.

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
- Public Service Regulations
- Health Compact Pillars

3.1 NATIONAL HEALTH INSURANCE (NHI) BILL

One of the main objectives of the Bill is to establish the National Health Insurance (NHI) Fund that will purchase healthcare services for all users who are registered with it. The Bill aims to realise Universal

Health Coverage for all. This will mean that all citizens will have the right to access comprehensive healthcare services for free at the point of care at accredited health facilities. On the 6th of December 2023, the National Council of Provinces (NCOP) passed the National Health Insurance Bill.

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 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*	2. Jobs 5. Digitalisation 6. Vaccination 10. Public procurement

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
					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	

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
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	
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	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 newborns 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	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

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
		by 50 percent from 2010 levels.	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			

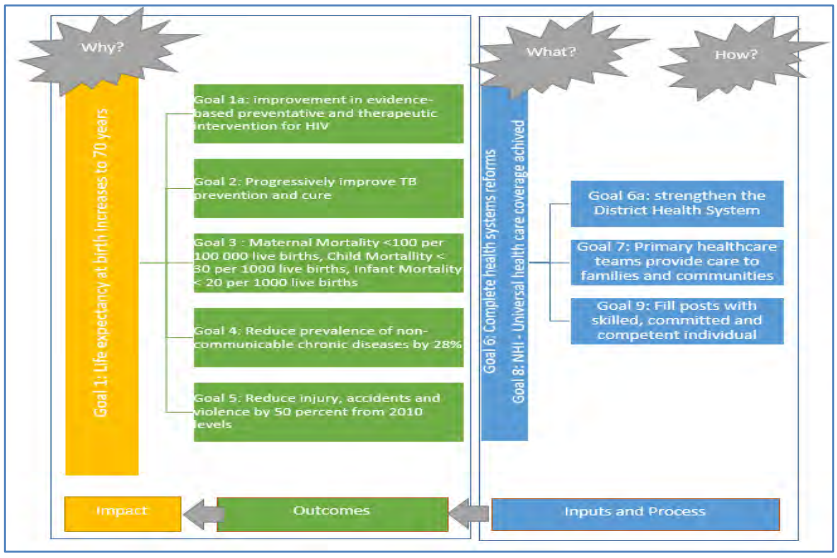
The Department of health responds to Priority 3: Education, Skills and health of the PGDS. The Action Work Group (AWG) E is led by the Department of Health and is supported by the Office of the Premier (OTP), Department of Social Development (DSD), Cooperative Governance and Traditional Affairs (CoGTA), 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

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

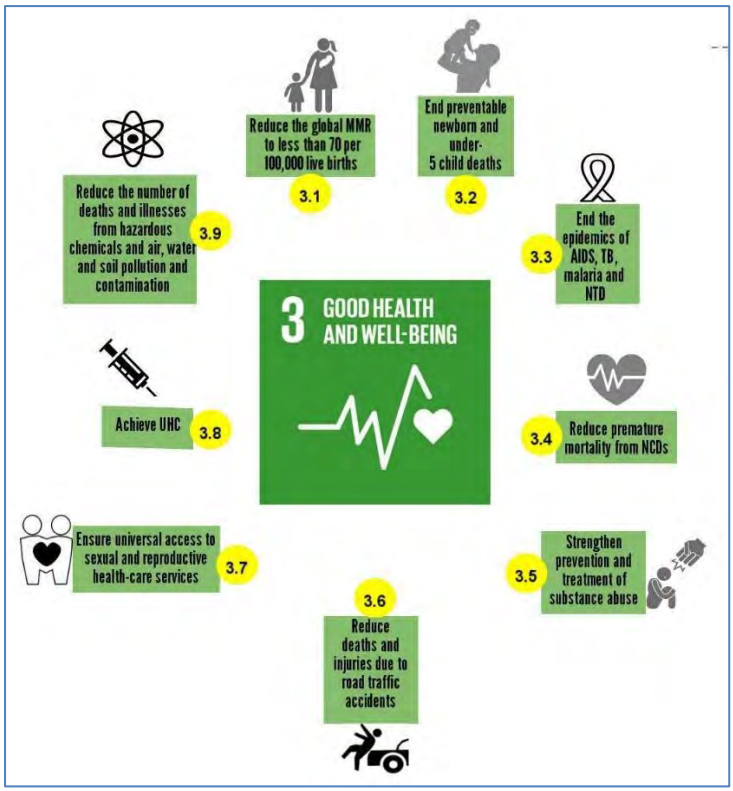
3.3 NATIONAL DEVELOPMENT PLAN: VISION 2030



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 the 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 HR plan 2021/22 to 2023/24 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 Coverage	*Pillar 9: Develop an Information System that will guide the health system policies, strategies and investments*
		Outcome: Universal	*Pillar 3: Execute the infrastructure plan to ensure adequate,*

MTSF 2019-2024 Impacts (National)	MTSF 2019-2024 (KZN) Interventions	**Health sector's** strategy 2019-2024	Presidential Health Summit Compact Pillars
		Health Coverage	*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		

3.5 PROVINCIAL STRATEGY ALIGNMENT TO THE PROVINCIAL SPATIAL DEVELOPMENT FRAMEWORK

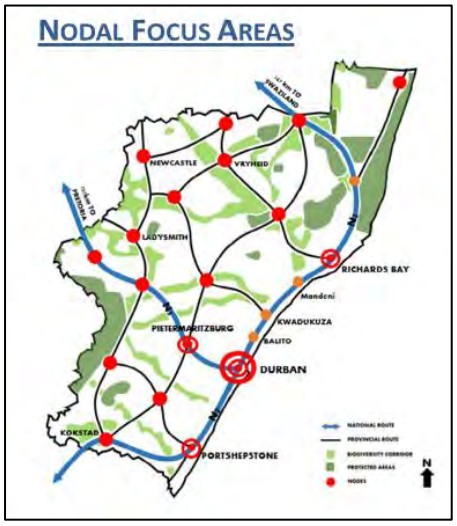
The Kwazulu-Natal Provincial Spatial Development Framework (PSDF) represents the long-term spatial vision of the province to be consistent with and be formulated within the context of the National Spatial Development Framework. The spatial expression of the KZN Provincial Growth and Development Strategy (PGDS) and provides spatial context for proposed strategic interventions. It must guide the spatial dimension to achieve the goals and objectives of the PGDS in a targeted and spatial coordinated manner.

Envisaged Provincial Spatial Development Outcomes

- Integrated and Inclusive Province
- Sustainable Province
- Resilient Province
- Productive and Efficient Province
- Well-managed Province

The Department of Health has ensured alignment with this Framework through the planned regionalization of 4 District Hospitals in identified nodal areas of Ixopo, Dundee, Jozini and Vryheid. This will impact on all 5 Development outcomes, once commissioned. The implementation of the Infrastructure Master Plan will also give expression to this Framework, as equity in accessing health services will be improved.

Map 1: Nodal Areas of KZN



Source: PSDF 2021, accessed on 22nd January 2024

4. RELEVANT COURT RULINGS

BILLS IN PROGRESS:

National health Amendment bill – Bill 29 of 2018 (Private Member's Bill) seeks to extend clinic hours- as per the 2019 South African Health Review, 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 Department projects an expenditure above the allocated budget for 2023 – 2034 financial year and this is a result of insufficient budget allocation due to budget cuts the Department is faced with. The situation will not improve as accruals increase, and budget cuts remains.

A total of 99 medico legal cases are recorded in the provision register (cases with conceded liability) with a total liability value of R 1,095 Billion and with best value R 650 million. It is anticipated that finalization of these 99 cases will take 3 years.

A total of 1 678 medico legal cases with summons with a contingent liability of R 20 Billion and with best value of R 5,932 Billion at 31 December 2023.

Total contingent liability for medico legal cases continues to increase as a result that the number of new medico legal cases exceed the cases settled. Archiving may result in decrease in contingent liability but await the response from Department of Justice.

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

1. Trustworthiness, honesty, and integrity
2. Open communication, transparency, and consultation
3. Professionalism, accountability, and commitment to excellence
4. Loyalty and compassion
5. Continuous learning, amenable to change and innovation
6. 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 94 359 km² which is the third smallest in the country and has a population of 11 683 165 for 2022/23 (Web District Health Information System (DHIS) 2023/09/27), 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 center 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.

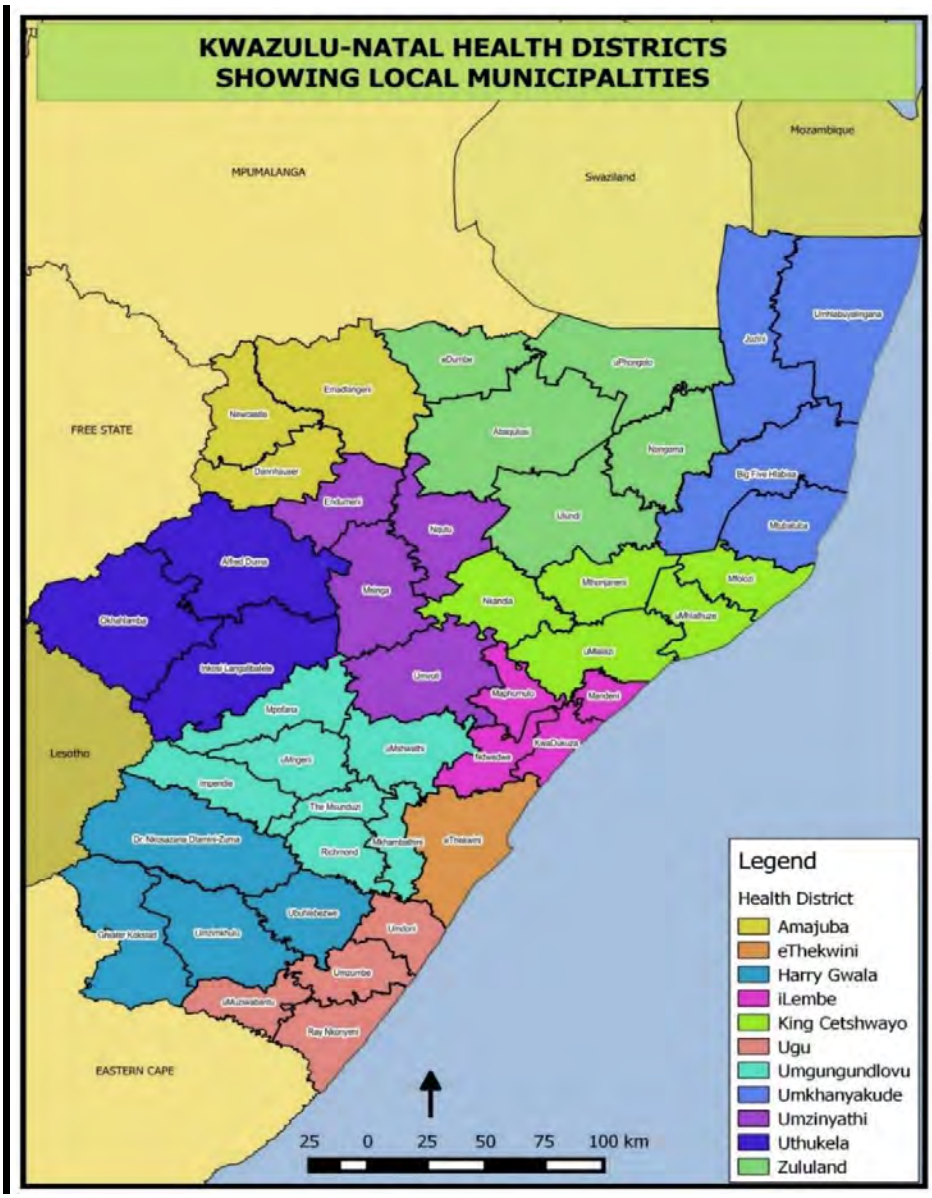
Table 4: KwaZulu-Natal Demographic Data for 2022/23

Demographic Data	KwaZulu-Natal
Geographical area	94 359 km^2
Total population (Statistics South Africa, Mid-year estimate 2022) as at March 2023	11 683 165
Population density (Based on SA Mid-year estimates 2022)	123.8 per Km^2
Percentage of population with medical insurance (General Household Survey, 2022)	11.1%

Source: Web District Health Information System (DHIS) Stats SA Mid-year estimates 2023

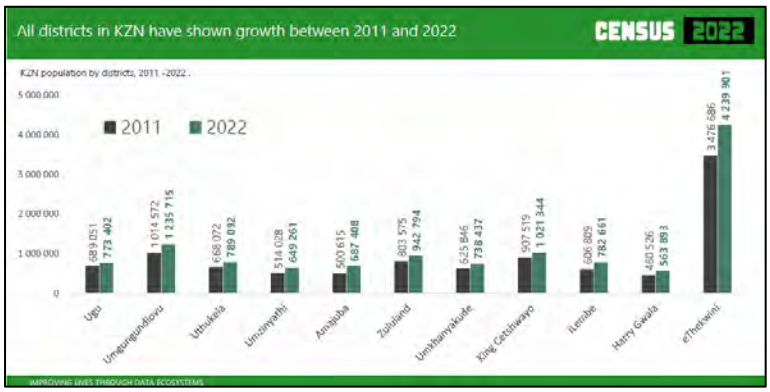
KwaZulu-Natal is divided into one metropolitan municipality (eThekwini Metropolitan Municipality) and 10 district municipalities, which are further subdivided into 43 local municipalities (National Department of Health, 2019).

Map 2: Map of KZN and Districts / Metroplotian



Source: Geographical Information System, KZN Health

Graph 1: Comparative of District populations



Source: Census 2022

eThekwini and uMgungundlovu remain the most populous districts in KwaZulu-Natal. Four (4) districts had a difference of over 20% between the 2 Census years, being Amajuba (37.3%), uMzinyathi (296.3%), iLembe (29%) and Harry Gwala (22.4%).

EXTERNAL ENVIRONMENT ANALYSIS

To ensure that optimal health for all persons in KwaZulu-Natal is achieved, it is critical to pay heed of the environment within which the public health delivery system is operating.

South Africa is still reeling from the effects of COVID-19. COVID-19 has to date impacted on health service delivery, utilization of health services and the general health of the public (Govender K, 2022). COVID-19 also had an impact on the population, birth rates and drastically increased the crude death rate in the country (Ndlovu N, 2023). Due to lockdown restrictions placed globally and nationally, the impact on the economic markets and livelihoods were severe (Ndlovu N, 2023). Despite these challenges, the world has learnt to adapt and still move forward and 'live with' SARS-CoV-2 (Ndlovu N, 2023).

Public health expenditure increased to respond to the COVID-19 pandemic. Health expenditure increased provincially and at the local government level collectively from R216 billion in 2019/2020 to R237 billion in 2020/2021. Approximately R110 billion of the expenditure was spent on District Health Services (DHS). The KZN province was one of the provinces with the highest amount of health expenditure in the 2020/2021 financial year with a total of R49 936 million. Approximately R25 million of the health expenditure in the province was spent on District Health Services during the same year, which was the highest amongst all the provinces (Govender K, 2022).

Medico legal claims have become a challenge for the public health sector and has become a huge risk to healthcare service delivery, especially considering the shrinking budgets allocated to health departments (Masweneng, 2023).

DEMOGRAPHY

KwaZulu-Natal (KZN) has a land area of 94 359 km^2 and has the second largest population consisting of 11,54 million people (19%) in the country after Gauteng (Govender K, 2022) (GCIS). During the 2022 period, it has been noted that South Africa had experienced a positive population growth rate (1.06%) despite the devastation caused by the COVID-19 pandemic (Statistics South Africa) (StatsSA, 2022).

The below table depicts demographics indicators for the province.

One would expect that the decline in economic markets experienced during the COVID-19 pandemic, would decrease the number of births. However, an increase in live births in 2021 (223 712)

was seen, compared to 2020 (205 781)(StatsSA, 2022). Factors such as low access to reproductive health services during the national lockdown period may have led to unintended pregnancies and contributed to an increase in births. Closure of schools could have also led to an increase in the adolescent pregnancies during this period. This finding is also consistent with patterns from past pandemics whereby "baby booms" occurred after the pandemic period (Ndlovu N, 2023).

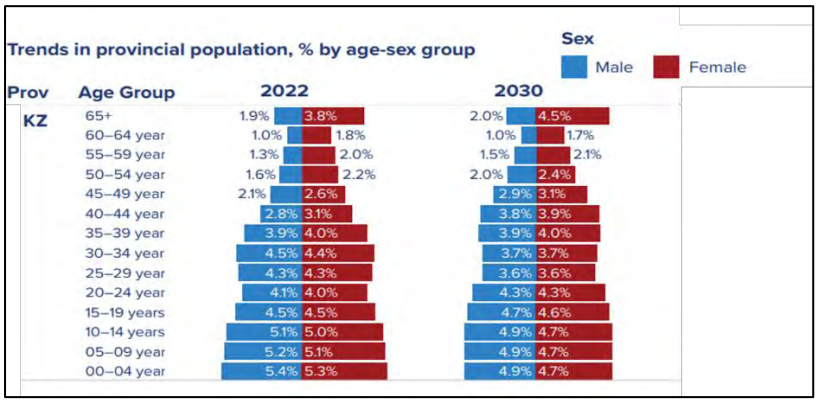
Between 2021 and 2022 there was an increase in the total population of the KZN province, which was the same pattern seen in the national population. However, a slight decline in the proportion of the population was seen between 2021 (19,1%) and 2022 (19,0%) in comparison to the national population (Ndlovu N, 2023).

Table 5: Demographic indicators for KwaZulu Natal for 2022

Indicator	Period	Sex / Age / Series / Category	SA	KZN
Ageing Index	2021	Both sexes mid-year	21.6	17.7
	2022		22.1	17.6
Annual Population Growth rate	2021	Both sexes mid-year	1.0	
	2022		1.1	
Crude death rate (deaths per 1 000 population	2020	Both sexes, all ages, mid-year	8.7	
	2021		11.5	
	2022		11.0	
Live birth occurrences registered	2020	Vital registration total	1 003 307	205 781
	2021		1 087 526	223 712
Population	2021	Both sexes, all ages, mid-year	60 142 9789	11 513 575
		Both sexes, all ages, StatsSA (2019-30FinYr Total)	60 354 419	11 728 948
		Female, all ages, mid-year	30 754 931	
		Mall, all ages, mid-year	29 388 047	
	2022	Both sexes, all ages, StatsSA (2019-30FinYr Total)	61 220 537	11 847 316
		Both sexes, mid-year	60 604 992	11 538 325
Population % by Province	2021	Both sexes, all ages, mid-year	100%	19.1%
	2022	Both sexes, all ages, mid-year	100%	19%
Population Density	2021	Mid-year	49.3 / km^2	122 / km^2
	2022	Mid-year	49.6 / km^2	122.3 / kms^2
Population under 1 year	2021/22	Both sexes under 1 year (DHIS)	1 139 382	255 744
Public sector dependent (uninsured) population	2020	Both sexes, all ages (General Household Survey)	49 798 387	10 005 297
		Both sexes, all ages, non-med schemes	51 256 046	10 223 911
	2021	Both sexes, all ages (General Household Survey)	50 847 588	10 326 801
		Both sexes, all ages, non-med schemes	51 499 090	9 922 960
Total fertility Rate	2022	Both sexes, mid-year	2.3	2.5

Source: N. Ndlovu, 2023

Figure 1: . Comparisons of the male and female population in KZN in 2022 and estimation in 2030



Source: Govender K, 2022

The above age and sex pyramid shows a *stable* population for the province in 2022. It should also be noted from the above figure that the female population in the 65 years age category is double that of males, confirming that females have a higher life expectancy.

In 2022, Statistics South Africa (StatsSA) documented the proportion of persons younger than 15 years of age was 31.1% of the population in KZN (StatsSA, 2022). The proportion of youth aged between 25 and 34 years was 17.5% in KwaZulu-Natal in 2022 (StatsSA, 2022).

The proportion of older persons (persons aged 60 years and older) in the country has increased and in KZN, the number of older persons in the province was 940 000 (8.1%) in 2022 (Statistics South Africa, 2023) (StatsSA, 2022). The proportion of female older persons (64.8%) was higher than males (35.2%). The increasing number of older persons in the population is an important factor in the population landscape to note, since this will have an impact on the healthcare system and policies, programmes, and planning since the needs of this growing population should be considered (StatsSA, 2022). Age-related illnesses that most commonly affect the elderly are high blood pressure, diabetes, and asthma (Statistics South Africa, 2023).

In 2021, the life expectancy rate in KZN for males were 57.8 years and for females 63.2 years (Govender K, 2022). Between March 2020 and June 2021, the rate of life expectancy was significantly affected by the estimated 34% rise in deaths in adults due to the COVID-19 pandemic in South Africa. Between July 2021 and 30th June 2022, the 5% reduction in deaths due to the decrease in COVID-19 related deaths has led to the increase in the life expectancy rate in the country (StatsSA, 2022). The average total fertility rate for the province between 2021 and 2026 was 2.5 (StatsSA, 2022).

SOCIAL DETERMINANTS OF HEALTH

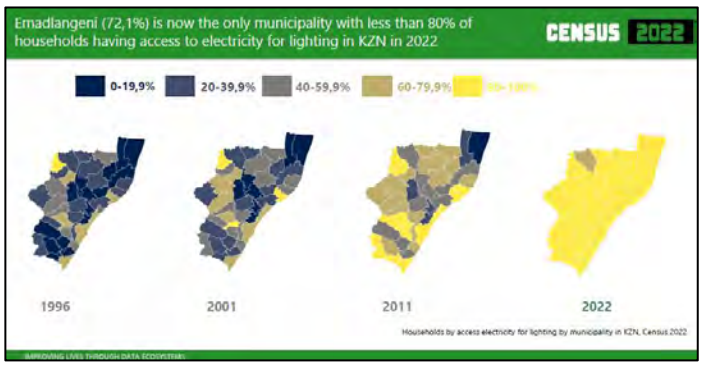
Table 6: Social determinants of health per district

District	Total households		Households living in formal dwellings		Households with access to Regional / Local water schemes		Households with access to flush toilets		Children (5 – 24) attending school		Government transfers and subsidies as % of total revenue
	Proportion of total KZN households	Number	Proportion of District Households	Number	Proportion of District Households	Number	Proportion of District Households	Number	Proportion of KZN children attending school	Number	
Amajuba	5.3%	150 239	93.5%	140 442	87.6%	131 626	65.1%	97 796	6.1%	191 695	81.60%
eThekwini	39.3%	1122738	89.2%	1001347	93.8%	1052684	80.4%	902 237	25.8%	805 315	15.50%
Harry Gwala	4.0%	115 068	66.2%	76 128	46.8%	53 858	37.1%	42 715	5.5%	173 230	89%
iLembe	6.6%	187 182	87.6%	163 881	74.3%	139 061	44.6%	83 478	8.7%	270 752	71.90%
King Cetshwayo	7.2%	205 739	87.4%	179 910	29.4%	60 418	45.0%	92 641	8.7%	270 752	86.90%
Ugu	6.0%	172 628	85.1%	146 927	70.4%	121 556	37.1%	64 114	6.6%	206 404	61.30%
uMgungundlovu	10.8%	307 842	88.6%	272 703	85.0%	261 675	58.3%	179 327	8.9%	277 566	52.50%
uMkhanyakude	4.5%	129 066	90.7%	117 079	42.4%	54 757	25.5%	32 925	7.0%	217 772	86.40%
uMzinyathi	4.4%	125 427	72.0%	90 295	48.5%	60 786	58.8%	73 760	6.5%	204 348	83.90%
uThukela	6.0%	172 197	84.1%	144 885	64.8%	111 501	46.5%	80 015	7.0%	218 090	66.90%
Zululand	5.8%	165 617	86.7%	143 558	58.7%	97 157	36.6%	60 668	9.3%	290 491	93.40%
KZN Totals	-	2 853 743	86.8%	2 477 155	75.2%	2 145 079	59.9%	1 709 676	-	3 126 415	-

Source: Stats SA, Census 2022

During Quarter 1 of 2023 (January – March 2023), the unemployment rate in KZN was 31% which was a decrease by 0.5% point compared to the previous quarter as reported by StatsSA (Statistics South Africa, Quarterly Labour Force Survey (QLFS), 2023). Whilst in Quarter 2 of 2023 (April – June 2023), KZN was one of the provinces that recorded one of the largest employment increases in the unemployment rate (31%) (StatsSA, StatsSA, 2023).

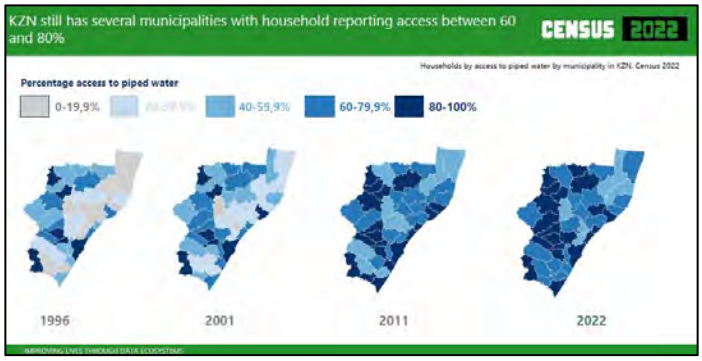
Graph 2: Comparitive District graph with access to electricity



Source: StatsSA (Census 2022)

Access to electricity affects health outcomes as it influences hygiene habits and the ability to boil water. Between 1996 and 2022, KZN has achieved over 80% of total households having access to electricity for lighting. eMandlangeni is the only sub-district not to have achieved over 80%, the reason being the extremely low population density, and the huge land space in between communities / homesteads.

Graph 3: Municipalities with access to piped water comparative

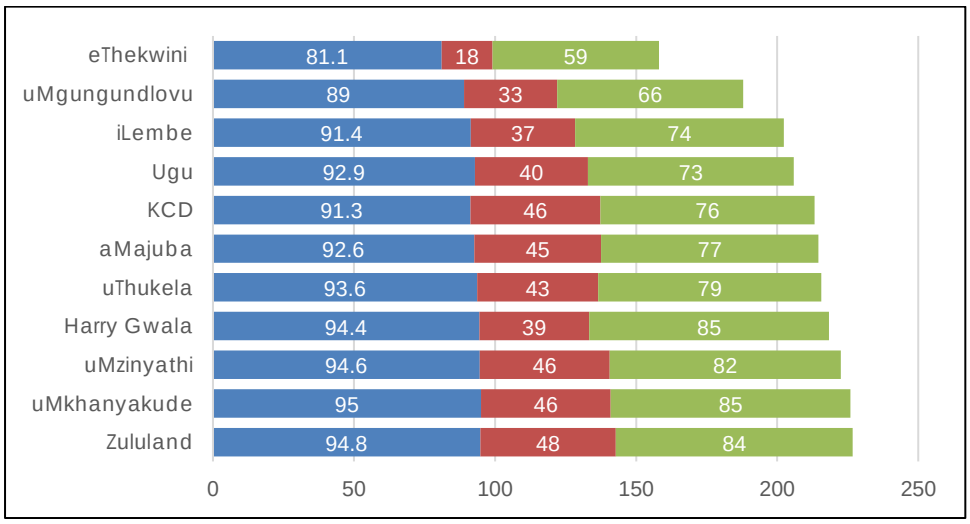


Source: StatsSA (Census 2022)

Access to potable water also influences health outcomes beyond the health facilities. Access to piped water between 1996 and 2022 has improved substantially, however there are sub-districts i.e., the more remote rural areas where access is still a challenge such as Nqutu, Nongoma, Hlabisa and Jozini.

The total number of recipients receiving social assistance through government funded grants in KZN in 2021/2022 were 4 110 241 (Western Cape Government, 2023). According to a report by StatsSA, in 2021, KZN was found to have the highest ratio (1.6) of children to older persons in households headed by older females. The old – age dependency ratio in the province which is indicative of the productive population and estimates the proportion of the population that is dependent on the state increased in 2021 to 12. 3%. The report also found that in 2021, more than two-thirds of the older persons in South Africa were recipients of social grants (Statistics South Africa, 2023).

Graph 4: Social Determinants per District for KZN (Unemployment, Uninsured and Living in Poverty)



Source: PMO Presentation at Gateway Aha – February 2023

In 2021, data showed that 2 736 households in KZN were headed by children under the age of 18 years (Western Cape Government, 2023). Between 2017 and 2021, the number of households that were headed by older persons in KZN was 2 236 with over half being headed by mainly females (55.3%) and the remainder by males (44.7%) (StatsSA). Trends in the usage of health facilities by older persons indicated that 69% used public clinics and 7% used public hospitals (StatsSA).

According to the General Household Survey, 2019, 70.8% of households (with an expenditure of less than R1200) in KZN took less than 30 minutes travel time to reach a health facility in 2019, which was the lowest compared to other provinces, whilst 23.9% of households took 30 - 89 minutes (Western Cape Government, 2023).

In 2021, the proportion of households in KZN that were classified as "formal" housing was 85.7%, whilst 5% was "informal" and 9.3% was classified as "traditional" (Ndlovu N, 2023). According to reported data, the percentage of the total households in a given year living in informal dwellings in KZN in 2022 rose to 5.6% (Western Cape Government, 2023).

The proportion of households in KZN in 2021 that had access to electricity from mains for lighting were 91.4% and the proportion of households that had access to piped (tap) water in dwellings were 36.7%.

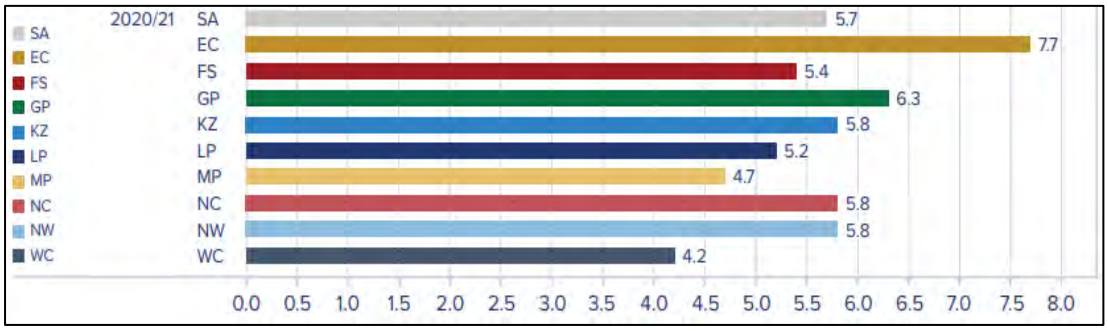
The quality of water supply, its availability as well as sanitation are important infrastructural factors that could have an impact on public health especially in disease transmission (Ndlovu N, 2023). The percentage of households that had access to improved sanitation in the province in 2021 was 84.5% (Ndlovu N, 2023). The Blue Drop Risk Rating, which is a measure, used to monitor and manage drinking water supply systems for the supply of safe drinking water, was 57.9% at the Provincial level in 2021 (Western Cape Government, 2023). Whilst the Green Drop rating which measures the wastewater management status, was 68% in 2021. This was a decrease from 81.5% in 2013 (Western Cape Government, 2023).

The rate of gender-based violence (GBV) in the country has dramatically increased. One reason for the recent increase in GBV was the national lockdown during the COVID-19 pandemic (Govender K, 2022). According to the South African Police Services (SAPS) crime statistics reports, in KZN 855 women were killed between April and June 2022, which was an increase by 53.2%, while 243 children were murdered, which rose by 46.4%. The report also noted a 54.7% increase in attacks on women, and 58.4% on children in the province (IOL, 2023). The number of reported rapes that occurred in a period of three months in KZN in the fourth quarter (January to March 2023) of 2022/2023 was 2 130. The highest number of rapes (82 cases) was recorded at the Inanda Police Station during the same period, which was the highest in the country (South African Police Services (SAPS, 2023)).

EPIDEMIOLOGY OF THE BURDEN OF DISEASE IN KZN

COVID-19 had a detrimental impact on the death toll globally and nationally. It became the 6th leading cause of global deaths in 2020 (Govender K, 2022). The inpatient death rate also increased during this time period due to the pandemic. The figure below shows the inpatient crude death rate for 2020/21 for KZN was 5.8 deaths per 1000 population which was an increase from 4.6 deaths per 1000 population from the previous year (Govender K, 2022).

Figure 2: Inpatient SA crude death rate for 2020/2021 nationally and provincially



Source: N Ndlovu, 2023

The estimated excess death rates were also calculated, which projected the amount all deaths further than what would be expected based on the expected mortality rate in the population, had the pandemic not struck. The estimated cumulative total of excess deaths for South Africa was 339 146

between May 2020 and December 2022 (Ndlovu N, 2023). The estimated number of excess deaths per 100 000 population for KZN between May 2020 and December 2022 was 612 (Ndlovu N, 2023).

South Africa is described as suffering from a quadruple burden of disease due to the striking rates of morbidity facing the population that is due to 'maternal, new-born and child health conditions', 'Human Immunodeficiency Virus (HIV) /Acquired Immune Deficiency Syndrome (AIDS) and tuberculosis (TB)', 'non-communicable diseases' and 'violence and injury' (South African Medical Research Council (SAMRC, 2022)). Similarly, the KwaZulu-Natal Province also follows the same pattern of burden of disease.

HIV/AIDS

The HIV/AIDS pandemic has been plaguing South Africa for the past two decades and has become a long-standing public health concern, more so, is the apparent gender disparity of infection since almost a fourth of South African women in their reproductive ages (15–49 years) are HIV infected (StatsSA, 2022). Even though South Africa has made tremendous efforts in averting the scourge of HIV, it remains the epicenter of the HIV pandemic (Ndlovu N, 2023). The total number of persons living with HIV (PLHIV) in South Africa increased from an estimated 3,68 million in 2002 to 8,45 million by 2022. Therefore, South Africa is known to have the largest number of people enrolled on an Anti-Retroviral Therapy (ART) programme in the world. The COVID-19 pandemic has also impacted on the HIV testing and treatment programmes in the country (StatsSA, 2022). In addition, data indicated that the case fatality rate for COVID-19 was higher for HIV infected persons (20,9%) when compared to non-HIV infected persons (18,9%) (StatsSA, 2022).

The prevalence of HIV in KZN was 18.1% in 2022, which is still higher than any other province and the national prevalence rate making it the global "hot spot" for HIV. The total number of people living with HIV in the province in the first quarter of 2021 was 1 986 692 of which 1 911 616 were adults living with HIV and 75 076 were children living with HIV. In 2022, the total number of people with HIV in the province rose to 2 034 810 (Ndlovu N, 2023). In the first quarter of the 2023/2024 financial year, a decrease in the total number of people living with HIV (1 979 165) in the province was seen (Johnson, 2023). Majority of the PLHIV in the province was in the eThekwini District (633 887) whilst the Harry Gwala District (81 573) seemed to have the lowest number of PLHIV (Johnson, 2023). Districts that showed an increase in the number of PLHIV between the first quarter of 2023/2024 and the last quarter of 2022/2023 were: Harry Gwala, uMkhanyakude, uMzinyathi, uThukela, and Zululand (Johnson, 2023).

In 2021, the U.S. Food and Drug Administration (FDA) approved an ARV drug called cabotegravir that could be used for pre-exposure prophylaxis (PrEP) to reduce the risk of HIV (FDA, 2021). This drug was subsequently recommended by The World Health Organization (WHO). However, due to the current market price of the injectable PrEP that requires dosages every two months, it remains inaccessible for most middle to low-income countries (Alcorn, 2023).

It was estimated that 42 000 HIV infections could be avoided by 2028 if the injectable PrEP was accessible to a third of young men and 60% of young women in South Africa (Alcorn, 2023). However, it was estimated that compared to oral PrEP, the price of cabotegravir PrEP had to be decreased between $9 - $14 per injection, or a cost of $60 to $119 a year in order for it to be cost effective in South Africa (Alcorn, 2023).

TUBERCULOSIS (TB)

Prior to the occurrence of the COVID-19 pandemic, TB was the foremost cause of death from a single infectious agent (Govender K, 2022). Although South Africa is on track in attaining the 2025 End TB Milestone in reducing the incidence of TB by 50%, it remains amongst the top five countries in the world with the highest TB incidence (Ndlovu N, 2023). The outbreak of COVID-19 has hampered efforts in reducing the burden of TB (Govender K, 2022). The TB drug susceptible death rate in 2019 increased to 7.5 in KZN. The number of all DS TB patients in the cohort for KZN in 2021 was 27 188. The number of DS TB patients that were cured or completed their treatment in 2021 were 31 184. Whilst there seemed to be an increase in the TB DS death rate between 2019 (7.5) to 2022 (8.1) (Ndlovu N, 2023).

MATERNAL, NEW-BORN AND CHILD HEALTH

The table below provides an overview of maternal and child health in the province over the past three years. The impact of COVID-19 can be seen on the maternal mortality ratio which increased in the 2020/2021 year but seemed to improve slightly thereafter in the 2021/2022 year in the province. The neonatal death rate is increasing and was the highest in the 2021/2022 year. The same pattern can be seen for the perinatal death rate (Ndlovu N, 2023).

Table 7: Maternal and Child Health Indicators for KZN

Indictor	Period	Sex / Age / Series / Category	SA	KZN
Early neonatal death in facility rate	2019/20	Both sexes, DHIS	9.6	8.7
	2020/21	Both sexes, DHIS	9.7	9.4
	2021/22	Both sexes, DHIS	10.0	9.8
Maternal mortality in facility ratio	2019/20	Female, DHIS	88.0	76.9
	2020/21	Female, DHIS	120.9	123.9
	2021/22	Female, DHIS	119.1	100.6
Neonatal death in facility rate	2019/20	Both sexes, DHIS	11.9	10.9
	2020/21	Both sexes, DHIS	12.6	12.1
	2021/22	Both sexes, DHIS	13.1	13.0
Neonatal mortality rate (deaths, 28 days old per 1 000 live births)	2018	Both sexes, WHO	11.0	
		Both sexes, Rapid Mortality Survey (RMS)	11.0	
	2019	Both sexes, WHO	11.0	
		Both sexes, Global Burden of Disease	20.7	

Indictor	Period	Sex / Age / Series / Category	SA	KZN
	2020	Both sexes, WHO	11.0	
		Both sexes, RMS	12.0	
Perinatal death in facility rate	2019/20	Both sexes, DHIS	29.1	29.7
	2020/21	Both sexes, DHIS	29.8	32.7
	2021/22	Both sexes, DHIS	30.8	32.3
Perinatal mortality rate (stillbirths plus deaths, 8 days old per 1 000 total births)	2018/19	Both sexes, DHIS	30.1	30.8
	2019/20	Both sexes, DHIS	25.0	24.5
	2021/22	Both sexes, DHIS	27.2	27.3
Stillbirth in facility rate	2019/20	Both sexes, DHIS	19.7	21.2
	2020/21	Both sexes, DHIS	19.9	23.6
	2021/22	Both sexes, DHIS	21.0	22.8

Source: N. Ndlovu, 2023

COVID-19

According to the South African coronavirus website, in South Africa, the cumulative number of COVID-19 cases as of the 3rd of April 2023 was 4 055 656 and there were 102 595 deaths due to COVID-19 (Ndlovu N, 2023). In KZN, the cumulative number of COVID-19 cases as of the 25th of March 2023 was recorded as 730 176, which was 17.9% of the total cases in the country (National Institute for Communicable Disease) (NICD, 2023). The cumulative incidence risk cases per 100 000 persons was 6 328.3 (NICD, 2023).

NON-COMMUNICABLE DISEASES (NCDs)

NCDs are not a notifiable medical condition (NMC), hence a paucity of data on NCDs remain (Ndlovu N, 2023). An increase in the prevalence of hypertension among South African adults living with HIV was seen between 2005 and 2017. In KZN, the prevalence of hypertension was recorded at 27.8% in 2017. Diabetes Miletus is also on the rise (Ndlovu N, 2023). In 2020, the diabetes prevalence for the province increased to 13.2% from 12.6% in 2019 (Govender K, 2022). During the pandemic, it became apparent that diabetes was a strong risk factor for adverse COVID-19 outcomes; therefore, persons with diabetes were more likely to be hospitalized or die as a result of COVID-19 infections than those who did not suffer from the disease (Ndlovu N, 2023). It has been estimated that South Africa has a total of 4.2 million people living with diabetes in 2021 (Ndlovu N, 2023). Prostate, breast, cervical, lung and colorectal cancers are becoming increasingly prevalent in the country (Ndlovu N, 2023).

VIOLENCE AND INJURY

In a StatsSA report published in 2021, KwaZulu-Natal was found to have had the highest proportion of deaths due to non-natural causes (13.5%). Non-natural deaths consisted of mainly: accidental injury, assault and road traffic injuries (StatsSA, 2021).

Table 8: Indicators for injuries in KZN

Indicator	Period	Sex / Age / Series / Category	SA	KZN
Road Accident fatalities	2020	Both sexes, all ages, Road Traffic Management Centre (RTMC)	9 969	2 013
Road accident fatalities per 100 000 population	2018	Both sexes, all ages, RTMC	22.3	22
		Both sexes, all ages, RTMC	21.3	20.5

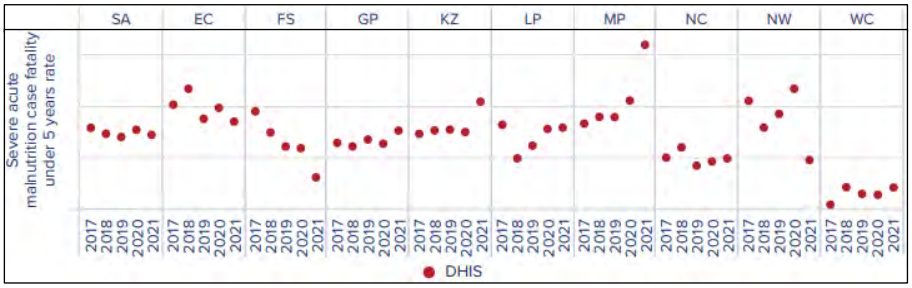
Source: StatsSA, 2021

MORBIDITY PROFILE FOR KZN

NUTRITION

Nutrition is a good indication of the impact of programs and policies being implemented and the state of public health. It also provides an overview of the socio-economic status of a country or a place since poor nutrition could indicate the presence of socio-economic factors such as food insecurity due to poverty (Grosso, 2020).

Figure 3: The case fatality rate for severe acute malnutrition (SAM) in under five-year olds over a five-year period in KZN



Source: N. Ndlovu, 2023

The above figure shows that the case fatality rate for SAM in under five-year is decreasing in South Africa however, in KZN we saw a steep increase in the rate in 2021 (Ndlovu N, 2023).

Table 9: Nutrition indicators for KwaZulu-Natal

Indicator	Period	Sex / Age / Series / Category	SA	KZN
Infant exclusively breastfed at DTaP-IPV-HiB-HBV	2019/20	Both sexes, DHIS	48.8	56.5
	2020/21	Both sexes, DHIS	45.9	56.7
	2021/22	Both sexes, DHIS	44.4	56.3
Overweight	2020	Both sexes, under 5 years, WHO	12.9	
Stunting	2020	Both sexes, WHO	23.2	
Vitamin A does 12 – 59 months	2019/20	Both sexes, DHIS	5 302 353	1 455 5096
	2020/21	Both sexes, DHIS	3 898 515	898 699
	2021/22	Both sexes, DHIS	4 428 184	1 030 246
Vitamin A dose 12 – 59 months coverage	2019/20	Both sexes, DHIS	56.6	68.2
	2020/21	Both sexes, DHIS	49.5	60.6
	2021/22	Both sexes, DHIS	60.3	78.2

Source: N. Ndlovu, 2023

The above table shows a slight decrease in breastfeeding practices in KZN during 2021/2022 and this was due to the fears of transmission of COVID-19. Vitamin A coverage, which is vital to infant development, decreased during 2020/2021 but seemed to recover in the subsequent year, 2021/2022. The drop in coverage was due to the national lockdown during the COVID-19 pandemic period where accesses to non-essential services were limited (Ndlovu N, 2023).

Leading Causes of death by age

In KwaZulu-Natal (KZN), natural causes contributed to most deaths across all ages and gender. The two most leading causes of death (LCD) among the newborns and perinatal period for both males and females were due to Respiratory and cardiovascular disorders (16.1% for both males and females) followed by disorders related to length of gestation and fetal growth which were 10.4% and 9.5% for males and females respectively.

Among the 1-14 years (yrs.) age group, the LCD were influenza and pneumonia for both males (6.2%) and females (7.3%) but more so females. Tuberculosis (TB) was the second LCD among males at 4.2% though it was the third LCD at 4.6% among females. For females the second LCD was related to intestinal infections (6.7%).

Among the 14-44 yrs. age group TB and Human Immunodeficiency Virus (HIV) were the two LCDs. Males died mostly due to TB (12.6%) followed by HIV (11.6%) whereas females mostly died due to HIV (16.3%) followed by TB (13.6). According to various studies conducted in KZN, HIV has shown to be more prevalent among this age group [1, 2].

Among the 45-64 yr. age group, TB was the most LCD among males (10.2%) whilst among females it was diabetes mellitus (12.2%). Other forms of heart diseases were the second most LCD among both males (7.5%) and females (7.3%).

Other forms of heart disease and diabetes mellitus were the most LCD among males who were 65yr old and above at 9.5% and 9.4% respectively. Among females the two most LCD were diabetes mellitus (12.9%) and cerebrovascular diseases (12.7%).

Table 10: Leading causes of death among the under 1 age group

	Males	Females
Respiratory and cardiovascular disorders specific to the perinatal period (P20-P29)	16.1%	16.1%
Disorders related to length of gestation and foetal growth (P05-P08)	10.4%	9.5%
Infectious specific	7.4%	4.1%
Influenza and Pneumonia	6.5%	8.5%
Intestinal infections	5.6%	7.2%
Other congenital malformations	2.4%	3.2%
Malnutrition	2.2%	2.7%

	Males	Females
Haemorrhagic and haematological disorders	2.2%	0%
Other natural	30.7%	32%
Non-natural	3.4%	4%
Foetus and Newborn affected by maternal factors	0%	5.7%

Source: Mortality and causes of death in South Africa: Findings from death notification (2017)

Table 11: Leading causes of death among 1 – 14 years age group

	Males	Females
Influenza and pneumonia (J09-J18)	6.2%	7.3%
Tuberculosis (A15-A19)	4.2%	4.6%
Intestinal infectious diseases (A00-A09)	4.2%	6.7%
Other forms of heart disease (I30-I52)	3.7%	3.8%
Human immunodeficiency virus [HIV] disease (B20-B24)	3.4%	2.9%
Cerebral palsy and other paralytic syndromes (G80-G83)	3.3%	3.3%
Malnutrition (E40-E46)	2.2%	2.4%
Episodic and paroxysmal disorders (G40-G47)	1.8%	1.3%
Other viral diseases (B25-B34)	1.5%	1.8%
Other bacterial diseases (A30-A49)	1.5%	0%
Other Natural	31.5%	37.9%
Non-natural	36.6%	26.3%

Source: Mortality and causes of death in South Africa: Findings from death notification (2017)

Table 12: Leading causes of death among 15 – 44 years age group

	Males	Females
Tuberculosis (A15-A19)	12.6%	13.6%
Human immunodeficiency virus [HIV] disease (B20-B24)	11.6%	16.3%
Other viral diseases (B25-B34)	4.2%	7.4%
Other forms of heart disease (I30-I52)	3.4%	3.9%
Influenza and pneumonia (J09-J18)	2.6%	3.2%
Certain disorders involving the immune mechanism (D80-D89)	1.7%	3%
Cerebrovascular diseases (I60-I69)	1.2%	1.8%
Episodic and paroxysmal disorders (G40-G47)	1.2%	0%
Intestinal infectious diseases (A00-A09)	1.1%	1.6%
Renal failure (N17-N19)	1.1%	1.6%
Other Natural	21.9%	32.2%
Non-natural	37.4%	12%
Malignant neoplasms of female genital organs (C51-C58)	0%	3.5%

Source: Mortality and causes of death in South Africa: Findings from death notification (2017)

Table 13: Leading causes of death among 45– 64 years age group

LCD	Males	Females
Tuberculosis (A15-A19)	10.2%	6.4%
Other forms of heart disease (I30-I52)	7.5%	7.3%
Human immunodeficiency virus [HIV] disease (B20-B24)	7.3%	6.6%
Diabetes mellitus (E10-E14)	6.4%	12.2%
Cerebrovascular diseases (I60-I69)	5.3%	6.7%
Ischaemic heart diseases (I20-I25)	3.9%	0%
Chronic lower respiratory diseases (J40-J47)	3.5%	0%
Malignant neoplasms of digestive organs (C15-C26)	3.1%	5.1%
Influenza and pneumonia (J09-J18)	3.1%	0%
Hypertensive diseases (I10-I15)	3.1%	4.6%
Other Natural	36.7%	37.8%
Non-natural	9.9%	4.6%
Malignant neoplasms of female genital organs (C51-C58)	0%	5.1%
Other viral diseases (B25-B34)	0%	3.1%
Renal failure (N17-N19)	0%	2.9%

Source: Mortality and causes of death in South Africa: Findings from death notification (2017)

Table 14: Leading causes of death among 65 years + age group

	Males	Females
Other forms of heart disease (I30-I52)	9.5%	10.1%
Diabetes mellitus (E10-E14)	9.4%	12.9%
Cerebrovascular diseases (I60-I69)	8.1%	12.7%
Hypertensive diseases (I10-I15)	6.1%	9.1%
Ischaemic heart diseases (I20-I25)	5.9%	4.2%
Chronic lower respiratory diseases (J40-J47)	4.6%	1.8%
Tuberculosis (A15-A19)	4.1%	0%
Malignant neoplasms of digestive organs (C15-C26)	3.5%	2.2%
Malignant neoplasms of male genital organs (C60-C63)	3.5%	2%
Influenza and pneumonia (J09-J18)	3.3%	3.3%
Other Natural	38.1%	36.7%
Non-natural	4%	2.6%
Renal failure (N17-N19)	0%	2.4%

Source: Mortality and causes of death in South Africa: Findings from death notification (2017)

Leading Causes of Death by Districts

Overall, the eThekwini and uMgungundlovu districts contributed to most deaths in the Province. Conditions origination in the perinatal period contributed to most deaths in KZN, followed by infections

and parasitic diseases. There were 4 926 and 2 067 deaths due to conditions origination in the perinatal period at eThekwini and uMgungundlovu respectively. Deaths due to infections and parasitic diseases were mostly from eThekwini (3 246) and uMgungundlovu (1 798).

Table 15: Leading causes of death categories for KZN Districts 2017

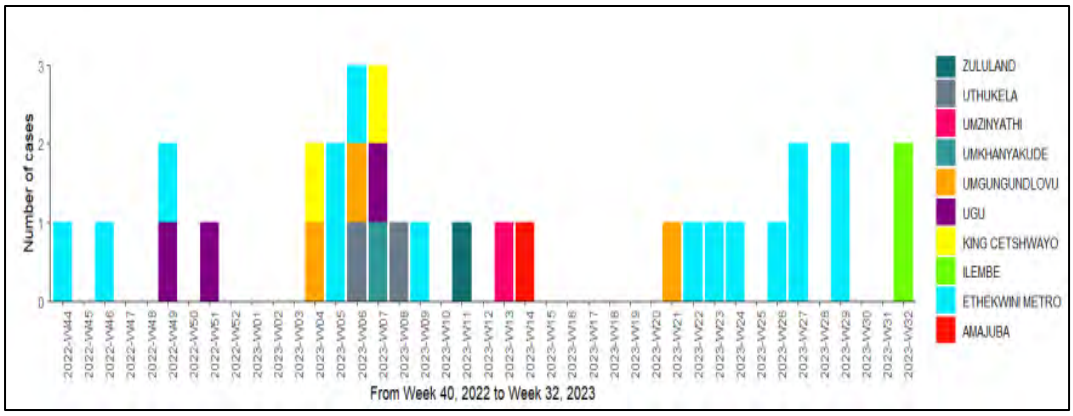
District	Certain infectious and parasitic diseases (A00-B99)*	Neoplasms (C00-D48)	Diseases of the blood and immune mechanism (D50-D89)	Endocrine nutritional and metabolic diseases (E00-E90)	Diseases of the nervous system (G00-G99)	Diseases of the circulatory system (I00-I99)	Diseases of the respiratory system (J00-J99)	Diseases of the digestive system (K00-K93)	Certain conditions originating in the perinatal period (P00-P96)	other natural causes	External causes of morbidity and mortality (V01-Y98)	Total
Amajuba	820	330	49	308	10	91	0	1	860	409	134	4 104
eThekwini	3 246	1 972	262	1 553	65	339	0	3	4 926	1 227	558	19 910
iLembe	898	310	75	311	11	87	0	0	748	311	100	3 955
Harry Gwala	857	235	85	317	8	92	1	0	652	403	92	3 862
KCD	1 496	604	148	558	22	120	3	0	1 112	369	200	7 049
Ugu	1 770	626	148	705	46	170	1	0	1 491	607	210	8 418
uMgungundlovu	1 798	1 101	141	1 026	58	234	2	3	2 067	724	330	9 966
uMkhanyakude	825	266	39	155	27	53	0	0	496	168	78	3 195
uMzinyathi	1 081	288	121	361	19	102	1	0	1 227	398	107	5 049
uThukela	1 442	329	121	434	20	149	0	1	1 273	491	202	5 877
Unspecified	275	109	27	112	6	32	0	0	288	112	33	1 390
Zululand	1 179	287	162	351	15	102	0	1	814	378	115	5 220
Total	15 687	6 457	1 378	6 191	307	1 571	8	9	15 954	5 597	2 159	77 995

EMERGING DISEASE BURDEN IN KZN

MEASLES

In the third quarter of 2022/2023 (October 2022), there was a national outbreak of measles since there were three or more laboratory classified measles cases reported within 30 days of onset of the disease (Ndlovu N, 2023). Besides the Eastern Cape, all provinces had experienced a measles outbreak (Ndlovu N, 2023). According to the NICD, there were 39 laboratory confirmed cases of measles between Week 40 of 2022 to week 36 of 2023 in KZN (NICD, 2023). A higher number of measles cases were detected in eThekwini, whilst two cases were reported in iLembe in week 32 (NICD, 2023). Overall, KZN had 15 reported cases of measles for 2022/2023 (Ndlovu N, 2023).

Figure 4: Number of confirmed cases of measles in Districts between the epidemiological week 40, 2022 and week 32, 2023.



Source: NICD, 2023

MUMPS

The NICD reports indicate that there seems to be outbreak of mumps in the country due to the increase in the number of reported cases testing positive for mumps and the majority of the cases were found in the KZN province in the period ending in March 2023 (NICD, 2023).

CHOLERA

The National Department of Health has noted a significant decline in the number of cholera cases in the country as of July 2023. Most cases were reported in Gauteng (NICD, 2023).

OTHER HEALTH CONDITIONS

DISABILITY

Persons with disabilities were also impacted by COVID-19 and were also at greater risk of poorer outcomes (Ndlovu N, 2023). It has been found that people with disabilities are more likely to be older, female, poorer, and to have additional comorbidities than their able peers (Ndlovu N, 2023).

STAKEHOLDERS OF THE KWAZULU-NATAL DEPARTMENT OF HEALTH

Apart from the uninsured population that features as the main stakeholder of the KZN Department of Health (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 16: 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
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	

Customer and Stake holder	Influence	Interest	Linkages with other stakeholders	Consultation Mechanism
Other National and Provincial departments	High	High	Key players in legislative and regulatory environment	• Tele - & video conferencing & Skype for business • Various inter – Governmental Forums • Provincial Consultative Health Forum • Provincial Health Council (PHC) meetings
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 Accounts	High	High	Approval of policy documents and plans	
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".

OPERATIONAL VULA

In an effort to align to the Provincial Growth and Development Strategy (PGDS) the Department of health will continue to prioritise the support offered to vulnerable groups. The vulnerable groups include women, youth, people with disabilities and military veterans. Targeted procurement initiatives in line with the provincial Operation Vula principles will continue to be implemented within the identified sectors to ensure that emerging contractors are supported. In particular, the department will strive to ensure that the local emerging producers are targeted for the sourcing of food items for patient catering. The department has developed targets for procurement spent on businesses owned by Persons living with disability, Youth, Women and Military Veterans for the 23/24 financial year and this practice will be sustained as part of the Annual Operational Plan for the 24/25 financial year.

