health
Department:
Health
PROVINCE OF KWAZULU-NATAL

ANNUAL
PERFORMANCE PLAN
2015/16 – 2017/18

FIGHTING DISEASE, FIGHTING POVERTY, GIVING HOPE

FOREWORD BY THE EXECUTIVE AUTHORITY

After extensive deliberation and reflection on the successes and challenges facing the health care system in the Province it is now time for action. The Annual Performance Plan set out the strategic priorities that the Department will pursue in 2015/16 to further strengthen and reform the public health care system in KwaZulu-Natal. The Department will continue to commit itself to implementing these strategic priorities, moving seamless from reflection to action – from planning to implementation with the ultimate aim of improving health care for all.

Although we made significant progress in a number of areas we cannot afford to be complacent, and unfinished business will receive the highest attention. The Department will also focus on the National Development Plan Health priorities as integral component of the Provincial strategic focus areas namely:

1. Address the social determinants that affect health and diseases
2. Strengthen the health system
3. Improve health information systems
4. Prevent and reduce the disease burden and promote health
5. Finance universal healthcare coverage
6. Improve human resources in the health sector
7. Review management positions and appointments and strengthen accountability mechanisms
8. Improve quality by using evidence
9. Meaningful public-private partnerships

We are committed to further expand our reach to communities this year to "listen to the voices of our people" in crafting the way forward – together we can do more.

Working collectively with the Head of Department and Senior Management, I commit myself to provide the necessary stewardship to ensure the successful implementation of this Annual Performance Plan for the period 2015/16 – 2017/18.

I hereby endorse the 2015/16 – 2017/18 Annual Performance Plan as guiding framework within which the Department will execute its mandate in serving the people of KwaZulu-Natal.

Dr SM Dhlomo

Member of the Executive Council (MEC)

KwaZulu-Natal Department of Health

Date: 03/03/2015

STATEMENT BY THE HEAD OF DEPARTMENT

I am pleased to present the KwaZulu-Natal Department of Health Annual Performance Plan for the period 2015/16 – 2017/18.

Over the next five years the Department will consolidate the strategic thrusts of the 2015-2019 Strategic Plan, further informed by emerging priorities and empirical evidence to guide decision-making. The Department's Long Term Plan will inform short, medium and long term planning to ensure coherent response to health demands.

Despite fundamental constraints surrounding financial limitations, this is the time to assess current approaches and interventions to give birth to innovations and transformation that can serve the health system well. We will continue to progressively improve service standards and performance, and embrace the change we face.

The Department identified 5 Strategic Goals, aligned with the National Development Plan 2030, the Medium Term Strategic Framework 2014-2019, the Provincial Growth & Development Plan 2030, and Sector priorities to guide the service priorities over the next 5 years starting in 2015/16.

Goal 1: Strengthen health system effectiveness

- The Department will focus on strengthening of the health system to ensure an enabling environment that will ground efficient health services. The Department will finalise its Long Term Plan to inform short, medium and long term planning and budget projections based on empirical evidence.
- Operation Clean Audit with specific emphasis on improving financial, supply chain, information and risk management and oversight.
- Information Communication and Technology systems and processes will be strengthened to improve information management and telemedicine.
- The Department will scale up implementation of Operation Phakisa Ideal Clinic Realisation & Maintenance over the next 5 years, as integral component of PHC re-engineering.
- Rationalisation of hospital services to improve efficiencies and clinical governance will receive intense attention.
- Implementation of turn-around strategies for Emergency Medical Services and Forensic Pathology Services to improve efficiencies will be operationalised and closely monitored.
- The Department will implement a comprehensive and pro-active Communication Strategy to broaden the reach to service providers, communities and stakeholders.
- Infrastructure development will remain a priority over the next 5 years and will be informed by the Long Term Plans for the Health and Infrastructure.

Goal 2: Reduce and manage the burden of disease

The Department will intensify and scale up services and programmes to:

- Reduce HIV incidence and manage HIV prevalence.
- Improve TB outcomes.
- Reduce maternal, neonatal and child morbidity and mortality and improve women's health.
- Reduce incidence of non-communicable diseases and manage prevalence.
- Reduce malaria incidence.
- Improve the nutritional status of the population.

Goal 3: Universal health coverage

- The Department will continue to implement the NHI Pilot in Umgungundlovu, Umzinyathi and Amajuba Districts including:
  - Contracting of General Practitioners to increase coverage at clinic level.
  - Rollout of the Chronic Medication Dispensing and Supply Model.
  - Implementation of the electronic patient record system (real time data).
  - Refining referral systems.

Goal 4: Strengthen human resources for health

- The Department will develop a Human Resources Long Term Plan to guide supply, demand and resource allocation.
- Costed organisational structures will be finalised.
- Performance Management and Development will be improved.
- Training in leadership and management will be scaled up and mentoring & succession training will receive more attention.
- The collaboration between the University of KwaZulu-Natal and the Department will be strengthened. Implementation of the Community-Based Training in a PHC Model will be rolled out over the next 5 years.

Goal 5: Improved quality of health care

- Implementation of the Ideal Clinic Dashboard (for PHC facilities) and National Core Standards (self-assessments and Quality Improvement Plans for hospitals) will be prioritised to improve efficiency and quality of health services.
- The Department will strengthen the contribution of research for health in evidence-based planning and practice.

I wish to express my appreciation to the Honourable MEC for Health, Dr SM Dhlomo, for his continued leadership and support. I wish to thank all my staff for their dedication and contribution to improved service delivery in KwaZulu-Natal. I am looking forward to this next phase of innovation, development and consolidation of ideas. I stay committed to work tirelessly with my staff to make all our aspirations a reality.

Dr SM Zungu

Head of Department

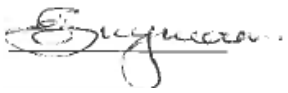
KwaZulu-Natal Department of Health

Date: 02 . 03. 2015

OFFICIAL SIGN-OFF: ANNUAL PERFORMANCE PLAN 2015/16 – 2017/18

It is hereby certified that this Annual Performance Plan:

- Was developed by the Management of the KwaZulu-Natal Department of Health under leadership of the MEC for Health Dr SM Dhlomo and Head of Department Dr SM Zungu.
- Takes into account all the relevant legislation and policies, and specific mandates for which the KwaZulu-Natal Department of Health is responsible.
- Accurately reflects the strategic outcome orientated goals and objectives which the KwaZulu-Natal Department of Health will endeavour to achieve during the 2015-2019 period.



Mrs E Snyman
Manager: Strategic Planning

Date: 2/3/2015

Mr J Govender
General Manager: Planning, Monitoring & Evaluation

Date: 2/3/2015

Mr S Mkhize
Acting Chief Financial Officer

Date: 2/3/2015

Dr SM Zungu
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Date: 02. 03. 2015

Approved by:

Dr SM Dhlomo
Executive Authority

Date: 03/03/2015

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- Provincial Service Delivery Environment
- Legislative Mandates and New Policy Initiatives
- Overview of the 2015/16 Budget and MTEF Estimates

1. STRATEGIC OVERVIEW

1.1 Vision, Mission and Values

Vision

Optimal health for all persons in KwaZulu-Natal

Mission

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

Values

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

1.2 Strategic Goals

Table 1: (A1) Strategic Goals

KZN Strategic Goals	National Development Plan	Medium Term Strategic Framework	Provincial Growth & Development Plan	Millennium Development Goals
Strategic Goal 1: Strengthen health system effectiveness	**Strategic Goal 6**: Health system reforms complete **Priority b**: Strengthen the health system **Priority c**: Improve health information systems **Strategic Goal 7**: PHC teams deployed to provide care to families & communities	**Sub-Output 3**: Implement the re-engineering of PHC **Sub-Output 4**: Reduced health care cost **Sub-Output 6**: Improved health management & leadership **Sub-Output 10**: Efficient health information management system developed and implemented to improve decision-making	**Strategic Objective 3.2a**: PHC re-engineering	
Strategic Goal 2: Reduce and manage the burden of disease	**Strategic Goal 2**: TB prevention & cure progressively improved **Strategic Goal 3**: Maternal, infant and child mortality reduced **Strategic Goal 4**: Prevalence of NCD's reduced by 28% **Strategic Goal 5**: Injury, accidents and violence reduced by 50% from 2010 levels **Priority a**: Address the social determinants that affect health and diseases **Priority d**: Prevent and reduce the disease burden and promote health	**Sub-Output 8**: HIV, AIDS & TB prevented & successfully managed **Sub-Output 9**: Maternal, infant & child mortality reduced	**Strategic Objective 3.2b**: Accelerate HIV, AIDS & STI prevention programmes **Strategic Objective 3.2g**: Accelerate programmes to improve TB outcomes **Strategic Objective 3.2f**: Accelerate programmes to improve maternal, child & women's health outcomes **Strategic Objective 3.2h**: Promote awareness programmes against substance abuse **Strategic Objective 3.2e**: Promote healthy lifestyle and mental health programmes	**Goal 1**: Eradicate extreme poverty & hunger (nutrition) **Goal 4**: Reduce child mortality **Goal 5**: Improve maternal health **Goal 6**: Combat HIV, Malaria & other diseases
Strategic Goal 3: Universal health coverage	**Strategic Goal 8**: Universal health coverage achieved **Priority e**: Financing universal health care coverage	**Sub-Output 1**: Universal health coverage progressively achieved through implementation of NHI **Sub-Output 7**: Improved health facility planning & infrastructure delivery	**Strategic Objective 3.2c**: Ensure equitable access to health services. **Strategic Objective 3.2d**: Implement the first phase of National Health Insurance pilot programme	
Strategic Goal 4: Strengthen human resources for health	**Strategic Goal 9**: Posts filled with skilled, committed & competent individuals **Priority f**: Improve human resources in the health sector	**Sub-Output 5**: Improved human resources for health		

KZN Strategic Goals	National Development Plan	Medium Term Strategic Framework	Provincial Growth & Development Plan	Millennium Development Goals
	Priority g: Review management positions and appointments and strengthen accountability mechanisms			
Strategic Goal 5: Improved quality of health care	**Priority h**: Improve quality by using evidence	**Sub-Output 2**: Improved quality of health care		

1.3 Situation Analysis

1.3.1 Demographic Profile

According to mid-year population estimates (StatsSA 2014), the KZN population increased from 10 456 909 in 2013 to 10 694 400 in 2014, and the uninsured population from an estimated 9 056 593 (2013) to 9 261 350.

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

The fertility rates in KwaZulu-Natal declined from 3.53 (2006) to 2.98 children per woman in 2014 (StatsSA) which, together with life expectancy, impacts on the demographic profile.

The life expectancy for males increased from 49.2 to 54.4 years and for females from 53.8 to 59.4 years between 2011 and 2014.

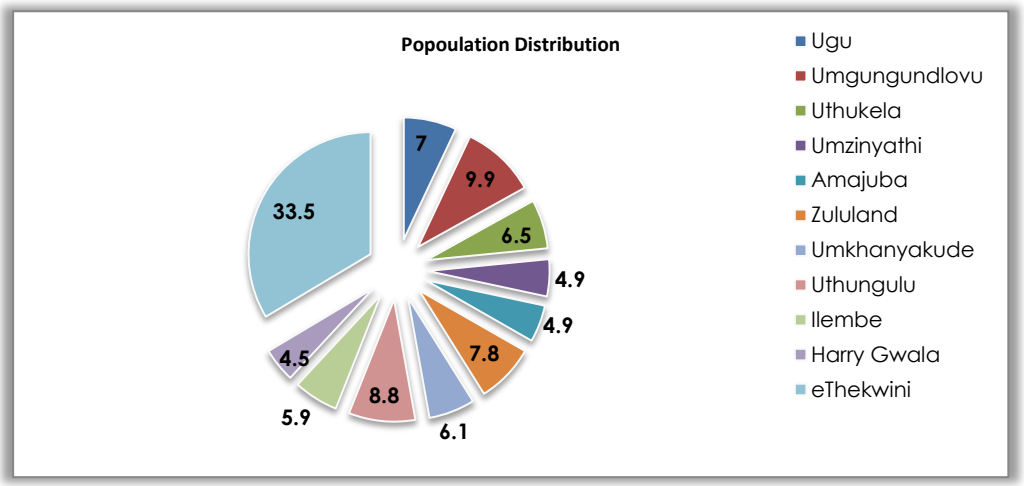
Umsunduzi (Umgungundlovu), eThekwini and Umhlatuze (Uthungulu) are considered the economic hubs in the Province as confirmed by the lower uninsured population of 80%, 84.3% and 87.5% respectively. Umkhanyakude continues to have the highest uninsured population (96.1%) followed by Uthukela (95%), both with low population densities.

Population density, one of the variables used in geo-spatial planning, varies between 48 people per km^2 (Umkhanyakude) and 1 502 people per km^2 (eThekwini). It is estimated that 25% of the eThekwini's population is living in informal settlements, which exacerbated by the burden of disease, poses unique challenges in ensuring adequate resources to manage the burden of disease. Innovation in service delivery will therefore be explored to ensure equitable access to health care in all areas.

The population of Ilembe and Ugu is mainly concentrated along the developed coastal belt with the more under-developed Tribal Authority Areas located in the "inland" sub-districts.

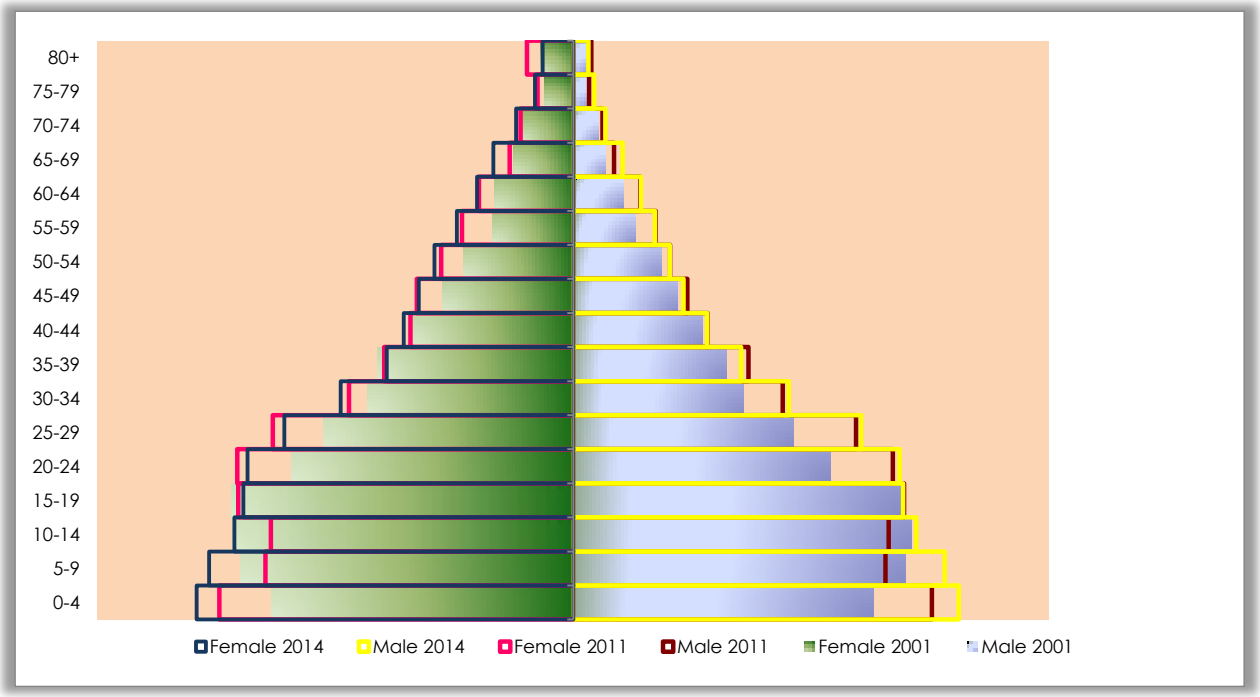
As with other districts that have a developed urban area surrounded by Tribal Authority Areas, chronic, promotive and preventative health services are often accessed from the urban centres due to convenience and ease of accessibility.

Graph 1: Population distribution per district



Source: Statistics South Africa

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



Source: Statistics South Africa

Although universal access includes both insured and uninsured people, the immediate challenge remains to improve access to the significant proportion of uninsured people (9 056 593) in the Province.

1.3.2 Socio-Economic Profile

Access to basic services improved significantly since 2001 (Table 2), although there is still a sizeable number of households without access to basic services which impacts on health outcomes. Implementation of the Provincial Growth and Development Plan, with inter-sectoral collaboration through the Office of the Premier, is expected to address the social determinants of health in a more coordinated approach.

Table 2: Social determinants of health

District	Number of households		Households with no access to piped water		Households with no access to sanitation		Households with no refuse disposal	
	2001	2011	2001	2011	2001	2011	2001	2011
Ugu	150 661	179 440	77 618	29 827	25 750	8 397	18 147	10 480
Umgungundlovu	217 558	272 666	34 289	24 290	12 702	8 394	13 698	13 337
Uthukela	134 982	147 286	44 300	29 785	24 874	12 398	23 943	15 775
Umzinyathi	93 733	113 469	52 575	38 735	41 095	14 746	28 125	15 377
Amajuba	96 670	110 963	21 018	8 540	6 285	3 874	6 755	5 183
Zululand	141 192	157 748	68 702	48 350	54 718	31 272	28 993	17 815
Umkhanyakude	101 563	128 195	58 384	48 909	57 654	23 624	28 587	15 989
Uthungulu	128 195	202 976	76 942	32 865	51 240	23 392	30 121	22 123
Ilembe	120 390	157 692	58 084	30 178	22 129	9 191	17 031	11 230
Harry Gwala	102 349	112 282	50 446	39 105	10 696	3 528	10 060	9 760
eThekwini	786 746	956 713	40 243	26 814	32 353	20 256	14 215	14 133
KZN	**2 074 039**	**2 539 430**	**582 601**	**357 398**	**339 496**	**159 072**	**219 675**	**151 202**

Source: Statistics South Africa

1.3.3 Epidemiological Profile/ Burden of Disease

Maternal, Neonatal, Child and Women's Health

The institutional maternal mortality ratio (iMMR) in KZN shows a consistent decline between 2010 and 2013 from 208.6/100 000 (2010); 186.6/100 000 (2011); 160/100 000 (2012); to 145.1 in 2013 (Provincial MaMMAS Report).

The Saving Mothers Report indicated that non-pregnancy related infections, mostly HIV, AIDS and TB, contributed most significantly to the maternal mortality over the years. This trend is similar in all other provinces (Saving Mothers Interim Report, Page 5). The decline that has been noted in the 2008 – 2010 Savings Mothers Report is believed to be due to the revision and implementation of the new PMTCT Guidelines which widened the eligibility criteria to a CD4 count of 350.

Until 2010, maternal deaths in facilities showed an increase (Table 3), especially noticeable in districts which have been reporting very high maternal deaths e.g. Uthungulu, eThekwini, Ugu and

Umgungundlovu. Four districts (Umzinyathi, Zululand, Umkhanyakude and Harry Gwala) do not have Regional Hospitals therefore increasing the burden on some Regional Hospitals.

Table 3: Maternal deaths per district

District	2009	2010	2011	2012	2013
Amajuba	11	9	6	5	10
eThekwini	124	126	122	113	97
Ilembe	19	35	12	11	21
Harry Gwala	2	7	13	14	7
Ugu	46	27	21	19	22
Umgungundlovu	21	42	49	54	34
Umkhanyakude	10	16	11	10	8
Umzinyathi	17	16	12	7	8
Uthukela	29	23	17	27	15
Uthungulu	54	49	57	52	38
Zululand	32	23	29	9	20
Province	**365**	**393**	**361**	**320**	**280**

Source: KZN MaMMAS Report

It is envisaged that the iMMR will continue to decline as a result of a number of high impact interventions including revision of the PMTCT Guidelines and implementation of Fixed Dose Combination (FDC); training of nurses and doctors on the Essential Steps in the Management of Obstetric Emergencies (all hospitals have at least one Master Trainer); appointment of District Clinical Specialist Teams (DCSTs); and revision and launch of the National Contraceptives Policy (particularly introduction of Implants).

According to the KZN MaMMAS Interim Report, maternal deaths showed a decline between 2011 and 2012 (Table 3). Deaths due to hypertension is >15% lower than the national average.

Table 4: Causes of death: Provincial MaMMAS Report

	2009	2010	2011	2012
Total maternal deaths (% decrease)	365	393	361 (8.1%)	320 (11.4%)
Causes of maternal deaths				
NPRI	176	83	157	129
ARV complications	5	15	30	12
Haemorrhage	35	38	42	42
Caesarean Section Bleeding	16	11	14	21
Hypertension	43	34	35	31
Medical and Surgical	23	38	32	43
Miscarriage	22	25	24	14

Source: KZN MaMMAS Report (Maternal Morbidity & Mortality Assessment Report)

HIV, AIDS and STIs

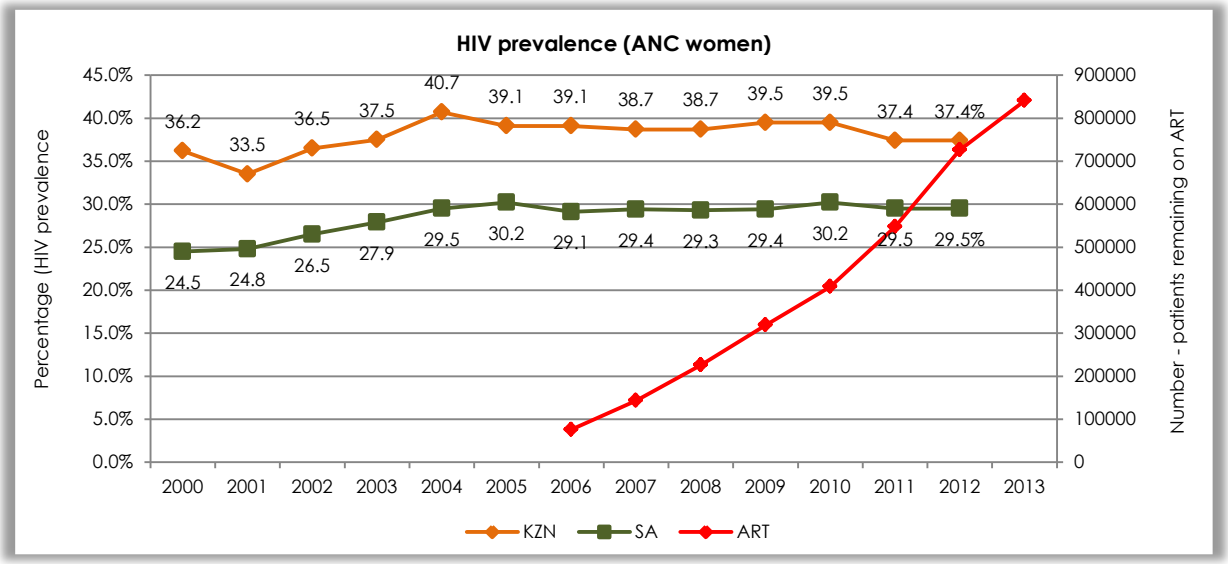
According to ASSA2008 projections, the HIV incidence is 1.01% (total general population); 3.48% (women 15-19 years); and 2.42% (youth 15-24 years). The estimated prevalence rate in the general population is 15.2%, compared to the 37.4% prevalence in antenatal women in 2011 (ANC surveillance Report).

AIDS sick patients *(untreated HIV stage 4 plus one quarter of those on ART experiencing HIV stages 5 and 6)* increased from 143 241 (2009) to 168 173 in 2013 (ASSA2008).

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

The Province reported the highest HIV prevalence among pregnant women for the past 13 years (Graph 2), with prevalence stabilising at 37.4% (35.8-39.0) in 2012 (National ANC Surveillance).

Graph 2: HIV prevalence (ANC women) and patients remaining on ART



Source: 2012 National ANC Surveillance Report and DHIS

The significant reduction in mother to child transmission of HIV (1.6% at 6 weeks) has had an impact on the number of children initiated on treatment. During 2013/14, of the 1 950 children under 1 year who were eligible for treatment, a total of 1 509 (77%) were initiated on treatment; and of the 3 076 children 1-5 years who were eligible, a total of 3 278 (106.5%) were initiated on treatment.[1]

At the end of September 2014, a total of 883 577 ART patients remained in care. The steep increase in patients on treatment is attributed to the nurse driven HIV programme at PHC level. In October 2013, a directive was issued to switch all stable Regimen 1 patients who are fully viral load suppressed to the

[1] Includes cross-border patients for initiations on treatment

Fixed Dose Combination (FDC), and at the end of 2013/14, a total of 274 151 ART patients, which included pregnant and breastfeeding women, were initiated on FDC.

Tuberculosis

The KZN TB incidence decreased from 1 149 new cases per 100 000 population in 2011 to 898 new cases per 100 000 population in 2013, and the TB death rate decreased from 5.2% to 4.7% during the same period. Drug-resistant TB is increasing with a current incidence of 26.8 cases per 100 000 population making it the highest incidence in the world. The mortality rates among MDR-TB/HIV co-infected patients are exceedingly high (71% one year mortality) with approximately 15% of MDR-TB/HIV co-infected patients receiving ART at the time of their diagnosis.

Non-Communicable Diseases

According to the World Health Organisation (WHO), non-communicable diseases constituted 63% of all deaths in 2008 including cardiovascular disease (48%), cancers (21%), chronic respiratory diseases (12%) and diabetes (3%). It is further estimated that deaths due to non-communicable diseases will increase by 17-24% in the African Region over the next 10 years. According to the 2012 General Household Survey, 19.8% of the total South African population and 20% of the population in KZN suffer from chronic diseases.

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

Diabetes incidence decreased from 3 per 1000 population (2010/11) to 1.7 per 1000 population in 2014/15, and the hypertension incidence decreased from 29.8 per 1000 population (2010/11) to 20.9 per 1000 population in 2014/15 (DHIS).

Dental caries is the most common condition affecting children in South Africa with an estimated 91% of children (6 years old) with untreated tooth decay (2012 Household Survey).

Mental Health

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

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

HIV and AIDS are associated with a significantly increased burden of neuropsychiatric disease and disability including depression, anxiety, psychosis and dementia. Mortality due to AIDS has a significant

impact on especially children whom are orphaned and therefore placing them at increased risk for mental disorders.

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

Intentional and Unintentional Injuries

The majority of admissions for injury, managed at KZN hospitals, include assault (35.5%), accidental injury (26.2%), motor vehicle accidents (19.6%), burns (8.9%), accidental poisoning (5.6%) and 4.2% snake bites (2011 KZN Hospital Survey).

In 2010, the pre-hospital trauma rate was approximately 11.6 per 1000 population and 12.9 per 1000 in public district and regional hospitals (*Brysiewicz P, Hardcastle T, Clarke D. The burden of trauma in KZN, projections for 5 years and recommendations for improved service delivery. Pietermaritzburg : KZN Department of Health, 2013*). This equated to 100 000 EMS calls for trauma and around 160 000 visits per year in public hospitals in KZN.

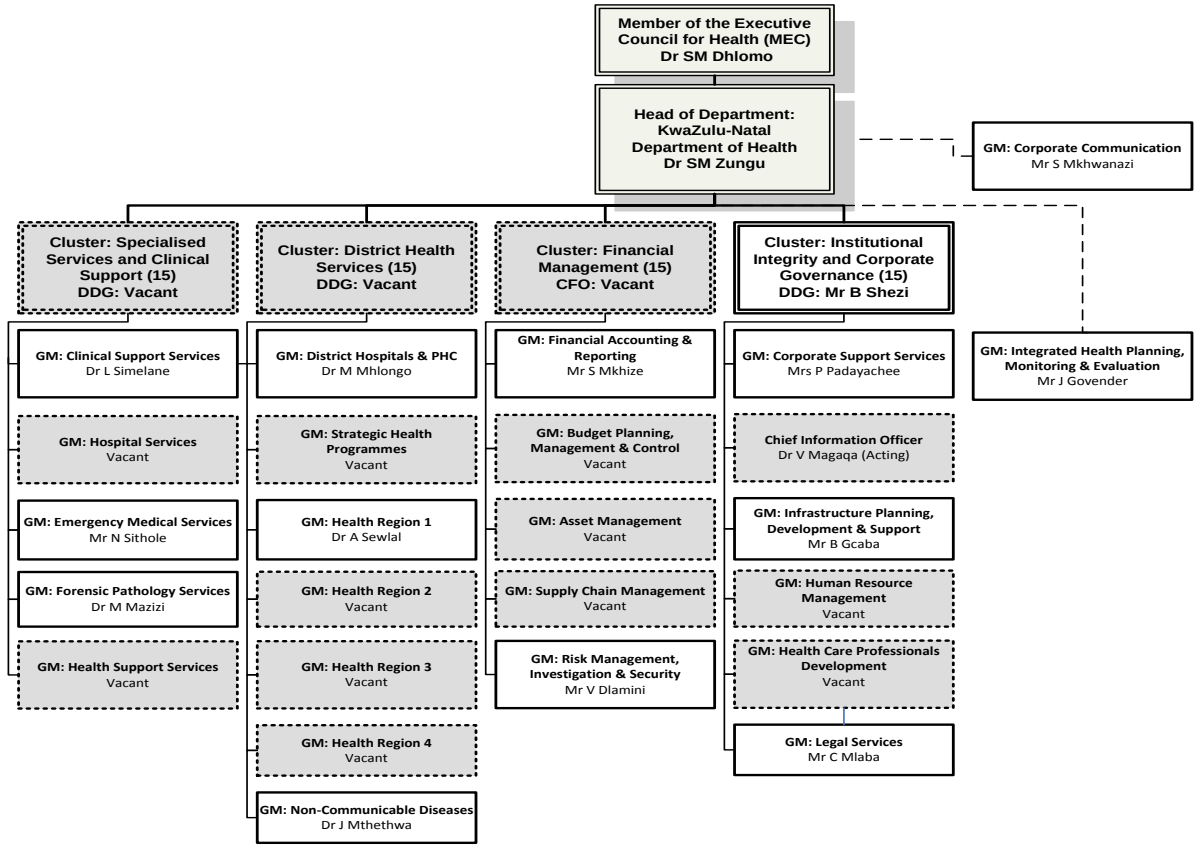
Malaria

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

The malaria incidence was 1.08 per 1000 at risk population. Between 2000 and 2013, new malaria cases decreased from 41 786 to 696 and deaths from 340 to 12 (KZN Malaria database).

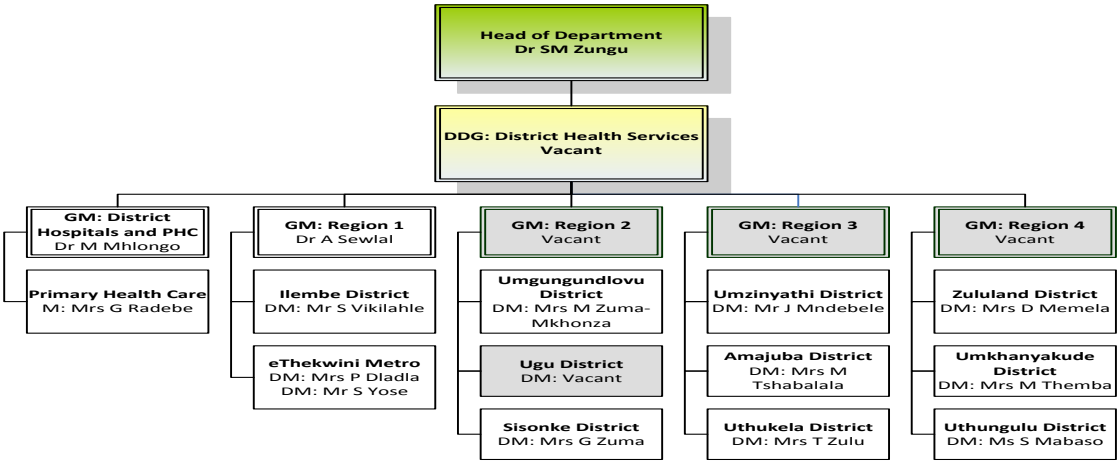
1.4 Organisational Environment

Figure 2: Macro Organisational Structure



Source: Persal and OES

Figure 3: KwaZulu-Natal Health Regions



Source: Persal and OES

Imbalances in Service Structures and Staff Mix

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

There is no current high level gap analysis on the distribution of human resources which impacts negatively on short, medium and long-term planning as well as high impact/ quick win strategies to address inequities and demand. This is considered a high risk taking into consideration the limited funding envelope and service demands.

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

Phase 1: Determine current distribution of human resources and average workload per staff category and level of care (using Persal, WISN and service delivery data), as well as a high level analysis of human resources versus service delivery platform (standard package of services per level of care) per facility. Summarise the burden of disease at municipal level to inform staffing norms/ standards in specific geographic areas.

Phase 2: Multi-disciplinary task team develop appropriate evidence-based human resource norms and standards using burden of disease data, current health care utilisation patterns, and health worker capacity. National norms and standards will be used as departure point.

Phase 3: Costing of the proposed Human Resource Plan (2014-2019) - using scenario planning. Model the additional number of staff (health care and allied health care professionals) required between 2014-2019 (using proposed norms and standards) including requirements for production of professionals by training institutions inside and outside KZN. New innovations to strengthen human resources for health will be incorporated in the model. Preliminary report expected by March 2014/15.

1.5 Provincial Service Delivery Environment

Table 5: (A2) Health Personnel – 2014/15

Categories of Staff	Number employed	% of total employed	Number per 100,000 people	Number per 100,000 uninsured people	Vacancy rate
Medical Officers	3 059	3.8%	29.3	33.8	25.2%
Medical Specialists	631	0.8%	6	*7*	27.8%
Dentists	144	0.2%	1.4	1.6	6.5%
Dental Specialists	0	0%	0	0	N/A
Professional Nurses	16 852	21%	161.2	*186.1*	10.6%
Enrolled Nurses	10 489	13.1%	100.3	115.8	5.9%

Categories of Staff	Number employed	% of total employed	Number per 100,000 people	Number per 100,000 uninsured people	Vacancy rate
Enrolled Nursing Auxiliaries	6 264	7.8%	59.9	69.2	8.5%
Student Nurses	1 621	2.0%	15.5	17.9	21.1%
Pharmacists	724	0.9%	6.9	8	15.5%
Physiotherapists	275	0.3%	2.6	3	13.0%
Occupational Therapists	177	0.2%	1.7	2	12.8%
Radiographers	573	0.7%	5.5	6.3	16.6%
Emergency Medical Staff	2 990	3.7%	28.6	33	5.6%
Nutritionists	11	0%	0.11	0.12	8.3%
Dieticians	189	0.2%	1.8	2.08	12.9%
Community Health Workers Care Givers	9 412	11.7%	90	103.9	N/A
All Other Personnel	26 842	33.4%	257	296.4	12.3%
Total	**80 253**	**100%**	**767**	**889.1**	**11.5%**

NOTE: Community Care Givers don't occupy posts on the establishment - vacancy rate is therefore not applicable (managed as abnormal appointments). Budgeting is not currently done per occupational category of staff but per programme/ institution.

Table 6: Impact indicator targets (Medium Term Strategic Framework)

Impact Indicator	Baseline (2009[2])	Baseline (2012[3])	2019 Targets (South Africa)	2012 Baseline (KZN)	2019 Target (KZN)
Life expectancy at birth (Total)	56.5 years	60.0 years (increase of 3,5years)	63 years by March 2019 (increase of 3 years)	51.5 years	60.5 years
Life expectancy at birth (Male)	54.0 years	57.2 years (increase of 3,2 years)	60.2 years by March 2019 (increase of 3 years)	49.2 years	58.4 years
Life expectancy at birth (Female)	59.0 years	62.8 years (increase of 3,8years)	65.8 years by March 2019 (increase of 3years)	53.8 years	62.7 years
Under-5 Mortality Rate (U5MR)	56 per 1,000 live-births	41 per 1 000 live-births (25% decrease)	23 per 1,000 live-births by March 2019 (20% decrease)	43.4 per 1 000 live births	40 per 1 000 live births
Neonatal Mortality Rate	-	14 per 1 000 live births	6 per 1000 live births	10.4 per 1 000 live births	6.5 per 1 000 live births
Infant Mortality Rate (IMR)	39 per 1,000 live-births	27 per 1 000 live births (25% decrease)	18 per 1000 live births	32.1 per 1 000 live births	29 per 1 000 live births

[2] Medical Research Council (2013): Rapid Mortality Surveillance (RMS) Report 2012
[3] Medical Research Council (2013): Rapid Mortality Surveillance (RMS) Report 2012

Impact Indicator	Baseline (2009[2])	Baseline (2012[3])	2019 Targets (South Africa)	2012 Baseline (KZN)	2019 Target (KZN)
Child under 5 years diarrhoea case Fatality rate	-	4.2%	<2%	4.3%	<2%
Child under 5 years severe acute malnutrition case fatality rate	-	9%	<5%	10.9%	6%
Maternal Mortality Ratio	304 per 100,000 live-births	269 per 100,000 live-births	Downward trend <100 per 100,000live-births by March 2019	165 per 100,000 live births (institutional)	100 per 100,000 live births (institutional)

1.5.1 Service Delivery Progress against the Negotiated Service Delivery Agreement

Output 1: Increasing Life Expectancy

Health is one of the contributing factors to an increase in life expectancy, which depends on a wide variety of other internal and external factors including broader development policies and other social, economic and environmental factors. It is therefore positioned as an overarching measure of all aspects of development including but not limited to health. All sub-outputs therefore add value to Output 1.

Sub-Output 1.1: Strengthening Governance Arrangements

The establishment of the Provincial Health Council (12 August 2012) and appointment of 5 District Health Councils in 2013 including Amajuba (April); Uthungulu (April); Umkhanyakude (July); Harry Gwala (July) and Umgungundlovu (November) strengthened governance structures within KwaZulu-Natal.

The annual Provincial Consultative Health Forum summits have been hosted annually since 2010/11.

In line with the requirements of the Mental Health Care Act, four Mental Health Review Boards were established.

Hospital Boards and Clinic Committees: 95% of hospitals have functional Hospital Boards; and 89.5% CHC's and 95.1% clinics have Clinic Committees.

Sub-Output 1.2: Eradicating Malaria

Table 7: Malaria performance measures

Indicator	Baseline (2010/11)	Target (2014/15)	Performance (2013/14)	
Malaria incidence per 1000 population at risk	0.03 per 1000 at risk population	<1 per 1000 at risk population	1.08 per 1000 population at risk	
Malaria case fatality rate	1.13%	<1%	1.7%	

Source: KZN Malaria Database

There are 3 Malaria Parasitology Laboratories with rapid testing available in Umkhanyakude (the main endemic district). There are 39 decentralised malaria camps and 39 malaria surveillance agent teams for active surveillance.

Ongoing assessment of antimalarial drug efficiency confirmed that anti-malaria drugs are still effective with no signs of resistance. Modernisation of home furnishings is however a challenge to indoor residual spraying which compromises the effectiveness of spraying. Cross border cases increase the reported number of malaria cases and deaths.

Sub-Output 1.3: Strengthening response to social determinants of health

Devolution of Municipal Health Services commenced and has been finalised in Harry Gwala (August 2012) and Amajuba (January 2013). Umkhanyakude (90%) and Umgungundlovu (70%) still need to be concluded. *Ward-based coverage of households* has been improved through implementation of the integrated provincial Flagship Programme (Operation Sukuma Sakhe – OSS) and integrated implementation of the Provincial Growth and Development Plan (PGDP).

Sub-Output 1.4: Revitalising Emergency Medical Services

Table 8: Emergency Medical Services performance measures

Indicator	Baseline (2010/11)	Target (2014/15)	Performance (2013/14)	
1. Rostered ambulances per 10 000 people	0.22	0.34	0.20	
2. EMS P1 rural response under 40 min rate	37%	80%	31%	
3. EMS P1 urban response under 15 min rate	29%	50%	6%	
4. EMS P1 call response under 60 min rate	53%	70%	44%	

Source: EMS Database

The Provincial *ambulance to population ratio* (1:49 558) is below the national norm of 1:10 000. The shortfall of 754 ambulances at an approximate cost of R527.8 million (±R 700 000 per ambulance) imposes significant pressure to the limited budget available to improve EMS services. The high accident rate and extended repair time for ambulances negatively affects the operational ambulances and response times.

Air Medical Services: Services are provided by Air Mercy Services (AMS) using 2 rotor wing aircraft (helicopters) and 1 fixed wing aircraft. On the 4th of September 2014, the Premier, Honourable Senzo Mchunu, launched the revolutionary Aero-Medical Night Vision Goggles system for Helicopter Emergency Services (HEMS), which increased operational times from daylight time to 24 hour services.

Flying doctor services: Flying doctor service flights are coordinated out of Durban (King Shaka international airport) and Pietermaritzburg, and during 2014/15, a total of 229 Specialists supported 43 Hospitals (December 2014).

Ambulance bases: There are 72 ambulance bases, with Wentworth refurbishment 100% complete; King Dinuzulu Medium Base in the design phase; and Dannhauser Medium Base, Pomeroy Small Base and Jozini Medium Base in construction phase. The Umzinyathi large base project has not commenced as planned as a result of budget constraints in Programme 8. The project has been re-prioritised for 2016/17.

Human Resources: During 2013/14, a total of 78 new operational EMS personnel were recruited including 21 Intermediate Life Support (Obstetrics); 2 Emergency Care Technicians (Obstetrics); 19 Basic Life Support (Operations); 5 Advanced Life Support (Operations); and 31 Shift Leaders (Operations).

Vehicle Tracking System: A vehicle management and recovery system (real time tracking) contract has been awarded to Altech Netstar in 2013/14 to improve the management of vehicles, and tracking units have been installed in 652 vehicles. Software to monitor vehicles has been installed at the Wentworth Communications Centre and training has been conducted for both operations management responsible for fleet management and District Management.

Inter-Facility Transport: Demand still superseded supply with approximately 50% of all inter-facility transportation for emergency inter-facility transport, which contributed to poor response times.

Planned Patient Transport (PPT): The PPT hub system was introduced in Empangeni, Durban and Pietermaritzburg to improve coordination.

Output 2: Decreasing Maternal and Child Mortality

Sub-Output 2.1: Reducing Infant and Child Morbidity and Mortality

Table 9: Child health performance measures

Indicator	Baseline (2010/11)	Target (2014/15)	Performance (2013/14)	
1. Child under 5 severe acute malnutrition case fatality rate	12.1%	10.2%	9.7%	
2. Diarrhoea with dehydration incidence (children under 5)	27/1000	14.2/1000	15/1000	
3. Child under 5 diarrhoea case fatality rate	7.1%	3.6%	3.3%	
4. Rota Virus 2nd dose coverage	90.9%	90% in all districts	91.9%	
5. Pneumonia incidence (children under 5)	147/1000	97.6/1000	92.2/1000	
6. Child under 5 pneumonia case fatality rate	5.4%	2.9%	3.2%	
7. PCV 3rd dose coverage	97.9%	90% in all districts	85.7%	
8. Immunisation under 1 year coverage	85%	90% in all districts	85.8%	
9. Measles 1st dose under 1 year coverage	88%	90% in all districts	84.5%	

Indicator	Baseline (2010/11)	Target (2014/15)	Performance (2013/14)	
10. Child under 5 years severe acute malnutrition incidence	7 per 1000	6 per 1000	5.6 per 1000	
11. Vitamin A 12 – 59 months coverage	32.6%	51% in all districts	47.8%	

Source: DHIS

The main causes of child morbidity and mortality in KwaZulu-Natal remain diarrhoea, pneumonia, malnutrition, HIV/AIDS, and neonatal causes. The non-availability of reliable community-based surveillance data to verify the impact of child health programmes remains a challenge.

Malnutrition: There has been an overall increase in case detection in all categories of malnutrition i.e. mild, moderate and severe. In some districts under-performance was attributed to increased case detection at PHC level due to intensification of awareness by PHC staff supported by IMCI training. Training for both in-patient and out-patient staff in hospitals, on the assessment and classification of acute malnutrition in children under 5 years, was conducted and outcomes are being monitored to assess the impact. Case detection has improved through active implementation of IMCI and the "Find, Assess, Classify and Treat" Algorithm.

National Integrated Nutrition Programme: The programme targeted Vitamin A supplementation to children and mothers; the promotion of exclusive breastfeeding; provision of therapeutic supplements including to ART clients; and the appropriate management and increased early detection of malnutrition should improve child mortality and morbidity in the Province.

Phila Mntwana Centres: The establishment of Phila Mntwana Centres (552) commenced in 2013/14 to promote and improve monthly growth monitoring; education and provision of oral rehydration; support for breastfeeding; and identification of children with incomplete immunisation schedules. Integration with PHC re-engineering and OSS has again been prioritised to reach more children at household level.

Immunisation: The RED (Reach Every District) Strategy, together with other community-based services, has been prioritised in especially districts with coverage below 90%, as immunisation remains one of the priority pillars of child health programmes. Under-performance against immunisation targets are being investigated.

Sub-Output 2.2: Reducing Maternal and Neonatal Morbidity and Mortality

Table 10: Maternal and neonatal performance measures

Indicator	Baseline (2010/11)	Target (2014/15)	Performance (2013/14)	
1. Institutional maternal mortality ratio	170 per 100 000	133 per 100 000	147 per 100 000	
2. Antenatal 1st visits before 20 weeks rate	36%	60%	56.2%	
3. Mother postnatal visit within 6 days rate	31%	73.3%	71%	
4. Infant 1st PCR test positive within 2 months rate	6.8%	1.2%	1.6%	
5. Neonatal mortality in facility rate	10.4 per 1000	10 per 1000	10.3 per 1000	

Source: DHIS

CARMMA: The main challenges identified to improve maternal and neonatal health outcomes remain: (a) The negative impact of HIV and AIDS; (b) Late booking for antenatal care; (c) Poor post natal care; and (d) Delays in clients reaching health facilities during labour. To combat these challenges, the Province launched CARMMA in May 2012 and since has actively implemented the programme.

ESMOE (Essential Steps in Management of Obstetric Emergencies): Complete midwife-doctor teams for ESMOE have been established in 51 hospitals and 191 Master Trainers have been trained. At least one clinician per hospital was included in the training.

Waiting Mothers Lodges and Midwifery Obstetric Units: The expansion of specific infrastructure to address challenges related to maternal mortality has been completed with the establishment of 10 Waiting Mothers Lodges to accommodate high risk pregnant women. There are no facilities in Ilembe, Ugu and Umgungundlovu Districts. Twenty (20) Midwife Obstetric Units (MOU's) have been established to provide basic emergency obstetric care to pregnant women and 40 Obstetric Ambulances are operational to improve access to maternal and neonatal emergency care.

Antenatal Care: The number of pregnant women accessing antenatal care services before 20 weeks has increased by 16.6% as has the upward trend in postnatal follow-up visits (within 6 days of delivery). This can be attributed to the increase in the number of mobiles (93) that offer ANC services allowing for improved community based services.

Prevention of Mother to Child Transmission of HIV: The Province adopted a cohesive multi-pronged approach towards reducing the mother to child transmission by establishing community structures in all districts and sub-districts to provide the platform for community leaders and civil society to engage with the social issues fuelling the epidemic. The programme focusses on (1) Primary prevention of HIV (HCT Campaign: Know Your Status, Anti-Sugar Daddy Campaign); (2) Prevention of unwanted pregnancies (5-Point Contraceptive Strategy); (3) Prevention of vertical transmission (PMTCT); and (4) Care and treatment of mothers, children and families (PHC ART initiation and NIMART).

ZAZI Communication Strategy: The Department developed the strategy for women and girls aiming to empower women and young girls in prevention of HIV; prevention of unwanted/teen pregnancies; prevention of gender-based violence and PEP; promoting healthy pregnancies for all women including early antenatal care booking, HIV testing and access to treatment for women living with HIV; and promoting post natal care and support including the uptake of exclusive breastfeeding.

Prevention of Mother to Child Transmission of HIV: The KZN PMTCT Programme received a nomination for the United Nations Dr L Jong-Wook Memorial Award in 2013/14 based on the remarkable results achieved in the PMTCT programme.

MomConnect: The mobile technology project is a collaborative pilot project in Umgungundlovu and eThekwini that aims to test the efficacy of personalised, unique antenatal and postnatal SMS reminders, to support pregnant women, irrespective of their HIV status, to improve health outcomes. It provides the mother with a toll free number to use for health messages. The system is centrally controlled and monitored to ensure that all queries are responded to promptly. At the end of October 2014, a total of 20 523 mothers-to be have been registered with Mom-connect.

Sub-Output 2.3: Improving Women's and Reproductive Health

Table 11: Sexual and reproductive health performance measures

Indicator	Baseline (2010/11)	Target (2014/15)	Performance (2013/14)	
1. Couple year protection rate	24.1%	45%	45%	
2. Cervical cancer screening coverage	57.4%	79.7%	75.3%	

Source: DHIS

Cervical and Breast Cancer Screening: The Phila Ma Campaign was re-launched by the MEC for Health in April 2013 to re-affirm the strategy. The programme enjoys the patronage of the First Lady Ms Thobeka Madiba Zuma. Through Phila Ma, the Department aims to rally business, health care institutions, families, and communities to play a participatory role in preventing cervical and breast cancer. Adequacy rates (Pap smears) improved from 37% (2012/13) to 46.4% in 2013/14. Delays in referred clients accessing treatment due to the limited number of facilities providing treatment is still a challenge. This will be addressed pending availability of funding for the purchase of equipment.

The HPV vaccine programme, targeting all Grade 4 girls, 9 years and older, was launched by the Minister of Health on 12 March 2014. The Province vaccinated 86% (68 593/79 657) eligible girls during the first campaign (10 March to 11 April 2014) and 72% during the second campaign (29 September to 31 October 2014).

Choice on Termination of Pregnancy (CTOP): The CTOP Policy was reviewed in 2013/14 and includes Medical Termination of Pregnancy. The number of facilities providing CTOP services increased from 16 (2012/13) to 19 in 2013/14. According to DHIS, termination of pregnancies increased with 80.5% between 2009/10 and 2012/13 with 2.5% of these terminations for women under the age of 18 years. Thirty health care workers attended a five day Values Clarification workshop to improve attitudes towards provision of CTOP services, and 10 PNs completed a 5-day training course in Medical Abortion.

Contraceptive Services: The Contraceptive Campaign was launched by the National Minister of Health on 27 February 2014 and will continue to 31 March 2015. The campaign aims to accelerate universal access to contraceptive services as a gate way to reach the South Africa's Millennium Development Goals, the Maputo Plan of Action, CARMMA, prongs one and two of the PMTCT strategy, as well as the goals of Family Planning 2020. A total of 12 community dialogues were conducted during 2013/14, which informed the Provincial communication strategy to improve communication on sexual and reproductive health and rights through OSS.

Prior to the official launch, the Province trained 2 000 health care workers on the insertion and removal of Implanon the new implant. To date, a total number of 189 503 implants were inserted with the highest demand in the age group 18 and 25 years.

Output 3: Combating HIV and AIDS and decreasing the Burden of Disease from Tuberculosis

Sub-Output 3.1: Reducing HIV Incidence and Managing HIV Prevalence

Table 12: HIV, AIDS and STI performance measures

Indicator	Baseline (2010/11)	Target (2014/15)	Performance (2013/14)	
1. Clients remaining on ART (TROA) at end of month	408 238	1 038 556	840 738	
2. Number of male medical circumcisions (Cumulative)	33 817	631 374	304 886	
3. Male condom distribution rate	8.1	64	41.2	
4. STI treated new episode incidence	65/1000	20/1000	63/1000	

Source: DHIS

The introduction of OSS, with direct access to the HIV/AIDS and TB coordinating structures, ensures that coordination and monitoring is linked to an implementation mechanism and hence, a greater level of accountability. This enables the Province to decentralise planning to the local level including integration of HIV, AIDS and TB into Integrated Development Plans at municipal level.