GENDER BASED VIOLENCE AND FEMICIDE (GBVF)

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 8 Thuthuzela Trauma Centres (TTC's) with a 9th at Othobothini CHC opened during 23/24. Thuthuzela Care Centres (TCC's) are a joint initiative between the Department of Health and the National Prosecuting Authority and are managed under the hospitals and the department ensures that Clinical 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 withstand rigorous cross-examination 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 workload in casualty, are able to collect samples correctly and are qualified to testify in court. In 2021, the competencies for the post basic Diploma in Forensic Nursing were approved by South African Nursing Council (SANC). Before nurses are recruited for this training nurse tutors have to be trained and qualified and certified to offer this training at a tertiary level. Once nurses obtain this post basic course it will enhance their credibility to testify in court. The Department is in the process of identifying the most suitable and accredited service providers to provide the training.

Post violence care for victims includes HIV prophylaxis, pregnancy prophylaxis, prophylaxis for other sexually transmitted infections and the provision of comfort packs. Advocacy campaigns are conducted in conjunction with various Non-Government Organisations (NGO's) with the aim of

improving timeous reporting by victims so that they present within the mandatory 72 hours to qualify for forensic evidence collection and prophylaxis as above.

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.

There are 8 TCC's in KZN, with more required due to the number of forensic cases being seen. Forensic Medicine staff in these centres are limited. National Department of Health (NDoH) have approved the standardised training for the Forensic Nursing post graduate course to commence in 2024/25. Discussions are ongoing to confirm the service provider. It is envisaged that this will allow the GB88 form to be correctly completed and result in a higher number of cases attaining a conviction.

Forty percent (40%) of all GBVF cases, are in children under 12 years, during 2023/24 a tool was launched in Youth Zone's to allow health professionals to do an assessment for abuse cases with a mental health tool being launched in 2024/25. In alignment with this, Forensic Medicine education is being provided to youth, included in the GBVF education provided, to create awareness within the communities.

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.

INTERNAL ENVIRONMENT ANALYSIS

Service Delivery Platform / Public Health Facilities

COMMUNITY-BASED SERVICES

Non-acute health services are provided at community and household level through Ward Based Outreach teams (WBOTs), School Health Teams, TB Surveillance and Multi Drug Resistant Tuberculosis (MDR-TB) Teams and Community Care Givers/Health Workers (CCGs /CHWs). Services include health promotion/ education; screening for health conditions; appropriate referral to health facilities; follow-up and support of patients on treatment; home-based care; school health services including implementation of health promoting schools; the management of MDR-TB patients at household level; mental health and chronic care.

Phila Mntwana Centres, linked to Operation Sukuma Sakhe (OSS) War Rooms, provide promotive and preventive health services targeting children. OSS is used as vehicle for inter-government service integration at community level including addressing the social determinants of health e.g., poverty eradication, provision of sanitation, water, electricity and waste removal.

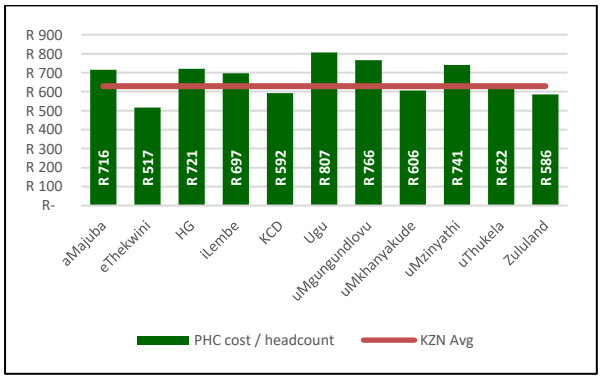
The Centralised Chronic Medication Dispensing and Distribution (CCMDD) Programme makes chronic medication available to patients at community level, close to where they reside. This decongests facilities, saves cost and travelling times to facilities and decreases waiting times at health facilities.

Services at truck stops, taxi ranks, and other high-risk areas increase access to basic and essential services e.g., testing for HIV, TB and other chronic conditions. Services offered at these easily accessible sites increases the possibility of timeous referral for appropriate clinical management of conditions at fixed facilities.

PRIMARY HEALTH CARE (PHC) SERVICES

Nurse driven services are provided at fixed (clinics and Community Health Centres (CHCs)) and mobile clinics covering a comprehensive range of curative, preventative, rehabilitative and palliative services. Included are services for minor ailments; maternal, child and women's health; communicable and non-communicable diseases and conditions; oral and dental health; environmental health and nutrition. Mobile services are used to improve access in sparsely populated areas or areas with poor access to fixed facilities. Outreach services from District Hospitals and services rendered by Private Practitioners increases access to clinical services at entry point.

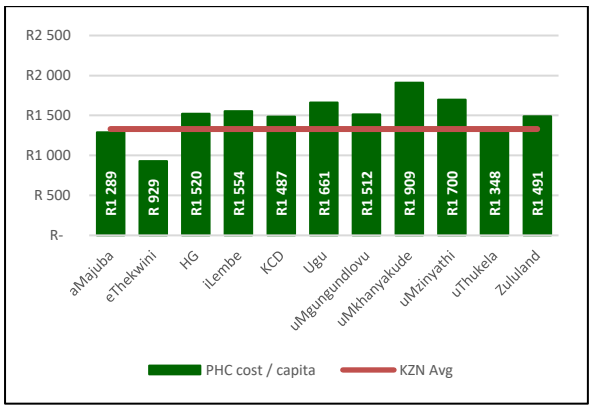
Graph 5: Cost per PHC headcount – district comparision for 2022/23



Source: webDHIS (2024.01.10)

The provincial average for the PHC cost per headcount for 2022/23 was R 629, with 6 districts being above the provincial target. Ugu and uMgungundlovu had the highest cost per headcount at R 807 and R 766 respectively. This has historically been the case, due to the way PHC services are structured within these districts. eThekwini, with its high headcount and greatest number of facilities, continues to be the most cost effective at R 517 per PHC headcount.

Graph 6: Cost per Capita – District comparison for 2022/23



Source: webDHIS (2024.01.10)

The average for KZN for Cost per Capita for PHC services is R 1 330, with 8 districts being above the average. eThekwini's very low PHC cost per capita at R 929, brings down the provincial average significantly. uMkhanyakude and uMzinyathi had the highest PHC cost per headcount at R 1 909 and R 1 700 respectively, but this is too be expected when the terrain and remoteness of the clinics within these districts is reviewed.

HOSPITAL SERVICES

In and out-patient services are rendered at District, Regional, Specialised, Tertiary and Central Hospitals. District Hospitals form part of the District Health System and include services at General Practitioner level with varying degrees of General Specialist services to improve access in especially rural areas.

Regional Hospitals render services at General Specialist level and serve as referral for District Hospitals. All Regional Hospitals render a significant proportion of level-one services mainly due to demographic distribution of households and location of hospitals. Queen Nandi and Newcastle Hospitals provide mother and child services. McCord's Hospital is the Provincial Eye Care Hospital.

Specialised TB and Psychiatric hospitals provide acute and sub-acute services for the two clinical disciplines.

The Step Down/ Sub-Acute Hospitals provide step-down care. Clairwood Hospital was repurposed to a COVID-19 Hospital with Hillcrest Hospital remaining as a step-down hospital.

Tertiary Hospitals and one Central Hospital provide highly specialised tertiary and quaternary services.

Outreach services are provided by level 2 and 3 hospitals to improve access to quality clinical management at lower levels of care. District hospitals provide outreach services to PHC clinics.

Emergency Medical Services (EMS) and Patient Transport Services (PTS)

Services include emergency response, special operations, communication, aeromedical services, and patient transport services. Aeromedical services are provided by the use of all available aeromedical services in KZN, namely Air Mercy Services, Netcare and Black Eagle. These are dispatched as and when required.

FORENSIC PATHOLOGY SERVICES

Specialised Forensic Pathology Services are provided at Medico-Legal Mortuaries throughout the Province.

CLINICAL FORENSIC MEDICINE

Crisis Centres have been established in all District and Regional Hospitals within the Province to strengthen clinical medico-legal services focusing on the management of survivors of violence (including rape and sexual assault).

Table 17: Health facilities per District as at 31st March 2023

	PHC			Hospitals							
District	Mobiles	Fixed Clinics	CHCs	District	Regional	Tertiary	Central	Special-ised TB	Special-ised	Special-ised Psych	Chronic
Ugu	16	52	2	3	1	0	0	0	0	0	0
uMgungundlovu	15	50	3	2	1	1	0	2	0	3	0
uThukela	14	36	1	2	1	0	0	0	0	0	0
uMzinyathi	13	53	1	4	0	0	0	1	0	0	0
Amajuba	8	24	1	1	2	0	0	0	0	0	0
Zululand	23	74	1	5	0	0	0	1	0	1	0
uMkhanyakude	20	58	1	5	0	0	0	0	0	0	0
King Cetshwayo	16	63	1	6	1	1	0	0	0	0	0
iLembe	11	34	2	3	1	0	0	0	0	0	0
Harry Gwala	15	37	2	4	0	0	0	0	0	1	0
eThekwini	22	105	8	4	5	1	1	0	1	1	2
KZN Total	173	586	23	39	13	3	1	4	1	6	2

Source: DHIS Quarter 4 of 2022/23

Referral Pathway / System: Levels of Health Care

Level 1

Primary Health Care (PHC) Clinic: A PHC Clinic is the first step in the provision of health care and offers services such as immunization, family planning, anti-natal care, and treatment of common diseases,

treatment and management of TB, HIV / AIDS counselling amongst other services. If the clinic cannot assist, they will refer the patient to a Community Health Centre.

Community Health Care Centre (CHC): A CHC is the second step in the provision of health care but can also be used for first contact care. A CHC offers similar services to a PHC Clinic with the addition of a 24 hour maternity service, emergency care and casualty and a short stay ward. The CHC will refer a patient to a district hospital, when necessary.

District Hospital: This is the third step in the provision of health care. These hospitals will normally receive referral from and provide generalist support to CHC's and PHC clinics such as diagnostic, treatment, care, counselling, and rehabilitation services. Clinical services include Surgery, Obstetrics & Gynecology, Out-Patients Department, Medicine, Peadiatrics, Mental health, Geriatrics, Casualty and Clinical Forensic Medical Services amongst other services. These hospitals receive referrals from the CHC and PHC clinics. Most care delivered by doctors and primary health care nurses. If the district hospital cannot help a patient, they will be referred to the local regional hospital for treatment.

Level 2

Regional Hospital: This is the second level of health care. These hospitals will normally receive referrals from and provide specialist support to several district hospitals. If the regional hospital cannot help, they will refer to the provincial tertiary hospital.

Level 3

Provincial Tertiary hospital: These hospitals will receive referral from and provide sub-specialist support to several regional hospitals and is the third level of health care. These hospitals are staffed by specialists and generalists and offer services such as neurosurgery, neurology, plastic and reconstructive surgery, cardiology, urology, peadiatric surgery, maxillo-facial surgery, psychiatry, occupational health, and orthopaedics amongst other services. If a provincial tertiary hospital cannot help, they will refer to a national central hospital.

Level 4

Central Hospital: The fourth and highest level of health care. These hospitals will consist of very highly specialised referral units which together provide an environment for multi-specialty clinical services, innovation, and research. People are referred to these hospitals by provincial tertiary hospitals.

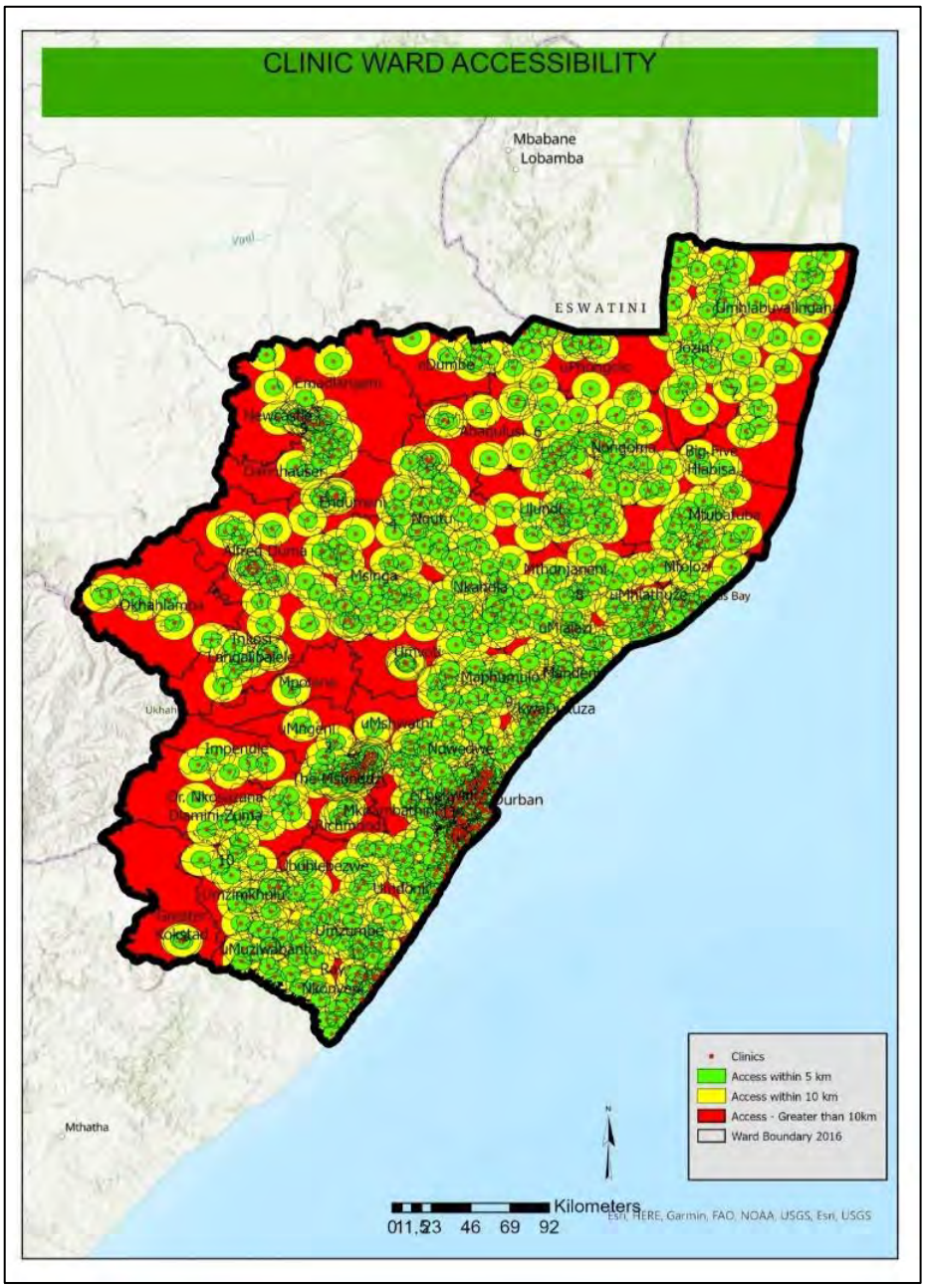
Specialised Hospital: These hospitals will provide care only for certain specialised groups of patients. They will include chronic, psychiatric and TB hospitals, as well as specialised spinal injury and acute infectious disease hospitals.

SERVICE DELIVERY CHALLENGES

Due to the poor road infrastructure, geographical terrain, and distances within KZN, the prospect of EMS services attaining 100% for responding within 30 minutes for urban areas, and 60 minutes for rural areas, is greatly reduced.

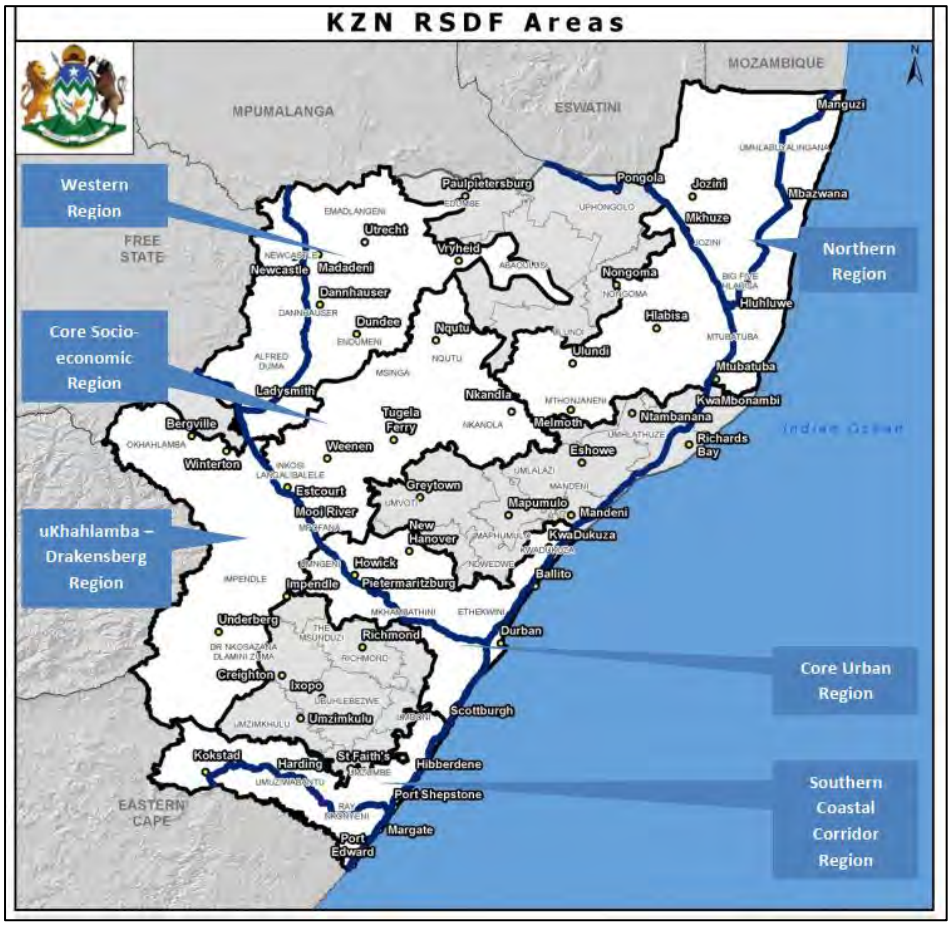
The following map details areas within the Province, with no PHC coverage. Caution should be used when exploring this map as there are two United Nations Education, Scientific and Cultural Organisation Heritage, namely the Maloti – uKhahlamba (Drakensberg) Park and the iSimangaliso Wetland Park in uMkhayakude.

Map 3: Map showing accessibility of PHC services



Source: KZN Geographical Information Systems (GIS)

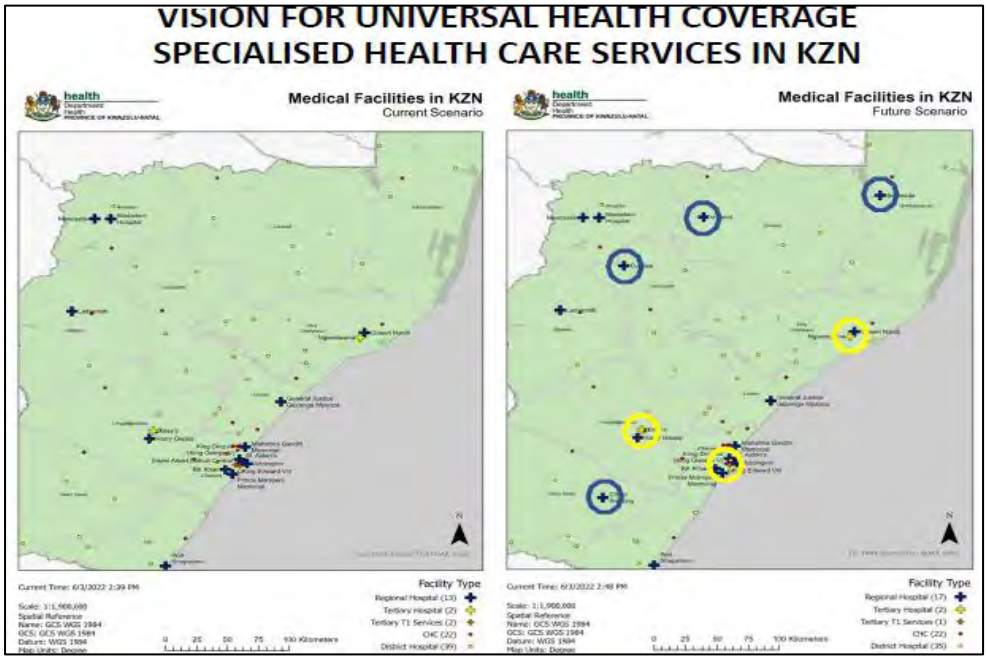
Map 4: KZN Regional Spatial Development Framework Areas



Source: KZN Spatial Development Framework

SERVICE COVERAGE GAPS

Map 5: Vision for Specialised health care in KZN



Source: KZN Department of Health, GIS

SPATIAL INTEGRATION AND REFERENCING OF THE SPATIAL DEVELOPMENT FRAMEWORK

The Regionalised Spatial Development Framework outlines the towns in KZN that have been identified for further development as part of the regionalization of KZN to be more economically inclusive. In this regard, Dundee, Vryheid, Christ the King (Ixopo) and Bethesda district hospitals have been identified as part of the vision to expand specialized health care services.

In the 5th June 2020 Budget Speech, the Department committed to a new tertiary hospital in the far north, and the regionalization of 4 identified district hospitals. This will assist in reducing the long travel times / distances that rural communities endure to access specialized health services. It will also reduce the high cost of inter-facility transportation of patients. The office of the Project Management Officer was established on 6th April 2022, to accelerate these projects, with a Steering Committee established on 11th October 2022 to oversee the projects.

SERVICE DELIVERY IMPROVEMENT PLAN

The Department did not have a Service Delivery Improvement Plan that covered the 2022/23 financial year, as per the Department of Public Service and Administration's (DPSA) directive on updates to the institutional arrangement. The 23/24 -24/25 SDIP is available.

OUTCOME: UNIVERSAL HEALTH COVERAGE

The Universal Health Coverage (UHC) service index is low at 59%, compared to the five year target of 73.3%, and this is due to targets in the tracer indicators not being met.

MEDICO-LEGAL

The Departmental Medico Legal Strategy is based on 5 pillars and captured in a strategic document:

1. Prevention
2. Redress, (includes providing rehab services within the doh as required for those who have suffered adverse events during their care in the DOH)
3. Mediation, (includes offering rehab within the DOH)
4. Engagements (internal and external)
5. Rehab, care and treatment

As part of ongoing efforts to reduce the medico-legal bill, the Department equipped and staffed three identified centres of excellence that will attend to the healthcare needs of children who are born with Cerebral Palsy and other ailments. These centres are at the Queen Nandi Hospital supported

by the Ngwelezana Hospital, Greys Hospital supported by the Pietermaritzburg Assessment and Therapy Centre, King Edward VIII Hospital supported by the KZN Children's Hospital and the Phoenix Assessment and Therapy Centre. Public Health defense is being pursued and will be tested in court in the near future; test cases were postponed during this financial year. The main objective of public health is to provide all future medical care at public health facilities and introduce periodic payment for non-medical claims. Post and equipment for these centres are exempted from cost containment measures introduced as result of budget cuts.

The Department has appointed district and facility safety committee in line with the National Guideline to strengthen clinical governance and thus a preventive measure.

Roadshows were conducted in 2023 – 2024 financial year by the legal unit.

FINANCIAL MANAGEMENT

The training on "Accruals" and "Payables Not Recognised" that was conducted in August and September 2022 and the District Financial Roadshows conducted in March 2023 resulted in the improvement in the processing of payments.

HUMAN RESOURCE MANAGEMENT

There were increases in the Professional Nurses per 100 000 and Medical Officers per 100 000 which is attributed to employment of additional nurses for COVID-19 purposes and allocation of additional Community Service Practitioners and Medical Interns.

The number of bursaries awarded to first year nursing students and internal employees increased from 520 in 2021/22 to 622 in 2022/23. The change from a 4-year to 3-year programme and the redirection of funds from the Republic of South Africa - Cuban Medical Programme, because of the reduced intake, allowed for the increase. Improvement of linen services is one of the outputs that the department is focusing on in the current strategic plan period.

EMERGENCY MEDICAL SERVICES

EMS has noted an increase for the demand of services however there are no service expansion plans in place to deal with the increased demand. The average emergency medical services response for both urban and rural areas has been decreasing from 51.7% in 2020/21 to 45.1% in 2022/23. The factors leading to the decline include insufficient base infrastructure, limited operational ambulances, inadequate staff complement especially intermediate and advanced life support paramedics, and increased demand for inter-facility transfers. The increase in downtime of ambulances due to aging fleet with increased costs places additional pressure on resources. EMS training is also proving a challenge with a delay in the introduction of higher education institutions aligned for training of EMS. The appointment of EMS operational contact staff has had minimal impact, as it is not new staff being

added into the system. The process for building suitable wash bays is in the final stages of consultations and should be able to commence in the 2024/25 cycle. The procurement of critical medical equipment including ventilators which was previously not available to EMS has been an achievement.

PHARMACY

Tracer medicine stock-out rate remained below 5% for both Provincial Pharmaceutical Supply Depot (PPSD) and facilities during 2022/23. The Demand Planning Review Forum is functional and allows for the facilitation of forecasts for inputting into contracts and in-Contract Forecasting Review. The number of PHC clinics that are supplied directly by PPSD increased from 585 (Q1 22/23) to 723 (Q1 23/24).

Challenges facing the programme include the lack of inadequate physical infrastructure and lack of vital equipment leading to non-compliance of the PPSD with legislation. The current PPSD Warehouse Management System (WMS) is outdated and not suitable for supporting current business processes. Furthermore, not all facilities (especially Primary Health Care clinics) are using electronic stock management system (e.g., Rx Solution). Dispensing remains mainly manual.

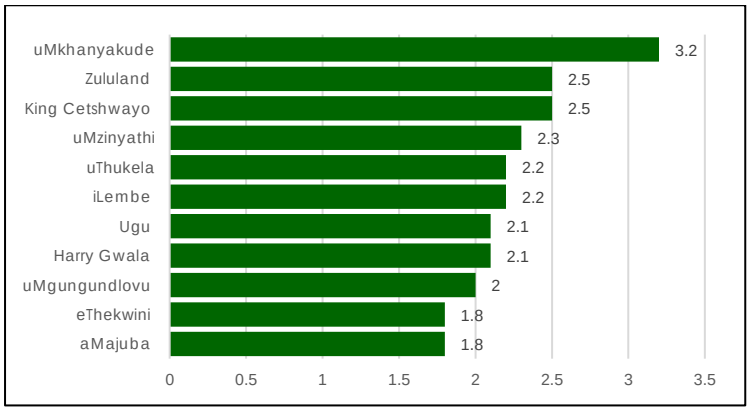
PRIMARY HEALTH CARE

The non-compliance to the non-negotiable vital elements in certain sub-domains resulted in the 28.2% actual performance on the percentage of facilities certified by the Office of Health Standards Compliance (OHSC). The percentages of PHC facilities with functional clinic committees decreased from the baselines due to expired membership and is at 22.7% for the 2022/23 reporting cycle.

The implementation of the quality improvement plans yielded positive results in terms of Ideal clinic status obtained. Adherence to Patient Safety Incidence (PSI) Guidelines through monitoring, and feedback engagements with service delivery components resulted to the target for 2022/23 being exceeded by 45%.

Positive results were achieved through the implementation of the full package of services post pandemic; complimented by Districts conducting community screening activities and referring clients to clinics for investigations. These strategies resulted in an improved PHC utilization rate. Inflation on goods and services and energy costs that outperformed inflation, resulted to a higher than planned cost per headcount, even though it was still lower than the baseline.

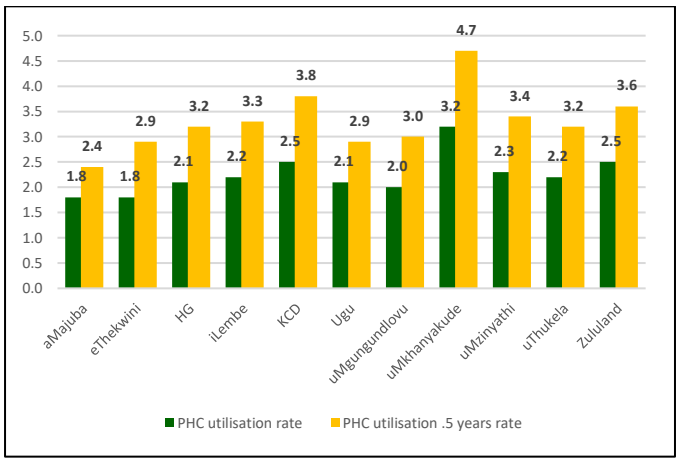
Graph 7: PHC Utilisation rate 2022/23 – per district



Source: webDHIS

As per previous years, uMkhanyakude continues to display a strong PHC utilization rate at 3.2 visits per person per year, compared with Amajuba which was 1.8 per annum. Both these districts are rural in nature, with different dynamics. The population density in uMkhanyakude is less than Amajuba at 53.84 km^2 (690 193 / 12 821 km^2) and 84.5 km^2 (583 415 / 6 911 km^2) respectively. However, the average population per clinic in uMkhanyakude is lower than Amajuba at 11 899 catchment population per clinic (690 193 / 58 clinics) compared to 24 309 catchment population per clinic (583 415 / 24). Both contribute to the community's ability to access health services.

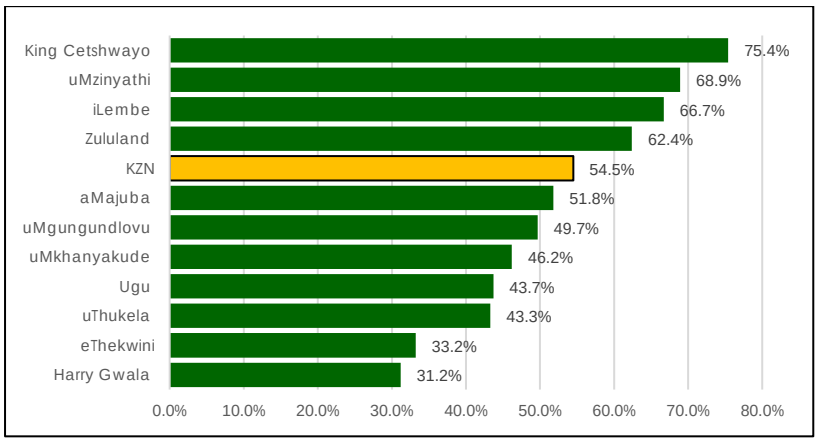
Graph 8: PHC Utilisation rates (including under 5 years) per District – 2022.23



Source: webDHIS (2024/01/10)

uMkhanyakude has the highest PHC utilisation rate at 3.2 and PHC utilization 5 years rate of 4.7. This is due in part to a functional PHC system within the District. Accessibility to hospitals is more difficult due to poor location of health facilities to communities, the poor road infrastructure, and the social determinants of health. Amajuba historically has always had the lowest performance with regards to PHC utilisation, at 1.8 for PHC utilisation and 2.4 for PHC utilisation under 5 years.

Graph 9: Out Patient Department (OPD) New Client Not Referred Rate for District Hospitals 2022/23 – per district



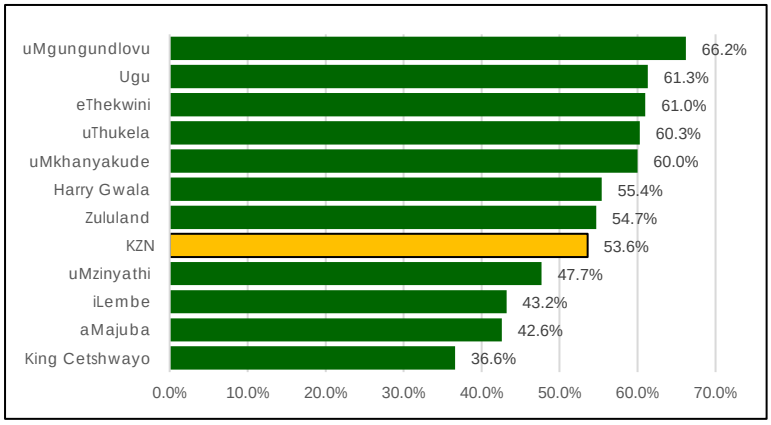
Source: webDHIS

In the districts that have a high OPD New Client not referred rate, the common challenge is the lack of Gateway Clinics to "catch" PHC patients accessing services at a hospital level. The implementation of Gateway clinics has proved successful in other districts i.e., eThekwini and uThukela.

DISTRICT HOSPITALS

Improved clinical management of patients, resumption of the district hospital integrated package of services and increased patient activity resulted to achievement of average length of stay, bed utilisation rate and expenditure per Patient Day Equivalent targets for 2022/23. The non-achievement of the Out-Patient Department (OPD) headcount new cases not referred is attributed to the absence of a gateway clinic at some hospitals.

Graph 10: Bed Utilisation Rate for District Hospitals 2022/23 – per district



Source: webDHIS

The Bed Utilisation Rate (BUR) across the districts differs depending on the different scenarios within the district. uMgungundlovu only has 2 district hospitals, with Northdale Hospital continually having a high BUR. Whereas, King Cetshwayo District (KCD) has 6 District hospitals with 5 being missionary hospitals that the Department has taken over, so location in relation to the communities is compromised, thus impacting on utilization rates. Strategic location, accessibility and community perceptions all play a major role in how the community access district hospital services.

Table 18: District Hospital Effeciencies per District for the period 2018/19 to 2022/23

Year	Indicator	Amajuba	eThekwini	Harry Gwala	iLembe	KCD	uMgungundlovu	Ugu	uMkhanyakude	uMzinyathi	uThukela	Zululand
18/19	*Average length of stay - total*	*4.3 Days*	*5.5 Days*	*4.7 Days*	*5.5 Days*	*6.0 Days*	*5.9 Days*	*5.3 Days*	*5.5 Days*	*5.8 Days*	*5.5 Days*	*5.3 Days*
	OPD headcount - sum	*24 034*	*421 676*	*97 765*	*69 471*	*296 344*	*204 334*	*223 698*	*257 981*	*200 166*	*92 508*	*225 431*
	OPD new client not referred rate	*64.6%*	*52.6%*	*49.4%*	*59.2%*	*77.2%*	*30.1%*	*44.2%*	*48.4%*	*67.8%*	*31.2%*	*53.9%*
	Inpatient crude death rate	*8.0%*	*4.5%*	*4.6%*	*5.7%*	*5.0%*	*4.9%*	*5.8%*	*4.6%*	*5.4%*	*5.0%*	*5.1%*
	Patient Day Equivalent	*21 442*	*355 889*	*203 640*	*91 456*	*309 551*	*257 857*	*278 698*	*333 932*	*300 780*	*150 651*	*353 974*
19/20	Average length of stay - total	4.9 Days	5.4 Days	4.5 Days	5.5 Days	5.9 Days	6.2 Days	5.4 Days	5.6 Days	5.9 Days	5.1 Days	5.2 Days
	OPD headcount - sum	23 629	433 017	105 492	65 716	298 492	189 729	226 561	255 069	199 507	102 069	243 838
	OPD new client not referred rate	56.6%	48.2%	53.8%	65.0%	78.0%	27.7%	43.2%	49.6%	67.9%	31.8%	50.7%
	Inpatient crude death rate	6.6%	4.1%	4.3%	5.3%	4.8%	4.7%	5.6%	4.7%	5.5%	5.2%	5.1%
	Patient Day Equivalent	21 904	362 437	214 175	88 971	308 628	253 641	280 023	330 813	296 969	141 810	360 477
20/21	*Average length of stay - total*	*6.5 Days*	*4.7 Days*	*4.6 Days*	*5.0 Days*	*5.2 Days*	*5.1 Days*	*5.1 Days*	*5.2 Days*	*5.2 Days*	*5.0 Days*	*4.5 Days*
	OPD headcount - sum	*7 934*	*289 263*	*85 063*	*43 084*	*228 391*	*142 797*	*173 317*	*195 634*	*153 118*	*90 214*	*212 631*
	OPD new client not referred rate	*58.0%*	*45.4%*	*46.0%*	*69.1%*	*81.2%*	*41.7%*	*46.3%*	*45.0%*	*69.3%*	*42.1%*	*57.5%*
	Inpatient crude death rate	*9.4%*	*5.6%*	*6.3%*	*6.2%*	*6.2%*	*4.8%*	*7.4%*	*5.2%*	*5.5%*	*5.2%*	*5.6%*
	Patient Day Equivalent	*3 202*	*267 770*	*168 385*	*68 569*	*244 284*	*188 828*	*228 875*	*281 818*	*231 916*	*125 966*	*298 904*
21/22	Average length of stay - total	8.6 Days	4.8 Days	5.1 Days	5.2 Days	5.2 Days	5.4 Days	5.0 Days	5.2 Days	5.5 Days	5.6 Days	4.4 Days
	OPD headcount - sum	10 001	373 634	98 294	53 155	273 730	167 382	198 741	223 536	162 333	96 594	205 537

Year	Indicator	Amajuba	eThekwini	Harry Gwala	iLembe	KCD	uMgungundlovu	Ugu	uMkhanyakude	uMzinyathi	uThukela	Zululand
	OPD new client not referred rate	56.7%	44.0%	42.5%	65.9%	85.5%	41.8%	43.0%	46.7%	70.4%	50.0%	60.7%
	Inpatient crude death rate	13.1%	4.8%	5.3%	4.7%	5.5%	4.5%	5.9%	4.6%	4.9%	4.5%	4.8%
	Patient Day Equivalent	5 979	317 094	185 564	74 908	262 075	212 413	255 009	295 958	242 033	138 332	301 865
22/23	*Average length of stay - total*	*4.9 Days*	*4.7 Days*	*5.1 Days*	*5.2 Days*	*5.0 Days*	*5.3 Days*	*5.0 Days*	*5.2 Days*	*5.4 Days*	*5.9 Days*	*4.4 Days*
	OPD headcount - sum	*14 016*	*353 311*	*88 379*	*62 840*	*265 377*	*174 937*	*215 800*	*242 195*	*192 187*	*103 981*	*259 831*
	OPD new client not referred rate	*51.8%*	*37.6%*	*31.2%*	*66.7%*	*75.4%*	*49.7%*	*43.7%*	*46.2%*	*68.9%*	*43.3%*	*62.4%*
	Inpatient crude death rate	*8.2%*	*4.3%*	*4.5%*	*4.8%*	*4.5%*	*4.2%*	*4.8%*	*4.4%*	*4.6%*	*4.4%*	*4.3%*
	Patient Day Equivalent	*13 300*	*319 152*	*184 457*	*85 409*	*267 990*	*215 700*	*268 940*	*333 779*	*276 099*	*148 474*	*341 488*

REGIONAL HOSPITALS

Regional hospitals in KwaZulu-Natal generally provide a combination of District Health Services and Specialised services. This allows for better access to services, especially in eThekwini where there are no district hospitals in the south of the metropolitan where R.K. Khan renders a combination of services. In 2023, Clairwood Chronic Hospital has been designated a district level hospital to allow for better access to district hospital services in the south of eThekwini.

Newcastle Hospital, and Queen Nandi Hospital are both designated Mother and Child Hospitals, which is reflected in Queen Nandi's high caesarian section rate. Ugu has traditionally always had a higher caesarian section rate. In 2022 /23 St Aiden's was complexed with King Edward VIII Hospital to improve their efficiencies.

Prince Mshiyeni Memorial Hospital, R.K. Khan Hospital and Addington Hospital all have high OPD headcounts, over the previous 3 years, reflecting the burden placed on hospitals that have better accessibility.

Table 19: Regional Hospital Effeciency Indicator Trend Analysis

Hospital Name	20/21			21/22			22/23		
	Average Length of Stay	Caesarean section rate	OPD headcount - sum	Average Length of Stay	Caesarean section rate	OPD headcount - sum	Average Length of Stay	Caesarean section rate	OPD headcount - sum
Addington Hospital	6.3 Days	44.5%	216 830	6.4 Days	44.3%	230 077	6.6 Days	44.6%	232 822
General Justice Gizenga Mpanza Hospital	5.0 Days	45.4%	121 763	5.1 Days	43.0%	173 101	5.1 Days	45.8%	181 598
Harry Gwala Hospital	7.3 Days	45.4%	199 352	7.7 Days	47.1%	202 198	7.6 Days	44.4%	180 745
King Dinuzulu Hospital	9.6 Days	35.4%	100 737	10.2 Days	33.4%	112 962	10.8 Days	36.9%%	115 948
Ladysmith Hospital	6.7 Days	30.3%	53 920	6.4 Days	32.6%	93 495	6.2 Days	32.5%	112 975
Madadeni Hospital	9.8 Days	-	135 755	10.4 Days	-	145 046	10.6 Days	-	141 304
Mahatma Gandhi Hospital	5.3 Days	40.4%	101 632	5.5 Days	40.2%	116 967	5.6 Days	39.9%	131 349
Newcastle Hospital	3.7 Days	32.3%	67 290	3.7 Days	35.2%	76 270	3.9 Days	35.4%	97 125
Port Shepstone Hospital	4.8 Days	54.6%	104 314	5.3 Days	56.0%	113 519	5.5 Days	52.4%	119 619
Prince Mshiyeni Memorial Hospital	6.7 Days	43.2%	321 136	7.4 Days	43.6%	341 714	7.3 Days	45.1%	311 083
Queen Nandi Regional Hospital	4.6 Days	58.9%	58 266	4.5 Days	62.6%	63 388	4.5 Days	63.8%	71 399
RK Khan Hospital	5.0 Days	38.9%	181 341	5.3 Days	40.6%	325 472	5.7 Days	45.6%	209 110
St Aidan's Hospital	1.7 Days	-	11 180	2.1 Days	-	15 656	2.2 Days	-	9 612

Source: webDHIS

TERTIARY AND CENTRAL HOSPITALS

Ngwelezana Hospital is a developing tertiary hospital situated in the third most populous region of the Province, with no access to district level hospital services. Therefore, Ngwelezana Hospital offers District, Regional and a few Tertiary services. It is the referral hospital for the northern part of KZN (Zululand, uMkhanyakude and KCD) and has a higher crude death rate, and slightly longer average length of stays. Maternity cases are referred to Queen Nandi Hospital, Eshowe.

Table 20: Tertiary and Central Hospital Effeciency Trends

Year	Indicator	Grey's Hospital	Inkosi Albert Luthuli Central Hospital	King Edward VIII Hospital	Ngwelezana Hospital
20/21	Average Length of Stay	9.5 Days	10.5 Days	5.9 Days	8.6 Days
	Caesarean Section Rate	74.6%	76%	50.9%	Not applicable
	Crude Death Rate	6.5%	5.6%	4.9%	12.6%
	OPD Headcount - Total	81 348	137 783	98 224	84 792
21/22	*Average Length of Stay*	*9.1 Days*	*10.2 Days*	*5.6 Days*	*7.6 Days*
	Caesarean Section Rate	*78.5%*	*79.7%*	*52.1%*	*Not applicable*
	Crude Death Rate	*5.2%*	*3.8%*	*4.5%*	*8.4%*
	OPD Headcount - Total	*104 209*	*169 989*	*157 696*	*101 708*
22/23	Average Length of Stay	9.2 Days	10.2 Days	5.6 Days	7.8 Days
	Caesarean Section Rate	75.3%	78.9%	50.7%	Not applicable
	Crude Death Rate	4.7%	3.9%	3.8%	8.4%
	OPD Headcount - Total	105 447	178 602	160 080	128 789

Source: webDHIS

OUTCOME: REDUCED MORBIDITY AND MORTALITY

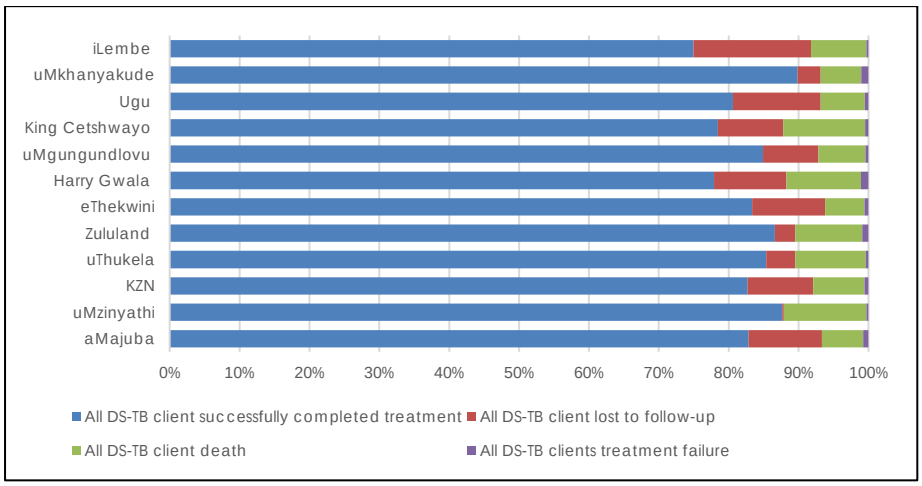
HIV / AIDS, TUBERCULOSIS AND SEXUALLY TRANSMITTED DISEASES (HAST)

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 death rate is highest amongst the HIV/TB co-infected patients who are virally unsuppressed. The high loss to follow up (9.1%) which is fueled by duplicates, unevaluated patient outcomes and to some extent the death rate (7.6%) have all impacted on the TB client success rate negatively.

Late presentation, TB and HIV co-infection with other co-morbidity and the high loss to follow up rates remain the leading causes of the high death rate. The target for 2022/23 for the All DS-TB client treatment success rate was not achieved despite the improvement against the baseline.

Graph 11: Proportion of TB cohort outcomes 2021/22 – per district

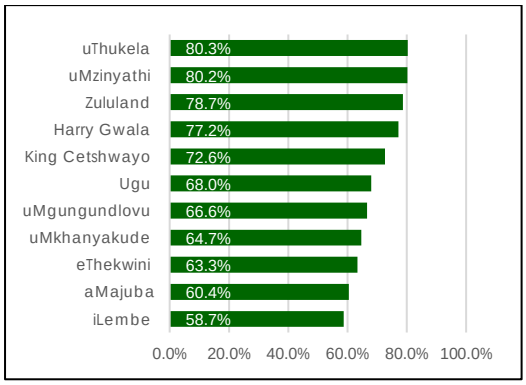


Source: DHIS

The initiation of a high number of clients on Tenofovir disoproxil, lamivudine and dolutegravir (TLD) transition played an important part in the achievement of viral load suppression in adults. The HIV positive 15-24 year olds (excluding antenatal care (ANC)) rate decreased due to various strategies implemented namely 1) the implementation of prevention programmes like Pre-Exposure Prophylaxis (PrEP), 2) mass media education, 3) increased community mobilisation aimed at reducing HIV and TB infections and 4) increasing positive sexual behaviour by individuals.

Steady improvement is noted year-on-year with a nett gain on Total Patients remaining on Anti-retro Viral Therapy (ART) (TROA). Total nett gain remains below in certain age categories which result in disproportionate gain. Loss to follow up contributes mainly to failure to achieve TROA targets as it remains at 29% at 12 months. Positivity yield among clients tested, 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.

Graph 12: ART Adult remain in care at 12 months rate 2022/23 – Per District



Source: DHIS

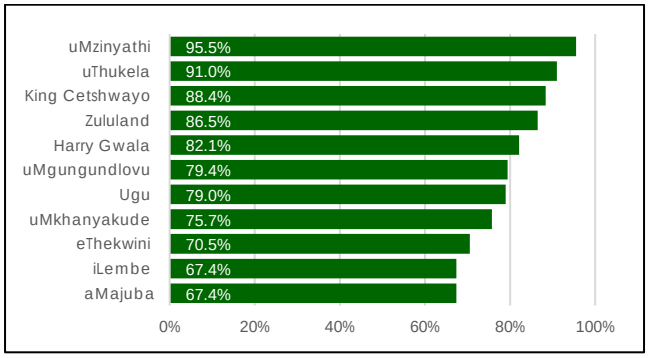
There has been significant improvement in the adult viral suppression rate, especially among women which is consistently above 90%. The viral suppression rate for men remains below target. Efforts are in

place to target men across the treatment cascades in the form of Isibaya Samadoda/iKhosomba lamajita/ men's friendly services.

Tenofovir Disoproxil, Lamivudine, Dolutegravir (TLD) an ART drug used in 1st treatment regime (which combines different types of drugs into one capsule), transition has registered benefits in terms of suppression goals.

"Loss to follow up" mainly contributes to failure on achieving the target in eThekwini, iLembe and uMkhanyakude Districts being above 30% for "loss to follow up". Fifteen (15%) of loss to follow up is because of file and patient duplicates.

Graph 13: ART Child remain in care at 12 months rate 2022/23 – Per District



Source: DHIS

The Province is still experiencing inconsistencies in the standard of care for children and adolescent with HIV within facilities and the community. This has resulted in a testing and treatment gap within the paediatric and adolescent sub-populations. Provincially, the current performance is at 80-65-71 in terms of performance against 90-90-90 in children under 15 years.

Graph 14: 95-95-95 Cascade – Total population as at September 2023

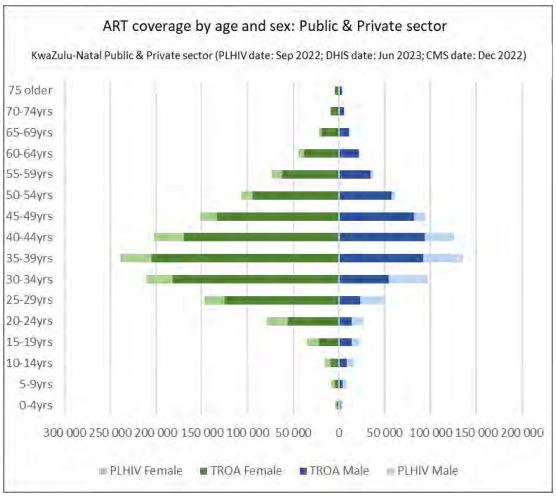
Source: HAST Unit – December 2023

As of September 2023, KwaZulu-Natal is at 97-86-80 in terms of performance against the 95-95-95 targets across its total population using data available in the public & private sector. Data available from the private sector suggest that a total of 95 549 clients receive ART through private medical aid schemes in KwaZulu-Natal. For adult females and adult males this number is 62 793 and 31 862 respectively.

Results for each of the sub-populations vary, with adult females being at 97-91-81, adult males at 96-79-81, and Children (<15) at 87-63-52. There are gaps across the cascade for adults & children. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions in this sub-population.

To achieve 95-95-95 targets, KwaZulu-Natal must increase the number of clients on ART with 132 790. For adult females the required increase is 18 580, whereas an increase of 94 375 ART adult males is required.

Graph 15: ART coverage by age and sex: Public and Private sector as at June 2023



Source: HAST Unit – December 2023

As of June 2023 KwaZulu-Natal is at 84% ART coverage of the total People living with HIV population using data from both the private and public sectors. Results vary between male and female populations. Among all females ART coverage is at 88%, while the data shows an ART coverage of 75% for all males. For females, ART coverage among adults (>15 years) is at 89% and 57% for female children (<15 years). For males, ART coverage among adults (>15 years) is at 76% and 52% for male children (<15).

MATERNAL, NEONATAL, CHILD & WOMEN'S HEALTH & NUTRITION

The reduction in the number of maternal deaths from COVID-19 has been noted as the pandemic subsided as noted in the 2021/22 FY report. Implementation of COVID 19 vaccination for pregnant women might have some added role in this reduction coupled with upgraded management

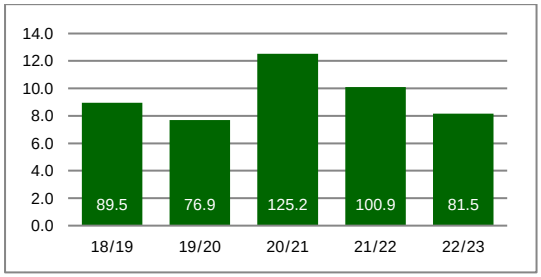
protocols in facilities. High rates of infections in pregnancy, in particular syphilis contribute significantly to high stillbirth rates and neonatal morbidity and mortality. There is an increasing prevalence of syphilis in pregnancy. Evaluation of minimum standards of safe Caesarean Section continues to produce positive results. Onsite Midwife-led Birth Units (OMBUs) were established at Newcastle and Prince Mshiyeni Memorial Hospitals with the aim to reduce overcrowding in the main labour wards and improve quality care. Establishment of monthly virtual Obstetric and Gynea outreach educational scenario discussions for midwives and doctors at CHCs and district hospitals on common conditions that contribute to maternal morbidity and mortality, including Hypertensive Disorders of Pregnancy (HDP) in order to improve management.

Reducing and sustaining decline in maternal mortality:

- Recommendations from Saving Mothers Report (2017-19) must be implemented and strengthened.
- Improve contraceptive use/strengthen family planning services. Integration with DSD, DOE and supporting NGOs to reduce and prevent teenage pregnancy.
- Improve quality antenatal care through strengthening sub district mentoring and coaching.
- Reduce overcrowding in busy regional and district hospitals by establishing OMBUs where there is available space, however challenges with human resource needs to be addressed urgently.
- Implementation of the new policy on management of syphilis in pregnancy at antenatal clinics; minimum standards for labour wards and reviewed intrapartum partogram for women in labour as according to new MCR, and roll-out upgraded management of post-partum haemorrhage (E-MOTIVE strategy)
- Strategies already in place like minimum standards of safe caesarean section, ESMOE needs to continue and closely monitored.
- Strengthen and monitor post-natal care.

Neonatal death in facility rate decreased due to increased coverage of key interventions such as Kangaroo Mother Care (KMC); therapeutic hypothermia; surfactant therapy; ventilation and continuous positive airways pressure (CPAP) support. The implementation of strategies to monitor ANC early booking, initiation of HIV positive and breastfeeding women, and to reduce high viral load resulted to positive performance in infant Polymerase Chain Reaction (PCR) test positive around 10 weeks.

Graph 16: Maternal Mortality in facility ratio – 5 year trend

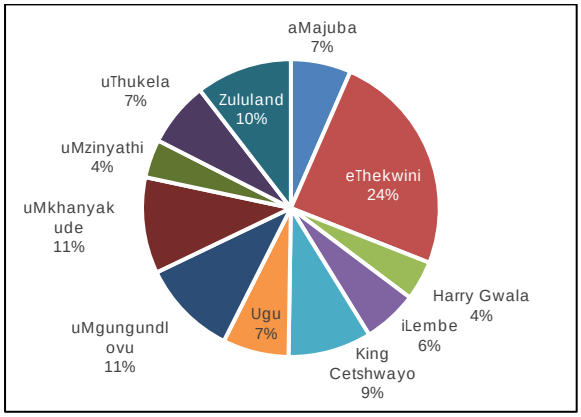


Source: DHIS

There has been a reduction in the number of maternal deaths from COVID-19 following the end of the pandemic; upgraded management protocols which include implementation of the COVID-19 vaccination programme for pregnant women. The evaluation of minimum standards has also yielded results.

To address the challenges over the next 5 years the Department will focus on improving family planning, reducing teenage pregnancies and continue the roll-out of the OMBU's at identified hospitals.

Graph 17: Number of deliveries 10 to 14 years in facility 2022/23 – Per District



Source: DHIS

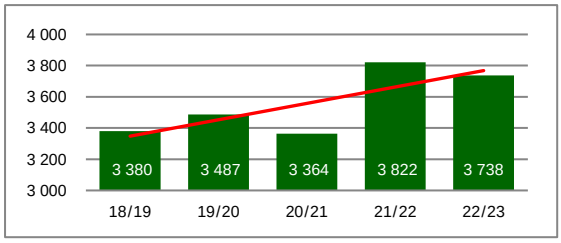
Multiple factors contributed to high teenage pregnancy including societal issues which are difficult to address. Low or poor attendance of antenatal care services by the teenagers and low contraceptives use amongst youth is also a challenge.

The number of inpatient deaths under 5 years decreased due to the reduction in neonatal deaths, the implementation of Essential packages of care and reporting for neonates and Peadiatrics, strengthening of primary health care programmes and increasing access to paediatric respiratory support. Increased coverage and uptake of pneumococcal vaccines reduced pneumonia cases. Implementation of catch-up drives, ongoing routine services, and data monitoring for action, resulted to the achievement of the immunisation under 1 year coverage. Vitamin A issued

routinely at community level coupled with inclusion of Vitamin A for the measles campaign contributed significantly to the improvement of the Vitamin A dose 12-59 month coverage.

Contributing factors include a history of poor infant and young child feeding practices, social ills, co-morbid conditions such as TB and HIV and delayed diagnosis of co-morbid conditions.

Graph 18: Number of Inpatient deaths under 5 years – 5 year trend



Source: DHIS

The majority of the under 5 deaths occurs in the Neonatal category (0 – 28 days) and this drives up the under 5 death rate. There is a correlation between neonatal death and maternal health, and therefore there is a high number of deaths at regional hospitals and District Hospitals compared to Tertiary and Central Hospital level. The number of deaths between 1 and 5 years has dropped significantly over the previous 10 years. Strengthening of health systems through the implementation of the Essential Packages of neonatal and paediatric care (EPOC) and promotion of neonatal interventions including early breastfeeding initiation, kangaroo mother care, surfactant therapy and respiratory support, have yielded results. Strengthening of primary health care programmes has also had a positive impact at hospital level. The current roll out of paediatric respiratory support to all hospitals is noted.

To reduce child mortality over the next 5 years, the following interventions will be implemented:

1. Current national accreditation programs like OHSC and Ideal Hospital are mainly generic and do not provide specific standards for the care of neonates and children. Therefore, implementation of the Essential Packages of Care (EPOC) for neonatal, paediatric and child health developed and rolled out in KZN need to be strengthened and integrated with other provincial M&E programs

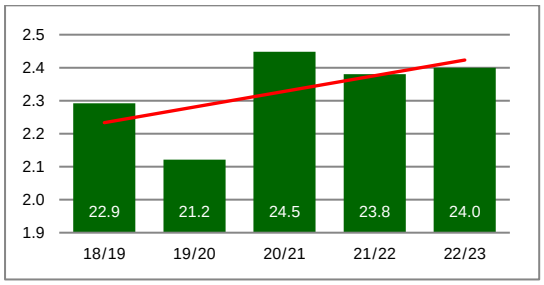
2. 80% of U1 and 70% of U5 facility deaths occur in the neonatal period. Therefore, reducing U1 and U5 deaths is primarily dependent on reducing neonatal deaths.

3. Reducing neonatal deaths is primarily dependent on reducing the number of pregnancies (increasing contraceptive cover) and improving antenatal and intrapartum care, and then strengthening the quality and coverage of neonatal interventions.

4. Reducing non neonatal deaths over the next 5 years will focus primarily on:

I. Strengthening the child health focus of community care giver (CCG) home visits
II. Roll out of the home safety checklist to try and reduce trauma related deaths
III. Strengthening the implementation of triage systems and use of the triage tool
IV. Strengthening the implementation of the standardised paediatric/child health record keeping system (including E-health)
V. Implementation of paediatric palliative care through the development and training of a multidisciplinary palliative care team at every hospital
VI. Strengthening the implementation of the Nurturing care framework and partnering with and empowering parents in the care of their children

Graph 19: Still birth in facility rate – 5 year trend



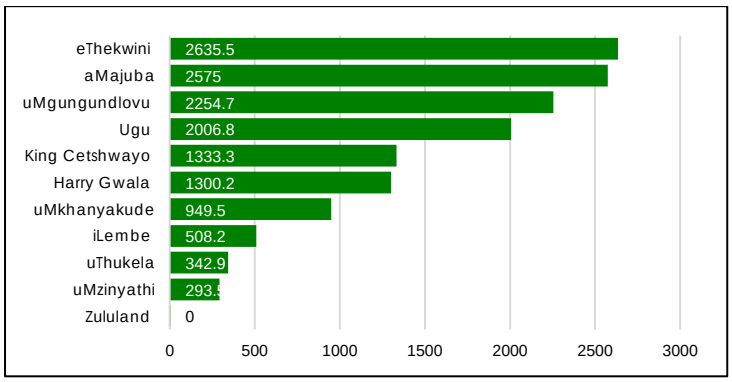
Source: DHIS

The Province has not succeeded in dropping still birth rate to below 20 / 1 000 due to various factors. Continuous infections during pregnancy 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 are not adequately screened in ANC clinics thus resulting in poor management and subsequently affect foetal wellbeing. Prompt treatment of positive syphilis test is mandatory to reduce foetal infections and other negative outcomes. Uncontrolled hypertensive disorders during pregnancy and unexplained intrauterine death due to silent, undetected placental dysfunction have also contributed to the negative performance.

DISEASE PREVENTION AND CONTROL

The number of deaths due to COVID-19 has decreased as a result individuals choosing to vaccinate. Most deaths occurred among individuals with co-morbid conditions and the unvaccinated. Intensified focus on screening following the training of clinic staff by Mental Health Coordinators resulted to the achievement of the mental disorders screening rate. A high demand for rehabilitation services was noted from new and existing clients who were seen for review and continuation of rehabilitation services.

Graph 20: Cataract Surgery Rate 2022/23 – per District



Source: DHIS

eThekwini displays the highest number of cataract surgeries per 1 000 population at 2 635.5 / 1 000 due to the location of McCord's specialized eye hospital located in Overport, eThekwini. Over the previous 5 financial years, eThekwini has performance 16 292 cataract surgeries. Zululand does not have either the equipment or the skills to undertake this kind of service at district hospital level and has performed no cataract surgeries over the previous 5 years. uThukela and uMzinyathi, are also struggling with performing cataract surgery operations.

Non-Communicable Diseases

Challenges within the non-communicable diseases, over the next 5 years, will be addressed with the following strategies. Reorientation of health workforce and communities on the prevention and control of NCD: This works on improving the health of the entire population and to provide the opportunity for everyone to have access to health resources whether sick or well. People have to understand pertinent health information in order to take the necessary steps to improve their own health. By knowing what could cause illness, individuals can be proactive in monitoring and supporting their wellness.

Creation of a supportive environment. Fostering an environment that physically and socially assists in health success is the goal. Eliminating harmful practices is also part of creating a supportive space. People living in the same area or those with the same health concerns can bond together to advocate for policy changes and development of new programs. Activities funded or conducted by the government to increase awareness, provide resources to help people take control of their personal health

Oral Health

The Department, in partnership with Wits University, has trained Four (4) Maxillofacial and Oral Surgery Specialist who are currently placed at Tertiary Hospitals to improve the provision of Maxillofacial Services in the Province. A total of forty-Six (46) Community Service Dentists were deployed to institutions across the Province to improve access to oral and dental health in 2023/24.

Collaboration and partnerships with both private sector and NGOs are planned to improve school health outcomes and the Community Dental Outreach Programme. A comprehensive Health promotion and prevention programme is currently being developed to include school-based tooth brushing programme, oral health education and screening, and fissure sealant programme.

Availability of Tertiary Dental Specialised Services (Maxillofacial and Oral Surgery) is limited due to insufficient theatre time, proper diagnosis of specimens by NHLS, the poor compliance to the referral pathway for dental services, and cases that require multidisciplinary clinical management. The funding for the dental laboratory at Inkosi Albert Luthuli Central Hospital (IALCH) is used by the craniofacially specialty clinic.

Mental Health

There is a shortage of mental health beds, that has been addressed by the 10-year infrastructure plan that is in place but been placed on hold due to budget constraints. Outreach services will be provided by the E-psychiatry model that has been developed. There are a few community organisations that Mental Health partner with for advocacy and campaigns.

There is a waiting list for psychological services, which also affects forensic assessments. Not all hospitals have psychologists appointed in their staff establishment dedicated for mental health. Hospital congestion results in high rates of re-admission and a long waiting list with insufficient number of beds at district hospitals for the corresponding population. There are very few community health organisations with 5 out of the 11 districts having NGO support and these have limited inclination for community initiatives.

There has been a strengthening of inclusion of Mental Health into planning processes at PHC level with the PHC Transformation model. There has also been a reduction in the number of forensic assessments for the Department of Justice.

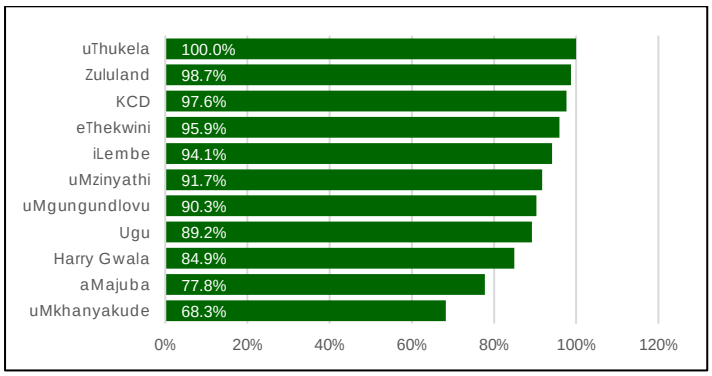
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE

There has been a gradual decrease in the Patient Experience of Care Satisfaction rate from 86.5% in 2020/21 to 84.4% in 2022/23. This is ascribed to limited access to care and negative staff attitudes, among other factors. A 1% decline in the Patient Experience of Care satisfaction rate at PHC level is attributed to negative responses on access to services in particular the referral pathway, and the attitude of staff at Community Health Centres.

Unreliable connectivity is one of the reasons for delayed actual capturing of patient safety incidents, resulting to the underreporting of the Severity assessment code (SAC) 1 incidents . On the other hand,

the percentage of Severity Assessment Code 1 (SAC 1) incidents reported within 24 hours has been steadily increasing between 2020/21 (63.9%) and 2022/23 (74.5%).

Graph 21: SAC 1 Per District for 2022/23



Source: DHIS

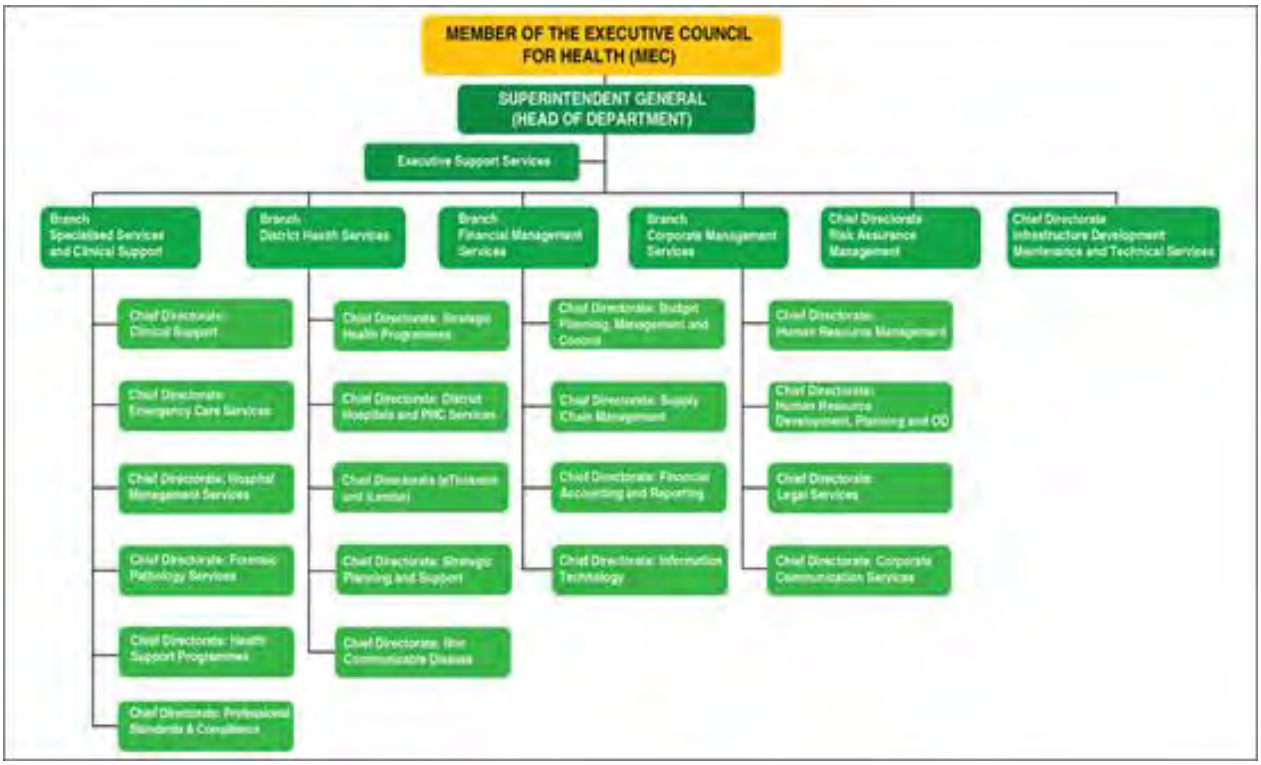
Laundry Services

Backlogs continue to be cleared by optimizing existing limited resources through remunerative overtime. Facilities have an option to outsource to private laundries when in-house capacity is constrained further improving turn-around times. Laundry services has been rationalized through the merger of Regional Laundry Durban / Coastal and the KwaZulu Central Provincial Laundry. There is increased laundry machine capacity at Regional Laundry Services Northern Natal further improving turn-around times in the north of the Province. Facilities have been allocated funding to procure new linen reserve stock.

ORGANISATIONAL STRUCTURE AND ORGANISATIONAL DESIGN

The Figure below is the approved MACRO structure by Department of Public Service Administration (DPSA) / OTP that 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 31st March 2023



Source: Approved Head Office Structure provided by Organisational Efficiency Services on the 16th May 2022

The Macro Organisational Structure was approved in 2017. The reporting lines of the KZN Department of health as at 6 July 2023 is reflected below:

Table 21: Reporting lines of the Department of Health as at 6th July 2023

Cluster/Unit name	Programmes under the unit/cluster
Office of the Head of Department	• Infrastructure ✓ Information Communication and Technology (ICT) ✓ Laundry Services ✓ Health Technology Systems • Executive Support Services • Special Projects and Intergovernmental Relations (IGR) • Security • Risk Assurance Management • Health Service Delivery Planning, Monitoring and Evaluation • Ombudsperson • Central Hospitals
Office of the Chief Financial Officer	• Supply Chain Management • Budget • Tax, Expenditure Management and Voucher Control • Banking and Reporting • Monitoring & Evaluation
Corporate Management Services	• Labour Relations, Organisational Efficiency Services and Employee Health and Wellness

Cluster/Unit name	Programmes under the unit/cluster
	• Human Resource Management Services, Service Conditions, HR Planning Practices, Human Resource Development, College of Emergency Care and KwaZulu-Natal Nursing College • Corporate Communications • Legal Services • Fleet Management Services • Corporate Services
National health insurance, facility accreditation & compliance directorate	• National Health Insurance (NHI) Directorate • Emergency Medical Services (EMS) Licensing & Inspectorate Unit • Private and State Aided Institutions • Quality Assurance • Infection Prevention & Control • Private Licensing
Clinical services	• District Health Service (CHWs/PHC/CCMDD/Health Promotion and School Health) • Hospital Management Services • Paediatric & Child Health –Specialised • Obstetrics and Gynecology – Specialised • Nursing • Traditional Medicine • District Clinical Specialist Teams
Clinical support services	• Clinical Support Services (EMS/Forensic pathology Services (FSP/LAB/Blood/Pharmacy/ • Strategic Programmes (TB/HIV/MCWH/STI inc Nutrition &Food Service, MMC, Advocacy, etc.) • Non-Communicable Diseases (NCDs) (Ortho/Chronic/Oral Health/Disability/Rehab/Mental Health/Substance Abuse • Environmental Health & Communicable Diseases Control (CDC) • Youth, Gender & transformation

Source: KZN DoH Annual Report 2022/23

HUMAN RESOURCES FOR HEALTH

A total number of 2 506 persons working days were lost as a result of strike action resulting from the non-agreement of the general salary adjustments for public servants. As is associated with strike action, service delivery at certain health facilities were compromised. The recoveries as part of the "No work, No pay" principle is being done over 4 months effective from April 2023. The facilitation process to end the strike action was concluded on 14th March 2023, with the Employer and the Labour Unions that were not participating in the negotiations, signing a settlement agreement that sought to end the strike and to have all parties to the PSCBC participate in the 2023/24 wage negotiations.

The senior appointments made in the Department for the 22/23 reporting period were for the posts of Chief Financial Officer, Chief Director: Risk Assurance Services, Director: Strategic Health Programmes, Director: Security Management Services, Director: Employee Health and Wellness, District Directors: uMzinyathi and uThukela District Offices whilst the posts of Chief Director: Human Resource

Management, Director: Labour Relations, Director: Revenue and Debt Management were vacated in the same period.

267 employees demised whilst 49 employees were discharged because of ill-health and 843 employees retired. 57 691 employees made use of their sick leave at an average of 9 days per employee over the reporting period whilst a total of 35 146 days were taken as incapacity leave. (NB. HR Data for deaths are not captured as "COVID"). Disciplinary cases are delayed due to various reasons including but limited to unavailability of witnesses, illnesses of employee or the employee or employer representatives.

The vacancy rate was reduced from 15.40% in 2021/2022 to 11.9% as at 31 March 2023. Further unfunded posts on PERSAL will be identified and a request will be forwarded to the Office of the Premier to abolish these posts on PERSAL.

The Department has appointed 7020 contract staff in various categories to assist with the fight against the COVID-19 pandemic. As at 31 March 2023, 1898 contract staff have been appointed into permanent posts.

The Accounting Officer's key result areas include overseeing the establishment of gender management systems and training such would include all training intervention that incorporate WYDP. Of the 79 SMS members, 75 signed performance agreements with their supervisors and complied by the deadline date, 2 were suspended and 2 non-compliant. In this regard all non-compliant managers were issued with disciplinary letters and furthermore did not qualify for package progressions.

Table 22: Employment and vacancies by programme as on 31 March 2023

Programme	Number of posts on approved establishment [2]	Number of posts filled [3]	Vacancy rate %	Number of employees additional to the establishment [4]
Administration	1 090	970	11	181
Central Hospital Services	6 366	5506	13,5	11
District Health Services	44 045	38786	11,9	5 851
Emergency Medical Services	3 199	2970	7,2	70
Health Care Support Services	616	511	17	3
Health Facilities Management	4	4	0	0
Health Sciences & Training	3 022	2596	14,1	2 303
Provincial Hospital Services	19 408	17295	10,9	18

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

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

[4] 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.

Programme	Number of posts on approved establishment [2]	Number of posts filled [3]	Vacancy rate %	Number of employees additional to the establishment [4]
Total	77 749	68 637	11,7	8 437

Source: Vulindlela HR Oversight Report extracted on 03/05/2023

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 23: Employment and vacancies by salary band as at 31 March 2023

Salary band	Number of posts on approved establishment	Number of posts filled[5]	Vacancy Rate	Number of employees additional to the establishment[6]
Lower Skilled (Levels 1-2)	3 729	3 317	11	14
Skilled (Levels 3-5)	28 592	25 243	11,7	113
Highly Skilled Production (Levels 6-8)	18 515	16 270	12,1	88
Highly Skilled Supervision (Levels 9-12)	17 890	14 815	17,2	7
Senior Management (Levels >= 13)	109	78	28,4	0
Other	1 045	1 045	0	626
Contract (Levels 1-2)	733	733	0	942
Contract (Levels 3-5)	3 308	3 308	0	3 165
Contract (Levels 6-8)	1 636	1 636	0	1 586
Contract (Levels 9-12	2 185	2 185	0	1 830
Contract (Levels >= 13)	7	7	0	1
Total	77 749	68 637	11,7	8 437

Source: Vulindlela HR Oversight Report extracted on 03/05/2023

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 Practioners 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.

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

[6] 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.

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" an examle 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 24: Employment and vacancies by critical occupation as on 31 March 2023

Critical occupation	Number of posts on approved establishment	Number of posts filled	Vacancy Rate	Number of employees additional to the establishment
All Artisans in the Building Metal Machinery Etc.	344	266	22,7	0
Ambulance and Related Workers	3 067	2847	7,2	94
Dental Practitioners	161	149	7,5	41
Dieticians and Nutritionists	259	222	14,3	61
Emergency Services Related	42	40	4,8	0
Engineering Sciences Related	16	15	6,3	14
Engineers and Related Professionals	47	34	27,7	3
Environmental Health	93	82	11,8	7
Head of Department	1	1	0	0
Medical Practitioners	4 759	4 265	10,4	1 497
Medical Research and Related Professionals	121	81	33,1	0
Medical Specialists	1 114	809	27,4	2
Medical Technicians/Technologists	199	171	14,1	0
Occupational Therapy	303	234	22,8	90
Optometrists And Opticians	73	65	11	2
Oral Hygiene	37	28	24,3	1
Pharmacists	1 093	982	10,2	279
Pharmacologists Pathologists & Related Professionals	399	378	5,3	0
Physicists	3	0	100	0
Physiotherapy	391	335	14,3	90
Professional Nurse	21 452	18 671	13	1 123
Psychologists and Vocational Counsellors	138	111	19,6	43
Radiography	768	655	14,7	73
Social Work and Related Professionals	302	270	10,6	7
Speech Therapy and Audiology	281	220	21,7	106
Total	35 463	30 931	12,8	3 533

Source: Vulindlela HR Oversight Report extracted on 03/05/2023

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 25: Total number of employees (including employees with disabilities) in each of the following occupational categories as at 31 March 2023

Occupational category	Male				Female				Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	
Senior Officials and Managers	36	1	7	1	36	2	8	6	97
Professionals	2594	58	845	255	2900	91	1197	330	8270
Technicians and Associate Professionals	4147	46	325	20	18289	427	1746	229	25229
Clerks	2740	38	257	18	4840	104	360	62	8419
Service Shop and Market Sales Workers	3805	32	388	10	14131	89	244	22	18721
Craft And Related Trade Workers	279	15	36	22	15	0	0	0	367
Plant and Machine Operators and Assemblers	454	5	43	1	170	4	7	1	685
Labourers and Related Workers	2253	32	151	16	4259	35	93	10	6849
TOTAL	16308	227	2052	343	44640	752	3655	660	68637
Employees with disabilities	184	3	38	7	164	3	21	10	430

Source: Employment Equity

GENDER MAINSTREAMING WITHIN THE DEPARTMENT OF HEALTH

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 Programmes. The Department has 48.8% of women in Senior Management Services with 707 (30%) female interns employed for 2022/23. 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.

AUDIT OUTCOMES

Leadership in the Department has always endeavored to ensure that approved policies and action plans were developed and implemented to fully address previous findings emanating from audits undertaken on the financial statements, predetermined objectives, and compliance with legislation.

Through these efforts, over the past three (3) financial years, the Department had overturned the following prior year audit qualifications:

1. Commuted overtime
2. Capital commitments
3. Capital work-in-progress
4. Contingent liabilities
5. Accruals and payables not recognised
6. Goods and services
7. Irregular expenditure
8. Asset management

The various initiatives undertaken over the past few financial years has culminated in the Department obtaining an unqualified audit opinion in the 2022/23 financial year. Notwithstanding this, management in the Department has developed and implemented a detailed Audit Improvement Plan and will be intensifying its efforts in maintaining the unqualified audit opinion in the 2023/24 financial year as well as moving towards achieving a clean audit in the outer years

DISASTER MANAGEMENT PLAN

The Disaster Management Plan for the Department has been submitted as a draft for approval. It is on the agenda to be presented at MANCO.

The effects of climate change are accepted, and the Province has seen the increase of adverse weather events. The Department is addressing the effects of climate change in various ways and include the following:

- Flood recovery programme aims to repair buildings that suffered from water damage due to severe storms, notably (but not exclusively) the storms in 2022. The repair work focuses on roof repairs or replacements, rainwater goods (i.e., gutters, downpipes and drains) and stormwater management as well as consequential repair work. To date there is 47 projects of which 19 are in construction, 4 completed projects, 18 are on tender and 6 are in the planning stage
- The Department is improving its maintenance to ensure that the impact of storms is reduced.
- All capital projects are designed to address problems identified.
- Over and the above, the Department is moving to introduce "green building" initiatives on projects which may include, solar energy, rainwater harvesting, permeable paving, greywater water systems as well as orientation of buildings and suitable building materials.

LEKGOTLA PRIORITIES

The Department responds to various Provincial priorities, and these include the Lekgotla priorities. The 23/24 Lekgotla priorities that are also considered in the 24/25 planning include:

- Support of vulnerable groups through targets procurement spend including the Military Veterans.
- Improved implementation of community-based health services, with emphasis on primary health care, without compromising other health care levels.
- Strengthening access to health care services through creation of new regional hospitals in rural districts and a tertiary hospital in the north of the Province.
- Implementing E-Health with a view to improve waiting time, improve medico-legal expenditure, improve quality of patient experience.
- Continue to prepare the health care platform for Universal Health coverage.
- Improving the systems at health, including the ICT system towards better client experience, reduced Medico-legal claims.
- Absorbing the COVID-19 Health Care Workers.
- Working towards a clean audit, while balancing service delivery with resource management.
- Partnering with all relevant stakeholders to increase the life expectancy at birth for all persons of KZN.

UPDATED KEY RISKS & MITIGATION STRATEGIES

Table 26: Key Risks and Mitigation Strategies

Key Risks	Risk Mitigation
Outcome: Universal Health Coverage	
Inefficient utilisation of laboratory tests.	Monitoring the effectiveness of the system following the user training
	Monthly Monitoring of the functioning of Laboratory Committees
	Monitor the functioning of Laboratory Order Entry System and report to IT
Funding provided to state aided institutions. Return on Investment - Possible failure to realise full returns	Engage District Management to identify officials who shall oversee state aided institutions
	Conduct workshop on the policy to all relevant stakeholders
	Conduct regular oversight visits to state aided institutions
	Implement remedial measures whenever areas of non-compliance are identified.
Inadequate resources (filling space and IT)	To request for additional storage space and fireproof for the existing storage space
Lack of capacity within Legal Services Unit	To motivate for the filling of vacant posts
Lack of understanding of protocol for routing of cases (from Institution to Head Office)	To review Circular G52/2008 Litigation Policy on the procedure to be followed when any legal proceedings are instituted on behalf of or against the Department.
Poor management of the Asset Register between Institutions and Head Office	Implement LOGIS system.
	Motivation for the appointment of more staff with more skills in Asset Management.
EMS Response time - Shortage of resources	Mechanical Resources; Update vehicle replacement plan
	Human Resources: Motivate for filling of vacant posts
Inability to provide a professional forensic pathology service in the medico-legal investigation of death for the criminal justice system where the death is due to causes other than natural.	Development of new Institutions`/ Facilities
Inadequate administration and management of Pharmaceutical Stock	Implement Rx Solution Stock Management System at PHC Clinics
	Monitor compliance of Pharmaceuticals and Therapeutics Committees (PTC's)
	Hold monthly demand review meetings
	Request IT to replace MEDSAS with a suitable warehouse management system.
	Train Pharmacy Managers on the effective use of Order tracking tool
	Arrange training for Pharmacy Managers and Depo staff on payments for suppliers
Inadequate staffing of PPSD	To engage HRMS (OES) in the development of a suitable Organisational Structure.

Key Risks	Risk Mitigation
	Motivate for the filling of key posts: Assistant Manager ,Finance Manager, Chief Security Officer, Principal Security Officer X 2, Health and Safety Officer, Occupational Health Nurse Practitioner, Finance & SCM personnel)
Lack of synergy between conventional Health Workers and Traditional Health Practitioners (THP's)	To establish MOU for cross-boundaries and cross-border
Increase in demand of health services	To implement Preventive and promotive programmes
	Integrate Traditional Medicine in Health Promotion Strategy
	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)
Escalating Medico Legal Litigation claims against the Department	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.
	Improve PSI awareness program against an established baseline
	Identify the clinically non-compliant facilities and motivate to Infrastructure component to improve such facilities to be clinically compliant (Prioritise existing facilities rather than building new - Department's IPMP)
	Implement Patients Records Management Plan — roll out best practices in records management.
	Staff training
	Create staff awareness about Patient's Charter at Facility and District levels
Inadequate/ Poor Clinical Governance	Ongoing monitoring of functionality of governance structures.
	Ongoing monitoring of essential basic equipment requirements
Human Resource Management Services. Shortage of staff at all levels Inability to fill vacant posts	Filling of all critical posts (Clinical and non-clinical)within the available funding envelope
	Develop a recruitment plan for the Department
	Motivate for additional funding on COE
	Issue circular on the timeframe for the recruitment process (to be finalised within three months)
	Issue circular on the timeframe for the recruitment process (to be finalised within three months)
Labour Relations: Disciplinary proceedings. Delays in finalisation of disciplinary cases	Follow up with OTP on the rollout of Labour Relations Case Management System.

Key Risks	Risk Mitigation
Outcome: Improved Client Experience of Care	
Insufficient number, categories of nurses allocated to perform nursing duties	Monitor the progress of facilities in absorbing the lower categories of nurses
	Monitoring and evaluation of continuous implementation of staff developmental programmes
Limited infrastructure to accommodate package of services.	Ongoing monitoring of the implementation of facility maintenance plan
	Facilitate the finalisation for approval of plans for Mental Health Care Units
	Ongoing engagements with the Infrastructure Development Unit on the implementation of planned infrastructure upgrade projects.
Outcome: Reduced Morbidity and Mortality	
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

The youth are not always aware of the inherent risk of not taking care of your health and as such, the visitation rate at PHC for screening and uptake of health services, is low. Barriers associated with the risky behaviour include long waiting times, staff attitude, hours of service that are not convenient for the youth. High teenage pregnancy, new HIV infections and STI's are all consequences associated with the lack of uptake of health services by the youth.

People living with disability are often margionalised due to their disability from accessing health services. The lack of ramps, poor infrastructure design, lack of sign language personnel and stigmitisation all contribute to the challenge. The consequences of these challenges it that there is a high defaulter rate and non-adherence to regular treatment.

One of the strategic risks identified is the inability to meet the gender and transformation requirements. This is due to the lack of economic empowerment, and the inability to halt gender based violence, femicide and the prevention of secondary victimisation. The results of this are poor prosecution of perpetrators, loss of evidence, loss of specimens and compromised patient care, especially children under the age of 12 years.

THE PLANNING PROCESS

The PESTLE (Political, Economic, Socio-Demographic, Technological, Legal and Environmental) has been used for external factors, these being opportunities and threats. The SWOT Analysis has been used for internal factors, categorizing them into strengths and weaknesses.

Table 27: Pestle Summary Analysis for external factors

Opportunities	Threats
Political	
The ruling party manifesto of 2017 and the implementation of NHI	Changing political environment within government and community
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.
	Delays in supply of materials (long lead times) and cost increases for infrastructure
	The implication of interference by Business Forums with regards to projects leads to delays and increased costs of the overall project.
Socio-Demographic	
Health Promotion is a priority of the Medium-Term Strategic Framework (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.	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	

Opportunities	Threats
	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	KZN has long distances between health facilities especially up north in uMkhayakude, Zululand and KCD. This impacts on EMS turnaround times and thus health outcomes.
Gains made in access to piped water, and electricity.	
	Changing Environment and priorities, i.e. Changing National & Departmental Policies and Norms.
	Poorly defined relations between the various role players in the public health sphere
	Contractor Default and thus Contract cancellation is a long process and delays construction / rehabilitation projects

Table 28: SWOT Combination Summary Analysis for internal factors

Strengths	Weaknesses
Good political will and leadership	Staff shortage in both critical and non-critical posts
Budget cut and cost constraints impact on services provided	Distribution of resources is skewed towards a hospi-centric approach.
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 targets for 2024/25 be achieved
Patient information systems already in place in 5 hospitals	The management of HAST Patients including the disclosure and management of children and the implementation of literacy classes needs to be improved.
There is a Medico-Legal Component in place within the Department to assist with the Medico-Legal claims	Computer literacy is still a challenge at PHC level in clinics for supervisions purposes
Administrative and systemic processes in place. Records and document management training has been conducted to improve records management systems and processes.	Poor record keeping allows for the increase in medico-legal cases
The establishment of Onsite Midwife Birthing Units will remove low risk maternity cases from overloading hight risk maternity units.	Poor documentation, failure to acknowledge lessons learnt & no proper closure, Delays in preparation of Final accounts due to delays in getting defects attended to in the defect's liability period
The Policy on Housing of Employees has been adopted by MANCO, and will be implemented	Poor implementation and compliance to Adherence Guidelines (AGL's) and SoP's.

Strengths	Weaknesses
	Shortage of midwifes in maternity units creates a high-risk environment for both maternal and perinatal adverse outcomes.
	Poor EMS response times impacts on patient's prognosis
	Poor screening processes for chronic conditions, communicable and non-communicable disease.
	There are challenges with implementation of the Logis System impacting on service delivery
	Funding limitations means that there are budget constraints for municipal services
	There is a backlog in maintenance due to the continuous deterioration of existing buildings, structures, plants and equipment with limited budgets available require flexible planning
	Regular breakdown of machinery due to ageing equipment
	Inadequate supply of hospital linen and patient clothing in circulation due to limited budget and cost constraints.

Table 29: Planning Processes for the 2024/ 25 planning cycle

No.	Activity	Description	Responsibility	Estimated timeframe[7]	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[8]: 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	All Business Unit Heads (All DDs: Strategic planning available	11 July to – 31 August	Completed draft template, and information as specified in the guide available from all clusters

[7] Subject to change based on annual calendar differences

No.	Activity	Description	Responsibility	Estimated timeframe[7]	Output
		Clusters to peruse APP template and guide and 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	for technical support to clusters)		
5.	Consult to obtain approval for hosting the strategic planning session[9]	Office of the Head of Department (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[10]	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
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	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

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

[10] For 5 year strategic planning cycle

No.	Activity	Description	Responsibility	Estimated timeframe[7]	Output
		g) Submit APP consolidated 1st draft with emphasis on Part B Situational Analysis and the completion of historical data in Part C 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.	Spatial Development Framework integration	Consideration of the Spatial Development Framework for integration into provincial planning purposes	DD: Strategic Planning	18 September	Evidence of integrated Spatial Referencing and planning with the APP.
10.	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
11.	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
12.	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)
13.	Unit Endorsement	Submit draft APP to Unit for review and comment	Director: Planning	25-28 September	Quality assured and endorsed draft APP (Unit level)
14.	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)
15.	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
16.	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

No.	Activity	Description	Responsibility	Estimated timeframe[7]	Output
17.	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
18.	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
19.	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
20.	Report Non submission and follow up		DD: Planning Director: Planning	7 Jan	
21.	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
22.	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
23.	Final draft consolidated APP and AOP submission to Director: Planning	For assessment / quality checking	DD: Provincial Planning	31 January	Evidence of submission
24.	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
25.	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

No.	Activity	Description	Responsibility	Estimated timeframe[7]	Output
26.	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
27.	Present draft APP and AOP to Oversight bodies MANCO/HPC	For MANCO assessment and inputs	Director: Planning	9-11 Feb	MANCO Report
28.	Presentation of APP to oversight bodies for input	Present APP to HPC	Director: Strategic Planning	HPC timelines (Q4)	Presentation of APP given at HPC
29.	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	
30.	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
31.	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
32.	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
33.	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

Table 30: Medium Term Expenditure Framework (MTEF) Budget for 2024/25

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Administration	1 307 061	1 040 001	1 120 318	1 266 483	1 257 454	1 304 572	1 367 949	1 429 487	1 495 244
District Health Services	24 937 252	27 269 871	27 180 146	26 310 574	26 575 886	28 404 446	27 545 469	28 508 982	29 814 006
Emergency Medical Services	1 605 927	1 596 766	1 667 866	1 655 515	1 677 615	1 720 099	1 789 779	1 867 908	1 953 828
Provincial Hospital Services	11 325 639	11 745 756	12 334 527	12 164 749	12 658 596	13 488 610	13 216 368	13 664 510	14 273 178
Central Hospital Services	5 385 460	5 355 155	5 663 085	5 492 145	5 867 180	6 079 190	5 981 864	6 146 917	6 429 675
Health Sciences and Training	1 265 197	1 362 187	1 338 906	1 481 009	1 513 941	1 545 036	1 552 250	1 654 840	1 747 069
Health Care Support Services	430 514	318 159	310 336	351 892	354 667	362 218	371 234	392 210	410 254
Health Facilities Management	3 113 195	1 942 082	1 912 676	1 965 145	1 874 788	1 874 788	1 971 979	1 970 877	1 994 974
Sub-Total	49 370 245	50 629 977	51 527 860	50 687 512	51 780 127	54 778 958	53 796 892	55 635 731	58 118 228
Unauthorized expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Baseline available for spending after 1st charge	49 370 245	50 629 977	51 527 860	50 687 512	51 780 127	54 778 958	53 796 892	55 635 731	58 118 228

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PART C: MEASURING OUR PERFORMANCE

PROGRAMME 1: ADMINISTRATION

Programme Purpose

Conduct the strategic management and overall administration of the Department of Health.

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

Render advisory, secretarial and 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 31: Programme 1 Outcome Indicators and Targets

Outcome Indicator Name	Data Source	South Africa		Provincial		MTEF Targets		
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2024/25	2025/26	2026/27
OUTCOME: UNIVERSAL HEALTH COVERAGE								
I Audit outcome for regulatory audit expressed by AGSA for the previous FY		Unqualified	Unqualified	Qualified	Unqualified	Unqualified	Unqualified	Unqualified
Audit opinion for Provincial DoH				*Qualified*	*Unqualified*	*Unqualified*	*Unqualified*	*Unqualified*
No denominator				-	-	-	-	-
II Contingent liability of medico-legal cases	Medico-legal case management system	R 90 Bn	R18 Bn	R 20 Bn	R32 bn	R 32 Bn	Less than R 32 Bn	Less than R 32 Bn

Table 32: Programme 1 Output Indicators and Targets

Outputs	Output Indicators	Audited Performance			Estimated Performance	MTEF Targets		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: UNIVERSAL HEALTH COVERAGE								
Hospitals implementing the E-Health System	1. Percentage of hospitals implementing E-Health beyond Module 1 (Phase 1)	New indicator	New indicator	New indicator	New indicator	90.5%	63.8%	69.6%
	Number of hospitals implementing - Health beyond Module 1 (Phase 1)	-	-	-	-	*38*	*44*	*48*
	Number of hospitals included in Phase 1 of the E-Health project	-	-	-	-	*42*	*69*	*69*

Outputs	Output Indicators	Audited Performance			Estimated Performance	MTEF Targets		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
Hospitals implementing the E-Health System	2. Percentage of hospitals implementing E-Health for the first time (At least Module 1)	New indicator	New indicator	New indicator	New indicator	55.6%	Not applicable	Not applicable
	Number of hospitals implementing E-Health for the first time (At least Module 1)	-	-	-	-	*15*	-	-
	Number of hospitals included in Phase 2 of the E-Health project	-	-	-	-	*27*	-	-
Supplier invoices paid within 30 days	3. Percentage of supplier invoices paid within 30 Days	New indicator	New indicator	New indicator	New indicator	96.2%	96%	97%
	Suppliers paid within 30 days (R '000)	-	-	-	-	*R 314 400*	*R 315 358*	*R 316 338*
	Suppliers paid within the given month (period) (R '000)	-	-	-	-	*R 326 800*	*R 326 796*	*R 326 796*
Expenditure spent on businesses owned by women	4. Proportion of expenditure paid to businesses owned by women	96.3%	95.5%	95.9%	14.5%	14,7%	18,1%	20,7%
	The Departments ACTUAL spend on procurement for businesses owned by women (R '000)				*R 2 320 368*	*R 2 350 459*	*R 3 150 000*	*R 3 850 000*
	The total amount of procurement done by the Department for the same period as numerator (R '000)				*R 15 950 243*	*R 15 950 244*	*R 17 385 765*	*R 18 602 769*

Table 33: Programme 1 Quarterly and Annual Targets

Indicator Name	2024/25				
	Annual targets	Q1	Q2	Q3	Q4
ANNUAL INDICATORS					
OUTCOME: UNIVERSAL HEALTH COVERAGE					
I Audit outcome for regulatory audit expressed by AGSA for the previous FY	Unqualified				
Audit opinion for Provincial DoH	*Unqualified*				
No denominator	*-*				
II Contingent liability of medico-legal cases	R 32 Bn				
QUARTERLY INDICATORS					
1. Percentage of hospitals implementing E-Health beyond Module 1 (Phase 1)	90.5%	47.6%	47.6%	76.2%	90.5%
Number of hospitals implementing E-Health beyond Module 1 (Phase 1)	*38*	*20*	*20*	*32*	*38*
Number of hospitals included in Phase 1 of the E-Health project	*42*	*42*	*42*	*42*	*42*
2. Percentage of hospitals implementing E-Health for the first time (At least Module 1)	55.6%	0%	0%	22.2%	55.6%
Number of hospitals implementing E-Health for the first time (At least Module 1)	*15*	*0*	*0*	*6*	*15*
Number of hospitals included in Phase 2 of the E-Health project	*27*	*27*	*27*	*27*	*27*
3. Percentage of supplier invoices paid within 30 Days	96.2%	96.2%	96.2%	96.2%	96.2%
Suppliers paid within 30 days (R '000)	*R 314 400*	*R 78 600*	*R 78 600*	*R 78 600*	*R 78 600*
Suppliers paid within the given month (period (R '000))	*R 326 800*	*R 81 700*	*R 81 700*	*R 81 700*	*R 81 700*
4. Proportion of expenditure paid to businesses owned by women	14.7%	14.7%	14.7%	14.8%	14.8%
The Departments ACTUAL spend on procurement for businesses owned by women(R '000)	*R 2 350 459*	*R 585 001*	*R 585 458*	*R 590 000*	*R 590 000*
The total amount of procurement done by the Department for the same period as numerator (R '000)	*R 15 950 244*	R 3 987 561	R 3 987 561	R 3 987 561	R 3 987 561

Explanation of Planned Performance over the Medium Term Period

OUTCOME: UNIVERSAL HEALTH COVERAGE

Universal health coverage (UHC) consists of 4 pillars namely 1) access, 2) equitable distribution of resources, 3) sustainability and 4) efficiency of resources utilised. The Provincial Office plays a major role in the determining of policies and strategies that affect these 4 pillars of UHC.

Medico-Legal: The Department has embarked on a project to archive files, which could reduce the contingent liability, which is impacting on the Department's available budget.

E-Health Strategy: The operationalization of the system is ongoing with patients now registering digitally.

Communications: The budget will be increased to manage communication and media campaigns, as the only means to achieve unmediated communications. Resources and tools for implementation of communication activities i.e., design software, audio and visual equipment, and IT equipment will be prioritised during the financial year. S

Community Health Workers Programme: a CHW vs population coverage mapping exercise will be conducted, to establish areas where CHWs are required, and recruit accordingly.

Nursing Services: The strengthening of programmes relating to ethics and professionalism will continue in 2024/25. The development and empowerment of nursing personnel in relation to service delivery needs will also continue. Strengthening of district nursing forums and coaching / mentoring will also continue to be rolled out in 2024/25.

Long Term Plan: The Turn-Around Strategy will be robustly monitored as part of the Long Term Plan, to inter alia, improve audit outcomes, improve financial, supply chain and human resource management, rationalisation of hospitals services to improve efficiencies and equitable access to clinical services, and strengthen clinical and corporate governance, leadership, and oversight.

National Health Insurance: Phase 2 will be implemented during the 24/25 reporting cycle

Human Resources: There is diversity management training planned for 2024/25, subject to funding availability and the National School of Government running the training programme, which amongst other matters, addresses employment equity targets. The Department does have an Employment Equity Plan; however; meeting the targets proves to be difficult in light the of cost cutting measures, disabled candidates not being available for scarce skill posts, etc. When recruitment processes are being undertaken. EE targets for the post/s are provided which includes race, gender and disability target/s for the post/s.

The Department also has Women's, Men's, and Disability Forums in place with a view of ensuring issues affecting these groups are addressed and resolved. It also serves as a support platform for employees and can be seen as a pull factor for external applicants wanting to join the Department.

As at the end of the 3rd Quarter of 2023/24 the women at SMS is 49% (was above 50% in the prior quarters) whilst the average youth in the Department was 24% over the last three quarters. It is thus easier to set a target of 50% women at the SMS as this achievable (subject to funds) whilst target setting of youth employment is a challenge. In certain programmes e.g., Internships, youth are targeted. The Department has since January 2022 increased the cohort of disabled employees in the Department from 430 employees to 545 in December 2023 (net gain of 115 employees) as a result of ongoing awareness and support. The Department has not reached 1% of the workforce with disabled employees. Therefore, the target of 3% is ambitious and is compounded by cost cutting measures.

The Anti-Fraud and Corruption strategies are designed to strengthen measures to prevent and combat fraud, corruption and corrupt activities. These strategies encourage fraud deterrence and prevention; raise awareness of fraud, bribery and corruption and promote their detection. Furthermore, Anti-fraud and corruption strategies provide guidance on how concerns should be reported and how they will be dealt with.

An approved Fraud Prevention Strategy is implemented through a guidance of a Fraud Prevention Plan which is monitored through the Departmental Risk Management Committee and the Cluster Audit and Risk Committee. Risk Assurance Management Services conduct fraud prevention workshops to all departmental officials to educate them on fraud and corruption which will assist them in performing their role of preventing, detecting, and reporting fraud and corruption. Fraud awareness campaigns are designed to focus on different levels of authority and different functions or operations of the Department.

ANNUAL OPERATIONAL PLAN 2024/25 INDICATORS

The following indicators are being monitored in the Annual Operational Plan (AOP) 24/25 to confirm implementation of provincial priorities and progress made against these priorities.

- Professional Nurses per 100 000 population
- Medical officers per 100 000 population
- Number of unprocedural dismissals (after appeals process)
- Number of labour relations workshops conducted at hospitals
- Vacancy Rate
- Number of districts with Quality Improvement Monitoring and response forums convened
- Number of CHW's contracted into the Health System

- Proportion of expenditure paid to businesses owned by youth
- Proportion of expenditure paid to businesses owned by MK Veterans
- Proportion of expenditure paid to businesses owned by People with disabilities
- Number of General Practitioners contracted in KZN
- Number of hospitals where Make me Look Like a Hospital is implemented
- Number of outreach programmes conducted in respect of Isibhedlela kubantu

PROGRAMME RESOURCE CONSIDERATIONS

Table 34: ***Budget allocation Estimates 2024/25 (R'000) (Programme 1)***

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Office of the MEC	19 676	21 243	26 721	24 890	25 861	29 866	25 755	27 166	28 414
Management	1 287 385	1 018 758	1 093 597	1 241 593	1 231 593	1 274 706	1 342 194	1 402 321	1 466 830
Sub-Total	1 307 061	1 040 001	1 120 318	1 266 483	1 257 454	1 304 572	1 367 949	1 429 487	1 495 244
Unauthorized expenditure (1st charge) not available for spending	-		-	-	-	-	-	-	-
Baseline available for spending after 1st charge	1 307 061	1 040 001	1 120 318	1 266 483	1 257 454	1 304 572	1 367 949	1 429 487	1 495 244

Table 35: Summary of Budget Allocations and Estimates by Economic Classification 2024/25 ***(R'000) (Programme 1)***

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Current payments	1 269 315	924 989	1 037 028	1 202 147	1 207 607	1 225 265	1 305 348	1 355 318	1 417 664
Compensation of employees	429 698	476 820	501 188	536 262	537 233	543 548	563 400	580 129	606 815
Goods and services	839 245	447 671	535 102	665 885	670 374	681 579	741 948	775 189	810 849
Communication	27 030	36 345	58 174	57 145	67 165	71 578	70 179	73 320	76 693
Computer Services	121 700	123 304	127 024	177 713	177 966	176 882	218 926	228 734	239 256
Consultants, Contractors and special services	38 271	47 119	38 958	55 929	49 345	63 133	52 570	54 927	57 453
Inventory	349 996	37 491	2 148	7 949	11 276	5 019	11 781	12 307	12 875

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Operating leases	8 476	7 828	9 451	10 981	10 293	9 690	10 757	11 239	11 756
Travel and subsistence	64 291	16 579	21 040	53 895	28 195	26 699	38 577	40 309	42 164
Maintenance, repair and running costs	32 333	6 996	22 604	29 140	24 088	29 309	22 422	23 428	24 506
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	197 148	172 009	255 703	273 133	302 046	299 269	316 736	330 925	346 146
Interest and rent on land	372	498	738	-	-	138	-	-	-
Transfers and subsidies to	11 076	23 049	27 660	9 908	9 908	27 373	10 354	10 817	11 315
Provinces and municipalities	3 243	6 426	5 098	4 751	4 751	4 953	4 965	5 187	5 426
Departmental agencies and accounts	4	-	-	1	1	4	1	1	1
Higher education institutions	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	7 829	16 623	22 562	5 156	5 156	22 416	5 388	5 629	5 888
Payments for capital assets	22 631	91 840	55 503	54 428	39 939	51 934	52 247	63 352	66 265
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Machinery and equipment	22 631	91 840	55 503	54 428	39 939	51 934	52 247	63 352	66 265
Payment for financial assets	4 039	123	127	-	-	-	-	-	-
Total economic classification	1 307 061	1 040 001	1 120 318	1 266 483	1 257 454	1 304 572	1 367 949	1 429 487	1 495 244
Unauthorised expenditure (1st charge) not available for spending	-								
Total economic classification	1 307 061	1 040 001	1 120 318	1 266 483	1 257 454	1 304 572	1 367 949	1 429 487	1 495 244

PERFORMANCE AND EXPENDITURE TRENDS

Programme 1 is allocated 2.6% of the Vote 7 budget, an increase from 4.9% from the 23/24 revised estimated. This amounts to an increase of R 63 377 000.