Medical Male Circumcision (MMC): Since the launch of MMC in April 2010, a total of 304 886 males (all ages) have been circumcised (134,146 in 2013/14) using the Tara Klamp and conventional methods. There are 25 MMC high volume sites in health facilities, each doing a minimum of 35 circumcisions per day. Fifteen roving teams provide MMC outreach services in identified facilities. A total of 1 563 health care workers have been trained at the Northdale Hospital.

The Department contracted 57 traditional MMC coordinators as part of the strategy to mobilise Traditional Leaders and Healers to support MMC. Coordinators mobilise males through the Traditional Leadership structures; distribute condoms and MMC promotional material at community level; monitor MMC clients before and after the procedure; and promote safer sexual behaviour. All circumcised males are inaugurated (Ukubuthwa) annually by His Majesty the King, which is part of behaviour change as the young men graduate to manhood. Dialogues with men "Men's convocation/ Isibaya samadoda" have been prioritised to expand discussions with men on men and family health in an effort to capacitate men as change agents for health in their families and communities. The introduction of the Medical Male Circumcision Truck, fully equipped with a reception area, 4 beds, and diathermy machine and other equipment for doing circumcision is expected to further increase access to MMC.

HIV Counselling and Testing (HCT): Available in all public health facilities and 105 non-medical sites including tertiary institutions, truck stops, taxi ranks, farms and non-governmental organisations. Since 2010, more than 2.5 million clients were counselled and tested for HIV through district campaigns including the Hlola, Manje Zivikele; First Things First and Graduate Alive campaigns in tertiary facilities. HCT has been integrated with health services at taxi ranks targeting taxi owners, drivers, hawkers and commuters. Five taxi ranks in eThekwini are being serviced once a week using mobile units. This will be rolled out to the rest of the Province in the next MTEF. The Department procured 5 mobile units that will be used to target key population groups and hard to reach areas. The noted decrease in the HIV positivity rate, from 15.6% (2012/13) to 13% in 2013/14 is encouraging and an indication that prevention strategies are beginning to show positive outcomes.

Weekly multi-sectoral Nerve Centre meetings, in partnership with the Office of the Premier, ensure that all District and Local AIDS Councils and Districts participate in prevention strategies and collectively monitor performance.

Inadequate space at clinic level remains a challenge which is expected to get worse as more clients use PHC services for ART initiation and management. The limited funding envelope delays interventions to address this challenge and alternatives are being explored as part of the re-engineering of PHC.

High Transmission Areas (HTA's): The Department established 92 HTA intervention sites. Seven truck stops provide services for truck drivers with a total of 13 356 truck drivers reached with services in 2013/14. The formalisation of a partnership between the Department of Correctional Services and the Department of Health in 2012/13 resulted in the sustainable Prevention Action Campaign "Hlola Manje, Zivikele" in Correctional facilities.

Post Exposure Prophylaxis (PEP): The number of PHC facilities that provides PEP increased from 90 (2012/13) to 110 in 2013/14, and 50 health care workers received three days training in the management of sexual assault. During 2013/14, children under the age of 12 years accounted for 40.5% of sexual assault cases (or 4 695 children).

Condom Distribution (Barrier methods): During 2013/14, the Province distributed 135 977 783 male and 3 268 241 female condoms from health facilities and non-health outlets with non-traditional outlets, including tribal courts and private companies such as the South African Breweries joining the Department in distributing condoms. An average of 6 000 male condoms are being distributed to taverns with each alcohol beverage delivery. CCG's distribute 200 condoms per household during household visits; Developmental Partners and NGOs distribute condoms from their service points; condoms are also distributed from doctor's rooms; and districts have established secondary distribution sites to improve condom access at the hard to reach areas. National condom stock outs remain one of the main challenges.

Sub-Output 3.2: Improving TB Outcomes

Table 13: TB performance measures

Indicator	Baseline (2010/11)	Target (2014/15)	Performance (2013/14)	
1. TB (new pulmonary) cure rate	68.2%	85%	81.8%	
2. TB (new pulmonary) defaulter rate	7%	4.5%	4.8%	
3. TB new client treatment success rate	69%	85%	85%	

Source: ETR.Net

Drug-Resistant TB: There are 8 DR-TB (Drug-Resistant Tuberculosis) management units in the Province (7 decentralised and 1 centralised) with no decentralised units in Ilembe, Amajuba and Uthukela Districts. Patients from these districts are initiated on treatment at King Dinuzulu Hospital in eThekwini. In 2014/15, four decentralised XDR-TB initiation sites has been targeted at Murchison, Greytown M3, Thulasizwe and Manguzi Hospitals, which will have an immediate impact on the workload at King Dinuzulu Hospital.

The extended waiting list at King Dinuzulu Hospital (managing all provincial TB drug resistant children, XDR-TB patients and referrals from districts with inadequate resources which accounts for 30% - 40% of the overall workload) is a concern, and confirms the urgency to develop more decentralised units to reduce waiting times and workload in the hospital. Once the outpatient department in King Dinuzulu has been commissioned, the TB ward will be commissioned which will increase the number of TB beds in eThekwini from 377 to 590. To further reduce the workload at King Dinuzulu, infrastructure upgrades at Madadeni, Estcourt and Montebello Hospitals have been prioritised for the next MTEF.

The expansion of integrated community based services, including community based management of MDR-TB, can be attributed to the expansion of integrated community services; scale up of outreach/surveillance teams, advances in diagnostic technology testing; and utilisation of evidence (research) to improve system efficiencies and clinical care.

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

The Province received 73 GeneXpert machines for systematic rollout in phases. To date, 38 machines have been installed in eThekwini (13), Harry Gwala (7 small machines), Umgungundlovu (4 medium machines), Ilembe (3) and Amajuba (3). Uthukela does not have access at all while the rest of the districts (Umzinyathi (2) Uthungulu (2), Umkhanyakude (2) Zululand (2) have limited access. Ugu district does not have machines but has full access to the test through machines at eThekwini.

TB case notifications have decreased year on year regardless of intensified case finding strategies including door to door TB screening, TB screening as part of HCT, and strengthened community-based services through PHC re-engineering and OSS.

Laboratory coverage for microscopy is good with 80 microscopy centres within KwaZulu-Natal, although culture services are still centralised in one laboratory at Inkosi Albert Luthuli Central Hospital. This centralisation of laboratory culture services impacts on result turn-around times and delays diagnosis and timeous treatment.

Output 4: Strengthening Health System Effectiveness

Sub-Output 4.1: Re-Engineering of PHC

Table 14: PHC re-engineering performance measures

Indicator	Baseline (2010/11)	Target (2014/15)	Performance (2013/14)	
1. PHC utilisation rate	2.5	3	3.1	
2. Utilisation under 5 years	4.5	5	4.4	
3. Number of Ward-Based PHC Teams	N/A	95	109	
4. PHC supervisor visit rate	63.3%	66.4%	62.2%	
5. Number of School Health Teams	87	159	176	
6. Number of District Clinical Specialist Teams	N/A	11	11 (not complete)	

Source: DHIS; DHS Database

Local Government clinics in all districts have been provincialised, with the exception of eThekwini Metro and Umhlathuze Municipality in Uthungulu. Services in these 2 areas are being rendered through a Service Level Agreement.

The introduction of PHC Outreach Teams as one of the four pillars of PHC re-engineering, will be closely monitored to determine the impact of the burden of disease, patient activity and economies of scale.

Provincial and municipal health services remain the main providers of PHC services with both increasing their "market" share by 1%. Provision of health services by other services providers has decreased

overall by 2%, therefore increasing the burden on provincial health services. The headcount in mobile services increased with 16% with the improvement of access of PHC services.

The professional nurse (PN) per 100 000 population increased to 145 showing an increase in the number of PN's at PHC level in relation to population. It is however evident that although the headcount has increased, the PN per 100 000 headcount (workload) remains consistent at 50 PN's per 100 000 headcount, indicating that the increase in staff has been parallel to the increase in headcount despite the increase in PN's per population.

The workload variations fluctuate with numerous contributing factors including the number of clinics in each district, extended opening hours and the vertical structures implemented at a PHC level for different programmes.

Eskom donated a customised Primary Health Mobile Clinic to provide high end health care services to primary school learners in Uthukela and Thabo Mofutsanyane Municipality. The learners will inter alia have access to eye care, dental hygiene and general health check-ups.

Through a partnership with SANTACO and allied Taxi Associations, the Department is rendering health services at taxi ranks in eThekwini; Amajuba; Ulundi; Umzinyathi and Umgungundlovu which is benefiting taxi bosses; drivers; assistants; vendors and passengers who leave home early and come back when clinics are closed.

On 28 November 2014, the Department launched the "Mobile Hospitals" with the theme: "Bringing Health Services Closer to Communities and Making PHC Re-Engineering a Reality in Readiness for NHI". Mobile Hospitals will be deployed in areas with high population densities without fixed clinics or hospitals where it will be stationed for a period of 1 week before it moves to another area. The full PHC package of services will be rendered by qualified personnel.

Ideal Clinics: There are 2 recognised Ideal Clinics in KZN i.e. Efaye and Phatheni Clinics. A baseline self-assessment conducted in 2014/15 indicated that out of 288 assessed clinics, 68 (23.6%) scored between 0-49%; 149 (51.7%) scored between 50-69%; and 70 (24.3%) scored between 70-100% against the Ideal Clinic Dashboard standards (Version 6.4).

National Health Insurance

Implementation of NHI is on track in the three NHI Pilot Districts with the following relevant activities:

- Completed the information baseline survey to monitor progress.
- Research commenced to determine the root cause of poor PHC/ ward supervision.
- Piloting of patient held record booklets in one municipality.
- Internet connectivity prioritised for the introduction of electronic patient records.
- Piloting and refining an improved referral system.
- Testing M&E systems and processes to improve data quality and reporting.
- Allocation of equipment in all facilities.
- Contracting of Private Practitioners.

To date (December 2014) there are 36 Family Health Teams; 47 School Health Teams; 9 District Clinical Specialists; 25 Contracted Family Medical Practitioners; 138 Phila Mntwana Centres; 36 Pharmacist Assistants; 2 Dental Assistants; 31 Chronic Medication Distribution Sites; and 1 712 CCG's in the NHI District.

The Department was acknowledged by the Director of the Presidential Monitoring Team, Mugivhela Rambado, as pronounced in the 10 September 2014 New Age publication: "We have made several unannounced visits to a number of state hospitals and clinics across the country and have to say that KZN leads the way in how they manage their service delivery and quality of care in their health facilities despite challenges they face. They are setting an example in how we want our facilities to operate within an NHI context".

Sub-Output 4.2: Improving Patient Care and Satisfaction

According to a 2013/14 National Core Standard assessment conducted by the Health Systems Trust:

- 80% of facilities showed an improvement in staff attitudes.
- 92% of facilities were compliant with the Patient Safety and Security criteria.
- 83% of facilities demonstrated improvement in cleanliness (assisted by the National Cleanest Government Project Initiative).
- 100% of facilities were compliant with criteria for Availability of Medicines and Blood Products.
- Patient Waiting Times: Outpatients (33%); Pharmacy (67%); and Patient files (42%).

The National Core Standards are implemented in all health facilities. Self-assessment and quality improvement programmes will receive intensive attention in the coming MTEF.

Sub-Output 4.3: Improving Health Infrastructure Availability

At the end of 2013/14 there were 12 new clinics under construction and 3 new CHCs with expected completion in 2014/15 (Dannhauser in Amajuba, Pomeroy in Umzinyathi and Jozini in Umkhanyakude. Infrastructure upgrades have commenced at the Inanda and Phoenix CHCs (eThekwini) and Phase 2 construction of Gamalakhe CHC (Ugu).

The following hospital projects are under construction: Greys (neonatal intensive care unit); Bethesda (new paediatric ward and 20-bed mother's lodge); Stanger (new labour and neonatal block); Church of Scotland (new paediatric ward); Prince Mshiyeni Memorial (nursery); KwaMagwaza (maternity upgrade); and Emmaus (maternity and nursery).

It is anticipated that the completion of the following infrastructure projects will improve maternal and child health outcomes, namely new maternity and paediatric wards at Untunjambili and Mosvold Hospitals; neonatal intensive care unit at Ladysmith Hospital; and Mother's Lodges at Niemeyer Memorial and Lower Umfolozi War Memorial (60 beds) Hospitals.

A number of facilities have been upgraded to improve TB management and outcomes including 40-bed MDR-TB facilities at Catherine Booth and Manguzi Hospitals. A Parkhome (60 bed) has been commissioned at Thulasizwe Hospital to replace the condemned buildings. A 97-bed TB ward at Murchison Hospital is due for completion, and installation of new air conditioning to the new TB multi-storey block in King Dinuzulu Hospital continues – the new TB complex and TB OPD is planned for commissioning in 2014/15. The Department continues to improve the ventilation in all health facilities as part of infection prevention and control.

The Department built/ refurbished the Wentworth Emergency Management Centre and base station and the KwaMashu base station.

The following medico-legal mortuaries have been upgraded: Gale Street (eThekwini); Newcastle (Amajuba); Richards Bay (Uthungulu); and Port Shepstone (Ugu). The Department is in the process to commission the new Phoenix forensic mortuary (460-body storage) to a value of R92.9 million.

To date, the Department has spent R46 million towards upgrading of the following Nursing Colleges: Charles Johnson Memorial, Edendale, Addington and the Greys Hospital Nursing Home.

During 2013/14, the Department upgraded laundry equipment in 30 hospital on-site mini laundries, and invested R210 million on upgrading of the Prince Mshiyeni Laundry. The second production line is expected to open in 2015/16. This will improve service reach to 11 hospitals. Design of the Dundee Laundry is at an advanced stage.

The Department embarked on a process to upgrade existing hospitals to improve physical infrastructure of existing hospitals as part of the improved health service platform. Major projects include: Emmaus – OPD, casualty & related facilities (R132 237 million), GJ Crookes – casualty, trauma and admissions (R 138 000 million), Stanger – new labour and neonatal ward and upgrading of existing psychiatric ward (R 146 290 million), Rietvlei – Admin, kitchen audio, ARV and staff accommodation (R127 097 million), Edendale – OPD, accident and emergency, CDC/ARV and psychiatric ward (R178 383 million), Lower Umfolozi War Memorial – upgrade and additions (R500 743 million), and Addington – repair & upgrade core block façade, operating theatres and maintenance (R206 866 million).

Sub-Output 4.4: Improving Human Resources for Health

The DPSA has approved the macro organisational structure in late 2013 and the Department commenced with alignment of this structure to micro structures. WISN, currently implemented as pilot project in the NHI districts, will be used to guide the review of institutional structures.

The Department introduced an exit notice delivery register to monitor turnaround time from notice to completion of all exit processes, and in partnership with the Government Pension Administration Agency (GPAA) an "e-channel" or online system to process pension benefits of employees that have exited.

Between October 2013 to February 2014, the Department conducted a diagnostic audit of leave files (1 July 2000 to date) including terminations and turnaround time with regards to payment of benefits after exit and timeous exit of an employee on the Persal system to prevent overpayment. Results informed improved processes that will lead to better audit outcomes in respect of leave management.

The University of Pretoria facilitated financial management training in partnership with National Treasury and Office of the Premier, to seventy five (75) Chief Executive Officers from eleven Districts.

Further capacitation of staff took the form of the Department enrolling Senior Managers in management/ leadership programmes including the Albertina Sisulu Executive Leadership Programme (ASELPH) Masters in Public Health at University of Pretoria (11); Master's Degree at the University of Fort Hare (11); Master's in Public Health through the University of KwaZulu-Natal (12); Oliver Tambo Fellowship programme through the University of Cape Town (3 District Managers completed the programme); Applied Population Science and Research Programme (APSTAR) through UKZN (3). Seven students were enrolled in the Clinical Associates Programme at the Walter Sisulu University.

To improve maternal health outcomes, the Department is investigating the development of a cadre of "midwife surgeons" based on a model that was explored during a study visit to Mozambique in 2013. The proposed model will be submitted to the World Health Organisation for support prior to implementation.

The collaboration between UKZN and the Department made significant progress with regards to the training of doctors and allied health professionals. Negotiations are at an advanced stage to conclude a new Memorandum of Understanding which will consolidate the training and development platform for these categories of staff in a mutually beneficial manner. The proposed model will support PHC re-engineering and ensure seamless alignment between the training and service delivery platforms.

Development of a "new" Decentralised PHC Training Model for medical professionals in conjunction with UKZN, when implemented, will be a first for South Africa. Selection of students and allocation of bursaries will be sensitive to quintile 1 and 2 areas to promote equity in opportunities and is expected to improve retention of staff.

Community Service Officials, were allocated throughout the Province including 199 Medical Officers; 32 Dentists; 44 Pharmacists; 12 Clinical Psychologists; 32 Dieticians; 8 Environmental Health Officers; 57 Occupational Therapists; 53 Physiotherapists; 67 Radiographers; 48 Speech Therapists & Audiologists; and 294 Professional Nurses.

The Department career pathed 1 364 CCG's in to nursing and nutrition fields as Nursing Assistants and Nutritional Advisors as part of the development obligation and to strengthen community-based PHC re-engineering.

Sub-Output 4.5: Strengthening Health Information Systems

In response to the poor accountability and ownership of data at facility level, the Department introduced a verification form from each hospital and district office. During the reporting period, district submission to Province was 100%, while two districts did not comply with submission requirements for hospital verification forms. This practice has seen noted improvement in data since CEO's are getting more involved with the review and verification of facility data.

The Department conducted 141 facility visits during 2013/14 to monitor compliance to information management policies and SOPs and provide technical support and development in relation to performance information and data quality.

With financial support from a Development Partner, two Data Quality Assurance Officers were employed during the reporting period to audit facilities in the Province. The two officers also provided support with training and development contributing to a notable improvement of data in targeted facilities. Mthimude Clinic in Ugu recorded a clean audit during the preliminary audit by the National AGSA, and the Province was invited to share improvement strategies at the National Health Information System of South Africa (NHISSA) meeting at the National Department of Health.

The update of District Health booklets incorporating information from the 2011 census was finalised in 2013/14. The Department also provided support for the incorporation of spatial data in the Decongestion Strategy for eThekwini as part of a study done by King Dinuzulu Hospital.

The number of research applications submitted to the Provincial Health Research and Ethics Committee has increased from 121 to 363 over the past 6 years. This is encouraging in light of the renewed efforts to improve evidence-based practice and planning. Most research processed by the Health Research and Knowledge Management Unit is for academic purposes, and most is conducted in the eThekwini Metro and Umgungundlovu District.

The Department aims to strengthen the research ethos within the Department to increase the number of research projects conducted primarily to improve health and health care in the Province.

The KZN Provincial Health Research and Ethics Committee (PHREC) was appointed in 2013 with membership including representatives from the KZN Department of Health, research and academic institutions in KZN, the private medical sector, and communities. The Umgungundlovu Health Ethics Review Board has been constituted, and is in the process of registering with the National Health Research Ethics Council.

Health research priorities were finalised during 2013/14 and are available on the following link (http://healthweb.kznhealth.gov.za/hrkm.htm). Research questions are being communicated to research and academic institutions to inform their research agenda. Compilations of research/ literature reviews are also available on the Departmental website.

Based on the survey of hospital admissions conducted in 2012/13, district analyses were done for all districts in KZN during 2013/14. Analysis presented the demographic profile and major causes of admission, categorised according to ICD code for a sample of district, regional and tertiary hospitals in the province. This information facilitates decentralised planning and contextualises the unique situation of each district. See study reports on (http://healthweb.kznhealth.gov.za/epidemiology.htm). An important limitation of this analysis is the small sample size due to limited funding.

The Department completed an analysis of the early warning systems within the Department (http://healthweb.kznhealth.gov.za/epidemiology.htm). The analysis covered systems for environmental health, communicable diseases, financial services and human resources management. Cross cutting issues that needed to be addressed in all of these systems included:

- Staffing numbers, distribution, and management of staff (Management of accountability, discipline and grievance issues; and Training and role clarification)
- Reporting channels: standardisation and avoidance of duplication
- Management (Monitoring (of staffing, activities, expenditure); and Internal control processes)
- Equipment including timeous ordering and maintenance.

Appropriate reporting tools and processes have been developed to improve provincial and district reporting. An assessment of reporting quality was conducted in 2013/14 which resulted in the amendment of reporting tools that will be implemented in 2014/15. The Department intensified technical support to districts and facilities in 2013/14 to address various data quality challenges.

Review of the various M&E structures, including roles and responsibilities, commenced in 2013/14 and is expected to be finalised in 2014/15.

Output 5: Preventing and Managing Non-Communicable Diseases

Table 15: Non-communicable diseases performance measures

Indicator	Baseline (2010/11)	Target (2014/15)	Performance (2013/14)	
1. Hypertension incidence	29.8/1000	22.8/1000	21.9/1000	
2. Diabetes incidence	3/1000	2.1/1000	1.3/1000	
3. Number of accredited Health Promoting Schools	188	295	245	
4. Cataract surgery rate	757/1mil	749/1mil	758.1/1mil	

Source: DHIS; Health Promoting Schools Database

The Department finalised the first draft of the Non-Communicable Disease Strategy and Mental Health Care Strategy and will both be finalised for implementation in 2014/15 onwards.

Disability and Rehabilitation: The Provincial Policy Guideline for Provision of Assistive Devices, approved in 2013/14, is standardising provisioning of assistive devices. Approximately 90% of health facilities have at least one Therapist available to improve access to rehabilitation services. The shortage of Therapists is a challenge although the allocation of Community Service Therapists has made it possible for communities and districts that did not have any form of rehabilitation service in the past to improve access. Space constraints and shortage of assistive devices and equipment receives attention. The Department strengthened partnerships with NGOs and Disabled People Organizations to improve rehabilitation services at community level, wheelchair repair and maintenance, and provision of services for the blind. Planning for the establishment of a Stroke Unit commenced in 2013/14.

Chronic Diseases and Geriatrics: Support groups for older persons have been established at health facilities to encourage participation in healthy life style programmes, and screening for hypertension, blood sugar levels, and eye testing, and weighing form part of the routine agenda.

In 2013/14, 20 454 flu vaccines were administered to older persons.

Eye Health: Orbis International signed an MOU with the Department to establish Comprehensive Child Eye Health Services in the Province. The project was launched with three principal objectives:

- To establish a Child Eye Health Tertiary Facility at IALCH. The project commenced.
- To strengthen the referral network and follow-up system for paediatric eye care. The project made considerable progress.
- To increase public awareness to ensure early detection and treatment of children with eye conditions. The project commenced.

Four hospital-based skills transfer programmes, designed in partnership with local child eye health staff, have been conducted at IALCH, Edendale and Greys Hospitals. Medical staff, volunteered by Orbis, assisted with training targeting Ophthalmologists, Anaesthesiologists, Biomedical Technicians, Nurses, and other essential eye care personnel in the areas of blindness prevention and treatment.

As part of the agreement with the Department of Health, Orbis Africa provided surgical and diagnostic equipment with the objective to improve access to services and improve quality of eye health services. To date, Orbis has contributed R 3 382 818 towards the project.

The Department is at an advanced stage in establishing specialist eye care services at McCords Hospital.

Mental Health: Implementation of the Mental Health Strategy 2014-2019 commenced in 2014/15 with focus on integration at PHC level to increase access and improve management of mental health care users. Implementation of the Out-Patient Community-Based Substance Abuse Model commenced at KwaMashu and Turton CHCs. The model includes strategies to reduce injuries and violence and will be rolled out to other facilities in coming years.

A Provincial Service Package for Psycho Social Rehabilitation has been finalised, enabling the Department to focus on projects most beneficial to end users. The package of services for Community Mental Health has been finalised in 2013/14 – awaiting approval.

Mental Health Review Boards have been established in all Health Regions in keeping with the Mental Health Care Act, 2002 (Act No. 17 of 2002). District Mental Health Forums have been established in all districts to (a) promote inter-sectoral collaboration; (b) ensure improved utilisation of available resources; and (c) strengthen advocacy.

HIV, AIDS and Mental Health programmes have been integrated with the psycho social support programme to improve mental well-being of all people living with HIV and AIDS. Screening and monitoring of psychological development of infants and children under 5 years, and depression in ante- and post natal women, has been improved through integration between the mental health and MNCWH programmes.

School Nurses from 7 districts have been trained on mental health promotion, provision of psycho social support and screening of children for psycho social problems using relevant screening tools.

Qualified psychological counsellors have been appointed to provide psychological services at CHC's, and 29 NGOs have been subsidised to provide rehabilitation services to chronic mental health care users. Vocational rehabilitation programmes are being implemented in rural districts, prioritising Regions 3 and 4.

The Department conducted 24 inspections of Substance Abuse Treatment Centres and Half-Way Houses to confirm registration and licensing.

Treatment centres are mostly located in urban areas with two State Rehabilitation Centres in Madadeni (Newcastle) and Newlands Park Centre in Durban. Inadequate access results in a high relapse/ low recovery rate, and, as a result, the Department initiated a Community-Based Model which has been rolled out to CHC's and Gateway Clinics at some hospitals.

Oral Health: The placement of 34 Community Service Dentists strengthened Oral Health services at PHC level. The Department recruited 21 Oral Hygienists to strengthen the Oral School Health Programme and facilities started the recruitment process for additional Oral Hygienists in institutions.

Three Dental Mobile Units have been deployed in eThekwini, Umzinyathi and Umgungundlovu Districts. Four Dental Therapists and 2 Dental Assistants have been appointed for the mobile units.

During the reporting period, the Department has managed to provide 161 dental prosthetics to patients including dentures, obturators, and orthodontic appliances.

1.6 Legislative Mandates and New Policy Initiatives

There are no 'current' specific court rulings that have a significant, ongoing impact on the operations or service delivery obligations of the Department.

1.6.1 Constitutional Mandates

The Constitution of the Republic of South Africa (Act No. 108 of 1996): In terms of the Constitutional provisions, the Department is guided by amongst others the following sections and schedules:

Section 27(1): "Everyone has the right to have access to … health care services, including reproductive health care".

Section 27 (2): The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

Section 27(3): "No one may be refused emergency medical treatment".

Section 28(1): "Every child has the right to …basic health care services…"

Schedule 4 list health services as a concurrent national and provincial legislative competence.

Section 195: Public administration must be governed by the democratic values and principles enshrined in the Constitution.

Section 195 (1b): Efficient, economic and effective use of resources must be promoted.

Section 195 (1d): Services must be provided impartially, fairly, equitably and without bias.

Section 195 (1h): Good human resource management and career development practices, to maximise human potential must be cultivated.

1.6.2 Legal Mandates

In carrying out its functions, the Department is governed mainly by the following national and provincial legislated Acts and Regulations. Some of the legislation has a specific/ direct impact on the Department whereas others have a more peripheral impact.

Basic Conditions of Employment Act (Act No. 75 of 1997): Provides for the minimum conditions of employment that employers must comply with in their workplace.

Child Care Act, 74 of 1983: Provides for the protection, welfare and treatment of certain children and to provide for incidental matters.

Choice of Termination of Pregnancy Act (Act No. 92 of 1996, as amended): Provides a legal framework for termination of pregnancies (under certain circumstances) and based on informed choice.

Chiropractors, Homeopaths and Allied Health Service Professions Act, 63 of 1982: Provides for the control of the practice of the professions of Chiropractors, Homeopaths and Allied Health Professions, to determine its functions and matters connected therewith.

Dental Technicians Act, 19 of 1979: Consolidate and amend laws relating to the profession of Dental Technician and to provide for matters connected therewith.

Division of Revenue Act (Act 7 of 2003): Provides for the manner in which revenue generated may be disbursed.

Health Professions Act (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.

Human Tissue Act (Act No. 65 of 1983): Provides for the administration of matters pertaining to human tissue.

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.

Labour Relations Act (Act No. 66 of 1995): Provides for the law governing labour relations and incidental matters.

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

Mental Health Care Act (Act No. 17 of 2002): Provides a legal framework for mental health and in particular the admission and discharge of mental health patients in mental health institutions.

National Health Act (Act No. 61 of 2003) and Amendments: Provides for a transformed National Health System to the entire Republic.

National Health Laboratories Services Act (Act No. 37 of 2000): Provides for a statutory body that provides laboratory services to the public health sector.

Nursing Act (Act 33 of 2005): Provides for the regulation of the nursing profession.

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

Public Finance Management Act (Act No. 1 of 1999 as amended) and Treasury Regulations: Provides for the administration of State funds by functionaries, their responsibilities and incidental matters.

Preferential Procurement Policy Framework Act (Act No. 5 of 2000): Provides for the implementation on the policy for preferential procurement pertaining to historically disadvantaged entrepreneurs.

Public Service Act (Act No. 103 of 1994) and the Public Service Regulations: Provisions for the administration of the public service in its national and provincial spheres, as well as provides for the powers of ministers to hire and fire.

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

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

Traditional Health Practitioners Act (Act No. 35 of 2004): Regulates the practice and conduct of Traditional Health Practitioners.

1.6.3 Policy Mandates

Clinical Policies and Guidelines: The Department is implementing and monitoring a considerable number of clinical health policies to improve management and clinical outcomes.

National and Provincial Data Management Policies: Provides the framework for effective management of health information at all levels of reporting.

Financial Management Policies: The Department generates financial management policies that are aligned with legislative and Treasury Regulations.

Provincial Health Research Policy and Guidelines: Provides the policy framework and guidelines for health research.

Human Resource Policies: The Department contributes to and develops numerous Provincial Human Resource Policies to ensure compliance to human resource imperatives.

Policy on National Health Insurance (Green Paper 2011): Provides for systems strengthening to ensure universal access to health care.

Policy on Management of Hospitals: Provides the policy imperatives for management of Public Health Hospitals.

Regulations Relating to Classification of Hospitals: Provides the policy framework for classification of Public Health Hospitals.

1.6.4 Planning Frameworks

The National Development Plan 2030

The National Development Plan (NDP) was adopted by government and will be implemented over three electoral cycles of government.

2030 Vision

A health system that works for everyone produces positive health outcomes and is accessible to all. By 2030, South Africa should have:

1. Increased life expectancy, for both males and females, to at least 70 years.
2. Produced a generation of under-20 year olds that are largely HIV free.
3. Reduced the burden of disease radically compared to the previous two decades.
4. Achieved an infant mortality rate of less than 20 deaths per 1000 live births.
5. Achieved an under-5 mortality rate of less than 30 deaths per 1000 live births.
6. Achieved a significant shift in equity, efficiency and quality of health care provision.
7. Achieved universal coverage for health.
8. Significantly reduced the social determinants of disease and adverse ecological factors.

Goals and Expected Outcomes

The NDP sets out 9 long-term health goals for South Africa. Five of these goals relate to improving health and well-being, and four describe health systems strengthening.

Goal 1: Average male and female life expectancy increased to 70 years.

- Mother to child transmission rates decrease to less than 2%.
- New HIV infections reduce with more than 4 times among women between 15-24 years.
- All HIV positive people are on ARV's.
- Consistent condom use.
- Effective microbicides are available to all women 15 years and older.
- Universal availability of post-exposure prophylaxis with ARV's.

Goal 2: Tuberculosis prevention and cure progressively improved.

- Reduced TB rates among adults and children.
- Successful treatment completion.
- Progressive decline in the latent infection rate amongst school-age children.

- TB contact indices decreased.
- Increased number of latently infected people receiving six month IPT.

Goal 3: Reduced maternal, infant and child mortality.

- Reduce the maternal mortality ratio from 500 to less than 100 per 100 000 live births.
- Reduce the infant mortality rate from 43 to less than 20 per 1 000 live births.
- Reduce the under-5 mortality rate from 104 to less than 30 per 1 000 live births.

Goal 4: Reduced prevalence of non-communicable chronic diseases by 28%.

- Cardiovascular diseases.
- Diabetes.
- Cancer.
- Chronic respiratory diseases.

Goal 5: Reduced injury, accidents and violence by 50% from 2010 levels.

- Motor vehicle accidents (MVA).
- Violent crimes.
- Inter-personal crimes.
- Substance abuse.

Goal 6: Complete health systems reforms.

- Revitalised and integrated health system.
- Evidence-based public and private health system.
- Clear separation of policy making from oversight and operations.
- Authority is decentralised and administration devolved to the lowest levels.
- Clinical processes are rationalised and systematic use of data incorporating community health, prevention and environmental concerns.
- Infrastructure backlogs addressed, including greater use of Information Communication Technology (ICT).

Goal 7: Primary Health Care Teams provide care to families and communities.

- Teams consisting of nurses, doctors, specialists and physicians established.
- Each household have access to a well-trained Community Care Givers (CCG's).
- Schools receive health education by teachers and health teams.
- PHC teams have adequate resources for delivery of services.

Goal 8: Universal health care coverage achieved.

- All people have equal access to quality health care regardless of income.
- Common health fund ensures equitable access to health care.

Goal 9: Posts filled with skilled, committed and competent individuals.

- Increased capacity for training of health professionals.
- Train more health professionals to meet requirements of re-engineered PHC.
- Link training of health professionals to future diseases, especially categories of non-communicable diseases.
- Set procedures of competency criteria for appointment of hospital managers.
- Set clear criteria for removal of under-performing hospital managers.

NDP Actions to Achieve the 2030 Vision

The NDP identifies a set of nine priorities with key interventions that will be required to achieve a more effective health system.

1. *Address the social determinants affecting health and diseases.*

    - Early childhood development.
    - Collaboration across sectors/ departments.
    - Promote healthy diets and physical activity (culture established in communities and at work).

2. *Strengthen the health system.*

    - Results-based health system especially at district level.
    - Appropriate and effective information systems.
    - Public-private partnerships to support improved service delivery.
    - Leadership and management: Organisational review in line with vision; improve technical capacity at national/provincial levels to improve guidance and support; improve functional competence to address silo funding and operation.
    - Improve accountability to users by establishing an effective governance and management framework.
    - Additional capacity and expertise: Strengthen results-based system specifically at district level.
    - Establish the Office of Standard Compliance to monitor compliance to national norms and standards.

3. *Improve health information systems.*

    - Prioritise the development and management of effective information systems.
    - Regular independent data quality audits.
    - Develop an effective information system for human resources including training.
    - Strengthen the culture of using information for planning and decision-making.
    - Accommodate expansion of data use e.g. sentinel sites and annual facility surveys to update routine basic information including infrastructure, HR, equipment, and other.
    - Improve access to digital information.

4. *Prevent and reduce the disease burden and promote health.*

    - Integrated approach in addressing HIV, AIDS and alcohol abuse.

5. *Financing the health system.*

    - Establish mechanisms to improve cost controls.

6. *Improve human resources in the health sector.*

    - Community-based health care including PHC teams and CCG's (propose 6 CCGs per PHC team; one CCG to 250 households or 1 000 people).
    - Accelerate production of appropriately skilled nurses; prioritise training of Advanced Midwifes; and review training curricula.
    - Doctor and specialist support teams including increasing family physicians with a public health qualification.
    - Rapid investment in health personnel development.

7. *Review management positions and appointments and strengthen accountability mechanisms.*

- Strengthen Human Resource Management including Performance Management.
- Collaborate with Traditional Healers.

8. *Improve quality by using evidence.*

- Use evidence to inform planning, resource allocation and clinical practice.
- Improve evaluation and use of information for decision-making.

9. *Meaningful public-private partnerships*

The Medium Term Strategic Framework 2014-2019

Sub-Outcome 1: Universal health coverage progressively achieved through implementation of National Health Insurance.

- Phased implementation of the building blocks of NHI.
- Establishment of NHI fora for engagement of non-state actors.
- Strengthen the input from patients on their experience of health services.
- Reform of Central Hospitals to increase their capacity for local decision-making and accountability to facilitate semi-autonomy (NDOH).

Sub-Outcome 2: Improved quality of health care.

- Establish an operational Office of Health Standards Compliance (NDOH).
- Appointment of the Ombudsperson and establishment of a functional office (NDOH).
- Improve compliance with the National Core Standards.
- Monitor the existence of and progress on annual and regular plans that addresses breaches of quality, safety and compliance in the public sector.
- Improve the acceptability, quality and safety of health services by increasing user/ community feedback and involvement.

Sub-Outcome 3: Implement the re-engineering of Primary Health Care.

- Expand coverage of ward-based PHC outreach teams.
- Accelerate appointment of district clinical specialist teams.
- Expand and strengthen integrated school health services.
- Ensure quality PHC services with optimally functional clinics by developing all clinics into Ideal Clinics.
- Improve intersectional collaboration with a focus on population wide community based interventions (promote healthy lifestyles) and address social and economic determinants of Non-Communicable Diseases.
- Reduce risk factors for Non-Communicable Diseases (NCD's) by designing and implementing a mass mobilisation strategy focusing on healthy options including the reduction of obesity.
- Improve awareness and management of prevalence of NCD's through screening and counselling for high blood pressure and raised blood glucose levels.
- Expand rehabilitation services.
- Screen the population for mental health disorders.
- Contribute to a comprehensive and inter-sectoral response by government to violence and injury.

Sub-Outcome 4: Reduced health care costs.

- Establish a National Health Pricing Commission to regulate health care in the private sector (NDOH).

Sub-Outcome 5: Improved human resources for health.

- Increase production of Human Resources of Health.
- Finalise and adopt Human Resources for Health norms.
- Produce, cost and implement Human Resource for Health Plans.

Sub-Outcome 6: Improved health management and leadership.

- Improve financial management skills and outcomes.
- Improve district health governance and strengthen management and leadership.
- Ensure equitable access to specialised health care by increasing the training platform for medical specialists.
- Establish the Academy for Leadership and Management in Health to address skills gap at all levels of the health care system (NDOH).

Sub-Outcome 7: Improved health facility planning and infrastructure delivery.

- Improve the quality of health infrastructure in SA by ensuring that all health facilities are compliant with facility norms and standards.
- Construct new clinics, community health centres and hospitals.
- Undertake major and minor refurbishment of health facilities.
- Strengthen partnership with the Department of Public Works to accelerate infrastructure delivery.

Sub-Outcome 8: HIV & AIDS and Tuberculosis prevented and successfully managed.

- Maximise opportunities for testing and screening to ensure that everyone in South Africa (including Correctional Services) has an opportunity to test for HIV and to be screened for TB at least once annually.
- Increase access to a preventive package of sexual and reproductive health services including medical male circumcision and provision of male and female condoms.
- Implement essential interventions to reduce HIV mortality.
- Improve the effectiveness and efficiency of the TB control programme.
- Improve TB treatment outcomes.
- Implement interventions to reduce TB mortality.
- Improve the effectiveness and efficiency of the MDR-TB control programme.
- Combat MDR-TB by ensuring access to treatment.

Sub-Outcome 9: Maternal, infant and child mortality reduced.

- Improve the implementation of Basic Antenatal Care.
- Expand the Prevention of Mother to Child Transmission coverage for pregnant women.
- Protect children against vaccine preventable diseases.
- Expand access to sexual and reproductive health by expanding availability of contraceptives and access to cervical cancer screening and HPV vaccine.

Sub-Outcome 10: Efficient health management information system developed and implemented for improved decision-making.

- Develop a complete system design for a national integrated patient based information system (NDOH).

The Provincial Growth and Development Plan

Vision

By 2030, KwaZulu-Natal will be a prosperous Province with a healthy, secure and skilled population, acting as a gateway to Africa and the world.

PGDP Strategic Goals

Strategic Goal 1: Job Creation.

Strategic Goal 2: Human Resource Development.

Strategic Goal 3: Human and Community Development.

Objective: The health of the KZN population is improved.

- *Development and implementation of a comprehensive PHC system.*
- *Accelerate HIV and AIDS intervention programmes.*
- *Ensure equitable access to health services.*
- *Support the implementation of the National Health Insurance System.*
- *Promote healthy lifestyle and mental health programmes.*
- *Accelerate programmes to improve maternal, women and child health outcomes.*
- *Accelerate programmes to improve TB outcomes.*
- *Promote awareness programmes against substance abuse.*

Strategic Goal 4: Strategic Infrastructure.

Strategic Goal 5: Environmental Sustainability.

Strategic Goal 6: Governance and Policy.

Strategic Goal 7: Spatial Equity.

16.5 Planned Policy Initiatives

The following National and Provincial Policies, Frameworks and Strategies are relevant:

- *Millennium Development Goals*: Target programmes specific to achievement of the targets e.g. child and women's health, HIV and AIDS, TB, Malaria and Nutrition. Other transversal services will be attended to in support of these programmes/ services.

- *Medium Term Strategic Framework 2014-2019*: Based on the NDP priorities and provides the framework for the 2015-2019 Strategic Plan and five Annual Performance Plans.

- *Negotiated Service Delivery Agreement (NSDA)*: The reviewed NSDA for Health will be aligned with sector priorities included in the MTSF to ensure effective monitoring of performance targets nationally.
- *Provincial Growth and Development Plan*: Based on the NDP and Provincial priorities. Alignment with the Strategic Plan and five Annual Performance Plans will improve monitoring, evaluation and reporting on provincial priorities.
- *Provincial Service Transformation Plan:* The plan will provide the blue print for short, medium and long term planning of the Department and will be based on evidence and projected service demands taking into consideration current service gaps and the burden of disease.
- *Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA)*: The programme will be expanded to improve maternal and child health outcomes.
- *Integrated Chronic Disease Management Model*: The Model will be rolled out and policies will be reviewed
- *National and Provincial Strategic Plans for HIV, AIDS, STI and TB 2012-2016*: Implementation will continue.
- *KwaZulu-Natal Monitoring and Evaluation Framework*: The current Framework will be reviewed in 2015/16 to ensure effective monitoring, evaluation and reporting.
- *Medical Male Circumcision Escalation Plan:* MMC will be scaled up as part of the Prevention Programme for HIV, AIDS, STI and TB.
- *National Human Resource for Health Strategy 2012-2016*: Human resource audit, gap analysis and costing; decentralised training platform (with UKZN); organisational review (micro structures) will be targeted over the reporting period.
- *National Nursing Strategy 2012-2016*: Training and development plan (included in HRD Plan) will be aligned with the Long Term Human Resources Plan.
- *National and Provincial Strategies for Non-Communicable Diseases 2014-2019*: The Provincial strategy will be finalised and rolled out in a phased approach taking into account the funding envelope.
- *National and Provincial Contraceptive Strategies*: Implementation will be scaled up as part of the intensified sexual and reproductive health strategy to improve health outcomes.
- *National and Provincial MNCWH Strategies 2012-2016*: Implementation will be scaled up.
- *Provincial Neonatal Strategy*: The strategy will be scaled up to all facilities and relevant policies will be developed or reviewed.
- *PHC Re-Engineering:* PHC re-engineering will be scaled up with a strong focus on community-based services and system strengthening.
- *Provincial Mental Health Care Strategy 2014-2019*: The Provincial strategy will be finalised and rolled out using a phased approach taking into consideration the funding envelope.
- *Clinical policies*: Review where indicated - new policies developed in line with needs.
- *Emergency Medical Services*: Implement turn-around strategy based on independent analysis.

- *Forensic Pathology Services*: Finalise and implement the Provincial Optimisation Plan.
- *Revitalisation of hospital services*: A comprehensive Hospital Rationalisation Plan will be developed in 2015/16 to guide implementation at all levels. The Implementation Plan, as part of the strategic approach in the plan, will inform annual priorities and targets.
- *Data Management Policy*: Effective management of health information through the District Health Information System will be monitored robustly.
- *Provincial Poverty Eradication Strategy*: The Department will implement services aligned with imperatives set out in the KZN Poverty Eradication Master Plan to ensure integrated reporting on targets.
- *Operation Phakisa: Ideal Clinic Realisation and Maintenance*: This will form part of PHC re-engineering and improved quality and access at PHC level. The focus will be on the following streams to achieve Ideal Clinic status in all PHC clinics: (1) Service delivery; (2) Waiting times; (3) Human resources; (4) Infrastructure; (5) Supply Chain Management; (6) Finance; (7) Institutional arrangements; and (8) Change Management, Scale-up and sustainability. Cross cutting issues that will be addressed include: Leadership; Accountability; Capacity & skills; and Delegations. The Provincial Strategy will be developed within the approved National Operation Phakisa Framework.

1.7 Strategic Planning Process

To ensure a comprehensive inclusive top-down-bottom-up consultation process, the Department embarked on the following process that will be concluded in February 2015. The final Strategic Plan 2015-2019 and Annual Performance Plan 2015/16 – 2017/18 will be tabled in the Provincial Legislature in March 2015. District Health Plans will be finalised in March 2015.

Consultation Process

Phase 1: Review April – July 2014	Health review and situation analysis to determine current status of health services *(Annual Report 2013/14 tabled in August 2014)*.
Phase 2: 2014-2019 Vision August – September 2014	Senior Management (ManCO, Regional and District Managers), Health Portfolio Committee and Organised Labour. On 18-20 September 2014, Senior Management (with representation from Organised Labour) adopted the draft Vision, Mission, Core Values, Strategic Goals, Priorities and Expected Outcomes based on presentations by the MEC for Health and Head of Department (within frameworks of the NDP 2030 and MTSF 2014-2019). On 23 September 2014, the draft priorities were presented to the Health Portfolio Committee.
Phase 3: Operationalise October – November 2014	Extended consultation with Senior Managers, Programme Managers (Head Office), District Management Teams, Hospitals and facilities, NGO's, Development Partners, Higher Education, etc. to operationalise identified priorities. Finalise strategies and performance measures. First alignment of service delivery and budget.
Phase 4: Finalise and Table December 2014 - February 2015	Final re-prioritisation, review of performance measures and budget allocation. Tabling final Plans.

1.8 Overview of the 2015/16 Budget and MTEF Estimates

In the 2015/16 MTEF, the following changes have been made to the Department's baseline:

- Carry-through costs of the 2014 wage agreement.
- Additional funding related to the purchase of St Aidans Hospital.
- Reduced budget related to the functional shift of Port Health Services to the National Department of Health.
- Ceasing of funding for the "takeover" of McCord Hospital in 2017/18.

Most programmes show sustained growth from 2011/12 to 2017/18, with Conditional Grants accounting for a significant portion of this increase. The allocation for the Health Facility Revitalisation Grant declines to zero in the outer years due to the reforms that were made to the provincial infrastructure grant system that are intended to institutionalise planning for infrastructure. This affects Programme 8: Health Facilities Management and *Buildings and other fixed structures* in 2016/17 and 2017/18.

The increase over the 2015/16 MTEF incorporates the carry-through costs of previous wage agreements, the increases to existing Conditional Grants, as well as R42.661 million additional funding in 2016/17 for the roll-out of the HPV vaccine.

Programme 1: The increase in 2013/14 and 2014/15 Revised Estimates was due to pressures from forensic investigations, communications and computer services. The negative growth in 2015/16 is attributed to a decision to utilise internal capacity to conduct disciplinary inquiries, with only complex cases to be referred to consultants.

Programme 2: The increase in the 2014/15 Revised Estimates is due to the filling of critical posts for community outreach programmes and the roll out of Flu and HPV vaccines with no funding received from the National Department of Health. The 2015/16 MTEF includes funding for the carry-through costs of previous wage agreements and general capacity building, as well as strong growth in the Comprehensive HIV and AIDS Conditional Grant, particularly in 2016/17.

Programme 3: The increase in the 2015/16 MTEF allocation includes carry-through costs for the various wage agreements, OSD payments, funding to expand emergency medical services, as well the carry-through costs of the danger allowance.

Programme 4: The 2015/16 MTEF includes carry-through costs for previous wage agreements and an increase in general health capacity.

Programme 5: Revised Estimates are mainly related to the filling of critical posts to strengthen the neonatal services. The 2015/16 MTEF includes carry-through costs of previous wage agreements.

Programme 6: Growth over the 2015/16 MTEF accounts for inflation only.

Programme 7: Funding for inflationary increases only has been provided over the 2015/16 MTEF, with a more significant increase in 2016/17 for the anticipated need to top-up the Medicine Trading Account.

Programme 8: The significant reduction over the 2015/16 MTEF is due to the previously mentioned reduction to zero in the Health Facility Revitalisation grant. As mentioned, baseline cuts were effected against both the equitable share and conditional grants, as well as funding re-prioritised from the equitable share portion of this programme, to other programmes, to cover the cost of commissioning facilities which have been completed and for which no funding was provided, for example, King Dinuzulu Hospital, Dannhauser CHC, Pomeroy CHC and clinics.

Compensation of employees shows a strong upward trend from 2011/12 to 2016/17, mainly due to the carry-through costs of the various OSDs for medical personnel and other staff categories, as well as higher than anticipated wage agreements. The increase in 2014/15 is due to pressures from the unfunded takeover of McCord Hospital (R53 million), the 2014 annual wage agreement being higher than budgeted (R171 million) and the absorption of staff (mainly community service) with contractual obligations (R70 million). The growth over the 2015/16 MTEF is mainly for inflationary adjustments.

Goods and services increases substantially from 2011/12 to 2016/17. This increase is primarily related to the increase in demand for health services, the high rate of inflation on medical supplies and services, as well as increased catering and fuel costs. Other contributing factors are the increasing demand for ART, treatment of MDR/XDR TB, the introduction of specific projects such as the reduction of infant and child mortality through immunisation, the HPV vaccine campaign, as well as a substantial increase in the Comprehensive HIV and AIDS Grant. The increase in 2014/15 Revised Estimates relates to the acceleration in the maintenance and repairs of existing facilities, pressures in forensic investigations, IT services and consultants. In addition, there are pressures against medicine (increased demand for HPV and flu vaccines and oral contraceptives), increased contract prices for medical supplies and security, patient catering, groceries. The growth over the 2015/16 MTEF, and particularly in 2016/17, includes additional funding for ARV treatment, the carry-through costs of national priority initiatives, acceleration in the day-to-day maintenance of existing facilities, as well as inflationary adjustments.

The erratic trend from 2011/12 to 2013/14 against *Transfers and subsidies to: Provinces and municipalities* was mainly due to the non-signing of SLAs by municipalities. The increase in 2014/15 relates to funding provided for the commitment to assist the municipal clinics in the treatment of HIV and AIDS, as well as funding for carry-over payments from 2013/14 following delays in the signing of SLAs with the eThekwini Metro and Umhlathuze Municipality. Most municipal clinics were taken over by the Department by the end of 2012/13. Funding has only been provided for the eThekwini Metro Municipality for the 2015/16 MTEF against this category, two clinics in uMhlathuze were provincialised in 2014/15. The increase over the 2015/16 MTEF, and particularly in 2016/17, caters for the commitment to assist the non-provincialised municipal clinics in the treatment of HIV and AIDS.

Transfers and subsidies to: Departmental agencies and accounts: The increasing trend over the 2015/16 MTEF provides for the HWSETA levy, in line with the growth in *Compensation of employees* and the increased demand for ARV medication, as well as the provision for the HPV vaccine in 2016/17.

Transfers and subsidies to: Households: The declining trend in 2015/16 is due to the once-off nature of the litigation costs in 2013/14, while the slower growth over the remainder of the MTEF is attributed to the need to scale down the number of new bursaries to be awarded, due to budget cuts, as well as the difficulty in estimating the litigation and staff exit costs.

Buildings and other fixed structures: The MTEF trend is affected by the previously mentioned reduction in the Health Facility Revitalisation grant from 2016/17.

Health Professions Training and Development Grant is providing funding for operational costs associated with the training and development of health professionals, development and recruitment of medical specialists in under-served provinces and support and strengthen under-graduate teaching and training processes in health facilities. The trend in this grant reflects inflationary increases only. A decision was taken in 2011/12 to use the grant to fund the personnel costs of Registrars only.