UPDATED KEY RISKS AND MITIGATION

Table 36: Key Risks and Mitigation Strategies 2024/25 (Programme 1)

Key Risks	Risk Mitigation
Outcome: Universal Health Coverage	
Inefficient utilisation of laboratory tests.	Monitoring the effectiveness of the system following the user training
	Monthly Monitoring of the functioning of Laboratory Committees
	Monitor the functioning of Laboratory Order Entry System and report to IT
Funding provided to state aided institutions. Return on Investment - Possible failure to realise full returns	Engage District Management to identify officials who shall oversee state aided institutions
	Conduct workshop on the policy to all relevant stakeholders
	Conduct regular oversight visits to state aided institutions
	Implement remedial measures whenever areas of non-compliance are identified.
Inadequate resources (filling space and IT)	To request for additional storage space and fireproof for the existing storage space
Lack of capacity within Legal Services Unit	To motivate for the filling of vacant posts
Lack of understanding of protocol for routing of cases (from Institution to Head Office)	To review Circular G52/2008 Litigation Policy on the procedure to be followed when any legal proceedings are instituted on behalf of or against the Department.
Poor management of the Asset Register between Institutions and Head Office	Implement LOGIS system.
	Motivation for the appointment of more staff with more skills in Asset Management.
Outcome: Improved Client Experience of Care	
Insufficient number, categories of nurses allocated to perform nursing duties	Monitor the progress of facilities in absorbing the lower categories of nurses
	Monitoring and evaluation of continuous implementation of staff developmental programmes

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

DISTRICT HEALTH SERVICES

Table 37: District Health Services Outcome Indicators and Targets for 2024/25

Indicator Name	Data Source	South Africa		Provincial		MTEF Period		
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2024/25	2025/26	2026/27
OUTCOME: UNIVERSAL HEALTH COVERAGE								
III Ideal clinic status obtained rate	Ideal Health Facility Software	56% (1920) PHC	100% PHC	75.6%	90%	94.9%	94.9%	94.9%
Fixed PHC health facilities have obtained Ideal Clinic status	*Ideal clinic report*			*461*	*548*	*577*	*577*	*577*
Fixed PHC clinics or fixed CHCs and or CDCs				*610*	*608*	*608*	*608*	*608*
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE								
IV Patient Experience of Care satisfaction rate	Patient surveys data base	Not available	Not available	68.9%	89.6%	89.6%	92.6%	95.5%
Patient Experience of Care survey satisfied responses (Total Responses)	Patient Surveys			*34 249*	*2 105 200*	*2 105 200*	*2 175 500*	*2 244 000*
Patient Experience of Care survey total responses				*49 677*	*2 350 000*	*2 350 000*	*2 350 000*	*2 350 000*
V Patient Safety Incident (PSI) case closure rate –District Health Services	Patient Safety Incidence Software	Not available	Not available	86.4%	97.8%	97.8%	98.1%	98.4%
Patient Safety Incident (PSI)case closed – District Health Services	*Patient Safety Incidence Reports*			*1 436*	*2 441*	*2 441*	2 448	*2 456*
Patient Safety Incident (PSI) case Reported – District Health Services				*1 662*	*2 495*	*2 495*	2 495	*2 495*

Table 38: District Health Services Outputs, Output Indicators and Targets for 2024/25

Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Period		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE								
Severity assessment code (SAC) 1 incident reported within 24 hours	5. Severity assessment code (SAC) 1 incident reported within 24 hours rate	66.8%	282.0%	83.8%	86.7%	100.0%	100.0%	100.0%
	Severity assessment code (SAC) 1 incident reported within 24 hours	*342*	*581*	*690*	*600*	*692*	*721*	*731*
	Severity assessment code (SAC) 1 incident reported	*512*	*206*	*823*	*692*	*692*	*721*	*731*

Table 39: District Health Services Quarterly and Annual Targets

Indicator		2024/25				
		Annual Targets	Q1	Q2	Q3	Q4
ANNUAL INDICATORS						
OUTCOME: UNIVERSAL HEALTH COVERAGE						
III	Ideal clinic status obtained rate	94.9%	0%	0%	0%	94.9%
	Fixed PHC health facilities have obtained Ideal Clinic status	*577*	-	-	-	*577*
	Fixed PHC clinics or fixed CHCs and or CDCs	*608*	*608*	*608*	*608*	*608*
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE						
IV	Patient Experience of Care satisfaction rate	89.6%				
	Patient Experience of Care survey satisfied responses (Total Responses)	*2 105 200*				
	Patient Experience of Care survey total responses	*2 350 000*				
V	Patient Safety Incident (PSI) case closure rate –District Health Services	97.8%	97.9%	97.8%	97.9%	97.8%
	Patient Safety Incident (PSI)case closed – District Health Services	*2 441*	*610*	*1 220*	*1 831*	*2 441*
	Patient Safety Incident (PSI) case Reported – District Health Services	*2 495*	*623*	*1 247*	*1 871*	*2 495*
QUARTERLY INDICATORS						
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE						
5.	Severity assessment code (SAC) 1 incident reported within 24 hours rate	100.0%	100.0%	100.0%	100.0%	100.0%
	Severity assessment code (SAC) 1 incident reported within 24 hours	*692*	*173*	*346*	*519*	*692*
	Severity assessment code (SAC) 1 incident reported	*692*	*173*	*346*	*519*	*692*

HIV / TB AND SEXUALLY TRANSMITTED INFECTIONS (HAST)

Table 40: HAST Outcome Indicators and Targets for 2024/25

Indicator Name		Data Source	South Africa		Provincial		MTEF Period		
			Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2024/25	2025/26	2026/27
OUTCOME: REDUCED MORBIDITY AND MORTALITY									
VI	All DS -TB Deaths	DS clinical stationary	New indicator	Not available	3 593	2 840	2 840	2 700	2 500
VII	All DS-TB client treatment success rate	DHIS	80.0%	Not available	72.2%	72.1%	72.1%	80.0%	85.0%
	All DS- TB client successfully completed treatment	*DS clinical stationary*	*182 084*		*42 178*	*37 500*	*37 500*	*41 600*	*44 200*
	All DS-TB treatment start		*227 547*		*58 411*	*52 000*	*52 000*	*52 000*	*52 000*
VIII	TB Rifampicin Resistant / Multidrug - resistant treatment success rate	DHIS	New indicator	Not available	59.9%	72.0%	72.0%	75.0%	75.0%
	TB Rifampicin resistant / Multidrug resistant successfully completed treatment	*DS clinical stationary*			*1 868*	*1 008*	*1 008*	*1 050*	*1 050*
	TB Rifampicin resistant / Multidrug resistant client started on treatment				*3 116*	*1 400*	*1 400*	*1 400*	*1 400*
IX	TB Pre-XDR treatment success rate	DHIS	New indicator	Not available	New indicator	55.0%	55.0%	60.0%	60.0%
	TB Pre-XDR client who successfully completed treatment	*DS clinical stationary*				*33*	*33*	*36*	*36*
	TB Pre-XDR client started on treatment					*60*	*60*	*60*	*60*
X	ART client remain on ART end of month – sum	ART register	4 629 831	5 271 837	1 387 688	1 677 836	1 677 836	1 786 196	1 786 196
XI	ART adult viral load suppressed rate - below 50 (12 months)	DHIS	79.2%	89.1%	New indicator	95.0%	95.0%	95.0%	95.0%
	ART adult viral load under 50		*278 975*	*-*		*91 200*	*91 200*	*90 866*	*90 866*

Indicator Name	Data Source	South Africa		Provincial		MTEF Period		
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2024/25	2025/26	2026/27
ART adult viral load done	*ART paper register*	*314 441*	*-*		*96 000*	*96 000*	*95 648*	*95 648*
XII ART child viral load suppressed rate - below 50 (12 months)	DHIS	74.8%	81.5%	New indicator	90.0%	90.0%	95.0%	95.0%
ART child viral load under 50	*ART paper register*	*5 369*	*-*		*2 250*	*2 250*	*2 375*	*2 375*
ART child viral load done		*8 321*	*-*		*2 500*	*2 500*	*2 500*	*2 500*
XIII ART death rate (6 months)	DHIS	1.5%	Not available	1.2%	1.0%	1.0%	1.0%	1.0%
ART cumulative death – total	*ART register, TIER.net*	*10 073*		*2 445*	*2 029*	*2 029*	*2 020*	*2 020*
ART start minus cumulative transfer out		*675 610*		*202 938*	*202 938*	*202 938*	*202 938*	*202 938*
XIV HIV positive 15-24 years (excl ANC) rate	DHIS	New indicator	3.5%	New indicator	1.0%	1.0%	1.0%	1.0%
HIV positive 15 – 24 years (excl ANC)	*PHC tick register, HTS register*		*-*		*2 029*	*2 029*	*2 020*	*2 020*
HIV test 15 – 24 years (excl ANC)			*-*		*202 938*	*202 938*	*202 938*	*202 938*

Table 41: HAST Outputs, Output Indicators and Targets for 2024/25

Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Period		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: REDUCED MORBIDITY AND MORTALITY								
All DS-TB client loss to follow-up	6. All DS-TB client LTF rate	10.7%	10.3%	9.1%	9.0%	9.0%	8.0%	8.0%
	All DS-TB client loss to follow-up	*5 495*	*3 826*	*3 457*	*4 572*	*4 680*	*4 160*	*4 160*
	All DS-TB treatment start	*51 150*	*37 312*	*37 840*	*51 040*	*52 000*	*52 000*	*52 000*

Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Period		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
TB Rifampicin resistant / multidrug- resistant lost to follow-up	7. TB Rifampicin resistant / Multidrug - Resistant lost to follow up rate	New indicator	New indicator	Not monitored	15.3%	15.0%	12.0%	12.0%
	TB Rifampicin resistance / multi-drug resistant client loss to follow-up				*228*	*210*	*168*	*168*
	TB Rifampicin Resistant / Multi-drug resistant client started on treatment				*1 488*	*1 400*	*1 400*	*1 400*
TB Pre-XDR loss to follow up	8. TB Pre-XDR Loss to follow up Rate	New indicator	New indicator	Not monitored	23.1%	21.7%	18.3%	18.3%
	TB Pre-XDR clients who are loss to follow-up				*12*	*13*	*11*	*11*
	TB Pre-XDR clients started on treatment				*52*	*60*	*60*	*60*
ART adult remain in care - total	9. ART adult remain in care rate [12 months]	52.6%	68.4%	67.5%	69.1%	75.0%	75.0%	80.0%
	ART adult remain in care – total	*390 644*	*78 003*	*67 907*	*66 936*	*75 000*	*75 000*	*80 000*
	ART adult start minus cumulative transfer out	*741 997*	*113 994*	*100 530*	*96 824*	*100 000*	*100 000*	*100 000*
ART child remain in care - total	10. ART child remain in care rate [12 months]	57.6%	76.6%	77.7%	77.5%	80.0%	80.0%	85.0%
	ART child remain in care – total	*9 898*	*1 799*	*1 506*	*1 560*	*1 600*	*1 600*	*1 700*
	ART child start minus cumulative transfer out	17 177	*2 349*	*1 939*	*2 012*	*2 000*	*2 000*	*2 000*

Table 42: HAST Quarterly and Annual Targets

Indicator Name		2024/25				
		Annual targets	Q1	Q2	Q3	Q4
ANNUAL INDICATORS						
OUTCOME: REDUCED MORBIDITY AND MORTALITY						
VI	All DS -TB Deaths	2 840				
VII	All DS-TB client treatment success rate	72.1%	72.1%	72.1%	72.1%	72.1%
	All DS- TB client successfully completed treatment	*37 500*	*9 375*	*18 750*	*28 125*	*37 500*
	All DS-TB treatment start	*52 000*	*13 000*	*26 000*	*39 000*	*52 000*
VIII	TB Rifampicin Resistant / Multidrug - resistant treatment success rate	72.0%	72.0%	72.0%	72.0%	72.0%
	TB Rifampicin resistant / Multidrug resistant successfully completed treatment	*1 008*	*252*	*504*	*756*	*1 008*
	TB Rifampicin resistant / Multidrug resistant client started on treatment	*1 400*	*350*	*700*	*1 050*	*1 400*
IX	TB Pre-XDR treatment success rate	55.0%	60.0%	56.7%	55.6%	55.0%
	TB Pre-XDR client who successfully completed treatment	*33*	*9*	*17*	*25*	*33*
	TB Pre-XDR client started on treatment	*60*	*15*	*30*	*45*	*60*
X	ART client remain on ART end of month – sum	1 677 836	1 584 007	1 622 676	1 677 309	1 677 836
XI	ART adult viral load suppressed rate - below 50 (12 months)	95.0%	95.0%	95.0%	95.0%	95.0%
	ART adult viral load under 50	*91 200*	*22 800*	*45 600*	*68 400*	*91 200*
	ART adult viral load done	*96 000*	*24 000*	*48 000*	*72 000*	*96 000*
XII	ART child viral load suppressed rate - below 50 (12 months)	90.0%	89.9%	89.9%	90.0%	90.0%
	ART child viral load under 50	*2 250*	*562*	*1 124*	*1 687*	*2 250*
	ART child viral load done	*2 500*	*625*	*1 250*	*1 875*	*2 500*
XIV	HIV positive 15-24 years (excl ANC) rate	1.8%	1.8%	1.8%	1.8%	1.8%
	HIV positive 15 – 24 years (excl ANC)	*14 058*	*3 514*	*7 028*	*10 543*	*14 058*
	HIV test 15 – 24 years (excl ANC)	*781 000*	*195 250*	*390 500*	*585 750*	*781 000*
QUARTERLY INDICATORS						
OUTCOME: REDUCED MORBIDITY AND MORTALITY						
6.	All DS-TB client LTF rate	9.0%	9.0%	9.0%	9.0%	9.0%
	All DS-TB client loss to follow-up	*4 680*	*1 170*	*2 340*	*3 510*	*4 680*
	All DS-TB treatment start	*52 000*	*13 000*	*26 000*	*39 000*	*52 000*
7.	TB Rifampicin resistant / Multidrug - Resistant lost to follow up rate	15.0%	15.1%	15.0%	15.0%	15.0%
	TB Rifampicin resistance / multi-drug resistant client loss to follow-up	*210*	*53*	*105*	*157*	*210*

Indicator Name	2024/25				
	Annual targets	Q1	Q2	Q3	Q4
TB Rifampicin Resistant / Multi-drug resistant client started on treatment	*1 400*	*350*	*700*	*1 050*	*1 400*
8. TB Pre-XDR Loss to follow up Rate	21.7%	20.0%	20.0%	22.2%	21.7%
TB Pre-XDR clients who are loss to follow-up	*13*	*3*	*6*	*10*	*13*
TB Pre-XDR clients started on treatment	*60*	*15*	*30*	*45*	*60*
9. ART adult remain in care rate [12 months]	75.0%	71.0%	73.0%	74.0%	75.0%
ART adult remain in care – total	*75 000*	*17 750*	*36 500*	*55 500*	*75 000*
ART adult start minus cumulative transfer out	*100 000*	*25 000*	*50 000*	*75 000*	*100 000*
10. ART child remain in care rate [12 months]	80.0%	77.0%	78.0%	79.0%	80.0%
ART child remain in care – total	*1 600*	*385*	*780*	*1 185*	*1 600*
ART child start minus cumulative transfer out	*2 000*	*500*	*1 000*	*1 500*	*2 000*

MATERNAL, WOMAN AND CHILD HEALTH INCLUDING NUTRITION (MCWHN)

Table 43: MCWHN Outcome Indicators and Targets for 2024/25

Indicator Name		Data Source	South Africa		Provincial		MTEF Period		
			Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2024/25	2025/26	2026/27
OUTCOME: REDUCED MORBIDITY AND MORTALITY									
XV	Maternal Mortality in facility Ratio - per 100 000 live births	DHIS	105.9 / 100 000	100 / 100 000	88.4 / 100 000	98 / 100 000	98.0 / 100 000	92.2 / 100 000	86.5 / 100 000
	Maternal death in facility	*Maternal death register*	*1 065*	-	*188*	*170*	*170*	*160*	*150*
	Live births known to facility	*Delivery register*	*1 005 398*	-	*212 723*	*173 464*	*173 464*	*173 464*	*173 464*
XVI	Neonatal death in facility rate (per 1 000 live births)	DHIS	12 / 1 000	< 10 / 1 000	11.5 / 1 000	13.9 / 1 000	13.9 / 1 000	13.7 / 1 000	13.5 / 1 000
	Neonatal deaths (under 28 days) in facility	*Midnight report*	*11 642*	-	*2 315*	*2 300*	*2 300*	*2 270*	*2 230*
	Live birth in facility	*Delivery register*	*959 533*	-	*201 947*	*165 454*	*165 464*	*165 464*	*165 464*
XVII	Death under 5 years against live birth rate	DHIS	4.8%	4.3%	1.8%	2.0%	2.0%	2.0%	1.9%
	Death in facility under 5 years total	*Delivery register*	*16 843*	-	*3 380*	*3 286*	*3 286*	*3 243*	*3 186*
	Live birth in facility		*959 533*	-	*191 813*	*165 464*	*165 464*	*165 464*	*165 464*
XVIII	Death in facility under 5 years rate	DHIS	Not available	Not available	3.9%	5.4%	5.4%	5.3%	5.2%
	Death in facility under 5 years	*Midnight report*			*3 444*	*3 286*	*3 286*	*3 243*	*3 186*
	Inpatient separations under 5 years	*Ward register*			*88 844*	*60 750*	*60 750*	*60 750*	*60 750*
XIX	Child under 5 years diarrhoea case fatality rate	DHIS	1.9%	1.4%	2.2%	1.6%	*1.6%*	1.6%	1.6%
	Diarrhoea death under 5 years	*Midnight report*	*679*	*407*	*171*	*117*	*152*	*150*	*148*

Indicator Name		Data Source	South Africa		Provincial		MTEF Period		
			Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2024/25	2025/26	2026/27
	Diarrhoea separation under 5 years	*DHIS*	*36 009*	*28 807*	*7 702*	*7 403*	*9 500*	*9 500*	*9 500*
XX	Child under 5 years Pneumonia case fatality rate	DHIS	1.9%	1.7%	2.3%	1.8%	*1.8%*	1.8%	1.8%
	Pneumonia death under 5 years	*Midnight report*	*962*	*673*	*279*	*217*	*217*	*217*	*217*
	Pneumonia separation under 5 years	*Ward register*	*50 212*	*40 170*	*12 370*	*11 914*	*11 914*	*11 914*	*11 914*
XXI	Child under 5 years Severe acute malnutrition case fatality rate	DHIS	7.1%	6.7%	7.8%	7.1%	7.1%	5.1%	4.5%
	Severe acute malnutrition (SAM) death under 5 years	*Midnight report*	*806*	*685*	*179*	*139*	*139*	*100*	*89*
	Severe acute malnutrition inpatient separation under 5 years	*Ward Register*	*11 280*	*10 152*	*2 289*	*1 965*	*1 965*	*1 965*	*1 965*
XXII	Still Birth in Facility Rate (Per 1 000 births)	DHIS	Not available	Not available	22.9 / 1 000	26.8 / 1 000	26.8 / 1 000	26.8 / 1 000	26.8 / 1 000
	Still birth in facility	*Midnight report*			*4 500*	*4 562*	*4 562*	*4 562*	*4 562*
	Total births in facility (include still birth in facility)	*Ward register*			*196 313*	*170 026*	*170 026*	*170 026*	*170 026*

Table 44: MCWHN Outputs, Output Indicators and Targets for 2024/25

Output Statements	Output Indicator	Audited Performance			Estimated Performance	MTEF Period		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: REDUCED MORBIDITY AND MORTALITY								
Couple Year Protection	11. IUCD Uptake (*IUCD - Intra Uterine Contraceptive Device)	New indicator	New indicator	New Indicator	25 876	27 216	28 631	28 631
	Number IUCD Inserted				*25 876*	*27 216*	*28 631*	*28 631*
	No denominator				-	-	-	-
Delivery 10 - 14 years in facility	12. Delivery 10 - 14 years in facility	New indicator	New indicator	New Indicator	636	632	632	632
	Number Delivery 10 - 14 years in facility				*636*	*632*	*632*	*632*
	No denominator				-	-	-	
Antenatal 1st visit before 20 weeks	13. Antenatal 1st visit before 20 weeks rate	74.3%	73.7%	73.8%	74.1%	75.0%	77.0%	77.0%
	Antenatal 1st visit before 20 weeks	*163 505*	*159 161*	*161 876*	*137 492*	*138 750*	*173 250*	*173 250*
	Antenatal 1st visit – total	*220 105*	*215 821*	*219 299*	*185 452*	*185 000*	*225 000*	*225 000*
Mother postnatal visit within 6 days	14. Mother postnatal visit within 6 days rate	77.6%	80.0%	83.5%	82.6%	73.6%	75.0%	75.0%
	Mother postnatal visit within 6 days after delivery	*156 605*	*163 512*	*168 633*	*157 288*	*123 048*	*125 340*	*125 340*
	Delivery in facility total	*201 783*	*204 450*	*201 873*	*190 536*	*167 120*	*167 120*	*167 120*
Infant PCR test positive under 5 years	15. Infant PCR test positive around 6 months rate	New indicator	New indicator	New Indicator	0.6%	1.0%	1.0%	1.0%
	Infant PCR test positive around 6 months					*336*	*336*	*336*
	Infant PCR test around 6 months					*33 580*	*33 580*	*33 580*
HIV test positive under 5 years	16. HIV Test positive around 18 months rate	New indicator	New indicator	New Indicator	0.5%	1.5%	1.3%	1.3%
	HIV Test positive around 18 months					*871*	*754*	*754*

Output Statements	Output Indicator	Audited Performance			Estimated Performance	MTEF Period		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
	HIV tests done around 18 months					*58 040*	*58 040*	*58 040*
Immunised fully under 1 year	17. Immunisation under 1 year coverage	82.8%	89.9%	92.2%	98.7%	95.0%	95.0%	95.0%
	Immunised fully under 1 year new	*217 217*	*229 899*	*234 249*	*249 092*	*238 284*	*237 848*	*237 510*
	Population under 1 year	*262 488*	*255 744*	*254 035*	*252 494*	*250 824*	*250 366*	*250 010*
Measles 2nd dose	18. Measles 2nd dose 1 year coverage	77.3%	86.7%	89.5%	100.9%	95.0%	95.0%	95.0%
	Measles 2nd dose	*202 795*	*218 837*	*227 178*	*254 896*	*238 320*	*237 683*	*237 435*
	Target population 1 year	*262 205*	*252 321*	*253 879*	*252 554*	*250 860*	*250 193*	*249 932*
Cervical cancer screening	19. Cervical Cancer Screening Coverage	New indicator	New indicator	New Indicator	63.3%	70.0%	75.0%	75.0%
	Cervical cancer screening done	-	-	-	*243 370*	*274 940*	*298 243*	*302 070*
	[(80% women aged 30-50yrs/10)+(20% women aged 20 years and above /3)	-	-	-	*384 564*	*392 773*	*397 658*	*402 760*

Table 45: MCWHN Quarterly and Annual Targets

Indicator Name		2024/25				
		Annual targets	Q1	Q2	Q3	Q4
ANNUAL INDICATORS						
OUTCOME: REDUCED MORBIDITY AND MORTALITY						
XV	Maternal Mortality in facility Ratio - per 100 000 live births	98.0 / 100 000	-	-	-	-
	Maternal death in facility	*170*	-	-	-	-
	Live births known to facility	*173 464*	-	-	-	-
XVI	Neonatal death in facility rate (per 1 000 live births)	13.9 / 1000	13.9 / 1000	13.9 /1000	13.9 /1000	13.9 /1000
	Neonatal deaths (under 28 days) in facility	*2 300*	*575*	*1 150*	*1 725*	*2 300*
	Live birth in facility	*165 464*	*41 366*	*82 732*	*124 098*	*165 464*
XVII	Death under 5 years against live birth rate	2.0%	2.2%	2.2%	2.2%	2.2%
	Death in facility under 5 years total	*3 286*	*900*	*1 801*	*2 704*	*3 607*
	Live birth in facility	*165 464*	*41 366*	*82 732*	*124 098*	*165 464*
XVIII	Death in facility under 5 years rate	5.4%				
	Death in facility under 5 years	*3 286*				
	Inpatient separations under 5 years	*60 750*				
XIX	Child under 5 years diarrhoea case fatality rate	1.6%	1.6%	1.6%	1.6%	1.6%
	Diarrhoea death under 5 years	*152*	*38*	*76*	*114*	*152*
	Diarrhoea separation under 5 years	*9 500*	*2 375*	*4 750*	*7 125*	*9 500*
XX	Child under 5 years Pneumonia case fatality rate	1.8%	1.7%	1.8%	1.8%	1.8%
	Pneumonia death under 5 years	*217*	*52*	*107*	*162*	*217*
	Pneumonia separation under 5 years	*11 914*	*2 978*	*5 956*	*8 935*	*11 914*
XXI	Child under 5 years Severe acute malnutrition case fatality rate	7.1%	6.7%	6.9%	6.9%	7.1%
	Severe acute malnutrition (SAM) death under 5 years	*139*	*33*	*68*	*101*	*139*
	Severe acute malnutrition inpatient separation under 5 years	*1 965*	*491*	*982*	*1 473*	*1 965*
XXII	Still Birth in Facility Rate (Per 1 000 births)	26.8 / 1 000	26.8 / 1 000	26.8 / 1 000	26.8 / 1 000	26.8 / 1 000
	Still birth in facility	*4 562*	*1 140*	*2 280*	*3 421*	*4 562*
	Total births in facility (include still birth in facility)	*170 026*	*42 506*	*85 012*	*127 519*	*170 026*
QUARTERLY INDICATORS						
OUTCOME: REDUCED MORBIDITY AND MORTALITY						

Indicator Name		2024/25				
		Annual targets	Q1	Q2	Q3	Q4
11.	IUCD Uptake (*IUCD - Intra Uterine Contraceptive Device)	27 216	6 804	13 608	20 412	27 216
	Number IUCD Inserted	*27 216*	*6 804*	*13 608*	*20 412*	*27 216*
	No denominator	-	-	-	-	-
12.	Delivery 10 - 14 years in facility	632	158	316	474	632
	Number Delivery 10 - 14 years in facility	*632*	*158*	*316*	*474*	*632*
	No denominator	-	-	-	-	-
13.	Antenatal 1st visit before 20 weeks rate	75.0%	75.0%	75.0%	75.0%	75.0%
	Antenatal 1st visit before 20 weeks	*138 750*	*34 688*	*69 375*	*104 063*	*138 750*
	Antenatal 1st visit – total	*185 000*	*46 250*	*92 500*	*138 750*	*185 000*
14.	Mother postnatal visit within 6 days rate	73.6%	73.6%	73.6%	73.6%	73.6%
	Mother postnatal visit within 6 days after delivery	*123 048*	*30 762*	*61 524*	*92 286*	*123 048*
	Delivery in facility total	*167 120*	*41 780*	*83 560*	*125 340*	*167 120*
15.	Infant PCR test positive around 6 months rate	1.0%	1.0%	1.0%	1.0%	1.0%
	Infant PCR test positive around 6 months	*336*	*84*	*168*	*252*	*336*
	Infant PCR test around 6 months	*33 580*	*8 395*	*16 790*	*25 185*	*33 580*
16.	HIV Test positive around 18 months rate	1.5%	1.5%	1.5%	1.5%	1.5%
	HIV Test positive around 18 months	*871*	*217*	*435*	*653*	*871*
	HIV tests done around 18 months	*58 040*	*14 510*	*29 020*	*43 530*	*58 040*
17.	Immunisation under 1 year coverage	95.0%	95.0%	95.0%	95.0%	95.0%
	Immunised fully under 1 year new	*238 284*	*59 571*	*119 142*	*178 713*	*238 284*
	Population under 1 year	*250 824*	*62 706*	*125 412*	*188 118*	*250 824*
18.	Measles 2nd dose 1 year coverage	95.0%	95.0%	95.0%	95.0%	95.0%
	Measles 2nd dose	*238 320*	*59 580*	*119 160*	*178 740*	*238 320*
	Target population 1 year	*250 860*	*62 715*	*125 430*	*188 145*	*250 860*
19.	Cervical Cancer Screening Coverage	70.0%	70.0%	70.0%	70.0%	70.0%
	Cervical cancer screening done	*274 940*	*68 735*	*137 470*	*206 205*	*274 940*
	[(80% women aged 30-50yrs/10)+(20% women aged 20 years and above /3)	*392 773*	*98 193*	*196 387*	*294 580*	*392 773*

DISEASE PREVENTION AND CARE (DPC)

Table 46: DPC Outcome Indicators and Targets for 2024/25

Indicator Name	Data Source	South Africa		Provincial		MTEF Period		
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2024/25	2025/26	2026/27
OUTCOME: REDUCED MORBIDITY AND MORTALITY								
XXIII Malaria case fatality rate	Manual calculation	0.64%	Not available	0.5%	0.0%	0.0%	0.0%	0.0%
Malaria deaths reported	*PHC tick register; Malaria Register*	*61*		*7*	-	-	-	-
Malaria cases reported		*5 164*		*1 493*	*600*	*600*	*600*	*600*

Table 47: Disease Prevention and Control Outputs, Output Indicators and Targets for 2024/25

Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Period		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: REDUCED MORBIDITY AND MORTALITY								
PHC mental disorders treated	20. PHC Mental Disorders Treatment Rate New	0.0%	0.0%	0.0%	0.02%	0.01%	0.01%	0.01%
	PHC client treated for mental disorders - new				*3 960*	*2 220*	*2 300*	*2 300*
	PHC headcount - total				*24 658 660*	*22 246 464*	*22 246 464*	*22 246 464*

Table 48: Disease Prevention and Control Quarterly and Annual Targets

Indicator Name		2024/25				
		Annual targets	Q1	Q2	Q3	Q4
ANNUAL INDICATORS						
OUTCOME: REDUCED MORBIDITY AND MORTALITY						
XXIII	Malaria case fatality rate	0%				
	Malaria deaths reported	*2 220*				
	Malaria cases reported	*22 246 464*				
QUARTERLY INDICATORS						
20.	PHC Mental Disorders Treatment Rate New	0.01%	0.01%	0.01%	0.01%	0.01%
	PHC client treated for mental disorders - new	*2 220*	*555*	*1 110*	*1 665*	*2 220*
	PHC headcount - total	*22 246 464*	*5 561 616*	*11 123 232*	*16 684 848*	*22 246 464*

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.

Cost containment measures will be implemented without compromising patient care.

OUTCOME: UNIVERSAL HEALTH COVERAGE

Universal health coverage (UHC) consists of 4 pillars namely 1) access, 2) equitable distribution of resources, 3) sustainability and 4) efficiency of resources utilised. The Provincial Office plays a major role in the determining of policies and strategies.

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. This will have implications for both accessibility, efficiency, and effectiveness.

Access to District Health services, is a major part of UHC, and as such will be improved through various interventions. The implementation of the KZN integrated Multi-stakeholder Health Promotion and Wellbeing Strategy (IMHPWS) will promote healthy lifestyles at a community level and allow citizens to engage and be part of their own health solutions. Currently, regional roadshows are underway to sensitise and orientate all relevant stakeholders on this strategy.

The CCMDD programme ensures that KZN citizens have easy access to chronic medication thus making it easier to remain on treatment. This programme also reduces the workload at facilities, allowing improved clinical management of acutely ill patients and lessening waiting times.

District Hospitals assessments in relation to the Ideal Hospital Realisation and Maintenance Programme (IHRM) standards will be facilitated. The package of service for District Hospitals is under review, with the aim to standardize the package provincially.

OUTCOME: REDUCED MORBIDITY AND MORTALITY

The reduction of morbidity and mortality focuses on various programmes implemented through the service delivery platform. These are the HAST programme, the MCWH programme and the DPC programme, all designed to reduce the burden of disease.

HAST Programme: Will continue with the implementation of the 95 / 95 / 95 strategy for HIV/ AIDS and TB with the focus on the capacity building of clinicians on HIV management for children and facilitate the ongoing mentorship programme. Key population sensitization training for all health care workers will be fast tracked for implementation. Male health services will be strengthened with the focus on male clinicians to provide services to male clients. Patient literacy will continue as it is an important contributor to improved outcomes. The Districts are to conduct social mobilization in collaboration with civil society on the importance of adherence to treatment.

Maternal mortality: will be reduced through the implementation of the OMBU Model for identified hospitals with labour wards that are overcrowded with low risk women in labour. Implementation of the revised National syphilis in pregnancy screening guidelines, which is in line with revised national Vertical Transmission Prevention guidelines, to ensure reliable rapid syphilis testing at increased frequency during antenatal care will also improve outcomes. Introduction of minimum standards for safe and respectful care during labour, applicable to all designated birthing sites, including objective measurement of blood loss post-delivery. Introduction of the new Maternity case record , with training and mentoring on its use to ensure high quality care, antenatally, intrapartum and post-natal, with Advanced midwife clinical mentors in each sub-district.

Child mortality: and the high number of premature related deaths will be addressed by strengthening the couple year protection rate through improved long activating reversible contraceptives (LARC) and increasing the early ANC booking rate thus increasing the coverage of ANC steroids. The increase in coverage of the 24hr KMC will improve prognosis for premature babies.

Disease Prevention and Control: relates to the programmes Malaria, Chronic Conditions, Disability and Rehabilitation, Oral health and Mental Health.

Malaria: Mortality audits for malaria will continue in 2024/25, with continued health worker training on case management and health education. The rollout of indoor spraying will also assist in the control of malaria, as well screening the population along the borders to implement test and treat.

Chronic Conditions: Interventions include the adoption of Integrated Person Centred Health Service, promotion of multi-sectoral action between government departments, other sectors & civil society through national mandates and to achieve cohesion between programmes within the Department. Monitor NCD Cascades with the 90/60/50 Strategy through significantly improved surveillance.

Disability and Rehabilitation: Interventions include technical support of district rehabilitation staff to optimise limited resources.

Mental Health: Interventions include the appointment of roving mental health teams, tele-psychiatry hubs, the inclusion of screening for common mental health disorders at strategic points like maternity clinics, trauma clinics and key areas at hospital levels and the entrenching of the role of the recently trained auxiliary social workers in critical time interventions before Mental Health Care Users are discharged from acute admissions.

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

OUTCOME: CLIENT EXPERIENCE OF CARE

Patient experience of care will be improved with the strengthening of the implementation of Batho Pele Principles. Workshops to engage staff on their attitudes and responsibilities, will commence.

Patient safety is measured through the Patient Safety Incident system. The Department is currently in discussions with the Office of Health Standards Compliance to identify alternate platforms where PSI reporting can be accepted even when capturing cannot be done immediately due various reasons. Discussions also include a review of definitions related to capturing vs reporting/notification of PSI's.

ANNUAL OPERATIONAL PLAN 2024/25 INDICATORS

The following indicators are being monitored in the Annual Operational Plan (AOP) 24/25 to confirm implementation of provincial priorities and progress made against District Health Services (PHC).

- Patient Experience of Care satisfaction rate – PHC
- Patient Safety Incident (PSI) case closure rate –PHC facility
- Severity assessment code (SAC) 1 incident reported within 24 hours rate – PHC facility
- Life expectancy at birth
- Life expectancy at birth (female)
- Life expectancy at birth (male)
- Number of health care workers orientated on traditional medicine
- Number of Traditional Health care practitioners orientated on health systems
- Number of school health teams
- Number of ward based outreach teams
- Number of active clients on CCMDD

The following indicators are being monitored in the Annual Operational Plan (AOP) 24/25 to confirm implementation of provincial priorities and progress made against District Health Services (District Hospitals).

- Patient Experience of Care satisfaction rate – District Hospitals
- Patient Safety Incident (PSI) case closure rate – District Hospitals
- Severity assessment code (SAC) 1 incident reported within 24 hours rate – District Hospitals

The following indicators are being monitored in the Annual Operational Plan (AOP) 24/25 to confirm implementation of provincial priorities and progress made against HAST

- TB screening rate
- TB notification rate
- ART child under 15 years remain on ART end of period
- Number of HIV test done
- Male urethritis syndrome incidence
- Proportion of HIV positive people who are initiated on ART (%)

The following indicators are being monitored in the Annual Operational Plan (AOP) 24/25 to confirm implementation of provincial priorities and progress made against MCWH

- Death in facility under 1 year rate – total
- ANC clients initiated on ART rate
- Percentage of pregnant women tested positive for syphilis
- Percentage of syphilis positive pregnant female receive Benz-penicillin 1st Dose

The following indicators are being monitored in the Annual Operational Plan (AOP) 24/25 to confirm implementation of provincial priorities and progress made against Disease Prevention and Control.

- Malaria incidence per 1 000 population at risk
- Client seen by audiologist
- Client seen by physiotherapist
- Client seen by occupational therapist
- Client seen by speech therapist

PROGRAMME RESOURCE CONSIDERATIONS

Table 49: ***Budget allocation Estimates 2024/25 (R'000) (Programme 2)***

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
District Management	312 661	345 336	353 072	351 098	368 376	379 257	379 703	397 315	415 590
Community Health Clinics	4 794 183	4 602 318	5 090 933	5 376 496	5 796 288	5 845 671	5 992 062	6 263 434	6 551 552
Community Health Centres	1 943 766	2 029 292	1 723 106	2 201 253	2 362 516	2 389 186	2 452 708	2 559 493	2 677 230
Community Based Services	875 248	333 169	944 883	1 116 390	1 132 451	1 109 067	1 207 716	1 255 901	1 313 673
Other Community Services	3 276 155	4 754 847	3 896 066	2 565 015	1 515 071	2 158 253	1 652 508	1 728 221	1 807 718
HIV and AIDS	5 710 861	6 817 236	6 512 292	6 448 252	6 172 841	6 172 842	6 661 021	6 693 033	7 000 055
Nutrition	28 927	32 175	30 882	35 812	35 812	35 812	37 424	39 099	40 897
Coroner Services	251 335	272 956	281 252	286 304	286 304	301 985	325 670	339 576	355 194
District Hospitals	7 744 116	8 082 542	8 347 660	7 929 954	8 906 227	10 012 373	8 836 657	9 232 910	9 652 097
Sub-Total	24 937 252	27 269 871	27 180 146	26 310 574	26 575 886	28 404 446	27 545 469	28 508 982	29 814 006
Unauthorized expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Baseline available for spending after 1st charge	24 937 252	27 269 871	27 180 146	26 310 574	26 575 886	28 404 446	27 545 469	28 508 982	29 814 006

Table 50: ***Summary of Budget Allocations and Estimates by Economic Classification 2024/25 (R'000)*** *(Programme 2)*

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Current payments	24 341 051	26 455 979	26 571 638	25 576 984	25 845 824	27 662 151	26 754 511	27 699 420	28 973 869
Compensation of employees	15 353 786	17 102 838	17 295 821	15 939 732	16 699 183	17 617 442	16 540 318	17 345 513	18 119 549
Goods and services	8 986 965	9 352 549	9 275 153	9 636 785	9 146 170	10 043 931	10 213 663	10 353 353	10 853 741
Communication	57 661	68 989	92 677	66 489	85 400	90 059	98 691	101 736	106 174
Computer Services	-	-	-	14	145 062	145 063	250 093	66	69
Consultants, Contractors and special services	210 679	270 516	354 829	351 689	466 846	413 507	426 593	367 021	383 653
Inventory	5 189 876	4 819 129	4 785 731	5 215 049	4 220 642	4 903 397	4 934 782	5 289 274	5 558 284
Operating leases	38 375	41 119	47 543	51 491	49 605	48 496	51 167	53 460	56 289
Travel and subsistence	26 617	31 376	49 827	65 069	54 312	56 252	47 514	49 678	51 712
Maintenance, repair and running costs	95 250	130 877	176 568	159 529	146 737	170 184	154 502	161 427	168 853
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	3 368 507	3 990 543	3 767 978	3 727 455	3 977 566	4 216 973	4 250 321	4 330 691	4 528 707
Interest and rent on land	300	592	664	467	471	778	530	554	579
Transfers and subsidies to	364 206	469 946	466 758	473 672	476 767	520 570	494 457	516 541	533 359
Provinces and municipalities	199 352	249 303	263 662	275 373	275 373	275 373	286 945	299 800	306 096
Departmental agencies and accounts	154	80	45	58	60	165	61	63	66
Higher education institutions	-	-	-	-	-	-	-	-	-
Non-profit institutions	51 651	53 489	63 440	64 778	66 773	66 807	67 693	70 726	73 979

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Households	113 049	167 074	139 611	133 463	134 561	178 225	139 758	145 952	153 218
Payments for capital assets	231 896	343 434	141 403	259 918	253 295	221 382	296 501	293 021	306 778
Buildings and other fixed structures	-	26	-	-	-	-	-	-	-
Machinery and equipment	231 896	343 408	141 403	259 918	253 295	221 382	296 501	293 021	306 778
Payment for financial assets	99	512	347	-	-	343	-	-	-
Total economic classification	24 937 252	27 269 871	27 180 146	26 310 574	26 575 886	28 404 446	27 545 469	28 508 982	29 814 006
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	24 937 252	27 269 871	27 180 146	26 310 574	26 575 886	28 404 446	27 545 469	28 508 982	29 814 006

PERFORMANCE AND EXPENDITURE TRENDS

Programme 2 is allocated 51.2% of the Vote 7 budget, a decrease from the 23/24 revised estimates. This amounts to a decrease of R 1858 977 (-3.0%).

UPDATED KEY RISKS AND MITIGATION

Table 51: Updated key risks and mitigation 2024/25 (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 strategy
	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 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 Organisational Structure
	Orientation and Re-orientation on Outbreak Response Team

Key Risks	Risk Mitigation
Improper management of HCRW	Enforce compliance to the legislation and HCRW policy
Inability to eliminate malaria	Intensify malaria education, indoor residual spraying and surveillance
Re-emergence of diseases	Strengthen risk communication and community engagement
Climate change	Awareness campaigns on climate change impacts Establishing of early warning systems in all municipalities
Low uptake of TB & HIV services in men	Re-train clinicians on men's health to improve clinical management Monitor TB and HIV indicators of men's health uptake
High loss to follow up for HV and TB	Monitor adherence guidelines and patient literacy implementation Facilitate auctioning of loss to missed appointment line lists
High HIV and TB death rate	Conduct Advocacy, communication, and social mobilisation to promote early health seeking behaviour. Market HIV and TB services in communities to improve health service uptake Provide community-based services to improve access
Poor care for women in labour, creating a high risk of both maternal and perinatal adverse outcomes.	Prioritise maternity staffing, ensure cost-effective allocation of midwives to where they are most needed
	OMBU model reduces the need for emergency transfer when complications arise during labour. Ensure availability of inter-transfer. Lobby for allocation for dedicated obstetrics ambulances
Poor performance levels leading to poor quality of care	Representation of MCWH & nutrition staffing needs on strategic platforms, e.g., HR Planning, District Health Services, National HR Strategy
Poor Oral Health Outcomes: Incomplete Medical Dental Teams	Motivate for employment all cadres of oral health service needed to balance up with ratios provided by norms and standards of oral health service.
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
Shortage of specialist nurses	Empowerment of non-specialised nurses until training can commence again
Inadequate patient records and records keeping	Continuous audits of nursing documentation
Increased patient safety incidents	Proper risk assessments and mitigation

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 52: EMS Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited I Performance			Estimated Performance	MTEF period		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: UNIVERSAL HEALTH COVERAGE								
EMS P1 urban response under 30 minutes	21. EMS P1 urban response under 30 minutes rate	50.9%	42.9%	41.9%	40.3%	42.0%	51.0%	52.0%
	EMS P1 urban response under 30 minutes	*62 018*	*44 726*	*39 676*	*40 280*	*46 200*	*58 650*	*62 400*
	EMS P1 urban responses	*121 770*	*104 286*	*94 781*	*100 048*	*110 000*	*115 000*	*120 000*
EMS P1 rural response under 60 minutes	22. EMS P1 rural response under 60 minutes rate	52.4%	51.1%	48.2%	46.6%	48.0%	50.0%	51.0%
	EMS P1 rural response under 60 minutes	*82 307*	*74 251*	*70 063*	*64 300*	*67 200*	*75 000*	*81 600*
	EMS P1 rural responses	*157 011*	*145 328*	*145 497*	*138 096*	*140 000*	*150 000*	*160 000*

Table 53: EMS Output Indicators Quarterly and Annual Targets

Indicator Name	2024/25				
	Annual Targets	Q1	Q2	Q3	Q4
QUARTERLY INDICATORS					
OUTCOME: UNIVERSAL HEALTH COVERAGE					
21. EMS P1 urban response under 30 minutes rate	42.0%	42.0%	42.0%	42.0%	42.0%
EMS P1 urban response under 30 minutes	*46 200*	*11 550*	*11 550*	*11 550*	*11 550*
EMS P1 urban responses	*110 000*	*27 500*	*27 500*	*27 500*	*27 500*
22. EMS P1 rural response under 60 minutes rate	48.0%	48.0%	48.0%	48.0%	48.0%
EMS P1 rural response under 60 minutes	*67 200*	*16 800*	*16 800*	*16 800*	*16 800*
EMS P1 rural responses	*140 000*	*35 000*	*35 000*	*35 000*	*35 000*

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

The Emergency Medical Services Unit will align to the National Department of Health with regards to EMS strategies in rendering services and to improve outcomes. There will be a focus on maximizing revenue generation combined with improved resource utilisation to minimize loss of life. Infrastructure needs in the form of wash bays are also prioritised.

Identification of satellite bases that are strategically located, will improve outcomes. A vehicle management service provided has been engaged to increase the pool of service providers and improve supervision of fleet matters. EMS operational staff roster and working hours to be revised in order to reduce the compulsory overtime expenditure. Once this has been achieved, EMS will have budget for the employment of new staff to ensure the operational schedule is maximized.

PROGRAMME RESOURCE CONSIDERATIONS

Table 54: ***Budget allocation Estimates 2024/25 (R'000) (Programme 3)***

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Emergency Services	1 478 434	1 434 921	1 490 117	1 473 709	1 473 709	1 466 736	1 550 374	1 619 122	1 693 600
Planned Patient Transport	127 493	161 845	177 749	181 806	203 906	253 363	239 405	248 786	260 228
Sub-Total	1 605 927	1 596 766	1 667 866	1 655 515	1 677 615	1 720 099	1 789 779	1 867 908	1 953 828
Unauthorized expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Baseline available for spending after 1st charge	1 605 927	1 596 766	1 667 866	1 655 515	1 677 615	1 720 099	1 789 779	1 867 908	1 953 828

Table 55: ***Summary of Budget Allocations and Estimates by Economic Classification 2024/25 (R'000) (Programme 3)***

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Current payments	1 429 072	1 512 031	1 568 514	1 558 285	1 580 385	1 622 645	1 689 073	1 762 692	1 843 773
Compensation of employees	1 074 827	1 189 352	1 221 376	1 217 755	1 239 855	1 259 912	1 296 010	1 352 492	1 414 706
Goods and services	354 242	322 675	346 688	340 530	340 530	362 721	393 063	410 200	429 067
Communication	9 246	9 577	9 449	10 081	10 026	9 897	10 712	11 192	11 707
Computer Services	-	-	-	-	-	-	-	-	-
Consultants, Contractors and special services	2 707	2 754	2 889	2 261	3 020	1 791	3 313	3 461	3 619
Inventory	35 669	23 552	23 761	25 482	26 417	20 965	36 917	38 572	40 346

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Operating leases	2 581	2 301	2 837	3 003	3 043	2 939	3 023	3 159	3 304
Travel and subsistence	649	2 089	1 029	2 851	1 878	2 564	2 087	2 181	2 281
Maintenance, repair and running costs	215 611	218 225	246 307	225 516	226 756	260 632	251 161	261 938	273 987
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	87 779	64 177	60 416	71 336	69 390	63 933	85 850	89 697	93 823
Interest and rent on land	3	4	450	-	-	12	-	-	-
Transfers and subsidies to	5 818	13 920	16 657	6 830	6 830	7 032	7 137	7 456	7 799
Provinces and municipalities	2 030	1 873	2 993	3 401	3 401	2 992	3 554	3 713	3 884
Departmental agencies and accounts	-	-	-	2	2	2	2	2	2
Higher education institutions	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	3 788	12 047	13 664	3 427	3 427	4 038	3 581	3 741	3 913
Payments for capital assets	171 037	70 815	82 683	90 400	90 400	90 400	93 569	97 760	102 256
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Machinery and equipment	171 037	70 815	82 683	90 400	90 400	90 400	93 569	97 760	102 256
Payment for financial assets	-	-	12	-	-	22	-	-	-
Total economic classification	1 605 927	1 596 766	1 667 866	1 655 515	1 677 615	1 720 099	1 789 779	1 867 908	1 953 828
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	1 605 927	1 596 766	1 667 866	1 655 515	1 677 615	1 720 099	1 789 779	1 867 908	1 953 828

PERFORMANCE AND EXPENDITURE TRENDS

Programme 3 is allocated 3.3% of the Vote 7 budget, maintaining the same allocation as the 23/24 revised estimates. This amounts to an actual rand value increase of R 69 680 000.

UPDATED KEY RISKS AND MITIGATION

Table 56: Updated key risks and mitigation (EMS)

Key Risks	Risk Mitigation
Outcome: Universal Health Coverage	
Budget constraints	Long Term Plan strategies to improve efficiencies with existing resources
	Robust monitoring of expenditure against budget.
	Improve revenue generation
Inadequate electronic information system	Re-prioritise electronic information system for triage as part of the ICT strategy
	Implementation of a computer aided dispatch (CAD) system in EMS communication centers.
Inadequate ambulance fleet	Prioritise procurement of ambulances (Long Term Plan) to replace old fleet
	Fleet management plan, including repairs
Inadequate EMS infrastructure	More effective use of existing infrastructure at facilities
	Prioritise according to need analysis and include in 10 year infrastructure plan

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.

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.

PROGRAMME 4 COMBINED

Table 57: Programme 4 Combined Outcome Indicators and Targets

Indicator Name		Data Source	South Africa		Provincial		MTEF Period		
			Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2024/25	2025/26	2026/27
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE									
XXIV	Patient Experience of Care satisfaction rate	Patient Safety Incidence Software	Not Available	Not Available	81.4%	86.1%	86.1%	87.8%	91.3%
	Patient experience of care survey satisfied responses (Total Responses)	Patient Safety Incidence Report	-	-	*4 969*	*107 308*	*107 308*	*108 388*	*112 764*
	Patient experience of care survey total responses		-	-	*6 101*	*124 700*	*124 700*	*123 500*	*123 540*
XXV	Patient Safety Incident (PSI) case closure rate	Patient Survey Database	Not Available	Not Available	90.8%	98.1%	98.1%	98.1%	98.1%
	Patient Safety Incident (PSI) case closed	Patient Surveys	-	-	*612*	*2 707*	*2 707*	*2 705*	*2 705*
	Patient Safety Incident (PSI) case reported		-	-	*674*	*2 760*	*2 760*	*2 756*	*2 756*
OUTCOME: REDUCED MORBIDITY AND MORTALITY									
XXVI	Maternal deaths in facility	Maternal death register	Not Available	Not Available	82	25	25	25	25
	Number Maternal death in facility				*82*	*25*	*25*	*25*	*25*
	No denominator				-	-	-	-	-
XXVII	Death in facility under 5 years	Midnight report	Not Available	Not Available	1 566	1 710	1 710	1 667	1 650
	Number Death in facility under 5 years total				*1 566*	*1 710*	*1 710*	*1 667*	*1 650*
	No denominator				-	-	-	-	-
XXVIII	Diarrhoea death under 5 years	Midnight report	Not Available	Not Available	68	48	48	46	44

Indicator Name	Data Source	South Africa		Provincial		MTEF Period		
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2024/25	2025/26	2026/27
Number diarrhoea death under 5 years				*68*	*48*	*48*	*46*	*44*
No denominator				-	-	-	-	-
XXIX Pneumonia death under 5 years	Midnight report	Not Available	Not Available	100	103	103	103	103
Number Pneumonia death under 5 years				*100*	*103*	*103*	*103*	*103*
No denominator				-	-	-	-	-
XXX Severe acute malnutrition (SAM) death under 5 years	Midnight report	Not Available	Not Available	76	49	49	14	7
Number Severe acute malnutrition (SAM) death under 5 years				*76*	*49*	*49*	*14*	*7*
No denominator				-	-	-	-	-

Note: For programme specific indicators, per level of care please refer to Annexure C

Table 58: Programme 4 Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Period		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE								
Severity Assessment Code (SAC) 1 incidence reported within 24 hrs	23. Severity assessment code (SAC) 1 incident reported within 24 hours rate	76.7%	82.5%	91.7%	100.0%	100.0%	100.0%	100.0%
	Severity assessment code (SAC) 1 incident reported within 24 hours	*333*	*353*	*299*	*257*	*261*	*268*	*268*
	Severity assessment code (SAC) 1 incident reported	*434*	*428*	*326*	*257*	*261*	*268*	*268*

Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Period		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: REDUCED MORBIDITY AND MORTALITY								
Cervical cancer screening	24. Cervical Cancer screening	New indicator	New indicator	New indicator	5 800	6 700	6 940	7 000
	Number Cervical Cancer Screening done				*5 800*	*6 700*	*6 940*	*7 000*
	No denominator				-	-	-	-

Note: For programme specific indicators, per level of care please refer to Annexure C

Table 59: Programme 4 Output Indicators Quarterly and Annual Targets

Indicator Name	2024/25				
	Annual targets	Q1	Q2	Q3	Q4
ANNUAL INDICATORS					
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE					
XXIV Patient Experience of Care satisfaction rate	86.1%				
Patient experience of care survey satisfied responses (Total Responses)	*107 308*				
Patient experience of care survey total responses	*124 700*				
XXV Patient Safety Incident (PSI) case closure rate	98.1%	98.1%	98.1%	98.1%	98.1%
Patient Safety Incident (PSI) case closed	*2 707*	*676*	*1 352*	*2 029*	*2 707*
Patient Safety Incident (PSI) case reported	*2 760*	*689*	*1 378*	*2 069*	*2 760*
OUTCOME: REDUCED MORBIDITY AND MORTALITY					
XXVI Maternal deaths in facility	25				
Number Maternal death in facility	*25*				
No denominator	-				
XXVII Death in facility under 5 years	1 710	427	854	1 282	1 710

Indicator Name		2024/25				
		Annual targets	Q1	Q2	Q3	Q4
	Number Death in facility under 5 years total	*1 710*	*427*	*854*	*1 282*	*1 710*
	No denominator	-	-	-	-	-
XXVIII	Diarrhoea death under 5 years	48	12	24	36	48
	Number diarrhoea death under 5 years	*48*	*12*	*24*	*36*	*48*
	No denominator	-	-	-	-	-
XXIX	Pneumonia death under 5 years	103	25	51	77	103
	Number Pneumonia death under 5 years	*103*	*25*	*51*	*77*	*103*
	No denominator	-	-	-	-	-
XXX	Severe acute malnutrition (SAM) death under 5 years	49	12	25	36	49
	Number Severe acute malnutrition (SAM) death under 5 years	*49*	*12*	*25*	*36*	*49*
	No denominator	-	-	-	-	-
QUARTERLY INDICATORS						
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE						
23.	Severity assessment code (SAC) 1 incident reported within 24 hours rate	100.0%	100.0%	100.0%	100.0%	100.0%
	Severity assessment code (SAC) 1 incident reported within 24 hours	*261*	*65*	*130*	*195*	*261*
	Severity assessment code (SAC) 1 incident reported	*261*	*65*	*130*	*195*	*261*
OUTCOME: REDUCED MORBIDITY AND MORTALITY						
24.	Cervical Cancer screening	6 700	1 675	3 350	5 025	6 700
	Number Cervical Cancer Screening done	*6 700*	*1 675*	*3 350*	*5 025*	*6 700*
	No denominator	-	-	-	-	-

Note: For programme specific indicators, per level of care please refer to Annexure C

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 hospitals across the Province, particularly where there is a trend of low bed-occupancy rates and low demand for services.

Access to care: Equitable distribution of resources according to service demand shall be monitored including recommendations for clinical disciplines which should be prioritized for registrar training as well as post basis nurse training intake. These recommendations shall be based on the current disease burden in the Province which includes an escalating number of surgical trauma and orthopaedic cases, patients that require nephrology as well as oncology services.

The Department aims to pilot a centralized radiology reporting. This system will pool radiologists into centralized regions where all hospitals with scans to be reported upon will be transmitted to and reported upon by this pool of radiologists thus ensuring efficiencies and reducing backlogs in CT scans reporting.

Strengthen outreach services: Monitoring of outreach services shall be strengthened through establishment of quarterly outreach forums in all the 3 regions.

A strategy to decentralize specialised services according to disease burden and capacity or resource availability irrespective of the level of care shall be developed and presented to Manco.

NHI readiness: The Department will continue to support all hospitals towards accreditation and certification by OHSC. This indicator is being monitored in the program AOP and is included in the KRA of all CEOs. A strategy has been developed to support hospitals to achieve 100% compliance with Non Negotiable Vital(NNV) Measures which was identified as the main contributing factor for hospitals to fail both the OHSC and IDEAL Hospital accreditation assessments. This strategy involves central procurement through a Provincial contract of all NNV items which are required in all emergency trolleys.

A system for strict monitoring for compliance with Early Warning System Reporting with OHSC was developed in 2023/24, monitored as an indicator in the AOP and will be sustained in the subsequent years of the MTEF.

Clinical Governance: The Department will continue to support a culture of compliance with strong clinical governance systems in all hospitals working in partnership with Quality Assurance Directorate. Compliance with guidelines for management of Patient Safety Incidents, Morbidity and Mortality Reviews, Clinical Audits, Infection Prevention and Control and all aspects of the Quality Assurance Policy Framework shall be sustained.

The Department shall continue to work on policies relating to hospital services, including the referral policy and the clinical outreach framework policy.

To strengthen general program performance, a CEO monthly hospital management reporting tool shall be developed which will include a selected list of a minimum data set to monitor the functioning of hospitals and their efficiencies. Hospital management support will be strengthened through development of a CEO handbook.

OUTCOME: REDUCED MORBIDITY AND MORTALITY

The Department will support the provision of safe quality patient care according to standard treatment guidelines across all programs. Performance of Strategic Health Programs shall be a priority and shall be closely monitored. Projects geared towards addressing the complications of the current disease burden shall be prioritized. These include ensuring fully functional theatres, partnering with outside stakeholders to reduce surgical backlogs. Projects responding to the disease burden as a result of non-communicable diseases shall be prioritized.

Regional Hospitals: PKISMH has been opened and all disciplined required for the regional hospital package of services have been commissioned with the exception of obstetrics, gynaecology and paediatrics, which are still provided at Mahatma Gandhi Memorial Hospital. The hospital was officially opened by the Honourable President Mr. Cyril Ramaphosa on the 24th of November 2023. As part of the commissioning process, a skills audit was done to determine the number of available suitably qualified personnel to commission obstetrics and gynae as well as paediatric services. The finding was that the current numbers in the hospital organogram were not adequate and a review of the hospital organizational structure was conducted. The finalized organizational structure is in the process of approval by the office of the Accounting Officer. Costing for commissioning the outstanding services was also concluded and services will be commissioned when budget is available.

During the 2024/25 financial year, Program 4 aims to commission the remaining 30 beds of the 54 bed newly built psychiatric ward at King Dinuzulu Regional Hospital.

A strategy shall be piloted to assist hospitals at the periphery including Madadeni and Ladysmith Regional Hospitals to be able to appoint and retain specialists and or sustain specialised services.

The Identified Regional Hospitals including General justice Gizenga Mpanza, Madadeni, Port Shepstone, Harry Gwala, Dr Pixley kalsaka Seme Memorial Hospital and Ladysmith shall be supported to commence and sustain chronic haemodialysis services.

The chronic haemodialysis services output for Addington Hospital shall be increased through allocation of a minimum of five(5) new dialysis machines in the financial year.

TB Hospitals: The Department has observed over years a decline in the bed utilization rate of all TB Specialised Hospitals . These hospitals admit patients with complicated TB including Multidrug resistant TB and Xtreme Drug resistant TB. However, with a change in treatment guidelines for drug resistant TB patients, more and more patients are treated at a community level without being admitted. Therefore the Province upon realizing that the TB Specialized hospitals were inefficient, decided to include them in the Provincial Hospitals Rationalisation Plan.

This rationalization plan in the past 3 to 7 years has led to the closure of Dunstan Farrell, Don McKenzie and Charles James TB Specialised Hospitals. St Margaret's a TB Hospital in Harry Gwala District changed its package of service to that of a Community Health Centre through the rationalization process. Thulasizwe TB Hospital in Zululand District is in the process of being merged with Ceza District Hospital whilst Richmond TB Hospital in uMgungundlovu changed its package of services and is being developed to a District Hospital following infrastructure investments as part of COVID 19 bed repurposing exercise.

Doris Goodwin currently designated as a TB Specialised Hospital has also been included in the Provincial rationalisation plan due to its continued low utilisation rates. This hospital is constructed in close proximity to Harry Gwala Regional Hospital.

In order to maximise its use, the Department considered that this hospital be merged with Harry Gwala regional Hospital. As of the 2023/2024 financial years, the two hospitals are already functioning collaboratively with Harry Gwala stepping down some of its patients to Doris Goodwin. The infrastructure of Doris Goodwin needs to be assessed to look at other services that can be provided in this hospital according to clinical services needs even outside of Harry Gwala Hospital and discussions are held in this regard. A package of service will then be crafted specific to this hospital and this will be followed by an official tabling of the merger in the Provincial Chamber and the rest of other relevant stakeholders as required.

The Program will conduct an infrastructure assessment and develop recommendations on the package of service for Doris Goodwin

Psychiatric Hospitals: Continue with the transfer of patients with intellectual disabilities from Ekuhlengeni Hospital in Amanzimtoti to uMngeni Hospital in Howick. While infrastructure refurbishments were finalised at the uMngeni Hospital and ward renovations to accommodate these patients were done, resourcing processes are still in progress in that HR and equipment costing of resources has been submitted Head of Department: Health for approval and is being considered for 2024/25.

Review the package of services for Ekuhlengeni Psychiatric Hospital and monitor the bed utilization rates against the reviewed bed state on the hospital.

Chronic Hospitals: Hillcrest Hospital currently designated and gazetted as a Chronic Rehabilitation Hospital was reviewed. An approval was granted to review the package of service for this hospital towards its redesignation as a Provincial Physical Rehabilitation Hospital. This need came as a result of high trauma rate and complications of non-communicable diseases amongst others which lead to permanent disability if no appropriate rehabilitation services are provided. Hillcrest will therefore be the hospital that provides short to medium term rehabilitation to patients to prevent permanent disability and to improve the quality of life. A plan was presented and approved by Manco and this plan will be implemented in stages. In the 2024/2025 financial year, a review of the organisational HR structure of the Hillcrest Hospital will be done. This process if essential to ensure that as a rehabilitation hospital, the hospital is equipped with appropriate professionals for this purpose. Coupled with this process of organisational structure review will be a Physical Infrastructure assessment; the process which will help identify infrastructure related needs that fit rehabilitation service needs

OUTCOME: CLIENT EXPERIENCE OF CARE

The Department will engage Districts to develop systems that will keep clients informed of expected waiting times and educated on patient rights and responsibilities.