Amalgamated Health Facility Revitalisation Grant: Aims to accelerate construction, maintenance, upgrading and rehabilitation of new and existing health infrastructure; enable provinces to plan, manage, modernize, rationalise and transform the infrastructure, health technology, monitoring and evaluation of hospitals and to transform hospital management and improve quality of care, in line with national policy objectives; and supplement provincial funding of health infrastructure to accelerate the provision of health facilities including office furniture and related equipment, as well as to ensure proper maintenance of provincial health infrastructure for nursing colleges and schools.

National Tertiary Services Grant: To plan, modernize, rationalise and transform the tertiary hospital service delivery platform in line with national policy objectives, including improving access and equity. The increasing trend relates mainly to additional funding provided for the modernisation of tertiary services.

Comprehensive HIV and AIDS Grant: To develop effective and integrated management of HIV and AIDS, to support the implementation of the National Operational Plan for comprehensive HIV and AIDS treatment and care and to subsidise, in part, funding for the ARV treatment programme.

Social Sector EPWP Incentive Grant for Provinces: Subsidise non-profit organisations in community-based programmes to provide stipends to previously unpaid volunteers to maximise job creation and skills development in line with the EPWP guidelines.

EPWP Integrated Grant for Provinces: To enhance the number of full time equivalent jobs created through labour intensive infrastructure programmes, which utilises local people to maintain grounds and clean buildings.

National Health Insurance Grant: To provide financial support for the development of projects directed at improving health delivery in line with the requirements of the introduction of the NHI.

In 2002/03, the Department entered into a PPP with Impilo Consortium (Pty) Ltd. The agreement covered the provision of equipment, information management and technology and facilities management for the Inkosi Albert Luthuli Central Hospital. The current contract with Impilo Consortium (Pty) Ltd comes to an end in 2016/17, and the Provincial Treasury PPP Unit is currently assisting the Department with an exit strategy.

Transfers to Local Government: The increase in trend over the 2015/16 MTEF is largely due to the commitment to assist clinics with pressures in the treatment of HIV and AIDS, the extension of hours of services, as well as to cater for an increase in neonatal services.

1.9 Expenditure Estimates

Table 16 (A2): Expenditure Estimates Summary of Payments and Estimates

Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
1. Administration (1)	577 395	635 763	689 089	581 340	581 140	581 140	737 119	776 143	818 148
2. District Health Services (2)	10 124 651	11 516 435	12 947 599	14 720 035	14 726 806	14 526 806	15 578 862	16 620 279	17 782 175
3. Emergency Medical Services (3)	1 070 387	926 036	1 009 940	1 073 438	1 073 438	1 073 438	1 160 311	1 196 476	1 256 299
4. Provincial Hospital Services (4)	6 897 820	7 567 375	8 121 196	8 788 275	8 785 841	8 785 841	8 775 638	9 370 522	9 832 823
5. Central Hospital Services (5)	3 240 467	3 338 850	3 640 586	3 079 392	3 079 392	3 079 392	3 984 966	4 097 277	4 368 087
6. Health Sciences and Training (6)	860 431	901 935	999 351f	1 051 400	1 051 367	1 051 367	1 055 250	1 135 410	1 192 681
7. Health Care Support Services (7)	124 968	130 541	122 844	140 959	140 934	140 934	138 288	146 337	153 654
8. Health Facilities Management (8)	1 894 999	2 373 597	2 000 806	1 479 357	1 680 547	1 680 547	1 551 352	1 399 221	1 469 681
Sub-total	24 791 118	27 390 533	29 531 410	30 914 196	31 119 465	30 919 465	32 981 786	34 741 665	36 873 548
Direct charges against National Revenue Fund	-	-	-	-	-	-	-	-	-
Total	24 791 118	27 390 533	29 531 410	30 914 196	31 119 465	30 919 465	32 981 786	34 741 665	36 873 548
Unauthorised expenditure (1st charge)	-	-	-	-	-	-	(107 607)	(107 607)	(107 608)
Baseline available for spending after 1st charge	**24 791 118**	**27 390 533**	**29 531 410**	**30 914 196**	**31 119 465**	**30 919 465**	**32 874 179**	**34 634 058**	**36 765 940**

Table 17 (A3): Summary of Provincial Expenditure Estimates by Economic Classification

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Current payments	**22 374 653**	**24 746 845**	**26 890 291**	**28 624 542**	**28 780 978**	**28 545 638**	**30 780 575**	**32 579 146**	**34 548 177**
Compensation of employees	15 118 307	16 886 345	18 676 776	20 188 402	20 211 032	20 109 624	21 138 481	22 383 173	23 592 758
Goods and services	**7 256 326**	**7 860 500**	**8 213 347**	**8 436 140**	**8 569 946**	**8 435 393**	**9 642 094**	**10 195 970**	**10 955 419**
Communication	83 607	90 818	93 271	112 863	112 867	98 439	99 521	106 596	110 794
Computer Services	164 578	152 690	197 733	133 765	134 765	126 547	175 329	196 058	253 967
Consultants, Contractors and special services	1 802 985	1 705 945	1 767 790	1 681 525	1 764 161	1 794 387	2 240 779	2 335 361	2 545 960
Inventory	3 631 544	4 198 476	4 552 711	4 676 629	4 689 570	4 543 856	5 136 205	5 516 123	5 880 416
Operating leases	43 352	109 010	98 849	116 150	116 150	129 973	159 431	140 864	142 521
Travel and subsistence	54 336	75 510	65 388	71 374	71 374	81 970	83 863	87 883	91 885
Interest and rent on land	20	-	169	-	-	621	-	-	-
Maintenance, repair and running costs									
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	1 475 904	1 528 052	1 437 437	1 643 834	1 681 059	1 660 221	1 746 966	1 827 480	1 929 880
Transfers and subsidies to	**515 845**	**486 764**	**740 159**	**692 479**	**694 193**	**860 320**	**648 156**	**681 322**	**711 308**
Provinces and municipalities	88 878	26 330	79 199	137 663	157 672	185 808	111 290	117 762	122 050
Departmental agencies and accounts	23 249	25 351	11 370	13 069	13 069	15 927	16 171	17 025	17 876
Higher Education institutions	-	57	501	-	-	16	-	-	-
Foreign governments and international organisations	-	-	-	-	-	66	-	-	-
Non-profit institutions	273 487	277 586	256 751	250 647	230 638	225 153	215 100	227 412	235 953
Households	130 231	157 440	392 339	291 100	292 814	433 350	305 595	319 123	335 429

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Payments for capital assets	**1 900 011**	**2 156 923**	**1 867 332**	**1 597 175**	**1 644 294**	**1 513 101**	**1 440 448**	**1 373 593**	**1 506 456**
Machinery and equipment	825 384	493 987	336 179	347 402	374 439	293 426	296 789	358 813	375 781
Buildings and other fixed structures	1 048 172	1 662 936	1 530 972	1 249 773	1 269 855	1 219 675	1 143 659	1 014 780	1 130 675
Land and sub-soil assets	26 455	-	-	-	-	-	-	-	-
Software and other tangible assets	-	-	181	-	-	-	-	-	-
Payment for financial assets	609	1	33 629	-	-	406	107 607	107 607	107 608
Total economic classification	**24 791 118**	**27 390 533**	**29 531 410**	**30 914 196**	**31 119 465**	**30 919 465**	**32 981 786**	**34 741 665**	**36 873 548**
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	(107 607)	(107 607)	(107 608)
Baseline available for spending after 1st charge	**24 791 118**	**27 390 533**	**29 531 410**	**30 914 196**	**31 119 465**	**30 919 465**	**32 874 179**	**34 634 058**	**36 765 940**

1.9.1 Relating Expenditure Trends to Specific Goals

Table 18: (A4) Trends in Provincial Public Health Expenditure (R'000)

Expenditure R'000	Audited/ Actual			Estimate	Medium Term Projections		
	2011 /12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Current prices							
Total	24 791 118	27 390 533	29 531 410	30 919 465	32 981 786	34 741 666	36 873 547
Total per person	2 333.90	2 558.93	2 824.11	2924.11	3085.82	3214.88	3375.22
Total per uninsured person	2 676.49	2 934.55	3 238.65	3354.18	3538.79	3686.78	3870.67
Constant (2011/12)							
Total	24 791 118	26 387 796	26 916 081	26 686 752	27 008 303	26 991 882	27 206 274
Total per person	2 333.90	2 465.25	2 574.00	2524.45	2526.93	2497.74	2490.33
Total per uninsured person	2 676.49	2 827.12	2 951.83	2895.01	2897.86	2864.38	2855.88
% of Total spent on:-							
DHS	40.84%	42.05%	43.84%	46.98%	47.23%	47.84%	48.22%
PHS	27.82%	27.63%	27.50%	28.42%	26.61%	26.97%	26.67%
CHS	13.07%	12.19%	12.33%	9.96%	12.08%	11.79%	11.85%
All personnel	15 118 307	16 886 345	18 676 776	20 109 625	21 138 481	22 383 179	23 592 766
Capital	1 900 011	2 156 923	1 867 332	1 513 101	1 445 448	1 373 590	1 506 458
Health as % of total public expenditure	31.92%	32.37%	32.24%	32.04%	32.35%	32.50%	32.70%

Table 19: Conditional Grants Expenditure Trends (R'000)

Conditional Grants R'000	Audited Actual			Estimate	Medium Term Projections		
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
National Tertiary Services	1 201 831	1 323 114	1 415 731	1 496 427	1 530 246	1 596 286	1 696 266
HIV and AIDS	1 907 312	2 226 706	2 651 997	3 257 992	3 813 094	4 293 096	4 840 949
Hospital Facility Revitalisation Grant	906 169	1 176 514	1 072 529	1 162 469	1 229 775	1 047 521	1 099 898
Health Professions Training and Development	249 917	261 860	276 262	292 837	299 513	312 377	331 942
National Health Insurance Grant	-	17 115	15 520	14 000	14 408	15 086	16 032
Forensic Pathology Services	161 550	-	-	-	-	-	-
EPWP Grant for the Social Sector	25 775	-	-	2 581	13 000	-	-
EPWP Incentive Grant for Provinces	0	1 000	3 000	2 580	3 683		
AFCON Health and Medical Services Grant	-	1 672	-	-	-	-	-
Total	**4 452 554**	**5 007 986**	**5 435 039**	**6 228 886**	**6 903 719**	**7 264 366**	**7 985 087**

PART B: PROGRAMME PLANS

- Programme 1: Administration
- Programme 2: District Health Services
- Programme 3: Emergency Medical Services
- Programme 4: Regional & Specialised Hospital Services
- Programme 5: Tertiary & Central Hospital Services
- Programme 6: Health Sciences Training
- Programme 7: Health Care Support Services
- Programme 8: Health Facilities Management

2. PROGRAMME 1: ADMINISTRATION

2.1 Programme Purpose

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

There are no changes to the Programme 1 structure.

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

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

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

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

2.2 2015/16 Priorities

1.	Strengthen Legal Services.	• Contract Management.
2.	Implement the Human Resources for Health Strategy (short, medium and long-term).	• Long Term Human Resources Plan aligned with service delivery priorities – inform essential post list (supported by WISN and research). • Approved and funded organisational structures. • Performance Management and Development. • Skills development programmes including leadership and management programmes and training of Mid-Level Workers. • Efficient management of labour related cases.
3.	Strengthen the partnership between the Department of Health and UKZN.	• Finalise "Community Based Training in a Primary Health Care Model" (Health Sciences). Costed Business Plan 2015/16, Phase 1 implementation planned to commence in 2016/17.
4.	Finalise and approve the Provincial Long Term Plan.	
5.	Efficient information technology and information management.	• ICT Governance & Policy Framework. • ICT Infrastructure including bandwidth connectivity; backup solutions; and infrastructure security. • Web-based health information system (National 700 Clinic Project). • Enterprise Content Management system. • E–Health, M-Health and Telemedicine. • Data and information quality and management.

		• Health reviews, monitoring, evaluation, reporting and research.
6.	Improve financial management.	• Automation of patient administrative system. • Monitoring of austerity measures. • Finalisation of Finance SOP's, training and M&E. • Implement the fixed asset management system. • Establish internal audit unit to improve audit outcomes. • Unqualified audit opinion.
7.	Improve Supply Chain Management.	• Automation of the SCM system and inventory management. • Decentralisation of SCM at district level. • Reduce turn-around time for procurement of low cost items at facility level. • Improve equipment maintenance management and manage repairs backlog.
8.	Strengthen Security Services.	• Compliance with security service standards.
9.	Implement the Communication Strategy.	• Finalise and implement the Communication Strategy. • Stakeholder analysis. • Development and maintenance of social media platform. • Events management.

2.3 Strategic Objectives, Indicators and Targets

Table 20: 2015-2019 Strategic Plan Targets

Strategic Goal	Strategic Objective	Strategic Objective Statement	Indicator	Target March 2020
Strategic Goal 1: Strengthen health system effectiveness	1.1) Finalise integrated long term health service improvement platform	1.1.1) Long Term Plan approved by March 2016, implemented and monitored thereafter	• Provincial Long Term Plan	Long Term Plan implemented and monitored
	1.2) Improve financial management and compliance to PFMA prescripts	1.2.1) Annual unqualified audit opinion for financial statements and performance information from 2015/16 onwards	• Audit opinion from Auditor-General	Unqualified opinion from 2015/16 onwards
		1.2.2) Maintain financial efficiency by ensuring under/ over expenditure within 1% of the annual allocated budget throughout the reporting cycle	• Percentage over/ under expenditure	Expenditure within 1% of annual allocated budget
	1.3) Improve Supply Chain Management	1.3.1) Costed Procurement Plan for minor and major assets by the end of April in each reporting year	• Annual Procurement Plan	Annual costed Procurement Plan
		1.3.2) Ensure that 100% sites registered on the system account for all assets by performing monthly reconciliation reports by March 2016 and annually thereafter	• Number of registered sites performing monthly asset reconciliation reports	All registered sites
	1.4) Improve health technology and information management	1.4.1) Connectivity established at 100% public health facilities by March 2018	• Percentage of public health facilities with stable bandwidth connectivity	100%
		1.4.2) Web-based health information system established in 90% public health facilities by March 2020 (National 700 Clinic Project)	• Percentage of public health facilities with a web-based health information system	90%
		1.4.6) Reduce performance data error rate to 2% (or less) by March 2020	• Audit error rate (PHC clinics, CHC's and Hospitals)	2% (or less)
Strategic Goal 4: Strengthen human resources for health	4.1) Improve human resources for health	4.1.1) Long Term Human Resources Plan approved by March 2016 and implemented and monitored thereafter	• Long Term Human Resources Plan	Long Term HRP implemented and monitored
		4.1.2) Finalise 610 organisational structures by March 2020	• Number of organisational structures finalised	610
		4.1.3) Implement the Community Based Training in a PHC Model in collaboration with the University of KwaZulu-Natal with Phase 1 pilot commencing in 2016/17	• Community Based Training in a PHC Model	Model implemented

Table 21: (ADMIN2) Programme Performance Indicators

Strategic Objective Statement	Indicators	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 1.2: Improve financial management and compliance to prescripts										
1.2.1) Annual unqualified audit opinion for financial statements and performance information from 2015/16 onwards	1. Audit opinion from Auditor-General	Annual Report	Annual/ Categorical	Qualification	Qualification	Qualification	Not applicable [4]	Unqualified opinion	Unqualified opinion	Unqualified opinion
Strategic Objective 1.4: Improve health technology and information management										
1.4.4) Ensure broadband access to 100% public health facilities by March 2018	2. Percentage of hospitals with broadband access	IT database – Internet rollout report	Quarterly %	New indicator	New indicator	New indicator	40%	90%	100%	100%
	Total number of Hospitals with minimum 2 Mbps connectivity		*No*	-	-	-	*29*	*64*	*72*	*72*
	Total number of hospitals	*DHIS*	*No*	-	-	-	*72*	*72*	*72*	*72*
	3. Percentage of fixed PHC facilities with broadband access	IT database – Internet rollout report	Quarterly %	New indicator	New indicator	8%	25%	45%	68%	100%
	Number of PHC facilities that have access to at least 512 Kbps connectivity		*No*	-	-	*52*	*133*	*241*	*364*	*535*
	Total number of fixed PHC facilities	*DHIS*	*No*			*644*	*532* [5]	*535*	*535*	*535*

[4] The 2014/15 Annual Report will be tabled in August 2015 which will include the AGSA Report for 2014/15
[5] Including Provincial clinics and CHC's, excluding LG, NGO and Satellite clinics

Table 22: (ADMIN1) Provincial Strategic Objectives and Targets

Strategic Objective Statement	Performance Indicators	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17	2017/18
FINANCE AND SUPPLY CHAIN MANAGEMENT										
Strategic Objective 1.2: Improve financial management										
1.2.2) Maintain financial efficiency by ensuring under/ over expenditure within 1% of the annual allocated budget throughout the reporting cycle	1. Percentage over/ under expenditure	BAS Reports	Annual/ %	New indicator	New indicator	New indicator	New indicator	Expenditure within 1% of annual allocated budget	Expenditure within 1% of annual allocated budget	Expenditure within 1% of annual allocated budget
	Total expenditure	*BAS*	*R'000*	-	-	-	-	33 446 247	34 163 803	34 245 969
	Allocated budget	*BAS*	*R'000*	-	-	-	-	33 115 097	33 825 548	33 906 900
Strategic Objective 1.3: Improve Supply Chain Management										
1.3.1) Costed annual Procurement Plan for minor and major assets by the end of April in each reporting year	2. Annual Procurement Plan	Procurement Plan	Annual/ Categorical	New indicator	New indicator	New indicator	New indicator	Approved & costed annual Procurement Plan	Approved & costed annual Procurement Plan	Approved & costed annual Procurement Plan
1.3.2) Ensure that 100% sites registered on the system account for all assets by performing monthly reconciliation reports by March 2016 and annually thereafter	3. Number of registered sites performing monthly asset reconciliation reports	Asset reconciliation reports	Quarterly / No	New indicator	New indicator	New indicator	New indicator	All registered sites	All registered sites	All registered sites
HUMAN RESOURCE MANAGEMENT SERVICES										
Strategic Objective 4.1: Improve human resources for health										
4.1.1) Long Term Human Resources (HR) Plan costed and approved by March 2016 and implemented and monitored thereafter	4. Long Term Human Resource Plan	Long Term Human Resource Plan	Annual/ Categorical	New indicator	New indicator	New indicator	No Long Term HR Plan	Approved Long Term HR Plan	Implement & review Long Term HR Plan	Implement & review Long Term HR Plan

Strategic Objective Statement	Performance Indicators	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17	2017/18
4.1.2) Finalise 610 organisational structures by March 2020	5. Number of organisational structures finalised	Organisational structures	Annual/ No	New indicator	New indicator	New indicator	New indicator	537 [6]	39 [7]	34 [8]
4.1.3) Implement the Community Based Training in a PHC Model in collaboration with the University of KwaZulu-Natal with Phase 1 pilot commencing in 2016/17	6. Community Based Training in a PHC Model	Business Plan/ Training Model	Annual/ Categorical	New indicator	New indicator	New indicator	Draft Business Plan	Approved Business Plan and Training Model	Phase 1 pilot commence	Implement Model
4.1.9) Provide sufficient staff with appropriate skills per occupational group within the framework of Provincial staffing norms by March 2020	7. Medical Officers per 100,000 people	Manually Calculated	Annual/ No per 100,000	30.3*	32	30.2	29	33.9	36.4	38.5
	Number of Medical Officers posts filled	*Persal*	*No*	*3 227*	*3 429*	*3 163*	*3 061*	*3 633*	*3 933*	*4 211*
	Total population	*Stats SA*	*Population*	*10 622 204*	*10 703 920*	*10 456 909*	10 571 313	10 688 168	10 806 536	10 924 776
	8. Professional Nurses per 100,000 people	Manually Calculated	Annual/ No per 100,000	137.4	145.5	138.9	137	141.3	143.9	146
	Number of Professional Nurses posts filled	*Persal*	*No*	*14 601*	*15 579*	*14 527*	*14 533*	*15 101*	*15 550*	*15 961*
	Total population	*Stats SA*	*Population*	*10 622 204*	*10 703 920*	*10 456 909*	10 571 313	10 688 168	10 806 536	10 924 776
	9. Pharmacists per 100,000 people	Manually Calculated	Annual/ No per 100,000	5.6	6.3	6.9	6.8	7.2	7.5	7.7
	Number of Pharmacists posts filled	*Persal*	*No*	*606*	*671*	*718*	*721*	*773*	*810*	*845*

[6] According to HRMS Strategy: Head Office (1), Regional (1), PHC clinics (513) and CHC's (22)
[7] According to HRMS Strategy: District Hospitals (37), EMS and FPS
[8] According to HRMS Strategy: Regional (13), Specialised (18), Tertiary (2), Central (1)

Strategic Objective Statement	Performance Indicators	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17	2017/18
	Total population	*Stats SA*	*Population*	*10 622 204*	*10 703 920*	*10 456 909*	10 571 313	*10 688 168*	*10 806 536*	*10 924 776*
Strategic Objective 4.2: Improve Performance Management and Development										
4.2.1) All personnel comply with performance management requirements from March 2015 onwards	10. Number of Hospital Managers who have signed Performance Agreements (PA's)	PMDS database/ Signed PAs	Annual/ No	55	50	41 (57.7%)	Not available [9]	72	72	72
	11. Number of District Managers who have signed PA's	PMDS database/ Signed PAs	Annual/ No	11	11	10 (90.9%)	Not available	11	11	11
	12. Percentage of Head Office Managers (Level 13 and above) who have signed PA's	PMDS database/ Signed PAs	Annual/ %	46%	58%	66%	Not available	100% [10]	100%	100%
	Head Office Managers (level 13 and above) who signed Pas in reporting cycle	*PMDS database/ Signed PAs*	*No*	*18*	*29*	*33*	-	-	-	-
	Number of Head Office Managers (level 13 and above)	*Persal*	*No*	*39*	*50*	*50*	-	-	-	-
PLANNING, MONITORING & EVALUATION										
Strategic Objective 1.1: Finalise integrated long term health service improvement platform										
1.1.1) Long Term Plan approved by March 2016 and implemented and monitored thereafter	13. Provincial Long Term Plan	Approved Long Term Plan	Annual / Categorical	Draft STP	Draft STP	Draft STP	Draft Long Term Plan[11]	Long Term Plan approved	Implement & review Long Term Plan	Implement & review Long Term Plan
Strategic Objective 1.4: Improve health technology and information management										
1.4.5) M&E Framework revised and approved by March 2016	14. Approved revised M&E Framework	Approved revised M&E Framework	Annual/ Categorical	Approved M&E Framework	Approved M&E Framework	Approved M&E Framework	Approved M&E Framework	Approved revised M&E Framework	Implement & review M&E Framework	Implement & review M&E Framework

[9] Indicators 10, 11 and 12: Unable to source verified information from HRMS before finalisation of the APP
[10] The numerator and denominator cannot be estimated as denominator will be based on the reviewed organisation structure therefor also determine the numerator. The requirement however imply that ALL Managers (level 13 and above) must sign Performance Agreements annually (relevant for MTEF)
[11] Renamed from the Service Transformation Plan to Long Term Plan

Strategic Objective Statement	Performance Indicators	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17	2017/18
1.4.3) Improve performance data integrity by ensuring a 100% submission rate from March 2018 onwards	15. Data submission rate	Data Management	Quarterly/ %	New indicator	New indicator	New indicator	92%	95%	99%	100%
	Number of facilities submitting complete performance data according to timeframes	*Completeness report*	*No*	-	-	-	*558*	*577*	*601*	*607*
	Number of facilities	*DHIS*	*No*	-	-	-	*607* [12]	*607*	*607*	*607*
1.4.6) Reduce performance data error rate to 2% (or less) by March 2020	16. Audit error rate (PHC clinics and CHC's)	Data Management Audit reports	Quarterly/ %	New indicator	New indicator	New indicator	New indicator	15% [13]	10%	*5%*
	Sum of variance between data collection tools and DHIS during audit at PHC and CHC facilities	*Audit Reports*	No No	-	-	-	-	-	-	-
	Reported PHC/CHC data on DHIS	*DHIS*		-	-	-	-	-	-	-
	17. Audit error rate (Hospitals)	*Data Management Audit Reports*	Quarterly/ %	New indicator	New indicator	New indicator	*New indicator*	15%	10%	*5%*
	Sum of variance during audit at Hospitals	*Audit Reports*	No	-	-	-	-	-	-	-
	Reported Hospital data on DHIS	*DHIS*	No	-	-	-	-	-	-	-
1.4.7) Functional Health Information Committees in 100% public health hospitals from March 2018	18. Percentage of public health hospitals with functional health information committees	District quarterly reports	Quarterly/ %	New indicator	New indicator	New indicator	New indicator	60%	80%	100%

[12] The denominator includes PHC clinics, CHCs and Public Hospitals. The MTEF targets (denominator) will be reviewed annually to make provision for new commissioned facilities

[13] Indicators 16 and 17: Numerators and denominators cannot be projected for the MTEF. These are new indicators with no historic data or trends to base targets on. The percentage is based on the Provincial norms for quality and accuracy of performance data. Baselines will be established in 2015/16 to inform targets for the outer years

Strategic Objective Statement	Performance Indicators	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17	2017/18
onwards	*Number of public health hospitals with a functional health information committee*	*District quarterly reports*	*No*	-	-	-	-	*43*	*58*	*72*
	Number of public health hospitals	*DHIS*	*No*	-	-	-	-	*72* [14]	*72*	*72*
1.4.8) Establish 4 Regional Level 1 Health Ethics Review Boards by March 2018	19. Number of level 1 Health Ethics Review Boards established (cumulative)	Appointment letters	Annual/ No	New indicator	New indicator	New indicator	1	2	3	4
CORPORATE COMMUNICATION										
Strategic Objective 1.9: Strengthen health system effectiveness										
1.9.3) Stakeholder analysis conducted by March 2016	20. Stakeholder analysis	Stakeholder analysis	Annual/ Categorical	New indicator	New indicator	New indicator	New indicator	Stakeholder Analysis conducted	Stakeholder Analysis updated	Stakeholder Analysis updated
1.9.4) Internal and external interactive communication platforms established by March 2016	21. Social media platforms	Social Media	Annual/ Categorical	New indicator	New indicator	New indicator	New indicator	Social media platforms established	Analysis of social media feedback	Analysis of social media feedback
	22. Number of corporate events conducted	Comm database	Quarterly/ No	New indicator	New indicator	New indicator	New indicator	24	24	24
INFORMATION COMMUNICATION TECHNOLOGY (ICT)										
Strategic Objective 1.4: Improve health technology and information management										
1.4.9) Establish the ICT Governance Framework by March 2016	23. ICT Governance Policy and Framework	ICT Governance Policy & Framework	Annual/ Categorical	New indicator	New indicator	New indicator	New indicator	Developed and imple-mented	-	-
1.4.1) Connectivity established at 100% public health facilities by March 2018	24. Percentage of public health facilities with stable bandwidth connectivity	Connectivity Report	Annual/ %	New indicator	New indicator	New indicator	New indicator	60%	80%	100%

[14] Excludes State Aided Hospitals

Strategic Objective Statement	Performance Indicators	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17	2017/18
	Total number of public health facilities with stable bandwidth connectivity	*Connectivity*	*No*	-	-	-	-	*372*	*496*	*621*
	Total number of public health facilities	*DHIS*	*No*	-	-	-	-	*607* [15]	*607*	*607*
1.4.10) Install ICT backup solution by March 2020	25. ICT backup solution installed	Backup solution	Annual/ Categorical	New indicator	New indicator	New indicator	New indicator	ICT backup solution installed	-	-
	26. ICT security Infrastructure	ICT security system	Annual/ Categorical	New indicator	New indicator	New indicator	New indicator	ICT security system installed	-	-
1.4.2) Web-based health information system established in 90% public health facilities by March 2020 (National 700 clinic Project)	27. Percentage of public health facilities with a web-based health information system	Web-based reports	Annual/ %	New indicator	New indicator	New indicator	New indicator	35% [16]	65%	75%
	Number of public health facilities submitting data on the web-based health information system	*Web-based reports*	*No*	-	-	-	-	*212*	*395*	*455*
	Number of public health facilities	*DHIS*	*No*	-	-	-	-	*607*	*607*	*607*
1.4.11) Implement an enterprise content management system in all public health facilities by March 2020	28. Percentage of public health facilities with an Enterprise Content Management system	Enterprise Content Management System	Annual/ %	New indicator	New indicator	New indicator	New indicator	30%	60%	90%
	Public health facilities with an enterprise content management system	*Facility system*	*No*	-	-	-	-	*182*	*364*	*546*
	Number of public health facilities	*DHIS*	*No*	-	-	-	-	*607*	*607*	*607*

[15] Indicators 24, 27, 28 and 33: Denominator includes all public health facilities (clinics, CHC's and hospitals) - The number of facilities (denominator) will be reviewed annually taking into consideration closed down or newly commissioned facilities

[16] The indicator is dependent on the speed with which the National Department of Health will be implementing the project (forms part of the National 700 Clinic Project)

Strategic Objective Statement	Performance Indicators	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17	2017/18
1.4.12) Expand telemedicine to 68 functional sites by March 2018	29. Number of functional Tele-Medicine sites	Telemedicine Register	Annual/ No	37	37	41	41	58	62	68
SPECIALISED SERVICES AND CLINICAL SUPPORT										
Strategic Objective 1.7: Improve hospital efficiencies										
1.7.2) Develop and implement the approved Hospital Rationalisation Plan by March 2016	30. Hospital Rationalisation Plan	Approved Hospital Rationalisation Plan	Annual/ Categorical	New indicator	New indicator	New indicator	New indicator	Implement approved Plan [17]	Implement & review Plan	Implement & review Plan
Strategic Objective 1.10: Improve transversal services										
1.10.1) 100% Public health hospitals score more than 75% on the Food Service Monitoring Standards Grading System (FSMSGS) by March 2020	31. Proportion of public health facilities that scored more than 75% on the Food Service Monitoring Standards Grading System	Food Services Grading Register	Annual/ %	New indicator	New indicator	New indicator	Not available [18]	69.4%	83.3%	90%
	Facilities that score more than 75% on the FSMSGS	*Grading Register*	*No*	-	-	-	-	*50*	60	69
	Public Health Hospitals total	*DHIS calculates*	*No*	-	-	-	-	72	72	72
	32. Number of public health facilities compliant with 2 priority Food Safety Standards	Food Service database	Annual No	New indicator	New indicator	New indicator	Not available	55	70	72

[17] The Plan will make provision for an Implementation Plan with performance measures and targets which will inform future Annual Performance Plans. The development of the plan has been included under Programme 1 as it covers all hospitals and the development of the plan will be facilitated by Head Office. The Implementation Plan will be operationalised and included under Programmes 2, 4 and 5 in outer years

[18] Indicators 31 and 32: Unable to source data for 2014/15 from the Food Services Programme before finalisation of the APP

Strategic Objective Statement	Performance Indicators	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012 /13	2013/14	2014/15	2015/16	2016/17	2017/18
SECURITY SERVICES										
Strategic Objective 1.10: Improve transversal services										
1.10.2) 100% Public health facilities comply with security policy requirements by March 2020	33. Percentage public health facilities with access control at the gate	Facility Security Audit Results	Annual/ %	New indicator	New indicator	New indicator	Data not available [19]	*75%*	100%	100%
	Public health facilities with access control at the gate	*Security audit results/Minutes*	*No*	-	-	-		*465*	*607*	*607*
	Total public health facilities	*DHIS calculates*	*No*	-	-	-		*607*	*607*	*607*

[19] Unable to source 2014/15 data from Security Services before finalisation of the APP

2.4 2015/16 Targets

Table 23: (ADMIN3) Quarterly and Annual Targets

Performance Indicators	Targets 2015/16	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Percentage of hospitals with broadband access	90%	50%	65%	80%	90%
2. Percentage of fixed PHC facilities with broadband access	45%	32%	35%	40%	45%
3. Number of registered sites performing monthly asset reconciliation reports	All registered sites	All registered sites	All registered sites	All registered sites	All registered sites
4. Data submission rate	95%	92%	93%	94%	95%
5. Audit error rate (PHC clinics & CHC's)	15%	30%	25%	20%	15%
6. Audit error rate (Hospitals)	15%	30%	25%	20%	15%
7. Percentage of public hospitals with functional health information committees	60%	50%	53%	57%	60%
8. Number of corporate events conducted	24	6	6	6	6
Annual Targets					
9. Audit opinion from Auditor-General	Unqualified opinion				Unqualified opinion
10. Percentage over/ under expenditure	Expenditure within 1% of allocated budget				Expenditure within 1% of allocated budget
11. Annual Procurement Plan	Approved & costed Procurement Plan				Approved & costed Procurement Plan
12. Long Term Human Resources Plan	Approved HR Long Term Plan				Approved HR Long Term Plan
13. Number of organisational structures finalised	537				537
14. Community Based Training in a PHC Model	Approved Business Plan & Training Model				Approved Business Plan & Training Model
15. Medical Officers per 100,000 people	33.9				33.9
16. Professional Nurses per 100,000 people	141.3				141.3
17. Pharmacists per 100,000 people	7.2				7.2
18. Number of Hospital Managers who have signed Performance Agreements (PA's)	72				72
19. Number of District Managers who have signed PA's	11				11
20. Percentage of Head Office Managers (Level 13 and above) who have signed PA's	100%				100%
21. Provincial Long Term Plan	Approved Long Term Plan				Approved Long Term Plan
22. Approved revised M&E Framework	Approved revised Framework				Approved revised Framework
23. Number of level 1 Health Ethics Review Boards established (cumulative)	2				2

Performance Indicators	Targets 2015/16	Targets			
		Q1	Q2	Q3	Q4
24. Stakeholder analysis	Stakeholder analysis conducted				Stakeholder analysis conducted
25. Social media platforms	Social media platforms established				Social media platforms established
26. IT Governance Policy and Framework	Developed & implemented				Developed & implemented
27. Percentage of public health facilities with stable bandwidth connectivity	60%				60%
28. ICT backup solution installed	ICT backup solution installed				ICT backup solution installed
29. ICT security infrastructure	ICT security system installed				ICT security system installed
30. Percentage of public health facilities with a web-based health information system	35%				35%
31. Percentage of public health facilities with an Enterprise Content Management system	30%				30%
32. Number of functional Tele-Medicine sites	58				58
33. Hospital Rationalisation Plan	Implement approved plan				Implement approved plan
34. Proportion of public health facilities that scored more than75% on the Food Service Monitoring Standards Grading System	69.4%				69.4%
35. Number of public health facilities compliant with 2 priority Food Safety Standards	55				55
36. Percentage public health facilities with access control at the gate	75%				75%

2.5 Reconciling Performance Targets with Expenditure Trends and Budgets

Table 24: (ADMIN4 a) Expenditure Estimates

Sub-Programme R'000	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
MEC's Office	15 615	20 371	17 011	19 498	19 498	15 939	18 189	19 160	20 118
Management	561 780	615 392	672 078	561 842	561 642	565 201	718 930	756 983	798 030
Sub-Total	577 395	635 763	689 089	581 340	581 140	581 140	737 119	776 143	818 148
Unauthorized expenditure (1st charge) not available for spending							(107 607)	(107 607)	(107 608)
Baseline available for spending after 1st charge	577 395	635 763	689 089	581 340	581 140	581 140	629 512	668 536	710 540

Table 25: (ADMIN4 b) Summary of Payments and Estimates by Economic Classification

Economic Classification R'000	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Current payments	**463 100**	**531 385**	**610 665**	**571 829**	**570 060**	**549 130**	**615 311**	**653 405**	**694 653**
Compensation of employees	208 965	246 972	273 361	307 734	307 734	295 591	326 673	345 804	371 672
Goods and services	**254 115**	**284 413**	**337 290**	**264 095**	**262 326**	**253 501**	**288 638**	**307 601**	**322 981**
Communication	3 210	7 143	4 009	13 820	13 820	10 786	13 399	14 037	14 739
Computer Services	144 531	140 220	176 019	122 490	122 490	119 646	145 329	158 204	166 113
Consultants, Contractors and special services	39 184	46 074	60 623	27 370	27 370	32 730	42 627	44 128	46 335
Inventory	6 456	8 011	9 772	4 930	4 930	3 971	5 679	5 978	6 278
Operating leases	6 392	5 471	3 879	4 570	4 570	4 734	5 580	5 348	5 615

Economic Classification R'000	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Travel and subsistence	16 312	22 714	18 829	22 100	22 100	19 143	16 000	16 871	17 714
Interest and rent on land	20	0	14.6	0	0	38	0	0	0
Maintenance, repair and running costs									
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	38 010	54 780	64 145	68 815	67 046	62 491	60 024	63 033	66 187
Transfers and subsidies to	**4 362**	**7 977**	**3 201**	**3 061**	**4 630**	**6 565**	**6101**	**6 519**	**6 845**
Provinces and municipalities	996	1900	1952	60	1629	3035	3 100	3 359	3527
Departmental agencies and accounts	1	0	0	1	1	1	1	1	1
Higher Education institutions	-	0	3	0	0	0	0	0	0
Foreign governments and international organisations	-	0	0	0	0	66	0	0	0
Non-profit institutions	-	0	0	0	0	0	0	0	0
Households	3 365	6 077	1 246	3 000	3 000	3 463	3 000	3 159	3 317
Payments for capital assets	**109 386**	**96 400**	**41 594**	**6 450**	**6 450**	**25 438**	**8 100**	**8 612**	**9 043**
Machinery and equipment	109 386	96400	41 413	6 450	6 450	25 438	8 100	8 612	9 043
Buildings and other fixed structures	-	0	0	0	0	0	0	0	0
Land and sub-soil assets	-	0	0	0	0	0	0	0	0
Software and other tangible assets	-	0	181	0	0	0	0	0	0
Payment for financial assets	547	1	33 629	-	-	7	107 607	107 607	107 608
Total economic classification	**577 395**	**635 763**	**689 089**	**581 340**	**581 140**	**581 140**	**737 119**	**776 143**	**818 148**
Unauthorised expenditure (1st charge) not available for spending	-	0	0	0	0	0	(107 607)	(107 607)	(107 608)
Baseline available for spending after 1st charge	**577 395**	**635 763**	**689 089**	**581 340**	**581 140**	**581 140**	**629 512**	**668 536**	**710 540**

2.6 Performance and Expenditure Trends

The increase in the 2013/14 and the 2014/15 *Revised Estimates* was due to pressures from forensic investigations, communications and computer services. The negative growth in 2015/16 is attributed to a decision to utilise internal capacity (as opposed to consultants) to conduct disciplinary inquiries, with only complex cases to be referred to consultants. The costs for computer services against *Goods and services* have been centralised from all programmes to Programme 1 from 2013/14 and historical data has been amended for comparative purposes. The replacement of all leased computer and printing equipment was also mostly completed in 2012/13 hence there was minimal spending on this project from 2013/14.

The negative growth in 2014/15 and 2015/16 are attributed to the decision to scale down in respect of the procurement of new computers and motor vehicles and focus on the replacement of essential equipment only. Growth in the two outer years of the MTEF is for inflationary purposes only.

The increasing trend in *Compensation of Employees* from 2012/13 and over the 2015/16 MTEF relates to the need to fill vacant Senior Management posts at Head Office to ensure appropriate leadership capacity. The high growth in 2012/13 and 2013/14 was for the provision of financial management capacity to improve audit outcomes and filling of various critical posts related to the SCM and Asset Management functions. The low spending in the 2014/15 *Revised Estimate* is due to the decision to defer the filling of Head Office posts to 2015/16, hence higher growth in 2015/16 and 2016/17.

The expenditure against *Transfers and Subsidies to: Provinces and Municipalities* are for motor vehicle licences. The increases over the 2015/16 MTEF is for inflationary adjustments as only replacement vehicles will be purchased.

Machinery and Equipment: Over the 2015/16 MTEF funding is provided to replace essential equipment only.

2.7 Risk Management

Table 26: Risk Management

Potential Risks	Mitigating Strategies
1. Budget limitations may impact on operationalising identified priorities due to competing service demands. *(High Risk)*	• Re-prioritisation and improved management control through implementation of costing framework and robust monitoring of financial and performance management.
2. Poor data quality (all information systems) remains a challenge with negative impact on evidence based decision-making and planning. *(High Risk)*	• Implementation of Information Management (all systems) strategy including regular information reviews, vigorous verification processes and improved processes for improved recording and reporting of data.
3. Ad hoc priorities (in-year) and unfunded policy decisions increase challenge of service delivery versus the available funding envelope. *(High Risk)*	• Strengthen alignment between budget and service delivery planning cycles.
4. Inadequate human resources for Health to respond to burden of disease and concomitant service demands. *(High Risk)*	• Development and implementation of the Long Term Human Resources Plan [including Essential Post List]
5. Inadequate management competences. *(High Risk)*	• Management training / mentoring strategy.

3. PROGRAMME 2: DISTRICT HEALTH SERVICES

3.1 Programme Purpose

To render Primary Health Care and District Hospital Services.

There are no changes to the structure of Programme 2.

Sub-Programme 2.1: District Management

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

Sub-Programme 2.2: Community Health Clinics

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

Sub-Programme 2.3: Community Health Centres

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

Sub-Programme 2.4: Community-Based Service

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

Sub-Programme 2.5: Other Community Services

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

Programme 2.6: HIV and AIDS

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

Sub-Programme 2.7: Nutrition

Render nutrition services aimed at specific target groups and combines 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

3.2 Overview

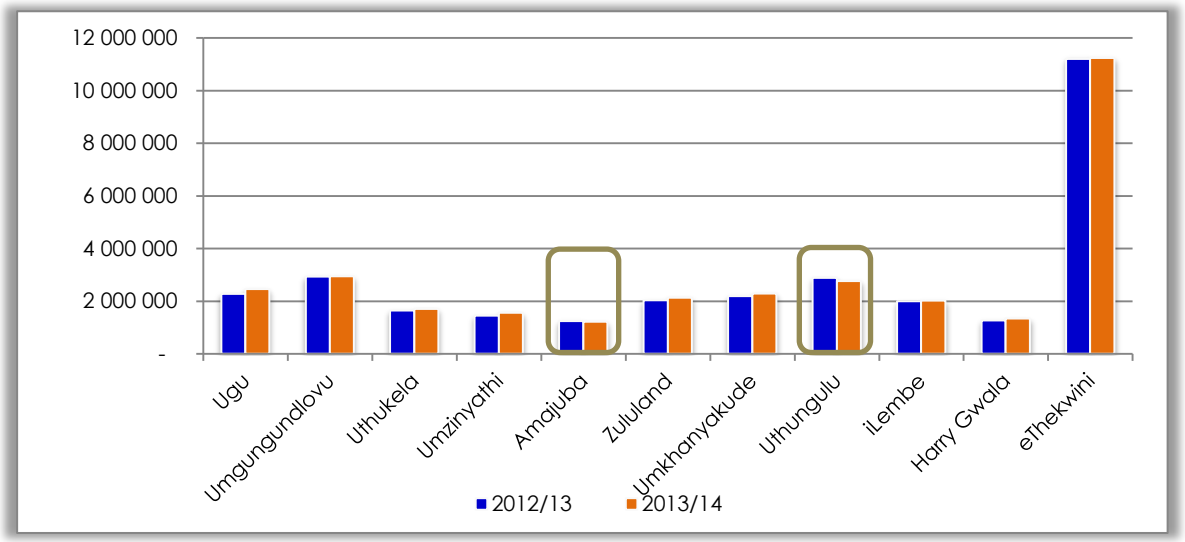
The average Provincial PHC utilisation rate (3) showed a slight increase over the past 4 years and in 2013/14 exceeded the national average of 2.43 visits per person per year. Although headcounts continue to show an upward trend, with the exception of Amajuba and Uthungulu, the increase is levelling off (Graph 3, Table 29). The reason for this is not clear and a more in-depth analysis will have to be conducted to explain the trend. Amajuba and Uthungulu Districts started to explore possible reasons for the decrease in headcounts in these districts.

In spite of the number of PHC health facilities in eThekwini remaining consistent over the past year (101 PDoH and LG), headcounts continue to increase significantly year on year (31.7% between 2010/11 and 2013/14), which serves as a clear marker of service and financial pressures.

Umkhanyakude, Zululand and Umzinyathi, where most clinics have been commissioned within the last 5 years, show a steady increase in PHC utilisation rates. Clinic to population ratios in the 3 districts are high compared to other districts (with the exception of Ugu and Ilembe) which should preclude further infrastructure expansion apart from projects already under construction.

Of the total PHC headcount, 74% have been reported by clinics and the remaining 26% by mobiles with 151 mobile teams servicing 8.6% of the total PHC headcount. eThekwini reported an annual PHC headcount of 7 820 480 with 48 Provincial clinics and CHC's (excluding LG and NGO clinics) compared with Zululand reporting a headcount of 1 860 443 with 69 clinics. State-Aided clinics and NGO's contributed 1.03% (330 414) towards the overall PHC headcount.

Graph 3: PHC Headcount for 2012/13 and 2013/14 per district



Source: DHIS

Data inconsistencies, misinterpretation of data elements, and poor reporting practices still have a negative impact on the analysis and interpretation of data thereby undermining evidence-based

planning and decision-making. The Department intensified data verification at all levels to improve data quality.

The lack of community-based data remains a challenge. The Department will be focussing on improving capturing of community-based data in the DHIS Module while the "Municipal Ward Profile Database" will provide additional community-based service delivery information to support monitoring of PHC re-engineering.

The incongruence between Compensation of Employees (CoE) per headcount compared to workload (DHIS) and number of patients per PN per annum (District Health Expenditure Review - DHER) confirms poor linkage of PHC outreach teams to facilities. The involvement of integrated district teams in DHER's is beginning to show improved linkage and will be strengthened in 2015/16 as part of improved financial management.

A total of 30 doctors were contracted in the NHI districts (November 2014) to improve medical coverage at PHC level (clinics) and decongest hospitals as a result of patients entering the health system at hospital level.

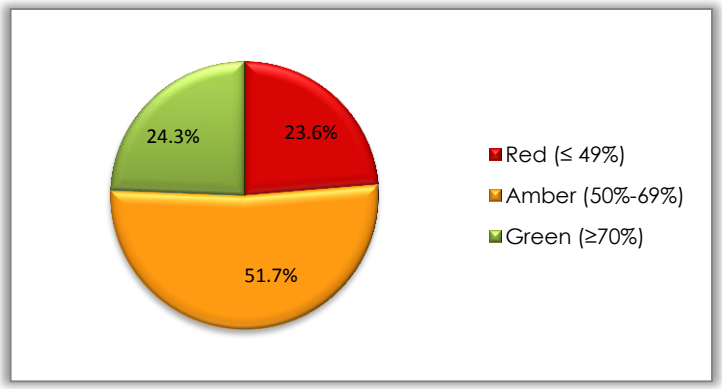
The Chronic Medication Dispensing and Supply Project commenced as a pilot project in the NHI districts. Pre-packed chronic medication, including ARV's, is distributed via community channels including PHC Outreach Teams and CCG's. Transport for effective distribution remains a challenge and innovative strategies are being explored to address this.

School Health Services remain a priority and 14 additional vehicles were provided by the National Department of Health to improve coverage. Health Promoting Hospitals will be re-introduced in 2016/17 with a pilot in 3 hospitals before rollout to other hospitals.

The establishment of gateway clinics and reporting of data at these clinics will be reviewed in 2015/16 to lower cost by reducing the number of unreferred PHC patients accessing services at hospital level especially in eThekwini with Mahatma Ghandi and King Dinuzulu Hospitals.

Implementation of the Ideal Clinic initiative will be scaled up as part of the Operation Phakisa Ideal Clinic Realisation and Maintenance (ICRM) Plan. Three clinics i.e. Efaye, Phatheni and Richmond (Umgungundlovu) form part of the national project, while the Department targeted 288 clinics for implementation of the programme in 2014/15. A baseline survey (self-assessments) conducted in the 4th quarter of 2014/15, indicated that 70 of the 288 clinics scored more than 70% on the Ideal Clinic Dashboard (Graph 4). [20]

Graph 4: Ideal Clinic Baseline Survey - 2014



A Provincial task team has been appointed to facilitate development of the provincial Operation Phakisa ICRM Implementation Plan, based on the national framework following the Operation Phakisa Lab (October-November 2014). Strengthening of the current "Peer Review" and "Community for Sharing Best Practices" will form an integral part of the plan.

[20] Used Version 6.4 of the Ideal Clinic Dashboard for self-assessments to date - the Dashboard is currently under review

The Implementation Plan will focus on the following streams: (1) Service delivery; (2) Waiting times; (3) Human resources); (4) Financial management; (5) Supply chain management; (6) Infrastructure; (7) Institutional arrangements; and (8) Scale up and sustainability.

There are 180 formally appointed Clinic Committees and 182 interim Clinic Committees with the formal appointment of Clinic Committees an on-going process hampered by the high turnover of committee members in especially the more rural areas. Six (6) CHC Committees from the 19 CHC's have been formally appointed with the appointment of the remaining 13 CHC Committees prioritised.

3.3 2015/16 Priorities

1.	Accelerate re-engineering of Primary Health Care.	• Community-based services including health promotion and prevention, ward-based outreach teams with focus on the 169 most deprived wards. • Health screening and testing at community and facility level. • Regional organisational structures and service arrangements (HRMS). • Align District Health Expenditure Reviews with service delivery planning.
2.	Implementation of Operation Phakisa ICRM.	• Develop Provincial Implementation Plan to inform implementation and scale-up of the 8 streams of Operation Phakisa Ideal Clinic Realisation and Maintenance (ICRM) – directly aligned with the re-engineering of PHC.
3.	National Health Insurance.	• Establish NHI Consultative Forums and facilitate consultation. • Improve universal access through innovation. • Increase coverage of Medical Officers at clinic level. • Rollout of the Chronic Medication Dispensing and Supply Model (Part of Operation Phakisa). • Commence with the implementation of the "Municipal Ward Profile Database".

Note: Due to the number and diverse nature of the Strategic Objectives, Objective Statements, Indicators and Targets for Programme 2 priority programmes, the tables reflecting these have been placed with priority programmes for ease of reference. It is not intended to be per Budget Sub-Programmes.

3.4 District Health Services

Table 27: (DHS1) District Health Services (2013/14 - DHIS)

Health District	Facility Type	Number of facilities	Total population	Population per PHC facility or hospital bed	Per capita utilisation
Ugu	Mobiles	17	733 863	12 863	3.4
	Mobile stopping points	280			
	Satellite facilities	0			
	Total non-fixed facilities	***17***			
	Provincial clinics	55			
	LG clinics	-			
	CHCs (Provincial & LG)	2			
	Total fixed clinics	***57***			
	District Hospitals	3			
Umgungundlovu	Mobiles	16	1 052 730	19 495	2.8
	Mobile stopping points	339			
	Satellite facilities	1			
	Total non-fixed facilities	***16***			
	Provincial clinics	51[21]			
	LG clinics	0			
	CHCs (Provincial & LG)	3			
	Total fixed clinics	***54***			
	District Hospitals	2			
Uthukela	Mobiles	14	682 798	19 508	2.5*
	Mobile stopping points	303			
	Satellite facilities	0			
	Total non-fixed facilities	***14***			
	Provincial clinics	35[22]			
	LG clinics	0			
	CHCs (Provincial & LG)	1			
	Total fixed clinics	***36***			
	District Hospitals	2			
Umzinyathi	Mobiles	11	514 217	10 494	300
	Mobile stopping points	241			
	Satellite facilities	0			
	Total non-fixed facilities	***11***			
	Provincial clinics	49			
	LG clinics	0			
	CHCs (Provincial & LG)	0			
	Total fixed clinics	***49***			
	District Hospitals	4			

[21] Mooi River Truck clinic incorrectly classified as LG clinic on DHIS – this will be corrected
[22] Ladysmith Gateway is classified as a mobile service on DHIS but has been amended for inclusion in this data

Health District	Facility Type	Number of facilities	Total population	Population per PHC facility or hospital bed	Per capita utilisation
Amajuba	Mobiles	7	507 468	20 298	2.4
	Mobile stopping points	179			
	Satellite facilities	0			
	Total non-fixed facilities	***7***			
	Provincial clinics	25			
	LG clinics	0			
	CHCs (Provincial & LG)	0			
	Total fixed clinics	***25***			
	District Hospitals	2			
Zululand	Mobiles	17	824 091	11 943	2.6
	Mobile stopping points	Not available			
	Satellite facilities	0			
	Total non-fixed facilities	***17***			
	Provincial clinics	68			
	LG clinics	0			
	CHCs (Provincial & LG)	1			
	Total fixed clinics	***69***			
	District Hospitals	5			
Umkhanyakude	Mobiles	17	638 011	11 393	3.6
	Mobile stopping points	257			
	Satellite facilities	0			
	Total non-fixed facilities	***17***			
	Provincial clinics	56			
	LG clinics	0			
	CHCs (Provincial & LG)	0			
	Total fixed clinics	***56***			
	District Hospitals	5			
Uthungulu	Mobiles	17	937 793	15 123	2.9
	Mobile stopping points	117			
	Satellite facilities	0			
	Total non-fixed facilities	***17***			
	Provincial clinics	59			
	LG clinics	2			
	CHCs (Provincial & LG)	1			
	Total fixed clinics	***62***			
	District Hospitals	6			
Ilembe	Mobiles	10	630 464	17 512	3.2
	Mobile stopping points	Not available			
	Satellite facilities	0			
	Total non-fixed facilities	***10***			

Health District	Facility Type	Number of facilities	Total population	Population per PHC facility or hospital bed	Per capita utilisation
	Provincial clinics	34			
	LG clinics	0			
	CHCs (Provincial & LG)	2			
	Total fixed clinics	***36***			
	District Hospitals	3			
Harry Gwala	Mobiles	13			
	Mobile stopping points	Not available			
	Satellite facilities	0			
	Total non-fixed facilities	***13***			
	Provincial clinics	38	471 904	12 418	2.8
	LG clinics	0			
	CHCs (Provincial & LG)	1			
	Total fixed clinics	***39***			
	District Hospitals	4			
eThekwini	Mobiles	33			
	Mobile stopping points	177			
	Satellite facilities	0			
	Total non-fixed facilities	***33***			
	Provincial clinics	43	3 464 205	32 375	3.3
	LG clinics	57			
	CHCs (Provincial & LG)	8			
	Total fixed clinics	***108****			
	District Hospitals	2*			
KwaZulu-Natal	**Mobiles**	**173**			
	Mobile stopping points	**1 893** [23]			
	Satellite facilities	**1**			
	Total non-fixed facilities	**173**			
	Provincial clinics	**513**	**10 456 909**	**17 783**	**3.0***
	LG clinics	***59***			
	CHCs (Provincial & LG)	**19**			
	Total fixed clinics	***591***			
	District Hospitals	**37***			

Source: DHIS - (Stats SA population estimates in DHIS)

Note

(*) Denotes updated data since publishing of the 2013/14 Annual Report

Only clinics reporting monthly data were included in the table above. Satellite Clinics: Only recorded clinics reporting data have been included in the table above. DHIS reflected 10 Satellite Clinics with no data – this is followed up with Data Management for clean-up.

[23] Excluding mobile stopping points in Zululand, Harry Gwala and Ilembe that were not available for inclusion in the APP

3.5 Situation Analysis Indicators per District

Table 28: (DHS2) Situation Analysis Indicators - 2013/14

Indicators	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	eThekwini 2013/14
1. Number of districts piloting NHI interventions	No	3	N/A	1	N/A	1	1	N/A	N/A	N/A	N/A	N/A	N/A
2. Established NHI Consultation Fora	Yes/ No	New indicator	N/A	New indicator	N/A	New indicator	New indicator	N/A	N/A	N/A	N/A	N/A	N/A
3. Percentage of fixed PHC facilities scoring above 80% on the Ideal Clinic Dashboard	%	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
Number of fixed PHC Facilities scoring above 80% on the ideal clinic dashboard	*No*	-	-	-	-	-	-	-	-	-	-	-	-
Number of fixed PHC facilities that conducted an assessment against the ideal clinic dashboard to date in the financial year	*No*	-	-	-	-	-	-	-	-	-	-	-	-

Indicators	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	eThekwini 2013/14
4. Patient experience of care survey rate (fixed PHC facilities)	%	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
Total number of fixed PHC facilities that conducted a patient experience of care survey to date in the current financial year	*No*	-	-	-	-	-	-	-	-	-	-	-	-
Total number of fixed PHC facilities	*No*	-	-	-	-	-	-	-	-	-	-	-	-
5. Patient experience of care rate at PHC fixed facilities	%	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
Sum of patient experience of care survey scores (in %) of all PHC facilities that conducted a patient experience of care survey to date in the current financial year	%	-	-	-	-	-	-	-	-	-	-	-	-

Indicators	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	eThekwini 2013/14
Total number of fixed PHC health facilities that conducted a patient experience of care survey to date in the current financial year	*No*	-	-	-	-	-	-	-	-	-	-	-	-
6. Outreach household registration visit coverage (annualised)	No	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
Outreach household registration visit	*%*	-	-	-	-	-	-	-	-	-	-	-	-
Number of households in the population	*No*	-	-	-	-	-	-	-	-	-	-	-	-
7. Number of districts with district clinical specialist teams (DCSTs)	No	0 complete teams [24]	0	0	0	0	0	0	0	0	0	0	0
8. PHC utilisation rate (annualised)	Rate	3.0*	3.4	2.8	2.5*	3.0	2.4	2.6	3.6	2.9	3.2	2.8	3.3
PHC headcount total	*No*	*31 641 638**	*2 456 035*	*2 941 215*	*1 705 654**	*1 557 375*	*1 217 741*	*2 216 638**	*2 291 132**	*2 762 539*	*2 016 413*	*1 336 558**	*11 230 150**

[24] This is based on the composition of teams as per Ministerial Task Team Report (Specialised Paediatric Nurse, PHC Nurse, Advanced Midwife, Obstetrician, Paediatrician, Public Health Specialist and Anaesthetist)

Indicators	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	eThekwini 2013/14
Population total	*No*	*10 456 909*	*733 228*	*1 052 730*	*682 798*	*514 217*	*507 468*	*824 091*	*638 011*	*937 793*	*630 464*	*471 904*	*3 464 205*
9. Complaint resolution rate [25]	%	76.8%	83.7%	64.9%	71.6%	50.9%	90.4%	79.7%	72.0%	59.3%	71.2%	64.6%	91.3%
Complaint resolved	*No*	*3 394*	*426*	*413*	*58*	*59*	*178*	*149*	*486*	*204*	*141*	*168*	*1 112*
Complaint received	*No*	*4 420*	*509*	*636*	*81*	*116*	*197*	*187*	*675*	*344*	*198*	*260*	*1 217*
10. Complaint resolution within 25 working days rate	No	88.7%*	90.6%	87.7%	79.3%*	94.9%	97.2%	89.2%*	72.4%	86.8%	70.9%	92.9%	88.3%*
Complaint resolved within 25 working days	*No*	*3 013**	*386*	*362*	*46*	*56*	*173*	*149**	*489**	*177*	*100*	*156*	*983**
Total number complaint resolved	*%*	*3 394**	*426*	*413*	*58**	*59*	*178*	*149**	*489**	*204*	*141*	*168*	*1 112**

Source: DHIS - (*) Denotes data that has been updated since the Annual Report 2013/14 was published

[25] Includes all PHC facilities (fixed, mobile, State Aided and LG)

3.6 Strategic Objectives, Indicators and Targets

Table 29: 2015-2019 Strategic Plan Targets

Strategic Goal	Strategic Objective	Strategic Objective Statement	Indicator	Target March 2020
		Life Expectancy		
Strategic Goal 2: Reduce and manage the burden of disease	2.1) Increase life expectancy at birth	2.1.1) Increase the total life expectancy to 60.5 years by March 2020	• Life expectancy at birth: Total	60.5 years (increase of 3.6 years from 2014)
		2.1.2) Increase the life expectancy of males to 58.4 years by March 2020	• Life expectancy at birth: Male	58.4 years (increase of 4 years from 2014)
		2.1.3) Increase the life expectancy of females to 62.7 years by March 2020	• Life expectancy at birth: Female	62.7 years (increase of 3.3 years from 2014)
		Primary Health Care		
Strategic Goal 1: Strengthen health system effectiveness	1.5) Accelerate implementation of PHC re-engineering	1.5.1) Accelerate implementation of PHC re-engineering by increasing household registration coverage with at least 15% per annum	• OHH registration visit coverage (annualised)	90%
		1.5.2) Increase the number of ward based outreach teams in the 169 wards worst affected by poverty to 169 by March 2020 as part of the Poverty Eradication Programme	• Number of ward based outreach teams in the 169 wards worst affected by poverty (cumulative)	169
		1.5.3) Increase the PHC utilisation rate to 3.1 visits per person per year by March 2020	• PHC utilisation rate	3.1
		1.5.4) Increase the PHC utilisation rate under 5 years to 4.8 visits per child by March 2020	• PHC utilisation rate under 5 years (annualised)	4.8
	1.6) Scale up implementation of Operation Phakisa Ideal Clinic Realisation & Maintenance	1.6.1) 100% Provincial fixed PHC facilities score above 80% on the Ideal Clinic Dashboard by March 2020	• Percentage of fixed PHC facilities scoring above 80% on the Ideal Clinic Dashboard	100%
Strategic Goal 5: Improved quality of health care	5.1) Improve compliance to the Ideal Clinic and National Core Standards	5.1.1) Sustain a patient experience of care rate of 95% (or more) at all public health facilities by March 2020	• Patient experience of care rate	95% (or more)

Table 30: (DHS4) Programme Performance Indicators

Strategic Objective Statement	Performance Indicators	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 3.1: Implement the National Health Insurance Pilot										
3.1.1) Improve universal access to health services through implementation of the NHI pilot in 3 districts	1. Number of districts piloting NHI interventions	Documented evidence	Annual/ No	New indicator	New indicator	3	3	3	3	3
	2. Established NHI Consultation Forum	Documented evidence	Annual/ Categorical	New indicator	New indicator	New indicator	Not established	Established	Established	Established
Strategic Objective 1.6: Scale up implementation of Operation Phakisa ICRM										
1.6.1) 100% Provincial fixed PHC facilities score above 80% on the Ideal Clinic Dashboard by March 2020	3. Percentage of fixed PHC facilities scoring above 80% on the Ideal Clinic Dashboard	Ideal Clinic Dashboard	Quarterly/ %	New indicator	New indicator	New indicator	6.25%	20% [26]	40%	60%
	Number of fixed PHC facilities scoring above 80% on the ideal clinic dashboard	*Documented evidence of assessment outcome*	*No*	-	-	-	*18*	*119*	*238*	*356*
	Number of fixed PHC facilities that conducted an assessment using the ideal clinic dashboard to date in the financial year	*Documented evidence of assessment*	*No*	-	-	-	*288*	*594* [27]	*594*	*594*
Strategic Objective 5.1: Improve compliance to the Ideal Clinic and National Core Standards										
5.1.5) Sustain a 100% patient experience of care survey rate in all	4. Patient experience of care survey rate (fixed PHC facilities)	PEC Survey	Quarterly/ %	New indicator	New indicator	New indicator	59.8%	100% [28]	100%	100%

[26] The current assessments for Ideal Clinics use Version 6.4 – the National Department of Health is currently finalising Version 15 that will be used in 2015/16
[27] Excludes NGO and State Aided facilities – denominator and numerator will be reviewed annually to make provision for adjustment in clinic numbers
[28] The significant increase in target corresponds with the Department's requirement that ALL facilities implement the Ideal Clinic Dashboard that requires annual surveys

Strategic Objective Statement	Performance Indicators	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
public health facilities from March 2016	*Total number of fixed PHC facilities that conducted a patient experience of care survey to date in the current financial year*	*PEC evidence*	*No*	-	-	-	*354*	*594*	*594*	*594*
	Total number of fixed PHC facilities	*DHIS calculates*	*No*	-	-	-	*591*	*594*	*594*	*594*
5.1.1) Sustain a patient experience of care rate of 95% (or more) at all public health facilities by March 2020	5. Patient experience of care rate at PHC facilities	PEC results	Annual/ %	New indicator	New indicator	New indicator	91% [29]	*75%*	85%	95%
	Sum of patient experience of care survey scores (in %) of all PHC facilities that conducted a patient experience of care survey to date in the current financial year	*PEC reports*	*No*	-	-	-	*4 191*	*3 450*	*3 910*	*45 370*
	Total number of fixed PHC health facilities that conducted a patient experience of care survey to date in the current financial year	*PEC reports*	*No*	-	-	-	*4 597*	*4 600*	*4 600*	*4 600*
Strategic Objective 1.5: Accelerate implementation of PHC re-engineering										
1.5.1) Accelerate implementation of PHC re-engineering by increasing household registration coverage with at least 15% per annum	6. Outreach household registration visit coverage (annualised)	DHIS	Quarterly/ %	New indicator	New indicator	35.3%[30]	44.7%	*60%*	*75%*	*90%*
	Outreach household registration visit	*DHIS/Tick register WBOT*	*No*	-	-	*40 092*	*50 708*	*68 097*	*85 121*	*102 145*
	Households in the population	*District Records*	*No*	-	-	*113 495*	*113 495*	*113 495* [31]	*113 495*	*113 495*

[29] Interpretation of the indicator and completeness of data has been identified as a challenge and are being investigated, hence the reduction in targets for the MTEF – this will be reviewed annually
[30] Module introduced in October 2013 – therefore not complete annual data
[31] The number of households is an estimate and based on StatsSA data hence denominator staying the same – households will be updated once new data (at sub-place) is available

Strategic Objective Statement	Performance Indicators	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
1.5.5) Maintain 4 complete district clinical specialist teams and the remaining 7 teams with all nursing posts filled from March 2018 onwards	7. Number of districts with District Clinical Specialist Teams	Documented evidence	Quarterly/ Number	Not reported	0 complete	0 complete	1 Complete District Team and 9 District Teams with all nursing posts filled [32]	2 Complete District Teams and remaining 9 District Teams with all nursing posts filled	3 Complete District Teams and remaining 8 District Teams with all nursing posts filled	4 Complete District Teams and remaining 7 District Teams with all nursing posts filled
1.5.3) Increase the PHC utilisation rate to 3.1 visits per person per year by March 2020	8. PHC utilisation rate (annualised)	DHIS	Quarterly/ No	2.7	2.9	3.1*	3	3	3	3
	PHC headcount total	*DHIS/PHC tick register*	*No*	*29 314 618*	*31 110 527*	*31 641 638**	*31 852 608*	*32 234 839*	*32 621 657*	*33 013 117*
	Population total	*DHIS/Stats SA*	*Population*	*10 622 204*	*10 703 920*	*10 456 909*	*10 571 313*	*10 688 165*	*10 806 538*	*10 924 776*
Strategic Objective 5.1: Improve compliance to the Ideal Clinic and National Core Standards										
5.1.6) Sustain a complaint resolution rate of 90% (or more) in all public health facilities from March 2018 onwards	9. Complaint resolution rate	DHIS	Quarterly %	73.6%	75%	76.8%	78%	80%	85%	90%
	Complaint resolved	*Complaints Register*	*No*	*2 803*	*3 344*	*3 394*	*3 712*	*3 520*	*3 695*	*3 870*
	Complaint received	*Complaints Register*	*No*	*3 803*	*4 456*	*4 420*	*4 758*	*4 400*	*4 350*	*4 300*
5.1.7) Sustain a 85% (or more) complaint resolution within 25 working days rate in all public health facilities from March 2018 onwards	10. Complaint resolution within 25 working days rate	DHIS	Quarterly %	New indicator	New indicator	88.7%*	89%	90%	91%	92%
	Complaint resolved within 25 working days	*Complaint register*	*No*	-	-	*3 013**	*3 303*	*3 168*	*3 362*	*3 560*
	Complaint resolved	*Complaint register*	*No*	-	-	*3 394*	*3 712*	*3 520*	*3 695*	*3 870*

Source: DHIS - (*) Denotes data that has been updated since the Annual Report 2013/14 was published

[32] Minimum requirement for composition of teams excludes the Anaesthetist (due to challenges to recruit at this level). The minimum requirement for teams in the Province therefore requires (Family Physician, Obstetrician, and Paediatrician) and (Advanced Midwife, Specialist PHC Nurse, and Paediatric Nurse). Anaesthetists will still be recruited to render services where possible.

Table 31: (DHS3) Provincial Strategic Objectives, Indicators and Targets

Strategic Objective Statement	Performance Indicators	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 2.1: Increase life expectancy at birth										
2.1.1) Increase the total life expectancy to 60.5 years by March 2020	1. Life expectancy at birth - Total	StatsSA mid-year estimates	Annual/ Years	50.6 years	52.6 years	56 years	56.9 years	58.6 years	59.3 years	60 years
2.1.2) Increase the life expectancy of males to 58.4 years by March 2020	2. Life expectancy at birth - Male	StatsSA mid-year estimates	Annual/ Years	48.4 years	50 years	53.4 years	54.4 years	56.4 years	57.1 years	57.9 years
2.1.3) Increase the life expectancy of females to 62.7 years by March 2020	3. Life expectancy at birth - Female	StatsSA mid-year estimates	Annual/ Years	52.8 years	55.2 years	58.7 years	59.4 years	60.7 years	61.4 years	62.1 years
Strategic Objective 1.5: Accelerate implementation of PHC re-engineering										
1.5.4) Increase the PHC utilisation rate under 5 years to 4.8 visits per child by March 2020	11. PHC utilisation rate under 5 years (annualised)	DHIS	Quarterly/ No per person	.6	4.7	4.4	4.4	4.5	4.6	4.7
	PHC headcount under 5 years	*DHIS/PHC tick register*	*No*	*5 161 689*	*5 173 787*	*5 113 307**	*5 161 868*	*5 213 487*	*5 265 622*	*5 318 278*
	Population under 5 years	*DHIS/Stats SA*	*No*	*1 118 510*	*1 104 893*	*1 171 910*	*1 165 062*	*1 154 059*	*1 142 878*	*1 132 753*
1.5.6) Increase the expenditure per PHC headcount to R 326 by March 2018	12. Expenditure per PHC headcount	DHIS/BAS	Quarterly/ R	R 194*	R 221	R 227[33]	R 257	R 300	R 318	R 340
	Total expenditure PHC (Sub-Programme 2.2-2.7)	BAS	R'000	*5 704 222*	*6 567 175*	*7 196 511*	*8 194 362*	*9 675 023*	*10 394 434*	*11 248 769*
	PHC headcount total	DHIS calculates	No	*29 314 618*	*31 110 527*	*31 888 199*	*31 852 608*	*32 234 839*	*32 621 657*	*33 013 117*

[33]This figure does not align to the DHER 2013/14 as the method of calculation is different

Strategic Objective Statement	Performance Indicators	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
1.5.7) Increase School Health Teams to 260 by March 2020	13. Number of School Health Teams (cumulative)	District Records/ Persal	Quarterly/ No (cum)	86 cum	147 cum (61)	176 cum (29)	186 cum (10)	206 cum (20)	229 cum (23)	255 cum (26)
1.5.2) Increase the number of ward based outreach teams in the 169 wards worst affected by poverty to 169 by March 2020 as part of the Poverty Eradication Master Plan	14. Number of Ward Based Outreach Teams in the 169 wards worst affected by poverty (cumulative)	District Records/ Persal	Quarterly/ No (cum)	New indicator	New indicator	New indicator	New indicator	20 [34]	63 cum (43)	89 cum (26)
1.5.8) Increase the accredited Health Promoting Schools to 380 by March 2020	15. Number of accredited Health Promoting Schools (cumulative)	Health Promotion database	Quarterly/ No (cum)	210	247	247	277	319 (24)	343 (24)	367 (24)
Strategic Objective 5.2: Improve quality of care										
5.2.4) Improve efficiencies in dental health by reducing the dental extraction to restoration ratio to less than 12 by March 2020	16. Dental extraction to restoration ratio	DHIS	Quarterly/ No	20	16	17	16	15	14	13
	Tooth extraction	*DHIS/Tick register*	*No*	*449 901*	*474 838*	*512 888*	*556 144*	*583 951*	*613 149*	*643 806*
	Tooth restoration	*DHIS/Tick register*	*No*	*20 996*	*29 161*	*30 089*	*33 982*	38 930	43 796	*49 523*

Source: DHIS (*) Denotes data that has been updated since publishing the 2013/14 Annual Report

[34] This is an ambitious target largely dependent on available funding to increase teams in the identified wards. Teams will however be required to cover more than one ward to ensure appropriate coverage

3.7 2015/16 Targets

Table 32: (DHS5) Quarterly and Annual Targets

Performance Indicators	Targets 2015/16	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Percentage of fixed PHC facilities scoring above 80% on the Ideal Clinic Dashboard	20%	8%	12%	15%	20%
2. Patient experience of care survey rate (fixed PHC facilities)	100%	25%	50%	75%	100%
3. Outreach household registration visit coverage (annualised)	60%	48%	53%	58%	60%
4. Number of districts with district clinical specialist teams	2 Complete District Teams and the remaining 9 District Teams with all nursing posts filled [35]	1 Complete District Team and the remaining 10 District Teams with all nursing posts filled	1 Complete District Team and the remaining 10 District Teams with all nursing posts filled	1 Complete District Team and the remaining 10 District Teams with all nursing posts filled	2 Complete District Teams and the remaining 9 District Teams with all nursing posts filled
5. PHC utilisation rate	3.0	3.0	3.0	3.0	3.0
6. Complaint resolution rate	80%	77%	78%	79%	80%
7. Complaint resolution within 25 working days rate	90%	90%	90%	90%	90%
8. PHC utilisation rate under 5 years (annualised)	4.5	4.4	4.4	4.5	4.5
9. Expenditure per PHC headcount	R 300	R 260	R 275	R 290	R 300
10. Number of School Health Teams (cumulative)	206	191	196	201	206
13. Number of Ward-Based Outreach Teams in the 169 wards worst affected by poverty (cumulative)	20	0	5	10	20
14. Number of accredited Health Promoting Schools (cumulative)	319	264	283	302	319
15. Dental extraction to restoration ratio	15	16	16	16	15
Annual Targets					
16. Number of districts piloting NHI interventions	3				3
17. Established NHI Consultation Forum	Forum established				Forum established
18. Patient experience of care rate at PHC facilities	75%				75%
20. Life expectancy at birth: Total	58.6 years				58.6 years
21. Life expectancy at birth: Male	56.4 years				56.4 years
22. Life expectancy at birth: Female	60.7 years				60.7 years

[35] The target is based on the minimum requirement for composition of teams – see previous comment

3.8 Risk Management

Table 33: Risk Management

Potential Risks	Mitigating Strategies
1. Limited funding envelope not supportive of expansion of services (short, medium and long term service demands – service transformation) in line with burden of disease and service demands. *(High Risk)*	• Re-prioritisation within funding envelope as part of the planning process. • Accountability framework to improve compliance with budget requirements and PFMA imperatives.
2. Inadequate integration of programmes/ services at PHC level resulting in inadequate utilisation of limited existing resources. *(Medium Risk)*	• Integration of programmes at service delivery level and change of budget allocation process to support integration.
3. Health system challenges e.g. HR, Finance, SCM and information systems/ management. *(High Risk)*	• Prioritised health system challenges in strategic period.
4. Organisational/ structural arrangement(s) not supportive of innovation and creativity. *(High Risk)*	• Review of organisation structures in line with service delivery mandates and functions including Regionalisation to address identified bottlenecks.
5. Slow implementation of health promotion and disease prevention interventions – curative biased health system. *(Medium Risk)*	• Included in Provincial Growth and Development Plan and Operation Sukuma Sakhe, making provision for multi-sectoral implementation.
6. Social determinants of health exacerbating the high burden of disease and health outcomes. *(High Risk)*	

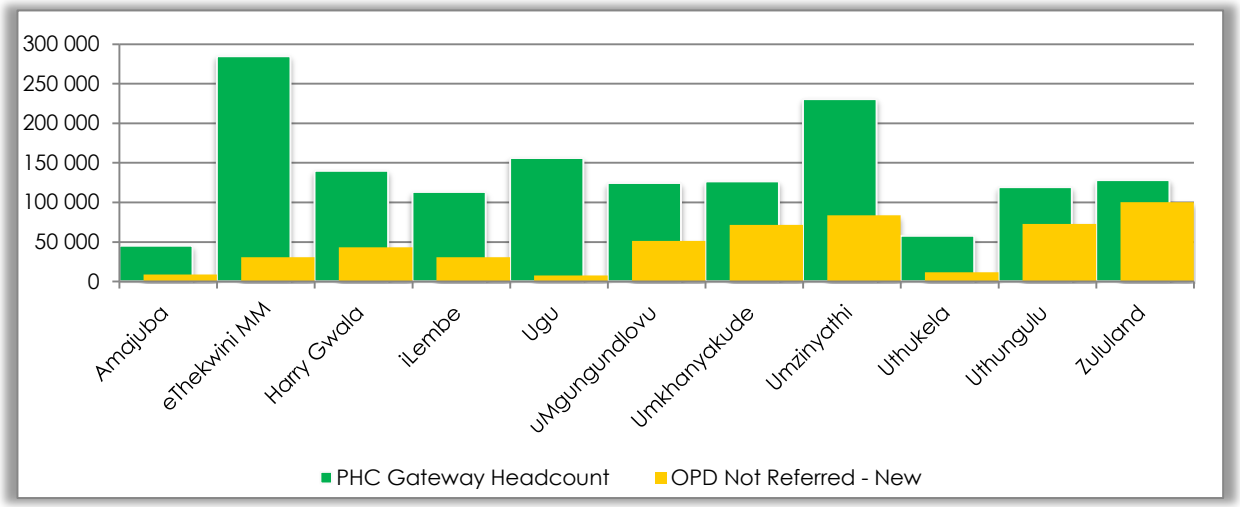
DISTRICT HOSPITALS

3.9 Overview

Thirty-seven (37) of the 72 hospitals in KwaZulu-Natal are classified as District Hospitals with each district having at least 2 District Hospitals. Location of some of the hospitals affects efficiencies and in eThekwini, Regional Hospitals provide a substantial portion of level one services to ensure accessibility. This trend is exacerbated by the growing informal settlements in the 3 economic hubs.

The tendency of patients to access PHC services at hospital level are exacerbated by inadequate PHC services at both community and facility levels which have significant cost and resource implications. One of the main focus areas therefore is to decongest hospitals by ensuring adequate access to PHC services at the appropriate level of care. PHC re-engineering, including the establishment and/or strengthening of Gateway clinics, has begun to show positive results in the reduction of PHC patients loads at hospital level. The GJ Crooks District Hospital in Ugu is a point in case reporting no un-referred PHC patients in 2013/14 as all un-referred patients entered the system through the Gateway Clinic at the hospital.

Graph 5: OPD not referred headcount vs PHC Gateway headcount



There are 29 District Hospitals with Gateway Clinics and 8 without (Mbongolwane, Catherine Booth, Rietvlei, Manguzi, Osindisweni, Nkandla, Vryheid and Benedictine). The high number of unreferred OPD cases in these 8 hospitals shows that Gateway clinics play a crucial role in decongesting hospitals. Seven (7) of the 8 hospitals without Gateway clinics have high un-referred headcounts in the top 40% provincially.

Graph 3 illustrates that although Gateway clinics are functional, seeing approximately 5% of the total PHC headcount (1 523 722), the un-referred cases are equivalent to 33% of the PHC Gateway headcount indicating that there are still missed opportunities in spite of established Gateways. Provincially, the headcount at Gateway clinics is increasing year-on-year as anticipated, however the un-referred headcounts is also increasing by 3% with Zululand having the most significant increase (30 081 headcount) offsetting the gains made in other districts.

Table 34: Relationship between PHC services and District Hospitals

District	Ambulatory to IPD ratio for District Hospital	OPD new client not referred rate[36] District Hospital	OPD new client not referred total (District Hospital)		PHC headcount at Gateway clinics (all hospital categories)	
			2013/14	2012/13	2013/14	2012/13
Amajuba	8.4	40.0%	8 601 ↓	10 463	45 178 ↓	76 483
eThekwini	2.1	46.7%	30 689 ↓	51 341	284 504 ↓	308 637
Harry Gwala	1.1	69.1%	42 918 ↑	32 874	139 634 ↑	139 458
Ilembe	1.4	84.9%	30 400 ↑	29 067	112 903 ↑	40 616
Ugu	1.3	15.4%	7 444 ↓	8 503	156 042 ↑	142 110
Umgungundlovu	2.4	29.7%	51 017 ↑	42 185	124 184 ↓	128 948
Umkhanyakude	1.3	50.3%	71 156 ↑	64 760	126 181 ↑	125 368
Umzinyathi	1.0	70.4%	83 444 ↓	100 412	230 423 ↑	212 341
Uthukela	1.5	42.9%	11 600 ↓	13 757	85 797 ↑	78 957
Uthungulu	1.8	62.6%	72 617 ↑	71 589	118 925 ↑	82 077
Zululand	1.0	61.6%	100 147 ↑	70 066	127 974 ↑	121 287
KwaZulu-Natal	**1.4[37]**	**52.5%**	**510 033 ↑**	**495 017**	**1 551 745 ↑**	**1 456 282**

Source: DHIS 2013/14 download and manual calculations

Note: The unreferred OPD clients in Umzinyathi were double counted during 2012/13 and 2013/14 and therefore skew district data. The District is aware of this and is correcting it.

The number of useable level 1 beds per 1000 population (0.76 or 7 921 usable beds) is above the provincial norm of 0.66 beds per 1000 population. Cognisance should however be taken of the location and efficiency of these hospitals when assessing equity. The Hospital Rationalisation Plan will make provision for the review of equities and efficiencies including referral pathways that will align with the review of Regional Hospital Complexes and Centres of Excellence.

Pressure areas for District Hospital beds have been identified in eThekwini with 457 beds for 3.4 million catchment population, Msunduzi with one District Hospital and uMhlathuze where there is no district hospital for the Richards Bay / Empangeni catchment area.

Mental Health Services, especially 72 hour observation, remain a challenge at District Hospitals especially referral to Regional Hospitals (inadequate number of beds) and Specialised Psychiatric Hospitals where the number of hospitals and distance plays a role in appropriate referral. To improve access in Region 4, Regional Psychiatric Units will be developed in identified District Hospitals (Mseleni, Benedictine and Eshowe Hospitals) with support from Ngwelezane Hospital.

[36]This indicator compares the number of "OPD Not Referred New" clients against "OPD Referred New Clients"
[37] Acceptable norm is 1:1

3.10 2015/16 Priorities

1. Rationalisation of Hospital Services.	• Hospital Rationalisation Plan (relevant to all hospitals). • District Hospital Caesarean Section Centres in identified hospitals to improve maternal health outcomes.
2. Improved quality and efficiency.	• National Core Standards including self-assessments and development/ implementation of Quality Improvement Plans to address identified gaps.
3. Improved Human Resources for Health.	• Leadership, management and mentorship programme(s) at facility level. • Filling of essential posts.
4. Support Services.	• Food, Security, Laundry and Clinical Support services (included in Programmes 1 and 7). • Review delegations including finance, SCM and HR and conduct training programmes to ensure effective implementation.

3.11 Situation Analysis Indicators per District

Table 35: (DHS6) Situation Analysis Indicators - 2013/14

Indicators	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	eThekwini 2013/14
1. National core standards self-assessment rate	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of District Hospitals that conducted national core standards self-assessment to date in the current financial year	*No*	*37*	*3*	*2*	*2*	*4*	*1*	*5*	*5*	*6*	*3*	*4*	*2*
District Hospitals total	*No*	*37*	*3*	*2*	*2*	*4*	*1*	*5*	*5*	*6*	*3*	*4*	*2*
2. Quality Improvement Plan after self-assessment rate	%	81%	Not available [38]	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Number of District Hospitals that developed a quality improvement plan to date in the current financial year	*No*	*30*	-	-	-	-	-	-	-	-	-	-	-

[38] District data could not be sourced from the Quality Assurance Programme before finalisation of the APP

Indicators	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	eThekwini 2013/14
Number of District Hospitals that conducted national core standard self-assessment to date in the current financial year	*No*	*37*	-	-	-	-	-	-	-	-	-	-	-
3. Percentage of hospitals compliant with all extreme and vital measures of the national core standards	%	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
Total number of District Hospitals that are compliant to all extreme measures and at least 90% of vital measures of national core standards	No	-	-	-	-	-	-	-	-	-	-	-	-

Indicators	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	eThekwini 2013/14
Number of District Hospitals that conducted national core standards self-assessment to date in the current financial year	*No*	-	-	-	-	-	-	-	-	-	-	-	-
4. Patient experience of care survey rate	%	83.7%	Not available [39]	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Total number of District Hospitals that conducted a patient experience of care (PEC) survey to date in the current financial year	*No*	*31*	-	-	-	-	-	-	-	-	-	-	-
Total number of District Hospitals	*No*	*37*	-	-	-	-	-	-	-	-	-	-	-
5. Patient experience of care rate	%	88.2%	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available

[39] Indicators 4 and 5: District data could not be sourced from the Quality Assurance Programme before finalisation of the APP

Indicators	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	eThekwini 2013/14
Sum of patient experience of care scores in District Hospitals that conducted a patient experience of care survey to date in the current financial year	*No*	*7 144*	-	-	-	-	-	-	-	-	-	-	-
Total number of hospitals that conducted a PEC Survey to date in the current financial year	*No*	*8 100*	-	-	-	-	-	-	-	-	-	-	-
6. Average length of stay	Days	5.8 Days	5.9 days	5.2 Days	5.3 Days	6.1 Days	3.7 Days	6.2 Days	5.5 Days	6.1 Days	6.3 days	5.5 Days	6.1 Days
Inpatient days - total	*No*	*1 986 431*	*211 944*	*153 156*	*105 557*	*239 831*	*9 040*	*318 441*	*270 775*	*201 880*	*80 165*	*172 026*	*223 616*
Day patients	*No*	*10 623*	*153*	*816*	*184*	*165*	*420*	*983*	*195*	*298*	*1 060*	*208*	*6 141*
Inpatient separations	No	342 311	36 094	29 317	20 089	39 484	2 484	51 407	49 071	332 342	12 806	31 185	37 032
7. Inpatient bed utilisation rate	%	64.5%	70.9%	74.6%	63.4%	63.6%	44.3%	67.5%	60.7%	47.2%	56.7%	66.8%	83.2%
Inpatient days - total	*No*	*1 986 431*	*211 944*	*153 156*	*105 557*	*239 831*	*9 040*	*318 441*	*270 775*	*201 880*	*80 165*	*172 026*	*223 616*
Day patients	No	*10 623*	*153*	*816*	*184*	*165*	*420*	*983*	*195*	*298*	*1 060*	*208*	*6 141*
Inpatient bed days available	No	*3 088 508*	*299 026*	*205 921*	*166 714*	*376 984*	*20 866*	*472 493*	*446 182*	*428 297*	*142 228*	*257 477*	*272 320*
8. Expenditure per PDE	R	R 1 941	R 1 523	R 1 708	R 1 781	R 1 829	R 1 981	R 1 692	R 1 674	R 1 750	R 2 119	R 1 736	R 1 063

Indicators	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	eThekwini 2013/14
Expenditure total	*R'000*	*R 5 433 841*	*R 463 734*	*R 444 694*	*R 281 521*	*R 589 499*	*R 68 259*	*R 718 039*	*R 647 730*	*R 560 609*	*R 248 913*	*R 405 470*	*R 317 950*
Patient day equivalent	*No*	*2 788 322*	*304 324*	*274 324*	*158 067*	*322 276*	*34 454*	*426 268*	*386 777*	*320 247*	*117 429*	*233 502*	*223 654*
9. Complaint resolution rate	%	73.1%	38.4%	82.7%	32.6%	45.3%	88.2%	75.4%	84.6%	83.3%	51.9%	64.0%	97.6%
Complaint resolved	*No*	*2 034*	*118*	*211*	*57*	*81*	*15*	*46*	*297*	*380*	*41*	*174*	*614*
Complaint received	*No*	*2 781*	*307*	*255*	*75*	*179*	*17*	*61*	*351*	*456*	*79*	*272*	*629*
10. Complaint resolution within 25 working days rate	%	84.9%	74.5%	108.5%	96.5%	87.7%	93.3%	34.8%	92.9%	92.9%	97.6%	90.8%	69.5%
Complaint resolved within 25 working days	*No*	*1 727*	*88*	*229*	*55*	*71*	*14*	*16*	*276*	*353*	*40*	*158*	*427*
Complaint resolved	*No*	*2 034**	*118**	*211*	*57*	*81*	*15*	*46*	*297*	*380*	*41*	*174*	*614*

Source: DHIS and Quality Assurance Programme database. (*) Denotes data that has been updated since the Annual Report 2013/14 was published

3.12 Strategic Objectives, Indicators and Targets

Table 36: 2015-2019 Strategic Plan Targets

Strategic Goal	Strategic Objective	Strategic Objective Statement	Indicator	Target March 2020
Strategic Goal 1: Strengthen health system effectiveness	1.7) Improve hospital efficiencies	1.7.1) Maintain a bed utilisation rate of 75% (or more)	• Inpatient bed utilisation rate	75% (or more)
		1.7.2) Develop and implement the approved Hospital Rationalisation Plan by March 2016	• Hospital Rationalisation Plan	Plan implemented
Strategic Goal 2: Reduce and manage the burden of disease	2.7) Reduce maternal mortality	2.7.2) Improve maternal health outcomes by establishing 11 District Caesarean Section Centres by March 2018	• Number of fully functional District Caesarean Section Centres (cumulative)	11
Strategic Goal 5: Improved quality of health care	5.1) Improve compliance to the Ideal Clinic and National Core Standards	5.1.1) Sustain a patient experience of care rate of 95% (or more) at all public health facilities by March 2020	• Patient experience of care rate	95% (or more)
		5.1.2) 60% (or more) public health hospitals compliant with extreme and vital measures of the national core standards by March 2020	• Percentage of hospitals compliant with all extreme and vital measures of the national core standards	60% (or more)

Table 37: (DHS8) Programme Performance Indicators

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 5.1: Improve compliance to the Ideal Clinic and National Core Standards										
5.1.3) 100% Public health hospitals conduct annual national core standard self-assessments by March 2016	1. National core standards self-assessment rate	DHIS/ NCS Module	Quarterly/ %	100%	94.6%	100%	21.6%	100%[40]	100%	100%
	Number of District Hospitals that conducted national core standard self-assessment to date in the current financial year	*NCS Assessment records*	*No*	*37*	*35*	*37*	*8*	*37*	*37*	*37*
	District Hospitals total	*DHIS calculates*	*No*	*37*	*37*	*37*	*37*	*37*	*37*	*37*
5.1.4) 100% Public health hospitals develop and implement Quality Improvement Plans based on national core standard assessment outcomes by March 2016	2. Quality improvement plan after self-assessment rate	DHIS – NCS Module	Quarterly/ %	New indicator	New indicator	81%	100%	100%	100%	100%
	Number of District Hospitals that developed a quality improvement plan to date in the current financial year	*DHIS/ QIP evidence*		-	-	*30 -*	*8*	*37*	*37*	*37*
	Number of District Hospitals that conducted national core standard self-assessment to date in the current financial year	*DHIS/ NCS self-assessment records*		-	-	*37*	*8*	*37*	*37*	*37*

[40] Indicators 1 and 2: The significant increase in the target for the MTEF is based on the Provincial requirement that ALL facilities must implement the National Core Standards, conduct annual assessments and develop Quality Improvement Plans to address the identified gaps

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
5.1.2) 60% (or more) public health hospitals compliant with extreme and vital measures of the national core standard by March 2020	3. Percentage of hospitals compliant with all extreme and vital measures of the national core standards	DHIS – NCS Module	Quarterly/ %	New indicator	New indicator	New indicator	New indicator	14%	30%	46%
	Total number of District Hospitals that are compliant to all extreme measures and at least 90% of vital measures of national core standards	*DHIS/ NCS assessment records*	*No*	-	-	-	-	*5*	*11*	*17*
	Number of District Hospitals that conducted national core standards self-assessment to date in the current financial year	*DHIS/ NCS assessment results*	*No*	-	-	-	-	*37*	*37*	*37*
5.1.5) Sustain a 100% patient experience of care survey rate in all public health facilities from March 2016	4. Patient experience of care survey rate	PEC survey results	Quarterly/ %	78%	84%	83.7%	91.8%	100%	100%	100%
	Total number of District Hospitals that conducted a patient experience of care (PEC) survey to date in the current financial year	*PEC evidence*	*No*	*28*	*31*	*31*	*34*	*37*	*37*	*37*
	Total number of District Hospitals	*DHIS*	*No*	*37*	*37*	*37*	*37*	*37*	*37*	*37*
5.1.1) Sustain a patient experience of care rate	5. Patient experience of care rate	PEC results	Annual/ %	New indicator	New indicator	88.2%	49.4% [41]	90%	95%	95%

[41] Data seems questionable and are being verified – not complete by time of finalising the APP. Based on the definition from the NDOH, the Quality Assurance Component uses an incorrect numerator and denominator for calculation of this indicator. Trend data will therefore NOT be used for the 2015/16 MTEF

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
of 95% (or more) at all public health facilities by March 2020	*Sum of patient experience of care survey scores (in %) of all District Hospitals that conducted a patient experience of care survey to date in the current financial year*	*PEC evidence*	*No*	-	-	*7 144*	*1 485*	- [42]	-	-
	Total number of District Hospitals that conducted a patient experience of care survey to date in the current financial year	*PEC evidence*	*No*	-	-	*8 100*	*3 007*	*37*	*37*	*37*
Strategic Objective 1.7: Improve hospital efficiencies										
1.7.3) Improve hospital efficiencies by reducing the average length of stay to less than 5 days (District & Regional), 15 days (TB), 280 days (Psych), 35 days (Chronic), 7.6 days (Tertiary), and 6.5 days (Central) by March 2020	6. Average length of stay - total	DHIS	Quarterly/ Days	5.8 Days	5.6 Days	5.8 Days	5.9 Days	5.8 Days	5.8 Days	5.8 Days
	In-patient days - total	*Midnight census*	*No*	*1 973 596*	*1 968 788*	*1 986 431*	*2 008 898*	*2 049 076*	*2 090 057*	*2 131 859*
	Day patients	*Midnight census*	*No*	*13 825*	*15 315*	*10 623*	*11 300*	*11 865*	*12 458*	*13 081*
	Inpatient separations	*DHIS calculates*	*No*	*337 550*	*353 017*	*342 311*	*340 412*	*348 922*	*357 645*	*366 586*
1.7.1) Maintain a bed utilisation rate of 75% (or more)	7. Inpatient bed utilisation rate - total	DHIS	Quarterly / %	63.7%	63.2%	64.5%	63.6%	64.7%	66.1 %	67.4%
	In-patient days - total	*Midnight census*	*No*	*1 973 596*	*1 968 788*	*1 896 431*	*2 008 898*	*2 049 076*	*2 090 057*	*2 131 859*
	Day patients	*Midnight census*	*No*	*13 825*	*15 315*	*10 623*	*11 300*	*11 865*	*12 458*	*13 081*
	Inpatient bed days available	*Management*	*No*	*3 170 390*	*3 128 354*	*3 088 508*	*3 174 770*	*3 173 310*	*3 173 310*	*3 173 310*

[42] According to the National Department of Health the system calculates different levels of satisfaction. The current system used by the Quality Assurance Component does not make provision for this – it is therefore not possible to estimate MTEF targets for the numerator – this will be based on data from national system. The Provincial target of 95% satisfaction by March 2020 is however binding irrespective of raw data

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 1.7: Improve hospital efficiencies										
1.7.4) Maintain expenditure per PDE within the provincial norms	8. Expenditure per patient day equivalent	BAS/DHIS	Quarterly R	R 1 434*	R 1 756*	R 1 941	R 1 971	R 1 871	R 1 948	R 2 024
	Expenditure total	*BAS*	*R'000*	*4 289 725*	*4 901 829*	*5 433 841*	*5 726 968*	*5 492 090*	*5 775 777*	*6 061 158*
	Patient day equivalent	*DHIS calculates*	*No*	*2 990 662*	*2 791 065*	*2 799 322*	*2 905 984*	*2 935 044*	*2 964 394*	*2 994 034*
Strategic Objective 5.1: Improve compliance to the Ideal Clinic and National Core Standards										
5.1.6) Sustain a complaint resolution rate of 90% (or more) in all public health facilities from March 2018 onwards	9. Complaints resolution rate	DHIS	Quarterly %	68.3%	77.9%	73.1%	68.6%	75% [43]	80%	90%
	Complaints resolved	*Complaints Register*	*No*	*1 570*	*1 763*	*2 034**	*1 920*	*2 100*	*2 224*	*2 412*
	Complaints received	*Complaints Register*	*No*	*2 299*	*2 263*	*2 781*	*2 800*	*2 800*	*2 780*	*2 680*
5.1.7) Sustain a 85% (or more) complaint resolution within 25 working days rate in all public health facilities from March 2018 onwards	*10.* Complaint resolution within 25 working days rate	DHIS	Quarterly %	Data not available	Data not available	84.9%	84%	85%	85%	85%
	Complaints resolved within 25 working days	*PSS*	*No*	-	-	*1 727*	*1 612*	*1 785*	*1 890*	*2 050*
	Complaints resolved	*PSS*	*No*	-	-	*2 034**	*1 920*	*2 100*	*2 224*	*2 412*

[43] Indicators 9 and 10: It is very difficult to predict the denominator for this indicator as patient complaints is not predictable. The intention is however to resolve all complaints preferably within 25 working days

Table 38: (DHS7) Provincial Strategic Objectives and Targets

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 2.7: Reduce maternal mortality										
2.7.2) Improve maternal health outcomes by establishing 11 District Caesarean Section Centres by March 2018	1. Number of fully functional District Caesarean Section Centres (cumulative)	Hospital records	Annual/ No	New indicator	New indicator	New indicator	New indicator	5 [44]	9	11
2.7.3) Reduce the caesarean section rate to 25% (District), 37% (Regional), 60% (Tertiary), and 60% (Central) by March 2020	2. Delivery by caesarean section rate	DHIS calculates	Quarterly %	26%	27%	27.4%	27.1%	26.7%	26.3%	26%
	Delivery by caesarean section	*Delivery register*	*No*	*22 819*	*23 523*	*23 862*	*24 450*	*24 331*	*24 206*	*24 169*
	Delivery in facility total	*Delivery register*	*No*	*87 843*	*87 124*	*87 009*	*90 225*	*91 127*	*92 039*	*92 959*
Strategic Objective 1.7: Improve hospital efficiencies										
1.7.5) Reduce the unreferred outpatient department (OPD) headcounts with at least 7% per annum	3. OPD headcount- total	DHIS/OPD tick register	Quarterly No	2 698 087	2 611 405	2 459 718	2 403 304	2 385 926	2 314 349	2 244 918
	4. OPD headcount not referred new	DHIS/OPD tick register	Quarterly No	475 782	458 379	525 032	522 292	454 101	422 314	392 753

[44] The number of Centres will be determined by national criteria (not yet finalised) and needs in the Province – target will be reviewed in 2015/16 based on approved criteria and need

3.13 2015/16 Targets

Table 39: (DHS9) Quarterly and Annual Targets

Performance Indicators	Targets 2015/16	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. National core standards self-assessment rate	100%	25%	50%	75%	100%
2. Quality improvement plan after self-assessment rate	100%	25%	50%	75%	100%
3. Percentage of hospitals compliant with all extreme and vital measures of the national core standards	14% (5)	0%	3%	10%	14% (5)
4. Patient experience of care survey rate	100%	25%	50%	75%	100%
5. Average length of stay - total	5.8 Days	5.8 Days	5.8 Days	5.8 Days	5.8 Days
6. Inpatient bed utilisation rate - total	64.7%	64.0%	64.3%	64.5%	64.7%
7. Expenditure per patient day equivalent (PDE)	R 1 808	R 1 930	R 1 900	R 1 850	R 1 808
8. Complaint resolution rate	75%	75%	75%	75%	75%
9. Complaint resolution within 25 working days rate	85%	85%	85%	85%	85%
10. Delivery by caesarean section rate	26.7%	27%	26.9%	26.8%	26.7%
11. OPD headcount- total	2 385 926	596 481	596 481	596 481	596 483
12. OPD headcount not referred new	454 101	113 525	113 525	113 525	113 526
Annual Targets					
13. Patient experience of care rate	90%				90%
14. Number of fully functional District Caesarean Section Centres (cumulative)	5				5

3.14 Risk Management

Table 40: Risk Management

Potential Risks	Mitigating Strategies
1. Classification of hospitals not in line with the service delivery platform which affects resource allocation, efficiencies and cost. *(High Risk)*	• Review classification as part of the Hospital Rationalisation Plan and aligned with the Provincial Long Term Plan.
2. Limited funding envelope challenges system reforms and development of appropriate services in line with burden of disease and service demands. *(High Risk)*	• Implementation of the Hospital Rationalisation Plan – inform resource allocation and service development.
3. Poor data quality and information management impacts on decision-making and planning. *(High Risk)*	• Implementation of the Data Management Strategy to improve data quality. Regular reviews and improved data verification as part of the strategy.
4. Inadequate human resources including appropriate skills to manage the burden of disease and service demands.	• Implementation of the Long Term HR Plan to ensure equity in human resource allocation. Review of recruitment and retention strategy (in especially rural areas).

Potential Risks	Mitigating Strategies
Inequities in allocation of resources (inadequate information) will affect rendering of the appropriate package of services. *(High Risk)*	
5. Inadequate management capacity – inadequate training, mentoring, outreach and support. *(High Risk)*	♦ Implementation of Hospital Rationalisation Plan.