ANNUAL OPERATIONAL PLAN 2024/25 INDICATORS

The following indicators are being monitored in the Annual Operational Plan (AOP) 24/25 to confirm implementation of provincial priorities and progress made against Regional Hospitals.

- Patient Experience of Care satisfaction rate – Regional Hospital
- Patient Safety Incident (PSI) case closure rate – Regional Hospital
- Maternal deaths in facility - Regional Hospital
- Deaths in facility under 5 years - Regional Hospitals
- Diarrhoea death under 5 years – Regional Hospital
- Pneumonia death under 5 years - Regional Hospital

- Severe acute malnutrition death under 5 years – Regional Hospital
- Severity assessment code (SAC) 1 incident reported within 24 hours rate – Regional Hospital
- Cervical cancer screening - Regional Hospitals

The following indicators are being monitored in the Annual Operational Plan (AOP) 24/25 to confirm implementation of provincial priorities and progress made against Specialised TB Hospitals.

- Patient Experience of Care satisfaction rate – Specialised TB Hospital
- Patient Safety Incident (PSI) case closure rate – Specialised TB Hospital
- Severity assessment code (SAC) 1 incident reported within 24 hours rate – Specialised TB Hospital

The following indicators are being monitored in the Annual Operational Plan (AOP) 24/25 to confirm implementation of provincial priorities and progress made against Specialised Psychiatric Hospitals.

- Patient Experience of Care satisfaction rate – Specialised Psychiatric Hospital
- Patient Safety Incident (PSI) case closure rate – Specialised Psychiatric Hospital
- Severity assessment code (SAC) 1 incident reported within 24 hours rate – Specialised Psychiatric Hospital

The following indicators are being monitored in the Annual Operational Plan (AOP) 24/25 to confirm implementation of provincial priorities and progress made against Specialised Chronic Hospitals.

- Patient Experience of Care satisfaction rate – Specialised Chronic Hospital
- Patient Safety Incident (PSI) case closure rate – Specialised Chronic Hospital
- Severity assessment code (SAC) 1 incident reported within 24 hours rate – Specialised Chronic Hospital

PROGRAMME RESOURCE CONSIDERATIONS

*Table 60: Budget allocation Estimates 2024/**25 (R'000) (Programme 4)***

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
General (Regional) Hospitals	9 376 385	9 916 354	10 432 675	10 202 275	10 683 534	11 513 555	11 103 367	11 456 784	11 966 141
Tuberculosis Hospitals	635 243	481 509	496 359	500 580	476 506	480 143	500 027	524 091	546 438
Psychiatric-Mental Hospitals	975 904	1 004 378	1 019 296	1 062 658	1 106 352	1 142 235	1 165 576	1 217 567	1 273 577
Sub-acute, Step-down and Chronic Medical Hospitals	317 902	322 245	366 697	379 146	370 793	332 231	426 737	444 397	464 354
Dental Training Hospital	20 205	21 270	19 500	20 090	21 411	20 446	20 661	21 671	22 668
Sub-Total	11 325 639	11 745 756	12 334 527	12 164 749	12 658 596	13 488 610	13 216 368	13 664 510	14 273 178
Unauthorized expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Baseline available for spending after 1st charge	11 325 639	11 745 756	12 334 527	12 164 749	12 658 596	13 488 610	13 216 368	13 664 510	14 273 178

*Table 61: **Summary of Budget Allocations and Estimates by Economic Classification 2024/25 (R'000)** (Programme 4)*

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Current payments	11 102 742	11 386 381	12 175 507	11 859 406	12 409 024	13 260 362	12 911 519	13 346 987	13 941 049
Compensation of employees	8 269 554	8 549 370	8 920 862	9 073 954	9 545 713	9 744 274	9 577 702	9 969 437	10 409 490
Goods and services	2 833 149	2 836 657	3 254 411	2 785 448	2 863 307	3 515 473	3 333 813	3 377 546	3 531 555
Communication	17 128	17 148	16 796	20 990	19 546	17 065	20 927	21 866	22 845

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Computer Services	158	137	137	176	80	66	84	88	92
Consultants, Contractors and special services	418 872	321 567	326 432	372 394	321 407	353 720	353 154	368 349	385 173
Inventory	1 324 645	1 371 991	1 655 846	1 068 083	1 208 379	1 801 631	1 444 104	1 438 786	1 504 542
Operating leases	15 775	16 741	19 498	32 270	29 685	18 485	40 338	42 145	44 052
Travel and subsistence	1 934	1 626	1 493	3 233	3 061	3 139	3 400	3 553	3 714
Maintenance, repair and running costs	12 580	20 762	27 106	16 042	19 118	25 446	19 976	20 870	21 792
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	1 042 057	1 086 685	1 207 103	1 272 260	1 262 031	1 295 921	1 451 830	1 481 889	1 549 345
Interest and rent on land	39	354	234	4	4	615	4	4	4
Transfers and subsidies to	98 425	211 951	118 498	90 205	90 205	129 545	94 265	98 488	103 018
Provinces and municipalities	-	-	-	-	-	-	-	-	-
Departmental agencies and accounts	68	87	65	113	113	77	118	123	129
Higher education institutions	-	-	-	-	-	-	-	-	-
Non-profit institutions	5 643	3 989	-	-	-	-	-	-	-
Households	92 714	207 875	118 433	90 092	90 092	129 468	94 147	98 365	102 889
Payments for capital assets	124 438	147 400	40 023	215 138	159 367	98 628	210 584	219 035	229 111
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Machinery and equipment	124 438	147 400	40 023	215 138	159 367	98 628	210 584	219 035	229 111
Payment for financial assets	34	24	499	-	-	75	-	-	-

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Total economic classification	11 325 639	11 745 756	12 334 527	12 164 749	12 658 596	13 488 610	13 216 368	13 664 510	14 273 178
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	11 325 639	11 745 756	12 334 527	12 164 749	12 658 596	13 488 610	13 216 368	13 664 510	14 273 178

PERFORMANCE AND EXPENDITURE TRENDS

Programme 4 is allocated 24.6% of the Vote 7 budget, a decrease from 24.9% allocation in the 23/24 revised estimates. This equates to a decrease in allocation amounts to an actual rand value increase of R 272 242 000 (-2.0%).

UPDATED KEY RISKS AND MITIGATION

Table 62: Updated key risks and mitigation 2024/25 (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

PROGRAMME 5: CENTRAL AND TERTIARY HOSPITALS

Programme Purpose

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

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.

PROGRAMME 5 COMBINED

Table 63: Programme 5 Outcome Indicators and Targets 2024/25

Indicator Name		Data Source	South Africa		Provincial		MTEF Period		
			Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2024/25	2025/26	2026/27
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE									
XXXI	Patient Experience of Care satisfaction rate	Patient Safety Incidence Software	Not Available	Not Available	79.2%	88.2%	88.2%	88.0%	92.9%
Patient experience of care survey satisfied responses (Total Responses)		Patient Safety Incidence Report			*928*	*52 920*	*52 920*	*53 721*	*57 684*
Patient experience of care survey total responses					*1 171*	*60 000*	*60 000*	*61 047*	*62 093*
XXXII	Patient Safety Incident (PSI) case closure rate	Patient Survey Database	Not Available	Not Available	74.4%	97.4%	97.4%	97.6%	98.1%
Patient Safety Incident (PSI) case closed		Patient Surveys			*348*	*2 192*	*2 192*	*2 436*	*2 472*
Patient Safety Incident (PSI) case reported					*468*	*2 250*	*2 250*	*2 496*	*2 519*
OUTCOME: REDUCED MORBIDITY AND MORTALITY									
XXXIII	Maternal deaths in facility	Maternal death register	Not Available	Not Available	29	13	13	13	13
Number Maternal death in facility					*29*	*13*	*13*	*13*	*13*
No denominator					-	-	-	-	-
XXXIV	Death in facility under 5 years	Midnight report	Not Available	Not Available	442	458	458	447	437
Number Death in facility under 5 years total					*442*	*458*	*458*	*447*	*437*
No denominator					-	-	-	-	-
XXXV	Diarrhoea death under 5 years	Midnight report	Not Available	Not Available	8	4	4	4	4
Number diarrhoea death under 5 years					*8*	*4*	*4*	*4*	*4*

Indicator Name		Data Source	South Africa		Provincial		MTEF Period		
			Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2024/25	2025/26	2026/27
	No denominator				-	-	-	-	-
XXXVI	Pneumonia death under 5 years	Midnight report	Not Available	Not Available	51	34	34	34	34
	Number Pneumonia death under 5 years				*51*	*34*	*34*	*34*	*34*
	No denominator				-	-	-	-	-
XXXVII	Severe acute malnutrition (SAM) death under 5 years	Midnight report	Not Available	Not Available	9	8	8	7	3
	Number Severe acute malnutrition (SAM) death under 5 years				*9*	*8*	*8*	*7*	*3*
	No denominator				-	-	-	-	-

Table 64: Programme 5 Outputs, Output Indicators and Targets 2024/25

Outputs	Output Indicator		Audited Performance			Estimated Performance	MTEF Period		
			2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE									
Severity Assessment Code (SAC) 1 incidence reported within 24 hrs	25.	Severity assessment code (SAC) 1 incident reported within 24 hours rate	85.9%	80.5%	91.0%	82.4%	100.0%	100.0%	100.0%
		Severity assessment code (SAC) 1 incident reported within 24 hours	*128*	*128*	*111*	*112*	*136*	*135*	*142*
		Severity assessment code (SAC) 1 incident reported	*149*	*159*	*122*	*136*	*136*	*135*	*142*
OUTCOME: REDUCED MORBIDITY AND MORTALITY									

Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Period		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
Cervical cancer screening	26. Cervical cancer screening	New indicator	New indicator	New indicator	1 118	1 480	1 500	1 500
	Number Cervical Cancer Screening Done				*1 118*	*1 480*	*1 500*	*1 500*
	No denominator				-	-	-	-

Table 65: Programme 5 Output Indicators Quarterly and Annual Targets 2024/25

Indicator Name	2024/25				
	Annual Target	Q1	Q2	Q3	Q4
ANNUAL INDICATORS					
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE					
XXXI Patient Experience of Care satisfaction rate	88.2%				
Patient experience of care survey satisfied responses (Total Responses)	*52 920*				
Patient experience of care survey total responses	*60 000*				
XXXII Patient Safety Incident (PSI) case closure rate	97.4%	97.3%	97.4%	97.4%	97.4%
Patient Safety Incident (PSI) case closed	*2 192*	*547*	*1 095*	*1 643*	*2 192*
Patient Safety Incident (PSI) case reported	*2 250*	*562*	*1 124*	*1 686*	*2 250*
OUTCOME: REDUCED MORBIDITY AND MORTALITY					
XXXIII Maternal deaths in facility	13				
Number Maternal death in facility	*13*				
No denominator	-				
XXXIV Death in facility under 5 years	458	114	228	343	458

Indicator Name		2024/25				
		Annual Target	Q1	Q2	Q3	Q4
	Number Death in facility under 5 years total	*458*	*114*	*228*	*343*	*458*
	No denominator	*-*	*-*	*-*	*-*	*-*
XXXV	Diarrhoea death under 5 years	4	1	2	3	4
	Number diarrhoea death under 5 years	*4*	*1*	*2*	*3*	*4*
	No denominator	*-*	*-*	*-*	*-*	*-*
XXXVI	Pneumonia death under 5 years	34	7	16	25	34
	Number Pneumonia death under 5 years	*34*	*7*	*16*	*25*	*34*
	No denominator	*-*	*-*	*-*	*-*	*-*
XXXVII	Severe acute malnutrition (SAM) death under 5 years	8	1	3	5	8
	Number Severe acute malnutrition (SAM) death under 5 years	*8*	*1*	*3*	*5*	*8*
	No denominator	*-*	*-*	*-*	*-*	*-*
QUARTERLY INDICATORS						
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE						
25.	Severity assessment code (SAC) 1 incident reported within 24 hours rate	100.0%	100.0%	100.0%	100.0%	100.0%
	Severity assessment code (SAC) 1 incident reported within 24 hours	*136*	*34*	*68*	*102*	*136*
	Severity assessment code (SAC) 1 incident reported	*136*	*34*	*68*	*102*	*136*
OUTCOME: REDUCED MORBIDITY AND MORTALITY						
26.	Cervical cancer screening	1 480	370	740	1 110	1 480
	Number Cervical Cancer Screening Done	*1 480*	*370*	*740*	*1 110*	*1 480*
	No denominator	*-*	*-*	*-*	*-*	*-*

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: UNIVERSAL HEALTH COVERAGE

Improving access to Tertiary Services: The Department will continue to strengthen oncology services in the northern parts of the Province at Ngwelezana Hospital. Chemotherapy services will be commissioned at Ngwelezana Hospital. An Oncology Services Unit Human Resources Organisational Structure will be drawn. An Oncology unit business case will be concluded and submitted for approval to the National Department of Health. An Oncology unit clinical brief will be concluded and submitted for approval to the National Department of Health.

Training priorities for both registrar and specialised nurse training will be identified and submitted as identified based on the disease burden and needs of the Province.

Improve and strengthen tertiary package of service at King Edward and Ngwelezana Tertiary Hospitals.

The following tertiary services will be strengthened:

- Neurosurgery at Greys
- Nephrology at Ngwelezana
- Modernization of tertiary services through provision of high-end equipment including the following:
    - Linear Accelerator for Greys
    - MRI Scan for King Edward
    - X Ray Bulky Unit for King Edward
    - Operating Microscope System at Greys

Strengthen outreach services: Monitoring of outreach services shall be strengthened through establishment of quarterly outreach forums in all the 3 regions. Develop a clinical outreach protocol that promotes access to specialised tertiary services at Regional Hospitals that have the capacity to provide such a service. All hospitals to work towards achieving an Ideal Hospital Realization and OHSC Certification status.

OUTCOME: REDUCED MORBIDITY AND MORTALITY

Tertiary Hospitals: The triaging system at Ngwelezana Hospital to improve outcomes will be implemented. The referral pathway for eThekwini District for alignment with services at the Dr Pixley Ka Isaka Seme Memorial Hospital, will be reviewed.

Nephrology Services shall be strengthened in all Tertiary Hospitals.

Additional chronic haemodialysis machines with subsequent additional dialysis slots will be provided at Ngwelezana Hospital. Ten (10) dialysis machines will be allocated to Greys Hospital to replace the current old machines thus improving output. St Aidan's which is a satellite site for King Edward viii will be piloted as a centre of excellence for nephrology services.

Central Hospitals: Increase training numbers in specialist areas, to improve access to different sub-specialities. Strengthen provision of cochlear implant services.

ANNUAL OPERATIONAL PLAN 2024/25 INDICATORS

The following indicators are being monitored in the Annual Operational Plan (AOP) 24/25 to confirm implementation of provincial priorities and progress made against Tertiary Hospitals.

- Patient Experience of Care satisfaction rate – Tertiary Hospital
- Patient Safety Incident (PSI) case closure rate – Tertiary Hospital
- Maternal deaths in facility - Tertiary Hospital
- Deaths in facility under 5 years - Tertiary Hospitals
- Diarrhoea death under 5 years – Tertiary Hospital
- Pneumonia death under 5 years - Tertiary Hospital
- Severe acute malnutrition death under 5 years – Tertiary Hospital
- Severity assessment code (SAC) 1 incident reported within 24 hours rate – Tertiary Hospital
- Cervical cancer screening - Tertiary Hospitals

The following indicators are being monitored in the Annual Operational Plan (AOP) 24/25 to confirm implementation of provincial priorities and progress made against Central Hospitals.

- Patient Experience of Care satisfaction rate – Central Hospital
- Patient Safety Incident (PSI) case closure rate – Central Hospital
- Maternal deaths in facility - Central Hospital
- Deaths in facility under 5 years - Central Hospitals
- Diarrhoea death under 5 years – Central Hospital
- Pneumonia death under 5 years - Central Hospital
- Severe acute malnutrition death under 5 years – Central Hospital
- Severity assessment code (SAC) 1 incident reported within 24 hours rate – Central Hospital
- Cervical cancer screening - Central Hospitals

PROGRAMME RESOURCE CONSIDERATIONS

Table 66: ***Budget allocation Estimates 2024/25 (R'000) (Programme 5)***

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Central Hospital Services	2 653 569	2 540 207	2 689 567	2 648 394	2 759 690	2 895 950	2 841 067	2 863 036	2 994 735
Provincial Tertiary Hospital Services	2 731 891	2 814 948	2 973 518	2 843 751	3 107 490	3 183 240	3 140 797	3 283 881	3 434 940
Sub-Total	5 385 460	5 355 155	5 663 085	5 492 145	5 867 180	6 079 190	5 981 864	6 146 917	6 429 675
Unauthorized expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Baseline available for spending after 1st charge	5 385 460	5 355 155	5 663 085	5 492 145	5 867 180	6 079 190	5 981 864	6 146 917	6 429 675

Table 67: ***Summary of Budget Allocations and Estimates by Economic Classification 2024/25 (R'000) (Programme 5)***

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Current payments	5 270 488	5 283 641	5 604 929	5 381 602	5 757 931	5 989 857	5 867 699	5 934 000	6 206 962
Compensation of employees	3 075 647	3 175 808	3 268 583	3 199 711	3 450 987	3 456 904	3 419 631	3 375 873	3 531 162
Goods and services	2 194 842	2 107 833	2 336 320	2 181 891	2 306 944	2 532 953	2 448 068	2 558 127	2 675 800
Communication	7 100	6 482	6 571	8 447	6 969	6 585	7 283	7 609	7 959
Computer Services	5 999	6 077	5 928	5 994	4 704	1 582	4 917	5 138	5 374
Consultants, Contractors and special services	962 870	825 725	820 070	1 042 555	1 027 505	982 215	1 056 220	1 103 956	1 154 738
Inventory	865 839	886 580	1 093 668	713 266	875 143	1 137 190	947 911	990 338	1 035 894

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Operating leases	2 321	2 143	2 547	2 899	2 700	2 374	2 822	2 949	3 085
Travel and subsistence	369	428	588	1 980	863	703	902	943	986
Maintenance, repair and running costs	478	825	1 134	876	1 773	915	1 853	1 936	2 025
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	349 866	379 573	405 814	405 874	387 287	401 389	426 160	445 258	465 739
Interest and rent on land	-1	-	26	-	-	-	-	-	-
Transfers and subsidies to	27 104	27 517	24 457	45 687	45 687	24 187	47 743	49 882	52 177
Provinces and municipalities	-	-	-	-	-	-	-	-	-
Departmental agencies and accounts	77	63	97	82	82	114	86	90	94
Higher education institutions	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	27 027	27 454	24 360	45 605	45 605	24 073	47 657	49 792	52 083
Payments for capital assets	87 868	43 997	33 644	64 856	63 562	65 005	66 422	163 035	170 536
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Machinery and equipment	87 868	43 997	33 644	64 856	63 562	65 005	66 422	163 035	170 536
Payment for financial assets	-	-	55	-	-	141	-	-	-
Total economic classification	5 385 460	5 355 155	5 663 085	5 492 145	5 867 180	6 079 190	5 981 864	6 146 917	6 429 675
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	5 385 460	5 355 155	5 663 085	5 492 145	5 867 180	6 079 190	5 981 864	6 146 917	6 429 675

PERFORMANCE AND EXPENDITURE TRENDS

Programme 5 is allocated 11.2% of the Vote 7 budget allocation, an increase from the 23/24 revised estimates of 10.8%. This equates to a decrease in actual Rand value of R 97 326 000 (-1.6%).

UPDATED KEY RISKS AND MITIGATION

Table 68: 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

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 69: Programme 6 Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Period		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: UNIVERSAL HEALTH COVERAGE								
Bursaries awarded to First Year Nursing Students	27. Number of Bursaries awarded to first year nursing students	101	160	160	Annual	120	120	120
Bursaries awarded to internal employees	28. Number of internal employees awarded bursaries	369	360	462	Annual	480	600	600

Table 70: Programme 6: Output Indicators Quarterly and Annual Targets

Indicator Name	2024/25 Period				
	Annual Targets	Q1	Q2	Q3	Q4
QUARTERLY INDICATORS					
OUTCOME: UNIVERSAL HEALTH COVERAGE					
27. Number of Bursaries awarded to first year nursing students	120	-	-	-	120
28. Number of internal employees awarded bursaries	480	-	-	-	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 Accreditation process, for the KZN Nursing College, is at an advanced stage with the South African Nursing Council (SANC) and Council on Higher Education (CHE) for Post Graduate Diplomas. Negotiantions and relevant approvals to be obtained for the motivation of the KwaZulu-Natal College of Nursig (KZNCN) to upgrade their IT service for the purpose of hosting the Student Information Management System.

Attempt to source funding from HWSETA and the National Skills Fund to supplement funding.

The breakdown for the bursary students for 2024 is as follows:

- Bursary : 160
- Bursary – female : 98
- Bursary – male : 62

The KZNCN plans every year to ensure both Male and Female bursary holders are given adequate opportunity. The ratio is generally to target approximately 60% Female and 40% Male, due to the many factors, especially since nursing has always been a female dominated profession.

It will be the same for 2024/2025. It is however not always possible to meet the targets as it depends on meeting admission criteria and selection up to ward level.

Sexual Harassment training forms part of the Labour Relations training conducted at health facilities. For 2024/25, 72 Labour Relations workshops are planned. Employee Health and Wellness services in the form of counselling services and support are available to employees that may have been subjected to any form of sexual harassment.

The Department ensures that all training programmes executed incorporate issues of diversity across the health care facilities. Majority of the beneficiaries of the training include women, youth and people with disability. Furthermore, courses such as Diversity Management, Gender Mainstreaming, Women in Management have been planned for senior, middle and junior

management as well as critical forum members such as Women's Forums, Men's Forums and Forums for People with Disability, to create awareness on issues that are critical to WYDP.

A Business Plan is developed annually whereby provisions are made for WYDP across all occupational categories. Programme 6 consist of various sub-programmes e.g. College of Emergency Care and KZN Nursing College who also provide capacity building and training for both employees and prospective employees.

The HRD Implementation Plan (HRDIP) is compiled annually which incorporates leadership and management training, generic and transversal skills programmes, bursaries for employees and prospective employees and clinical training. Such programmes are inclusive of all employees in terms of gender, race, and WYPD. Additionally, the 2024/25 Workplace Skills Plan, which unpacks the HRD Implementation Plan, is currently being compiled which makes provisions for the disaggregated information on planned training which include WYPD and also information is being provided through inputs on training executed in the Quarterly Monitoring Reports.

ANNUAL OPERATIONAL PLAN 2024/25 INDICATORS

The following indicators are being monitored in the Annual Operational Plan (AOP) 24/25 to confirm implementation of provincial priorities and progress made against these priorities.

- Number of employees subjected to orientation and re-orientation programmes

PROGRAMME RESOURCE CONSIDERATIONS

Table 71: ***Budget allocation Estimates (R'000) (Programme 6)***

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Nursing Training Colleges	220 796	212 037	211 895	222 764	234 551	236 122	238 491	249 667	261 149
EMS Training Colleges	19 568	22 326	23 680	31 082	31 082	28 528	36 788	38 437	40 205
Bursaries	109 494	74 129	43 573	138 610	138 610	138 610	145 354	151 866	158 851
Primary Health Care Training	37 753	33 505	30 879	48 295	44 325	37 100	49 212	51 415	53 780
Training Other	877 586	1 020 190	1 028 879	1 040 258	1 065 373	1 104 676	1 082 405	1 163 455	1 233 084
Sub-Total	1 265 197	1 362 187	1 338 906	1 481 009	1 513 941	1 545 036	1 552 250	1 654 840	1 747 069
Unauthorized expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Baseline available for spending after 1st charge	1 265 197	1 362 187	1 338 906	1 481 009	1 513 941	1 545 036	1 552 250	1 654 840	1 747 069

Table 72: ***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	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Current payments	1 137 118	1 267 526	1 277 569	1 318 406	1 351 338	1 393 059	1 380 783	1 475 691	1 559 680
Compensation of employees	1 103 769	1 230 693	1 234 400	1 239 511	1 272 443	1 313 069	1 298 433	1 389 654	1 469 688
Goods and services	33 347	36 833	43 168	78 895	78 895	79 990	82 350	86 037	89 992
Communication	827	861	816	875	899	767	932	974	1 019

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Computer Services	202	-	-	-	738	4	750	783	819
Consultants, Contractors and special services	171	101	57	97	284	328	71	74	77
Inventory	2 300	3 449	2 874	4 882	6 499	6 807	5 373	5 612	5 869
Operating leases	1 247	1 009	963	2 138	2 191	1 936	2 272	2 371	2 480
Travel and subsistence	5 341	4 266	7 754	12 875	12 872	13 169	13 513	14 118	14 767
Maintenance, repair and running costs	1 784	1 129	2 316	3 562	3 123	4 005	3 267	3 417	3 574
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	21 475	26 018	28 388	54 466	52 289	52 974	56 172	58 688	61 387
Interest and rent on land	2	-	1	-	-	-	-	-	-
Transfers and subsidies to	126 123	92 096	59 295	150 499	150 499	143 952	157 779	164 847	172 430
Provinces and municipalities	-	-	-	-	-	-	-	-	-
Departmental agencies and accounts	23 248	23 248	23 248	25 436	25 436	25 436	26 581	27 772	29 050
Higher education institutions	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	102 875	68 848	36 047	125 063	125 063	118 516	131 198	137 075	143 380
Payments for capital assets	1 956	2 564	2 042	12 104	12 104	8 025	13 688	14 302	14 959
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Machinery and equipment	1 956	2 564	2 042	12 104	12 104	8 025	13 688	14 302	14 959
Payment for financial assets	-	1	-	-	-	-	-	-	-

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Total economic classification	1 265 197	1 362 187	1 338 906	1 481 009	1 513 941	1 545 036	1 552 250	1 654 840	1 747 069
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	1 265 197	1 362 187	1 338 906	1 481 009	1 513 941	1 545 036	1 552 250	1 654 840	1 747 069

PERFORMANCE AND EXPENDITURE TRENDS

Programme 6 is allocated 2.9% of the Vote 7 budget allocation, the same allocation as the 2.9% from the 23/24 revised estimates. This equates to an increase of R 7 214 000 (0.5%).

UPDATED KEY RISKS AND MITIGATION

Table 73: 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
The Departmental Organisational Structures are not aligned to the Departmental Strategic Objectives and the prescribed legislative mandates	Follow-up with the principals on the finalization of the Departmental organizational structures for all levels
Non- recovery of breach of bursary contract obligations	Capture all bursaries on Persal.
	Maintain a data base
	Effective continuous follow-up of all payments
Inadequate safe keeping and transportation of assessments	Sealed material and internal department transport is used, and 2 personnel (security and admin) transport the material
	Tracking record of material transported
	Strong room / lockable safe
Academic staff not adequately qualified to teach Post Graduate Diploma (nursing specialist programmes)	Skills audit and training
	Priority areas identified for staff training
	Funding from Human Resource Development (HRD) (Nursing Programme)
	Recruitment of suitably qualified nurse educators to teach in Post Graduate Diploma Programmes
Threats and intimidation of employer representatives, presiding officers and witnesses during misconduct hearings	Secure a neutral venue for the hearing.
	Report incidents of intimidation and threats to Security Services and Law Enforcement Agencies.
	Conduct disciplinary hearings through virtual platforms
Non-compliance with disciplinary code and procedure and the SMS handbook in handling disciplinary cases	Ongoing training of managers and supervisors on handling disciplinary matters

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

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

Programme Purpose

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

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 74: Programme 7: Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Period		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: UNIVERSAL HEALTH COVERAGE								
Tracer medicine stock out rate - PPSD	29. Tracer Medicine Stock-Out Rate at the Provincial Pharmaceutical Supply Depot (PPSD)	9.1%	6.8%	3.9%	1.7%	**≤ 5%**	**≤ 5%**	**≤ 5%**
	Number of medicines out of stock	*84*	*63*	*36*	*16*	*Varies*	*Varies*	*Varies*
	Total number of tracer medicines expected to be in stock	*924*	*924*	*924*	*924*	*Varies*	*Varies*	*Varies*
Tracer medicine stock out rate at facilities	30. Tracer Medicine Stock-Out Rate at facilities (hospitals, community health centres and clinics)	0.2%	1.7%	1.4%	1.9%	**≤ 5%**	**≤ 5%**	**≤ 5%**
	Number of Tracer medicines stock out in bulk store	*1 198*	*10 709*	*8 160*	*17 344*	*Varies*	*Varies*	*Varies*
	Number of tracer medicines expected to be stocked in the bulk store	*581 666*	*616 162*	*577 068*	*918 260*	*Varies*	*Varies*	*Varies*

Table 75: Programme 7: Output Indicators Quarterly and Annual Targets

Indicator Name	2024/25				
	Annual targets	Q1	Q2	Q3	Q4
QUARTERLY INDICATORS					
OUTCOME: UNIVERSAL HEALTH COVERAGE					
29. Tracer Medicine Stock-Out Rate at the Provincial Pharmaceutical Supply Depot (PPSD)	**≤ 5%**	**≤ 5%**	**≤ 5%**	**≤ 5%**	**≤ 5%**
Number of medicines 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 centralization of laundry services, as well as the provision of specialised orthotic and prosthetic services is housed in this programme.

Pharmaceutical services: will improve the physical infrastructure of the Provincial Pharmaceutical Supply Depot (PPSD) to enable issuing of the Wholesaler Pharmacy Licence by the National Department of Health (NDOH) on recommendation of the South African Health Products Regulatory Authority (SAHPRA). A Warehouse Management System to support business processes of PPSD, will be sourced during this financial year. The implementation of the Electronic Stock Management System (e.g., Rx Solution) at facilities, including electronic dispensing to enable accounting for stock to the level of provision to the patient, will improve efficiencies. Review resourcing of PPSD to align with current business strategies (e.g., Direct Delivery System, and Warehousing System) and improve outcomes. Improve medicine supply management at Primary Health Care clinics through deployment of suitably trained Pharmacists' Assistants (Post-basic) to support Clinical Nurse Practitioners in caring for patients. Improve the turn-around time for payment of direct delivery orders invoices.

ANNUAL OPERATIONAL PLAN 2024/25 INDICATORS

The following indicators are being monitored in the Annual Operational Plan (AOP) 24/25 to confirm implementation of provincial priorities and progress made against these priorities.

- Percentage of clients needing orthotics that are fitted with orthotics
- Percentage of clients needing prosthetics that are fitted with orthotics

PROGRAMME RESOURCE CONSIDERATIONS

*Table 76: Budget allocation Estimates 2**024/25 (R'000) (Programme 7)***

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Medicine Trading Account	200 379	70 219	69 028	78 430	82 152	82 152	82 210	87 154	91 164
Laundry Services	182 588	188 976	178 194	206 864	203 291	213 139	217 900	229 468	240 026
Orthotic and Prosthetic Services	47 547	58 964	63 114	66 598	69 224	66 927	71 124	75 588	79 064
Sub-Total	430 514	318 159	310 336	351 892	354 667	362 218	371 234	392 210	410 254
Unauthorized expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Baseline available for spending after 1st charge	430 514	318 159	310 336	351 892	354 667	362 218	371 234	392 210	410 254

*Table 77: Summary of Budget Allocations and Estimates by **Economic Classification 2024/25 (R'000) (Programme 7)***

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Current payments	423 608	309 839	307 649	339 483	342 258	350 503	357 642	378 010	395 400
Compensation of employees	151 147	161 735	165 124	173 349	176 124	176 541	184 034	196 625	205 669
Goods and services	272 461	148 104	142 525	166 134	166 134	173 962	173 608	181 385	189 731
Communication	969	1 079	1 027	1 192	790	788	827	864	904
Computer Services	2 754	2 461	2 540	3 291	3 291	3 206	3 439	3 593	3 758
Consultants, Contractors and special services	196	3 062	2 507	3 099	3 099	3 129	3 244	3 389	3 545

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Inventory	214 064	79 899	79 031	93 889	98 307	98 773	103 700	108 343	113 327
Operating leases	470	503	369	453	362	426	483	505	529
Travel and subsistence	456	464	667	531	4 647	885	4 779	4 993	5 223
Maintenance, repair and running costs	4 025	5 363	6 915	7 374	7 761	5 726	8 110	8 474	8 864
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	49 527	55 273	49 469	56 305	47 877	61 029	49 026	51 224	53 581
Interest and rent on land	-	-	-	-	-	-	-	-	-
Transfers and subsidies to	1 001	803	782	948	948	1 335	991	1 035	1 083
Provinces and municipalities	-	-	-	-	-	-	-	-	-
Departmental agencies and accounts	-	-	-	-	-	-	-	-	-
Higher education institutions	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	1 001	803	782	948	948	1 335	991	1 035	1 083
Payments for capital assets	5 905	7 516	1 905	11 461	11 461	10 380	12 601	13 165	13 771
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Machinery and equipment	5 905	7 516	1 905	11 461	11 461	10 380	12 601	13 165	13 771
Payment for financial assets	-	1	-	-	-	-	-	-	-
Total economic classification	430 514	318 159	310 336	351 892	354 667	362 218	371 234	392 210	410 254
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	430 514	318 159	310 336	351 892	354 667	362 218	371 234	392 210	410 254

PERFORMANCE AND EXPENDITURE TRENDS

Programme 7 is allocated 0.7% of the Vote 7 budget allocation, the same as allocated in the 23/24 revised estimates. This equates to a rand value increase of R 9 016 000 (2.5%).

UPDATED KEY RISKS AND MITIGATION

Table 78: Updated key risks and mitigation 2024/25 (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.
Statutory closure of PPSD for operating without a license	Improve physical infrastructure of PPSD (Install back up power generator to run the heating, ventilation, and air-conditioning (HVAC) system to enable issuing of the Wholesaler Pharmacy License by NDoH on recommendation of South African Health Product Regulatory Authority (SAHPRA)
Decline of medicine availability and escalation of fruitless and wasteful expenditure due to expiries at PHC clinics	Deploy suitably trained pharmacist's assistants (post-basic)
Contracted suppliers of pharmaceutical products not complying with contractual obligations	Improve Demand Planning and Management purchase order follow-ups and turn-around time for payment of invoices without discrepancies
The organizational structure of PPSD is old and inadequate to support the current business processes and systems. The staffing is also not aligned to business demands	Review the organizational structure and resourcing of PPSD to align with current business strategies (e.g., Direct Delivery System and Warehousing System).
Poor Management of linen stock at Facilities	Provincial office continues to provide guidance to the facilities on proper linen stock management
Running out of clean linen at facilities resulting from constrained in-house laundry capacity	Fill posts as per approval received
	Utilise remunerative overtime
	Explore an option to outsource to approved private laundries
	Procure new linen to build reserves
	Install generators to reduce impact of loadshedding
	Replace old laundry machinery as funds become available
	Reduce downtime through SLAs with agents of Original Equipment Manufacturers (OEMs)

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

Programme Purpose

Provision of new health facilities and the refurbishment, upgrading and maintenance of existing health facilities.

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 79: Programme 8: Outputs, Output Indicators and Targets

Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Period		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: UNIVERSAL HEALTH COVERAGE								
Preventative maintenance activities to prevent failure	31. Percentage of preventative maintenance expenditure	33.2%	37.1%	49.9%	46.7%	48.0%	50.0%	50.0%
	Expenditure on Preventative Maintenance Activities (R '000)	*R 133 919*	*R 82 172*	*R 131 667*	*R 115 000*	*R 120 000*	*R 120 000*	*R 120 000*
	Expenditure on Preventative Maintenance plus Day-to-day Maintenance (R '000)	R 402 909	R 221 219	*R 263 781*	*R 246 312*	*R 250 000*	*R 240 000*	*R 240 000*
Renovated and refurbished projects completed	32. Number of Capital Infrastructure Projects completed	50	66	147	100	103	104	82

Table 80: Programme 8: Output Indicators Quarterly and Annual Targets

Indicator Name	2024/25				
	Annual Targets	Q1	Q2	Q3	Q4
QUARTERLY INDICATORS					
OUTCOME: UNIVERSAL HEALTH COVERAGE					
31. Percentage of preventative maintenance expenditure	48.0%	48.0%	48.0%	48.0%	48.0%
Expenditure on Preventative Maintenance Activities (R '000)	*R 120 000*	*R 30 000*	*R 30 000*	*R 30 000*	*R 30 000*
Expenditure on Preventative Maintenance plus Day-to-day Maintenance (R '000)	*R 250 000*	*R 62 500*	*R 62 500*	*R 62 500*	*R 62 500*
32. Number of Capital Infrastructure Projects completed	103	35	25	25	18

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. The following corrective measures are planned for the 24/25 financial year:

Budget limitations to be mitigated by exploring alternative buildings and structures to reduce time and cost (such as expensive leases)

- Capacitation of HUB be finalized
- Streamline and standardize tender documentation
- Apply flexible planning by creating scenarios which will adapt to unforeseen situations
- Continue with Condition Assessment to improve maintenance and planning

The Department is experiencing major disruptions in energy (specifically electricity) supply due to load shedding to intuitions that consequently resulted in poor or interrupted service delivery and specifically to life expectancy. The department is currently focusing on ensuring reliable energy supply and has institute a number of programmes and projects, which include the following:

Ensuring that all facilities have a backup power supply by way of generators. This is ongoing programme and to date 460 Generators have been installed at various facilities, such as Clinics, Community Health Centres, Hospitals and Medico Legal Mortuaries.

The Department has also provided inverters to some facilities, i.e. 30 x facilities to Ugu and 4 x facilities to Amajuba.

The Department has embarked on a Renewable Energy Program in all 11 districts, with the focus on hospitals. To date the programmes at iLembe, King Cetshwayo, uMkhanyakude and Zululand are on tender for the appointment of Professional Service providers. The remaining 7 districts are in the planning stage.

All capital projects in the planning stage will now include provision for alternative energy as is applicable.

ANNUAL OPERATIONAL PLAN 2024/25 INDICATORS

The following indicators are being monitored in the Annual Operational Plan (AOP) 24/25 to confirm implementation of provincial priorities and progress made against these priorities.

- Number of jobs created through the EPWP
- Appointment of PSP consultants for the design of the new tertiary hospital in the North
- Initiation reports for prioritised projects as part of the regionalisation initiative developed
- Appointment of contractor for the design and construction of the New Oncology Centre in Ngwelezana Hospital

PROGRAMME RESOURCE CONSIDERATIONS

Table 81: ***Budget allocation Estimates 2024/25 (R'000) (Programme 8)***

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Community Health Facilities	209 326	294 055	482 804	285 449	501 884	717 250	630 653	544 312	620 761
District Hospital Services	808 108	465 265	529 573	534 341	321 166	353 628	333 917	369 080	409 255
Emergency Medical Services	-	-	-	55 345	-	-	-	-	-
Provincial Hospital Services	1 723 875	901 083	570 408	451 807	517 912	366 856	616 870	608 758	603 948
Central Hospital Services	76 072	35 616	60 881	153 816	70 287	67 073	18 700	19 400	21 062
Other Facilities	295 814	246 063	269 010	484 387	463 539	369 981	371 839	429 327	339 948
Sub-Total	3 113 195	1 942 082	1 912 676	1 965 145	1 874 788	1 874 788	1 971 979	1 970 877	1 994 974
Unauthorized expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Baseline available for spending after 1st charge	3 113 195	1 942 082	1 912 676	1 965 145	1 874 788	1 874 788	1 971 979	1 970 877	1 994 974

Table 82: ***Summary of Budget Allocations and Estimates by Economic Classification 2024/25 (R'000) (Programme 8)***

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Current payments	712 973	753 619	810 229	670 766	832 747	1 115 588	562 397	479 867	517 582
Compensation of employees	78 563	96 731	91 730	109 614	109 614	109 614	96 951	102 000	102 000
Goods and services	634 410	656 888	718 499	561 152	723 133	1 005 974	465 446	377 867	415 582

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Communication	-	21	-	-	-	-	-	-	-
Computer Services	-	970	80	-	65	65	-	-	-
Consultants, Contractors and special services	2 904	286	12 961	-	3 721	10 687	-	-	-
Inventory	39 841	23 660	28 617	19 493	25 916	32 997	16 505	13 379	13 994
Operating leases	169 469	236 800	123 369	130 679	97 444	159 842	120 000	100 000	116 069
Travel and subsistence	1 172	1 951	2 192	-	1 029	1 698	-	-	-
Maintenance, repair and running costs	-	-	-	-	-	-	-	-	-
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	421 024	393 200	551 280	410 980	594 958	800 685	328 941	264 488	285 519
Interest and rent on land	-	-	-	-	-	-	-	-	-
Transfers and subsidies to	-	-	-	-	-	130	-	-	-
Provinces and municipalities	-	-	-	-	-	-	-	-	-
Departmental agencies and accounts	-	-	-	-	-	-	-	-	-
Higher education institutions	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	-	-	-	-	-	130	-	-	-
Payments for capital assets	2 400 222	1 188 463	1 102 447	1 294 379	1 042 041	759 070	1 409 582	1 491 010	1 477 392
Buildings and other fixed structures	2 218 868	1 008 097	840 608	1 252 318	916 597	606 979	1 358 671	1 458 320	1 472 392
Machinery and equipment	181 354	180 366	261 839	42 061	125 444	152 091	50 911	32 690	5 000

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R'000	2020/21	2021/22	2022/23	2023/24			2024/25	2025/26	2026/27
Payment for financial assets	-	-	-	-	-	-	-	-	-
Total economic classification	3 113 195	1 942 082	1 912 676	1 965 145	1 874 788	1 874 788	1 971 979	1 970 877	1 994 974
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	3 113 195	1 942 082	1 912 676	1 965 145	1 874 788	1 874 788	1 971 979	1 970 877	1 994 974

PERFORMANCE AND EXPENDITURE TRENDS

Programme 8 is allocated 3.7% of the Vote 7 budget, an increase from 3.9% in the 23/24 revised estimates. This equates to a Rand value decrease of R 97 191 000 (5.1%).

UPDATED KEY RISKS AND MITIGATION

Table 83: Updated key risks and mitigation 2024/25 (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
Delay in implementation of projects due to procurement	Standardized tender documents
Protracted payment approval process SCM and Finance due to LOGIS	LOGIS process to be streamlined to limit the issuing and re-issuing of orders to ensure payments are made within 30 days
Non-availability and unreliable Infrastructure	Improved and increased maintenance planning and implementation as well as capacitation of HUB's
Non availability of medical equipment	Improved and increased HTS planning, requirements and maintenance; and implementation

INFRASTRUCTURE PROJECTS

The department follows the National and Provincial guideline on preferential procurement to ensure the Women, Youth, and persons with disabilities are included. This is also applied to recruitment of staff in the Infrastructure unit as well as the Expanded Public Works Programme.

All current capital projects in planning and construction have been designed to ensure that buildings make provision for persons with disabilities in compliance to the National Building Regulations and SANS 10400. This includes wheelchair friendly parking, ramps and wheelchair accessible ablutions. Lifts are fitted with braille buttons and voice announcements. The use of mirrors in lifts are limited in order that persons with eyesight limitations not get disorientated.

Table 84: Infrastructure Projects 2024/25 funded by the Health Facility Reviatlisation Grant (HFRG)

No.	Project Name	Programme	District (Geospatial referencing)	Outputs	Start Date	Contracted Construction End Date	Total estimated cost	Total Project Expenditure to date
Category New or Replaced Infrastructure								
1	KwaGwebu: Installation of a Temporary Clinic	Community Health Facilities	Zululand	Construction 26% - 50%	08/08/2023	TBD	R10,000,000	R0
Category: Upgrading and Additions								
2	Addington Hospital - Restoration Of Fire Services	Provincial Hospital Services	eThekwini	Construction 76% - 99%	04/12/2020	05/02/2024	R34,591,470	R31,083,833
3	Benedictine Hospital - Upgrade water reticulation	District Hospital Services	Zululand	Construction 51% - 75%	19/10/2023	18/04/2024	R4,800,000	R186,715
4	Church of Scotland Hospital - Renovation of Existing EMS Wash Bay	Emergency Medical Services	uMzinyathi	Construction Started	23/11/2023	24/06/2024	R2,696,158	R1,589,190
5	Church of Scotland Hospital- Installation of Hot Water Tanks and Heat Pumps	District Hospital Services	uMzinyathi	Construction Started	17/01/2024	14/03/2024	R4,000,000	R0
6	eDumbe CHC - Construction of New EMS Wash Bay	Emergency Medical Services	Zululand	Construction 1% - 25%	30/11/2023	28/06/2024	R4,684,712	R2,354,136

No.	Project Name	Programme	District (Geospatial referencing)	Outputs	Start Date	Contracted Construction End Date	Total estimated cost	Total Project Expenditure to date
7	Empangeni EMS Station- Construction of New Wash Bay	Emergency Medical Services	King Cetshwayo	Construction 1% - 25%	30/11/2023	28/06/2024	R3,851,995	R2,402,855
8	eThekwini District - Installation New Generator Sets in 2 Central Laundries	Other Facilities	All Districts	Construction 1% - 25%	14/08/2023	30/06/2024	R14,000,000	R64,565
9	Hlabisa EMS Station - Construction of New Wash Bay	Emergency Medical Services	uMkhanyakude	Construction 1% - 25%	30/11/2023	31/07/2024	R2,988,109	R2,423,109
10	Isangcwaba Clinic -Installation of standby Generator Set	Community Health Facilities	Harry Gwala	Construction Started	17/01/2023	TBD	R511,700	R511,700
11	King Cetshwayo District - Installation Of 21 x 20kl Elevated Water Tanks	Community Health Facilities	All Districts	Construction 76% - 99%	03/02/2022	TBD	R16,200,000	R12,564,041
12	King Cetshwayo District - Replace perimeter fence in 16 clinics	Community Health Facilities	All Districts	Construction 76% - 99%	01/10/2020	TBD	R6,064,251	R15,440,252
13	King Cetshwayo District Clinics - Installation of 39 Standby Generator Sets DoPW	Community Health Facilities	All Districts	Construction 76% - 99%	02/11/2020	29/03/2024	R14,455,979	R14,991,826
14	KwaZulu Provincial Central Laundry - Erect additional ablutions	Other Facilities	eThekwini	Construction 1% - 25%	27/07/2023	29/03/2024	R1,972,642	R0
15	Ladysmith Hospital - 72 hr Water and Fire Storage Upgrade	Provincial Hospital Services	uThukela	Construction 1% - 25%	28/10/2022	31/03/2025	R15,530,022	R5,391,048
16	Madadeni Hospital- Replacement of Reservoir tank	Provincial Hospital Services	Amajuba	Construction 51% - 75%	21/01/2022	07/05/2024	R27,585,004	R13,567,941
17	Marburg EMS - Installation of 20KL elevated water tank	Other Facilities	Ugu	Construction 76% - 99%	14/07/2023	TBD	R1,000,000	R0
18	Margate Clinic - Install 20kl steel elevated water tank	Community Health Facilities	Ugu	Construction 76% - 99%	06/02/2023	TBD	R700,000	R294,656
19	McCord's Hospital-EMS College of Emergency Care - Installation of New 250 kVA generator including as	Community Health Facilities	eThekwini	Construction 26% - 50%	11/09/2023	29/03/2024	R3,000,000	R0

No.	Project Name	Programme	District (Geospatial referencing)	Outputs	Start Date	Contracted Construction End Date	Total estimated cost	Total Project Expenditure to date
20	Mpungamhlophe Clinic - Install a 20kl elevated steel water tank	Community Health Facilities	Zululand	Construction 76% - 99%	01/08/2022		R700,000	R611,015
21	Murchison Hospital - Replace Theatre HVAC System	District Hospital Services	Ugu	Construction Started	16/08/2023	30/04/2024	R6,829,584	R1,397,887
22	Murchison Hospital- Alterations and Renovations to Staff Accommodation	District Hospital Services	Ugu	Construction 26% - 50%	14/09/2022	30/08/2024	R34,649,213	R10,118,904
23	Ndwebu Clinic - Install a 20kl elevated water tank	Community Health Facilities	Ugu	Construction 76% - 99%	01/03/2023	31/03/2024	R700,000	R302,434
24	Newcastle Hospital -Package D-CCTV cameras and access control, heat pumps ,fire detection	Provincial Hospital Services	Amajuba	Construction 26% - 50%	01/06/2022	31/08/2024	R194,034,844	R23,539,074
25	Newcastle Hospital -Installation of packaged HVAC units to Theatres 1, 2, 3 and 4	Provincial Hospital Services	Amajuba	Construction 76% - 99%	03/11/2021	TBD	R16,681,186	R15,595,462
26	Newcastle Hospital Package E -Upgrade to Bulk Sewer , Stormwater , Hot and Cold water reticulation	Provincial Hospital Services	Amajuba	Construction 26% - 50%	17/04/2023	30/09/2024	R57,000,000	R18,671,215
27	Ngwelezana Hospital - Replacement of Backup Generator	Provincial Hospital Services	King Cetshwayo	Construction Started	04/08/2023	31/01/2024	R5,852,856	R5,109,377
28	Nkandla Hospital - Construction of New EMS Wash Bay	Emergency Medical Services	King Cetshwayo	Construction 1% - 25%	30/11/2023	28/02/2025	R4,357,085	R2,421,988
29	Nkonjeni Hospital - Build a new Neonatal facility & renovate existing	District Hospital Services	Zululand	Construction 51% - 75%	03/07/2020	29/03/2024	R77,112,606	R53,575,495
30	Northdale Hospital - Renovate Existing Nurses Home and Construct new 28 Unit	District Hospital Services	uMgungundlovu	Construction 1% - 25%	23/01/2023	08/11/2024	R69,272,578	R22,721,163
31	Nseleni CHC- Fencing of the newly acquired site	Community Health Facilities	King Cetshwayo	Construction Started	23/01/2024	31/12/2024	R1,000,000	R0

No.	Project Name	Programme	District (Geospatial referencing)	Outputs	Start Date	Contracted Construction End Date	Total estimated cost	Total Project Expenditure to date
32	Nsimbini Clinic - Install a 20kl elevated steel water tank	Community Health Facilities	eThekwini	Construction 76% - 99%	06/12/2022	TBD	R700,000	R101,247
33	Prince Mshiyeni Hospital - Replace 7 standby generators	Provincial Hospital Services	eThekwini	Construction 1% - 25%	12/07/2023	16/02/2024	R20,508,662	R0
34	Sokhela Clinic- Clinic Expansion to include Hast Unit and Midwife Obstetric Unit	Community Health Facilities	Harry Gwala	Construction Started	09/06/2022	02/02/2024	R32,013,417	R22,816,559
35	Sokhulu Clinic (Nsel CHC)- New borehole	Community Health Facilities	King Cetshwayo	Construction 76% - 99%	14/03/2019	TBD	R1,373,328	R0
36	Southport Clinic - Install a 20kl elevated steel water tank	Community Health Facilities	Ugu	Construction 76% - 99%	06/02/2023	TBD	R700,000	R332,021
37	St Apollinaris Gateway Clinic - Installation of Standby Generator Set	Community Health Facilities	Harry Gwala	Construction Started	03/01/2023	TBD	R938,750	R0
38	uMkhanyakude District Clinics - Installation of 23 Standby Generator Sets DoH	Community Health Facilities	All Districts	Construction 76% - 99%	03/12/2021	29/02/2024	R6,918,731	R9,100,947
39	uMngeni Hospital - Replacement of 86 doors	Provincial Hospital Services	uMgungundlovu	Construction 76% - 99%	02/08/2023	TBD	R996,500	R0
40	uMtentweni Clinic - Install a 20kl elevated steel water tank	Community Health Facilities	Ugu	Construction 76% - 99%	06/02/2023	TBD	R700,000	R0
41	uMzimkhulu and Ixopo Medico Legal Mortuaries - Installation of Walk-In Coldrooms	Other Facilities	All Districts	Construction 26% - 50%	19/08/2022	TBD	R1,548,956	R630,500
42	Wela Clinic - Install a 20kl elevated steel water tank	Community Health Facilities	Zululand	Construction 76% - 99%	01/08/2022	TBD	R700,000	R929,810
43	Weza Clinic - Install a 20kl elevated steel water tank	Community Health Facilities	Ugu	Construction 76% - 99%	06/02/2023	TBD	R700,000	R0
44	Zululand District - Installation Of 18 x 20kl Elevated Water Tanks	Community Health Facilities	All Districts	Construction 76% - 99%	10/01/2022	30/03/2024	R10,800,000	R10,337,818

No.	Project Name	Programme	District (Geospatial referencing)	Outputs	Start Date	Contracted Construction End Date	Total estimated cost	Total Project Expenditure to date
45	Zululand District Clinics - Installation of 18 Standby Generator Sets DoPW	Community Health Facilities	All Districts	Construction 76% - 99%	31/08/2020	29/03/2024	R8,448,799	R14,076,384
Category Rehabilitation, Renovations & Refurbishment								
46	Addington Hospital Flood Damage Recovery 2022	Provincial Hospital Services	eThekwini	Construction 1% - 25%	20/11/2023	29/03/2024	R6,952,946	R6,213,305
47	Addington Nursing Campus - Replacement of Flat Roof Waterproofing and Full-bores(Flood damage2022)	Provincial Hospital Services	eThekwini	Construction 26% - 50%	31/07/2023	30/04/2024	R18,318,216	R0
48	Dannhauser CHC - Structural Repairs	Community Health Facilities	Amajuba	Construction 76% - 99%	01/07/2022	28/02/2024	R32,241,307	R20,079,199
49	eThekwini District - Perimeter Fence Replacement Programme 2020 (30 Clinics)	Community Health Facilities	All Districts	Construction 76% - 99%	02/11/2020	TBD	R7,956,338	R10,682,098
50	eThekwini District Office: Flood Damage recovery 2022	Other Facilities	eThekwini	Construction Started	01/09/2023	31/05/2024	R4,224,692	R0
51	GJ Crooke's Hospital Flood Damage Recovery 2022	District Hospital Services	Ugu	Construction 1% - 25%	03/07/2023	28/06/2024	R10,320,260	R1,708,931
52	Grey's Hospital - Upgrade and renovation to Nurse's and Doctor's accommodation	Central Hospital Services	uMgungundlovu	Construction 26% - 50%	17/06/2022	12/06/2024	R40,562,964	R29,786,631
53	Greytown TB Hospital - Extractor Fans at Male TB ward x6	Provincial Hospital Services	uMzinyathi	Construction 1% - 25%	16/03/2023	TBD	R1,040,000	R60,054
54	Groutville Clinic - Replace fence	Community Health Facilities	iLembe	Construction 76% - 99%	04/11/2022	TBD	R300,000	R0
55	Groutville Old Clinic used as PHC offices - Replace Asbestos with Zinculum roof	Community Health Facilities	iLembe	Construction 76% - 99%	10/11/2022	TBD	R500,000	R643,401
56	Harry Gwala Regional Hospital Nursing Campus Flood Damage Recovery 2022	Other Facilities	uMgungundlovu	Construction 1% - 25%	18/08/2023	13/12/2024	R5,950,000	R0

No.	Project Name	Programme	District (Geospatial referencing)	Outputs	Start Date	Contracted Construction End Date	Total estimated cost	Total Project Expenditure to date
57	King Cetshwayo District Clinics - Asbestos Eradication & Associated Roofing Works in 2 Clinics	Community Health Facilities	All Districts	Construction 1% - 25%	28/10/2021	31/03/2024	R1,827,988	R51,620,176
58	King Cetshwayo District Clinics - Cluster 1 Asbestos Eradication & Associated Roofing Works in 4 Clinics	Community Health Facilities	All Districts	Construction 76% - 99%	10/03/2023	31/01/2024	R20,000,000	R3,047,726
59	King Cetshwayo District Clinics - Cluster 2 Asbestos Replacement Programme (6 Clinics)	Community Health Facilities	All Districts	Construction 51% - 75%	31/05/2023	30/04/2024	R88,000,000	R19,516,416
60	King Cetshwayo District Clinics - Cluster 3 Asbestos Replacement Programme (5 Clinics)	Community Health Facilities	All Districts	Construction 26% - 50%	09/03/2023	28/03/2024	R40,000,000	R28,504,914
61	King Edward Hospital - Replacement of 8 Lifts	Central Hospital Services	eThekwini	Construction Started	01/08/2022	30/08/2024	R3,550,000	R0
62	King Edward VIII Hospital - Repairs and Renovations to the Nursing College	Central Hospital Services	eThekwini	Construction Started	28/07/2023	30/08/2024	R41,589,570	R0
63	King Edward VIII Hospital: Flood Damage Recovery 2022	Provincial Hospital Services	eThekwini	Construction Started	21/07/2023	01/05/2024	R11,561,827	R0
64	KwaDabeka CHC - Asbestos Eradication & Associated Roofing Works	Community Health Facilities	eThekwini	Construction 51% - 75%	03/06/2022	TBD	R17,850,000	R7,557,299
65	KZN Central provincial Laundry - Epoxy application at PMMH KZNPCL	Other Facilities	eThekwini	Construction Started	18/01/2024	29/02/2024	R2,000,000	R0
66	KZN Children's Hospital Flood Damage Recovery 2022	Provincial Hospital Services	eThekwini	Construction Started	21/09/2023	28/03/2024	R1,503,506	R0
67	Mahatma Ghandi Hospital Flood Damage Recovery 2022	District Hospital Services	eThekwini	Construction Started	24/10/2023	24/04/2024	R11,369,221	R0
68	Mahlungulu Clinic Flood Damage Recovery Project 2022	Community Health Facilities	uMkhanyakude	Construction Started	27/07/2022	31/05/2024	R682,053	R682,053

No.	Project Name	Programme	District (Geospatial referencing)	Outputs	Start Date	Contracted Construction End Date	Total estimated cost	Total Project Expenditure to date
69	Maqumbi Clinic - Replace fence	Community Health Facilities	iLembe	Construction 1% - 25%	04/11/2022	TBD	R400,000	R621,956
70	McCord's Hospital Flood Damage Recovery 2022	Provincial Hospital Services	eThekwini	Construction 1% - 25%	31/08/2023	29/02/2024	R1,520,374	R0
71	Natalia Building - Replacement of flat roof waterproofing and full-bores	Other Facilities	uMgungundlovu	Construction 76% - 99%	22/03/2022	31/03/2024	R14,731,729	R14,301,255
72	Natalia Building: Replacement of 4 x Generator Sets	Other Facilities	uMgungundlovu	Construction 1% - 25%	04/07/2023	09/02/2024	R12,190,258	R0
73	Ndwedwe CHC - Asbestos Eradication and Associated roofing works	Community Health Facilities	iLembe	Construction 26% - 50%	07/02/2023	TBD	R1,202,130	R1,223,997
74	Ngwelezana Hospital: Repairs to HVAC in 192-bed surgical ward building	Provincial Hospital Services	King Cetshwayo	Construction 26% - 50%	30/11/2023	TBD	R3,500,000	R2,321,636
75	Nkandla Hospital Flood Damage Recovery 2022	District Hospital Services	King Cetshwayo	Construction 1% - 25%	05/09/2023	13/05/2024	R11,200,293	R2,923,056
76	Northdale Hospital - Replacement of Roofs	District Hospital Services	uMgungundlovu	Construction 76% - 99%	02/08/2021	28/03/2024	R40,365,000	R14,087,296
77	Ntumeni Clinic - Replace Asbestos with Zinculum Roof	Community Health Facilities	King Cetshwayo	Construction 76% - 99%	30/05/2023	29/02/2024	R3,182,000	R0
78	Osizweni (Umlazi Q) Clinic - Asbestos Eradication & Associated Roofing Works (flood damage recovery)	Community Health Facilities	eThekwini	Construction 26% - 50%	21/08/2023	16/02/2024	R2,374,280	R0
79	Otimati Clinic - Replace fence	Community Health Facilities	iLembe	Construction 26% - 50%	02/11/2022	TBD	R400,000	R659,356
80	Phoenix CHC: Flood Damage Recovery project 2022	Community Health Facilities	eThekwini	Construction Started	29/05/2023	29/03/2024	R10,844,846	R515,338
81	PPSD Flood Damage Recovery 2022	Other Facilities	eThekwini	Construction Started	15/08/2023	31/01/2024	R4,000,000	R0

No.	Project Name	Programme	District (Geospatial referencing)	Outputs	Start Date	Contracted Construction End Date	Total estimated cost	Total Project Expenditure to date
82	Prince Mshiyeni Memorial Hospital - Refurbishment of water reservoir	Provincial Hospital Services	eThekwini (	Construction 26% - 50%	01/08/2023	31/08/2024	R14,693,955	R3,689,698
83	Prince Mshiyeni Memorial Hospital Flood Damage Recovery 2022	Provincial Hospital Services	eThekwini	Construction Started	15/06/2023	29/02/2024	R9,509,868	R855,531
84	Richmond Hospital - Asbestos Eradication & Associated Roofing Work	District Hospital Services	uMgungundlovu	Construction 26% - 50%	01/04/2022	31/03/2026	R1,465,100	R0
85	RK Khan Hospital - Re-waterproofing of flat roofs and internal renovations at Blocks D, E & CSSD	Provincial Hospital Services	eThekwini	Construction 26% - 50%	17/06/2021	31/07/2024	R10,584,999	R1,773,177
86	RK Khan Hospital- Flood Damage 2022 Repair Leaks at M-Block flat roof , Leaks through box gutter at	Provincial Hospital Services	eThekwini	Construction 1% - 25%	20/11/2023	30/04/2024	R6,804,872	R0
87	RK Khan Nurses Residence-Urgent Repairs to Leaking Nurses Residence Roof	Provincial Hospital Services	eThekwini	Construction Started	28/07/2023	28/06/2024	R3,342,917	R702,524
88	St Aidan's Hospital Flood Damage Recovery 2022	Provincial Hospital Services	eThekwini	Construction Started	19/10/2023	30/04/2024	R2,648,104	R0
89	uMzimkhulu Medico Legal Mortuary - Refurbishments of the autopsy area and park home.	Other Facilities	Harry Gwala	Construction 51% - 75%	02/09/2022	TBD	R1,000,000	R885,600
90	uThukela District Perimeter Fence Replacement Programme 2020 12 Clinics	Community Health Facilities	All Districts	Construction 76% - 99%	12/04/2021	31/03/2024	R5,697,964	R6,135,871
91	uThukela District-Asbestos Eradication Programme and associated Roofing Works 12 Clinics	Community Health Facilities	All Districts	Construction 76% - 99%	15/11/2020	31/03/2024	R3,970,823	R3,164,439
92	Wentworth Hospital Flood Damage Recovery 2022	District Hospital Services	eThekwini	Construction Started	03/11/2023	20/02/2025	R18,011,383	R0

PUBLIC-PRIVATE PARTNERSHIPS (PPPS)

Table 85: Public Private Partnerships (PPPs)

PPP Name	Purpose	Output	Current value of agreement (Current Annual Budget for 24/25)	End-date of agreement
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 Systems to ensure that they remain state of the art.	Delivery of non-clinical services to IALCH	R914 733 000.00	29 February 2024
	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			

The Inkosi Albert Luthuli Central Hospital (IALCH) Public Private Partnership (PPP) relates to the agreement regulating the provision of Medical Equipment, Information Management & Technology, Facilities Management and all associated services at the Inkosi Albert Luthuli Central Hospital, which was entered into by the KwaZulu-Natal Department of Health (acting for and on behalf of the KwaZulu-Natal Provincial Government), Cowslip Investment (SOC) Ltd, and Impilo Consortium (RF) (Pty) Ltd in December 2001 (the "Project Agreement").

The PPP agreement with Impilo Consortium (RF) (Pty) Ltd at IALCH was further extended form 1 August 2023 to 29 February 2024. The Department is in final stages of the negotiations with the preferred bidder for the new 12 years Public Private Partnership Agreement, which is planned to commence on the 1 June 2024. The procurement process is proceeding well but has since experienced three months delays, and the Department now envisages to apply for Treasury Approval III (TA III) by March 2024 and to reach Financial Close by the 30 May 2024.

Financial Close as per the procurement timelines is expected to be achieved on or before 30 May 2024. However, as the current extension contract terminates on the 29 February 2024, the Department will have to make alternative arrangements to extend the existing contract for the months of March, April and May 2024 to ensure sufficient time to reach Financial Close and to ensure long-term continuation of services at the IALCH, which is currently provided for by Impilo Consortium (RF) (Pty) Ltd (the "Concessionaire").

STATE AIDED FACILITIES

Table 86: State Aided Facilities 2024/25

No.	Organisation	District	2023/24 Allocation	2024/25 Allocation
Disability and Rehabilitation				
1	Disabled People South Africa KZN (CBR)	All	R1 176 000	R 1 229 000
2	Disabled People South Africa KZN (WCR)	All	R 1 064 000	R 1 112 000
3	CBR Education & Training for Empowerment (CREATE)	uMgungundlovu	R 800 000	R 836 000
4	I–Matter Foundation	Amajuba	R 600 000	R 627 000
5	Ikhayalethu Health & Education Centre	uMkhanyakude	R 1 749 000	R 1 828 000
6	KZN Blind & Deaf Society	Zululand	R 1 045 000	R 1 092 000
7	Magaye Visually Impaired People's Association	uMgungundlovu	R 800 000	R 836 000
8	Nominated Disability Organisation	Ugu	R 360 000	R 376 000
9	Rachel Swart Fund	All	R 800 000	R 836 000
10	South African Mobility for the Blind Trust	All	R 800 000	R 836 000
Mental Health				
11	Akehlulwa Lutho	uMkhanyakude	R 680 000	R 711 000
12	Clermont Day Care Centre	eThekwini	R 487 000	R 509 000
13	DCMH - Austerville Halfway House	eThekwini	R 682 000	R 713 000
14	DCMH - Azalea House	eThekwini	R 628 000	R 656 000
15	DCMH - Happy Hours Amaoti	eThekwini	R 682 000	R 713 000
16	DCMH - Happy Hours Durban North	eThekwini	R 568 000	R 594 000
17	DCMH - Happy Hours KwaXimba	eThekwini	R 487 000	R 509 000
18	DCMH - Happy Hours Ninikhona	iLembe	R 340 000	R 355 000
19	DCMH - Happy Hours Phoenix	eThekwini	R 324 000	R 339 000
20	DCMH - Jona Vaughn Centre	eThekwini	R 4 396 000	R 4 594 000
21	DCMH - Madeline Manor	eThekwini	R 1 090 000	R 1 139 000
22	DCMH - Umlazi Halfway House	eThekwini	R 449 000	R 469 000
23	Hlanganani Ngothando Organisation	Harry Gwala	R 459 000	R 480 000
24	Indlu Youkuphephela Skills Training	Ugu	R 655 000	R 711 000
25	Ikhwezi Welfare Organisation	iLembe	R 1 968 000	R 2 057 000
267	John Peattie House	uMgungundlovu	R 2 450 000	R 2 560 000
27	Lynn & Imbali House	uMgungundlovu	R 1 446 000	R 1 511 000
28	Othandweni Cerebral Palsy Organisation	Ugu	R 425 000	R 444 000
29	Rainbow Haven	uMgungundlovu	R 658 000	R 688 000
30	Ramakrishna Umzamo Home	eThekwini	R 758 000	R 792 000
31	SCDIFA Centre	eThekwini	R 2 102 000	R 2 197 000
32	Sparks Estate	eThekwini	R 2 418 000	R 2 527 000

No.	Organisation	District	2023/24 Allocation	2024/25 Allocation
33	Solid Foundation for Rural Development (SORD)	uMkhanyakude	R 775 000	R 810 000
34	South Coast Hospice	Ugu	R 1 891 000	R 1 976 000
35	St Luke Home for Healing	iLembe	R 658 000	R 688 000
36	Still A Time	eThekwini	R 214 000	R 224 000
37	Sunfield Home	uMgungundlovu	R 302 000	R 316 000
38	Talitha Cumi Special Needs & Development Care Centre	uMgungundlovu	R 680 000	R 711 000
39	The Word of God	Ugu	R 192 000	R 204 000
Palliative, Hospice & Step Down Care				
40	Blessed Gerard Care Centre	iLembe	R 418 000	R 437 000
41	Chatsworth Regional Hospice	eThekwini	R 350 000	R 366 000
42	Duduza Care Centre	uMzinyathi	R 880 000	R 920 000
43	Estcourt Hospice	uThukela	R 1 242 000	R 1 304 000
44	Ekukhanyeni Clinic	eThekwini	R 660 000	R 690 000
45	Ethembeni Care Centre	King Cetshwayo	R 5 590 000	R 5 870 000
46	Highway Hospice	eThekwini	R 860 000	R 860 000
47	Hillcrest Aids Centre Trust	eThekwini	R 880 000	R 920 000
48	Howick Hospice	uMgungundlovu	R 748 000	R 782 000
49	KwaHilda Ongcwele HIV/AIDS Centre	Amajuba	R 300 000	R 315 000
50	Ladysmith Hospice	uThukela	R 560 000	R 585 000
51	Msunduzi Hospice	uMgungundlovu	R 1 100 000	R 1 100 000
52	Ntokozweni Village for the Vulnerable	Ugu	R 180 000	R 188 000
53	Philanjalo Hospice	uMzinyathi	R 2 958 000	R 3 106 000
54	South Coast Hospice	Ugu	R 560 000	R 585 000
55	Thembalethu Care Organisation	uThukela	R 300 000	R 314 000
56	TLC Hospice	Harry Gwala	R 350 000	R 366 000
57	Woza Moya Organisation	Harry Gwala	R 369 000	R 386 000
Primary Health Care				
58	Bekimpelo Trust	eThekwini	R 3 662 000	R 2 441 000
59	Enkumane Clinic	uMgungundlovu	R 329 000	-
60	Matikwe Clinic	eThekwini	R 611 000	R 638 000
61	Mountain View	Zululand	R 1 995 000	-
62	Philakade TLC	eThekwini	R 1 438 000	R 1 503 000
	TOTAL		R 64 398 000	R 63 454 000

Achievements for 2022/23

- The full budget of R62.04 million was spent on state aided institutions

  - R 21.3 on mental health; R 15.5 on primary health; R 12.9 on step down; R 7.5 on palliative care; and R 4.8 on disability & rehab services
- Through funding provided to the disability & rehab programme, more than:
  - 1 400 wheelchairs & other assistive devises were repaired; 1 200 households were visited; and 800 persons with disabilities identified & referred for appropriate care
- Through funding provided to the palliative care programme, more than:
  - 100 000 interventions were made to clients with terminal illnesses & their families
- Through funding provided to mental health organisations, more than:
  - 550 residential care beds were secured & approximately 200 mental health clients attended day care psychosocial rehab programmes
- Funding of the step down care programme provided relief to Church of Scotland, Osindisweni & Ngwelezana Hospitals by securing a total of 92 beds at an overage utilisation rate of 58%

PART D: TECHNICAL INDICATOR DESCRIPTION (TID) FOR APP

STRATEGIC PLAN / OUTCOME INDICATORS

Note: Indicators shaded in light green indicate provincial indicators. Non-shaded indicators form part of the Customised / Standardised Indicator set for Health.

Table 87: Strategic Plan / Outcome Indicator Definitions

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transform-...	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
PROGRAMME 1: ADMINISTRATION													
I.	Audit opinion of Provincial DoH	Audit opinion for Provincial Departments of Health for financial and performance information	AGSA Findings	Audit opinion for Provincial Departments of Health for financial performance	No denominator	AGSA Findings	Accurate data	None	None	Not applicable	Annual	Unqualified audit opinion	Office of the CFO
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	Not applicable	Annual progress against the five year target	Equal or lower than target	Legal Services
PROGRAMME 2: SUB-PROGRAMME DISTRICT HEALTH SERVICES (PHC, CHC AND DISTRICT HOSPITALS)													
III.	Ideal clinic status obtained rate	Fixed PHC health facilities that obtained Ideal Clinic status (bronze, silver, gold) as a	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	Cumulative (year-end)	Annual progress against the five	Equal or higher than target	DHS

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transform-	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
		proportion of fixed PHC clinics and CHCs/CDCs									year target		
IV.	Patient Experience of Care satisfaction rate	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 (total responses)	Patient experience of care survey total responses	Patient Surveys	Accurate data submitted by health facilities	None	None	Cumulative (year-to-date)	Annual	Equal or higher than the target	QA
V.	Patient Safety Incident (PSI) case closure rate	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	Patient Safety Incident (PSI) case reported	Patient Safety Incidence Reports	Accurate data submitted by health facilities	None	None	Cumulative (year-to-date)	Quarterly	Equal or higher than the target	QA
PROGRAMME 2: SUB-PROGRAMME HIV / AIDS, TB AND SEXUALLY TRANSMITTED INFECTIONS													
VI.	Number of All TB Deaths	TB clients who started drug-susceptible tuberculosis (DS-TB) treatment and who subsequently died	DHIS	Number of ALL TB deaths (include all clients who died whilst on TB treatment – both DS TB and DR-TB treatment)	No denominator	TB Clinical stationery	Accurate data submitted by health facilities	Cohort	None	Cumulative (year-end)	Annual progress against the five year target	Lower or equal to target	HAST
VII.	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	Cumulative (year-to-date)	Quarterly	Higher or equal to target	HAST

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transform-	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
VIII.	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	TB Rifampicin resistant / Multidrug resistant clients successfully completed treatment	TB Rifampicin resistant / Multidrug resistant client started on treatment	TB Clinical Stationery;	Accurate data submitted by health facilities	Cohort	None	Cumulative (year-to-date)	Quarterly	Higher or equal to target	HAST
IX.	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	Cumulative (year-to-date)	Quarterly	Higher or equal to target	HAST
X.	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	Cumulative (year-to-date)	Annual progress against five year target	Higher or equal to target	HAST
XI.	ART Adult Viral load suppressed rate (below 50) [12 months]	ART adult viral load under 50 as a proportion of ART adult viral load done	TIER.Net	ART adult viral load under 50	ART adult viral load done	ART paper Register;	Accurate data submitted by health facilities	Cohort	None	Cumulative (year-to-date)	Quarterly	Higher or equal to target	HAST
XII.	ART Child viral load suppressed rate	ART child viral load under 50 as a	TIER.Net	ART child viral load under 50	ART child viral load done	ART paper Register;	Accurate data submitted	Children under 15	None	Cumulative (year-to-date)	Quarterly	Higher or equal to target	HAST

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transform-	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
	(below 50) [12 months]	proportion of ART child viral load done					by health facilities	years cohort					
XIII.	ART death rate	ART cumulative death - total as a proportion of ART start minus cumulative transfer out at 6 months	ART Register; TIER.Net; DHIS	ART cumulative death at 6 months	ART start minus cumulative transfer out at 6 months	ART Register; TIER.Net; DHIS	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	None	Cumulative (year-to-date)	Annual progress against the five year target	Lower or equal to target	HAST
XIV.	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 dependent on Accurate data submitted by health facilities	Youth	None	Cumulative (year-to-date)	Quarterly	Lower or equal to target	HAST
PROGRAMME 2: SUB-**PROGRAMME MATERNAL, CHILD AND WOMAN'S HEALTH INCLUDING NUTRTION**													
XV.	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 (In DHS and referral hospitals)	Live births known to facility (in DHS and Referral hospitals)	Maternal death register, Delivery register	Accurate data submitted by health facilities	Women	None	Cumulative (year-to-date)	Annual	Equal or lower than target	MCWH

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transform-	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
XVI.	Neonatal death in facility rate (per 1 000 live births)	Infants 0-28 days who died during their stay in the facility live births in facility expressed as a ratio per 1 000	DHIS	Neonatal deaths (under 28 days) in facility	Live birth in facility	Delivery register, Midnight report	Accurate data submitted by health facilities	Neonates	None	Cumulative (year-to-date)	Quarterly	Equal or lower than target	MCWH
XVII.	Death under 5 years against live birth rate	Children under 5 years who died during their stay in the facility as a proportion of all live births	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	Cumulative (year-to-date)	Quarterly	Equal or lower than target	MCWH
XVIII.	Death in facility under 5 years rate	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	Cumulative (year-to-date)	Quarterly	Equal or lower than target	MCWH
XIX.	Child under 5 years diarrhoea case fatality rate	Diarrhoea deaths in children under 5 years as a proportion of diarrhoea separations under 5 years in health facilities	DHIS	Diarrhoea death under 5 years	Diarrhoea separation under 5 years	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Cumulative (year-to-date)	Quarterly	Equal or lower than target	MCWH
XX.	Child under 5 years pneumonia case fatality rate	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	DHIS	Pneumonia death under 5 years	Pneumonia separation under 5 years	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Cumulative (year-to-date)	Quarterly	Equal or lower than target	MCWH

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transform-	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
XXI.	Child under 5 years Severe acute malnutrition case fatality rate	Severe acute malnutrition deaths in children under 5 years as a proportion of total deaths in facility under 5 years	DHS	Severe acute malnutrition (SAM) death under 5 years	Severe acute malnutrition inpatient under 5 years	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Cumulative (year-to-date)	Quarterly	Equal or lower than target	MCWH
XXII.	Still birth in facility rate (Per 1 000 births)	Infants born still as proportion of total infants born in health facilities	DHIS	Still birth in facility	Total births in facility (include still birth in facility)	Ward register, Midnight census	Accurate data submitted by health facilities	All births	None	Cumulative (year -to-date)	Quarterly	Equal or lower than target	MCWH
PROGRAMME 2: SUB-PROGRAMME DISEASE PREVENTION AND CONTROL													
XXIII.	Malaria case fatality rate	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 (Note: all malaria cases cumulative since new FY)	Malaria Information System	Accurate data submitted by health facilities	None	None	Non-cumulative	Annual progress against the five year target	Equal or lower than target	Environmental Health & CDC
PROGRAMME 4: PROVINICAL HOSPITALS (REGIONAL, TB, PSYCHIATRIC & CHRONIC HOSPITALS)													
XXIV.	Patient Experience of Care satisfaction rate	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 (total responses)	Patient experience of care survey total responses	Patient Surveys	Accurate data submitted by health facilities	None	None	Cumulative (year-to-date)	Annual	Equal or higher than the target	QA
XXV.	Patient Safety Incident (PSI) case closure rate	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	Patient Safety Incident (PSI) case reported	Patient Safety Incidence Reports	Accurate data submitted by health facilities	None	None	Cumulative (year-to-date)	Quarterly	Equal or higher than the target	QA

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transform-	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
XXVI.	Maternal deaths in facility	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 maternal deaths in facility (Referral Hospitals)	No denominator	Maternal death register,	Accurate data submitted by health facilities	Pregnant women	None	Cumulative (year-to-date)	Annual	Lower or equal to the target	MCWH
XXVII.	Death in facility under 5 years	Children under 5 years who died during their stay in the facility	DHIS	Number death in facility under 5 years total	No denominator	Midnight census;	Accurate data submitted by health facilities	Children under 5 years	None	Cumulative (year-to-date)	Quarterly	Lower or equal to target	MCWH
XXVIII.	Diarrhoea death under 5 years	Diarrhoea deaths in children under 5 years as a proportion of diarrhoea separations under 5 years in health facilities	DHIS	Number Diarrhoea death under 5 years (in referral hospitals)	No denominator	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Cumulative (year-to-date)	Quarterly	Lower or equal to target	MCWH
XXIX.	Pneumonia death under 5 years	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	DHIS	Number Pneumonia death under 5 years (in referral hospitals)	No denominator	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Cumulative (year-to-date)	Quarterly	Lower or equal to target	MCWH

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transform-	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
XXX.	Severe acute malnutrition (SAM) death under 5 years	Severe acute malnutrition deaths in children under 5 years as a proportion of total deaths in facility under 5 years	DHIS	Number Severe acute malnutrition (SAM) deaths under 5 years	No denominator	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Cumulative (year-to-date)	Quarterly	Lower or equal to target	MCWH
PROGRAMME 5: COMBINED (TERTIARY AND CENTRAL HOSPITALS)													
XXXI.	Patient Experience of Care satisfaction rate	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 (total responses)	Patient experience of care survey total responses	Patient Surveys	Accurate data submitted by health facilities	None	None	Cumulative (year-to-date)	Annual	Equal or higher than the target	QA
XXXII.	Patient Safety Incident (PSI) case closure rate	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	Patient Safety Incident (PSI) case reported	Patient Safety Incidence Reports	Accurate data submitted by health facilities	None	None	Cumulative (year-to-date)	Quarterly	Equal or higher than the target	QA
XXXIII.	Maternal deaths in facility	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 maternal deaths in facility (Referral Hospitals)	No denominator	Maternal death register,	Accurate data submitted by health facilities	Pregnant women	None	Cumulative (year-to-date)	Annual	Lower or equal to the target	MCWH

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transform-	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
XXXIV.	Death in facility under 5 years	Children under 5 years who died during their stay in the facility	DHIS	Number death in facility under 5 years total	No denominator	Midnight census;	Accurate data submitted by health facilities	Children under 5 years	None	Cumulative (year-to-date)	Quarterly	Lower or equal to target	MCWH
XXXV.	Diarrhoea death under 5 years	Diarrhoea deaths in children under 5 years as a proportion of diarrhoea separations under 5 years in health facilities	DHIS	Number Diarrhoea death under 5 years (in referral hospitals)	No denominator	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Cumulative (year-to-date)	Quarterly	Lower or equal to target	MCWH
XXXVI.	Pneumonia death under 5 years	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	DHIS	Number Pneumonia death under 5 years (in referral hospitals)	No denominator	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Cumulative (year-to-date)	Quarterly	Lower or equal to target	MCWH
XXXVII.	Severe acute malnutrition (SAM) death under 5 years	Severe acute malnutrition deaths in children under 5 years as a proportion of total deaths in facility under 5 years	DHIS	Number Severe acute malnutrition (SAM) deaths under 5 years	No denominator	Ward register	Accurate data submitted by health facilities	Children under 5 years	None	Cumulative (year-to-date)	Quarterly	Lower or equal to target	MCWH

APP OUTPUT INDICATORS

Table 88: 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 performance	Indicator Responsibility
				Number / Numerator	Denominator								
PROGRAMME 1: ADMINISTRATION													
1.	Percentage of hospitals implementing E-Health beyond Module 1 (Phase 1)	Hospitals that use an electronic system to capture clinical codes for each patient visit	Hospitals that use an electronic system to capture clinical codes for each patient visit	Hospitals that have access to and use an electronic system for patient records	Number of hospitals implementing E-Health beyond Module 1 (Phase 1)	Number of hospitals included in Phase 1 of the E-Health project	Hospitals that use an electronic system to capture clinical codes for each patient visit	Accurate data	All health clients	Cumulative (Year-to-date)	Quarterly	Equal or higher than target	ICT
2.	Percentage of hospitals implementing E-Health for the first time (At least Module 1)	Hospitals that use an electronic system to capture clinical codes for each patient visit	Hospitals that use an electronic system to capture clinical codes for each patient visit	Hospitals that have access to and use an electronic system for patient records	Number of hospitals implementing E-Health for the first time (At least Module 1)	Number of hospitals included in Phase 2 of the E-Health project	Hospitals that use an electronic system to capture clinical codes for each patient visit	Accurate data	All health clients	Cumulative (Year-to-date)	Quarterly	Equal or higher than target	ICT
3.	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	Accurate data	All health suppliers	All facilities and administration offices in districts	Cumulative (year-to-date)	Quarterly	Equal or higher than target	Finance

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.	Proportion of expenditure paid to businesses owned by women	The proportion of the ownership by women is equated (as a percentage) to the rand value of the amount spent on that company	Cognos	The Departments ACTUAL spend on procurement for businesses owned by women	The total amount of procurement done by the Department for the same period as numerator	All payment vouchers from all the institutions are physically submitted to voucher control at head office where they can be viewed for verification purposes	Accurate Data	Women – 100%	All facilities and administration offices in districts	Cumulative (year-t-date)	Quarterly	Equal or higher than target	Finance
PROGRAMME 2: SUB-PROGRAMME DISTICT HEALTH SERVICES (PHC, CHC AND DISTRICT HOSPITALS)													
5.	Severity assessment code (SAC) 1 incident reported within 24 hours rate	Severity assessment code (SAC) 1 incidents reported within 24 hours as a proportion of Severity assessment code (SAC) 1 incident reported	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	All health clients	All PHC facilities and District Hospitals in the Province	Cumulative (year-to-date)	Quarterly	Equal or higher than target	QA
PROGRAMME 2: SUB-PROGRAMME HIV / AIDS, TB AND SEXUALLY TRANSMITTED INFECTIONS													
6.	All DS-TB LTF 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	All health facilities in the Province	Cumulative (year-to-date)	Quarterly	Lower or equal to target	HAST
7.	TB Rifampicin resistant / Multidrug - Resistant lost to follow up rate	TB Rifampicin Resistant/Multidrug Resistant client's loss to follow-up as a proportion of TB Rifampicin	DHIS	TB Rifampicin resistance / multi-drug resistant	TB Rifampicin Resistant / Multi-drug client	DS-TB Clinical Stationery;TIER .Net	Accurate data submitted	Cohort	All health facilities in	Cumulative (year-to-date)	Quarterly	Lower or equal to target	HAST

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								
		Resistant/Multidrug Resistant clients started on treatment		client loss to follow-up	started on treatment		by health facilities		the Province				
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 loss to follow-up	TB Pre-XDR clients started on treatment	DS-TB Clinical Stationery;TIER.Net	Accurate data submitted by health facilities	Cohort	All health facilities in the Province	Cumulative (year-to-date)	Quarterly	Lower or equal to target	HAST
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 - total	ART adult start minus cumulative transfer out	ART paper Register; DHIS	Accurate data submitted by health facilities	Cohort	All health facilities in the Province	Cumulative (year-to-date)	Quarterly	Higher or equal to target	HAST
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 - total	ART child start minus cumulative transfer out	ART paper Register; DHIS	Accurate data submitted by health facilities	Children and youth cohort	All health facilities in the Province	Cumulative (year-to-date)	Quarterly	Higher or equal to target	HAST
PROGRAMME 2: SUB-**PROGRAMME MATERNAL, CHILD AND WOMAN'S HEALTH INCLUDING NUTRTION**													
11.	IUCD Uptake (*IUCD – Intra Uterine Contraceptive Device)	Intra Uterine Contraceptive Device (IUCD) inserted into a woman aged 15-49 years	DHIS	Number IUCD inserted	No denominator	PHC Comprehensive Tick Register StatsSA	Accurate data submitted by health facilities	Women	All health facilities in the Province	Cumulative (Year-to-date)	Quarterly	Equal or higher than target	MCWH
12.	Delivery 10 – 14 years in facility	Delivery where the mother is 10-14 years old. These deliveries are done in facilities under the supervision of trained medical/nursing staff	DHIS	Number delivery 10 – 14 years in facility	No denominator	Health Facility Register, Delivery/Maternity register	Accurate data submitted by health facilities	Youth, women	All health facilities in the Province	Cumulative (Year-to-date)	Quarterly	Equal or lower than target	MCWH

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								
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	All health facilities in the Province	Cumulative (Year-to-date)	Quarterly	Higher or equal to target	MCWH
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	All health facilities in the Province	Cumulative (Year-to-date)	Quarterly	Higher or equal to target	MCWH
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	Infant PCR test around 6 months	PHC Comprehensive Tick Register	Accurate data submitted by health facilities	Children under 5 years	All health facilities in the Province	Cumulative (Year-to-date)	Quarterly	Equal or lower than target	MCWH
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	All health facilities in the Province	Cumulative (Year-to-date)	Quarterly	Equal or lower than target	MCWH
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	All health facilities in the Province	Cumulative (Year-to-date)	Quarterly	Higher or equal to target	MCWH
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	All health facilities in the Province	Cumulative (Year-to-date)	Quarterly	Higher or equal to target	MCWH

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								
19.	Cervical Cancer Screening Coverage	Cervical smears in women 30 years and older as a proportion of the female population 30-50 years80% of these women should be screened for cervical cancer every 10 years and 20% must be screened every 3 years which should be included in the denominator because it is estimated that 20% of women 20 years and older are HIV positive	DHIS	Cervical cancer screening done	[(80% women aged 30-50yrs/10)+(20% women aged 20 years and above /3)	PHC Comprehensive Tick Register; OPD Tick register; Inpatient register	Accurate data submitted by health facilities	Females	All health facilities in the Province	Cumulative (year-to-date)	Quarterly	Higher or equal to target	MCWH
PROGRAMME 2: SUB-PROGRAMME DISEASE PREVENTION AND CONTROL													
20.	PHC Mental Disorders Treatment Rate New	Clients treated for the first time for mental disorders (depression, anxiety, dementia, psychosis, mania, suicide attempt, developmental disorders, behavioural disorders and substance abuse/addiction disorders) as a proportion of total PHC headcount	DHIS	PHC client treated for mental disorders - new	PHC headcount - total	PHC Comprehensive Tick Register;	Accurate data submitted by health facilities	All health facility clients	All PHC facilities and District Hospitals in the Province	Cumulative (year-to-date)	Quarterly	Equal or lower than target	NC
PROGRAMME 3: EMERGENCY MEDICAL CARE													
21.	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	All EMS clients	All 11 districts	Rate	Quarterly [Cumulative year-end]	Higher or equal to target	EMS

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								
22.	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	All EMS clients	All 11 districts	Rate	Quarterly [Cumulative year-end]	Higher or equal to target	EMS
PROGAMME 4: PROVINICAL HOSPITAL SERVICES (COMBINED PROGRAMME 4)													
23.	Severity assessment code (SAC) 1 incident reported within 24 hours rate	Severity assessment code (SAC) 1 incidents reported within 24 hours as a proportion of Severity assessment code (SAC) 1 incident reported	Ideal Health Facility Software	Severity assessment code (SAC) 1 incidents reported within 24 hours	Severity assessment code (SAC) 1 incident reported Hospitals	Patient Safety Incident Reports	Accurate data submitted by health facilities	All health facility clients	All health facilities funded under Programmes 4 in the 11 Districts	Cumulative (year-to-date)	Quarterly	Equal or higher than target	NHI
24.	Cervical cancer screening	Women aged between 30 - 50 years who had a cervical cancer screen using any method (Pap Smear, VIA, OR LBC are included) plus Cervical cancer screening done in HIV positive women at three years intervals using any method (Pap Smear, VIA, OR LBC are included)	DHIS	Number cervical cancer screening done	No denominator	PHC Comprehensive Tick Register; OPD Tick register; Inpatient register	Accurate data submitted by health facilities	Females	All health facilities funded under Programmes 4 in the 11 Districts	Cumulative (year-to-date)	Quarterly	Equal or higher than target	SHP
PROGRAMME 5: COMBINED PROGRAMME 5													
25.	Severity assessment code (SAC) 1 incident reported within 24 hours rate	Severity assessment code (SAC) 1 incidents reported within 24 hours as a proportion of Severity	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	All health facility clients	All health facilities funded under Programme	Cumulative (year-to-date)	Quarterly	Equal or higher than target	NHI

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								
		assessment code (SAC) 1 incident reported							s 5 in the 11 Districts				
26.	Cervical cancer screening	Women aged between 30 - 50 years who had a cervical cancer screen using any method (Pap Smear, VIA, OR LBC are included) plus Cervical cancer screening done in HIV positive women at three years intervals using any method (Pap Smear, VIA, OR LBC are included)	DHIS	Number Cervical Cancer screening done	No denominator	PHC Comprehensive Tick Register; OPD Tick register; Inpatient register	Accurate data submitted by health facilities	Females	All health facilities funded under Programmes 5 in the 11 Districts	Cumulative (year-to-date)	Quarterly	Equal or higher than target	SHP
PROGRAMME 6: HEALTH SCIENCES													
27.	Number of Bursaries awarded to first year nursing students	Bursaries awarded for first year nursing students as part of implementation of the Human Resource Plan.	Bursary record Database	Number of bursaries awarded for first year nursing students.	Not applicable	Bursary records	Accurate data	60% Female 40% Male bursary holders	All 11 districts	Non-Cumulative	Annual	Higher or equal to target	HRMS
28.	Number of internal employees awarded bursaries	Internal employees awarded bursaries as part of implementation of the Human Resource Plan.	Bursary record Database	Number of internal employees awarded bursaries	Not applicable	Bursary records	Accurate data	Internal employees	All 11 districts	Non-Cumulative	Annual	Higher or equal to target	HRMS
PROGRAMME 7: CLINICAL SUPPORT													
29.	Tracer Medicine Stock-Out Rate at the Provincial Pharmaceutical Supply Depot (PPSD)	Number of tracer medicines out of stock as proportion of medicines expected to be in stock (any item on the Tracer Medicine List that had a zero	Pharmacy record Database	Number of tracer medicines out of stock	Total number of medicines expected to be in stock	Pharmacy records	Accurate data	All health facility clients	All 11 districts	Cumulative (year-end)	Quarterly	Lower or equal to target	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								
		balance in the Bulk Store on a Stock Control System.											
30.	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 record Database	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	All health facility clients	All 11 districts	Cumulative (year-end)	Quarterly	Lower or equal to target	Pharm acy
PROGRAMME 8: INFRASTRUCTURE													
31.	Percentage of Preventative Maintenance expenditure	This is the Percentage of Preventative maintenance (Category B) expenditure compared to Category A & B expenditure	PO8, BAS, PMIS	Expenditure on Preventative Maintenance Activities (Category B)	Expenditure on Preventative Maintenance plus Day-to-day Maintenance (Category A & B)	Orders issues	Accurate data submitted by health facilities	All health facility clients	All facilities in all 11 Districts	Cumulative (year-end)	Quarterly	Higher or equal to target	Infrastr ucture
32.	Number of new and replacement projects completed	New or Replacement projects, upgrade and addition projects, renovation and refurbishment projects which have reached practical completion during the reporting period	Project Management System/ Annexure B	Number of projects which have reached practical completion	None	Practical Completion Certificate	Accurate data submitted by health facilities	All health facility clients	All identified facilities in the Master Infrastructur e Plan	Cumulative (year-end)	Quarterly	Higher or equal to target	Infrastr ucture

CONSOLIDATED INDICATORS (OUTCOME & OUTPUT INDICATORS PER LEVEL OF CARE)

Table 89: Consolidated indicators at a service delivery level Definitions

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficia	Spatial Transform-ation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
PROGRAMME 2: SUB-PROGRAMME PHC CLINICS													
i.	Patient Experience of Care satisfaction rate – PHC facilities	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 for PHC facilities	Number of Patient Experience of Care survey total responses for PHC facilities	Patient Surveys	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Annual	Equal or higher than the target	NHI
ii.	Patient Safety Incident (PSI) case closure rate – PHC facilities	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 for PHC facilities	Number of Patient Safety Incident (PSI) case reported in the reporting month for PHC facilities	Patient Safety Incidence Reports	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than the target	NHI
iii.	Severity assessment code (SAC) 1 incident reported within 24 hours rate – PHC facilities	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 – PHC facilities	Severity assessment code (SAC) 1 incident reported – PHC facilities	Patient Safety Incident Reports	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than target	NHI
PROGRAMME 2: SUB-PROGRAMME DISTRICT HOSPITALS													
iv.	Patient Experience of Care satisfaction rate – District Hospitals	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 for District Hospitals	Number of Patient Experience of Care survey total responses for District Hospitals	Patient Surveys	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Annual	Equal or higher than the target	NHI

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficia	Spatial Transform-ation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
v.	Patient Safety Incident (PSI) case closure rate – District 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	Number of Patient Safety Incident (PSI) case closed in the reporting month for District Hospitals	Number of Patient Safety Incident (PSI) case reported in the reporting month for District Hospitals	Patient Safety Incidence Reports	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than the target	NHI
vi.	Severity assessment code (SAC) 1 incident reported within 24 hours rate – District 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 – District Hospitals	Severity assessment code (SAC) 1 incident reported – District Hospitals	Patient Safety Incident Reports	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than target	NHI
PROGRAMME 4: SUB-PROGRAMME REGIONAL HOSPITALS													
vii.	Patient Experience of Care satisfaction rate – Regional Hospitals	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 for Regional Hospitals	Number of Patient Experience of Care survey total responses for Regional Hospitals	Patient Surveys	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Annual	Equal or higher than the target	NHI
viii.	Patient Safety Incident (PSI) case closure rate – Regional 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	Number of Patient Safety Incident (PSI) case closed in the reporting month for Regional Hospitals	Number of Patient Safety Incident (PSI) case reported in the reporting month for Regional Hospitals	Patient Safety Incidence Reports	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than the target	NHI
ix.	Maternal death in facility – Regional Hospitals	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of	DHIS	Number maternal death in facility for Regional Hospitals	No denominator	Maternal death register,	Accurate data submitted by health facilities	Women	All 11 districts	Cumulative (year-to-date)	Annual	Lower or equal to the target	SHP

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficia	Spatial Transform-ation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
		termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric)											
x.	Death in facility under 5 years – Regional Hospitals	Children under 5 years who died during their stay in the facility	DHIS	Number Death in facility under 5 years for Regional Hospitals	No denominator	Midnight census;	Accurate data submitted by health facilities	Children under 5 years	All 11 districts	Cumulative (year-to-date)	Quarterly	Lower or equal to target	SHP
xi.	Diarrhoea death under 5 years – Regional Hospitals	Diarrhoea deaths in children under 5 years as a proportion of diarrhoea separations under 5 years in health facilities	DHIS	Number Diarrhoea death under 5 years for Regional Hospitals	No denominator	Ward register	Accurate data submitted by health facilities	Children under 5 years	All 11 districts	Cumulative (year-to-date)	Quarterly	Lower or equal to target	SHP
xii.	Pneumonia death under 5 years – Regional Hospitals	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	DHIS	Number Pneumonia death under 5 years for Regional Hospitals	No denominator	Ward register	Accurate data submitted by health facilities	Children under 5 years	All 11 districts	Cumulative (year-to-date)	Quarterly	Lower or equal to target	SHP
xiii.	Severe acute malnutrition death under 5 years – Regional Hospitals	Severe acute malnutrition deaths in children under 5 years as a proportion of total deaths in facility under 5 years	DHIS	Number Severe acute malnutrition death under 5 years for Regional Hospitals	No denominator	Ward register	Accurate data submitted by health facilities	Children under 5 years	All 11 districts	Cumulative (year-to-date)	Quarterly	Lower or equal to target	SHP
xiv.	Severity assessment code (SAC) 1 incident reported within 24 hours rate – Regional Hospitals	Severity assessment code (SAC) 1 incidents reported within 24 hours as a proportion of Severity	Ideal Health Facility Software	Severity assessment code (SAC) 1 incidents reported within 24 hours – Regional Hospitals	Severity assessment code (SAC) 1 incident reported –	Patient Safety Incident Reports	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than target	NHI

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficia	Spatial Transform-ation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
		assessment code (SAC) 1 incident reported			Regional Hospitals								
xv.	Cervical cancer screening - Regional Hospitals	Women aged between 30 -50 years who had a cervical cancer screen using any method (Pap Smear, VIA, OR LBC are included) plus Cervical cancer screening done in HIV positive women at three years intervals using any method (Pap Smear, VIA, OR LBC are included)	DHIS	Number Cervical Cancer screening done - Regional Hospitals	No denominator	OPD Tick register; Inpatient register	Accurate data submitted by health facilities	Females	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than target	SHP
PROGRAMME 4: SUB-PROGRAMME TB HOSPITALS													
xvi.	Patient Experience of Care satisfaction rate – TB Hospitals	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 for TB Hospitals	Number of Patient Experience of Care survey total responses for TB Hospitals	Patient Surveys	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Annual	Equal or higher than the target	NHI
xvii.	Patient Safety Incident (PSI) case closure rate – TB 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	Number of Patient Safety Incident (PSI) case closed in the reporting month for TB Hospitals	Number of Patient Safety Incident (PSI) case reported in the reporting month for TB Hospitals	Patient Safety Incidence Reports	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than the target	NHI
xviii.	Severity assessment code (SAC) 1 incident reported within 24 hours rate – TB 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 – TB Hospitals	Severity assessment code (SAC) 1 incident reported – TB Hospitals	Patient Safety Incident Reports	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than target	NHI

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficia	Spatial Transform-ation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
PROGRAMME 4: SUB-PROGRAMME PSYCHIATRIC HOSPITALS													
xix.	Patient Experience of Care satisfaction rate – Psychiatric Hospitals	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 for Psychiatric Hospitals	Number of Patient Experience of Care survey total responses for Psychiatric Hospitals	Patient Surveys	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Annual	Equal or higher than the target	NHI
xx.	Patient Safety Incident (PSI) case closure rate – Psychiatric 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	Number of Patient Safety Incident (PSI) case closed in the reporting month for Psychiatric Hospitals	Number of Patient Safety Incident (PSI) case reported in the reporting month for Psychiatric Hospitals	Patient Safety Incidence Reports	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than the target	NHI
xxi.	Severity assessment code (SAC) 1 incident reported within 24 hours rate – Psychiatric 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 – Psychiatric Hospitals	Severity assessment code (SAC) 1 incident reported – Psychiatric Hospitals	Patient Safety Incident Reports	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than target	NHI
PROGRAMME 4: SUB-PROGRAMME CHRONIC HOSPITALS													
xxii.	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	Number of Patient Experience of Care survey "satisfied" responses for Chronic Hospitals	Number of Patient Experience of Care survey total responses for Chronic Hospitals	Patient Surveys	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Annual	Equal or higher than the target	NHI

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficia	Spatial Transform-ation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
xxiii.	Patient Safety Incident (PSI) case closure rate – Chronic 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	Number of Patient Safety Incident (PSI) case closed in the reporting month for Chronic Hospitals	Number of Patient Safety Incident (PSI) case reported in the reporting month for Chronic Hospitals	Patient Safety Incidence Reports	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than the target	NHI
xxiv.	Severity assessment code (SAC) 1 incident reported within 24 hours rate – Chronic 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 – Chronic Hospitals	Severity assessment code (SAC) 1 incident reported – Chronic Hospitals	Patient Safety Incident Reports	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than target	NHI
PROGRAMME 5: SUB-PROGRAMME TERTIARY HOSPITALS													
xxv.	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	Number of Patient Experience of Care survey "satisfied" responses for Tertiary Hospitals	Number of Patient Experience of Care survey total responses for Tertiary Hospitals	Patient Surveys	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Annual	Equal or higher than the target	NHI
xxvi.	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	Number of Patient Safety Incident (PSI) case closed in the reporting month for Tertiary Hospitals	Number of Patient Safety Incident (PSI) case reported in the reporting month for Tertiary Hospitals	Patient Safety Incidence Reports	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than the target	NHI
xxvii.	Maternal death in facility – Tertiary Hospitals	Maternal death is death occurring during pregnancy, childbirth and	DHIS	Number maternal death in facility for Tertiary Hospitals	No denominator	Maternal death register,	Accurate data submitted	Women	All 11 districts	Cumulative (year-to-date)	Annual	Lower or equal to the target	SHP

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficia	Spatial Transform-ation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
		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)					by health facilities						
xviii.	Death in facility under 5 years – Tertiary Hospitals	Children under 5 years who died during their stay in the facility	DHIS	Number Death in facility under 5 years for Tertiary Hospitals	No denominator	Midnight census;	Accurate data submitted by health facilities	Children under 5 years	All 11 districts	Cumulative (year-to-date)	Quarterly	Lower or equal to target	SHP
xxix.	Diarrhoea death under 5 years – Tertiary Hospitals	Diarrhoea deaths in children under 5 years as a proportion of diarrhoea separations under 5 years in health facilities	DHIS	Number Diarrhoea death under 5 years for Tertiary Hospitals	No denominator	Ward register	Accurate data submitted by health facilities	Children under 5 years	All 11 districts	Cumulative (year-to-date)	Quarterly	Lower or equal to target	SHP
xxx.	Pneumonia death under 5 years – Tertiary Hospitals	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	DHIS	Number Pneumonia death under 5 years for Tertiary Hospitals	No denominator	Ward register	Accurate data submitted by health facilities	Children under 5 years	All 11 districts	Cumulative (year-to-date)	Quarterly	Lower or equal to target	SHP
xxxi.	Severe acute malnutrition death	Severe acute malnutrition deaths in children under 5 years as a proportion of	DHIS	Number Severe acute malnutrition	No denominator	Ward register	Accurate data submitted	Children under 5 years	All 11 districts	Cumulative (year-to-date)	Quarterly	Lower or equal to target	SHP

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficia	Spatial Transform-ation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
	under 5 years – Tertiary Hospitals	total deaths in facility under 5 years		death under 5 years for Tertiary Hospitals			by health facilities						
xxxii.	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 – Tertiary Hospitals	Severity assessment code (SAC) 1 incident reported – Tertiary Hospitals	Patient Safety Incident Reports	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than target	NHI
xxxiii.	Cervical cancer screening - Tertiary Hospitals	Women aged between 30 -50 years who had a cervical cancer screen using any method (Pap Smear, VIA, OR LBC are included) plus Cervical cancer screening done in HIV positive women at three years intervals using any method (Pap Smear, VIA, OR LBC are included)	DHIS	Number Cervical Cancer screening done - Tertiary Hospitals	No denominator	OPD Tick register; Inpatient register	Accurate data submitted by health facilities	Females	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than target	SHP
PROGRAMME 5: SUB-PROGRAMME CENTRAL HOSPITAL													
xxiv.	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	Number of Patient Experience of Care survey "satisfied" responses for Central Hospital	Number of Patient Experience of Care survey total responses for Central Hospital	Patient Surveys	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Annual	Equal or higher than the target	NHI
xxxv.	Patient Safety Incident (PSI) case	Patient Safety Incident case closed in the reporting month as a	Ideal Health Facility Software	Number of Patient Safety Incident (PSI) case closed in the	Number of Patient Safety Incident (PSI)	Patient Safety	Accurate data submitted	All health facility clients	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than the target	NHI

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficia	Spatial Transform-ation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
	closure rate – Central Hospital	proportion of Patient Safety Incident cases reported in the reporting month		reporting month for Central Hospital	case reported in the reporting month for Central Hospital	Incidence Reports	by health facilities						
xxvi.	Maternal death 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 maternal death in facility for Central Hospital	No denominator	Maternal death register,	Accurate data submitted by health facilities	Women	All 11 districts	Cumulative (year-to-date)	Annual	Lower or equal to the target	SHP
xxvii.	Death in facility under 5 years – Central Hospital	Children under 5 years who died during their stay in the facility	DHIS	Number Death in facility under 5 years for Central Hospital	No denominator	Midnight census;	Accurate data submitted by health facilities	Children under 5 years	All 11 districts	Cumulative (year-to-date)	Quarterly	Lower or equal to target	SHP
xviii.	Diarrhoea death under 5 years – Central Hospital	Diarrhoea deaths in children under 5 years as a proportion of diarrhoea separations under 5 years in health facilities	DHIS	Number Diarrhoea death under 5 years for Central Hospital	No denominator	Ward register	Accurate data submitted by health facilities	Children under 5 years	All 11 districts	Cumulative (year-to-date)	Quarterly	Lower or equal to target	SHP

Indicator Title		Definition	Source of Data	Method of calculation		Means of Verification	Assumptions	Disaggregation of Beneficia	Spatial Transform-ation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
				Number / Numerator	Denominator								
xxix.	Pneumonia death under 5 years – Central Hospital	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	DHIS	Number Pneumonia death under 5 years for Central Hospital	No denominator	Ward register	Accurate data submitted by health facilities	Children under 5 years	All 11 districts	Cumulative (year-to-date)	Quarterly	Lower or equal to target	SHP
xl.	Severe acute malnutrition death under 5 years – Central Hospital	Severe acute malnutrition deaths in children under 5 years as a proportion of total deaths in facility under 5 years	DHIS	Number Severe acute malnutrition death under 5 years for Central Hospital	No denominator	Ward register	Accurate data submitted by health facilities	Children under 5 years	All 11 districts	Cumulative (year-to-date)	Quarterly	Lower or equal to target	SHP
xli.	Severity assessment code (SAC) 1 incident reported within 24 hours rate – Central 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 – Central Hospital	Severity assessment code (SAC) 1 incident reported – Central Hospital	Patient Safety Incident Reports	Accurate data submitted by health facilities	All health facility clients	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than target	NHI
xlii.	Cervical cancer screening - Central Hospital	Women aged between 30 -50 years who had a cervical cancer screen using any method (Pap Smear, VIA, OR LBC are included) plus Cervical cancer screening done in HIV positive women at three years intervals using any method (Pap Smear, VIA, OR LBC are included)	DHIS	Number Cervical Cancer screening done - Central Hospital	No denominator	OPD Tick register; Inpatient register	Accurate data submitted by health facilities	Females	All 11 districts	Cumulative (year-to-date)	Quarterly	Equal or higher than target	SHP

ANNEXURES

ANNEXURE A: AMENDMENTS TO THE STRATEGIC PLAN

STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 20/21 to 24/25

The table below: "*Universal Health Coverage*" 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 strikethrough font. The changes for the 24/25 reporting period are highlighted in yellow. The Revised Table 14 is subsequently reflected.

Table 90: Outcome Indicators for Universal health Coverage as at September 2023

Outcome Indicator	Data Source	South Africa		Provincial			Changes made in 2024/25 planning cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
OUTCOME: UNIVERSAL HEALTH COVERAGE							
UHC service Index	SAHR	68%	75%	71.7%	73.5%		Monitoring will take place in the Annual Operational Plan
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	

Outcome Indicator	Data Source	South Africa		Provincial			Changes made in 2024/25 planning cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
~~Percentage of facilities certified by OHSC~~	~~To be determined~~	~~NA~~	~~NA~~	~~New~~	~~71.4%~~		
Number of districts with Quality Improvement; monitoring and response forums formalized and convened quarterly	Terms of reference for response forums	Baseline to be determined	52	New	11		• Monitoring will take place in the Annual Operational Plan
Ideal clinic status obtained rate	Ideal Health Facility Software	56% (19/3400)	100%	75.6%	~~100%~~ ~~(610 / 610)~~	94.9% (577 / 608)	• Infrastructure challenges, especially in the non-Provincial clinics • Emergency rooms do not meet the standards. • No Waste storage areas. • No Guardrooms, where available, they do not meet the standards • Aged infrastructure • Maintenance of buildings, grounds, as well as pest control, is poor
Percentage of PHC facilities with functional clinic committees	Attendance registers of clinic committees' meetings	Baseline to be determined	Not available	New	100% ~~(610/ 610)~~	100% (609 / 609)	• Clinic numbers have changed

Outcome Indicator	Data Source	South Africa		Provincial			Changes made in 2024/25 planning cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
Percentage of hospitals with functional hospital boards	Attendance registers of hospital board meetings	Baseline to be determined	Not available	New	100% ~~(72/72~~)	100% (69 / 69)	• Hospital numbers have changed with 3 hospitals being decommissioned
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)~~	152.5 / 100k (18 177 / 11 919 939)	• Monitoring will take place in the Annual Operational Plan
Medical officers per 100 000 population	Persal/ StatsSA	Not available	Not available	34 / 100k (3 879 / 11 417 126)	27.4 / 100k ~~(3 310 /12 079 648)~~	27.4 / 100k (3 260 / 11 919 339)	• Monitoring will take place in the Annual Operational Plan
Percentage of population with private medical cover	StatsSA	Not available	Not available	12.6%	Monitor trends		• Monitoring will take place in the Annual Operational Plan
Percentage of the population within a 5 km radius of a health service	DHIS/GCIS	Not available	Not available	77%	≥ 84%		• Monitoring will take place in the Annual Operational Plan
EMS P1 urban response under 30 minutes rate	EMS Database	Not available	Not available	New indicator	50%	42%	• EMS main tool of trade are ambulances. These operate on a 24 hour basis and high mileages are reached in a very short space of time. This results in increased repairs and downtime as well as increases
EMS P1 rural response under 60 minutes rate	EMS Database	Not available	Not available	New Indicator	55%	48%	

Outcome Indicator	Data Source	South Africa		Provincial			Changes made in 2024/25 planning cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
							cost to keep these ambulances on the road. • Departmental vehicle replacement policy stipulates that ambulances should be replaced at 250 000km. This is not possible due to the speed at which ambulances reach this mileage and due to the many budget cuts, we have been faced with. • The new ambulances that have been procured over the past years have all been for replacement of old, removed ambulances and due to the low number of ambulances procured, not all removed ambulances were replaced, therefore EMS is operating with fewer ambulances. None of the new ambulances procured were for expansion of services. • EMS is in the process of procuring 32 new ambulances this financial year (2023/24), and once again, these are all for replacement of old, removed ambulances. • EMS operational staff roster is currently under review as the current roster results in

Outcome Indicator	Data Source	South Africa		Provincial			Changes made in 2024/25 planning cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
							exorbitant overtime expenditure which could rather be utilised for the employment of additional operational staff. • EMS is therefore unable to achieve the targets previously set as these create an expectation of improved response times as compared to what is currently being achieved.