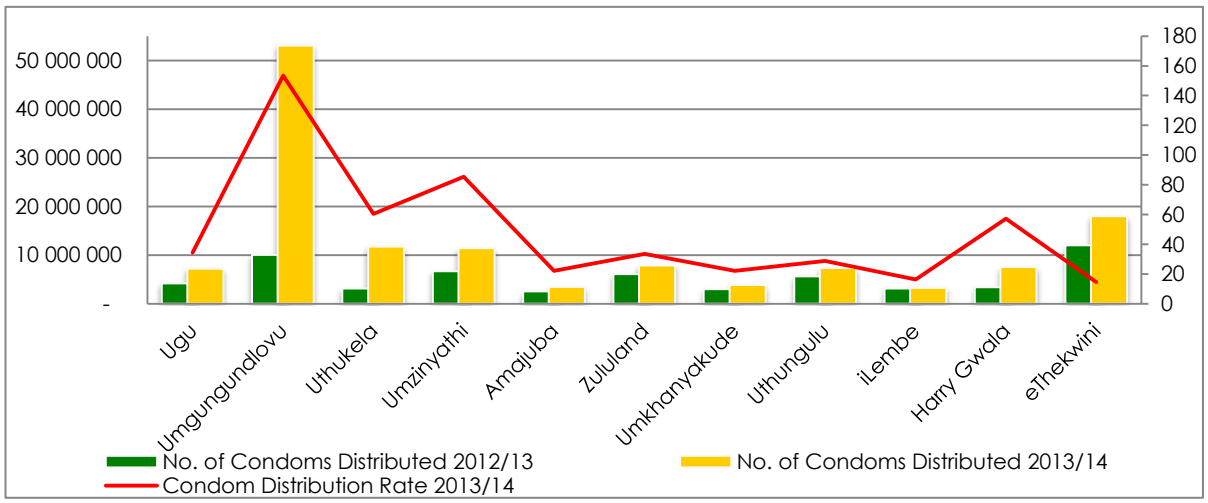
HIV, AIDS, STI & TB CONTROL (HAST)

3.15 Overview

The prevention of new HIV infections remains a priority with the main focus on male medical circumcision (MMC), increase in condom distribution and expansion of various media platforms to educate and inform the public of available services and how/ where to access these services. In 2015/16, billboards will be placed at entrances and exits of one major town in each district to create awareness and increase demand for MMC. Roving district MMC teams will be re-established to ensure that MMC procedures can be performed daily at all facilities.

The increase in distribution sites for male condoms has had a direct impact on both the male condom distribution rate as well as the couple year protection rate, the effects of which can clearly be seen in the data reported for Umgungundlovu District for 2013/14 (Graph 6).

Graph 6: Number of condoms distributed 2012/13 – 2013/14 and condom distribution rate 2013/14



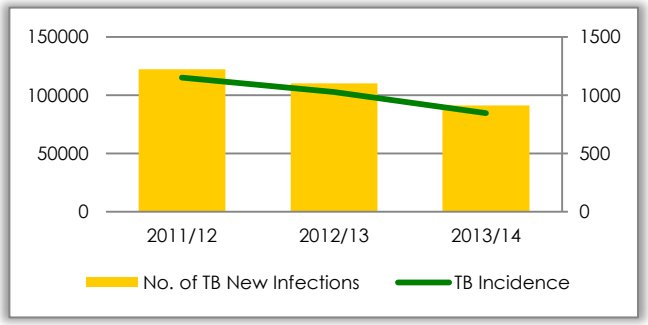
Source: DHIS

The change in the HIV/AIDS Policy, increasing the threshold for the CD4 Count from 200 to 350 between 2011/12 and 2012/13 is clearly evident in the increased number of patients on ART. It is anticipated that a similar increase will be recorded during 2015/16 due to the increase of the CD4 Count threshold to 500

(informed by international practices expounded by the World Health Organisation). The rationale behind the policy change is that outcomes are better when treating patients who are still healthy.

It is hypothesised that as the ART programme increases and more clients access ART services, the HIV prevalence should remain high, as is the trend currently. As incidence decreases the younger age cohorts will however begin to show a decrease in prevalence over time.

Graph 7: TB new infections versus TB incidence



TB incidence shows a steady decrease over the past 3 years (Graph 7).

Currently, approximately 2.5% of all identified TB cases are drug-resistant TB (DR-TB) cases, with 10% of these cases being XDR-TB. Strengthening of the OSS strategy, supported by the integration of TB at PHC level, is expected to increase the number of TB cases over the next few years.

Source: ETR.Net

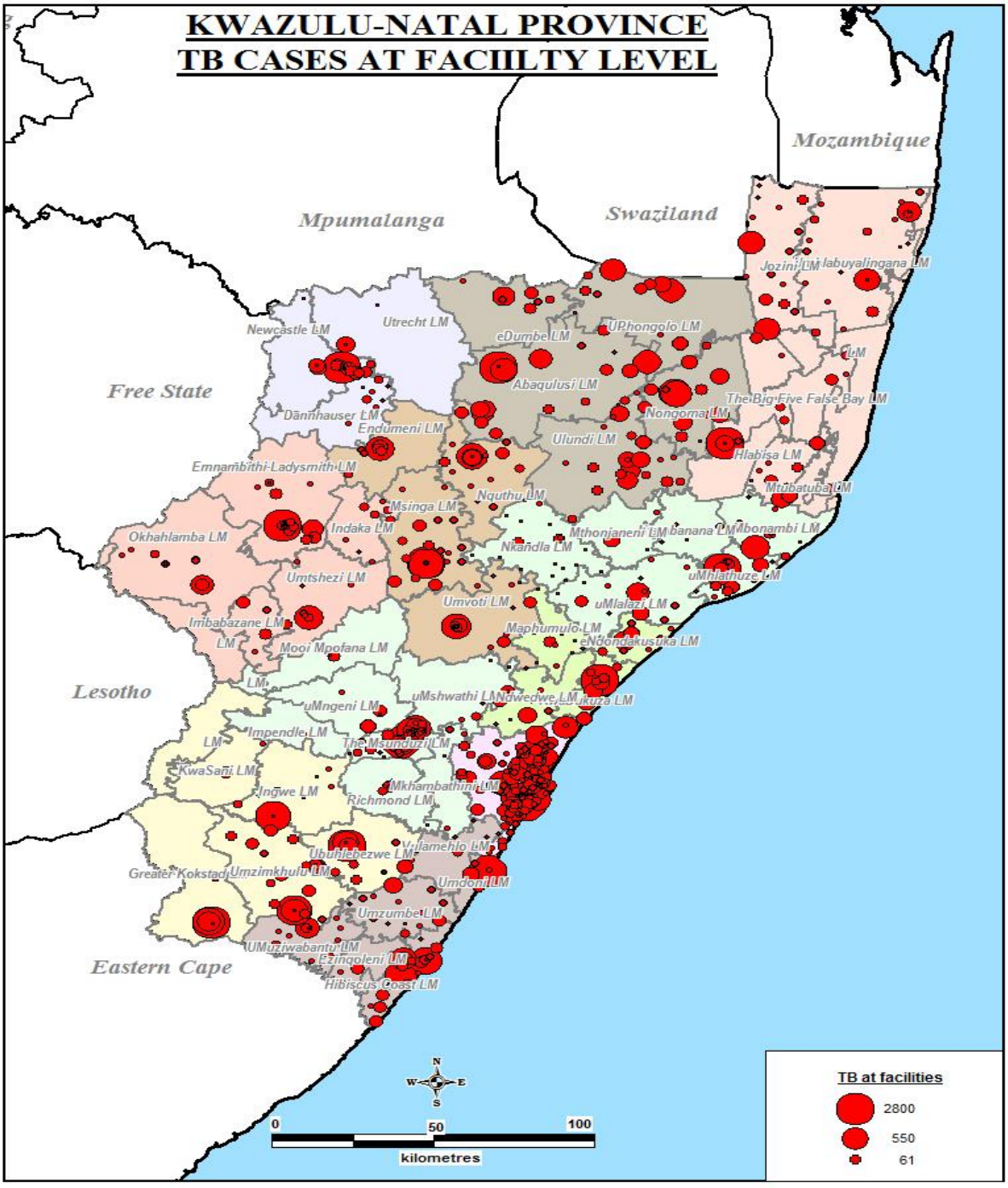
At community level, the early identification and treatment of TB has been prioritised to reduce both the mortalities and morbidities associated with this disease. TB hotspots are being prioritised to ensure pro-active interventions including appropriate resource allocation at these identified areas (Map 1).

The focus for the 2015/16 MTEF will be the intensification of case finding/ surveillance. Research has shown that intensified case finding at a household level yields 1% of new TB cases whereas intensified case findings at a hospital level yield 10% - 12% of new TB cases with less resources required. Intensified case finding at Edendale Hospital in 2014/15 is showing a definite increase in the number of TB cases.

The commissioning of the 96 TB beds at King Dinuzulu Hospital will have a direct impact on patient activity in the 3 SANTA hospitals in eThekwini, the logistics of which should be reviewed to ensure efficiencies are maintained. The 3 proposed Decentralised MDR-TB Initiation Sites at Madadeni (Amajuba), Montebello (Ilembe) and Estcourt (Uthukela) Hospitals, once commissioned, will alleviate some of the backlog pressure that King Dinuzulu is currently experiencing.

The initiation of TB patients on IPT has had a positive impact in reducing mortality. A current study at Edendale Hospital will provide the Department with valuable information to inform future strategies.

Map 1: TB "Hotspots" within KwaZulu-Natal



Source: ETR.Net (Map developed by GIS Component – KwaZulu-Natal Department of Health)

3.16 2015/16 Priorities

1. Prevention of HIV/AIDS and STI's - reduce HIV incidence.	• Prevention programmes through Operation Sukuma Sakhe and the Hlola Manje Campaign. • Mass mobilisation and community dialogues targeting key populations including prisons and farm workers. • Medical male circumcision. Mobile services and Roving Teams – daily MMC slots at all hospitals. • Condom distribution using secondary condom distribution sites e.g. taxi ranks.
2. Comprehensive Management of HIV, AIDS and STI's – manage HIV prevalence.	• ART guidelines. All medical officers trained to initiate patients on ART. • HIV Counselling and Testing (community and facility) targeting vulnerable groups. • Comprehensive Care, Management and Treatment. • Adherence management.
3. Improve TB outcomes.	• TB case finding (community and facility level) also targeting key populations e.g. prisoners. • Establish decentralised MDR-TB Initiation Sites in Amajuba, Ilembe and Uthukela Districts. • TB Outreach Teams increasing door to door training follow up and support. • Identify and target TB hot spots with particular attention to informal settlements and the 169 most deprived wards. • Community-based management of MDR/XDR-TB. • TB (INH) prophylaxis for HIV patients.
4. Information Management.	• Improve data quality, monitoring, evaluation and reporting to inform evidence-based planning.

3.17 Situation Analysis Indicators per District

Table 41: (DHS10) Situation Analysis Indicators - 2013/14

Indicator	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	Ethekwini 2013/14
1. Total clients remaining on ART Clients remaining on ART equals [Naive (including PEP and PMTCT) + *Experienced + Transfer in + Restart] minus [Died) + Lost to follow-up + Transfer out*	No	840 738	59 928	92 220	40 916	41 694	34 187	66 428	58 614	88 989	49 890	36 572	271 330
2. Client tested for HIV (incl. ANC)	No	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
3. TB symptom 5yrs and older screened rate	%	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
Client 5 years and older screened for TB symptoms	*No*	-	-	-	-	-	-	-	-	-	-	-	-
PHC headcount 5 years and older	*No*	-	-	-	-	-	-	-	-	-	-	-	-
4. Male condom distribution coverage (annualised)	Rate	41.2	34.3	153.4	60.5	85.3	22.0	33.6	22.0	28.8	16.3	57.1	14.6

Indicator	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	Ethekwini 2013/14
Male condoms distributed	*No*	*134 737 662*	*7 215 024*	*53 064 747*	*11 733 928*	*11 438 182*	*3 427 916*	*7 899 603*	*3 852 193*	*7 349 291*	*3 267 984*	*7 509 098*	*17 979 697*
Population 15 years and older male	*No*	*3 258 094*	*209 771*	*344 096*	*193 224*	*133 296*	*155 245*	*234 104*	*174 299*	*254 396*	*198 888*	*130 838*	*1 229 937*
5. Female condom distribution coverage (annualised)	Rate	0.9	1.3	1.1	0.6	1.4	0.6	1.1	0.7	1.2	0.7	1.3	0.6
Female condoms distributed	*No*	*3 268 241*	*343 021*	*420 282*	*139 064*	*259 479*	*106 317*	*317 879*	*164 011*	*384 237*	*174 740*	*211 701*	*747 510*
Population 15 years and older female	*No*	*3 779 454*	*263 146*	*392 460*	*247 553*	*191 389*	*180 007*	*288 040*	*218 133*	*332 639*	*255 494*	*165 595*	*1 264 998*
6. Medical male circumcision performed	No	45 940	1 787	3 167	2 772	8 606	401	6 761	8 755	3 784	2 652	5 098	2 157
Sum of Males 10 to 14 years and males 15 years and older who are circumcised under medical supervision													
7. TB new client treatment success rate	%	85%	82.8%	85.1%	82%	86.8%	81.3%	85%	81.8%	96.1%	88.8%	82.7%	83.2%
TB client successfully completed treatment	*No*	*26 256*	*1 814*	*2 750*	*1 054*	*1 112*	*936*	*1 523*	*1 583*	*2 895*	*2 899*	*1 406*	*9 633*

Indicator	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	Ethekwini 2013/14
TB client start on treatment	*No*	*30 902*	*2 190*	*3 233*	*1 287*	*1 281*	*1 151*	*1 792*	*1 936*	*3 018*	*1 741*	*1 701*	*11 572*
8. TB client lost to follow up rate [45]	%	4.4%	5.4%	5.2%	3.3%	1.6%	4.4%	3.7%	3.0%	0.4%	2.5%	4.6%	7.3%
TB client lost to follow up	*No*	*1 504*	*118*	*167*	*42*	*20*	*51*	*66*	*59*	*11*	*43*	*79*	*848*
TB client start on treatment	*No*	*30 902*	*2 190*	*3 233*	*1 287*	*1 281*	*1 151*	*1 792*	*1 936*	*3 018*	*1 741*	*1 701*	*11 572*
9. TB death rate	%	4.7%	Data not available [46]	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available
TB client death during treatment	*No*	*1 457*	-	-	-	-	-	-	-	-	-	-	-
TB client start on treatment	*No*	*25 499*	-	-	-	-	-	-	-	-	-	-	-
10. TB MDR confirmed treatment initiation rate	%	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
TB MDR confirmed client start on treatment	*No*	-	-	-	-	-	-	-	-	-	-	-	-
TB MDR confirmed client	*No*	-	-	-	-	-	-	-	-	-	-	-	-

[45] Indicator previously defined as TB defaulter rate
[46] District data could not be sourced from the TB Programme (ETR.Net) before finalisation of the APP

Indicator	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	Ethekwini 2013/14
11. TB MDR treatment success rate	%	62%	61%	50%	No initiating unit	56.8%	No initiating unit	63%	67%	58%	No initiating unit	55%	60.8%
TB MDR client successfully completed treatment	*No*	*447*	*49*	*14*	-	*12*	-	*48*	*47*	*45*	-	*31*	*222*
TB MDR confirmed client start on treatment	*No*	*717*	*80*	*28*	-	*21*	-	*76*	*70*	*77*	-	*56*	*365*

3.18 Strategic Objectives, Indicators and Targets

Table 42: 2015-2019 Strategic Plan Targets

Strategic Goal	Strategic Objective	Strategic Objective Statement	Indicator	Target March 2020
		HIV, AIDS and STI		
Strategic Goal 2: Reduce and manage the burden of disease	2.2) Reduce HIV Incidence	2.2.1) Reduce the HIV incidence to 1% (or less) by March 2020 (ASSA2008 estimates)	• HIV incidence	1% (or less)
		2.2.2) Test 9 million people (cumulative) for HIV by March 2020	• Client tested for HIV (including ANC)	9 million (cumulative)
	2.3) Manage HIV prevalence	2.3.1) Reduce the HIV prevalence among 15-24 year old pregnant women to 25% by March 2020	• HIV prevalence among 15-24 year old pregnant women	25%
		2.3.2) Increase the number of patients on ART to 1 450 000 (cumulative) by March 2018	• Total clients remaining on ART	1 450 000
		Tuberculosis		
Strategic Goal 2: Reduce and manage the burden of disease	2.4) Improve TB outcomes	2.4.1) Increase the TB new client treatment success rate to 90% (or more) by March 2020	• TB new client treatment success rate	90% (or more)
		2.4.2) Reduce the TB incidence to 400 (or less) per 100 000 by March 2020	• TB incidence (per 100 000 population)	400 (or less) per 100 000
		2.4.3) Decrease the TB death rate to 2% by March 2020	• TB death rate	2%
		2.4.4) Increase the MDR-TB treatment success rate to 75% (or more) by March 2020	• TB MDR treatment success rate	75% (or more)

Table 43: (DHS12) Programme Performance Indicators

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 2.3: Manage HIV prevalence										
2.3.2) Increase the number of patients on ART to 1 450 000 (cumulative) by March 2018	1. Total clients remaining on ART *Clients remaining on ART equals [Naive (including PEP and PMTCT) + Experienced (Exp) + Transfer in (TFI) + Restart] minus [Died (RIP) + Lost to follow-up (LTF) + Transfer out]*	DHIS/ ART Register	Quarterly/ No	547 411	726 338	840 738	926 416	1 276 200 [47]	1 368 247	1 450 000
Strategic Objective 2.2: Reduce HIV Incidence										
2.2.2) Test 9 million people for HIV by March 2020 (cumulative)	2. Client tested for HIV (including ANC)	DHIS	Quarterly/ No	New indicator	New indicator	New indicator	2 373 268	2 067 065 (4 134 130 cumulative)	2 067 065 (6 201 195 cumulative)	2 067 065 (8 268 260 cumulative)
Strategic Objective 2.4: Improve TB outcomes										
2.4.5) Increase the TB screening rate for people 5 years and older to at least 70% by March 2020	3. TB symptom 5yrs and older screened rate	DHIS	Quarterly/ %	New indicator	New indicator	New indicator	9%	20%	35%	45%
	Client 5 years and older screened for TB symptoms	*DHIS/ Tick Register*	*No*	-	-	-	*2 283 292*	*6 417 887*	*11 526 096*	*15 207 162*
	PHC headcount 5 years and older	*DHIS/ Stats SA Estimates*	*No*	-	-	-	*25 369 910*	*32 089 437*	*32 931 705*	*33 793 695*
Strategic Objective 2.2: Reduce HIV Incidence										
2.2.3) Increase the male condom distribution rate to 60.8 condoms per	4. Male condom distribution coverage (annualised)	DHIS	Quarterly/ No	9	17.1	41.2	62.8	62.9 [48]	61.8	60.8

[47] The MTEF targets have been aligned with the projected targets in the Provincial draft DORA Business Plan (HIV/AIDS Grant). Final DORA Business Plan not available before finalisation of the APP

[48] Both male and female condom distribution (indicators 4 & 5) remain constant over the MTEF (decreasing the ratio) which is not consistent with strategy to increase condom distribution. This has been discussed with the HIV/AIDS Unit. The Unit indicated that the number of condoms to be distributed will NOT change

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
male per year by March 2018	*Male condoms distributed*	*DHIS/ Distribution evidence*	*No*	*31 914 706*	*59 771 737*	*134 737 662*	*208 140 490*	*212 mil*	*212 mil*	*212 mil*
	Population 15 years and older male	*DHIS/ Stats SA estimates*	*No*	*3 440 461*	*3 493 699*	*3 258 094*	*3 315 112*	*3 370 509*	*3 428 445*	*3 488 484*
2.2.4) Increase the female condom distribution rate to 0.9 condoms per female per year by March 2018	5. Female condom distribution rate (annualised)	DHIS	Quarterly/ No	New indicator	New indicator	0.9	1.5	0.9	0.9	0.9
	Female condoms distributed	*DHIS/ Distribution evidence*	*No*	-	-	*3 268 241*	*5 683 148*	*3 500 000*	*3 500 000*	*3 500 000*
	Population 15 years and older female	*DHIS/ Stats SA estimates*	*No*	-	-	*3 779 454*	*3 835 859*	*3 892 659*	*3 951 125*	*4 013 834*
2.2.5) Increase the medical male circumcisions to 3,021,714 by March 2018	6. Medical male circumcision performed	MMC Register/DHIS calculates	Quarterly/ (%) No	137 823 cum	258 946 cum	304 886 (cum)	399 476 (cum)	631 374 cum[49]	1 826 544 cum	3 021 714 cum
	Sum of Males 10 to 14 years and males 15 years and older who are circumcised under medical supervision									
Strategic Objective 2.4: Improve TB outcomes										
2.4.1) Increase the TB new client treatment success rate to 90% (or more) by March 2020	7. TB new client treatment success rate	ETR.Net calculates	Quarterly/ %	68.4%	70.1%	85%	86.6%	85%	86%	87%
	TB client successfully completed treatment	*TB register*	No	*21 983*	*24 500*	*26 256*	*26 854*	*27 149*	*28 293*	29 480
	TB client start on treatment	*TB Register*	No	*32 139*	*34 951*	*30 902*	*31 010*	*31 940*	*32 899*	33 885

[49] The targets seem unrealistic taking into consideration current performance and available resources – the HIV/AIDS Programme indicated that the intended strategies will increase the number of procedures significantly therefore keeping the target

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
2.4.6) Decrease the TB client lost to follow up to 2.5% (or less) by March 2020	8. TB client lost to follow up rate	ETR.Net	Quarterly/ %	6.7%	5.4%	4.8%	3.6%	3.9%	3.4%	2.9%
	TB client lost to follow up	*TB Register*	*No*	*2 075*	*1 809*	*1 504*	*1 092*	*1 530*	*1 377*	*1 239*
	TB client start on treatment	*TB Register*	*No*	*30 787*	*33 731*	*30 902*	*31 010*	*38 255*	*40 435*	*42 740*
2.4.3) Decrease the TB death rate to 2% by March 2020	9. TB death rate	ETR.Net	Annual/ %	New indicator	5.4%	4.7%	4.7%	4%	3.5%	3%
	TB client death during treatment	*TB Register*	*No*	-	*1 402*	*1 480*	*1 457*	*1 277*	*1 151*	*1 016*
	TB client on treatment	*TB Register*	*No*	-	*25 851*	*25 499*	*31 010*	*31 940*	*32 899*	*33 885*
2.4.7) Improve Drug Resistant TB outcomes by ensuring that 90% (or more) diagnosed MDR/XDR-TB patients are initiated on treatment by March 2020	10. TB MDR confirmed treatment initiation rate	ETR.Net	Annual/ %	New indicator	New indicator	New indicator	[50]Data not available	60%	70%	80%
	TB MDR confirmed client start on treatment	*MDR Register*	*No*	-	-	-	-	*750*	*775*	*800*
	TB MDR confirmed client	*MDR Register*	*No*	-	-	-	-	*1 250*	*1 107*	*1 000*
2.4.4) Increase the MDR-TB treatment success rate to 75% (or more) by March 2020	11. TB MDR treatment success rate	ETR.Net	Annual/ %	New indicator	New indicator	62%	50%	60.9%	62.5%	65%
	TB MDR client successfully completed treatment	*MDR Register*	*No*	-	-	*447*	- [51]	*450*	*484*	*520*
	TB MDR confirmed client start on treatment	*MDR Register*	*No*	-	-	*717*	-	*750*	*775*	*800*

[50] Unable to source data from the TB Programme before finalisation of the APP
[51] Unable to source data for the numerator and denominator from the TB Programme before finalisation of the APP

Table 44: (DHS11) Provincial Strategic Objectives and Targets

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 2.4: Improve TB outcomes										
2.4.8) Maintain the MDR-TB six month interim outcome at 85% (or more) from March 2018 onwards	1. TB MDR six month interim outcome	EDR Web	Annual/ %	New indicator	61%	64%	61.8%	75%	80%	85%
	Number of patients with a negative culture at 6 months who started treatment for 9 months	*EDR register*	*No*	-	*1 593*	*1 953*	*2 228*	*2 400*	*2 400*	*2 380*
	Total patients who started treatment in the same period	*EDR register*	*No*	-	*2 588*	*3 054*	*3 608*	*3 200*	*3 000*	*2 800*
2.4.7) Improve Drug Resistant TB outcomes by ensuring that 90% (or more) diagnosed MDR/XDR-TB patients are initiated on treatment by March 2020	2. Number of patients that started XDR-TB treatment	EDR Web	Annual/ No	New indicator	265	207	120	400	425	425
2.4.9) Increase the XDR-TB six month interim outcome to 80% by March 2020	3. XDR-TB six month interim outcome	EDR Web	Annual/ %	New indicator	35.85%	42%	44.4%	60%	65%	70%
	Number of clients with a negative culture at six months who has had started treatment for 9 months	*EDR register*	*No*	-	*90*	*109*	*80*	*120*	*130*	*140*
	Total of patients who started treatment in the same period	*EDR register*	*No*	-	*251*	*261*	*180*	*200*	*200*	*200*
2.4.2) Reduce the TB incidence to 400 (or less) per 100 000 by March	4. TB incidence (per 100 000 population)	ETR.Net	Annual/ No per 100,000	1 149/100 000	1 027/100 000	898 / 100 000	Annual indicator – not available for 2014/15	700 /100 000	600 /100 000	500 / 100 000

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
2020	*New confirmed TB cases*	*ETR.Net/ TB Register*	*No*	*122 058*	*109 995*	*99 460*	-	*74 817*	*64 839*	*54 623*
	Total population in KZN	*DHIS/Stats SA*	*Population*	*10 622 204*	*10 703 920*	*10 456 909*	-	*10 688 165*	*10 806 538*	*10 924 776*
Strategic Objective 2.2: Reduce HIV Incidence										
2.2.1) Reduce the HIV incidence to 1% (or less) by March 2020 (ASSA2008 estimates)	5. HIV incidence	ASSA2008 estimates (not routinely collected)	Annual/ %	1.01%	1.01%	1.01%	1.01%	1.01%	1.01%	1.01%
2.2.6) Decrease the STI incidence to 56.5/ 1000 by March 2018	6. STI treated new episode incidence (annualised)	DHIS	Quarterly/ No per 1000	68.8/ 1000	64.9/ 1000	63.4 / 1000	61.3/ 1000	60/ 1000	58.5/ 1000	56.5/1000
	STI treated new episode	*DHIS/Tick register PHC/ casualty*	*No*	*492 215*	*471 781*	*446 502*	*438 642*	*435 790*	*431 705*	*423 881*
	Population 15 years and older	*DHIS/Stats SA*	*Population*	*7 153 184*	*7 264 197*	*7 037 548*	*7 152 045*	*7 263 166*	*7 379 574*	*7 502 318*
2.2.7) Increase the HIV testing coverage to 65% by March 2018	7. HIV testing coverage (annualised)	DHIS calculates	Quarterly/ %	New indicator	New indicator	34.5%	35.9%	59.4%	60%	65%
	HIV test client 15-49 years	*DHIS/Tick register PHC & Counsellor*	*No*	-	-	*1 914 487*	*2 015 548*	*3 384 862*	*3 469 831*	*3 816 582*
	Population 15-49 years	*DHIS/Stats SA*	*Population*	-	-	*5 543 497*	*5 619 285*	*5 697 177*	*5 780 841*	*5 871 665*
Strategic Objective 2.3: Manage HIV prevalence										
2.3.1) Reduce the HIV prevalence among 15-24 year old pregnant women to 25% by March 2020	8. HIV prevalence among 15 to 24 year old pregnant women	HIV prevalence survey (NDOH) – data not routinely collected	Annual/ %	25.5%	25.8%	Not yet available	Not yet available	25.7%	25.6%	25.4%
Strategic Objective 2.4: Improve TB outcomes										

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
2.4.10) Maintain a 90% (or more) TB AFB sputum result turn-around time of under 48 hours from March 2018 onwards	9. TB AFB sputum result turn-around time under 48 hours rate	ETR.Net calculates	Quarterly/ %	81%	70.1%	79%	82.4%	85%	88%	90%
	TB AFB sputum result received within 48 hours	*TB register*	*No*	*778 211*	*487 257*	*159 001*	*284 930*	*337 908*	*402 309*	*473 170*
	TB AFB sputum sample sent	*TB Register*	*No*	*961 874*	*694 643*	*200 767*	*345 686*	*397 539*	*457 170*	*525 745*
2.4.11) Maintain TB (new pulmonary) cure rate of 85% from March 2016 onwards	10. TB (new pulmonary) cure rate	ETR.Net calculates	Quarterly/ %	69.8%	73.5%	81.8%	83.7%	85%	85%	85%
	TB (new pulmonary) client cured	*TB register*	*No*	*21 478*	*24 799*	*25 285*	*25 942*	*27 149*	*27 964*	*28 802*
	TB (new pulmonary) client initiated on treatment	*TB Register*	*No*	*30 787*	*33 731*	*30 902*	*31 010*	*31 940*	*32 899*	*33 885*

3.19 2015/16 Targets

Table 45: (DHS13) Quarterly and Annual Targets

Performance Indicators	Targets 2015/16	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Total clients remaining on ART (cumulative)	1 276 200	1 097 968	1 157 380	1 216 792	1 276 200
2. Client tested for HIV (incl. ANC)	2 067 065	516 766	1 033 532	1 550 299	2 067 065
3. TB symptom 5yrs and older screened rate	20%	5%	10%	15%	20%
4. Male condom distribution coverage(annualised)	62.9	16	32	48	62.9
5. Female condom distribution coverage(annualised)	0.9	0.9	0.9	0.9	0.9
6. Medical male circumcision performed – total (cumulative)	631 374	460 000	520 000	570 000	631 374
7. TB new client treatment success rate	85%	85%	85%	85%	85%
8. TB client lost to follow up rate	3.9%	3.9%	3.9%	3.9%	3.9%
9. STI treated new episode incidence (annualised)	60/ 1000	61.1/ 1000	61/ 1000	60.5/ 1000	60/ 1000
10. HIV testing coverage (annualised)	59.4%	40%	45%	50%	59.4%
11. TB AFB sputum result turn-around time under 48 hours rate	85%	80%	82%	84%	85%
12. TB (new pulmonary) cure rate	85%	82%	83%	84%	85%
Annual Targets					
13. TB death rate	4%				4%
14. TB MDR confirmed treatment initiation rate	60%				60%
15. TB MDR treatment success rate	60.9%				60.9%
16. TB MDR six month interim outcome	75%				75%
17. Number of patients that started XDR-TB treatment	400				400
18. XDR-TB six month interim outcome	60%				60%
19. TB incidence (per 100 000 population)	700 /100 000				700 / 100 000
20. HIV incidence	1.01%				1.01%
21. HIV prevalence among 15 to 24 year old pregnant women	25.7%				25.7%

3.20 Risk Management

Table 46: Risk Management

Potential Risks	Mitigating Strategies
1. The impact of HIV, AIDS and TB on health outcomes continues to be a major risk. The limited funding envelope limits rapid scale-up of programmes/ services to mitigate this. *(High Risk)*	• Target integrated prevention programmes for high risk groups.
2. The limited funding envelope and inadequate integration at service delivery level limits development of innovative programmes and services to comprehensively address the disease burden. *(High Risk)*	• Optimal use of resources through integration at all levels of care.
3. Inadequate space at facilities to accommodate increase in patient numbers including down-referral of patients on ART. *(High Risk)*	• Re-engineering of business processes including utilisation of space at facility level. Increase community management of patients where appropriate. Align infrastructure requirements with the Infrastructure Long Term Plan.
4. Patients lost to follow-up as a result of inadequate resources for follow-up will have a negative impact on outcomes for HIV and TB. *(High Risk)*	• Integration of HIV, AIDS and TB at PHC level (community and facility-based) - including follow-up by CCG's and Operation Sukuma Sakhe inter-sectoral collaboration.
5. Increasing burden of TB in children impact on TB outcomes. *(High Risk)*	• Integration of TB and School Health Services and acceleration of screening programmes (including routine screening) at community and facility levels.

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

3.21 Overview

Appropriate complementary feeding has been identified as one of the key interventions to reduce child morbidity and mortality, and infant and young child feeding therefore remains a priority. To further expand on breastfeeding support to newly delivered mothers, the Department proposes the employment of Lactation Advisors at health facilities determined by the number of maternity beds. The Lactation Advisors will support the early initiation and establishment of breastfeeding as well as human breastmilk donors. In addition, while the Province has made some gains in raising the awareness and improving attitudes of staff and communities towards exclusive breastfeeding for the first six months of life, the focus for 2015/16 will shift slightly towards complementary feeding together with continued breastfeeding up to one year of life.

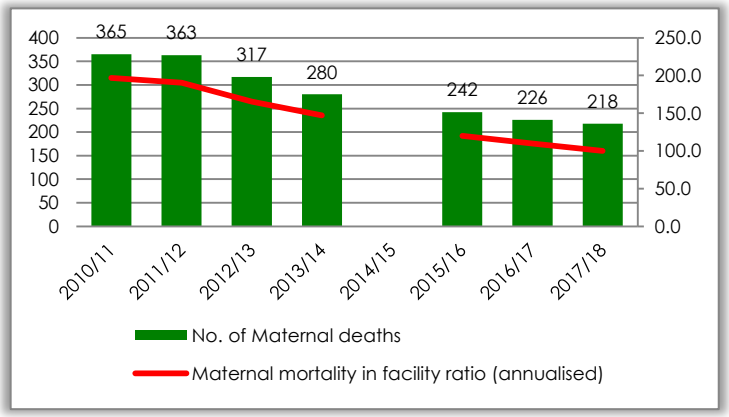
During 2014/15 the Department continued with the roll out of the integrated management of acute malnutrition. Greater emphasis has been placed on supportive monitoring visits to health facilities, which will be scaled up in 2015/16.

The prevention of malnutrition in communities remains a priority and greater efforts will be made to raise awareness and highlight the role of other government departments and NGO partners in the prevention and management of malnutrition. This is also being addressed at the level of the Social Cluster based within the Office of the Premier to improve multi-sectoral collaboration.

Reducing the maternal mortality remains one of the core focus areas of the Department. The MDG target will not be met by 2015 and a continual effort is required over the next five years to reduce the maternal mortality ratio and to maintain gains made.

After a steady increase in the maternal mortality during the previous decade, due mainly to the effects of the HIV epidemic, maternal mortality in KZN has since 2010 shown a steady decline (Graph 8). The facility-based maternal mortality ratio in 2013 was 147 per 100,000 live births, down from 198 in 2011. However, the National MDG target of 38 per 100 000 will not be achieved, indicating that existing efforts need to be strengthened.

Graph 8: Maternal deaths vs maternal mortality in facility ratio (DHIS)



The graph includes the projected decrease in maternal deaths over the MTEF period based on expected outcomes with the implementation of CARMMA and Priority Interventions to save the lives of Mothers and Children in KwaZulu-Natal 2014-2019.

In the combined approach of these two strategies, there would be 18 (16 + 2) areas of intervention where efforts will be focussed to yield positive outcomes. Only 16 of these priorities are under direct control of the Department of Health, the other two areas (improved sanitation and the

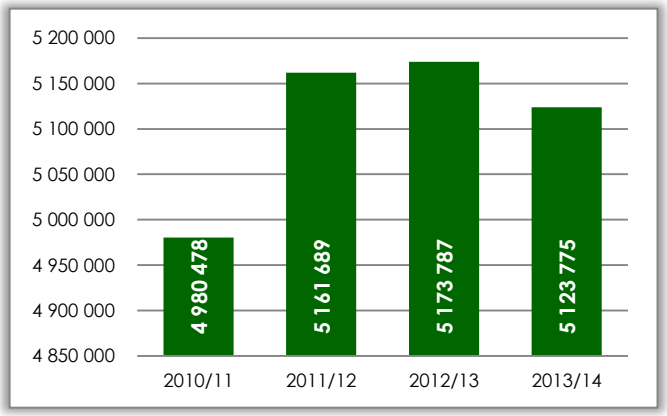
connection of potable water) will require inter-sectoral collaboration. The implementation of this Strategy is a two pronged approach requiring both pro-active (contraceptive services) and reactive (Magnesium sulphate for eclampsia) interventions to yield results.

Interventions to reduce maternal mortality overlap with interventions to reduce stillbirths, neonatal deaths, and child deaths. Success in reducing the maternal mortality ratio will likely be associated with improvements in the stillbirth rate, neonatal death rate and child death rates. Furthermore reduction of maternal mortality is closely linked to and dependent on woman's health interventions, particularly in the field of sexual and reproductive health.

The Department's strategy for reducing maternal mortality has been aligned with the Recommendations of the Saving Mothers Reports, with priorities including the reduction of maternal deaths due to HIV, obstetric haemorrhage and hypertensive disorders of pregnancy. These are the three causes which contribute the biggest numbers of preventable maternal deaths. To achieve success in reducing deaths due to these and other causes, health worker training in the management of obstetric emergencies (ESMOE programme) will be scaled up supported by health system re-engineering and strengthening consisting of the improved use of the partogram, improved management of labour and neonates and the early identification of emergencies for referral for appropriate intervention. The District Clinical Specialist Teams and the Medical and Nursing Heads in the maternity departments at regional and tertiary level will be key facilitators in achieving progress through implementation of the strategy.

Key areas for intervention in order to implement the strategy include ensuring that health workers offer a high quality of maternity care; facilities providing caesarean sections comply with standards for safe caesarean section; ensuring adequate access for pregnant women to safe delivery facilities; community interaction and involvement in maternal care; and better access to dual contraception for women and girls who need it.

Graph 9: Under 5 PHC headcount from 2010/11 – 2013/14



There was a 1% (50 022) decrease in the under 5 headcount at PHC level between 2012/13 and 2013/14. It is presumed that the decrease is due to the commissioning of the Phila Mntwana Centres in 2013/14 which specifically target children under the age of 5 years. Data from the Phila Mntwana Centres has been collected since inception however due to technical challenges with the systems itself the data will only be available for reporting from May 2015.

Source: DHIS

3.22 2015/16 Priorities

1. Accelerate community-based health promotion and prevention interventions.	• Health education (partnerships through OSS) including danger signs of pregnancy and newborns; early ANC booking; and postnatal care at 3 days after discharge and at 6 weeks. • Phila Mntwana Centres in functional war rooms – focus on output/outcome. • Oral rehydration; feeding practices; deworming; and growth monitoring. • Active case finding of children with malnutrition including community-based screening by CCG's using MUAC at Phila Mntwana Centres, OSS war rooms, and household level.
2. Improve quality and access to antenatal care.	• Midwifery and quality of clinical care at all levels. • Access to and quality of labour and delivery management - EMS harmonization (location of specialised EMS vehicles at high volume delivery facilities). • PMTCT. • Early detection/ treatment of HIV and TB in pregnant women. • Nutrition screening and support of pregnant women.
3. Improve access to and quality of labour and delivery management.	• Management of labour and delivery: Partogram Quality Improvement Project – monthly auditing of completeness and correctness; clean birth practices; and expanding availability of district specialist support teams. • Accredit hospitals as safe caesarean section centres - close caesarean section services where caesarean sections cannot be performed safely or where delivery numbers are too low to justify service. Accreditation criteria must be confirmed by national. • Establish Midwifery Obstetric Units (MOU's) at Regional Hospitals, and strengthen functionality of MOU's at 24 hour PHC clinics and Waiting Mothers Lodges. Establish Waiting Mothers Lodges in all delivery facilities. • Management of obstetric emergencies e.g. MgS04 for pre-eclampsia; ESMOE training (obstetric complications and neonatal resuscitation). All hospitals with at least 2 ESMOE Master Trainers running regular ESMOE drills. • Adequate and appropriately staffed and equipped maternity wards, including placement of Advanced Midwifes in PHC and District Hospitals.
4. Strengthen postnatal care (3 days, 6 weeks).	• Counselling on newborn and maternal danger signs. • 3 Days and 6 week visits at clinics and home visits by CCG's -

	6x6x6 linking all postnatal neonates to CCG's prior to discharge.
	• Support for breastfeeding or appropriate feeding practices.
5. Improve the survival of neonates.	• Implement Integrated Management of Newborn Care package. • Kangaroo Mother Care for all low birth weight babies in all hospitals and CHCs. • Management of birth asphyxia; case management of severe neonatal infection; infant feeding counseling and support. • Neonatal ICU's at identified hospitals in districts where there are no regional hospitals; appropriate equipped and staffed nurseries.
6. Improve the quality of management of common childhood and emergency illnesses.	• Immunisation. • IMCI case management; oral antibiotics - case management of pneumonia in children; ART for Paediatrics integrated into child care (early diagnosis and initiation on HAART); testing of exposed infants at 6 weeks and Cotrimoxazole. • Therapeutic feeding for severe malnutrition. • Daily ward rounds in all paediatric and neonatal wards.
7. Increase access to Family Planning.	• "Reaching 3 Million Young Women by 2015 campaign" with main focus on teenage pregnancy. • Rollout of Long Acting Reversible Contraceptives • Promote healthy timing and spacing of pregnancies – improving contraceptive awareness and access at health facilities and community. • Improve health care provider training and mentoring.
8. Promote women's health through early identification of common preventable conditions.	• Screening, early detection and treatment of breast and cervical cancers. • Provision of Choice on Termination of Pregnancy services (medical and surgical) in all hospitals and CHC's.
9. Poverty reduction strategies to decrease malnutrition where it is an underlying condition of mortalities.	• Inter-sectoral co-ordination (Action Work Group 8 of the PGDP) to ensure malnutrition remains part of the strategic plans of all Departments.
10. Improve business processes to improve maternal, women and child health.	• Develop and implement service standards and SOP's. • Client charter for quality of care. • Monthly mortality review meetings

3.23 Situation Analysis Indicators per District

Table 47: (DHS14) Situation Analysis Indicators - 2013/14

Indicator	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	eThekwini 2013/14
1. Antenatal 1st visit before 20 weeks rate	%	56.2%	58.6%	58.8%	84.4%	59.6%	59.5%	58.1%	61.2%	57.1%	52.1%	53.5%	52.9%*
Antenatal 1st visit before 20 weeks	*No*	*136 813*	*9 508*	*12 065*	*8 005*	*8 047*	*7 240*	*11 942*	*10 802*	*13 303*	*7 445*	*6 522*	*41 934*
Antenatal 1st visit total	*No*	*242 759*	*16 202*	*20 616*	*14 693*	*13 503*	*10 488*	*20 537*	*17 657*	*23 315*	*14 298*	*12 197*	*79 253*
2. Mother postnatal visit within 6 days rate	%	71.4%*	60%	61.2%	67.2%	66.9%	79.1%	51.2%	87.5%	60.1%	158.4%	65.1%	68.2%
Mother postnatal visit within 6 days after delivery	*No*	*139 120**	*8 232*	*10 664*	*8 261*	*7 542*	*7 184*	*8 427*	*13 051*	*12 331*	*17 183*	*5 483*	*40762*
Delivery in facility total	*No*	*194 758**	*13 710*	*17 422*	*12 285*	*11 278*	*9 083*	*16 459*	*14 919*	*20 522*	*10 650*	*8 422*	*59 808*
3. Antenatal client initiated on ART rate	%	85.3%	91.3%	102.9%	99.1%	93.5%	92.4%	85.6%	73.1%	94.0%	96.2%	96.3%	72.7%
Antenatal client start on ART	*No*	*55 984**	*4 159*	*6 037*	*3 958*	*2 484*	*2 319*	*4 590*	*3 507*	*5 657*	*3 781*	*2 522*	*16 970*
Antenatal client eligible for ART initiation	*No*	*65 635**	*4 553*	*5 866*	*3 992*	*2 657*	*2 511*	*5 364*	*4 797*	*6 016*	*3 930*	*2 618*	*23 331*
4. Infant 1st PCR test positive around 6 weeks rate	%	1.6%	2.1%	1.4%	1.6%	1.3%	1.4%	2.0%	1.8%	1.3%	2.7%	1.6%	1.3%
Infant 1st PCR test positive around 6 weeks	*No*	*1 188*	*116*	*102*	*74*	*51*	*44*	*134*	*103*	*94*	*133*	*54*	*283*
Infant 1st PCR test around 6 weeks	*No*	*75 081*	*5 498*	*7 152*	*4 731*	*3 945*	*6 694*	*3 088*	*5 866*	*7 310*	*4 960*	*3 360*	*22 477*

Indicator	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	eThekwini 2013/14
5. Immunisation coverage under 1 year (annualised)	%	85.8%	73.8%	96.3%	76.5%	77.2%	70.3%	80.6%	74.3%	81.2%	75.2%	80.9%	104.7%
Immunised fully under 1 year new	*No*	*201 824*	*13 571*	*19 947*	*13 632*	*11 892*	*7 989*	*17 030*	*13 899*	*19 954*	*11 610*	*10 062*	*63 138*
Population under 1 year	*No*	*236 094*	*18 525*	*20 691*	*17 941*	*15 621*	*11 256*	*21 177*	*18 897*	*23 477*	*15 568*	*12 382*	*60 559*
6. Measles 2nd dose coverage (annualised)	%	77.1%	69.6%	65.1%	70.4%	80.1%	59.2%	70.3%	69.8%	76.1%	73.4%	80.2%	92.8%
Measles 2nd dose	*No*	*181 123*	*12 951*	*13 860*	*12 015*	*11 383*	*6 754*	*14 576*	*12 546*	*18 329*	*10 616*	*9 951*	*58 142*
Population 1 year	*No*	*236 094*	*18 525*	*20 691*	*17 941*	*15 621*	*11 256*	*21 177*	*18 897*	*23 477*	*15 568*	*12 382*	*60 559*
7. DTaP-IPV/Hib 3 - Measles 1st dose drop-out rate	%	8.2%	4.3%	5.5%	3.0%	1.5%	9.0%	5.9%	5.7%	7.4%	8.4%	2.3%	13.6%
DTaP-IPV/Hib 3 to Measles1st dose drop-out	*No*	*17 820*	*615*	*884*	*417*	*183*	*808*	*1 073*	*895*	*1 553*	*1 051*	*253*	*10 088*
DTaP-IPV/Hib 3rd dose	*No*	*218 648*	*14 157*	*16 188*	*14 084*	*12 463*	*9 016*	*18 274*	*15 726*	*21 129*	*12 533*	*10 871*	*74 207*
8. Child under 5 years diarrhoea case fatality rate	*%*	*3.3%*	*4.3%*	*3.4%*	*3.3%*	*5.6%*	*0.9%*	*5.1%*	*4.5%*	*3.3%*	*2.5%*	*3.4%*	*1.6%*
Child under 5 years with diarrhoea death	*No*	*387*	*41*	*38*	*42*	*41*	*5*	*52*	*45*	*34*	*21*	*30*	*38*
Child under 5 years with diarrhoea admitted	*No*	*11 813*	*955*	*1 113*	*1 262*	*727*	*570*	*1 012*	*995*	*1 039*	*830*	*892*	*2 418*
9. Child under 5 years pneumonia case fatality rate	*%*	*3.2%*	*3.0%*	*1.6%*	*2.6%*	*6.1%*	*0.8%*	*6.5%*	*2.9%*	*5.1%*	*1.1%*	*4.3%*	*3.2%*
Child under 5 years pneumonia death	*No*	*304*	*35*	*21*	*16*	*38*	*3*	*30*	*26*	*34*	*8*	*28*	*65*

Indicator	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	eThekwini 2013/14
Child under 5 years pneumonia admitted	*No*	*9 489*	*1 162*	*1 303*	*620*	*625*	*371*	*460*	*888*	*673*	*719*	*653*	*2 015*
10. Child under 5 years severe acute malnutrition case fatality rate	%	9.7%	12.5%	6.8%	19.3%	12.7&	10.3%	26.9%	12.2%	11.7%	3.2%	7.3%	5.8%
Child under 5 years severe acute malnutrition death	*No*	*336*	*46*	*28*	*32*	*31*	*16*	*42*	*32*	*33*	*13*	*23*	*40*
Child under 5 years severe acute malnutrition admitted	*No*	*3 466*	*369*	*414*	*166*	*245*	*155*	*156*	*263*	*283*	*410*	*317*	*688*
11. School Grade R learners screening coverage (annualised)	5	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
School Grade R learners screened	*No*	-	-	-	-	-	-	-	-	-	-	-	-
School Grade R learners - total	*No*	-	-	-	-	-	-	-	-	-	-	-	-
12. School Grade 1 learners screening coverage (annualised)	%	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
School Grade 1 learners screened	*No*	-	-	-	-	-	-	-	-	-	-	-	-
School Grade 1 learners - total	*No*	-	-	-	-	-	-	-	-	-	-	-	-
13. School Grade 8 learners screening coverage (annualised)	%	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator

Indicator	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	eThekwini 2013/14
School Grade 8 learners screened	No	-	-	-	-	-	-	-	-	-	-	-	-
School Grade 8 learners - total	No	-	-	-	-	-	-	-	-	-	-	-	-
14. Couple year protection rate (annualised)	%	45%	41.9%	110.7%[52]	53.1%	59.9%	34.9%	37.0%	32.6%	36.0%	32.7%	51.7%	30.4%
Contraceptive years dispensed[53].	No	*1 293 378*	*82 891*	*332 000*	*1 271*	*86 642*	*48 836*	*83 980*	*56 272*	*92 408*	*58 860*	*66 490*	*264 729*
Population 15-49 years females	No	*2 864 858*	*197 433*	*298 839*	*188 143*	*144 044*	*139 422*	*226 190*	*171 950*	*256 275*	*179 152*	*128 264*	*935 146*
15. Cervical cancer screening coverage (annualised)	%	*75.3%*	87.8%	78.9%	63.8%	102.2%	53.0%	78.0%	51.4%	68.0%	53.2%	79.9%	81.0%
Cervical cancer screening in woman 30 years and older	No	*169 315*	*13 045*	*19 065*	*8 933*	*10 551*	*5 424*	*11 592*	*5 978*	*12 862*	*7 314*	*6 871*	*67 649*
Population 30 years and older female/10	No	*223 346*	*14 764*	*24 044*	*13 919*	*10 268*	*10 164*	*14 738*	*11 552*	*18 812*	*13 633*	*8 574*	*83 177*
16. Human papilloma virus vaccine 1st dose coverage	%	86%	Not available[54]	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Girls 9 years and older that received HPV 1st dose	No	*69 254*	-	-	-	-	-	-	-	-	-	-	-
Grade 4 girl learners ≥ 9 years	No	*80 499*	-	-	-	-	-	-	-	-	-	-	-

[52] High as a result of the high number of male condoms per male per year (153.4)
[53] Contraceptive years are the total of (Oral pill cycles / 13) + (Medroxyprogesterone injection / 4) + (Norethisterone enanthate injection / 6) + (IUCD x 4) +) + (Subdermal implant x3) + Male condoms distributed / 200) + (Female condoms distributed / 200) + (Male sterilisation x 20) + (Female sterilisation x 10).
[54] District data could not be sourced from DHIS at time of finalising the APP

Indicator	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	eThekwini 2013/14
17. Vitamin A dose 12-59 months coverage (annualised)	%	47.8%	45.7%	42.2%	59.7%	56.4%	51.4%	66.4%	51.0%	51.4%	61.9%	70.8%	66.7%
Vitamin A dose 12 - 59 months	No	*893 481*	*13 571*	*19 947*	*13 632*	*11 892*	*7 989*	*17 030*	*13 899*	*19 054*	*11 610*	*10 062*	*63 138*
Population 12-59 months (multiplied by 2)	No	1 862 246	18 525	20 691	17 941	15 621	11 256	21 177	18 897	23 477	15 568	12 382	60 559
18. Maternal mortality in facility ratio (annualised)	Ratio	147/100 k	160.5/100k	200.8/100k	123.0/100k	71.6/100k	109.8/100k	123.3/100k	53.6/100k	186.6/100k	194.1/100k	84.0/100k	171.0/100k
Maternal death in facility	No	*280*	*22*	*34*	*15*	*8*	*10*	*20*	*8*	*38*	*21*	*7*	*97*
Live birth in facility	No	*190 512*	*13 708*	*16 929*	*12 199*	*11 175*	*9 104*	*16 223*	*14 939*	*20 362*	*1 820*	*8 331*	*56 722*
19. Inpatient early neonatal death rate	Ratio	10.2 /1000	11.2/1000	12.6/1000	9.0/1000	11.3/1000	0.8/1000	7.6/1000	4.0/1000	14.9/1000	11.8/1000	14.4/1000	9.2/1000
Inpatient death early neonatal (0-7 days)	No	*1 945*	*154*	*208*	*110*	*127*	*80*	*123*	*60*	*302*	*128*	*120*	*533*
Live birth in facility	No	*190 608*	*13 708*	*16 431*	*12 187*	*11 195*	*9 104*	*16 223*	*14 946*	*20 323*	*10 820*	*8 331*	*57 340*