The table below: "*Outcome: Improved Client Experience of Care*" below is reflected on page 59 of the Revised Strategic Plan 20/21 to 24/25 as Table 16. The Indicators and Targets that are being updated are in strikethrough font. The changes for the 24/25 reporting period are highlighted in yellow. The revised Table 16 is subsequently reflected.

Table 91: Revised Outcome Indicators for Improved Client Experience of Care as at September 2023

Outcome Indicator	Data Source	South Africa		Provincial			Changes made in 24/25 Planning cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE							
Patient Experience of Care satisfaction rate – District Health Services	Patient surveys	Not available	Not available	68.9% (34 249 / 49 677)	Not applicable	89.6% (2 105 200 / 2 350 000)	Changes in the way NDoH request for

Outcome Indicator	Data Source	South Africa		Provincial			Changes made in 24/25 Planning cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
Patient Experience of Care satisfaction rate – Prog 4		Not available	Not available	81.4% (4 969 / 6 101)	Not applicable	86.1% (107 308 / 124 700)	the data and indicators to be reflected
Patient Experience of Care satisfaction rate – Prog 5		Not available	Not available	79.2% (98 / 1 171)	Not applicable	88.2% (52 920 / 60 000)	
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)	Reflected in Annexure C: Consolidated indicators as these make up the Standardised Consolidated Indicators in Part C of the APP
Patient Experience of Care satisfaction rate - District Hospitals		Not available	Not available	81% (2 923/3 609)	85.1% ~~(3 227/3 793)~~	85.1% (170 200/ 200 000)	
Patient Experience of Care satisfaction rate - Regional Hospitals		Not available	Not available	81% (4 547/5 613)	85.1% ~~(50/5 899))~~	85.1% (85 100/100 000)	
Patient Experience of Care satisfaction rate – TB Hospitals		Not available	Not available	92.3% (131 / 142)	97.3% ~~(145 / 149)~~	97.3% (1 654/ 1 700)	
Patient Experience of Care satisfaction rate– Psychiatric Hospital		Not available	Not available	88% (169 / 192)	92.6% ~~(187 / 2~~)	92.6% (13 890/ 15 000)	
Patient Experience of Care satisfaction rate) – Chronic/Sub-acute Hospital		Not available	Not available	79% (122 / 154)	83.3% ~~(135 / 162)~~	83.3% (6 664/ 8 000)	
Patient Experience of Care satisfaction rate– Tertiary Hospitals		Not available	Not available	74% (585 / 790)	~~77.8%~~ ~~(646 / 830)~~	86% (38 700 / 45 000)	
Patient Experience of Care satisfaction rate - Central Hospitals		Not available	Not available	90% (343 / 381)	94.8% ~~(379 / 400)~~	94.8% (14 220/15 000)	
Patient Safety Incident (PSI) case closure rate) – District Health Services	Patient safety incident software	Not available	Not available	86.4% (1 436 / 1 662)	Not applicable	97.8% (2 441 / 2 495)	Changes in the way NDoH request for the data and indicators to be reflected
Patient Safety Incident (PSI) case closure rate– Prog 4		Not available	Not available	90.8% (612 / 674)	Not applicable	98.1% (2 707 / 2 760)	

Outcome Indicator	Data Source	South Africa		Provincial			Changes made in 24/25 Planning cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
Patient Safety Incident (PSI) case closure rate) – Prog 5		Not available	Not available	74.4% (348 / 468)	Not applicable	97.4% (2 192 / 2 250)	
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)	Reflected in Annexure C: Consolidated indicators as these make up the Standardised Consolidated Indicators in Part C of the APP
Patient Safety Incident (PSI) case closure rate– District Hospital		Not available	Not available	~~88.3%~~ 93.1% (1 166/1 252)	99.0% ~~(1 013/1 023)~~	99.0% (1 757 / 1 775)	
Patient Safety Incident (PSI) case closure rate– Regional Hospital		Not available	Not available	86% (240 /279)	~~93.2%~~ ~~(247/265)~~	98% (2 205 / 2 250)	
Patient Safety Incident (PSI) case closure rate – TB Hospital		Not available	Not available	88% (44 / 50)	~~97.9%~~ ~~(46 / 47)~~	100% (250 / 250)	
Patient Safety Incident (PSI) case closure rate– Psychiatric Hospital		Not available	Not available	94.6% (192 / 203)	96% ~~(190 / 198)~~	96% (192/200)	
Patient Safety Incident (PSI) case closure rate– Chronic/Sub-acute		Not available	Not available	95.8% (136 / 142)	100% ~~(137 / 137)~~	100% (60 / 60)	
Patient Safety Incident (PSI) case closure rate – Tertiary Hospital		Not available	Not available	72.1% (310 / 430)	~~78%~~ ~~(319 / 409)~~	97% (1 867 / 1 925)	
Patient Safety Incident (PSI) case closure rate – Central Hospital		Not available	Not available	100% (38 / 38)	100% ~~(33 / 33)~~	100% (325 / 325)	

The table below: *Outcome: Reduced Morbidity and Mortality* below is reflected as table 18 on page 62 of the Revised Strategic Plan 20/21 to 24/25. The Indicators and Targets that are being updated are ~~strikethrough~~ font. The changes for the 24/25 reporting period highlighted in yellow. The revised Table 18 is subsequently reflected.

Table 92: Revised Outcome indicators for Reduced Morbidity and Mortality as at March 2024

Outcome Indicator	Data Source	South Africa		Provincial			Changes for 24/25 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
OUTCOME: REDUCED MORBIDITY AND MORTALITY							
Maternal Mortality in facility (Ratio – per 100 000 live births *(originally known as "Maternal Mortality in facility (Ratio (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)~~ 98.0 / 100 000 (170 / 173 464)	A significant drop in estimated live births (denominator) has impacted on the calculation. The actual number of maternal mortalities has decreased.
~~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)~~	Replaced by NDoH indicator "*[Number of] maternal deaths in facility – per level of care* (District, Regional, Tertiary and Central Hospitals)
~~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)~~	
Maternal Deaths in facility – Prog 4 (*originally known as "[Number of] maternal deaths in facility – Prog 4")*	Maternal death register, Delivery Register	Not available	Not available	82	Not applicable	~~102~~ 25	Change by NDoH in the way mortality data is collected and presented. These indicators appear in Part C of the APP.
Maternal Deaths in facility – Prog 5 (*originally known as "[Number of] maternal deaths in facility – Prog 5")*		Not available	Not available	29	Not applicable	~~30~~ 13	
~~[Number of] maternal deaths in facility – District Hospital~~		~~Not available~~	~~Not available~~	~~51~~	~~44~~	~~48~~	Change by NDoH in the way mortality

Outcome Indicator	Data Source	South Africa		Provincial			Changes for 24/25 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
~~[Number of] maternal deaths in facility – Regional Hospital~~	~~Maternal death register, Delivery Register~~	~~Not available~~	~~Not available~~	~~82~~	~~62~~	~~102~~	data is collected and presented. These indicators appear in Annexure C: Consolidated indicators
~~[Number of] maternal deaths in facility – Tertiary Hospital~~		~~Not available~~	~~Not available~~	~~29~~	~~24~~	~~22~~	
~~[Number of] maternal deaths in facility – Central Hospital~~		~~Not available~~	~~Not available~~	~~7~~	~~7~~	~~8~~	
~~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)~~	NDoH has removed this indicator for monitoring
Neonatal death in facility rate (per 1000 live births) *(originally known as "Neonatal death in facility rate – total"*	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)~~ 13.9 / 1 000 (2 300 / 165 464)	The large drop in live births targeted, neonatal deaths are unlikely to drop at the same rate
~~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)~~		
~~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)~~		
~~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)~~		

Outcome Indicator	Data Source	South Africa		Provincial			Changes for 24/25 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
Infant PCR test positive around 6 months rate	~~PHC comprehensive tick register~~	New Indicator	Not Available	New indictor	New indicator	1%	
HIV test positive around 18 months rate		New Indicator	Not available	New Indicator	New indicator	1.5%	
Over-weight or obese child under 5 years incidence	SADHS 16	13%	10%	22.8	To be determined		Monitoring will take place in the Annual Operational Plan
~~School learner overweight rate~~	~~DHIS~~	~~Not Available~~	~~Not Available~~	~~Not monitored~~	~~To be determined~~		
Children <5 who are stunted	SADHS 16	27%	Not Available	14.3%	17%	17%	Monitoring will take place in the Annual Operational Plan
Death under 5 years against live birth rate	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)~~ 2.0% (3 286 / 165 464)	Alignment with live births and deaths under 5 years in facility
~~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)~~	Replaced by the NDoH indicator [Number of] death in facility under 5 years – per level of care
~~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)~~	
~~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)~~	

Outcome Indicator	Data Source	South Africa		Provincial			Changes for 24/25 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
Death in facility under 5 years rate total	Midnight register	Not available	Not available	3.8% (3 380 / 88 844)	~~3.8%~~ ~~(3 577 / 94 142)~~	~~5.9%~~ ~~(3 607 / 60 750)~~ 5.4% (3 286 / 60 750)	70% of under 5 deaths occur in the neonatal period. Actual numbers of separations have been variable over the last 5 years with no clear trend hence the decision to keep separations static. Targets for deaths have been reduced slightly in line with reductions in neonatal deaths
Death in facility under 5 years – Prog 4 *(originally known by "[Number of] Death in facility under 5 years – Prog 4"*	Midnight register, Ward Register	Not available	Not available	1 566	Not applicable	1 710	Change by NDoH in the way mortality data is collected and presented. These indicators appear in Part C of the APP.
Death in facility under 5 years – Prog 5 *(originally known by "[Number of] Death in facility under 5 years – Prog 5"*		Not available	Not available	442	Not applicable	458	
~~[Number of] Death in facility under 5 years – District Hospital~~	~~Midnight register, Ward Register~~	~~Not Available~~	~~Not Available~~	~~1 334~~	~~1 032~~	~~1 439~~	Change in the data collection and reflection of mortality data from NDoH. These indicators appear in Annexure C: Standardised Consolidated Indicators
~~[Number of] Death in facility under 5 years – Regional Hospital~~		~~Not available~~	~~Not available~~	~~1 703~~	~~1 710~~		
~~[Number of] Death in facility under 5 years – Tertiary Hospital~~		~~Not available~~	~~Not available~~	~~229~~	~~177~~	~~278~~	
~~[Number of] Death in facility under 5 years – Central Hospital~~		~~Not available~~	~~Not available~~	~~213~~	~~165~~	~~180~~	

Outcome Indicator	Data Source	South Africa		Provincial			Changes for 24/25 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
Child under 5 years diarrhoea case fatality rate	DHIS, Midnight register, Ward Register	Not available	Not available	2.2% (171 / 7 702)	1.6% ~~(117/ 7 403)~~	1.6% (152 / 9 500)	Diarrhoea separations currently are remaining static at around 10 000 with a small reduction in the number of deaths hence the change in raw data
~~Child under 5 years diarrhoea case fatality rate – District Hospital~~		~~Not available~~	~~Not available~~	~~2.2% (94 /4 360)~~	~~1.5% (56/3 744)~~	~~1.5% (65 / 4 212)~~	Replaced by the NDoH indicator [Number of] Diarrhoea deaths in facility under 5 years – per level of care
~~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)~~	
~~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)~~	
Diarrhoea death under 5 years – Prog 4 *(originally known as "[Number of] Diarrhoea deaths under 5 years – Prog 4"*	Midnight register, Ward Register	Not available	Not available	68	Not applicable	48	Change by NDoH in the way mortality data is collected and presented. These indicators appear in Part C of the APP.
Diarrhoea death under 5 years – Prog 5 *(originally 5known as "[Number of] Diarrhoea deaths under 5 years – Prog54"*		Not available	Not available	8	Not applicable	4	
~~[Number of] Diarrhoea deaths under 5 years – District Hospital~~	~~Midnight register, Ward Register~~	~~Not Available~~	~~Not Available~~	~~94~~	~~56~~	~~65~~	Change in the data collection and reflection of mortality data from NDoH. These indicators appear in Annexure C: Standardised
~~[Number of] Diarrhoea deaths under 5 years – Regional Hospital~~		~~Not available~~	~~Not available~~	~~68~~	~~40~~	~~48~~	
~~[Number of] Diarrhoea deaths under 5 years – Tertiary Hospital~~		~~Not available~~	~~Not available~~	~~8~~	~~6~~	~~4~~	

Outcome Indicator	Data Source	South Africa		Provincial			Changes for 24/25 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
~~[Number of] Diarrhoea deaths under 5 years – Central Hospital~~		~~Not available~~	~~Not available~~	~~0~~	~~0~~		Consolidated Indicators
Child under 5 years Pneumonia case fatality rate	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)~~	~~1.3% (80 / 6, 243)~~	Replaced by the NDoH indicator [Number of] Pneumonia deaths in facility under 5 years – per level of care
~~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)~~	
~~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)~~	
Pneumonia death under 5 years – Prog 4 *(originally known as "[Number of] Pneumonia deaths under 5 years – Prog 4")*	Midnight Report, Ward Register	Not available	Not available	100	Not applicable	103	Change by NDoH in the way mortality data is collected and presented. These indicators appear in Part C of the APP.
Pneumonia death under 5 years – Prog 5 *(originally known as "[Number of] Pneumonia deaths under 5 years – Prog 5")*		Not available	Not available	51	Not applicable	34	
~~[Number of] Pneumonia deaths under 5 years – District Hospitals~~	~~Midnight Report, Ward Register~~	~~Not Available~~	~~Not Available~~	~~128~~	~~76~~	~~80~~	Change in the data collection and reflection of mortality data from NDoH. These indicators appear in Annexure C: Standardised
~~[Number of] Pneumonia deaths under 5 years – Regional Hospitals~~		~~Not available~~	~~Not available~~	~~100~~	~~59~~	~~103~~	
~~[Number of] Pneumonia deaths under 5 years – Tertiary Hospitals~~		~~Not available~~	~~Not available~~	~~6~~	~~9~~	~~19~~	

Outcome Indicator	Data Source	South Africa		Provincial			Changes for 24/25 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
~~[Number of] Pneumonia deaths under 5 years – Central Hospitals~~		~~Not available~~	~~Not available~~	~~45~~	~~16~~	~~15~~	Consolidated Indicators
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)~~	Replaced by the NDoH indicator [Number of] Severe Acute Malnutrition (SAM) deaths in facility under 5 years – per level of care
~~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)~~	
Severe Acute malnutrition (SAM) death under 5 years – Prog 4 *(originally known as "[Number of] Severe Acute Malnutrition (SAM) deaths under 5 years – Prog 4"*	Midnight register, Ward Register	Not available	Not available	76	Not applicable	49	Change by NDoH in the way mortality data is collected and presented. These indicators appear in Part C of the APP.
Severe Acute malnutrition (SAM) death under 5 years – Prog 4 *(originally known as "[Number of] Severe Acute Malnutrition (SAM) deaths under 5 years – Prog 4"*		Not available	Not available	9	Not applicable	8	
~~[Number of] Severe Acute Malnutrition (SAM) deaths under 5 years – District Hospitals~~	~~Midnight register, Ward Register~~	~~Not available~~	~~Not available~~	~~94~~	~~48~~	~~82~~	Change in the data collection and reflection of mortality data from NDoH. These indicators appear in Annexure C: Standardised
~~[Number of] Severe Acute Malnutrition (SAM) deaths under 5 years – Regional Hospitals~~		~~Not available~~	~~Not available~~	~~76~~	~~40~~	~~49~~	
~~[Number of] Severe Acute Malnutrition (SAM) deaths under 5 years – Tertiary Hospitals~~		~~Not available~~	~~Not available~~	~~5~~	~~1~~	~~7~~	

Outcome Indicator	Data Source	South Africa		Provincial			Changes for 24/25 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
~~[Number of] Severe Acute Malnutrition (SAM) deaths under 5 years – Central Hospitals~~		~~Not available~~	~~Not available~~	~~4~~	~~1~~	~~1~~	Consolidated Indicators
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)	Monitoring will take place in the Annual Operational Plan
~~Death in facility under 1 year rate – District Hospital~~		~~Not available~~	~~Not available~~	~~5.3%~~ ~~(1 153/21 880)~~	~~3.7%~~ ~~(892 / 24 157)~~		Change in the manner in which mortality indicators and data elements are monitored
~~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)~~		
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)	
~~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)~~	
~~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)~~	

Outcome Indicator	Data Source	South Africa		Provincial			Changes for 24/25 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
Still Birth in facility rate (per 1000 births) *(originally known as "Still Birth in Facility Rate"*	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)~~ 26.8 / 1 000 (4 562 / 170 026)	A significant drop in estimated live births (denominator) has impacted on the calculation.
~~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)~~		
~~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)~~		
~~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)~~		
~~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)~~		
~~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)~~	72% (1 008 / 1 400)	Raw data only amended. There is a decline in the number of diagnosed drug resistant TB clients

Outcome Indicator	Data Source	South Africa		Provincial			Changes for 24/25 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
~~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)~~		
Number of All TB deaths	DR-TB Clinical Stationery; TIER.Net	Not Available	Not Available	3 593 ~~2 854~~	~~1 920~~	2 840	
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)~~	72.1% (37 500 / 52 000) ~~86%~~ ~~(40 703 / 47 329)~~	The targets had to be reduced for 2024/25 because of the latest performance declined by 10%. The reasons for the decline resulted from the changes in the denominator used in calculating the indicator treatment success rate as the information system is unable to adjust for transferred in and outpatients.
TB Pre-XDR Treatment Success Rate	-TB Clinical Stationery; TIER.net	Not available	Not available	New Indicator	~~68.3%~~ ~~(41 / 60)~~	55% (33 / 60)	The target is based on the performance trends. A high proportion of the patients die (19%) as a result of co-morbidities

Outcome Indicator	Data Source	South Africa		Provincial			Changes for 24/25 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
ART Death rate (6 months) at 6 months	TIER.net: DHIS	Not Available	Not Available	1.2% (2 435 / 2 938)	1% (2 029 / 2 938)		
~~ART adult death rate (6 months) at 6 months~~	~~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~~	~~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)	
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)	TIER.net; DHIS	Not Available	Not Available	90.6% (38 371 / 42 374)	~~90% (38 136 / 42 374~~)	95% (90 866/ 95 648)	
ART Child viral load suppressed rate (Below 50) [12 months)	TIER.net; DHIS	Not Available	Not Available	68.7% (826 / 1 203)	90% ~~(1 082 / 1 203)~~	90% (2 250 / 2 500)	
ART Client remain on ART end of month -sum	TIER.net: DHIS	Not Available	Not Available	1 387 688	~~1 959 000~~	1 677 836 ~~1 701 031~~	Change in NDoH target in relation to the Conditional Grant Business Plan
~~Infant Mortality Rate~~	~~ASSA 08~~	~~Not Available~~	~~Not Available~~	~~30.9/1 000~~	~~27/1 000~~		
~~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)~~		

Outcome Indicator	Data Source	South Africa		Provincial			Changes for 24/25 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
~~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)~~		
~~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)~~		
Men and Women 15 years and older with hypertension	Survey Data	Not available	Not available	Not available		Not available	New Outcome indicators from NDoH received in the 24/25 planning cycle
Men and women 15 years and older with diabetes	Survey Data	Not available	Not available	Not available		Not available	
~~HIV incidence~~	~~Thembisa Model~~	~~Not Available~~	~~Not Available~~	~~0.55%~~	~~<1%~~		
~~COVID-19 Testing Coverage~~	~~Not available~~	~~Not Available~~	~~Not Available~~	~~New Indicator~~	~~2,070 / 100k~~		
~~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)~~	Indictor removed from the Strategic Plan
~~COVID-19 Case Fatality Rate: 5 to 60 years~~	~~Not available~~	~~Not Available~~	~~Not Available~~	~~New Indicator~~	~~Monitor Trends 0.5%~~		

Outcome Indicator	Data Source	South Africa		Provincial			Changes for 24/25 Planning Cycle
		Baseline (18/19)	Five Year Target (24/25)	Original Baseline (18/19)	Original Five Year Target (24/25)	Updated Five Year Target (24/25)	
~~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)~~		
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) 0/1 000 (0 / 694 485)	0.87 / 1 000 (600 / 692 588)	Monitoring will take place in the Annual Operational Plan
Malaria case fatality rate	Malaria Information system	0.01% (70 / 581 700)	Malaria eliminated by 23	0.5% (7 / 1 493)	0% ~~(0 / 1000)~~	0% (0 / 600)	There has been a decline in the number of cases reported

ANNEXURE B: CONDITIONAL GRANTS

Table 93: Conditional Grants for 2024/25

Name of Grant	Purpose	Outputs	2024/25 allocation
District Health Programmes Grant	See below	See below	R 7 367 534
	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	
	TB Component		
	• 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		
	• 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-up traced Number of TB clients lost to follow traced	

Name of Grant	Purpose	Outputs	2024/25 allocation
	• Malaria Elimination Component		
	• 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		
	• To enable the health sector to prevent cervical cancer by making available HPV vaccinations from grade 5 schoolgirls in all public and special schools and progressive integration of Human Papillomavirus into the integrated school health programme.	• Percentage of grade five schoolgirls 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 schoolgirls 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 1 458 192

Name of Grant	Purpose	Outputs	2024/25 allocation
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 769 534
National Health Insurance Grant	Health Practitioners contracts Grant Component		R 87 732
	• Implementation of strategic purchasing platform for primary health care services	• Number of health professionals contracted (per discipline)	
	Oncology Grant Component		
	• 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 Component		
	• 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 2 201 200

Name of Grant	Purpose	Outputs	2024/25 allocation
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 6 951

ANNEXURE C: CONSOLIDATED INDICATORS

Table 94: Outcome Indictors for PHC for 2024/25

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)	2024/25	2025/26	2026/27
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE								
i. Patient Experience of Care satisfaction rate – PHC	Patient surveys data base	N/A	N/A	68%	95.0%	95.0%	96.0%	97%
Patient Experience of Care survey satisfied responses - PHC	Patient Surveys			*31 326*	*684*	*684*	*691*	*699*
Patient Experience of Care survey total responses - PHC				*46 068*	*720*	*720*	*720*	*720*
ii. Patient Safety Incident (PSI) case closure rate –PHC facility	Patient Safety Incidence Software	N/A	NA/	65.9%	90.0%	90.0%	93.0%	96%
Patient Safety Incident (PSI)case closed – PHC facility	*Patient Safety Incidence Reports*			*270*	*1 935 000*	*1 935 000*	1 999 500	*2 064 000*
Patient Safety Incident (PSI) case Reported – PHC facility				*410*	*2 150 000*	*2 150 000*	2 150 000	*2 150 000*

Table 95: Output Indictors for PHC for 2024/25

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE								
Severity Assessment Code (SAC) incidence reported within 24 hours	iii. Severity assessment code (SAC) 1 incident reported within 24 hours rate – PHC	55.7%	64.6%	82.1%	83.7%	100.0%	100.0%	100.0%
	Severity assessment code (SAC) 1 incidents reported within 24 hours – PHC facility	*122*	*133*	*174*	*164*	*196*	*196*	*196*
	Severity assessment code (SAC) 1 incident reported – PHC facility	*219*	*206*	*212*	*196*	*196*	*196*	*196*

Table 96: Outcome indicators for District Hospitals for 2024/25

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)	2024/25	2025/26	2026/27
OUTCOME: IMPROVED EXPERIENCE OF CARE								
ix. Patient Experience of Care satisfaction rate – District Hospitals	Patient survey database	NA	NA	81.0%	99.0%	99.0%	99.0%	99.0%
Patient Experience of Care survey satisfied responses – District Hospitals	Patient surveys			*2 923*	*1 757*	*1 757*	*1 757*	*1 757*
Patient Experience of Care survey total responses – District Hospitals				*3 609*	*1 775*	*1 775*	*1 775*	*1 775*

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)	2024/25	2025/26	2026/27
x. Patient Safety Incident (PSI) case closure rate – District Hospital	Patient Safety Incidence Software	NA	NA	93.1%	85.1%	85.1%	88.0%	90.0%
Patient Safety Incident (PSI)case closed - District Hospital	Patient Safety Incidence Reports			*1 166*	*170 200*	*170 200*	*176 000*	*180 000*
Patient Safety Incident (PSI) case Reported – District Hospital				*1 252*	*200 000*	*200 000*	*200 000*	*200 000*

Table 97: Output Indictors for District Hospitals for 2024/25

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: IMPROVED EXPERIENCE OF CARE								
Severity Assessment Code (SAC) incidence reported within 24 hours	xi. Severity assessment code (SAC) 1 incident reported within 24 hours rate – District Hospital	75.1%	72.2%	84.5%	87.9%	100.0%	100.0%	100.0%
	Severity assessment code (SAC) 1 incidents reported within 24 hours – District Hospital	*220*	*459*	*516*	*436*	*496*	*525*	*535*
	Severity assessment code (SAC) 1 incident reported – District Hospital	*293*	*636*	*611*	*496*	*496*	*525*	*535*

Table 98: Outcome Indictors for Regional Hospitals for 2024/25

Indicator		Data Source	South Africa		Provincial		Medium Term Targets		
			Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2024/25	2025/26	2026/27
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE									
vii.	Patient Experience of Care satisfaction rate – Regional Hospitals	Patient Safety Incidence Software	Not Available	Not Available	81.0%	85.1%	85.1%	87.0%	91.0%
	Patient experience of care survey satisfied responses - Regional Hospitals	Patient Safety Incidence Report	-	-	*4 547*	*85 100*	*85 100*	*87 000*	*91 000*
	Patient experience of care survey total responses - Regional Hospitals		-	-	*5 613*	*100 000*	*100 000*	*100 000*	*100 000*
viii.	Patient Safety Incident (PSI) case closure rate - Regional Hospital	Patient Survey Database	Not Available	Not Available	86.0%	98.0%	98.0%	98.0%	98.0%
	Patient Safety Incident (PSI) case closed - Regional Hospitals	Patient Surveys	-	-	*240*	*2 205*	*2 205*	*2 205*	*2 205*
	Patient Safety Incident (PSI) case reported - Regional Hospitals		-	-	*279*	*2 250*	*2 250*	*2 250*	*2 250*
OUTCOME: REDUCED MORBIDITY AND MORTALITY									
ix.	Maternal deaths in facility - Regional Hospitals	Maternal register	374	Not Available	82	25	25	25	25
x.	Deaths in facility under 5 years - Regional Hospitals	Midnight report	5 518	4 966	1 566	1 710	1 710	1 667	1 650
xi.	Diarrhoea deaths under 5 years - Regional Hospitals	DHIS	Not Available	Not Available	68	48	48	46	44
xii.	Pneumonia deaths under 5 years - Regional Hospitals	DHIS	Not Available	Not Available	100	103	103	103	103
xiii.	Severe Acute Malnutrition deaths under 5 years - Regional Hospitals	DHIS	Not Available	Not Available	76	49	49	14	7

Table 99: Output Indictors for Regional Hospitals for 2024/25

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: IMPROVED PATIENT EXPERIENCE OF CARE								
Severity Assessment Code (SAC) 1 incidence reported within 24 hrs	xiv. Severity assessment code (SAC) 1 incident reported within 24 hours rate – Regional Hospital	83.3%	79.5%	92.3%	100.0%	100.0%	100.0%	100.0%
	Severity assessment code (SAC) 1 incidents reported within 24 hours – Regional Hospital	*305*	*290*	*262*	*240*	*240*	*240*	*240*
	Severity assessment code (SAC) 1 incident reported – Regional Hospital	*366*	*365*	*284*	*240*	*240*	*240*	*240*
Cervical cancer screening	xv. Cervical cancer screening	New indicator	New indicator	New indicator	5 800	6 700	6 940	7 000

Table 100: Outcome Indictors for TB Hospitals for 2024/25

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)	2024/25	2025/26	2026/27
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE								
xvi. Patient Experience of Care satisfaction rate – TB Hospital	Patient Safety Incidence Software	Not available	Not available	92.3%	97.3%	97.3%	97.5%	98.0%
Patient experience of care survey satisfied responses – TB Hospital		-	-	*131*	*1 654*	*1 654*	*1 658*	*1 666*

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)	2024/25	2025/26	2026/27
Patient experience of care survey total responses – TB Hospital	Patient Safety Incidence Software	-	-	*142*	*1 700*	*1 700*	*1 700*	*1 700*
xvii. Patient Safety Incident (PSI) case closure rate – TB Hospital	Patient Safety Incidence Software	Not available	Not available	88.0%	100.0%	100.0%	100.0%	100.0%
Patient Safety Incident (PSI) case closed – TB Hospital	Patient Safety Incidence Software	-	-	*44*	*250*	*250*	*250*	*250*
Patient Safety Incident (PSI) case reported – TB Hospital		-	-	*50*	*250*	*250*	*250*	*250*

Table 101: Output Indictors for TB Hospitals for 2024/25

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE								
Severity Assessment Code (SAC) 1 incidence reported within 24 hrs	xvii i. Severity assessment code (SAC) 1 incident reported within 24 hours rate – TB Hospital	0.0%	93.5%	92.3%	100.0%	100.0%	100.0%	100.0%
	Severity assessment code (SAC) 1 incidents reported within 24 hours – TB Hospital	*0*	*29*	*24*	*1*	*1*	*1*	*1*
	Severity assessment code (SAC) 1 incident reported – TB Hospital	*0*	*31*	*26*	*1*	*1*	*1*	*1*

Table 102: Outcome Indictors for Pyschiatric Hospitals for 2024/25

Indicator	Data Source	South Africa		Provincial		Medium Term Targets		
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2024/25	2025/26	2026/27
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE								
xix. Patient Experience of Care satisfaction rate – Psychiatric Hospital	Patient Safety Incidence Software	Not available	Not available	88.0%	92.6%	92.6%	93.0%	95.0%
Patient experience of care survey satisfied responses – Psychiatric Hospital	Patient Safety Incidence Software	-	-	*169*	*13 890*	*13 890*	*13 950*	*14 250*
Patient experience of care survey total responses – Psychiatric Hospital		-	-	*192*	*15 000*	*15 000*	*15 000*	*15 000*
xx. Patient Safety Incident (PSI) case closure rate – Psychiatric Hospital	Patient survey Database	Not available	Not available	94.6%	96.0%	96.0%	96.9%	96.9%
Patient Safety Incident (PSI) case closed – Psychiatric Hospital	Patient survey Database	-	-	*192*	*192*	*192*	*190*	*190*
Patient Safety Incident (PSI) case reported – Psychiatric Hospital		-	-	*203*	*200*	*200*	*196*	*196*

Table 103: Output Indictors for Psychiatric Hospitals for 2024/25

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE								
Severity Assessment Code (SAC) 1	xxi. Severity assessment code (SAC) 1 incident reported within 24 hours rate – Psychiatric Hospital	28.6%	85.0%	81.3%	100.0%	100.0%	100.0%	100.0%

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
incidence reported within 24 hrs	*Severity assessment code (SAC) 1 incidents reported within 24 hours – Psychiatric Hospital*	*16*	*34*	*13*	*16*	*16*	*15*	*15*
	Severity assessment code (SAC) 1 incident reported – Psychiatric Hospital	*56*	*40*	*16*	*16*	*16*	*15*	*15*

Table 104: Outcome Indictors for Chronic Hospitals for 2024/25

Indicator		Data Source	South Africa		Provincial		Medium Term Targets		
			Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	2024/25	2025/26	2026/27
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE									
xxii.	Patient Experience of Care satisfaction rate – Chronic/Sub-acute Hospital	Patient Safety Incidence Software	Not available	Not available	79.2%	83.3%	83.3%	85.0%	85.5%
	Patient experience of care survey satisfied responses – Chronic/Sub-acute Hospital	Patient Safety Incidence Software	-	-	*122*	*6 664*	*6 664*	*5 780*	*5 848*
	Patient experience of care survey total responses – Chronic/Sub-acute Hospital		-	-	*154*	*8 000*	*8 000*	*6 800*	*6 840*
xxiii.	Patient Safety Incident (PSI) case closure rate – Chronic/Sub-acute Hospital	Patient survey Database	Not available	Not available	95.8%	100.0%	100.0%	100.0%	100.0%
	Patient Safety Incident (PSI) case closed – Chronic/Sub-acute Hospital	Patient survey Database	-	-	*136*	*60*	*60*	*60*	*60*
	Patient Safety Incident (PSI) case reported – Chronic/Sub-acute Hospital		-	-	*142*	*60*	*60*	*60*	*60*

Table 105: Output Indictors for Chronic Hospitals for 2024/25

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE								
Severity Assessment Code (SAC) 1 incidence reported within 24 hrs	xxiv. Severity assessment code (SAC) 1 incident reported within 24 hours rate – Chronic/Sub-acute Hospital	100.0%	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%
	Severity assessment code (SAC) 1 incidents reported within 24 hours – Chronic/Sub-acute Hospital	*12*	-	-	-	*4*	*12*	*12*
	Severity assessment code (SAC) 1 incident reported – Chronic/Sub-acute Hospital	*12*	-	-	-	*4*	*12*	*12*

Table 106: Outcome Indictors for Tertiary Hospitals for 2024/25

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)	2024/25	2025/26	2026/27
OUTCOME: IMROVED CLIENT EXPERIENCE OF CARE								
xxv. Patient Experience of Care satisfaction rate – Tertiary Hospitals	Patient Safety Incidence Software	Not available	Not available	74.1%	86.0%	86%	88.0%	90.6%
Patient experience of care survey satisfied responses - Tertiary Hospitals	*Patient Safety Incidence Reports*	-	-	*585*	*38 700*	*38 700*	*40 521*	*42 684*
Patient experience of care survey total responses - Tertiary Hospitals		-	-	*790*	*45 000*	*45 000*	*46 047*	*47 093*
xxvi. Patient Safety Incident (PSI) case closure rate – Tertiary Hospital	Patient survey Database	Not available	Not available	72.1%	97.0%	97%	97.5%	98.0%

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)	2024/25	2025/26	2026/27
Patient Safety Incident (PSI) case closed - Tertiary Hospitals	*Patient Survey's*	*-*	*-*	*310*	*1 867*	*1867*	*2 117*	*2 150*
Patient Safety Incident (PSI) case reported - Tertiary Hospitals		*-*	*-*	*430*	*1 925*	*1925*	*2 171*	*2 194*
OUTCOME: REDUCED MORBIDITY AND MORTALITY								
xxvii. Maternal deaths in facility - Tertiary Hospital	Maternal register	192	Not available	29	8	8	8	8
xxviii. Death in facility under 5 years - Tertiary Hospital	Midnight Report	2 499	2 249	229	278	278	271	265
xxix. Diarrhoea deaths under 5 years -Tertiary Hospitals	Midnight Report	77	46	8	4	4	4	4
xxx. Pneumonia deaths under 5 years - Tertiary Hospitals	Midnight Report	112	78	6	19	19	19	19
xxxi. Severe Acute Malnutrition deaths under 5 years - Tertiary Hospitals	Midnight Report	81	69	5	7	7	6	2

Table 107: Output Indictors for Tertiary Hospitals for 2024/25

Outputs	Output Indicator	Audited / Actual Performance			Estimated Performance	Medium Term Targets		
		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE								
Severity Assessment Code (SAC) 1 incidence reported within 24 hrs	xxxii. Severity assessment code (SAC) 1 incident reported within 24 hours rate – Tertiary Hospital	92.3%	85.1%	94.3%	87.5%	100.0%	100.0%	100.0%
	Severity assessment code (SAC) 1 incidents reported within 24 hours – Tertiary Hospital	*84*	*86*	*100*	*84*	*96*	*89*	*91*
	Severity assessment code (SAC) 1 incident reported – Tertiary Hospital	*91*	*101*	*106*	*96*	*96*	*89*	*91*
OUTCOME: REDUCED MORBIDITY AND MORTALITY								
Cervical cancer screening	xxxiii. Cervical cancer screening - Tertiary Hospital	New indicator	New indicator	New indicator	1 118	1 273	1 290	1 290

Table 108: Outcome Indictors for Central Hospitals for 2024/25

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)	2024/25	2025/26	2026/27
OUTCOME: IMROVED CLIENT EXPERIENCE OF CARE								
xxxiv. Patient Experience of Care satisfaction rate – Central Hospitals	Patient Safety Incidence Software	Not available	Not available	90%	94.8%	94.8%	88.0%	90.0%

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)	2024/25	2025/26	2026/27
	Patient experience of care survey satisfied responses - Central Hospitals	Patient Safety Incidence Software	-	-	*343*	*14 220*	*14 220*	*13 200*	*13 500*
	Patient experience of care survey total responses - Central Hospitals		-	-	*381*	*15 000*	*15 000*	*15 000*	*15 000*
xxxv.	Patient Safety Incident (PSI) case closure rate – Central Hospital	Patient Survey Database	Not available	Not available	100%	100%	100%	98%	99%
	Patient Safety Incident (PSI) case closed - Central Hospitals	Patient Survey Database	-	-	*38*	*325*	*325*	*319*	*322*
	Patient Safety Incident (PSI) case reported - Central Hospitals		-	-	*38*	*325*	*325*	*325*	*325*
OUTCOME: REDUCED MORBIDITY AND MORTALITY									
xxxvi.	Maternal deaths in facility - Central Hospital	Maternal register	188	Not available	7	5	5	5	5
xxxvii.	Death in facility under 5 years - Central Hospital	Midnight Report	2 920	2 628	213	180	180	176	172
xxxviii.	Diarrhoea deaths under 5 years - Central Hospitals	Midnight Report	Not available	Not available	Not available	Not available	Not monitored	Not monitored	Not monitored
xxxix.	Pneumonia deaths under 5 years - Central Hospitals	Midnight Report	130	91	45	15	15	15	15
xl.	Severe Acute Malnutrition deaths under 5 years - Central Hospitals	Midnight Report	50	43	4	1	1	1	1

Table 109: Output Indictors for Central Hospitals for 2024/25

Outputs	Output Indicator		Audited / Actual Performance			Estimated Performance	Medium Term Targets		
			2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
OUTCOME: IMPROVED CLIENT EXPERIENCE OF CARE									
Severity Assessment Code (SAC) 1 incidence reported within 24 hrs	xii.	Severity assessment code (SAC) 1 incident reported within 24 hours rate – Central Hospital	75.9%	89.4%	68.8%	70.0%	100.0%	100.0%	100.0%
		Severity assessment code (SAC) 1 incidents reported within 24 hours – Central Hospital	*44*	*42*	*11*	*28*	*40*	*46*	*51*
		Severity assessment code (SAC) 1 incident reported – Central Hospital	*58*	*47*	*16*	*40*	*40*	*46*	*51*
OUTCOME: REDUCED MORBIDITY AND MORTALITY									
Cervical cancer screening	xiii.	Cervical cancer screening - Central hospital	New indicator	New indicator	New indicator	182	207	210	210

ANNEXURE D: DISTRICT DEVELOPMENT MODEL

Table 110: District Development Model

Area of Intervention	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 Unions
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	
Electricity	Molweni Clinic- Installation of Standby Generator Set	900,000.00	eThekwini	Longitude 30.879 Latitude (29.740)	Dept of Health	
Electricity	PPSD - New Generator Set	2,500,000.00	eThekwini	Longitude 30.957 Latitude (29.936)	Dept of Health	
Electricity	Prince Mshiyeni Hospital - Replace 7 standby generators	20,508,662.00	eThekwini	Longitude 30.937 Latitude (29.955)	Dept of Health	
New clinic including services	Obanjeni Clinic - Construction of a new clinic with residence	78,000,000.00	King Cetshwayo	Site to be confirmed	Dept of Health	
New clinic including services	Mpaphala Clinic - Construction of New Medium Clinic	70,000,000.00	King Cetshwayo	Site to be confirmed	Dept of Health	
New hospital including services	Construction of a tertiary hospital in uMhlathuze	To be determined	King Cetshwayo	Site to be confirmed	Dept of Public Works	
New accommodation	Construction of staff accommodation in Ekombe hospital	To be determined	King Cetshwayo	Site to be confirmed	Dept of Public Works	
Health EMS Base	Bergville Base – Upgrades and Additions to existing Medium Base	To be determined	uThukela	Latitude: -28730019 Longitude: 29.349583	Dept of Health	
Health Hospital	Emmaus Hospital – Upgrades and additions to Staff Accommodation	To be determined	uThukela	Latitude: 28.6413468 Longitude:30.893212	Dept of Health	

Area of Intervention	Project Description	Budget Allocation	District Municipality	Location: GPS Co-ordinates	Project Leader	Social Partners
Health Hospital	Estcourt Hospital – Upgrade and Additions to Rehabilitation facilities	To be determined	uThukela	Latitude: 28.8524878 Longitude: 29.381334	Dept of Health	
Health Hospital	Estcourt Hospital – New 35 Bed Mental Health unit	To be determined	uThukela	Latitude: 28.8524878 Longitude: 29.381334	Dept of Health	
Health Hospital	Ladysmith Hospital – New 65 Bed Male, Female and Adolescent Mental Health unit	To be determined	uThukela	Latitude: -29.86668 Longitude: 31.042836	Dept of Health	
Water	Madadeni Hospital- Replacement of Reservoir tank	27,585,004.00	Amajuba	Longitude 30.051 Latitude (27.764)	Dept of Health	
New clinic including services	Mahhehle / Ncakubana Clinic -Construction of a New Clinic with residence	55,000,000.00	Harry Gwala	Site to be confirmed	Dept of Health	
New clinic including services	Ikhwezi Lokusa Clinic- Construction of New Clinic	64,766,054.00	Harry Gwala	Site to be confirmed	Dept of Health	
New clinic including services	Ofafa/ Ntakama Clinic - Construct New Clinic	45,000,000.00	Harry Gwala	Site to be confirmed	Dept of Health	
New clinic including services	Shayamoya Clinic - Construction of a New Small Clinic	59,868,243.00	Harry Gwala	Site to be confirmed	Dept of Health	
New clinic including services	Mahloni Clinic: Construction of a small clinic with accommodation	50,000,000.00	Zululand	S 27 35'"36.64212 E 30 54'6.77988	Dept of Health	
New clinic including services	Ntombiyephahla Clinic – new clinic	To be determined	Zululand	28.13731602657852 30.897541288516237	Dept of Health	
New clinic including services	Cwaka Clinic - New Replacement Clinic	87,028,270.00	uMzinyathi	Site to be confirmed	Dept of Health	
Church of Scotland Hospital	Renovations and Upgrades to existing burnt Mental Health Spaces and Ablutions.	To be determined	uMzinyathi	Longitude 30.44 Latitude 28.745	Dept of Health	
CJM Hospital	Upgrades water, sewer, signage, staff parking and helipad	To be determined	uMzinyathi	Longitude 30.673 Latitude 28.211	Dept of Health	

Area of Intervention	Project Description	Budget Allocation	District Municipality	Location: GPS Co-ordinates	Project Leader	Social Partners
New clinic including services	Madundube Clinic - Construct New Medium Clinic	110,000,000.93	iLembe	Site to be confirmed	Dept of Health	
New clinic including services	Mambulu Clinic (Kranskop)- Construction of a New Clinic	45,000,000.00	iLembe	Site to be confirmed	Dept of Health	
New clinic including services	Driefontein Clinic – construct new small clinic	To be determined	iLembe	Site to be confirmed	Dept of Health	
New clinic including services	Mpolweni Clinic- Construction of New Small Clinic	70,000,000.00	uMgungundlovu	Site to be confirmed	Dept of Public Works	
New clinic including services	Mpukunyoni Clinic - Replacement of Existing Clinic	50,000,000.00	uMkhanyakude	Site to be confirmed	Dept of Health	
Staff Accommodation	Staff Flats and Paediatric Ward	To be determined	uMkhanyakude	Not available	Dept of Health	
Health Facilities	Mtubatuba CHC	To be determined	uMkhanyakude	Not available	Dept of Health	
Health facilities	Mpukunyoni Clinic	To be determined	uMkhanyakude	Not available	Dept of Health	
Forensic	Jozini Forensic Mortuary	To be determined	uMkhanyakude	Not available	Dept of Health	
New clinic including services	Nyavini Clinic - Construction Outlier Clinic	56,000,000.00	Ugu	30.4008° S, 30.3608° E	Dept of Health	
Hospital infrastructure project	Port Shepstone Hospital-New 28 bedded Psychiatric Unit	To be determined	Ugu	30.7431° S, 30.4515° E	Department of Public Works	
Hospital infrastructure project	Murchison Hospital- Alterations and Renovations to Staff Accommodation	To be determined	Ugu	30.7280° S, 30.3435° E	Department of Public Works	
Hospital infrastructure project	St Andrew's Hospital - New Staff Accommodation	To be determined	Ugu	30.5754° S, 29.8895° E	Department of Public Works	

Area of Intervention	Project Description	Budget Allocation	District Municipality	Location: GPS Co-ordinates	Project Leader	Social Partners
Upgrade of Umzinto Clinic to a CHC	Brief finalized and presented to HIAC committee. Will commence design phase	To be determined	Ugu	30.3043° S, 30.6678° E	Department of Public Works	
Relocation of Pennington Clinic to Emalangeni ward 9.	Design stage	To be determined	Ugu	29.6407° S, 30.7178° E	Department of Public Works	
Relocation of Weza Clinic to the old police station.	Awaiting communication from SAPs regarding use of the old police station as a clinic	To be determined	Ugu	30.5915° S, 29.7490° E	Department of Public Works	
Expansion of South Port Clinic	Use of South Port Bowling Club and provision of fencing	To be determined	Ugu	30.6783° S, 30.5054° E	Department of Public Works	

ANNEXURE E: POPULATION

Table 111: KwaZulu-Natal Province - DHIS downloaded 28/09/2023

Data Element	21/22	22/23	23/24	24/25	25/26	26/27
Female 02-04 years	364 650	367 988	370 594	370 397	370 020	369 417
Female 05 years	119 588	120 744	121 721	122 196	122 765	122 955
Female 05-09 years	590 744	594 339	598 790	602 366	607 143	610 385
Female 06-09 years	471 156	473 595	477 066	480 168	484 382	487 429
Female 1 year	124 334	125 130	124 450	123 557	123 204	123 057
Female 10-11 years	235 760	234 105	234 063	234 090	235 463	238 028
Female 10-14 years	583 377	585 432	586 317	584 427	584 798	587 554
Female 12 years	117 828	118 167	117 034	116 296	116 708	117 020
Female 13 years	116 110	117 528	117 972	116 567	116 180	116 542
Female 14 years	113 673	115 628	117 251	117 476	116 445	115 966
Female 15 years	110 114	112 920	115 150	116 657	117 312	116 113
Female 15-19 years	509 897	523 907	539 955	552 595	565 021	572 282
Female 15-44 years	2 811 907	2 840 695	2 871 674	2 895 357	2 924 793	2 948 629
Female 16 years	106 559	109 146	112 214	114 397	116 431	116 894
Female 17 years	102 445	105 382	108 232	111 267	114 030	115 891
Female 18-19 years	190 776	196 457	204 362	210 277	217 250	223 377
Female 20-24 years	477 258	469 532	465 672	466 441	474 054	485 917
Female 25-29 years	509 115	501 241	490 189	477 352	465 161	455 493
Female 30-34 years	515 493	517 086	517 020	513 437	509 767	503 989
Female 35-39 years	451 461	465 896	479 156	489 534	497 702	501 209
Female 40-44 years	348 688	363 037	379 680	395 995	413 090	429 741
Female 45 years and older	1 438 605	1 460 048	1 480 741	1 497 905	1 521 488	1 551 531
Female 45-49 years	303 950	307 369	308 683	310 146	315 779	326 334

Data Element	21/22	22/23	23/24	24/25	25/26	26/27
Female 50-54 years	256 132	259 514	265 469	271 044	276 675	281 568
Female 55-59 years	239 026	238 722	237 542	235 680	235 161	236 250
Female 60-64 years	201 243	205 714	209 580	212 411	215 259	217 071
Female 65-69 years	161 135	163 991	167 489	170 141	173 250	176 974
Female 70-74 years	125 639	127 370	128 644	130 156	132 387	135 072
Female 75-79 years	80 071	85 159	89 878	93 399	96 107	98 111
Female 80 years and older	71 410	72 210	73 466	74 923	76 864	80 162
Female under 1 year	126 006	125 148	124 362	123 500	123 250	123 059
Female under 5 years	614 988	618 270	619 404	617 452	616 471	615 529
Male 02-04 years	375 376	378 741	381 318	381 238	381 091	380 684
Male 05 years	123 068	124 195	125 268	125 702	126 330	126 581
Male 05-09 years	608 777	611 993	616 265	619 459	624 243	627 728
Male 06-09 years	485 706	487 796	490 999	493 752	497 911	501 141
Male 1 year	127 987	128 749	128 104	127 303	126 989	126 875
Male 10-11 years	242 080	241 006	241 127	241 066	242 253	244 461
Male 10-14 years	595 611	599 333	601 917	601 175	601 575	604 117
Male 12 years	120 065	121 213	120 302	119 839	120 053	120 457
Male 13 years	117 885	119 774	121 015	119 792	119 660	119 830
Male 14 years	115 576	117 346	119 478	120 479	119 610	119 370
Male 15 years	112 016	114 619	116 747	118 806	120 246	119 164
Male 15-19 years	517 240	530 377	545 897	559 009	573 084	581 943
Male 15-44 years	2 782 738	2 815 764	2 849 827	2 876 644	2 908 646	2 934 918
Male 16 years	108 321	110 724	113 691	115 855	118 485	119 689
Male 17 years	103 969	106 712	109 479	112 501	115 335	117 778
Male 18-19 years	192 935	198 323	205 976	211 852	219 022	225 312
Male 20-24 years	481 955	473 222	468 544	468 553	475 543	487 323

Data Element	21/22	22/23	23/24	24/25	25/26	26/27
Male 25-29 years	516 430	506 627	493 810	479 790	466 943	456 654
Male 30-34 years	518 526	520 734	519 994	514 469	508 073	500 059
Male 35-39 years	438 551	456 335	471 552	484 035	493 743	497 548
Male 40-44 years	310 034	328 472	350 034	370 788	391 256	411 395
Male 45 years and older	903 331	920 910	938 979	956 130	979 963	1 009 083
Male 45-49 years	244 387	249 123	253 603	258 845	268 802	283 879
Male 50-54 years	177 137	185 100	194 171	202 516	210 366	216 183
Male 55-59 years	146 038	146 184	146 028	146 229	148 530	153 425
Male 60-64 years	115 863	117 051	118 546	119 586	120 608	121 186
Male 65-69 years	89 952	90 016	90 042	89 846	90 089	90 690
Male 70-74 years	64 231	65 430	66 120	66 306	66 380	66 281
Male 75-79 years	37 053	38 584	40 254	41 738	43 090	44 211
Male 80 years and older	28 671	29 414	30 215	31 066	32 095	33 227
Male under 1 year	129 738	128 887	128 132	127 324	127 116	126 951
Male under 5 years	633 108	636 379	637 554	635 871	635 195	634 516
Total population	11 563 185	11 683 165	11801473	11 886 773	12 004 318	12 123 993

ANNEXURE F: LIST OF DELAYED INFRASTRUCTURE PROJECTS

The limited growth on budgets over the last few years continues and the expectation is that this trend will continue, and the Department are planning projects to ensure that MTEF Plan(s) balance with allocated budget(s). However, the need is great and there is still a list of projects that are delayed. Below is a complete list of projects that are currently delayed to various degrees.

Table 112: New and Replacement Clinic Delays

New / Replacement Clinics delayed:			
Alcockspruit Clinic	Ezimpakeni Clinic	Mahokweni Clinic	Ntabeni Clinic
Alva/Mozane Clinic	Ezwenelisha Clinic	Manekane Clinic	Nteneshane Clinic
Amahlongwa Clinic	Fiti-Park Clinic	Manyane Clinic	Ntimbankulu Clinic
Amakhabela Clinic	Frisgewacht Clinic	Manzengwenya / Chithumuzi - Clinic	Park Rynie Clinic
Amalalaphansi Clinic	G J Crookes Gateway Clinic	Manzibomvu Clinic	Paulpietersburg Clinic
Amatshensikazi Clinic	Gcilima Clinic	Maphodwa Clinic	Peacetown Clinic
Assisi Clinic	Glencoe Central Clinic	Margate Clinic	Phungashe Clinic
Avoca /Mt Moria/ Mt Royal Clinic	Gowan-Lea Clinic	Mashunka Clinic	Port Edward Clinic
Balanghei Clinic	Harding Clinic	Masons Clinic	Qiko Clinic
Bergville Clinic	Hibberdene Clinic	Mduda Clinic	Qwasha Clinic
Bethesda Gateway Clinic	Injisuthi Clinic	Mfekayi Clinic	
Bhadeni Clinic	Inkosi Yamabomvu Clinic	Mhlongo Farm Clinic	Rosary Clinic
Bhambanana Clinic	Isandhlwana Clinic	Mhongozini Clinic	Shelly Beach Clinic
Bhangonom Clinic	Isinembe Clinic	Mkhonjane Clinic	Sigodiphola Clinic
Bhokodisa Clinic	Izimpethuzendlovu Clinic	Mkhuphula Clinic	Sinamfini Clinic
Burford Clinic	Khethani Clinic	Mpanzakazi Clinic	Siyalala-la Clinic
Cabhane Clinic	KoMbuzi Clinic	Mpembeni Clinic	Sizinda Clinic
Ceza Gateway Clinic	KwaBotha Clinic	Mphakathini Clinic	Somkhele Clinic
Cezwana Clinic	KwaDumisa-Joni Clinic	Mpungamhlo Clinic	South Port Clinic
Cross Road Clinic	KwaMakhutha Clinic	Msizini Clinic	St Faith's Clinic
Dalton Clinic	KwaMpunza Clinic	Mthungweni Clinic	St Margaret's Clinic
Debe Clinic	KwaNdaba Clinic	Mvutshini Clinic	St Paul Clinic
Deepdale Clinic	KwaNguza Clinic	Mvuzini Clinic	Thafamasi Clinic
Dongothule Clinic	KwaNikwe Clinic	Mxhakeni Clinic	Thokazi Clinic
Dwarsland Clinic	KwaNkulu Clinic	Ncepheni Clinic	Thorndale/ Mahlabathini Clinic
EG and Usher Gateway Clinic	KwaNsele Clinic	Ngudwini Clinic	Tobolsk Clinic
Efuyeni Clinic	KwaNyoni Clinic	Nguga Clinic	Umbumbulu Clinic

New / Replacement Clinics delayed:			
Ekubungazeleni Clinic	KwaShukela Clinic	Nhlababo Clinic	Umdumezulu Clinic
Ekubuseni Clinic	Kweyezulu Clinic	Nhlazantshe Clinic	Umkhunya Clinic
Ekujulukeni Clinic	Limit Hill Clinic	Nhlugwane Clinic	Umtentweni Clinic
Emahlonga Clinic	Lubisi Clinic	Niemeyer Gateway Clinic	Uphaphasi ama Clinic
Emalangeni Clinic	Mabedlane Clinic	Njampela Clinic	Vezubuhle Clinic
Emfilhlweni Clinic	Mabeka Clinic	Nkonjeni Gateway Clinic	Vukani Clinic
Ezibayeni Clinic	Mabophe Clinic	Nkunyane Clinic	Vulamelho Clinic
Ezihlabeni Clinic	Machibini Clinic	Nongamlana Clinic	Vumanhlamvu Clinic
Ezihlalo Clinic	Madanyini Clinic	Ntababomvu Clinic	Xolo Clinic
Ezimpakane clinic	Magongangozi Clinic	Ntabasibahle Clinic	Zamazama Clinic

*Table 113**: New CHC's that have been delayed***

New Community Health Centres delayed:
East/Boom Community Health Centre
Esikhawini/ Esikhaleni Community Health Centre
Gamalakhe Community Health Centre (Phase 3)
Kwahlengabantu Community Health Centre
Marburg Community Health Centre
Taylors Halt Community Health Centre

Table 114: New EMS bases that have been delayed

New EMS Bases delayed:			
Cato Ridge Base	Hlabisa Base	Melmoth Base	Phoenix Base
Charlestown Base	Hlobane/Vryheid Base	Mkhambathini Base	Pholela Base
Cleremont Base	Hluhluwe Base	Mkhuze Base	Pomeroy Base
Creighton Base	Howick Base	Mooi River Base	Pongola Base
Dannhauser Base	Illovo Base	Mosvold Base	Richmond Base
Dududu Base	Imbali Base	Mseleni Base	Sawoti/Umzinto Base
Dundee/Endumeni Base	IMpendle Base	Mtubatuba Base	Shaka's Kraal Base
eDumbe Base	Isithebe Base	Ndumo Base	Sigweje / Rockcliffe Base
Ekhombe Base	Kokstad Base	Ndwedwe Base	St Chads / Ezakheni Base
Emmaus Base	KwaDukuza Base	New Hanover Base	St Faith's Base
Ensikeni Base	Kwamachi Base	Newcastle Base	Tongaat Base
Eshowe Base	KwaMashu Base	Nondweni Base	Umlazi Base
Esidumbini Base	KwaMbonambi Base	Nongoma Base	Umsinga Base
Esikhaleni Base	Ladysmith Base	Nquthu Base	Umzimkhulu Base
Estcourt Base	Loskop Base	Nseleni Base	Umzinto Base
Ezimpondweni Base	Madadeni Base	Ntabamhlophe Base	Underberg Base

New EMS Bases delayed:			
Gingindlovu Base	Mandini Base	Ntambanana Base	Untunjambili Base
Glencoe Base	Manguzi Base	Okhukho Base	Van Reenen Base
Glenmore/Thongasi Base	Mariannhill Base	Oliviershoek Base	Vryheid Base
Golela/Phongolo Base	Mbongolwane Base	Osizweni Base	Weenen Base
Harding Base	Mdakane Base	Othobothini Base	Zaaihoek Base

Table 115: New Forensic Mortuaries that have been delayed:

New Forensic Mortuaries delayed:
Nongoma Forensic Mortuary

Table 116: New Hospitals that have been delayed:

New Hospitals delayed:
Bergville Hospital - Construction of District Hospital
Bulwer Hospital - Construction of District Hospital
Dr John Dube Hospital - Construction of District Hospital
Madadeni Hospital - New Psychiatric Hospital
Mthonjaneni Hospital - Construction of District Hospital

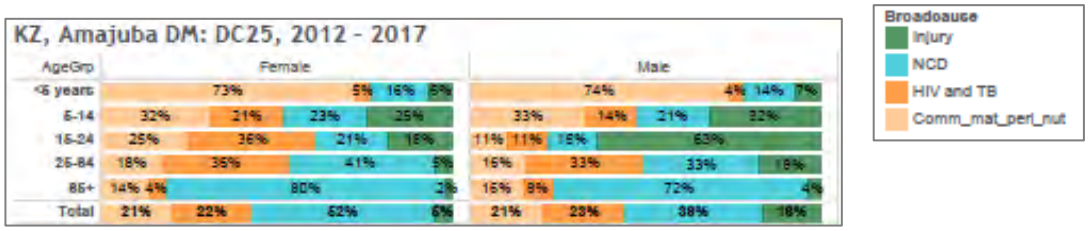
ANNEXURE G: DISTRICT PROFILES

AMAJUBA DISTRICT

DISTRICT DEMOGRAPHIC

Figure 6: District percentage population by age – gender compared to South Africa (DHB 2019/20)

Figure 7: 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 117: Amajuba Social determinants of health

		Amajuba	KZN
Total householders	Proportion of total KZN Households	5.3%	-
	Number	150 239	2 853 743

		Amajuba	KZN
Households living in formal dwellings	Proportion of District Households	93.5%	86.8%
	Number	140 442	2 477 155
Households with access to Regional / Local water schemes	Proportion of District Households	87.6%	75.2%
	Number	131 626	2 145 079
Households with access to flush toilets	Proportion of District Households	65.1%	59.9%
	Number	97 796	1 709 676
Children (5 – 24) attending school	Proportion of KZN children attending school	6.1%	-
	Number	191 695	3 126 415
Government transfers and subsidies as % of total revenue-		81.60%	

Source: StatsSA – Census 2022

Graph 22: Amajuba HIV / AIDS Cascades as at September 2023

Source: HAST Unit – December 2023

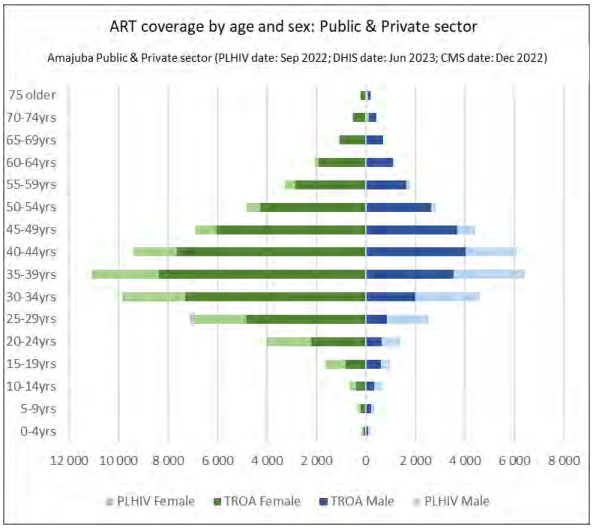
As of September 2023, Amajuba is at 97-79-90 in terms of performance against the 95-95-95 targets across its total population using data available in the public & private sector. Data available from the private sector suggest that a total of 4 070 clients receive ART through private medical aid schemes in Amajuba. For adult females and adult males this number is 2 699 and 1 341 respectively.

Results for each of the sub-populations vary, with adult females being at 97-84-91, adult males at 96-71-91, and children (<15) at 87-66-73. There are gaps across the cascade for adults & children. Case

finding, ART initiation and retention have all underperformed and should be addressed through focused interventions in this sub-population.

To achieve 95-95-95 targets, Amajuba must increase the number of clients on ART with 13 001. For adult females the required increase is 5 204, whereas an increase of 7 029 ART adult males is required.

Figure 8: Amajuba District ART Coverage at June 2023



Source: HAST Unit – December 2023

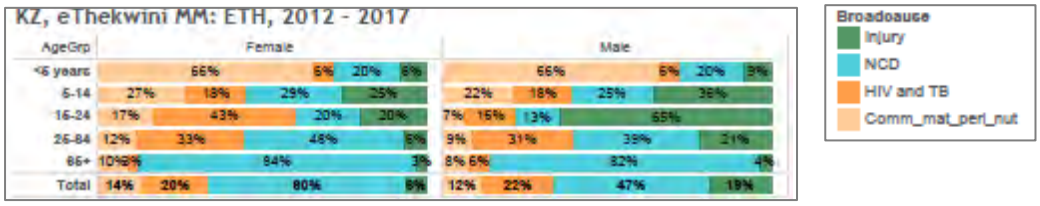
As of June 2023, Amajuba is at 76% ART coverage of the total PLHIV population using data from both the private and public sectors. Results vary between male and female populations. Among all females ART Coverage is at 81%, while the data shows an ART Coverage of 68% for all males. For females, ART coverage among adults (>15 years) is at 81% and 61% for female children (<15 years). For males, ART coverage among adults (>15 years) is at 68% and 53% for male children (<15)."

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.[11]

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.

[11] eThekwini IDP 2019/20

Table 118: eThekwini Social determinants of health

			KZN
Total householders	Proportion of total KZN Households	39.3%	-
	Number	1 122 738	2 853 743
Households living in formal dwellings	Proportion of District Households	89.2%	86.8%
	Number	1 001 347	2 477 155
Households with access to Regional / Local water schemes	Proportion of District Households	93.8%	75.2%
	Number	1 052 684	2 145 079
Households with access to flush toilets	Proportion of District Households	80.4%	59.9%
	Number	902 237	1 709 676
Children (5 – 24) attending school	Proportion of KZN children attending school	25.8%	-
	Number	805 315	3 126 415
Government transfers and subsidies as % of total revenue		15.50%	

Source: StatsSA – Census 2022

Graph 23: eThekwini HIV / AIDS Cascades as at September 2023

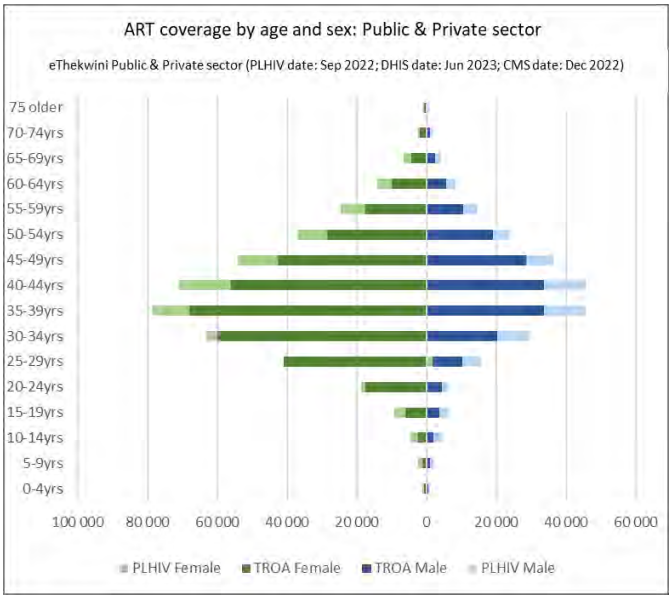
Source: HAST Unit – December 2023

As of September 2023, eThekwini is at 97-87-77 in terms of performance against the 95-95-95 targets across its total population using data available in the Public & Private sector. Data available from the private sector suggest that a total of 38 837 clients receive ART through private medical aid schemes in eThekwini. For adult females and adult males this number is 24 976 and 13 507 respectively.

Results for each of the sub-populations vary, with adult females being at 97-92-78, adult males at 96-80-78,and children (<15) at 87-56-49.There are gaps across the cascade for adults & children. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions in this sub-population.

To achieve 95-95-95 targets, eThekwini must increase the number of clients on ART with 38 371. For adult females the required increase is 1 488, whereas an increase of 30 312 ART Adult Males are required."

Figure 11: eThekwini Municipality ART Coverage as at June 2023



Source: HAST Unit – December 2023

As of June 2023, eThekwini is at 84% ART coverage of the total PLHIV population using data from both the private and public sectors. Results vary between male and female populations. Among all females ART Coverage is at 89%, while the data shows an ART Coverage of 76% for all males. For females, ART coverage among adults (>15 years) is at 90% and 52% for female children (<15 years). For males, ART coverage among adults (>15 years) is at 77% and 46% for male children (<15)."

HARRY GWALA DISTRICT

DISTRICT DEMOGRAPHIC

Figure 12: District percentage population by age – gender compared to South Africa (DHB 2019/20)

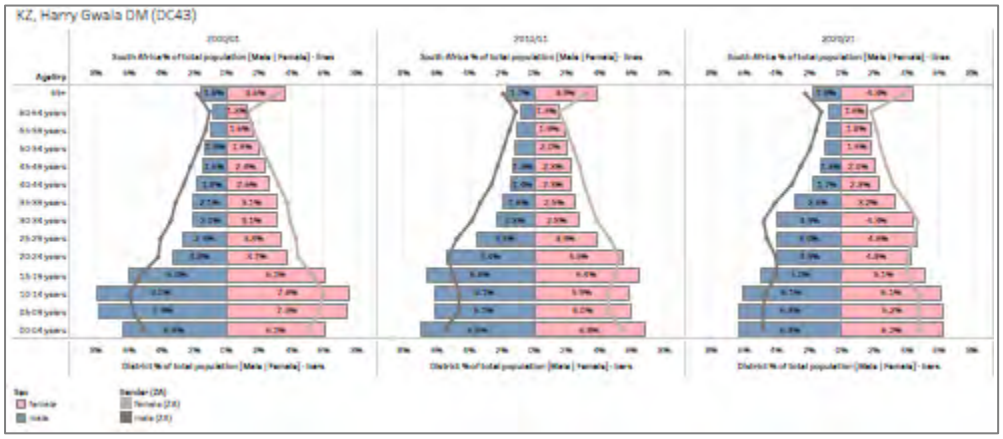
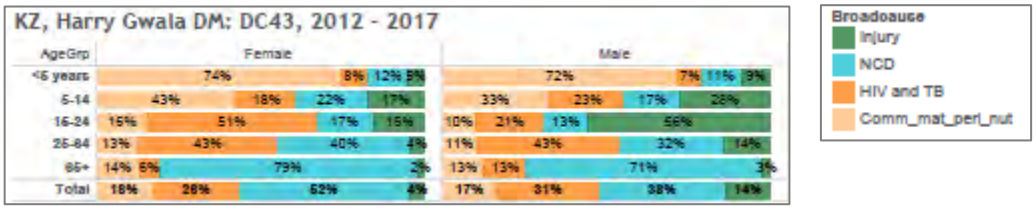


Figure 13: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)



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 male's 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 119: Harry Gwala Social determinants of health

			KZN
Total householders	Proportion of total KZN Households	4.0%	-
	Number	115 068	2 853 743
Households living in formal dwellings	Proportion of District Households	66.2%	86.8%
	Number	76 128	2 477 155
Households with access to Regional / Local water schemes	Proportion of District Households	46.8%	75.2%
	Number	53 858	2 145 079
Households with access to flush toilets	Proportion of District Households	37.1%	59.9%
	Number	42 715	1 709 676
Children (5 – 24) attending school	Proportion of KZN children attending school	5.5%	-
	Number	173 230	3 126 415
Government transfers and subsidies as % of total revenue	-	89%	

Source: StatsSA – Census 2022

Graph 24: Harry Gwala District HIV / AIDS Cascades as at September 2023

Source: HAST Unit – December 2023

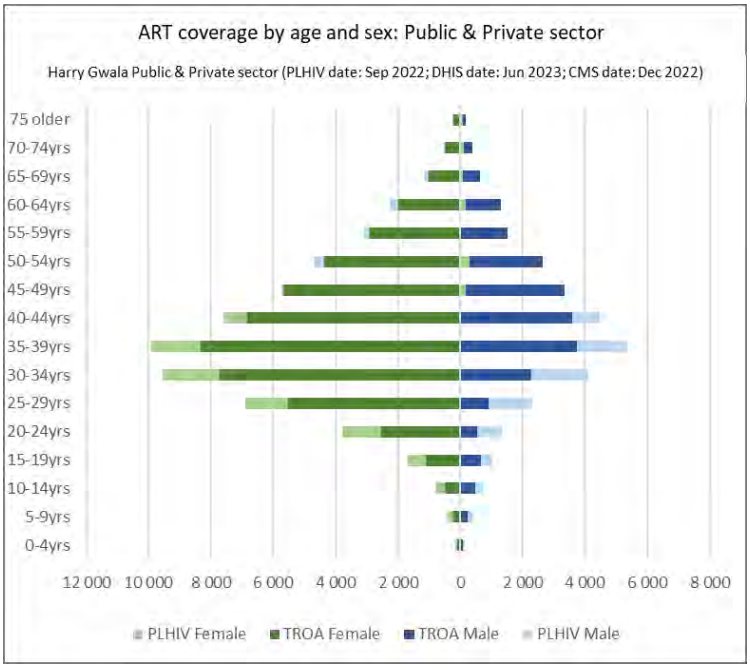
As of September 2023, Harry Gwala is at 97-90-88 in terms of performance against the 95-95-95 targets across its total population using data available in the public & private sector. Data available from

the private sector suggest that a total of 3 054 clients receive ART through private medical aid schemes in Harry Gwala. For adult females and adult males this number is 2 105 and 0 908 respectively.

Results for each of the sub-populations vary, with adult females being at 97-94-89, adult males at 96-84-89, and children (<15) at 87-70-42. There are gaps across the cascade for adults & children. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions in this sub-population.

To achieve 95-95-95 targets, Harry Gwala must increase the number of clients on ART with 2 498. For adult females the target has been reached, whereas an increase of 2 496 ART adult males is required.

Figure 14: Harry Gwala District ART Coverage as at June 2023



Source: HAST Unit – December 2023

As of June 2023, Harry Gwala is at 87% ART coverage of the total PLHIV population using data from both the private and public sectors. Results vary between male and female populations. Among all females ART Coverage is at 91%, while the data shows an ART Coverage of 80% for all males. For females, ART coverage among Adults (>15 years) is at 92% and 62% for female children (<15 years). For males, ART coverage among adults (>15 years) is at 81% and 60% for male children (<15).

ILEMBE DISTRICT

DISTRICT DEMOGRAPHIC

Figure 15: District percentage population by age – gender compared to South Africa (DHB 2019/20)

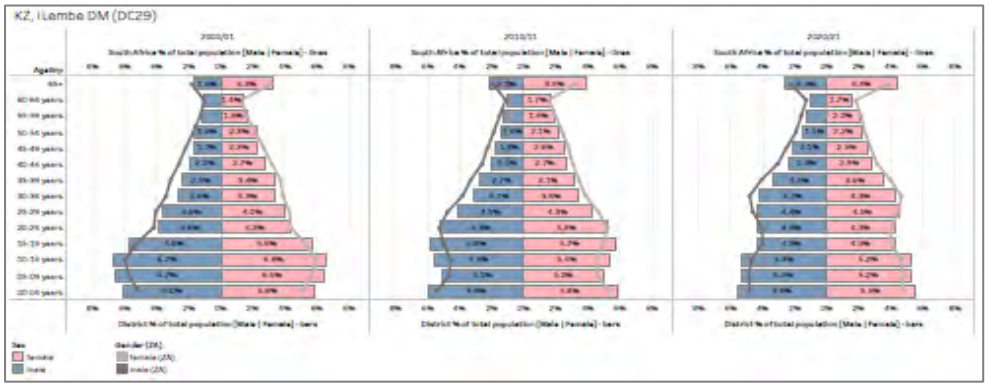
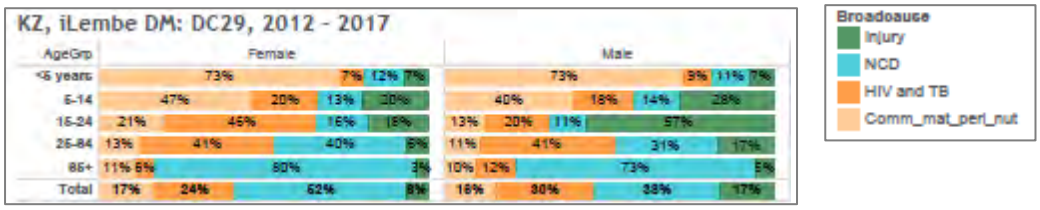


Figure 16: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)



BRIEF OVERVIEW OF THE MAJOR SOCIAL DETERMINANT CHALLENGES

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 120: iLembe Social Determinants of Health

			KZN
Total householders	Proportion of total KZN Households	6.6%	-
	Number	187 182	2 853 743
Households living in formal dwellings	Proportion of District Households	87.6%	86.8%

			KZN
	Number	163 881	2 477 155
Households with access to Regional / Local water schemes	Proportion of District Households	74.3%	75.2%
	Number	139 061	2 145 079
Households with access to flush toilets	Proportion of District Households	44.6%	59.9%
	Number	83 478	1 709 676
Children (5 – 24) attending school	Proportion of KZN children attending school	8.7%	-
	Number	270 752	3 126 415
Government transfers and subsidies as % of total revenue	-	71.90%	

Source: StatsSA – Census 202

Graph 25: iLembe District HIV / AIDS Cascades as at September 2023

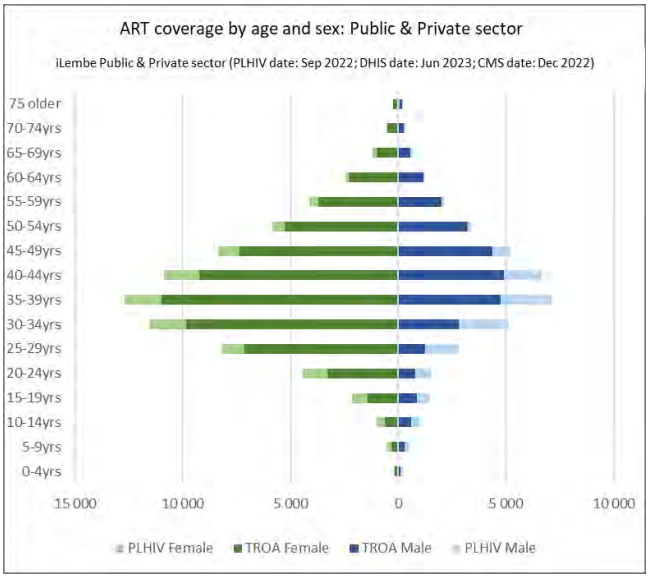
Source: HAST Unit – December 2023

As of Sep 2023 iLembe, is at 97-86-73 in terms of performance against the 95-95-95 targets across its total population using data available in the public & private sector. Data available from the private sector suggest that a total of 3 239 clients receive ART through private medical aid schemes in iLembe. For adult females and adult males this number is 2 091 and 1 109 respectively.

Results for each of the sub-populations vary, with adult females being at 97-91-73, adult males at 96-77-73, and children (<15) at 87-71-45. There are gaps across the cascade for adults & children. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions in this sub-population.

To achieve 95-95-95 targets, iLembe must increase the number of clients on ART with 8 245. For adult females the required increase is 1 316, whereas an increase of 5 940 ART adult males are required.

Figure 17: iLembe District ART Coverage as at September 2023



Source: HAST Unit – December 2023

KING CETSHWAYO DISTRICT

DISTRICT DEMOGRAPHIC

Figure 18: District percentage population by age – gender compared to South Africa (DHB 2019/20)

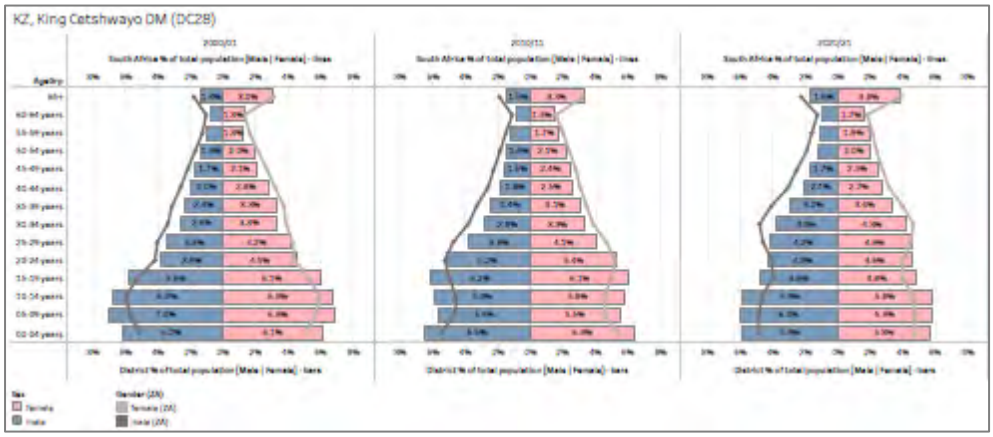
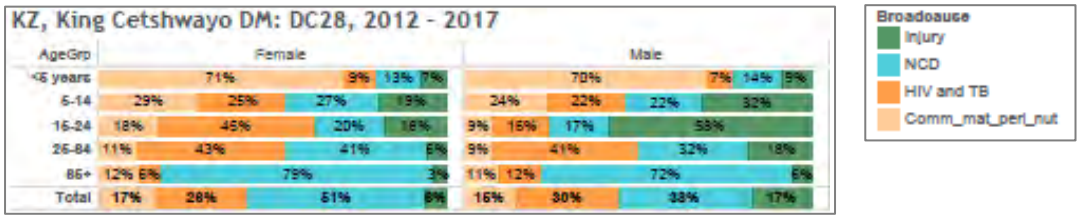


Figure 19: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)



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 121: KCD Social determinants of health

			KZN
Total householders	Proportion of total KZN Households	7.2%	-
	Number	205 739	2 853 743
Households living in formal dwellings	Proportion of District Households	87.4%	86.8%
	Number	179 910	2 477 155
Households with access to Regional / Local water schemes	Proportion of District Households	29.4%	75.2%
	Number	60 418	2 145 079
Households with access to flush toilets	Proportion of District Households	45.0%	59.9%
	Number	92 641	1 709 676
Children (5 – 24) attending school	Proportion of KZN children attending school	8.7%	-
	Number	270 752	3 126 415
Government transfers and subsidies as % of total revenue-		86.90%	

Source: StatsSA – Census 2022

Graph 26: King Cetshwayo District HIV / AIDS Cascades as at September 2023

Source: HAST Unit – December 2023

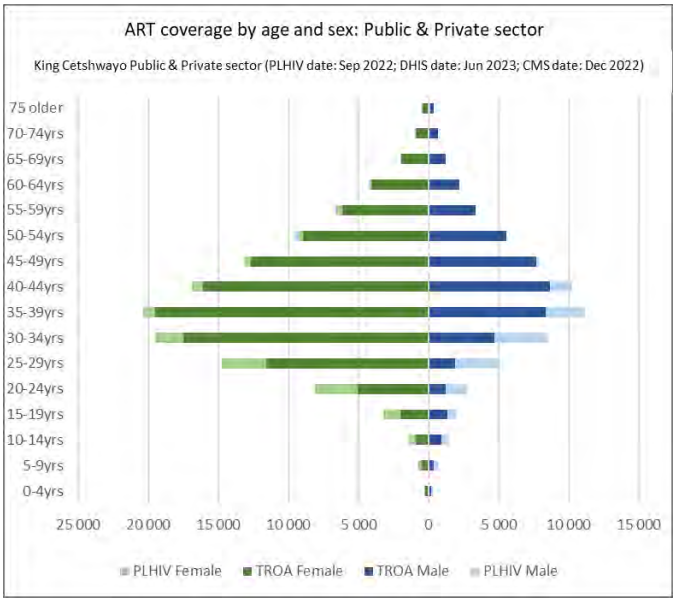
As of September 2023, King Cetshwayo is at 97-94-79 in terms of performance against the 95-95-95 targets across its total population using data available in the public & private sector. Data available from the private sector suggest that a total of 10 481 clients receive ART through private medical aid

schemes in King Cetshwayo. For adult females and adult males this number is 6 716 and 3 670 respectively.

Results for each of the sub-populations vary, with adult females being at 97-98-80, adult males at 96-87-80, and children (<15) at 87-72-47. There are gaps across the cascade for adults & children. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions in this sub-population.

To achieve 95-95-95 targets, King Cetshwayo must increase the number of clients on ART with 300. For adult females the target has been reached, whereas an increase of 3 769 ART adult males is required.

Figure 20: King Cetshwayo District ART Coverage as at June 2023



Source: HAST Unit – December 2023

As of June 2023, King Cetshwayo is at 90% ART coverage of the total PLHIV population using data from both the private and public sectors. Results vary between male and female populations. Among all females ART Coverage is at 94%, while the data shows an ART Coverage of 83% for all males. For females, ART coverage among adults (>15 years) is at 95% and 66% for female children (<15 years). For males, ART coverage among adults (>15 years) is at 84% and 59% for male children (<15).

UGU DISTRICT

DISTRICT DEMOGRAPHICS

Figure 21: District percentage population by age – gender compared to South Africa (DHB 2019/20)

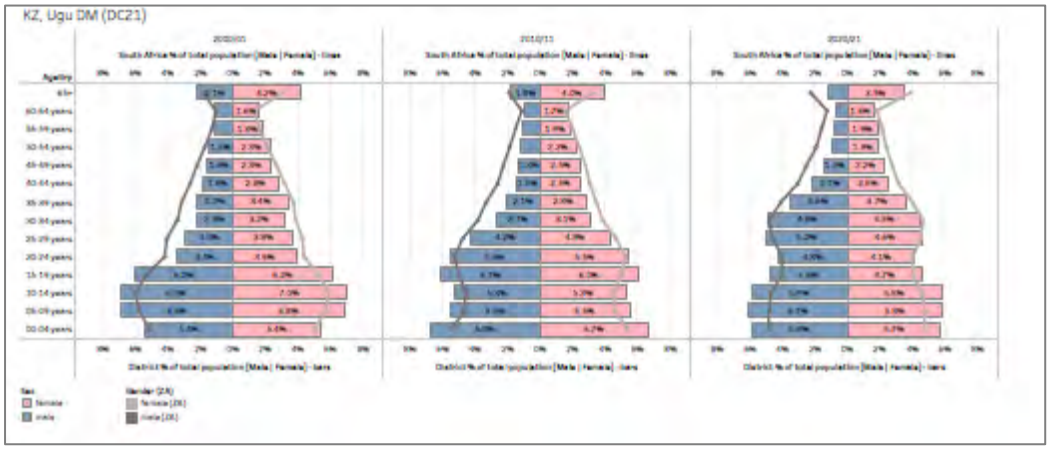


Figure 22: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)

BRIEF OVERVIEW OF THE MAJOR SOCIAL DETERMINANT CHALLENGES

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 122: Ugu Social determinants of health

			KZN
Total householders	Proportion of total KZN Households	6.0%	-
	Number	172 628	2 853 743
Households living in formal dwellings	Proportion of District Households	85.1%	86.8%
	Number	146 927	2 477 155
Households with access to Regional / Local water schemes	Proportion of District Households	70.4%	75.2%
	Number	121 556	2 145 079
Households with access to flush toilets	Proportion of District Households	37.1%	59.9%
	Number	64 114	1 709 676
Children (5 – 24) attending school	Proportion of KZN children attending school	6.6%	-
	Number	206 404	3 126 415
Government transfers and subsidies as % of total revenue-		61.30%	

Source: StatsSA – Census 2022

Graph 27: Ugu District HIV / AIDS Cascades as at September 2023

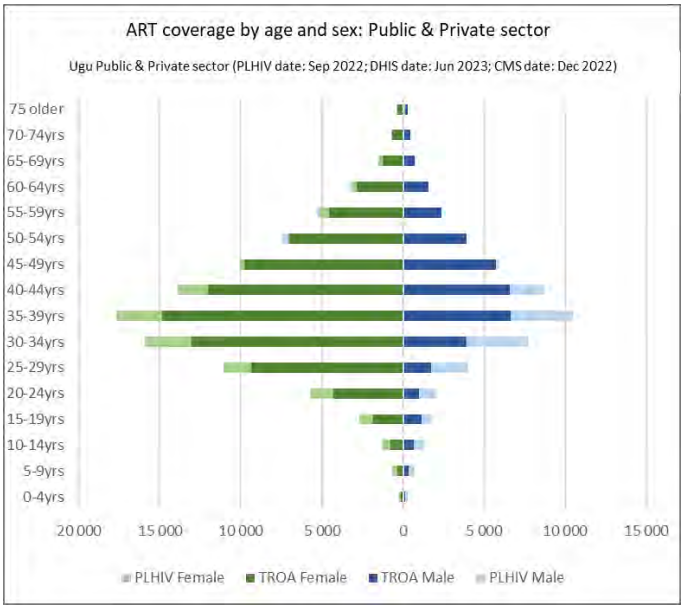
Source: HAST Unit – December 2023

As of September 2023, Ugu is at 97-87-88 in terms of performance against the 95-95-95 targets across its total population using data available in the public & private sector. Data available from the private sector suggest that a total of 5 650 clients receive ART through private medical aid schemes in Ugu. For adult females and adult males this number is 3 779 and 1 808 respectively.

Results for each of the sub-populations vary, with adult females being at 97-93-88, adult males at 96-79-88, and children (<15) at 87-63-56. There are gaps across the cascade for adults & children. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions in this sub-population.

To achieve 95-95-95 targets, Ugu must increase the number of clients on ART with 8 640. For adult females the required increase is 332, whereas an increase of 6 736 ART adult males is required."

Figure 23: Ugu District ART Coverage as atJune 2023



Source: HAST Unit – December 2023

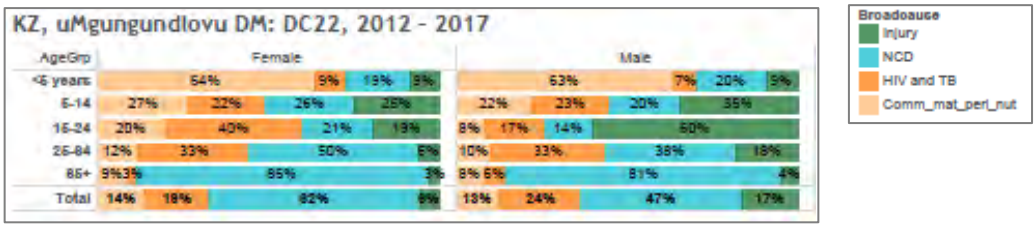
As of June 2023, Ugu is at 84% ART coverage of the total PLHIV population using data from both the private and public sectors. Results vary between male and female populations. Among all females ART Coverage is at 89%, while the data shows an ART Coverage of 75% for all males. For females, ART coverage among adults (>15 years) is at 90% and 59% for female children (<15 years). For males, ART coverage among adults (>15 years) is at 76% and 50% for male children (<15)."

UMGUNGUNDLOVU DISTRICT

DISTRICT DEMOGRAPHIC

Figure 24: District percentage population by age – gender compared to South Africa (DHB 2019/20)

Figure 25: 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 123: uMgungundlovu Social determinants of health

			KZN
Total householders	Proportion of total KZN Households	10.8%	-
	Number	307 842	2 853 743

			KZN
Households living in formal dwellings	Proportion of District Households	88.6%	86.8%
	Number	272 703	2 477 155
Households with access to Regional / Local water schemes	Proportion of District Households	85.0%	75.2%
	Number	261 675	2 145 079
Households with access to flush toilets	Proportion of District Households	58.3%	59.9%
	Number	179 327	1 709 676
Children (5 – 24) attending school	Proportion of KZN children attending school	8.9%	-
	Number	277 566	3 126 415
Government transfers and subsidies as % of total revenue-		52.50%	

Source: StatsSA – Census 2022

Graph 28: uMgungundlovu District HIV / AIDS Cascades as at September 2023

Source: HAST Unit – December 2023

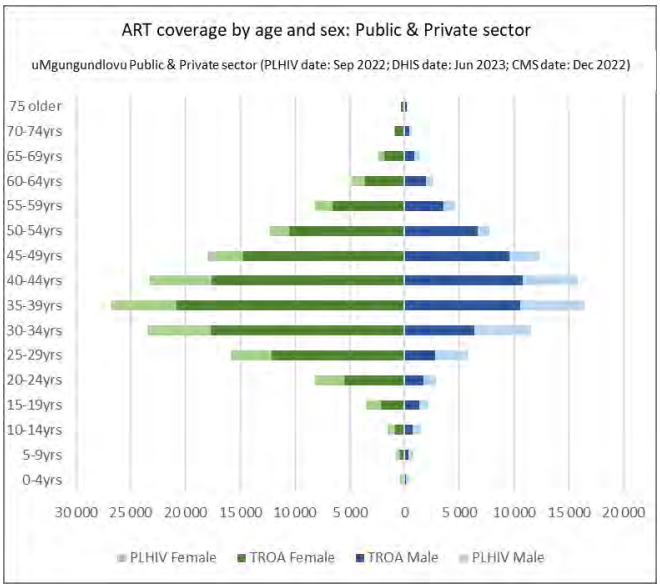
As of September 2023, uMgungundlovu is at 97-80-83 in terms of performance against the 95-95-95 targets across its total population using data available in the public & private sector. Data available from the private sector suggest that a total of 11 947 clients receive ART through private medical aid schemes in uMgungundlovu. For adult females and adult males this number is 7 960 and 3 888 respectively.

Results for each of the sub-populations vary, with adult females being at 97-84-84, adult males at 96-73-84, and children (<15) at 87-56-48. There are gaps across the cascade for adults & children. Case

finding, ART initiation and retention have all underperformed and should be addressed through focused interventions in this sub-population.

To achieve 95-95-95 targets, uMgungundlovu must increase the number of clients on ART with 29 914. For adult females the required increase is 11 988, whereas an increase of 15 671 ART adult males is required.

Figure 26: uMgungundlovu District ART Coverage as at June 2023



Source: HAST Unit – December 2023

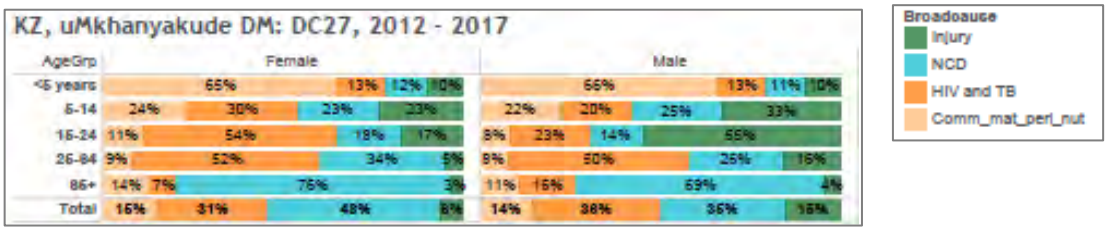
As of June 2023, uMgungundlovu is at 77% ART coverage of the total PLHIV population using data from both the private and public sectors. Results vary between male and female populations. Among all females ART Coverage is at 81%, while the data shows an ART Coverage of 70% for all males. For females, ART coverage among adults (>15 years) is at 82% and 52% for female children (<15 years). For males, ART coverage among adults (>15 years) is at 71% and 46% for male children (<15).

UMKHANYAKUDE 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

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 124: uMkhanyakude Social determinants of health

			KZN
Total householders	Proportion of total KZN Households	4.5%	-
	Number	129 066	2 853 743
Households living in formal dwellings	Proportion of District Households	90.7%	86.8%
	Number	117 079	2 477 155
Households with access to Regional / Local water schemes	Proportion of District Households	42.4%	75.2%
	Number	54 757	2 145 079
Households with access to flush toilets	Proportion of District Households	25.5%	59.9%
	Number	32 925	1 709 676
Children (5 – 24) attending school	Proportion of KZN children attending school	7.0%	-
	Number	217 772	3 126 415
Government transfers and subsidies as % of total revenue-		86.40%	

Source: StatsSA – Census 2022

Graph 29: uMkhanyakude District HIV / AIDS Cascades as at September 2023

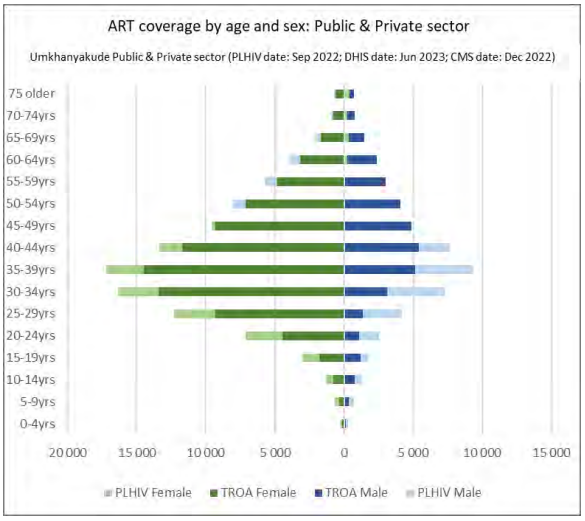
Source: HAST Unit – December 2023

As of September 2023, uMkhanyakude is at 97-87-80 in terms of performance against the 95-95-95 targets across its total population using data available in the public & private sector. Data available from the private sector suggest that a total of 5 468 clients receive ART through private medical aid schemes in uMkhanyakude. For adult females and adult males this number is 3 720 and 1 698 respectively.

Results for each of the sub-populations vary, with adult females being at 97-92-81, adult males at 96-79-81, and children (<15) at 87-66-69. There are gaps across the cascade for adults & children. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions in this sub-population.

To achieve 95-95-95 targets, uMkhanyakude must increase the number of clients on ART with 8 187. For adult females the required increase is 499 , whereas an increase of 6 205 ART adult males is required.

Figure 29: uMkhanyakude District ART Coverage as at June 2023



Source: HAST Unit – December 2023

As of June 2023, uMkhanyakude is at 84% ART coverage of the total PLHIV population using data from both the private and public Sectors. Results vary between male and female populations. Among all females ART Coverage is at 89%, while the data shows an ART Coverage of 75% for all males. For females, ART coverage among adults (>15 years) is at 90% and 57% for female children (<15 years). For males, ART coverage among adults (>15 years) is at 76% and 57% for male children (<15)."

UMZINYATHI DISTRICT

DISTRICT DEMOGRAPHIC

Figure 30: District percentage population by age – gender compared to South Africa (DHB 2019/20)

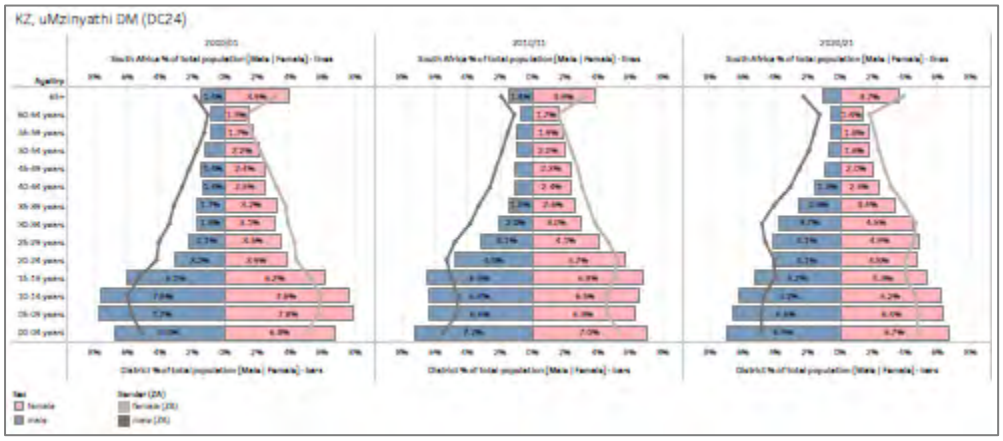
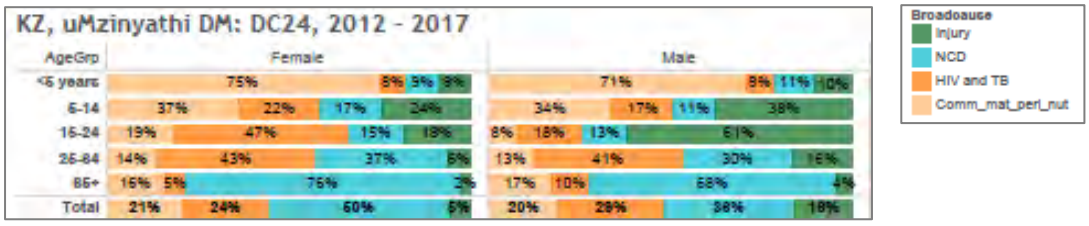


Figure 31: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)



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 125: uMzinyathi Social determinants of health

			KZN
Total householders	Proportion of total KZN Households	4.4%	-
	Number	125 427	2 853 743
Households living in formal dwellings	Proportion of District Households	72.0%	86.8%
	Number	90 295	2 477 155
Households with access to Regional / Local water schemes	Proportion of District Households	48.5%	75.2%
	Number	60 786	2 145 079
Households with access to flush toilets	Proportion of District Households	58.8%	59.9%
	Number	73 760	1 709 676
Children (5 – 24) attending school	Proportion of KZN children attending school	6.5%	-
	Number	204 348	3 126 415
Government transfers and subsidies as % of total revenue-		83.90%	

Source: StatsSA – Census 2022

Graph 30: uMzinyathi District HIV / AIDS Cascades as at September 2023

Source: HAST Unit – December 2023

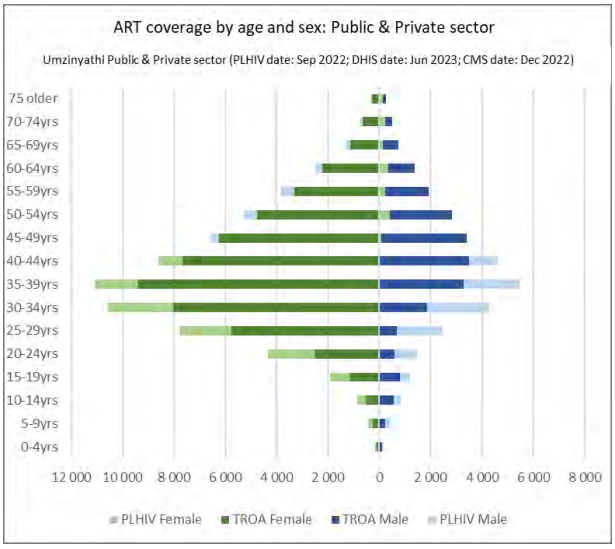
As of September 2023, uMzinyathi is at 97-88-81 in terms of performance against the 95-95-95 targets across its total population using data available in the public & private sector. Data available from the

private sector suggest that a total of 3 175 clients receive ART through private medical aid schemes in uMzinyathi. For adult females and adult males this number is 2 257 and 0 889 respectively.

Results for each of the sub-populations vary, with adult females being at 97-93-82, adult males at 96-80-82, and children (<15) at 87-71-50. There are gaps across the cascade for adults & children. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions in this sub-population.

To achieve 95-95-95 targets, uMzinyathi must increase the number of clients on ART with 4 496. For adult females the required increase is 174, whereas an increase of 3 496 ART adult males is required.

Figure 32: uMzinyathi District ART Coverage as at June 2023



Source: HAST Unit – December 2023

As of June 2023, uMzinyathi is at 85% ART coverage of the total PLHIV population using data from both the private and public sectors. Results vary between male and female populations. Among all females ART Coverage is at 89%, while the data shows an ART Coverage of 76% for all males. For females, ART coverage among adults (>15 years) is at 90% and 62% for female children (<15 years). For males, ART coverage among adults (>15 years) is at 77% and 61% for male children (<15)."

UTHUKELA DISTRICT

DISTRICT DEMOGRAPHIC

Figure 33: District percentage population by age – gender compared to South Africa (DHB 2019/20)

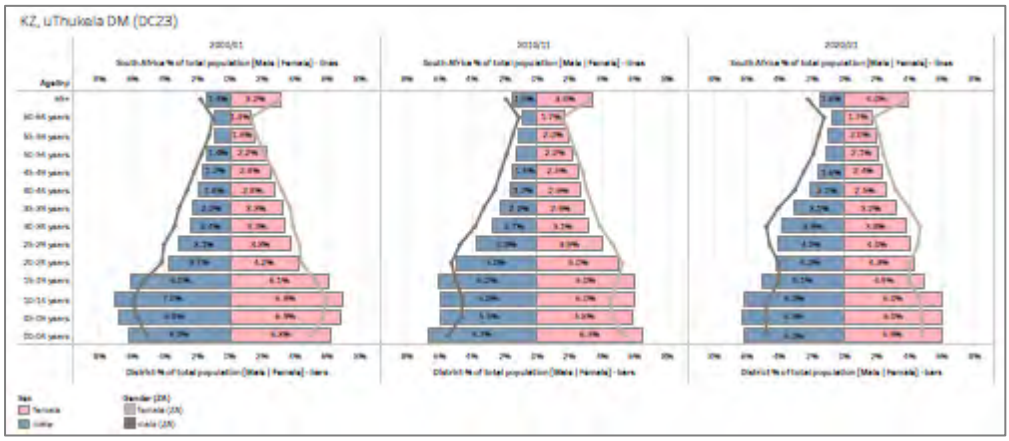
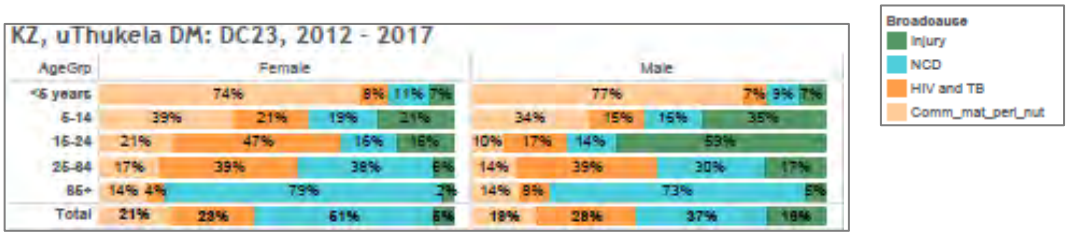


Figure 34: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)



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 126: uThukela Social determinants of health

		uThukela	KZN
Total householders	Proportion of total KZN Households	6.0%	-
	Number	172 197	2 853 743
Households living in formal dwellings	Proportion of District Households	84.1%	86.8%
	Number	144 885	2 477 155
Households with access to Regional / Local water schemes	Proportion of District Households	64.8%	75.2%
	Number	111 501	2 145 079
Households with access to flush toilets	Proportion of District Households	46.5%	59.9%
	Number	80 015	1 709 676
Children (5 – 24) attending school	Proportion of KZN children attending school	7.0%	-
	Number	218 090	3 126 415
Government transfers and subsidies as % of total revenue-		66.90%	

Source: StatsSA – Census 2022

Graph 31: uThukela District HIV / AIDS Cascades as at September 2023

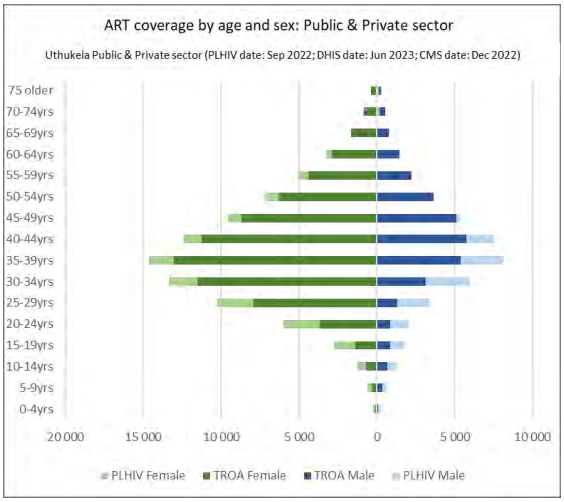
Source: HAST Unit – December 2023

As of September 2023, uThukela is at 97-86-88 in terms of performance against the 95-95-95 targets across its total population using data available in the public & private sector. Data available from the private sector suggest that a total of 4 300 clients receive ART through private medical aid schemes in uThukela. For adult females and adult males this number is 2 926 and 1 339 respectively.

Results for each of the sub-populations vary, with adult females being at 97-91-89, adult males at 96-78-89, and children (<15) at 87-61-57. There are gaps across the cascade for adults & children. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions in this sub-population.

To achieve 95-95-95 targets, uThukela must increase the number of clients on ART with 9 310. For adult females the required increase is 1 687, whereas an increase of 6 045 ART adult males is required.

Figure 35: uThukela ART Coverage as at June 2023



Source: HAST Unit – December 2023

As of June 2023, uThukela is at 83% ART coverage of the total PLHIV population using data from both the private and public sectors. Results vary between male and female populations. Among all females ART Coverage is at 87%, while the data shows an ART Coverage of 74% for all males. For females, ART coverage among Adults (>15 years) is at 88% and 54% for female children (<15 years). For males, ART coverage among adults (>15 years) is at 75% and 52% for male children (<15).

ZULULAND DISTRICT

DISTRICT DEMOGRAPHIC

Figure 36: District percentage population by age – gender compared to South Africa (DHB 2019/20)

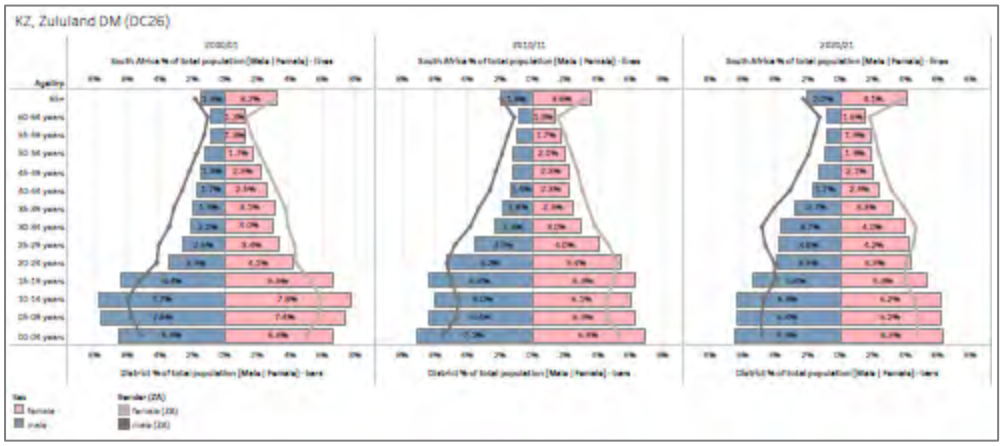
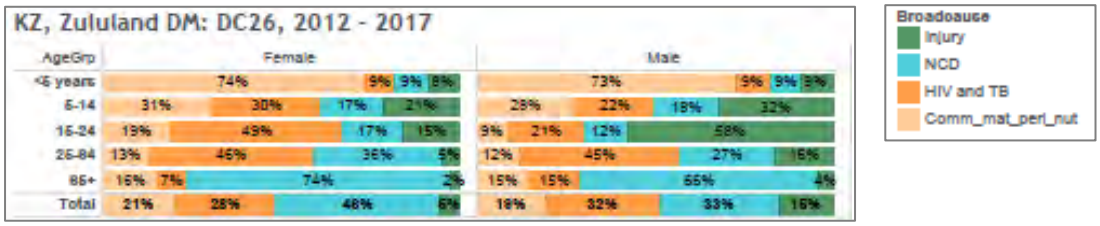


Figure 37: District Percentage of deaths by broad cause and leading cause 2012 – 2017 (DHB 2019/20)



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 127: Zululand Social determinants of health

		Zululand	KZN
Total householders	Proportion of total KZN Households	5.8%	-
	Number	165 617	2 853 743
Households living in formal dwellings	Proportion of District Households	86.7%	86.8%
	Number	143 558	2 477 155
Households with access to Regional / Local water schemes	Proportion of District Households	58.7%	75.2%
	Number	97 157	2 145 079
Households with access to flush toilets	Proportion of District Households	36.6%	59.9%
	Number	60 668	1 709 676
Children (5 – 24) attending school	Proportion of KZN children attending school	9.3%	-
	Number	290 491	3 126 415
Government transfers and subsidies as % of total revenue-		93.40%	

Source: Local Government Handbook, Stats SA; 2014 Blue Drop Report

Graph 32: Zululand District HIV / AIDS Cascades as at September 2023

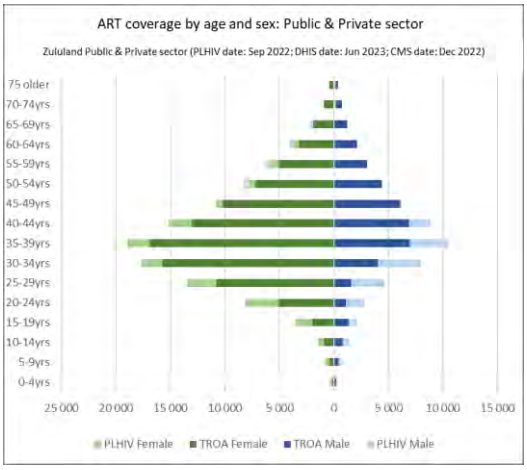
Source: HAST Unit – December 2023

As of September 2023, Zululand is at 97-87-74 in terms of performance against the 95-95-95 targets across its total population using data available in the public & private sector. Data available from the private sector suggest that a total of 5 330 clients receive ART through private medical aid schemes in Zululand. For adult females and adult males this number is 3 564 and 1 706 respectively.

Results for each of the sub-populations vary, with adult females being at 97-91-75, adult males at 96-80-75, and children (<15) at 87-66-55. There are gaps across the cascade for adults & children. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions in this sub-population.

To achieve 95-95-95 targets, Zululand must increase the number of clients on ART with 10 427. For adult females the required increase is 1 900, whereas an increase of 6 852 ART adult males is required.

Figure 38: Zululand District ART Coverage as at June 2023



Source: HAST Unit – December 2023

As of June 2023, Zululand is at 84% ART coverage of the total PLHIV population using data from both the private and public Sectors. Results vary between male and female populations. Among all females ART Coverage is at 88%, while the data shows an ART Coverage of 76% for all males. For females, ART coverage among adults (>15 years) is at 88% and 60% for female children (<15 years). For males, ART coverage among adults (>15 years) is at 77% and 55% for male children (<15)."

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