3.24 Strategic Objectives, Indicators and Targets

Table 48: Strategic Plan 2015-2019 Targets

Strategic Goal	Strategic Objective	Strategic Objective Statement	Indicator	Target March 2020
Strategic Goal 2: Reduce and manage the burden of disease	2.5) Reduce infant mortality	2.5.1) Reduce the infant mortality rate to 29 per 1000 live births by March 2020	• Infant mortality rate	29 per 1000 live births
		2.5.2) Reduce the mother to child transmission of HIV to less than 0.5% by March 2020	• Infant 1st PCR test positive around 6 weeks rate	Less than 0.5%
	2.6) Reduce under 5 mortality	2.6.1) Reduce the under 5 mortality rate to 40 per 1000 live births by March 2020	• Under 5 mortality rate	40 per 1000 live births
		2.6.2) Reduce severe acute malnutrition incidence under 5 years to 4.6 per 1000 by March 2020	• Child under 5 years severe acute malnutrition incidence (annualised)	4.6 per 1000
	2.7) Reduce maternal mortality	2.7.1) Reduce the maternal mortality in facility ratio to 100 (or less) per 100 000 live births by March 2020	• Maternal mortality in facility ratio	100 (or less) per 100 000 live births
	2.8) Improve women's health	2.8.1) Increase the couple year protection rate to 75% by March 2020	• Couple year protection rate	75%
		2.8.2) Maintain the cervical cancer screening coverage of 75% (or more)	• Cervical cancer screening coverage	75% (or more)

Table 49: (DHS16) Programme Performance Indicators

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 2.7: Reduce maternal mortality										
2.7.4) Increase the antenatal 1st visit before 20 weeks rate to 65% by March 2018	1. Antenatal 1st visit before 20 weeks rate	DHIS	Quarterly/ %	41%	46.4%	56.2%	56.1%	60%	62.6%	65%
	Antenatal 1st visit before 20 weeks	*DHIS/Tick register PHC*	*No*	*91 525*	*104 507*	*136 813*	*65 488*	*139 012*	*146 402*	*153 805*
	Antenatal 1st visit total	*DHIS calculates*	*No*	*223 145*	*225 121*	*242 759*	*116 768*	*231 686*	*234 003*	*236 343*
2.7.5) Increase the postnatal visit within 6 days rate to 90% by March 2018	2. Mother postnatal visit within 6 days rate	DHIS	Quarterly/ %	58.1%	69.4%	71.4%	68.7%	74.4%	82%	90%
	Mother postnatal visit within 6 days after delivery	*DHIS/Tick register PHC*	No	*112 418*	*133 758*	*139 120**	*141 758*	*151 711*	*169 262*	189 066
	Delivery in facility total	*DHIS/Delivery register*	No	*193 375*	*192 659*	*194 758**	*206 294*	*203 910*	*206 969*	210 073
2.7.6) Initiate 98% eligible antenatal clients on ART by March 2018	3. Antenatal client initiated on ART rate	DHIS	Annual/ %	New indicator	New indicator	85.3%	92.7%	95%	97%	98%
	Antenatal client initiated on ART	DHIS/ ART Register	No	-	-	55 984*	56 654	62 482	64 117	65 102
	Antenatal client eligible for ART	ART Register	No	-	-	65 635*	61 092	65 771	66 100	66 431
Strategic Objective 2.5: Reduce infant mortality										
2.5.2) Reduce the mother to child transmission of HIV to less than 0.5% by March 2020	4. Infant 1st PCR test positive around 6 weeks rate	DHIS	Quarterly/ %	4%	2.2%	1.6%	1.2%	Less than 1%	Less than 1%	Less than 0.5%
	Infant 1st PCR test positive around 6 weeks	*DHIS/Tick register PHC*	No	*2 900*	*1 702*	*1 188*	*990*	*905*	*972*	*522*
	Infant 1st PCR test around 6 weeks	*DHIS/Tick register PHC*	No	*73 193*	*78 040*	*75 081*	*79 530*	*90 535*	*97 220*	104 414

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 2.6: Reduce under 5 mortality										
2.6.3) Maintain immunisation coverage of 90% (or more) from March 2016 onwards	5. Immunisation coverage under 1 year (annualised)	DHIS	Quarterly/ %	97%	95.1%[55]	85.8%	89.7%	90%	90%	90%
	Immunised fully under 1 year new	*DHIS/Tick register PHC*	No	*212 468*	*202 617*	*201 824*	*208 620*	*204 494*	*199 792*	195 804
	Population under 1 year	*DHIS/Stats SA*	No	*219 033*	*213 213*	*236 094*	*232 450*	*227 216*	*221 991*	217 560
2.6.4) Maintain the measles 2nd dose coverage of 90% (or more) from March 2017 onwards	6. Measles 2nd dose coverage (annualised)	DHIS	Quarterly/ %	89%	86.5%	77.1%	90.1%	85%	90%	95%
	Measles 2nd dose	*DHIS/Tick register PHC*	No	*195 038*	*184 359*	*181 123*	*209 542*	*193 133*	*199 792*	*206 682*
	Population 1 year	*DHIS/Stats SA*	No	*219 033*	*213 213*	*236 094*	*232 450*	*227 216*	*221 991*	*217 560*
2.6.5) Reduce the measles drop-out rate to 5% by March 2018	7. DTaP-IPV/Hib 3 - Measles 1st dose drop-out rate	DHIS	Quarterly/ %	New indicator	New indicator	8.2%	5.6%	*7%*	*6%*	*5%*
	DTaP-IPV/Hib 3 to Measles1st dose drop-out	*DHIS/Tick register PHC*	No	-	-	*17 820*	*12 500* [56]	*15 941*	*13 855*	*11 708*
	DTaP-IPV/Hib 3rd dose	*DHIS/Stats SA*	No	-	-	*218 648*	*224 592*	*227 736*	*230 925*	*234 158*
2.6.6) Reduce the under-5 diarrhoea case fatality rate to less than 2% by March 2020	8. Child under 5 years diarrhoea case fatality rate	DHIS	Quarterly/ %	4.3%	4.3%	3.3%	3.2%	3.2%	2.96%	2.53%
	Child under 5 years with diarrhoea death	*DHIS/Tick Register*	No	*311*	*375*	*387*	*384*	*329*	*296*	241
	Child under 5 years with diarrhoea admitted	*Admission records*	No	*7 205*	*8 669*	*11 813*	*11 866*	*10 224*	*10 000*	9 500 7
2.6.7) Reduce the under-5 pneumonia case fatality rate to less	9. Child under 5 years pneumonia case fatality rate	DHIS	Quarterly/ %	3.7%	2.6%	3.2%	3.0%	2.4%	2.1%	1.6%

[55] All actual data with DHIS as source are based on the DHIS calculation to ensure standardisation in reporting
[56] Data is questionable and are being verified – no conclusion reached by time of finalising the APP

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
than 1.5% by March 2020	*Child under 5 years pneumonia death*	*DHIS/Tick Register*	*No*	*345*	*206*	*304*	*285*	*227*	*204*	*155*
	Child under 5 years pneumonia admitted	*Admission records*	*No*	*9 204*	*7 945*	*9 489*	*9 592*	*9 500*	*9 500*	*9 500*
2.6.8) Reduce the under-5 severe acute malnutrition case fatality rate to 6% by March 2020	10. Child under 5 years severe acute malnutrition case fatality rate	DHIS	Quarterly/ %	9.2%	10.9%	9.7%	8.4%	8%	7.5%	7%
	Child under 5 years severe acute malnutrition death	*DHIS/Tick Register*	*No*	*318*	*345*	*336*	*310*	*256*	*233*	*210*
	Child under 5 years severe acute malnutrition admitted	*Admission records*	*No*	*3 458*	*3 162*	*3 466*	*3 706*	*3 200*	*3 100*	*3 000*
Strategic Objective 1.5: Accelerate implementation of PHC re-engineering										
1.5.9) Increase school health screening coverage with at least 10% per annum	11. School Grade R learners screening coverage (annualised)	DHIS	Quarterly/ %	New indicator	New indicator	New indicator	New indicator	40% [57]	50%	60%
	School Grade R learners screened	*DHIS/ SHS Records*	*No*	-	-	-	-	-	-	-
	School Grade R learners - total	*DoE database*	*No*	-	-	-	-	-	-	-
	12. School Grade 1 learners screening coverage (annualised)	DHIS	Quarterly/ %	New indicator	New indicator	New indicator	31.7%	*55%*	*60%*	*65%*
	School Grade 1 learners screened	*DHIS/ SHS Records*	*No*	-	-	-	*85 440*	*148 500*	*162 000*	*175 500*
	School Grade 1 learners - total	*DoE database*	*No*	-	-	-	*268 943*	*270 000*	*270 000*	*270 000*

[57] Indicators 11, 12 and 13: Awaiting updated 2015/16 data for the number of enrolled Grade R learners (denominator) from the Department of Basic Education. Indicator 11: No baseline data available to estimate MTEF targets and targets based on minimum screening coverage. All three indicators will be reviewed once updated data is available

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	13. School Grade 8 learners screening coverage (annualised)	DHIS	Quarterly/ %	New indicator	New indicator	New indicator	16.2%	40%	50%	60%
	School Grade 8 learners screened	*DHIS/ SHS Records*	*No*	-	-	-	*36 154*	*90 000*	*112 500*	*135 000*
	School Grade 8 learners - total	*DoE database*	*No*	-	-	-	*222 871*	*225 000*	*225 000*	*225 000*
Strategic Objective 2.8: Improve women's health										
2.8.1) Increase the couple year protection rate to 75% by March 2020	14. Couple year protection rate (annualised)	DHIS	Quarterly/ %	25.5% [58]	37.5%	45%	54.3%	55%	60%	65%
	Contraceptive years dispensed[59]	*DHIS calculates*	*No*	*Not available*	*1 019 668*	*1 293 378*	*1 572 960*	*1 611 360*	*1 779 620*	*1 954 646*
	Population 15-49 years females	*DHIS/Stats SA*	*No*	*Not available*	*2 936 748*	*2 864 858*	*2 897 495*	*2 929 745*	*2 966 034*	*3 007 148*
2.8.2) Maintain the cervical cancer screening coverage of 75% (or more)	15. Cervical cancer screening coverage (annualised)	DHIS	Quarterly/ %	76.1%	81.8%	75.3%	73.5%	75%	75%	75%
	Cervical cancer screening in woman 30 years and older	*DHIS/Tick register PHC/ Hospital register*	*No*	*159 096*	*172 000*	*169 315*	*168 220*	*175 671*	*179 341*	183 240
	Population 30 years and older female/10	*DHIS/Stats SA*	*No*	*209 051*	*165 300*	*223 346*	*228 912*	*234 228*	*239 122*	244 320
2.8.3) Maintain 90% (or more) HPV vaccine 1st dose coverage from March 2018 onwards	16. Human papilloma virus vaccine 1st dose coverage	DHIS	Annual/ %	New indicator	New indicator	86%	82.9%	85%	85%	90% (or more)
	Girls 9 years and older that received HPV 1st dose	*DHIS/Tick Register school health*	*No*	-	-	*69 254*	*68 834*	*72 250*	*72 250*	*76 500*

[58] Contraceptive years dispensed not available on DHIS as a result of change in indicator definition
[59] Contraceptive years total (Oral pill cycles / 13) + (Medroxyprogesterone injection / 4) + (Norethisterone enanthate injection / 6) + (IUCD x 4) +) + (Subdermal implant x3) + Male condoms distributed / 200) + (Female condoms distributed / 200) + (Male sterilisation x 20) + (Female sterilisation x 10).

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	Grade 4 girl learners ≥ 9 years	*DHIS/DOE enrolment*	No	-	-	*80 499*	*83 056*	*85 000* [60]	*85 000*	*85 000*
Strategic Objective 2.6: Reduce under 5 mortality										
2.6.9) Increase the Vit A dose 12-59 month coverage to 70% by March 2018	17. Vitamin A dose 12-59 months coverage (annualised)	DHIS	Quarterly/ %	42%	43.7%	47.8%	56.6%	60%	65%	70%
	Vitamin A dose 12 - 59 months	*DHIS/Tick register PHC*	No	*769 685*	*776 254*	*893 481*	*1 055 350*	*1 072 060*	*1 169 528*	*1 281 275*
	Population 12-59 months (multiplied by 2)	*DHIS/Stats SA*	*Population*	*1 804 178*	*1 783 364*	*1862 246*	*1 864 456*	*1 786 768*	*1 799 275*	*1 830 394*
Strategic Objective 2.7: Reduce maternal mortality										
2.7.1) Reduce the maternal mortality in facility ratio to 100 (or less) per 100 000 live births by March 2020	18. Maternal mortality in facility ratio (annualised)	DHIS	Annual/ Ratio per 100,000	190.6/100 000	165.5/100 000	147/100 000	140.3/100 000	120 100 000	115/100 000	105/ 100 000
	Maternal death in facility	*DHIS/Midnight census*	No	*363*	*317*	*280*	*274*	*242*	*236*	*228*
	Live birth in facility	*DHIS/Delivery register*	No	*190 452*	*191 587*	*190 512*	*195 274*	*202 473*	*205 712*	*218 054*
Strategic Objective 2.5: Reduce infant mortality										
2.5.3) Reduce the early neonatal death rate to less than 8/ 1000 by March 2020	19. Inpatient early neonatal death rate	DHIS	Annual/ Per 1000	New indicator	New indicator	10.2/ 1000	10.3/ 1000	9.7/ 1000	9.3/ 1000	9/ 1000
	Inpatient death early neonatal (0-7 days)	*DHIS/Midnight census*		-	-	*1 945*	*2 011*	*1 873*	*1 797*	*1 741*
	Live birth in facility	*DHIS/Delivery register*		-	-	*190 608*	*195 274*	*193 134*	*193 327*	*193 520*

[60] Estimated number of learners – awaiting 2015 enrolment numbers from the Department of Basic Education

Table 50: (DHS15) Provincial Strategic Objectives and Targets

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 2.5: Reduce infant mortality										
2.5.1) Reduce the infant mortality rate to 29 per 1000 live births by March 2020	1. Infant mortality rate	ASSA2008 (2011) StatsSA and RMS[61] (2012 onwards)	Annual/ No per 1000 pop	43/ 1000*	32.1/ 1000	32/ 1000	31.4/1000	30.5/ 1000 [62]	30/ 1000	29.5/ 1000
Strategic Objective 2.6: Reduce under 5 mortality										
2.6.1) Reduce the under 5 mortality rate to 40 per 1000 live births by March 2020	2. Under 5 mortality rate	ASSA2008 (2011) StatsSA and RMS (2012 onwards)	Annual/ No per 1000 pop	63/ 1000*	43.4/ 1000	43/ 1000	42.6/ 1000	42/ 1000	41.5/ 1000	41/ 1000
2.6.10) Reduce under-5 diarrhoea with dehydration incidence to 10.9 per 1000 by March 2018	3. Child under 5 years diarrhoea with dehydration incidence (annualised)	DHIS	Annual/ No per 1000	20.7/ 1000	9.5/ 1000	15/ 1000	11.5/ 1000	12.9/ 1000	11.6/ 1000	10.9 / 1000
	Child under 5 years diarrhoea with dehydration new	*PHC Tick Register*	*No*	*37 364*	*17 013*	*17 564*	*13 402*	*14 887*	*13 257*	*12 347*
	Population under 5 years	*DHIS/Stats SA*	*No*	*1 804 178*	*1 783 364*	*1 171 910*	*1 165 062*	*1 154 059*	*1 142 878*	*1 132 753*
2.6.11) Reduce the under-5 pneumonia incidence to 86 per 1000 by March 2018	4. Child under 5 years pneumonia incidence (annualised)	DHIS	Annual/ No per 1000	143/ 1000	118.5/ 1000	92.2/ 1000	85.6/ 1000	88.9/ 1000	87/ 1000	86/ 10000
	Child under 5 years with pneumonia new	*PHC Tick Register*	*No*	*257 997*	*130 557*	*107 894*	*99 740*	*99 138*	*98 112*	*87 416*
	Population under 5 years	*DHIS/Stats SA*	*No*	*1 804 178*	*1 783 364*	*1 171 910*	*1 165 062*	*1 154 059*	*1 142 878*	*1 132 753*

[61] Rapid Mortality Surveillance
[62] Indicators 1 and 2: Not routinely collected by the Department. Uses StatsSA and RMS data as estimates for reporting purposes

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
2.6.2) Reduce severe acute malnutrition incidence under 5 years to 4.6 per 1000 by March 2020	5. Child under 5 years severe acute malnutrition incidence (annualised)	DHIS	Annual/ No per 1000	6.7/1000	6.5/1000	5.6/ 1000	5.8/ 1000	5.5/1000	5.2/1000	4.9/1000
	Child under 5 years with severe acute malnutrition new	*DHIS/Tick register PHC*	*No*	*7 522*	*7 137*	*6 598*	*6 752*	*6 347*	*5 943*	*5 550*
	Population under 5 years	*DHIS/Stats SA*	*No*	*1 118 510*	*1 104 893*	*1 171 910*	*1 165 062*	*1 154 059*	*1 142 878*	*1 132 753*
2.6.12) Reduce the child under 1 year mortality in facility rate to less than 5.5% by March 2020	6. Child under 1 year mortality in facility rate (annualised)	DHIS	Annual/ %	*7%*	*6.5%*	*6.5%*	*7.4%*	*6.5%*	*6.3%*	*6.1%*
	Inpatient death under 1 year	*DHIS calculates*	*No*	*2 342*	*2 978*	*3 348*	*3 832*	*3 354*	*3 252*	*3 151*
	Inpatient separations under 1 year	*DHIS calculates*	*No*	*33 257*	*46 024*	*51 874*	*51 582*	*51 608*	*51 634*	*51 659*
2.6.13) Reduce the inpatient death under-5 rate to less than 4.5% by March 2020	7. Inpatient death under 5 year rate	DHIS	Annual/ %	*4.8%*	*5.2%*	*5.2%*	*5.9%*	*5.5%*	*5.4%*	*5.3%*
	Inpatient death under 5 years	*DHIS calculates*	*No*	*2 779*	*3 831*	*4 215*	*4 802*	*4 446*	*4 369*	*4 288*
	Inpatient separations under 5 years	*DHIS calculates*	*No*	*57 774*	*69 661*	*80 644*	*80 796*	*80 836*	*80 877*	*80 917*

3.25 2015/16 Targets

Table 51: (DHS17) Quarterly and Annual Targets

Performance Indicators	Targets 2015/16	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Antenatal 1st visit before 20 weeks rate (annualised)	60%	57%	58%	59%	60%
2. Mother postnatal visit within 6 days rate	74.4%	72%	73%	74%	74.4%
3. Infant 1st PCR test positive around 6 weeks rate	<1%	1.4%	1.2%	1%	<1%
4. Immunisation coverage under 1 year (annualised)	90%	89%	90%	90%	90%
5. Measles 2nd dose coverage (annualised)	85%	79%	81%	83%	85%
6. DTaP-IPV-HepB-Hib 3 - Measles 1st dose drop-out rate	7%	8.0%	7.8%	7.4%	7%
7. Child under 5 years diarrhoea case fatality rate	3.2%	3.3%	3.2%	3.2%	3.2%
8. Child under 5 years pneumonia case fatality rate	2.4%	3%	2.8%	2.6%	2.4%
9. Child under 5 years severe acute malnutrition case fatality rate	8%	8%	8%	8%	8%
10. School Grade R learner screening coverage (annualised)	40%	35%	37%	38%	40%
11. School Grade 1 learner screening coverage (annualised)	55%	42%	47%	50%	55%
12. School Grade 8 learner screening coverage (annualised)	40%	35%	37%	38%	40%
13. Couple year protection rate (annualised)	55%	46%	48%	49%	55%
14. Cervical cancer screening coverage (annualised)	75%	75%	75%	75%	75%
15. Vitamin A dose 12-59 months coverage (annualised)	60%	50%	54%	56%	60%
Annual Targets					
16. Antenatal client initiated on ART rate	95%	87%	89%	93%	95%
17. Human papilloma virus vaccine 1st dose coverage	85%				85%
18. Maternal mortality in facility ratio (annualised)	120/100 000				120/100 000
19. Inpatient early neonatal death rate	9.7/1000				9.7/1000
20. Infant mortality rate	30.5/ 1000				30.5/ 1000
21. Under 5 mortality rate	42/ 1000				42/ 1000
22. Child under 5 years diarrhoea with dehydration incidence (annualised)	12.9/1000				12.9/1000
23. Child under 5 years pneumonia incidence (annualised)	88.9/1000				88.9/1000
24. Child under 5 years severe acute malnutrition incidence (annualised)	5.5/1000				5.5/1000
25. Child under 1 year mortality in facility rate (annualised)	6.5%				6.5%
26. Inpatient death under 5 years rate	5.5%				5.5%

3.26 Risk Management

Table 52: Risk Management

Potential Risks	Mitigating Strategies
1. Negative impact of HIV, AIDS, TB, malnutrition and poor socio-economic determinants of health on maternal and child health outcomes. *(High Risk)*	• Improved management of pregnancy and labour (policies, protocols and practices). • Improved clinical governance at service delivery level. • Improve HIV and TB screening of pregnant women and children. • Improve screening and management of malnutrition at community and facility levels. • Focus on community-based programmes to address socio-economic determinants of health (OSS).
2. Inadequate funding envelope limits expansion and pace of implementation of new interventions. *(High Risk)*	• Maternal and child health services shift focus to interventions with highest impact (quick fast results).
3. Late booking for antenatal care and poor adherence to requirements for postnatal care. *(High Risk)*	• Integration with OSS and PHC re-engineering (CCG household coverage) to educate women on importance of early booking for ANC and adherence to requirements for postnatal care. • Linking all mothers and newborns to CCG before discharge from hospital to ensure follow-up for postnatal care.
4. Systemic challenges including poor quality of data and information management. *(High Risk)*	• Prioritised as part of the 5-year strategy to improve health system effectiveness.
5. Early sexual debut and unsafe sexual practices resulting in unplanned, unwanted and early pregnancies. *(High Risk)*	• Implementation of the Contraceptive Strategy and School Health education programmes to promote safe sexual behaviour.

DISEASE PREVENTION AND CONTROL

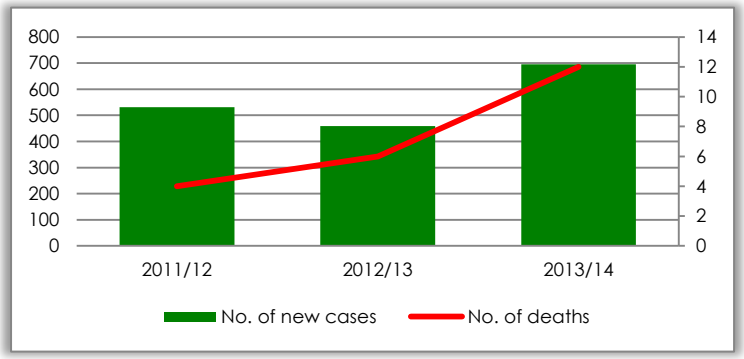
3.27 Overview

Disability and Rehabilitation render services in more than 90% of hospitals and 60% PHC clinics and CHC's, and established 3 therapy forums for Physiotherapy, Occupational, Speech Therapy & Audiology and Employees with Disabilities Consultative Forums. Approval was obtained for the Provincial Standardised Policy Guidelines on the Provision of Assistive Devices. The main challenge identified during 2013/14 was the lack of adequate funding for the provision of assistive devices and therapeutic equipment, the limited space to render services especially at PHC level, and the shortage of personnel. Negative staff attitudes towards disabled patients also played a role in utilisation of services.

A programme for the prevention and management of accidents and violence has been proposed to ensure continuum of care for affected patients. The programme will be supported by an Emergency Unit, as it is proven that the correct management of trauma cases can decrease the medico-legal litigation costs.

The Malaria Programme continues to use DDT as an effective insecticide for prevention of malaria. The 5 year strategic aim is for the Province to be declared malaria free. The slow SCM and HR turnaround times however directly impact on the spraying of infrastructures thereby increasing the risk of malaria re-occurring in that area.

Graph 10: New malaria cases vs Number of deaths



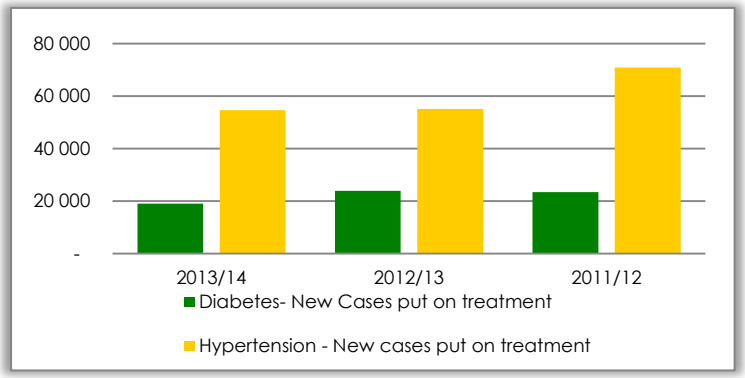
The number of deaths due to Malaria is showing an upward trend (Graph 10).

Cross border malaria cases are considered one of the challenges that need to be addressed in order to achieve the targets of a malaria free province.

Source: KwaZulu-Natal Malaria database

Both hypertension and diabetes incidence show a decrease between 2010/11 and 2013/14 (29.5/1000 to 21.9/1000 and 2.2/1000 to 1.8/1000 respectively), although cases put on treatment increased year on year (Graph 11).

Graph 11: New Diabetes cases vs New Hypertension cases



Source: DHIS

An estimated amount of R8 million is required to clear the backlog of assistive devices including wheelchairs, walking sticks, etc. The Department is working closely with NGOs in the provision of rehabilitation services for the blind as the Department does not have Orientation and Mobility Practitioners to assist patients with the transition. The process for training in sign language is currently with SCM demand management and will be prioritised in 2015/16.

Training of Trainers on PC101 commenced in December 2014 with eight trainers from Uthungulu & Ugu districts trained, and 68 Professional Nurses from non-NHI Districts have been targeted for training in 2015/16.

Eye services, currently rendered at Addington and St Aiden's Hospitals, are being consolidated at McCords Hospital from 1 April 2015. Renovations (R 4 million) and the procurement of equipment (R15 million) has been invested in the hospital to date and it is anticipated that approximately 8 000 cataract operations will be done at the hospital per annum.

The development of the Provincial Palliative Care Policy is in progress and will address all levels of care. As part of palliative care, Mental Health step-down facilities, similar to HIV step-down, are being planned and prioritised in Port Shepstone, Ngwelezane and Pietermaritzburg.

The improvement of psychosocial rehabilitation services will occur within designated health facilities through the establishment of vocational rehabilitation sites and capacity development of Community Care Workers on psychosocial rehabilitation.

KZN Provincial Oral Health Services has a total of six (6) Dental Mobile Units, three are operational, and the remainder are awaiting registration and allocation to districts.

3.28 2015/16 Priorities

1. Improved control of Non-Communicable Diseases through health system strengthening and reform.	• Integrated Chronic Disease Management Model. • PHC101 training for professional nurses. • Rationalisation of eye care services in McCords Hospital. • Mobile health services e.g. Oral Health.
2. Reduce Non-Communicable Disease risk factors and manage prevalence.	• Healthy lifestyle programmes including programmes to reduce obesity (community and facility-based programmes). • Mass screening and early detection and diagnosis of Non-Communicable Diseases - community-based programmes and health events. • Counselling, screening and appropriate management for all Non-Communicable Diseases with focus on cancer, diabetes, hypertension, blindness, hearing and genetic defects.
3. Scale up implementation of mental health, disability and rehabilitation services.	• Palliative care and review of step-down facilities. • Universal access for people with disabilities and those at risk. • Psychosocial rehabilitation services. • Disability and rehabilitation services - clear backlog for assistive devices. • Training in sign language.
4. Maintain malaria incidence at <1/1000 population.	• Early diagnosis and treatment.
5. Environmental Health Services.	• Technical support for Municipal Health Services. • Control of waste and hazardous substances.
6. Participate in inter-sectoral response by government to violence and injury.	• Provision of comprehensive care and support.

3.29 Situation Analysis Indicators per District

Table 53: (DHS18) Situation Analysis Indicators - 2013/14

Indicator	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	eThekwini 2013/14
1. Clients screened for hypertension – 25 years and older	No	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
Number of clients (25 years and older), not on treatment for hypertension, screened for hypertension	*No*	-	-	-	-	-	-	-	-	-	-	-	-
2. Clients screened for diabetes – 5 years and older	No	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
Number of clients (5 years and older), not on treatment for diabetes, screened for diabetes	*No*	-	-	-	-	-	-	-	-	-	-	-	-
3. Percentage of people screened for mental disorders	%	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
PHC Client screened for mental disorders	*No*	-	-	-	-	-	-	-	-	-	-	-	-
PHC headcount total	*No*	-	-	-	-	-	-	-	-	-	-	-	-

Indicator	Type	Provincial 2013/14	Ugu 2013/14	Umgungundlovu 2013/14	Uthukela 2013/14	Umzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	Umkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	eThekwini 2013/14
4. Percentage of people treated for mental disorder - new	%	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
Client treated for mental disorders at PHC level	No	-	-	-	-	-	-	-	-	-	-	-	-
Clients screened for mental disorders at PHC level	No	-	-	-	-	-	-	-	-	-	-	-	-
5. Cataract surgery rate (annualised)	Rate	758.1/1mil	690.5/1mil	1743.5/1mil	249.4/1mil	448.9/1mil	644/1mil	0	935/1mil	1375.9/1mil	697.3/1mil	1605.7/1mil	835/1mil
Cataract surgery total	No	*6 866*	*443*	*1 606*	*149*	*202*	*286*	*0*	*522*	*1 129*	*335*	*663*	*2 531*
Population uninsured total	No	*9 056 593*	*641 575*	*921 139*	*597 448*	*449 940*	*444 034*	*721 080*	*558 260*	*820 569*	*551 656*	*412 916*	*3 031 179*
6. Malaria case fatality rate	Rate	187%	0%	0%	0%	0%	25%	4%	1.9%	3.6%	0%	0%	0.4%
Deaths from malaria	No	*13*	*0*	*0*	*0*	*0*	*1*	*1*	*4*	*6*	*0*	*0*	*1*
Total number of Malaria cases reported	No	*696*	*14*	*23*	*7*	*1*	*4*	*25*	*211*	*106*	*106*	*2*	*209*

3.30 Strategic Objectives, Indicators and Targets

Table 54: Strategic Plan 2015-2019 Targets

Strategic Goal	Strategic Objective	Strategic Objective Statement	Indicator	Target March 2020
Strategic Goal 2: Reduce and manage the burden of disease	2.9) Reduce incidence of non-communicable diseases	2.9.1) Decrease the hypertension incidence by at least 10% per annum	• Hypertension incidence (annualised)	11.4 per 1000
		2.9.2) Decrease the diabetes incidence by at least 10% per annum	• Diabetes incidence (annualized)	0.65 per 1000
	2.10) Eliminate malaria	2.10.1) Zero new local malaria cases by March 2020	• Malaria incidence per 1000 population at risk	Zero new local malaria cases
		2.10.2) Reduce malaria case fatality rate to less than 0.5% by March 2020	• Malaria case fatality rate	Less than 0.5%

Table 55: (DHS20) Programme Performance Indicators

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 2.9: Reduce incidence of non-communicable diseases										
2.9.4) Screen at least 95 000 people for hypertension by March 2020	1. Clients screened for hypertension – 25 years and older	DHIS	Quarterly/ No	New indicator	New indicator	New indicator	New indicator	Establish baseline [63]	-	-
	Number of clients (25 years and older), not on treatment for hypertension, screened for hypertension	*PHC Tick Register*		-	-	-	-	-	-	-
2.9.5) Screen at least 70 000 people for diabetes by March 2020	2. Clients screened for diabetes – 5 years and older	DHIS	Quarterly/ No	New indicator	New indicator	New indicator	New indicator	Establish baseline	-	-
	Number of clients (5 years and older), not on treatment for diabetes, screened for diabetes	*PHC Tick Register*		-	-	-	-	-	-	-
2.9.6) Increase the number of people screened for mental disorders with at least 20% per annum	3. Percentage of people screened for mental disorders	DHIS	Quarterly/ %	New indicator	New indicator	New indicator	New indicator	Establish baseline	-	-
	PHC Client screened for mental disorders	*PHC Tick Register*	*No*	-	-	-	-	-	-	-
	PHC headcount total	*DHIS/PHC Tick Register*	*No*	-	-	-	-	-	-	-
2.9.7) Improve access to treatment for mental health care users by treating 100% eligible patients by March 2020	4. Percentage of people treated for mental disorders - new	DHIS	Quarterly/ %	New indicator	New indicator	New indicator	New indicator	Establish baseline	-	-
	Client treated for mental disorders at PHC level	*PHC Tick Register*	*No*	-	-	-	-	-	-	-

[63] Concerns have been raised with the National Department of Health re data collection system for indicators 1, 2, 3 and 4 (national customised indicators). Essentially all patients that are screened at community and facility level should be included in the indicators and the current system is not accommodating this. It is not possible to set targets for the MTEF as no baselines are available and it is impossible to estimate numbers without any trend data. The Provincial Treasury is in agreement with establishing baselines for the first year of new indicators

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	Clients screened for mental disorders at PHC level	*PHC Tick Register*	*No*	-	-	-	-	-	-	-
2.9.9) Increase the number of cataract surgeries to 13 341 by March 2018	5. Cataract surgery rate (annualised)	DHIS	Quarterly/ No per 1mil uninsured population	1 030.8/ 1 mil	931.2/ 1 mil	758.1/ 1mil	945.2/ 1mil	930/ 1mil	1 154/ 1mil	1 395/ 1 mil
	Cataract surgery total	*DHIS/Theatre register*	*No*	*9 170*	*8 871*	*6 866*	*8 294*	*8 895*	*11 118*	*13 341*
	Population uninsured	*DHIS/Stats SA*	*No*	*8 895 443*	*9 526 488*	*9 056 593*	*8 774 190*	*9 566 487*	*9 633 452*	*9 559 179*
Strategic Objective 2.10: Eliminate malaria										
2.10.2) Reduce malaria case fatality rate to less than 0.5% by March 2016 and onwards	6. Malaria case fatality rate	Malaria Information System / DHIS	Quarterly/ %	0.75%	1.3%	1.7%	1.8%	<0.5%	<0.5%	<0.5%
	Deaths from malaria	*Malaria register/Tick sheets PHC*	*No*	*4*	*6*	*12*	*10*	*2*	*2*	*2*
	Total number of Malaria cases reported	*Malaria register/Tick sheets PHC*	*No*	*531*	*459*	*696*	*502*	*510*	*517*	*525*
Strategic Objective 2.9): Reduce incidence of non-communicable diseases										
2.9.8) Establish 11 district mental health teams by March 2020	17. Number of district mental health teams established (cumulative)	Letters of appointment	Annual/ No	New indicator	New indicator	New indicator	New indicator	4	8	11

Table 56: (DHS19) Provincial Strategic Objectives and Targets

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 2.10: Eliminate malaria										
2.10.1) Zero new local malaria cases by March 2020	1. Malaria incidence per 1000 population at risk	Malaria register	Annual/ Per 1000 population at risk	0.79/ 1000	0.11/ 1000	1.08/ 1000	0.7/ 1000	<1/ 1000	<1/ 1000	<1/ 1000
	Number of malaria cases (new)	*Malaria register/Tick register PHC*	*No*	*531*	*75*	696	*502*	*<649*	*<655*	*<660*
	Population Umkhanyakude	*DHIS/Stats SA*	*Population*	*666 524*	*666 524*	*643 757*	*643 757*	*649 645*	*655 616*	*660 933*
Strategic Objective 2.9: Reduce incidence of non-communicable diseases										
2.9.1) Decrease the hypertension incidence by at least 10% per annum	2. Hypertension incidence (annualised)	DHIS	Quarterly/ No. per 1000	29.5/ 1000	22.8/ 1000	21.9/ 1000	20.9/ 1000	18.9/ 1000	16.5/ 1000	14.1/ 1000
	Hypertension client treatment new	*DHIS / PHC tick registers*	*No*	*70 821*	*55 041*	*54 601*	*53 290*	*48 140*	*43 326*	*38 994*
	Population 40 years and older	*DHIS / Stats SA*	*Population*	*2 393 085*	*2 409 836*	*2 479 517*	*2 547 122*	*2 547 127*	*2 614 590*	*2 748 474*
2.9.2) Decrease the diabetes incidence by at least 10% per annum	3. Diabetes incidence (annualised)	DHIS	Quarterly/ No. per 1000	2.2/1000	1.3/1000	1.8/ 1000	1.7/ 1000	1.5/1000	1.3/1000	1.2/1000
	Diabetes client treatment new	*DHIS / PHC tick registers*	*No*	*23 307*	*23 856*	*18 931*	*18 262*	*16 032*	*14 429*	*12 987*
	Population total	*DHIS / Stats SA*	*Population*	*10 622 204*	*10 703 920*	*40 456 909*	*10 571 313*	*10 688 165*	*10 806 538*	*10 924 776*
2.9.10) Improve access to rehabilitation services at all levels of care	4. Number of clients accessing rehabilitation services	DHIS	Quarterly/ No	No data available	438 680	566 994	714 856	862 718	1 012 718	1 172 718

3.31 2015/16 Targets

Table 57: (DHS21) Quarterly and Annual Targets

Performance Indicators	Targets 2015/16	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Clients screened for hypertension – 25 years and older	Establish baseline	-	-	-	Baseline established
2. Clients screened for diabetes – 5 years and older	Establish baseline	-	-	-	Baseline established
3. Percentage of people screened for mental disorders	Establish baseline	-	-	-	Baseline established
4. Percentage of people treated for mental disorder - new	Establish baseline	-	-	-	Baseline established
5. Cataract surgery rate (annualised)	930/1mil	233 / 1 mil	466 / 1 mil	699 / 1 mil	930 / 1 mil
6. Malaria case fatality rate	<0.5%	<0.5%	<0.5%	<0.5%	<0.5%
7. Hypertension incidence (annualised)	18.9/ 1000	21.6/ 1000	20.5/ 1000	19/ 1000	18.9/ 1000
8. Diabetes incidence (annualised)	1.5/1000	1.7 / 1000	1.7 / 1000	1.6 / 1000	1.5/ 1000
9. Number of clients accessing rehabilitation services	862 718	215 680	215 680	215 680	215 680
Annual Targets					
10. Malaria incidence per 1000 population at risk	<1/1000				</1000
11. Number of district mental health teams established (cumulative)	4				4

3.32 Risk Management

Table 58: Risk Management

Potential Risks	Mitigating Strategies
1. Inadequate screening and detection for non-communicable and chronic diseases (especially at community level) partly due to limitations of the funding envelope impacting on prevention and early management of conditions. *(High Risk)*	• Integrated strategies with re-engineering of PHC and Operation Sukuma Sakhe to increase screening and detection at household level. • Developing reporting system for community-based screening services.
2. Inadequate human resources and theatre time for cataract surgery may impact on achievement of targets. *(Medium Risk)*	• Development of McCords Hospital as Specialised Eye Hospital which will increase the number of cataract surgeries.
3. Non-Communicable Diseases and Mental Health Strategies not costed and approved for implementation. This may impact on operationalisation of the strategies and expected output. *(High Risk)*	• Finalise and cost strategies including implementation plans. Align with Provincial Long Term Plan.
4. Limited budget for assistive devices and therapeutic equipment. *(Medium Risk)*	• Ring fenced budget should be allocated at institutional and district level.
5. Inability to control cross border malaria cases may impact on malaria targets for new cases. *(High Risk)*	• Robust surveillance to detect new malaria cases.

3.33 Reconciling Performance Targets with Expenditure Trends

Table 59: (DHS22 a) Summary of Payments and Estimates

Sub-Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
District Management	165 891	218 582	217 300	246 328	233 858	226 468	238 592	267 750	280 814
Community Health Clinics	2 314 886	2 480 318	2 790 347	3 055 573	3 065 892	3 112 750	3 321 028	3 510 238	3 686 101
Community Health Centres	767 666	955 647	1 048 435	1 296 961	1 281 471	1 214 357	1 388 550	1 506 905	1 583 750
Community Based Services	25 774	790	-	2 580	2 580	2 580	13 000	-	-
Other Community Services	616 374	692 921	906 723	955 141	988 742	1 042 913	1 089 351	1 031 545	1 082 688
HIV and AIDS	1 914 056	2 392 689	2 725 639	3 257 992	3 257 992	3 057 992	3 813 094	4 293 097	4 840 949
Nutrition	65 237	44 433	44 089	47 772	47 772	47 772	50 000	52 649	55 281
Coroner Services	141 575	146 073	156 225	158 329	158 208	158 208	173 157	182 318	191 434
District Hospitals	4 113 192	4 584 982	5 058 841	5 699 359	5 690 291	5 663 765	5 492 090	5 775 777	6 061 158
Total economic classification	**10 124 651**	**11 516 435**	**12 947 599**	**14 720 035**	**14 726 806**	**14 526 805**	**15 578 862**	**16 620 279**	**17 782 175**

Table 60: (DHS22 b) Summary of Payments and Estimates by Economic Classification

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Current payments	**9 647 354**	**11 151 083**	**12 510 682**	**14 210 678**	**14 210 378**	**13 976 385**	**15 106 704**	**16 124 560**	**17 266 722**
Compensation of employees	6 710 880	7 690 784	8 714 714	9 832 214	9 837 336	9 779 724	10 184 010	10 727 085	11 324 131

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Goods and services	**2 936 474**	**3 460 300**	**3 795 947**	**4 378 464**	**4 373 042**	**4 196 551**	**4 922 694**	**5 397 475**	**5 942 591**
Communication	44 069	45 643	53 192	61 750	61 750	52 346	49 937	55 865	57 524
Computer Services	108	8	8 141	11 275	12 275	6 692	30 000	37 854	87 854
Consultants, Contractors and special services	518 880	478 400	555 763	607 253	607 253	673 868	899 206	1 005 507	1 126 462
Inventory	1 861 710	2 329 498	2 522 040	2 879 796	2 873 374	2 683 178	3 093 752	3 432 928	3 717 390
Operating leases	17 626	19 371	19 679	24 286	24 286	36 770	72 885	53 431	54 043
Travel and subsistence	17 701	22 810	21 497	23 485	23 485	25 864	23 028	26 517	27 462
Interest and rent on land	-	-	22	-	-	110	-	-	-
Maintenance, repair and running costs									
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	476 380	564 569	615 613	770 619	770 619	717 833	753 886	785 373	871 856
Transfers and subsidies to	**326 249**	**268 218**	**333 524**	**391 617**	**394 240**	**451 459**	**332 658**	**349 025**	**361 893**
Provinces and municipalities	86 040	22 893	74 736	134 838	153 806	180 647	105 000	111 048	115 000
Departmental agencies and accounts	130	6	21	32	32	41	38	41	43
Higher Education institutions	-	-	-	-	-	-	-	-	-
Foreign governments and international organisations	-	-	-	-	-	-	-	-	-
Non-profit institutions	213 387	204 686	207 922	220 147	202 102	194 288	182 000	192 558	199 356
Households	26 692	40 633	50 846	36 600	38 300	76 483	45 620	45 378	47 494
Payments for capital assets	**151 005**	**97 134**	**103 393**	**117 740**	**122 188**	**98 941**	**139 500**	**146 694**	**153 560**
Machinery and equipment	151 005	97 134	103 393	117 740	122 188	98 941	139 500	146 694	153 560
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Land and sub-soil assets	-	-	-	-	-	-	-	-	-

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Software and other tangible assets	-	-	-	-	-	-	-	-	-
Payment for financial assets	43	-	-	-	-	20	-	-	-
Total economic classification	**10 124 651**	**11 516 435**	**12 947 599**	**14 720 035**	**14 726 806**	**14 526 805**	**15 578 862**	**16 620 279**	**17 782 175**
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	**10 124 651**	**11 516 435**	**12 947 599**	**14 720 035**	**14 726 806**	**14 526 805**	**15 578 862**	**16 620 279**	**17 782 175**

3.34 Performance and Expenditure Trends

The biggest increases in expenditure can be seen in Sub-Programmes 2.2: Clinics (10%); 2.3: CHC's (8.8%); 2.6: HIV & AIDS (16.6%); and 2.9: District Hospitals (10%). This is attributed to (a) substantial increase in medicine costs which was above the CPIX index of 5.3%[64] (December 2013) and (b) increase in staffing costs. Improved PHC, through PHC re-engineering, is expected to continue placing pressure on existing expenditure trends in these Sub-Programmes. It is also expected that with improved PHC the expenditure trends in district hospitals will change.

District Management has remained consistent at 1.7% of the total Programme 2 (District Health Services) budget for the previous 5 year cycle. The difference in actual expenditure is an additional R 80.8 million (2009/10 – 2013/14) despite 29 vacant posts in salary level 9 – 14 at District Offices. During the reporting year, 2 District Manager posts were vacant. In 2012/13, the expenditure of R 786 513 under Sub-Programme 2.4 was for Community Service Officers (CSO's) e.g. Professional Nurses, Medical Officers, Therapists, etc. This was moved to Sub-Programme 2.5 in 2013/14.

Organisation unit	District Hospitals	Management	PHC 2.2-2.7
KwaZulu-Natal Province	42.3%	1.7%	56.0%

PHC remains a priority in the Province, which therefore shows a consistent increase in budget allocation and expenditure over the past 4 years.

District Hospitals will in turn continue to require a substantial proportion of the Programme 2 budget due to the high number of hospitals in the Province. The rationalisation of hospital services, to address existing inefficiencies, should be prioritised to ensure appropriate investment at PHC level.

Staff linked to the School Health Services and Ward-Based Outreach Team Objectives are not always the same staff linked to the School Health/ Ward-Based Outreach Component of the Clinic establishment which skew analysis of expenditure as well as economies of scale and impact of community-based services on the burden of disease. The expenditure for Sub-Programme 2.5 (Other Community Services) must be reviewed to address poor linkages between BAS & Persal in respect of community-based outreach teams including Ward-Based Outreach and School Health Teams. Data system issues (Persal and BAS) must be resolved to allow effective use of information.

[64] Source: http://www.global-rates.com/economic-indicators/inflation/consumer-prices/cpi/south-africa.aspx

4. PROGRAMME 3: EMERGENCY MEDICAL SERVICES

4.1 Programme Purpose

To render 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 mandate.

Sub-Programme 3.1: Emergency Medical Services

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

Sub-Programme 3.2: Patient Transport Services (PTS)

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

4.2 Overview

Emergency Medical Services operates at the frontline of the health system and therefore has a direct impact on the outcome of a patient in an emergency situation. The purpose of the EMS programme is to ensure rapid and effective emergency medical care and transport, and efficient planned patient transport in accordance with agreed norms and standards.

EMS consists of various components of which the largest and most important is Emergency Services, which is currently delivered in all 11 districts. A decision was taken to provincialize EMS in KZN in order to improve the service by addressing all challenges of the current arrangement and to standardize services provided in all districts.

The EMS service attends to more than half a million emergency cases every year. In 2013/14, the total number of emergency cases was 610 115 and the number of inter facility transfers 192 814. The population per ambulance is currently 49 558 as opposed to the national norm of 1 per 10 000 population. This gap places a huge burden on resource allocation as a further 754 operational ambulances are required in KZN to meet the norm.

4.3 2015/16 Priorities

1. Review, finalise and implement the Emergency Medical Services Model.
   - Independent analysis of the current EMS services to inform preferred model and Implementation Plan.

2. Improve EMS efficiencies.	• Obstetric ambulances to improve maternal health outcomes. • Increase operational ambulances per shift (include emergency, obstetric, and inter-facility transport). • Rationalise and upgrade communication centres. • Northern KZN (Empangeni) PTS Hub for inter and intra district transportation. • Electronic patient booking system. • Dedicated HR team to manage current EMS dissatisfaction. • EMS governance. • Internal and external communication campaign.

4.4 Situation Analysis Indicators per District

Table 61: (EMS1) Situation Analysis Indicators

Indicator	Data Source	Province 2013/14	Ugu 2013/14	UMgungundlovu 2013/14	Uthukela 2013/14	UMzinyathi 2013/14	Amajuba 2013/14	Zululand 2013/14	UMkhanyakude 2013/14	Uthungulu 2013/14	Ilembe 2013/14	Harry Gwala 2013/14	eThekwini 2013/14
EMS P1 urban response under 15 minutes rate	*EMS register*	*6%*	*5%*	*4%*	*8%*	*45%*	*80%*	Not collected	Not collected	18%	*6%*	Not collected	*4%*
No P1 urban calls with response times under 15 minutes	*EMS callout register*	*10 408*	*738*	*806*	*945*	*496*	*2 558*	-	-	*97*	*395*	-	*4 373*
All P1 urban call outs	*EMS callout register*	*174 157*	*14 863*	*18 759*	*12 377*	*1 096*	*3 196*	-	-	*540*	*6 625*	-	*116 701*
EMS P1 rural response under 40 minutes rate	*EMS register*	31%	22%	10%	27%	34%	81%	*57%*	16%	14%	18%	18%	33%
No P1 rural calls with response times under 40 minutes	*EMS callout register*	*69 846*	*3 590*	*1 431*	*5 610*	*8 898*	*17 114*	*17 759*	*4 008*	*4 453*	*2 400*	*4 467*	*116*
All P1 rural call outs	*EMS callout register*	*226 280*	*16 031*	*14 027*	*21 113*	*26 199*	*21 016*	*31 285*	*24 930*	*32 741*	*13 460*	*25 393*	*355*
EMS inter-facility transfer rate	*EMS register / database*	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
EMS inter-facility transfer	*EMS register*	-	-	-	-	-	-	-	-	-	-	-	-
EMS clients total	*EMS register*	-	-	-	-	-	-	-	-	-	-	-	-

Source: From 2012/13 Annual Report unless otherwise indicated

Rural Development Node Districts highlighted in tan (only Umzimkhulu Municipality in Harry Gwala)

4.5 Strategic Objectives, Indicators and Targets

Table 62: Strategic Plan 2015-2019 Targets

Strategic Goal	Strategic Objective	Strategic Objective Statement	Indicator	Target March 2020
Strategic Goal 1: Strengthen health system effectiveness	1.8) Improve EMS efficiencies	1.8.1) Evidence-based EMS Model approved and implemented by March 2016	• Approved revised EMS Model	Approved revised EMS Model implemented
		1.8.2) Increase the average number of daily operational ambulances to 550 by March 2020	• Average number of daily operational ambulances	550
		1.8.3) Rationalise 4 clustered communication centres by March 2020	• Number of clustered communications centres established and operational	4
Strategic Goal 5: Improved quality of health care		1.8.4) Improve P1 urban response times of under 15 minutes to 25% by March 2020	• EMS P1 urban response under 15 minutes rate	25%
		1.8.5) Improve P1 rural response times of under 40 minutes to 45% by March 2020	• EMS P1 rural response under 40 minutes rate	45%
		1.8.6) Increase the inter-facility transfer rate to 50% by March 2020	• EMS inter-facility transfer rate	50%

Table 63: (EMS3) Programme Performance Indicators

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 1.8: Improve EMS efficiencies										
1.8.4) Improve P1 urban response times of under 15 minutes to 25% by March 2020	1. EMS P1 urban response under 15 minutes rate	EMS register	Quarterly/ %	11.4%	8.4%	6%	5.1%	6.5%	7.2%	7.9%
	EMS P1 urban response under 15 minutes	*EMS callout register*	*No*	*16 242*	*14 336*	*10 408*	*8 535*	*12 677*	*15 441*	*18 807*
	EMS P1 urban calls	*EMS callout register*	*No*	*142 864*	*171 053*	*174 157*	*167 366*	*192 618*	*213 035*	*235 617*
1.8.5) Improve P1 rural response times of under 40 minutes to 45% by March 2020	2. EMS P1 rural response under 40 minutes rate	EMS register	Quarterly/ %	35.9%	32.1%	31%	30.8%	33%	35.3%	37.9%
	EMS P1 rural response under 40 minutes	*EMS callout register*	*No*	*66 567*	*69 903*	*69 846*	*71 501*	*71 802*	*73 812*	*75 879*
	EMS P1 rural calls	*EMS callout register*	*No*	*185 479*	*217 491*	*226 280*	*232 148*	*217 229*	*208 540*	*200 198*
1.8.6) Increase the inter-facility transfer rate to 50% by March 2020	3. EMS inter-facility transfer rate	EMS inter-facility register / database	Quarterly/ %	29.3%	32.2%	31.6%	36.2%	37%	38%	39%
	EMS inter-facility transfer	*EMS register*	*No*	*171 868*	*185 489*	*192 814*	*209 859*	*230 000*	*240 000*	*250 000*
	EMS clients total	*EMS register*	*No*	*585 955*	*576 682*	*610 115*	*579 722*	*620 000*	*630 000*	*640 000*

Table 64: (EMS2) Provincial Strategic Objectives and Targets

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 1.8: Improve EMS efficiencies										
1.8.1) Evidence-based EMS Model approved and implemented by March 2016	1. Revised EMS Model	Approved EMS Model	Annual/ Categorical	New indicator	New indicator	New indicator	New indicator	EMS Model approved	EMS Model implemented	EMS Model implemented
1.8.7) Increase the number of obstetric ambulances to 72 by March 2020	2. Number of obstetric ambulances – cumulative	Handover documents	Annual/ No	New indicator	New indicator	32	26	32 (6)	38 (6)	(44) 6
1.8.8) Increase the number of inter-facility ambulances to 72 by March 2020	3. Number of IFT ambulances – cumulative	Handover documents	Annual/ No	New indicator	New indicator	24	34	40 (6)	46 (6)	52 (6)
1.8.2) Increase the average number of daily operational ambulances to 550 by March 2020	4. Average number of daily operational ambulances	EMS daily Operations reports/ EMS database	Annual/ No	New indicator	New indicator	216	196	356	431	500
1.8.3) Rationalise 4 clustered communication centres by March 2018	5. Number of clustered Communications Centres established and operational	Infrastructure project report/ EMS database	Annual/ No	New indicator	New indicator	0	1 Region 1	2 (Region 2)	3 Region 4	4 Region 3
1.8.9) Increase purpose built wash bays with sluice facilities to 45 by March 2020	6. Number of purpose built wash bays with sluice facilities	Infrastructure project report/ EMS database	Annual/ No	New indicator	New indicator	New indicator	0	9	18 (9)	27 (9)

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
1.8.10) Increase EMS revenue collection to at least R22 million by March 2020	7. Revenue generated	BAS	Annual/ R	New indicator	New indicator	New indicator	R 2 513 144	R 17 million	R 19 million	R 20 million
1.8.11) Increase the number of bases with access to internet to 75 by March 2020	8. Number of bases with access to computers and intranet/ e-mail	IT roll-out report/ IT database	Annual/ No	New indicator	New indicator	21	48	48	55	65

4.6 2015/16 Targets

Table 65: (EMS4) Quarterly and Annual Targets

Performance Indicators	Targets 2015/16	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. EMS P1 urban response under 15 minutes rate	6.5%	6%	6.2%	6.4%	6.5%
2. EMS P1 rural response under 40 minutes rate	33%	31%	31.6%	32.4%	33%
3. EMS inter-facility transfer rate	37%	32%	34%	36%	37%
Annual Targets					
4. Revised EMS Model	EMS model approved				EMS model approved
5. Number of obstetric ambulances - cumulative	32 (6)				32 (6)
6. Number of IFT ambulances - cumulative	40 (6)				40 (6)
7. Average number of daily operational ambulances	356				356
8. Number of clustered Communications Centres established and operational	2 (Region 2)				2 (Region 2)
9. Number of purpose built wash bays with sluice facilities	9				9
10. Revenue generated	R 17 million				R 17 million
11. Number of bases with access to computers and intranet/ e-mail	48				48

4.7 Reconciling Performance Targets with Expenditure Trends

Table 66: (EMS5 a) Expenditure Estimates

Sub-Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Emergency Transport	1 032 954	863 099	967 208	1 012 736	1 012 736	1 027 223	1 094 031	1 137 189	1 194 048
Planned Patient Transport	37 433	62 937	42 732	60 702	60 702	46 215	66 280	59 287	62 251
Total	**1 070 387**	**926 036**	**1 009 940**	**1 073 438**	**1 073 438**	**1 073 438**	**1 160 311**	**1 196 476**	**1 256 299**

Table 67: (EMS5 b) Summary of Provincial Expenditure Estimates by Economic Classification

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Current payments	**856 411**	**870 638**	**975 416**	**1 026 957**	**1 026 957**	**1 042 907**	**1 095 120**	**1 143 906**	**1 201 100**
Compensation of employees	595 253	641 810	715 735	751 280	751 280	770 618	789 187	826 698	868 032
Goods and services	**261 158**	**228 827**	**259 679**	**275 677**	**275 677**	**272 275**	**305 933**	**317 208**	**333 068**
Communication	9 574	10 766	8 250	9 058	9 058	8 067	8 399	8 847	9 289
Computer Services	-	-	2 233	-	-	45	-	-	-
Consultants, Contractors and special services	86 220	7 833	1 610	6 667	6 667	1 592	850	912	958
Inventory	106 933	98 348	133 626	25 219	25 219	26 654	24 224	25 516	26 792
Operating leases	4 469	2 591	2 270	2 520	2 520	1 432	1 917	2 020	2 121
Travel and subsistence	4 936	4 991	3 536	5 100	5 100	3 740	4 050	4 269	4 483
Interest and rent on land	-	-	2	-	-	14	-	-	-
Maintenance, repair and running costs	-	-	-	-	-	-	-	-	-

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	49 026	104 300	108 152	227 113	227 113	230 745	266 493	275 644	289 425
Transfers and subsidies to	**3 230**	**4 165**	**3 946**	**4 340**	**4 340**	**3 909**	**4 891**	**5 148**	**5 406**
Provinces and municipalities	1 842	1 537	2 511	2 040	2 040	1 949	3 190	3 355	3 523
Departmental agencies and accounts	-	-	-	-	-	1	1	2	2
Higher Education institutions	-	-	-	-	-	-	-	-	-
Foreign governments and international organisations	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	1 388	2 628	1 435	2 300	2 300	1 959	1 700	1 791	1 881
Payments for capital assets	**210 745**	**51 234**	**30 578**	**42 141**	**42 141**	**26 252**	**60 300**	**47 422**	**49 793**
Machinery and equipment	210 745	51 234	30 578	42 141	42 141	26 252	60 300	47 422	49 793
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Land and sub-soil assets	-	-	-	-	-	-	-	-	-
Software and other tangible assets	-	-	-	-	-	-	-	-	-
Payment for financial assets	1	-	-	-	-	370	-	-	-
Total economic classification	**1 070 387**	**926 036**	**1 009 940**	**1 073 438**	**1 073 438**	**1 073 438**	**1 160 311**	**1 196 477**	**1 256 301**
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	**1 070 387**	**926 036**	**1 009 940**	**1 073 438**	**1 073 438**	**1 073 438**	**1 160 311**	**1 196 476**	**1 256 299**

4.8 Performance and Expenditure Trends

The fluctuating trend over the seven-year period is largely due to funding provided to appoint additional staff and to purchase additional vehicles, as well as the planned expansion of emergency medical services to under-served areas. The increase in the 2015/16 MTEF allocation includes carry-through costs for the various wage agreements, OSD payments, funding to expand emergency medical services, as well the carry-through costs of the danger allowance.

The high growth in *Compensation of Employees in* 2013/14 relates to the absorption of trainees, the strengthening of obstetrical ambulance services, as well as the provision for standard danger allowances to various categories of Emergency Medical Services personnel. The growth over the 2015/16 MTEF provides for inflation only.

The main cost drivers under *Goods and Services* are fuel and repairs to emergency vehicles, the latter being related to the rough terrain in rural areas and these costs will increase as the service expands. The minimal growth over the 2015/16 MTEF is attributed to the new fleet of emergency vehicles that will be procured with lesser running costs.

The variable trend in *Transfers and Subsidies to: Provinces and Municipalities* is driven by the size of the fleet of emergency medical service vehicles, with new ambulances being procured and the old fleet being relegated, and registration and licensing costs thereof will thus vary accordingly.

The reduced budget for *Machinery and Equipment* from 2013/14 onward relates to the reprioritisation of funding which will be reviewed during 2016/17 with funding provided only for the replacement of ambulances.

4.9 Risk Management

Table 68: Risk Management

Potential Risks	Mitigating Strategies
1. Delays in finalising the costed EMS Model. *(High Risk)*	• Prioritised costed EMS Model for strategic period.
2. Aging infrastructure including equipment and fleet will impact negatively on the EMS efficiencies. The limited funding envelope restricts accelerated procurement of equipment and vehicles to address the current gap. *(High Risk)*	• Strategic positioning of resources and prioritisation based on need/ demand and available resources.
3. Organised labour instability impacts negatively on staff morale and productivity. *(High Risk)*	• Improve labour relations – continuous consultation and communication. • Establish dedicated HR Team to deal with labour related cases.
4. Exodus of highly skilled EMS staff (high turnover rate) impacting on quality of services. *(High Risk)*	• Revitalisation of EMS Training College to improve access to training and support.
5. Demand outweighs supply – low efficiencies e.g. extended response times. *(High Risk)*	• Re-positioning available resources as part of revitalisation process.

5. PROGRAMME 4: REGIONAL AND SPECIALISED HOSPITALS

5.1 Programme Purpose

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

There are no changes to the Programme 4 structure.

Sub-Programme 4.1: General (Regional) Hospitals

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

Sub-Programme 4.2: Specialised 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: Specialised Psychiatric/ Mental Health 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: Chronic Medical Hospitals

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

Sub-Programme 4.5: Oral and Dental Training Centre

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

5.2 2015/16 Priorities

Rationalisation of hospital services to improve optimisation of resources, efficiencies and quality.	• Hospital Rationalisation Plan. • Emergency Units at identified hospitals pending approved Business Plan (implemented in phased approach). 1. Ngwelezana Hospital 2. Stanger Hospital 3. Ladysmith Hospital 4. Port Shepstone Hospital 5. Prince Mshiyeni Memorial Hospital 6. Addington Hospital 7. Greys Hospital 8. King Edward Hospital • Review functioning and management of Gateway clinics to reduce unreferred outpatients and associated costs. • Establish the eye care service package at McCords Hospital.
Improve quality of care.	• Clinical governance including policy to standardise Clinical Governance Structures, induction of Clinical Governance Committees, and monitoring effectiveness against adverse clinical incidents. • Electronic patient Information Management system (basic modules implemented at King Edward VIII Hospital in 2015/16 and clinical modules added at Addington and King Dinuzulu Hospitals in 2016/17 pending approval of Business Plan). • Phased implementation of ICD 10 coding (first targeting Tertiary Hospitals, then Addington and other Regional Hospitals). • National Core Standards, self-assessments and development of Quality Improvement Plans to address gaps. • Outreach services – including services in partnership with Aero Medical Services.
Improved human resources for health.	• Leadership training, mentoring & support with focus on training of Clinical/Medical Managers on general management and Management Teams on Clinical Governance. • Filling of essential posts.
Clinical Support Services.	• SCM processes and systems (decentralized delegations). • Essential Medical Equipment List based on package of services per level of care to improve optimisation of resources.

5.3 Strategic Objectives, Indicators and Targets

Table 69: 2015-2019 Strategic Plan Targets

Strategic Goal	Strategic Objective	Strategic Objective Statement	Indicator	Target March 2020
Strategic Goal 1: Strengthen health system effectiveness	1.7) Improve hospital efficiencies	1.7.2) Develop and implement the approved Hospital Rationalisation Plan by March 2016	• Hospital Rationalisation Plan	Plan implemented
		1.7.1) Maintain a bed utilisation rate of 75% (or more)	• Inpatient bed utilisation rate	75% (or more)
Strategic Goal 4: Strengthen human resources for health	4.1) Improve human resources for health	4.1.3) Implement the Community Based Training in a PHC Model in collaboration with the University of KwaZulu-Natal with Phase 1 pilot commencing in 2016/17 *(included under Programme 1)*	• Community Based Training in a PHC Model	Model implemented
Strategic Goal 5: Improved quality of health care	5.1) Improve compliance to the Ideal Clinic and National Core Standards	5.1.2) 60% (or more) public health hospitals compliant with extreme and vital measures of the national core standards by March 2020	• Percentage of hospitals compliant with all extreme and vital measures of the national core standards	60% (or more)
		5.1.1) Sustain a patient experience of care rate of 95% (or more) at all public health facilities by March 2020	• Patient experience of care rate	95% (or more)

Note: Strategic Objectives, Objective Statements, Indicators and Targets from the Strategic Plan 2015-2019 are the same for Provincial Hospitals (Regional, Specialised TB, Specialised Psychiatric, and Chronic/Sub-Acute) - Programme 4. The table is therefore not repeated in Programme 4.

The Hospital Rationalisation Plan that will be developed in 2015/16 will make provision for specific strategic and operational priorities that will be specific to hospitals and hospital categories. Details of the Plan will be unpacked in the next Annual Performance Plan for 2016/17 and onwards.

REGIONAL HOSPITALS

5.4 Overview

Regional Hospitals render services at General Specialist level and serve as referral for District Hospitals.

There are 14 Regional Hospitals in the Province (including St Aidens) with two hospitals rendering Mother and Child services (Lower Umfolozi War Memorial in Uthungulu and Newcastle in Amajuba) and McCords being developed as a specialised Eye Care Hospital.

Classification of hospitals will be reviewed in 2015/16 as part of the Hospital Rationalisation Plan which will address some of the current anomalies including (but not exclusive to):

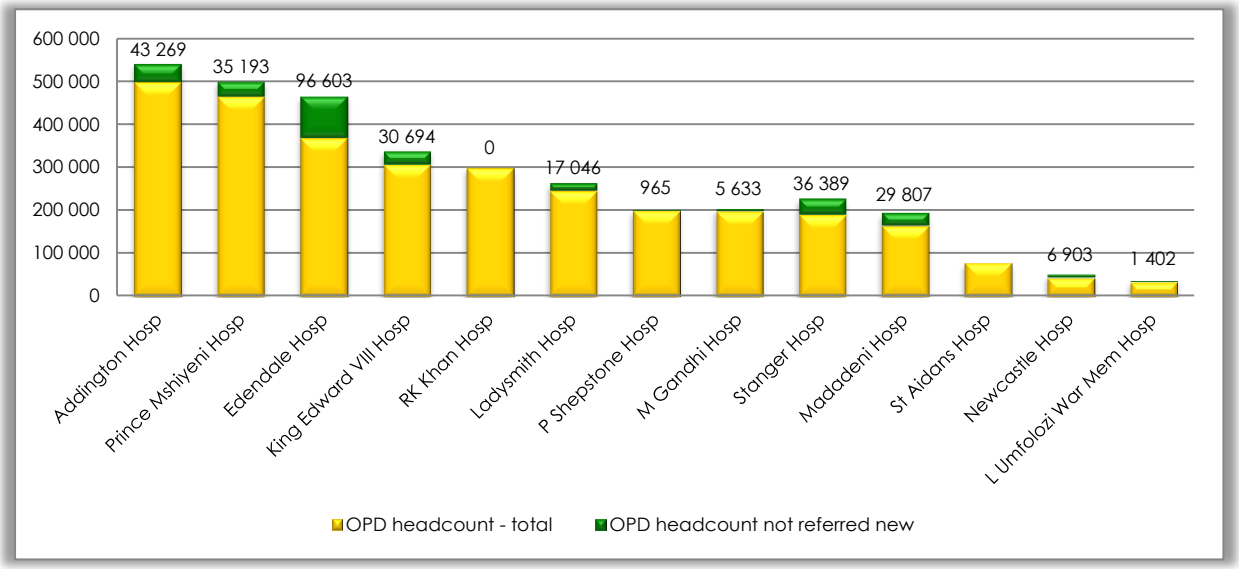
- Ngwelezana Hospital, classified as Developing Tertiary Hospital, is rendering District, Regional and Tertiary services and reported in DHIS under Tertiary Hospitals thus skewing data for Tertiary services. The current reporting system (BAS and DHIS) does not make provision for segregation of levels of care in hospitals which affects resource allocation based on the package of services and patient activity per level of care.
- King Edward VIII Hospital, classified as Central Hospital, is rendering regional and tertiary services and data in DHIS is under Regional Hospitals. The inability of systems to segregate data therefore also impacts on interpretation of data to determine efficiencies and resource allocation.
- Specialised Mother and Child Hospitals are reported under Regional Hospitals (DHIS) thus influencing analysis and interpretation of data to determine efficiencies and inform appropriate resource allocation.
- King Dinuzulu Hospital, servicing the Durban South area, is classified as a Regional Hospital, although it renders mainly District Hospital services (400 beds) with Specialised TB and Psychiatric services. Hospital data is reported under Specialised TB Hospitals in DHIS.

Unreferred patients seen at outpatient departments accounted for 10% (303 904) of the total outpatient headcount at Regional Hospitals in 2013/14 (Graph 12). This must be analysed in the context of availability of and access to health services at PHC clinics and District Hospitals before appropriate interventions can be implemented to reduce unreferred cases.

Port Shepstone Hospital has successfully implemented a plan over the previous 3 years to strengthen PHC and district hospital services within the Ugu District to reduce unreferred cases at the hospital. The unreferred cases reduced to 0.48% of the total outpatient cases in 2013/14.

When comparing the average cost per PDE for regional hospitals (R 2 192) with the average cost per PHC headcount at clinic level (R 227) it is clear that unreferred patients at this level increase expenditure considerably.

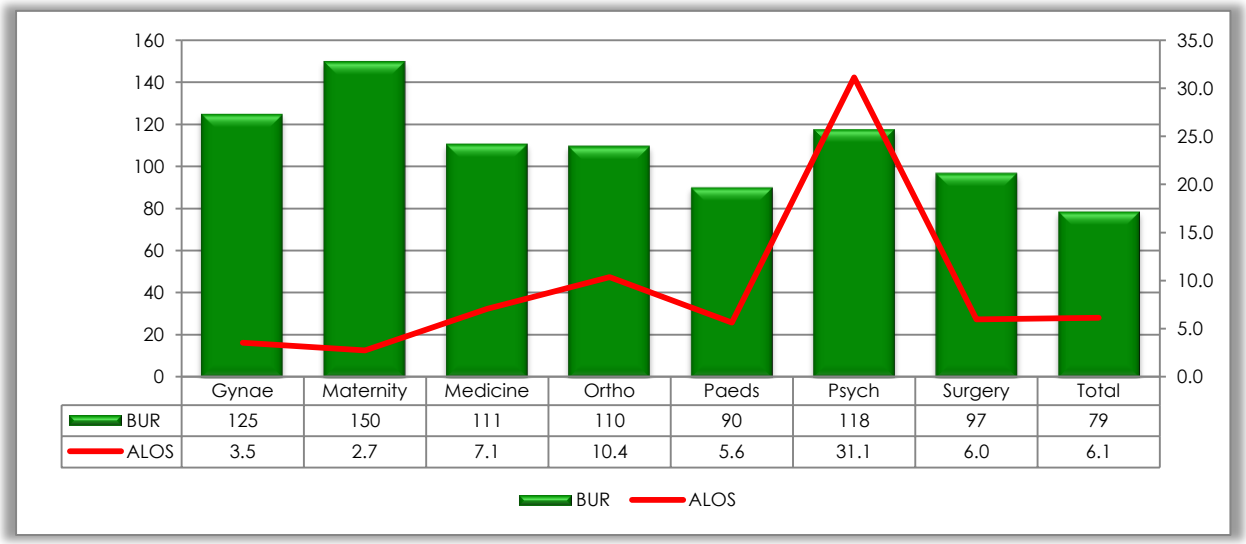
Graph 12: OPD headcount not referred – Regional Hospitals



The bed utilisation rate is consistently higher than 75% (efficiency norm). Bed norms per clinical domain will be reviewed as part of the Hospital Rationalisation Plan to address over/ under-utilised beds per clinical domain (Graph 13).

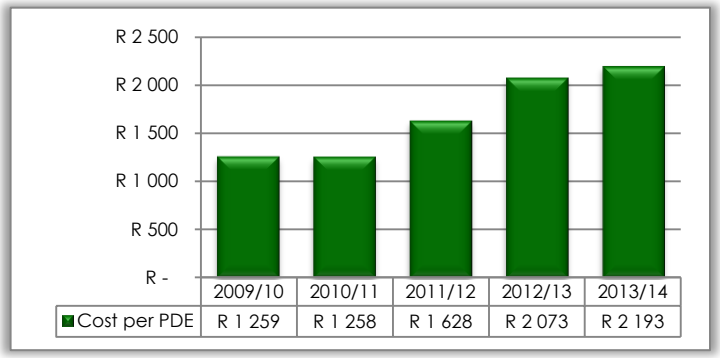
The average length of stay, averaged in DHIS, is influenced by the average stay of 31 days of mental health users (Graph 13). Implementation of the Mental Health Strategy is expected to improve management of mental health care users at PHC and District Hospital level, which might reduce the number of patients and length of stay in regional hospitals.

Graph 13: Regional Hospital per clinical domain – 2013/14



	Gynae	Maternity	Medicine	Ortho	Paeds	Psych	Surgery	Total
BUR	125	150	111	110	90	118	97	79
ALOS	3.5	2.7	7.1	10.4	5.6	31.1	6.0	6.1

Graph 14: Regional Hospital – Cost per PDE



The cost per PDE for Regional Hospitals has increased exponentially by 74% from 2009/10 to 2013/14 due to the high cost of medication and medical equipment, the Rand / Dollar exchange and the fall of the global market.

Most Regional Hospitals are also rendering some District Hospital services especially where access to district hospitals is poor resulting in a lower cost per PDE than anticipated. Once the package of services for Regional Hospitals is confirmed and implemented correctly, the cost to treat patients at regional level should force an increase in the cost per PDE. It is however suspected that there might be a decrease in the number of patients (long term) once lower levels of care are more efficient. This will be actively monitored.

Table 70: (PHS2) Programme Performance Indicators

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 5.1: Improve compliance to the Ideal Clinic and National Core Standards										
5.1.3) 100% Public health hospitals conduct annual national core standard self-assessments by March 2016	1. National core standards self-assessment rate	QA database	Quarterly/ %	New indicator	New indicator	100%	53.8%	100% [65]	100%	100%
	Number of Regional Hospitals that conducted national core standard self-assessment to date in the current financial year	*QA database/ Self-assessment reports*	*No*	-	-	*13*	*7*	*13*	*13*	*13*
	Regional Hospitals total	*DHIS calculates*	*No*	-	-	*13*	*13*	*13*	*13*	*13*
5.1.4) 100% Public health hospitals develop and implement Quality Improvement Plans based on national core standard assessment outcomes by March 2016	2. Quality improvement plan after self-assessment rate	DHIS – NCS Module	Quarterly/ %	New indicator	New indicator	76.9%	100%	100%	100%	100%
	Number of Regional Hospitals that developed a quality improvement plans to date in the current financial year	*Quality Improvement Plans*	*No*	-	-	*10*	*7*	*13*	*13*	*13*
	Number of Regional Hospitals that conducted national core standard self-assessment to date in the current financial year	*Assessment Records*	*No*	-	-	*13*	*7*	*13*	*13*	*13*
5.1.2) 60% (or more) public health hospitals compliant with extreme and vital measures of the national core	3. Percentage of hospitals compliant with all extreme and vital measures of the national core standards	*DHIS – NCS Module*	Quarterly/ %	New indicator	New indicator	*8%*	*0%*	23%	38%	62%

[65] ALL hospitals must implement the National Core Standards and conduct annual self-assessments to inform Quality Improvement Plans hence significant increase in target(s)

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
standards by March 2020	*Total number of Regional Hospitals that are compliant to all extreme measures and at least 90% of vital measures of national core standards*	*Assessment Records*	*No*	-	-	*1*	*0*	*3*	*5*	*8*
	Number of Regional Hospitals that conducted national core standards self-assessment to date in the current financial year	*Assessment Records*	*No*	-	-	*13*	*7*	*13*	*13*	*13*
5.1.5) Sustain a 100% patient experience of care survey rate in all public health facilities from March 2016	4. Patient experience of care survey rate	DHIS – NCS Module	Quarterly/ %	New indicator	New indicator	100%	100%	100%	100%	100%
	Total number of Regional Hospitals that conducted a patient experience of care (PEC) survey to date in the current financial year	*PEC*	*No*	-	-	*13*	*13*	*13*	*13*	*13*
	Total number of Regional Hospitals	*DHIS calculates*	*No*	-	-	*13*	*13*	*13*	*13*	*13*
5.1.1) Sustain a patient experience of care rate of 95% (or more) at all public health facilities by March 2020	5. Patient experience of care rate	DHIS - NCS Module	Annual/ %	Data not available	Data not available	95.6% [66]	84.7%	85.4% [67]	86.1%	86.8%
	Sum of patient experience of care survey scores (in %) of all Regional Hospitals that conducted a patient experience of care survey to date in the current financial year	*PEC results*	*No*	-	-	*Not available*	*1 193*	*1 217*	*1 241*	*1 266*

[66] The numerator and denominator could not be sourced from the Quality Assurance Programme before finalisation of the APP
[67] The national definition of this indicator (changed from last year) indicates that the Quality Assurance Component is using incorrect numerator/denominator to calculate indicator. This will therefore be reviewed during 2015/16 once clarity has been obtained from the NDOH. Current targets are still based on the QA interpretation of the indicator

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	Total number of Regional Hospitals that conducted a patient experience of care survey to date in the current financial year	*PEC results*	*No*	-	-	*Not available*	*1 407*	*1 424*	*1 441*	*1 458*
Strategic Objective 1.7: Improve hospital efficiencies										
1.7.3) Improve hospital efficiencies by reducing the average length of stay to less than 5 days (District & Regional), 15 days (TB), 280 days (Psych), 35 days (Chronic), 7.6 days (Tertiary), and 6.5 days (Central) by March 2020	6. Average length of stay - total	DHIS	Quarterly/ Days	5.3 Days	5.4 Days	6.1 Days	6.1 Days	6.1 Days	6.0 Days	6.0 Days
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*2 086 603*	*1 930 175*	*1 911 384*	*1 929 980*	*1 949 612*	*1 988 604*	*2 028 376*
	Day Patients	*DHIS/ Midnight Census*	*No*	*35 051*	*41 603*	*45 561*	*47 760*	*50 148*	*52 655*	*55 288*
	Inpatient Separations total	*DHIS calculates*	*No*	*381 657*	*361 422*	*315 039*	*319 618*	*326 010*	*332 531*	*339 181*
1.7.1) Maintain a bed utilisation rate of 75% (or more)	7. Inpatient bed utilisation rate - total	DHIS	Quarterly/ %	78.4%	75.2%	77.4%	76.9%	76.1%	77.6%	79.2%
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*2 086 603*	*1 930 175*	*1 911 384*	*1 929 980*	*1 949 612*	*1 988 604*	*2 028 376*
	Day Patients	*DHIS/ Midnight Census*	*No*	*35 051*	*41 603*	*45 561*	*47 760*	*50 148*	*52 655*	*55 288*
	Inpatient bed days available	*DHIS*	*No*	*2 675 778*	*2 591 934*	*2 498 942*	*2 571 060*	*2 594 785*	*2 594 785*	*2 594 785*
1.7.4) Maintain expenditure per PDE within the provincial norms	8. Expenditure per patient day equivalent	BAS/DHIS	Quarterly/ R	R 1 872*	R 2 067*	R 2 186	R 2 365	R 2 225	R 2 386	R 2 497
	Expenditure total	*BAS*	*R'000*	*5 773 286*	*6 375 683*	*6 744 282*	*7 105 561*	*6 881 905*	*7 398 047*	*7 761 725*
	Patient day equivalents	*DHIS calculates*	*No*	*3 343 858*	*3 083 881*	*3 085 116*	*3 004 622*	*3 092 628*	*3 100 359*	*3 108 110*
Strategic Objective 5.1: Improve compliance to the Ideal Clinic and National Core Standards										

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
5.1.6) Sustain a complaint resolution rate of 90% (or more) in all public health facilities from March 2018 onwards	9. Complaint resolution rate	DHIS	Quarterly/ %	New indicator	New indicator	78.5%	75.1%	80%	84%	89%
	Complaint resolved	*Complaints Register*	*No*	-	-	*1 266*	*1 066*	*1 071*	*1 077*	*1 082*
	Complaint received	*Complaints Register*	*No*	-	-	*1 612*	*1 418*	*1 347*	*1 280*	*1 216*
5.1.7) Sustain a 85% (or more) complaint resolution within 25 working days rate in all public health facilities by March 2018 and onwards	10. Complaint resolution within 25 working days rate	DHIS	Quarterly/ %	*66%*	*57.4%*	*94%*	*93.8%*	*95%*	*96%*	*97%*
	Complaint resolved within 25 working days	*Complaints register*	*No*	*534*	*529*	*1 190*	*1 000*	*1 051*	*1 030*	*1 046*
	Complaint resolved	*Complaints register*	*No*	*807*	*916*	*1 266*	*1 066*	*1 071*	*1 077*	*1 082*

Table 71: (PHS1) Provincial Strategic Objectives and Targets

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 2.7: Reduce maternal mortality										
2.7.3) Reduce the caesarean section rate to 25% (District), 37% (Regional), 60% (Tertiary), and 60% (Central) by March 2020	1. Delivery by caesarean section rate	DHIS	Quarterly/ %	38.2%	39.8%	39.7%	38.8%	39%	38.8%	38.5%
	Delivery by caesarean section	*Theatre Delivery Register*	*No*	*31 259*	*30 393*	*29 660*	*30 048*	*29 113*	*28 713*	*28 391*
	Delivery in facility total	*Delivery Register*	*No*	*81 790*	*76 306*	*74 755*	*77 536*	*74 650*	*74 003*	*73 745*
Strategic Objective 1.7: Improve hospital efficiencies										
1.7.5) Reduce the unreferred outpatient department (OPD) headcounts with at least 7% per annum	2. OPD headcount - total	*DHIS/OPD tick register*	Quarterly/ No	3 336 687	3 158 541	3 086 956	2 849 286	2 792 300	2 736 454	2 681 725
	3. OPD headcount new case not referred	*DHIS/OPD tick register*	Quarterly/ No	552 314	397 096	303 904	245 168	208 393	177 134	150 564

5.5 2015/16 Targets

Table 72: (PHS2 a) Quarterly and Annual Targets

Performance Indicators	Targets 2015/16	Target			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. National core standards self-assessment rate	100%	25%	50%	75%	100%
2. Quality improvement plan after self-assessment rate	100%	25%	50%	75%	100%
3. Percentage of hospitals compliant with all extreme and vital measures of the national core standards	23%	10%	10%	23%	23%
4. Patient experience of care survey rate	100%	25%	50%	75%	100%
5. Average length of stay – total	6.1 Days	6.1 Days	6.1 Days	6.1 Days	6.1 Days
6. Inpatient bed utilisation rate – total	76.1%	76.7%	76.5%	76.3%	76.1%
7. Expenditure per patient day equivalent (PDE)	R 2 225	R 2 300	R 2 280	R 2 260	R 2 225
8. Complaint resolution rate	80%	80%	80%	80%	80%
9. Complaint resolution within 25 working days rate	95%	94%	94%	94.5%	95%
10. Delivery by caesarean section rate	39%	39.5%	39.3%	39.1%	39%
11. OPD headcount - total	2 792 300	698 075	1 396 150	2 094 225	2 792 300
12. OPD headcount new case not referred	208 393	52 098	104 196	156 294	208 393
Annual Targets					
13. Patient experience of care rate	85.4%				85.4%

SPECIALISED TB HOSPITALS

5.6 Overview [68]

There are 10 Specialised TB Hospitals in the Province providing acute and sub-acute TB services. Two state-aided TB Hospitals, Mountain View and Siloah Lutheran, render TB services in Zululand with a subsidy of R 28.8 million paid by the Department.

King Dinuzulu Hospital in eThekwini is the Centre of Excellence for XDR-TB in KwaZulu-Natal and initiates patients from Ilembe, Uthukela and Amajuba Districts on treatment for DR-TB. The TB Wing in the hospital has 192 commissioned TB beds (March 2014) with inpatient days for TB 34.8% of the total inpatient days.

All data for King Dinuzulu Hospital is reported under Specialised TB Hospitals on DHIS (including data for district hospital services (400 beds). Exclusion of King Dinuzulu (district hospital services) and State-Aided data from the provincial oversight below (Table 73) reflects a more realistic picture of TB Hospitals efficiencies at a provincial level.

Table 73: TB Hospital Efficiencies 2013/14 excluding King Dinuzulu Hospital

Hospital	Average length of stay - Total	Inpatient bed utilisation rate - Total	Inpatient crude death rate	Inpatient days - Total	Inpatient deaths - Total	Inpatient beds - Total
Charles James	69 days	29.2%	6.8%	18 134	18	170
Dunstan Farrell	61.3 days	43.6%	7%	28 191	32	180
Doris Goodwin	60.4 days	50.6%	13.1%	18 478	40	100
Don McKenzie	64.5 days	59.6%	34.6%	40 451	217	196
FOSA	96.2 days	76.5%	3.7%	47 451	18	170
Greytown M3	47.2 days	72.1%	18%	9 732	37	37
Richmond Chest	58.6 days	32.3%	17.1%	21 226	62	180
St Margaret's	27.5 days	90.6%	5.5%	15 107	30	54
Thulasizwe	35.0 days	31.3%	14.5%	12 106	50	106
KwaZulu-Natal	**58.4 days**	**49.3%**	**13.9%**	**210 876**	**504**	**1 193**

Note: The total figures for KwaZulu-Natal will not align with Table PHS 3a as King Dinuzulu Hospital data has been excluded in the Provincial total above.

The low bed turnover at FOSA, mainly as a result of the long ALOS is contributing to the above average bed utilisation rate. Both Greytown and St Margaret's reported above average utilisation rates although both have a limited number of beds available.

Review of the ex-SANTA (South African National Tuberculosis Association) Hospitals, namely Charles James, Doris Goodwin, Don McKenzie, Dunstan Farrell and FOSA, will be part of the Hospital Rationalisation Plan over the next 5 years to address inefficient use of resources.

Richmond, an ex-SANTA hospital has been purchased by the KZN Department of Health and St Margaret's' was inherited from the Eastern Cape with the change in borders with East Griqualand.

[68] King Dinuzulu Hospital is classified as Regional Hospital, renders predominantly District Hospital services and reports as a Specialized TB Hospital on the DHIS

Thulasizwe is currently under renovation with park homes erected as temporary accommodation to allow for the continuation of services at the hospital thus accounting for the low utilisation rate for 2013/14.

Don McKenzie has reported a high number of deaths (217) in 2013/14 which accounts for 43% of all deaths occurring in specialised TB Hospitals excluding King Dinuzulu Hospital.

Table 74: MDR-TB Decentralized and Satellite Sites

District	Decentralised MDR-TB Management Units	No. of MDR-TB beds – Decentralised Units	MDR-TB Satellite Sites	Proposed New Units to ensure equitable access and distribution of resources
Ugu	Murchison	40	Dustan Farrell	-
eThekwini	King Dinuzulu	377	FOSA, Don McKenzie, Charles James	-
Zululand	Thulasizwe	65	Itshelejuba, Nkonjeni, Benedictine	-
Harry Gwala	St Margaret's	30	Rietvlei	-
Umkhanyakude	Manguzi Hlabisa	40 35	Bethesda, Mseleni and Mosvold	-
Uthungulu	Catherine Booth	40	Ngwelezana, Eshowe and Mbongolwane	-
Ilembe	None	0	None	Montebello decentralised MDR-TB unit for Ilembe (12 beds without provision for OPD services). Park home donated by URC used in interim.
Umgungundlovu	Doris Goodwin	64	Edendale	-
Umzinyathi	Greytown	37	COSH and Charles Johnson Memorial	-
Uthukela	None	0	None	Estcourt decentralised MDR-TB unit for Uthukela (12 beds with no provision for OPD services). Park home donated by URC used in interim.
Amajuba	None	0	None	Madadeni decentralised MDR-TB unit (32 dedicated MDR-TB beds unofficially allocated). Building in need of renovation/ repair. MDR-TB initiation of treatment will start once renovations are complete.

Source: KZN TB Control Programme

5.7 Strategic Objectives, Indicators and Targets

Table 75: (PHS3 a) Provincial Strategic Objectives and Targets

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 5.1: Improve compliance to the Ideal Clinic and National Core Standards										
5.1.3) 100% Public health hospitals conduct annual national core standards self-assessments by March 2016	1. National core standards self-assessment rate	QA database	Quarterly/ %	New indicator	New indicator	30%	20%	100% [69]	100%	100%
	Number of Specialised TB Hospitals that conducted national core standards self-assessment to date in the current financial year	*QA database/ Self-assessment reports*	*No*	-	-	*3*	*2*	*10*	*10*	*10*
	Specialised TB Hospitals total	*DHIS calculates*	*No*	-	-	*10*	*10*	*10*	*10*	*10*
5.1.4) 100% Public health hospitals develop and implement Quality Improvement Plans based on national core standards assessment outcomes by March 2016	2. Quality improvement plan after self-assessment rate	DHIS – NCS Module	Quarterly/ %	New indicator	New indicator	0%	100%	100%	100%	100%
	Number of Specialised TB Hospitals that developed a quality improvement plan to date in the current financial year	*Quality Improvement Plans*	*No*	-	-	*0*	*2*	*10*	*10*	*10*
	Number of Specialised TB Hospitals that conducted national core standards self-assessments to date in the current financial year	*Assessment Records*	*No*	-	-	*3*	*2*	*10*	*10*	*10*

[69] Indicators 1 and 2: The significant increase in targets for the indicators is based on the requirement that ALL hospitals must implement the National Core Standards and conduct annual self-assessments to inform Quality Improvement Programmes

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
5.1.2) 60% (or more) public health hospitals compliant with extreme and vital measures of the national core standards by March 2020	3. Percentage of hospitals compliant with all extreme and vital measures of the national core standards	*DHIS – NCS Module*	Quarterly/ %	New indicator	New indicator	0%	0%	20%	30%	40%
	Total number of Specialised TB Hospitals that are compliant to all extreme measures and at least 90% of vital measures of national core standards	*Assessment Records*	*No*	-	-	*0*	*0*	*2*	*3*	*4*
	Number of Specialised TB Hospitals that conducted national core standards self-assessment to date in the current financial year	*Assessment Records*	*No*	-	-	*0*	*2*	*10*	*10*	*10*
5.1.5) Sustain a 100% patient experience of care survey rate in all public health facilities from March 2016	4. Patient experience of care survey rate	DHIS – NCS Module	Quarterly/ %	New indicator	New indicator	New indicator	60%	100%	100%	100%
	Total number of Specialised TB Hospitals that conducted a patient experience of care (PEC) survey to date in the current financial year	*PEC surveys*	*No*	-	-	-	6	*10*	*10*	*10*
	Total number of Specialised TB Hospitals	*DHIS*	*No*	-	-	-	*10*	*10*	*10*	*10*
5.1.1) Sustain a patient experience of care rate	5. Patient experience of care rate	DHIS - NCS Module	Annual/ %	New indicator	New indicator	Data not available [70]	75.3%	76%	80%	85%

[70] Data could not be sourced from the Quality Assurance Programme

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
of 95% (or more) at all public health facilities by March 2020	*Sum of patient experience of care survey scores (in %) of all Specialised TB Hospitals that conducted a patient experience of care survey to date in the current financial year*	*PEC survey*	*No*	-	-	-	*403*	*421*	*454*	*490*
	Total number of Specialised TB Hospitals that conducted a patient experience of care survey to date in the current financial year	*PEC survey*	*No*	-	-	-	*535*	*555*	*567*	*576*
Strategic Objective 1.7: Improve hospital efficiencies										
1.7.3) Improve hospital efficiencies by reducing the average length of stay to less than 5 days (District & Regional), 15 days (TB), 280 days (Psych), 35 days (Chronic), 7.6 days (Tertiary), and 6.5 days (Central) by March 2020	6. Average length of stay – total	DHIS	Quarterly/ Days	39.9 Days	26.1 Days	17.5 Days	16.4 Days	15.7 Days	15 Days	14.3 Days
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*424 248*	*400 051*	*381 451*	*379 628*	*380 767*	*381 909*	*383 055*
	Day Patients	*DHIS/ Midnight Census*	*No*	*2 691*	*1 212*	*588*	*526*	*531*	*537*	*542*
	Inpatient separations total	*DHIS calculates*	*No*	*10 662*	*15 354*	*21 693*	*23 084*	*24 238*	*25 450*	*26 723*
1.7.1) Maintain a bed utilisation rate of 75% (or more)	7. Inpatient bed utilisation rate – total	DHIS	Quarterly/ %	62.2%	55.6%	56.5%	52.3%	52.5%	52.6%	52.8%
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*424 248*	*400 051*	*366 100*	*379 628*	*380 767*	*381 909*	*383 055*
	Day Patients	*DHIS/ Midnight Census*	*No*	*2 691*	*1 212*	*548*	*526*	*531*	*537*	*542*
	Inpatient bed days available	*DHIS*	*No*	*610 280*	*720 285*	*648 696*	*725 620*[71]	*725 620*	*725 620*	*725 620*

[71] If the 400 District Beds at King Dinuzulu are removed out of the Inpatient Bed days available bring the total down to 579 620 inpatient bed days, the BUR will increase to 65.4%

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
1.7.4) Maintain expenditure per PDE within the provincial norms	8. Expenditure per patient day equivalent (PDE) [72]	BAS/DHIS	Quarterly/ R	R 1 813*	R 1 217	R 1 314	R 1 332	R 1 542	R 1 595	R 1 673
	Total expenditure TB Hospitals	*BAS*	*R'000*	*891 705*	*591 900*	*599 097*	*644 250*	*746 111*	*772 749*	*811 386*
	Patient day equivalents	*DHIS calculates*	*No*	*491 803*	*486 284*	*455 721*	*483 388*	*483 871*	*484 355*	*484 840*
Strategic Objective 5.1: Improve compliance to the Ideal Clinic and National Core Standards										
5.1.6) Sustain a complaint resolution rate of 90% (or more) in all public health facilities from March 2018 onwards	9. Complaint resolution rate	DHIS	Quarterly/ %	35.2%	39.1%	41.6%	38.2%	50%	70%	90%
	Complaint resolved	*Complaints Register*	*No*	*113*	*61*	99	*110*	*137*	*182*	*222*
	Complaint received	*Complaints Register*	*No*	*321*	*41*	238	*288*	*274*	*260*	*247*
5.1.7) Sustain a 85% (or more) complaint resolution within 25 working days rate in all public health facilities by March 2018 and onwards	10. Complaint resolution within 25 working days rate	DHIS	Quarterly/ %	New indicator	New indicator	55.6%	65.1%	70%	75%	80%
	Complaint resolved within 25 working days	*Complaints Register*	*No*	-	-	*55*	*72*	96	*117*	*138*
	Complaint resolved	*Complaints Register*	*No*	-	-	99	*110*	*137*	*156*	*173*
Strategic Objective 1.7: Improve hospital efficiencies										
1.7.5) Reduce the unreferred OPD headcounts with at least 7% per annum	11. OPD headcount – total	DHIS/OPD tick register	Quarterly/ No	206 452	236 657	246 728	292 786	300 106	307 608	315 298
	12. OPD headcount new case not referred	DHIS/OPD tick register	Quarterly/ No	2 839	20 449	38 024	48 204	35 363	32 888	30 586

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

5.8 2015/16 Targets

Table 76: (PHS4 a) Quarterly and Annual Targets

Performance Indicators	Targets 2015/16	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. National core standards self-assessment rate	100%	25%	50%	75%	100%
2. Quality improvement plan after self-assessment rate	100%	25%	50%	75%	100%
3. Percentage of hospitals compliant with all extreme and vital measures of the national core standards	20%	0%	0%	0%	20%
4. Patient experience of care survey rate	100%	25%	50%	75%	100%
5. Average length of stay – total	15.7 Days	16.6 Days	16.3 Days	16.0 Days	15.7 Days
6. Inpatient bed utilisation rate - total	52.5%	52.3%	52.4%	52.5%	52.5%
7. Expenditure per patient day equivalent(PDE)	R 1 542	R 1 400	R 1 450	R 1 500	R 1 542
8. Complaint resolution rate	50%	40%	43%	46%	50%
9. Complaint resolution within 25 working days rate	70%	60%	64%	67%	70%
10. OPD headcount - total	300 106	75 026	75 026	75 026	75 028
11. OPD headcount new case not referred	35 363	8 840	8 840	8 840	8 843
Annual Targets					
13. Patient experience of care rate	76%				76%

SPECIALISED PSYCHIATRIC HOSPITALS

5.9 Overview

There are 6 Specialised Psychiatric Hospitals in the Province providing acute and sub-acute psychiatric services. Low efficiencies of the Specialised Psychiatric Hospitals are a concern which will be addressed as part of the Hospital Rationalisation Plan over the next 5 years.

The different package of services rendered by the Specialised Psychiatric Hospitals creates substantial variations within the provincial range. This is especially relevant to Ekuhlengeni and Umgeni that provide chronic long term (or life time) care for in-hospital patients versus Townhill which provides acute short term care (Table 77).

Table 77: Psychiatric Hospital efficiencies

Hospital	Inpatient beds - Total	Inpatient days - Total	Inpatient deaths - Total	Average length of stay - Total	Inpatient bed utilisation rate - Total	Inpatient crude death rate
Ekuhlengeni	965	259 119	28	5 633.0	73.9	60.9
Fort Napier	370	80 731	2	312.9	60.2	0.8
St Francis	52*	8 981	79	12.6	47.2	11.1
Townhill	304	62 633	1	89.7	57.7	0.1
Umgeni	459	128 443	14	2 071.7	76.7	22.6
Umzimkhulu	320	87 993	2	234.0	75.3	0.5

* Note: The number of beds quoted is an annual average as it ranges from 19 to 105 useable beds in DHIS

St Francis Hospital, classified as a Psychiatric Hospital still provides a broad range of District Hospital services. The crude death rate at this hospital is higher than expected at 11.1% due to a high number of deaths in September 2013 and January 2014. The crude death rate of Umgeni and Ekuhlengeni Hospital is expected to be high due to their package of service.

Fort Napier Hospital is the only Provincial Forensic Psychiatric Hospital in KwaZulu-Natal hence the long ALOS due to the large number of awaiting trial prisoners that require psychiatric assessment.

Ekuhlengeni and Umgeni Hospitals need be to be reviewed for rationalisation and this would include identifying patients who do not require/require minimum medical care but admitted for social reasons and can be cared for by the Department of Social Development.

5.10 Strategic Objectives, Indicators and Targets

Table 78: (PHS3 b) Provincial Strategic Objectives and Targets

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 5.1: Improve compliance to the Ideal Clinic and National Core Standards										
5.1.3) 100% Public health hospitals conduct annual national core standard self-assessments by March 2016	1. National core standards self-assessment rate	DHIS – NCS Module	Quarterly/ %	New indicator	New indicator	33%	0%	100% [73]	100%	100%
	Number of Specialised Psych Hospitals that conducted national core standard self-assessment to date in the current financial year	*QA database/ Self-assessment reports*	*No*	-	-	2	*0*	6	6	6
	Specialised Psych Hospitals total	*DHIS calculates*	*No*	-	-	6	6	6	6	6
5.1.4) 100% Public health hospitals develop and implement Quality Improvement Plans based on national core standard assessment outcomes by March 2016	2. Quality improvement plan after self-assessment rate	DHIS – NCS Module	Quarterly/ %	New indicator	New indicator	100%	0%	100%	100%	100%
	Number of Specialised Psych Hospitals that developed a quality improvement plan to date in the current financial year	*Quality Improvement Plans*	*No*	-	-	2	*0*	6	6	6
	Number of Specialised Psych Hospitals that conducted national core standard self-assessment to date in the current financial year	*Assessment Records*	*No*	-	-	2	*0*	6	6	6

[73] Indicators 1 and 2: ALL hospitals must implement the National Core Standards and conduct annual self-assessments to inform Quality Improvement Plans hence the significant increase in target

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
5.1.2) 60% (or more) public health hospitals compliant with extreme and vital measures of the national core standard by March 2020	3. Percentage of hospitals compliant with all extreme and vital measures of the national core standards	DHIS – NCS Module	Quarterly/ %	New indicator	New indicator	0%	0%	17%	33%	50%
	Total number of Specialised Psych Hospitals that are compliant to all extreme measures and at least 90% of vital measures of national core standards	*Assessment records*	*No*			*0*	*0*	*1*	2	3
	Number of Specialised Psych Hospitals that conducted national core standard self-assessment to date in the current financial year	*Assessment Records*	*No*			2	*0*	6	6	6
5.1.5) Sustain a 100% patient experience of care survey rate in all public health facilities from March 2016	4. Patient experience of care survey rate	DHIS – NCS Module	Quarterly/ %	New indicator	New indicator	Data not available [74]	100%	100%	100%	100%
	Total number of Specialised Psychiatric Hospitals that conducted a patient experience of care (PEC) survey to date in the current financial year	*PEC survey*	*No*			-	6	6	6	6
	Total number of Specialised Psychiatric Hospitals	*DHIS*	*No*			-	6	6	6	6
5.1.1) Sustain a patient experience of care rate	5. Patient experience of care rate	DHIS – NCS Module	Annual/ %	new indicator	New indicator	Data not available	75%	78%	80%	85%

[74] Indicators 4 and 5: Data for 2013/14 could not be sourced from the Quality Assurance Programme

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
of 95% (or more) at all public health facilities by March 2020	*Sum of patient experience of care survey scores (in %) of all Specialised Psychiatric Hospitals that conducted a patient experience of care survey to date in the current financial year*	*PEC Survey results*	*No*	-	-	-	*135*	*152*	*167*	*187*
	Total number of Specialised Psychiatric Hospitals that conducted a patient experience of care survey to date in the current financial year	*PEC Survey results*	*No*	-	-	-	*180*	*195*	*209*	*220*
Strategic Objective 1.7: Improve hospital efficiencies										
1.7.3) Improve hospital efficiencies by reducing the average length of stay to less than 5 days (District & Regional), 15 days (TB), 280 days (Psych), 35 days (Chronic), 7.6 days (Tertiary), and 6.5 days (Central) by March 2020	6. Average length of stay – total	DHIS	Quarterly/ Days	254 Days	264 Days	291.8 Days	287 Days	274 Days	261.8 Days	287 Days
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*645 803*	*641 542*	*627 900*	*639 397*	*640 995*	*642 597*	*639 397*
	Day Patients	*DHIS/ Midnight Census*	*No*	*6*	*2*	*0*	*0*	*0*	*0*	*0*
	Inpatient separations total	*DHIS calculates*	*No*	*2 533*	*2 430*	*2 152*	*2 226*	*2 337*	*2 454*	*2 226*
1.7.1) Maintain a bed utilisation rate of 75% (or more)	7. Inpatient bed utilisation rate – total	DHIS	Quarterly/ %	72%[75]	68.7%	70.1%	71.3%	71.5%	71.7%	71.3%
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*645 803*	*641 542*	*627 900*	*639 397*	*640 995*	*642 597*	*639 397*
	Day Patients	*DHIS/ Midnight Census*	*No*	*6 (17 881)*	*2*	*0*	*0*	*0*	*0*	*0*
	Inpatient bed days available	*DHIS*	*No*	*900 455*	*934 107*	*895 649*	*895 649*	*895 649*	*895 649*	*895 649*

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

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
1.7.4) Maintain expenditure per PDE within the provincial norms	8. Expenditure per patient day equivalent (PDE)	BAS/DHIS	Quarterly/ R	R 911*	R 991*	R 1 073	R 1 165	R 1 237	R 1 295	R 1 358
	Total expenditure Psychiatric Hospitals	*BAS*	*R'000*	*570 999*	*641 667*	*679 875*	*750 298*	*797 229*	*835 469*	*877 242*
	Patient day equivalents	*DHIS calculates*	*No*	*626 312*	*647 115*	*633 336*	*643 840*	*644 484*	*645 128*	*645 773*
Strategic Objective 5.1: Improve compliance to the Ideal Clinic and National Core Standards										
5.1.6) Sustain a complaint resolution rate of 90% (or more) in all public health facilities from March 2018 onwards	9. Complaint resolution rate	DHIS	Quarterly/ %	87.5%	86%	86.2%	94.3%	95%	96%	96%
	Complaint resolved	*Complaints Register*	*No*	*98*	*77*	*81*	*66*	*58*	*53*	*47*
	Complaint received	*Complaints Register*	*No*	*112*	*90*	*94*	*70*	*61*	*55*	*49*
5.1.7) Sustain a 85% (or more) complaint resolution within 25 working days rate in all public health facilities by March 2018 and onwards	10. Complaint resolution within 25 working days rate	DHIS	Quarterly/ %	New indicator	New indicator	96.3%	72.7%	81%	87%	89%
	Complaint resolved within 25 days	*Complaints register*	*No*	*-*	*-*	*78*	*48*	*47*	*46*	*42*
	Complaint resolved	*Complaints register*	*No*	*-*	*-*	*81*	*66*	*58*	*53*	*47*
Strategic Objective 1.7: Improve hospital efficiencies										
1.7.5) Reduce the unreferred OPD headcounts with at least 7% per annum	11. OPD headcount – total	DHIS/OPD tick register	Quarterly/ No	15 425	17 647	16 215	16 714	17 671	17 406	17 145
	12. OPD headcount new case not referred	DHIS/OPD tick register	Quarterly/ No	986	1 003	715	1 360	665	619	576

5.11 2015/16 Targets

Table 79: (PHS4 b) Quarterly and Annual Targets

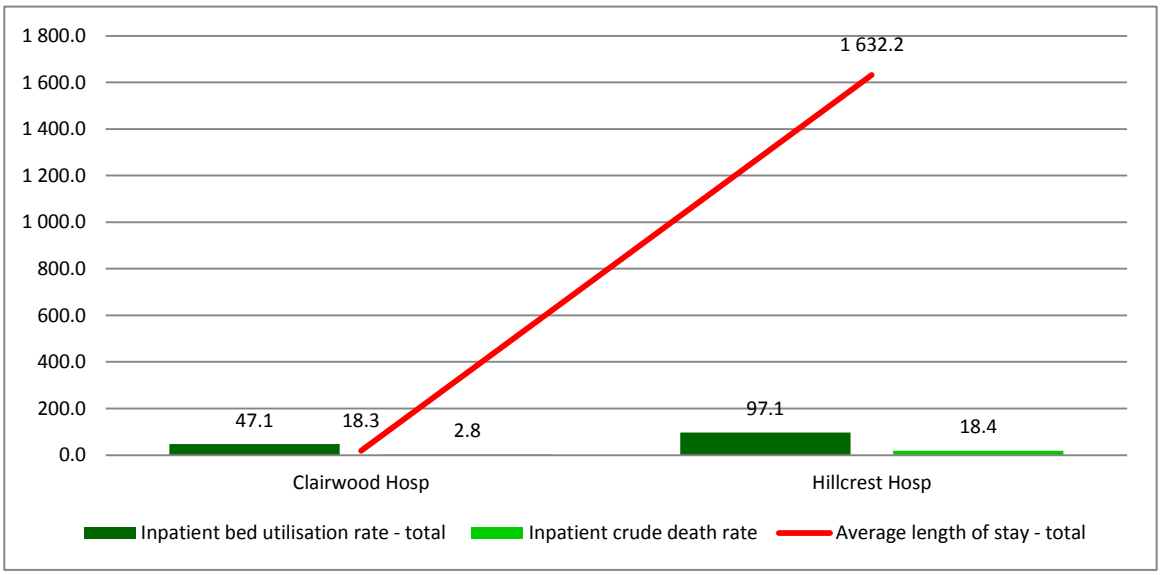
Performance Indicators	Targets 2015/16	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. National core standards self-assessment rate	100%	25%	50%	75%	100%
2. Quality improvement plan after self-assessment rate	100%	25%	50%	75%	100%
3. Percentage of hospitals compliant with all extreme and vital measures of the national core standards	17%	-	-	-	17%
4. Patient experience of care survey rate	100%	25%	50%	75%	100%
5. Average length of stay – total	274 Days	287 Days	285 Days	280 Days	274 Days
6. Inpatient bed utilisation rate -total	71.3%	71.2%	71.2%	71.3%	71.3%
7. Expenditure per patient day equivalent (PDE)	R 1 237	R 1 158	R 1 200	R 1 215	R 1 237
8. Complaint resolution rate	95%	95%	95%	95%	95%
9. Complaint resolution within 25 working days rate	81%	72.8%	74%	77%	81%
10. OPD headcount - total	17 671	4 418	8 835	13 254	17 671
11. OPD headcount new case not referred	665	166	166	166	167
Annual Targets					
12. Patient experience of care rate	78%				78%

CHRONIC/SUB-ACUTE HOSPITALS

5.12 Overview

There are 2 classified Chronic Hospitals in KwaZulu-Natal namely Hillcrest and Clairwood. Hillcrest is a chronic long term care facility and Clairwood renders rehabilitative services. This is currently being reviewed as part of the 5 year Strategic Planning process and the package of service could be redefined in accordance with the identified strategic priorities of the Department and the quadruple burden of disease.

Graph 15: Efficiency indicators



5.13 Strategic Objectives, Indicators and Targets

Table 80: (PHS3 d) Provincial Strategic Objectives and Targets

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 5.1: Improve compliance to the Ideal Clinic and National Core Standards										
5.1.3) 100% Public health hospitals conduct annual national core standard self-assessments by March 2016	1. National core standards self-assessment rate	DHIS – NCS Module	Quarterly/ %	New indicator	New indicator	50%	50%	100%	100%	100%
	Number of Chronic/Sub-Acute Hospitals that conducted national core standard self-assessment to date in the current financial year	*Self-assessment reports*	*No*	-	-	*1*	*1*	2	2	2
	Chronic/ Sub-Acute Hospitals total	*DHIS calculates*	*No*	-	-	2	2	2	2	2
5.1.4) 100% Public health hospitals develop and implement Quality Improvement Plans based on national core standard assessment outcomes by March 2016	2. Quality improvement plan after self-assessment rate	DHIS – NCS Module	Quarterly/ %	New indicator	New indicator	0%	100%	100%	100%	100%
	Number of Chronic/Sub-Acute Hospitals that developed a quality improvement plan to date in the current financial year	*Quality Improvement Plans*	*No*			*0*	*1*	2	2	2
	Number of Chronic/Sub-Acute Hospitals that conducted national core standard self-assessment to date in the current financial year	*Assessment Records*	*No*			*1*	*1*	2	2	2

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
5.1.2) 60% (or more) public health hospitals compliant with extreme and vital measures of the national core standards by March 2020	3. Percentage of hospitals compliant with all extreme and vital measures of the national core standards	DHIS – NCS Module	Quarterly/ %	New indicator	New indicator	0%	0%	0%	50%	100%
	Total number of Chronic/Sub-Acute Hospitals that are compliant to all extreme measures and at least 90% of vital measures of national core standards	*Assessment records*	*No*	-	-	*0*	*0*	*0*	*1*	2
	Number of Chronic/Sub-acute Hospitals that conducted national core standard self-assessment to date in the current financial year	*Assessment Records*	*No*	-	-	*1*	*1*	2	2	2
5.1.5) Sustain a 100% patient experience of care survey rate in all public health facilities from March 2016	4. Patient experience of care survey rate	PEC Survey Results	Quarterly/ %	New indicator	New indicator	Data not available [76]	50%	100%	100%	100%
	Total number of Chronic/ Long-Term Hospitals that conducted a patient experience of care (PEC) survey to date in the current financial year	*PEC Survey*	*No*	-	-	-	*1*	2	2	2
	Total number of Chronic/ Long Term Hospitals	*DHIS*	*No*	-	-	-	*2*	2	2	2
5.1.1) Sustain a patient experience of care rate	5. Patient experience of care rate	PEC Survey Results	Annual/ %	New indicator	New indicator	Data not available	Data not available [77]	60% [78]	70%	80%

[76] Indicators 4 and 5: 2013/14 data could not be sourced from the Quality Assurance Programme
[77] Data could not be sourced from the Quality Assurance Programme before finalisation of the APP
[78] It is not possible to quantify performance for the MTEF due to lack of trend data. The standard is however to maintain the percentage client satisfaction – targets will be quantified once trend data is available (no cost involved). The definition and calculation of the indicator must also be confirmed with NDOH to ensure correct interpretation – will be done in 2015/16

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
of 95% (or more) at all public health facilities by March 2020	*Sum of patient experience of care survey scores (in %) of all Chronic/ Long-Term Hospitals that conducted a patient experience of care survey to date in the current financial year*	*PEC Survey results*	*No*	-	-	-	-	-	-	-
	Total number of Chronic/ Long-Term Hospitals that conducted a patient experience of care survey to date in the current financial year	*PEC Survey results*	*No*	-	-	-	-	-	-	-
Strategic Objective 1.7: Improve hospital efficiencies										
1.7.3) Improve hospital efficiencies by reducing the average length of stay to less than 5 days (District & Regional), 15 days (TB), 280 days (Psych), 35 days (Chronic), 7.6 days (Tertiary), and 6.5 days (Central) by March 2020	6. Average length of stay – total	DHIS	Quarterly/ Days	33.5 Days	39.1 Days	37.2 Days	37.7 Days	36.9 Days	36.5 Days	36.0 Days
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*130 183*	*129 037*	*120 549*	*117 026*	*116 441*	*115 859*	*115 279*
	Day Patients	*DHIS/ Midnight Census*	*No*	*2 982*	*354*	*0*	*0*	*0*	*0*	*0*
	Inpatient separations total	*DHIS calculates*	*No*	*3 884*	*3 302*	*3 239*	*3 104*	*3 153*	*3 166*	*3 198*
1.7.1) Maintain a bed utilisation rate of 75% (or more)	7. Inpatient bed utilisation rate – total	DHIS	Quarterly/ Rate	61.2%	67.4%	64%	62.1%	61.8%	61.5%	61.2%
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*131 436*	*129 037*	*120 549*	*117 026*	*116 441*	*115 859*	*115 279*
	Day Patients	*DHIS/ Midnight Census*	*No*	*0*	*354*	*0*	*0*	*0*	*0*	*0*
	Inpatient bed days available	*DHIS*	*No*	*151 840*	*191 707*	*188 340*	*188 340*	*188 340*	*188 340*	*188 340*
1.7.4) Maintain expenditure per PDE within the provincial	8. Expenditure per patient day equivalent (PDE)	BAS/DHIS	Quarterly/ R	R 1 097*	R 1 217*	R 1 436	R 1 703	R 1 928	R 2 075	R 2 258

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
norms	*Total expenditure – Chronic Hospitals*	*BAS*	*R'000*	*199 149*	*203 283*	*224 618*	*303 550*	*331 496*	*344 359*	*361 577*
	Patient day equivalent	*DHIS calculates*	*No*	*181 411*	*167 007*	*156 378*	*178 190*	*171 953*	*165 935*	*160 127*
Strategic Objective 5.1: Improve compliance to the Ideal Clinic and National Core Standards										
5.1.6) Sustain a complaint resolution rate of 90% (or more) in all public health facilities from March 2018 onwards	9. Complaint resolution rate	DHIS	Quarterly/ %	103%	100%	87.4%	87%	88%	89%	90%
	Complaint resolved	*Complaints Register*	*No*	*79*	*85*	*97*	*120*	*110*	*101*	*91*
	Complaint received	*Complaints Register*	*No*	*76*	*85*	*111*	*138*	*125*	*114*	*101*
5.1.7) Sustain a 85% (or more) complaint resolution within 25 working days rate in all public health facilities by March 2018 and onwards	*10.* Complaint resolution within 25 working days rate	DHIS	Quarterly/ %	Not reported	Not reported	100%	98.3%	99%	100%	100%
	Complaint resolved within 25 days	*Complaints Register*	*No*	-	-	*97*	*118*	*109*	*101*	*91*
	Complaint resolved	*Complaints Register*	*No*	-	-	*97*	*120*	*110*	*101*	*91*
Strategic Objective 1.7: Improve hospital efficiencies										
1.7.5) Reduce the unreferred OPD headcounts with at least 7% per annum	11. OPD headcount – total	DHIS/OPD tick register	Quarterly/ No	158 684	115 055	107 487	182 960	183 143	183 326	183 509
	12. OPD headcount new cases not referred	DHIS/OPD tick register	Quarterly/ No	157 386	109 232	101 461	74 356	94 359	87 754	81 612

5.14 2015/16 Targets

Table 81: (PHS4 d) Quarterly and Annual Targets

Performance Indicators	Targets 2015/16	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. National core standards self-assessment rate	100%	25%	50%	75%	100%
2. Quality improvement plan after self-assessment rate	100%	25%	50%	75%	100%
3. Percentage of hospitals compliant with all extreme and vital measures of the national core standards	0%	-	-	-	0%
4. Patient experience of care survey rate	100%	25%	50%	75%	100%
5. Average length of stay – total	36.9 Days	37.5 Days	37.3 Days	37 Days	36.9 Days
6. Inpatient bed utilisation rate - total	61.8%	62%	61.9%	61.8%	61.8%
7. Expenditure per patient day equivalent (PDE)	R 1 928	R 1 755	R 1 810	R 1 865	R 1 928
8. Complaint resolution rate	88%	88%	88%	88%	88%
9. Complaint resolution within 25 working days rate	99%	99%	99%	99%	99%
10. OPD headcount - total	183 143	45 785	91 570	137 355	183 143
11. OPD headcount new case not referred	94 359	23 589	23 589	23 589	23 592
Annual Targets					
12. Patient experience of care rate	60%				60%

The Oral and Dental Training Centre is situated at King Dinuzulu Hospital, and is responsible for training of Oral Hygienists and Dental Therapists. It also offers Primary and Secondary Oral and Dental health services.

The Addington Children's Hospital is currently functioning as a children's clinic. The newly renovated outpatient building of the KZN Children's Hospital was officially opened by the Honourable MEC for Health, Dr SM Dhlomo in July 2013. The renovated building houses a Child Neuro-Development Assessment Centre, the Regional Paediatric and Adolescent Training Centre and the KZN Children's Hospital Trust offices. The next phase of development has commenced.

5.15 Reconciling Performance Targets with Expenditure Trends

Table 82: (PHS7) Summary of Payments and Estimates

Sub-Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
General [Regional] Hospitals	5 221 536	6 115 757	6 560 190	7 114 952	7 114 482	7 034 859	6 881 905	7 398 047	7 761 725
Tuberculosis Hospitals	891 682	591 880	631 342	669 183	667 219	674 971	746 111	772 749	811 386
Psychiatric Hospitals	570 974	641 596	686 549	743 815	743 815	751 398	797 229	835 469	877 242
Sub-acute, step-down and chronic medical hospitals	199 147	203 274	226 848	242 501	242 501	307 214	331 496	344 359	361 577
Dental training hospital	14 481	14 868	16 267	17 824	17 824	17 399	18 897	19 898	20 893
Other specialised hospitals									
Total	**6 897 820**	**7 567 375**	**8 121 196**	**8 788 275**	**8 785 841**	**8 785 841**	**8 775 638**	**9 370 522**	**9 832 823**

Table 83: (PHS7) Summary of payments and expenditure by Economic Classification

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Current payments	**6 772 925**	**7 486 935**	**7 969 342**	**8 634 529**	**8 634 529**	**8 613 784**	**8 644 111**	**9 180 340**	**9 633 133**
Compensation of employees	5 100 164	5 654 254	6 146 682	6 814 383	6 814 383	6 745 935	6 735 829	7 195 285	7 548 324
Goods and services	1 672 761	1 832 681	1 822 532	1 820 146	1 820 146	1 867 715	1 908 282	1 985 055	2 084 809
Communication	20 339	20 922	20 896	21 287	21 287	22 366	21 415	21 144	22 203
Computer Services	108	805	2 963	-	-	119	-	-	-
Consultants, Contractors and special services	367 203	336 608	299 687	215 261	215 261	251 395	328 044	334 057	350 760

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Inventory	916 984	1 039 596	1 101 831	1 166 457	1 166 457	1 175 534	1 149 541	1 194 981	1 255 229
Operating leases	10 612	10 734	9 361	11 904	11 904	9 790	10 815	11 289	11 853
Travel and subsistence	5 685	5 145	4 840	7 460	7 460	5 399	7 234	6 129	6 435
Interest and rent on land	-	-	128	-	-	134	-	-	-
Maintenance, repair and running costs	-	-	-	-	-	-	-	-	-
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	351 830	418 871	382 826	397 777	397 777	403 112	391 233	417 455	438 329
Transfers and subsidies to	68 019	68 886	124 336	67 085	64 651	120 228	63 607	66 995	70 346
Provinces and municipalities	-	-	-	549	79	80	-	-	-
Departmental agencies and accounts	47	56	15	36	36	64	77	82	86
Higher Education institutions	-	-	-	-	-	-	-	-	-
Foreign governments and international organisations	-	-	-	-	-	-	-	-	-
Non-profit institutions	35 802	37 770	28 829	30 500	28 536	30 865	33 100	34 854	36 597
Households	32 170	31 060	95 492	36 000	36 000	89 219	30 430	32 059	33 663
Payments for capital assets	56 861	11 554	27 518	86 661	86 661	51 824	67 920	123 187	129 344
Machinery and equipment	56 861	11 554	27 439	86 661	86 661	51 824	67 920	123 187	129 344
Buildings and other fixed structures	-	-	79	-	-	-	-	-	-
Land and sub-soil assets	-	-	-	-	-	-	-	-	-
Software and other tangible assets	-	-	-	-	-	-	-	-	-
Payment for financial assets	15	-	-	-	-	5	-	-	-
Total economic classification	6 897 820	7 567 375	8 121 196	8 788 275	8 785 841	8 785 841	8 775 638	9 370 522	9 832 823
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Total economic classification	6 897 820	7 567 375	8 121 196	8 788 275	8 785 841	8 785 841	8 775 638	9 370 522	9 832 823

5.16 Performance and Expenditure Trends

The sustained growth in Programme 4 relates to the various wage agreements, OSD for medical personnel, high inflation rates for medical supplies and services, and NHLS costs. Further contributing factors include the carry-through costs of MDR/XDR-TB facilities commissioned at Greytown, Murchison and Thulasizwe Hospitals. The increase in Regional Hospitals in 2013/14 relates to the commissioning of 80 beds at Lower Umfolozi War Memorial Hospital, increasing costs of medicines, and unbudgeted medico-legal claims against the Department.

Specialised TB Hospitals: *Goods and Services* shows a peak in 2015/16 attributed to the projected medicine payments that will be deferred to this financial year. After 2015/16 the increase includes inflationary adjustments only.

The increasing trend for Specialised Psychiatric Hospitals relates to the various wage agreements and OSDs, and the MTEF includes carry-through costs and inflationary increases only.

The significant increase for Chronic/Sub-Acute Hospitals in the 2014/15 Revised Estimate is attributed to the takeover of McCord Hospital. The 2015/16 MTEF allocation makes provision for the operational costs of McCord Hospital to function as a Specialised Eye-Care Hospital with more funding allocated in the outer years.

The Dental Training Hospital sub-programme shows steady growth with inflationary growth over the 2015/16 MTEF.

The increase against *Compensation of Employees* in the 2015/16 MTEF is making provision for the commissioning of McCord Hospital, the carry-through costs of the commissioning of additional beds at Lower Umfolozi War Memorial Hospital and to cover budget gaps in this programme.

The expenditure on *Goods and Services* was increased in 2011/12 as a result of payments to the NHLS based on an agreement to increase the monthly payment from R34 million to R43 million, backdated to January 2011, increased stock levels for medical supplies, as well as clearing of payment backlogs which arose due to some facilities not paying within 30 days. The minimal growth in 2013/14 was attributed to the reduction in the "buying out" of beds from the private hospitals, as well as the correct allocation of NHLS expenditure, mainly to Programme 2. The increase in the 2014/15 Revised Estimate is due to the take-over of McCord Hospital.

The substantial reduction in *Transfers and Subsidies to: Non-Profit Institutions* in 2013/14 was the result of the reassessment of all Non-Profit Institutions. The reduction in the 2014/15 Adjusted Appropriation is due to the decision to reallocate unallocated funding for Non-Profit Institutions to other service delivery pressures. This decision was not carried over to the 2015/16 MTEF hence the substantial increase in 2015/16 with provision for inflationary increases in the outer years.

Additional funding is provided under *Machinery and Equipment* over the 2015/16 MTEF for the replacement of redundant essential equipment under this programme, and increases are matched to identified cyclical replacement needs.

5.17 Risk Management – All Sub-Programmes

Table 84: Risk Management

Potential Risks	Mitigating Factors
1. Limited funding envelope versus service delivery demands and needs. *(High Risk)*	• Development and implementation of the Hospital Rationalisation Plan making provision for re-prioritisation to ensure optimal use of resources, system re-engineering, processes and clinical programmes (package of services, resources, etc.).
2. Poor management and leadership capacity at facility level, and difficulty in attracting appropriate candidates for various positions - medically qualified CEO's (partly attributed to OSD) which impact on efficiencies and achievement of performance targets. *(High Risk)*	• Leadership and management training programmes including mentoring, coaching and support. • Implementation of the Long Term HR Plan targeting essential posts (based on evidence). • Review of recruitment and retention strategies to attract the appropriate workforce.
3. Inadequate patient information system(s) and poor quality of information to inform decision-making. *(High Risk)*	• Implement ICD 10 coding (identified hospitals – phased approach) to improve disease specific information. • Implement patient-based information system (pending available funding).
4. Response to the burden of disease jeopardised as a result of limited funding as well as inadequate resources e.g. HR, equipment, etc. *(High Risk)*	• Re-prioritisation and phased implementation of priority speciality services through extensive consultation and analysis of information.
5. Ineffective clinical governance structures and processes – increased legal claims/cost. *(High Risk)*	• Establish governance structures/ processes as part of National Core Standards and in line with the Hospital Rationalisation Plan.

6. PROGRAMME 5: CENTRAL AND TERTIARY HOSPITALS

6.1 Programme Purpose

There are no changes to the structure of Programme 5.

Sub-Programme 5.1: Central Hospitals

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: Tertiary Hospitals

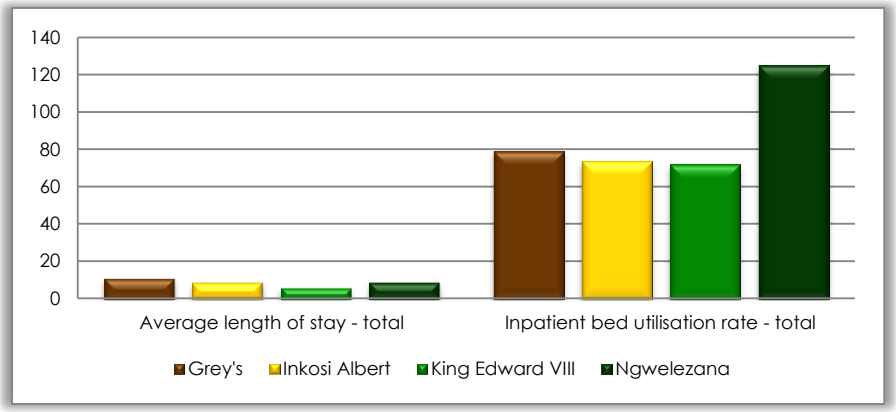
To provide tertiary health services and creates a platform for the training of Specialist health professionals.

6.2 Overview

There are two Tertiary Hospitals in the Province, with Greys Hospital rendering 80% Tertiary services and 20% Regional Services to the western area of KwaZulu-Natal including Uthukela, Umzinyathi, Amajuba, Harry Gwala and Umgungundlovu districts. Ngwelezane Hospital, classified as a Developing Tertiary, renders 25% District, 42% Regional and 33% Tertiary services to the northern part of KwaZulu-Natal with King Edwards supporting tertiary services for the eastern seaboard. There is no district hospital within the economic hub of Umhlatuze sub-district (Richards Bay / Empangeni area), therefore until such time as the service delivery platform within the sub-district can be amended to accommodate level 1 hospital services, this arrangement will continue.

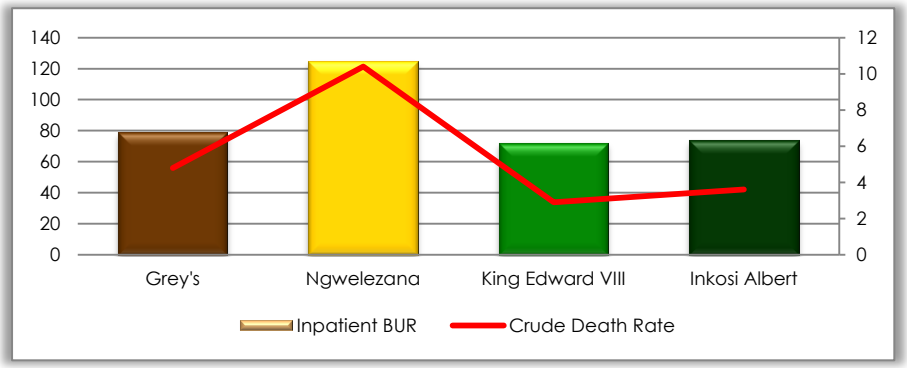
There are 2 classified Central Hospitals with Inkosi Albert Luthuli Central Hospital rendering 100% Tertiary services (T1, 2, and 3). King Edward VIII Hospital is rendering 70% Regional and 30% Tertiary services. DHIS reporting has not been aligned with classification as reporting for King Edward Hospital still falls under Regional Hospitals skewing data for both Regional Hospitals and Central Hospitals. This will be resolved in the year under reporting.

Graph 16: Central and Tertiary Hospital Efficiencies – 2013/14



Ngwelezana hospital forms part of the Hospital Revitalisation programme with major construction continuing, affecting the number of useable beds available to render services thus affecting the BUR rate to 124.6%. There is no district and regional hospital in Umhlatuze.

Graph 17: Inpatient day vs Inpatient Death Tertiary and Central Hospitals



Ngwelezana has a high number of deaths at 1 948 for 2013/14 compared with other Tertiary and Central Hospitals accounting for 44% (4 439) of all deaths at this level of care. There are several factors influencing the level of care provided by Ngwelezana including the referral pattern in Region 4, inability to attract and retain specialists, lack of updated equipment and the long distances between the referring institutions.

6.3 2015/16 Priorities

Rationalisation of hospital services.

- Hospital Rationalisation Plan including package of services and staffing norms informed by research and National Package of Tertiary Services. The Plan will detail strategies and interventions and will include an Implementation Plan over the next 5 years.
- Review Oncology, Nephrology, Orthopaedic and Neurosurgery services, and implement the Dialysis service plan (all pending approval of Business Plans and funding envelope).
- Electronic patient information management system (targeting Greys Hospital for 2015/16).
- Strengthen management capacity at facility level (Performance Management, partnerships with Academic Institutions of Higher

	Learning and management/ leadership training programmes). • Revise delegation of authorities and capacitate management to implement. • Clinical Governance and reporting.
Implementation and monitoring of the National Core Standards.	• National Core Standard including self-assessments and Quality Improvement Plans.

6.1 Strategic Objectives, Indicators and Targets

Table 85: Strategic Plan 2015-2019 Targets

Strategic Goal	Strategic Objective	Strategic Objective Statement	Indicator	Target March 2020
Strategic Goal 1: Strengthen health system effectiveness	1.7) Improve hospital efficiencies	1.7.1) Maintain a bed utilisation rate of 75% (or more).	Inpatient bed utilisation rate	75% (or more)
		1.7.2) Develop and implement the approved Hospital Rationalisation Plan by March 2016	Hospital Rationalisation Plan	Plan implemented
Strategic Goal 4: Strengthen human resources for health	4.1) Improve human resources for health	4.1.3) Implement the Community Based Training in a PHC Model in collaboration with the University of KwaZulu-Natal with Phase 1 pilot commencing in 2016/17 *(included in Programme 1)*	Community Based Training in a PHC Model	Model implemented
Strategic Goal 5: Improved quality of health care	5.1) Improve compliance to the Ideal Clinic and National Core Standards	5.1.2) 60% (or more) public health hospitals compliant with extreme and vital measures of the national core standards by March 2020.	Percentage of hospitals compliant with all extreme and vital measures of the national core standards	60% (or more)
		5.1.1) Sustain a patient experience of care rate of 95% (or more) in all public health facilities by March 2020.	Patient experience of care rate	95% (or more)

Note: Strategic Objectives, Objective Statements, Indicators and Targets from the Strategic Plan 2015-2019 are the same for Tertiary and Central Hospitals – Programme 5. The table is therefore not repeated in Programme 5.

The Hospital Rationalisation Plan that will be developed in 2015/16 will make provision for specific strategic and operational priorities that will be specific to the different hospitals and categories of hospitals. That will be unpacked in the Annual Performance Plan for 2016/17 onwards.

CENTRAL HOSPITAL (INKOSI ALBERT LUTHULI CENTRAL)

Table 86: (C&THS5) Programme Performance Indicators

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 5.1: Improve compliance to the Ideal Clinic and National Core Standards										
5.1.3) 100% Public health hospitals conduct annual national core standard self-assessments by March 2016	1. National core standards self-assessment rate	DHIS – NCS Module	Quarterly/ %	New indicator	100%	100%	0%	100%	100%	100%
	Number of Central Hospitals that conducted national core standard self-assessment to date in the current financial year	*Self-assessment records*	*No*	-	*1*	*1*	*0*	*1*	*1*	*1*
	Total number of Central Hospitals	*DHIS calculates*	*No*	-	*1*	*1*	*1*	*1*	*1*	*1*
5.1.4) 100% Public health hospitals develop and implement Quality Improvement Plans based on NCS assessment outcomes by March 2016	2. Quality improvement plan after self-assessment rate	DHIS – NCS Module	Quarterly/ %	New indicator	New indicator	New indicator	0%	100%	100%	100%
	Number of Central Hospitals that developed a quality improvement plan to date in the current financial year	*Quality Improvement Plans*	*No*	-	-	*1*	*0*	*1*	*1*	*1*
	Number of Central Hospitals that conducted national core standard self-assessment to date in the current financial year	*Self-assessment records*	*No*	-	-	*1*	*0*	*1*	*1*	*1*

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
5.1.2) 60% (or more) public health hospitals compliant with extreme and vital measures of the national core standards by March 2020	3. Percentage of hospitals compliant with all extreme and vital measures of the national core standards	DHIS – NCS Module	Quarterly/ %	New indicator	New indicator	New indicator	0%	100%	100%	100%
	Total number of Central Hospitals that are compliant to all extreme measures and at least 90% of vital measures of national core standards	*Assessment records*	*No*	-	-	-	*0*	*1*	*1*	*1*
	Number of Central Hospitals that conducted national core standard self-assessment to date in the current financial year	*Assessment records*	*No*	-	-	-	*0*	*1*	*1*	*1*
5.1.5) Sustain a 100% patient experience of care survey rate in all public health facilities from March 2016	4. Patient experience of care survey rate	DHIS – NCS Module	Quarterly/ %	100%	100%	100%	0%	100%	100%	100%
	Total number of Central Hospitals that conducted a patient experience of care (PEC) survey to date in the current financial year	*PEC Survey Evidence*		*1*	*1*	*1*	*0*	*1*	*1*	*1*
	Total number of Central Hospitals	*DHIS*		*1*	*1*	*1*	*1*	*1*	*1*	*1*
5.1.1) Sustain a patient experience of care rate	5. Patient experience of care rate	PEC results/ response	Annual/ %	96%	90%	95%	Not available [79]	94% [80]	100%	100%

[79] Data could not be sourced from the Quality Assurance Programme before finalisation of the APP

[80] The indicator definition sourced from the NDOH indicates that the QA Programme misinterpret the current calculation of the indicator. The MTEF targets used the current interpretation to estimate targets – this will be reviewed in 2015/16 to make provision for change in definition

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
of 95% (or more) at all public health facilities by March 2020	*Sum of patient experience of care survey scores (in %) of all Central hospitals that conducted a patient experience of care survey to date in the current financial year*	*PEC Survey results*	*No*	-	*18*	*19*	-	*15*	*14*	*10*
	Total number of Central Hospitals that conducted a patient experience of care survey to date in the current financial year	*PEC Survey results*	*No*	-	*20*	*20*	-	*16*	*14*	*10*
Strategic Objective 1.7: Improve hospital efficiencies										
1.7.3) Improve hospital efficiencies by reducing the average length of stay to less than 5 days (District & Regional), 15 days (TB), 280 days (Psych), 35 days (Chronic), 7.6 days (Tertiary), and 6.5 days (Central) by March 2020	6. Average length of stay - total	DHIS	Quarterly/ Days	9.1 Days	8.4 Days	8.9 Days	8.4 Days	8.5 Days	8.5 Days	8.6 Days
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*220 104*	*217 577*	*225 640*	*210 818*	*215 034*	*219 335*	*223 722*
	Day Patients	*DHIS/ Midnight Census*	*No*	*1 037*	*1 526*	*1 737*	*1 552*	*1 568*	*1 583*	*1 599*
	Inpatient separations	*DHIS calculates*	*No*	*24 331*	*26 068*	*25 579*	*25 152*	*25 404*	*25 658*	*25 914*
1.7.1) Maintain a bed utilisation rate of 75% (or more)	7. Inpatient bed utilisation rate - total	DHIS	Quarterly/ %	72.5%	70.5%	73.5%	68.5%	70.0%	71.4%	72.9%
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*220 104*	*217 577*	*225 640*	*210 818*	*215 034*	*219 335*	*223 722*
	Day Patients	*DHIS/ Midnight Census*	*No*	*1 037*	*1 526*	*1 737*	*1 552*	*1 568*	*1 583*	*1 599*
	Inpatient bed days available	*DHIS calculates*	*No*	*304 291*	*309 920*	*307 938*	*308 790*	*307 938*	*307 938*	*307 938*
1.7.4) Maintain expenditure per PDE	8. Expenditure per patient day equivalent	BAS/DHIS	Quarterly/ R	R 2 700*	R 2 937*	R 2 873	R 3 728.0	R 7 651	R7 898	R 8 142

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
within the provincial norms	*Total expenditure Central Hospital*	*BAS*	*R'000*	*R 758 623*	*R 873 086*	*R 839 485*	*1 039 324*	*2 154 298*	*2 246 075*	*2 338 533*
	Patient day equivalents	*DHIS calculates*	*No*	*280 971*	*279 186*	*292 157*	*278 770*	*281 558*	*284 373*	*287 217*
Strategic Objective 5.1: Improve compliance to the Ideal Clinic and National Core Standards										
5.1.6) Sustain a complaint resolution rate of 90% (or more) in all public health facilities from March 2018 onwards	9. Complaint resolution rate	DHIS	Quarterly/ %	85.7%	84.6%	74.2%	42.9%[81]	80%	84%	90%
	Complaint resolved	*Complaints Register*		*36*	*22*	*46*	*6*	*41*	*38*	*35*
	Complaint received	*Complaints Register*		*42*	*26*	*62*	*14*	*51*	*45*	*39*
5.1.7) Sustain a 85% (or more) complaint resolution within 25 working days rate in all public health facilities by March 2018 and onwards	10. Complaint resolution within 25 working days rate	DHIS	Quarterly/ %	85.7%	84.6%	100%	100%	100%	100%	100%
	Complaint resolved within 25 working days	*Complaints register*	*No*	*36*	*22*	*46*	*6*	*41*	*38*	*35*
	Complaint resolved	*Complaints register*	*No*	*42*	*26*	*46*	*6*	*41*	*38*	*35*

[81] Data considered an outlier and could not be verified before finalisation of the APP. Targets for the MTEF are therefore based on previous trends

Table 87: (C&THS4) Provincial Strategic Objectives and Targets

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 2.7: Reduce maternal mortality										
2.7.3) Reduce the caesarean section rate to 25% (District), 37% (Regional), 60% (Tertiary), and 60% (Central) by March 2020	1. Delivery by caesarean section rate	DHIS	Quarterly/ %	74.7%	79.8%	78.5%	79.7%	74.8%	71%	68%
	Delivery by caesarean section	*Theatre Register*	*No*	*355*	*394*	*394*	*208*	*386*	*378*	*371*
	Delivery in facility total	*Delivery Register*	*No*	*475*	*494*	*502*	*261*	*516*	*531*	*545*
Strategic Objective 1.7: Improve hospital efficiencies										
1.7.6) Appropriate referral as per referral criteria	2. OPD headcount – total	DHIS/ Tick Register OPD	Quarterly/ No	178 484	179 617	192 629	196 604	199 553	202 546	205 585

6.2 2015/16 Targets

Table 88: (C&THS6) Quarterly and Annual Targets

Performance Indicators		Targets 2015/16	Targets			
			Q1	Q2	Q3	Q4
Quarterly Targets						
1.	National core standards self-assessment rate	100%	0%	0%	0%	100%
2.	Quality improvement plan after self-assessment rate	100%	100%	100%	100%	100%
3.	Percentage of hospitals compliant with all extreme and vital measures of the national core standards	100%	0%	0%	0%	100%
4.	Patient experience of care survey rate	100%	0%	0%	0%	100%
5.	Average length of stay – total	8.5 Days	8.5 Days	8.5 Days	8.5 Days	8.5 Days
6.	Inpatient bed utilisation rate - total	70%	69%	69.3%	69.7%	70%
7.	Expenditure per patient day equivalent (PDE)	R 7 651	R 7 651	R 7 651	R 7 651	R 7 651
8.	Complaint resolution rate	80%	75%	76%	78%	80%
9.	Complaint resolution within 25 working days rate	100%	100%	100%	100%	100%
10.	Delivery by caesarean section rate	74.8%	78%	77.5%	76%	74.8%
11.	OPD headcount – total	199 553	49 888	99 776	149 664	199 553
Annual Targets						
12.	Patient experience of care rate	94%				94%

TERTIARY HOSPITALS (GREYS AND NGWELEZANA)

Table 89: (C&THS2) Programme Performance Indicators

Strategic Objective Statement	Performance Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 5.1: Improve compliance to the Ideal Clinic and National Core Standards										
5.1.3) 100% Public health hospitals conduct annual national core standard self-assessments by March 2016	1. National core standards self-assessment rate	DHIS – NCS Module	Quarterly/ %	New indicator	100%	100%	50%	100%	100%	100%
	Number of Tertiary Hospitals that conducted national core standard self-assessment to date in the current financial year	*Self-Assessment records*	*No*	-	2	2	*1*	*2*	*2*	*2*
	Total number of Tertiary Hospitals	*DHIS calculates*	*No*	-	*2*	*2*	*2*	*2*	*2*	*2*
5.1.4) 100% Public health hospitals develop and implement Quality Improvement Plans based on national core standard assessment outcomes by March 2016	2. Quality improvement plan after self-assessment rate	DHIS – NCS Module	Quarterly/ %	New indicator	New indicator	New indicator	100%	100%	100%	100%
	Number of Tertiary Hospitals that developed a quality improvement plan to date in the current financial year	*Quality Improvement Plans*	*No*	-	-	-	*2*	*2*	*2*	*2*
	Number of Tertiary Hospitals that conducted national core standard self-assessment to date in the current financial year	*Self-assessment reports*	*No*	-	-	-	*2*	*2*	*2*	*2*
5.1.2) 60% (or more) public health hospitals compliant with extreme and vital measures of the national core	3. Percentage of hospitals compliant with all extreme and vital measures of the national core standards	DHIS – NCS Module	Quarterly/ %	New indicator	New indicator	New indicator	0%	50%	50%	50%

Strategic Objective Statement	Performance Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
standards by March 2020	*Total number of Tertiary Hospitals compliant to all extreme measures and at least 90% of vital measures of national core standards*	*Assessment records*	*No*	-	-	-	*0*	*1*	*1*	*1*
	Number of Tertiary Hospitals that conducted national core standard self-assessments	*Assessment records*	*No*	-	-	-	*1*	*2*	*2*	*2*
5.1.5) Sustain a 100% patient experience of care survey rate in all public health facilities from March 2016	4. Patient experience of care survey rate	DHIS/NCS Module	Quarterly/ %	New indicator	100%	100%	100%	100%	100%	100%
	Total number of Tertiary Hospitals that conducted a patient experience of care (PEC) survey to date in the current financial year	*PEC evidence*	*No*	-	*2*	*2*	*2*	*2*	*2*	*2*
	Total number of Tertiary Hospitals	*DHIS*	*No*	-	*2*	*2*	*2*	*2*	*2*	*2*
5.1.1) Sustain a patient experience of care rate of 95% (or more) at all public health facilities by March 2020	5. Patient experience of care rate	DHIS – NCS Module	Annual/ %	New indicator	New indicator	New indicator	89.2%	90% [82]	91%	93%
	Sum of patient experience of care survey scores (in %) of all Tertiary Hospitals that conducted a patient experience of care survey to date in the current financial year	*PEC Survey results*	*No*	-	-	-	*400*	*408*	*416*	*433*

[82] According to the new indicator definition sourced from the NDOH the current calculation of this indicator is incorrect (targets based on current interpretation). The indicator will be reviewed in 2015/16 to make provision for change in calculation

Strategic Objective Statement	Performance Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	Total number of Tertiary Hospitals that conducted a patient experience of care survey to date in the current financial year	*PEC Survey results*	*No*	-	-	-	*448*	*453*	*459*	*464*
Strategic Objective 1.7: Improve hospital efficiencies										
1.7.3) Improve hospital efficiencies by reducing the average length of stay to less than 5 days (District & Regional), 15 days (TB), 280 days (Psych), 35 days (Chronic), 7.6 days (Tertiary), and 6.5 days (Central) by March 2020	6. Average length of stay - total	DHIS	Quarterly/ Days	9.9 Days	10.2 Days	9.9 Days	10 Days	9.6 Days	9.4 Days	9.3 Days
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*126 616*	*294 660*	*308 673*	*307 328*	*308 096*	*308 867*	*309 639*
	Day Patients	*DHIS/ Midnight Census*	*No*	*670*	*371*	*9 153*	*8 994*	*9 084*	*9 175*	*9 267*
	Inpatient separations total	*DHIS calculates*	*No*	*12 785*	*28 801*	*31 553*	*31 750*	*32 385*	*33 033*	*33 693*
1.7.1) Maintain a bed utilisation rate of 75% (or more)	7. Inpatient bed utilisation rate - total	DHIS	Quarterly/ %	70.5%	85.3%	98.7%	83.9%	84.0%	84.4 .7%	84.5%
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*126 616*	*294 660*	*308 673*	*307 328*	*308 096*	*308 867*	*309 639*
	Day Patients	*DHIS/ Midnight Census*	*No*	*670*	*371*	*9 153*	*8 994*	*9 084*	*9 175*	*9 267*
	Inpatient bed days available	*DHIS calculates*	*No*	*185 055*	*345 632*	*317 459*	*376 680*	*371 935*	*371 395*	*371 935*
1.7.4) Maintain expenditure per PDE within the provincial norms	8. Expenditure per patient day equivalent	BAS/DHIS	Quarterly/ R	R 9 177*	R 4 605	R 3 257	R 5 392	R 4 377	R 4 470	R 4 951
	Expenditure – Total Tertiary Hospital	*BAS*	*R'000*	*1 754 031*	*1 889 885*	*1 400 958*	*2 275 494*	*1 830 668*	*1 851 202*	*2 029 554*
	Patient day equivalents	*DHIS calculates*	*No*	*191 113*	*410 345*	*430 124*	*422 464*	*418 239*	*414 057*	*409 916*

Strategic Objective Statement	Performance Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 5.1: Improve compliance to the ideal Clinic and National Core Standards										
5.1.6) Sustain a complaint resolution rate of 90% (or more) in all public health facilities from March 2018 onwards	9. Complaint resolution rate	DHIS	Quarterly/ %	92.6%	83.3%	74.4%	73%	78%	84%	90%
	Complaint resolved	*Complaints Register*	*No*	*199*	*280*	*203*	*250*	*255*	*260*	*265*
	Complaint received	*Complaints register*	*No*	*215*	*336*	*273*	*342*	*325*	*309*	*293*
5.1.7) Sustain a 85% (or more) complaint resolution within 25 working days rate in all public health facilities by March 2018 and onwards	10. Complaint resolution within 25 working days rate	DHIS	Quarterly/ %	92%	83.3%	100%	100%	100%	100%	100%
	Complaint resolved within 25 working days	*Complaints Register*	*No*	*199*	*280*	*203*	*250*	*255*	*260*	*265*
	Complaint resolved	*Complaints Register*	*No*	*216*	*336*	*203*	*250*	*255*	*260*	*265*

Table 90: (C&THS1) Provincial Strategic Objectives and Targets

Strategic Objective Statement	Performance Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 2.7: Reduce maternal mortality										
2.7.3) Reduce the caesarean section rate to 25% (District), 37% (Regional), 60% (Tertiary), and 60% (Central) by March 2020	1. Delivery by caesarean section rate	DHIS	Quarterly/ %	69%	73.2%	69%	72.8%	68%	66%	65%
	Delivery by caesarean section	*Theatre Register*	*No*	*1 093*	*1 004*	*898*	*782*	*889*	*880*	*871*
	Delivery in facility total	*Delivery Register*	*No*	*1 585*	*1 372*	*1 301*	*1 074*	*1 314*	*1 327*	*1 340*

Strategic Objective Statement	Performance Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 1.7: Improve hospital efficiencies										
1.7.5) Reduce the unreferred OPD headcounts with at least 7% per annum	2. OPD headcount – total	DHIS/ Tick Register OPD	Quarterly/ No	188 637	314 027	308 513	292 522	288 134	283 812	279 555
	3. OPD headcount new cases not referred	DHIS/ Tick Register OPD	Quarterly/ No	0	30 962	33 039	28 086	30 272	*28 122*	*26 154*

6.3 2015/16 Targets

Table 91: (THS3) Quarterly and Annual Targets

Performance Indicators		Targets 2015/16	Targets			
			Q1	Q2	Q3	Q4
Quarterly Targets						
1.	National core standards self-assessment rate	100%	50%	50%	50%	100%
2.	Quality improvement plan after self-assessment rate	100%	50%	50%	50%	100%
3.	Percentage of hospitals compliant with all extreme and vital measures of the national core standards	50%	0%	0%	0%	50%
4.	Patient experience of care survey rate	100%	50%	50%	50%	100%
5.	Average length of stay – total	9.6 Days	9.9 Days	9.8 Days	9.7 Days	9.6 Days
6.	Inpatient bed utilisation rate - total	84%	84%	84%	84%	84%
7.	Expenditure per patient day equivalent (PDE)	R 4 377	R 5 000	R 4 800	R 4 500	R 4 377
8.	Complaint resolution rate	78%	74.5%	75%	75%	78%
9.	Complaint resolution within 25 working days rate	100%	100%	100%	100%	100%
10.	Delivery by caesarean section rate	68%	69%	69%	68.5%	68.5%
11.	OPD headcount – total	288 134	72 033	72 033	72 033	72 035
12.	OPD headcount new cases not referred	30 272	7 568	7 568	7 568	7 568
Annual Targets						
13.	Patient experience of care rate	90%				90%

6.4 Reconciling Performance Targets with Expenditure Trends

Table 92: (C&THS7 a) Summary of Payments and Estimates

Sub-Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Central Hospitals	1 532 389	1 697 441	1 785 076	888 645	888 645	889 625	2 154 298	2 246 075	2 338 533
Tertiary Hospitals	1 708 078	1 641 409	1 855 510	2 190 747	2 190 747	2 189 767	1 830 668	1 851 202	2 029 554
Total	**3 240 467**	**3 338 850**	**3 640 586**	**3 079 392**	**3 079 392**	**3 079 392**	**3 984 966**	**4 097 277**	**4 368 087**

Table 93: (C&THS7 b) Summary of Payments and Estimates by Economic Classification

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Current payments	**3 225 558**	**3 326 365**	**3 563 853**	**3 053 388**	**3 053 388**	**3 051 474**	**3 962 062**	**4 072 580**	**4 342 155**
Compensation of employees	1 694 541	1 805 528	1 984 474	1 619 167	1 619 167	1 669 802	2 226 728	2 340 298	2 482 046
Goods and services	**1 531 017**	**1 520 837**	**1 579 379**	**1 434 221**	**1 434 221**	**1 381 347**	**1 735 334**	**1 732 282**	**1 860 109**
Communication	4 662	4 743	5 449	4 700	4 700	3 348	4 733	4 977	5 227
Computer Services	422	5 534	3 509	-	-	-	-	-	-
Consultants, Contractors and special services	737 361	757 503	762 124	798 650	798 650	728 537	832 368	835 948	934 048
Inventory	705 384	675 596	727 269	564 762	564 762	597 069	802 576	791 674	816 354
Operating leases	2 426	1 016	818	918	918	440	550	1 001	1 022
Travel and subsistence	1 376	1 341	867	1 000	1 000	966	1 071	482	495
Interest and rent on land	-	-	-	-	-	325	-	-	-
Maintenance, repair and running costs	-	-	-	-	-	-	-	-	-

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	79 386	75 104	79 343	64 191	64 191	50 987	94 036	98 200	102 963
Transfers and subsidies to	5 384	4 920	45 259	5 004	5 004	26 022	10 324	10 856	11 399
Provinces and municipalities	-	-	-	4	4	8	-	-	-
Departmental agencies and accounts	-	-	52	-	-	52	54	57	60
Higher Education institutions	-	-	-	-	-	-	-	-	-
Foreign governments and international organisations	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	5 384	4 920	45 207	5 000	5 000	25 962	10 270	10 799	11 339
Payments for capital assets	9 525	7 565	31 474	21 000	21 000	1 896	12 580	13 841	14 533
Machinery and equipment	9 525	7 565	31 474	21 000	21 000	1 896	12 580	13 841	14 533
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Land and sub-soil assets	-	-	-	-	-	-	-	-	-
Software and other tangible assets	-	-	-	-	-	-	-	-	-
Payment for financial assets	-	-	-	-	-	-	-	-	-
Total economic classification	3 240 467	3 338 850	3 640 586	3 079 392	3 079 392	3 079 392	3 984 966	4 097 277	4 368 087
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	**3 240 467**	**3 338 850**	**3 640 586**	**3 079 392**	**3 079 392**	**3 079 392**	**3 984 966**	**4 097 277**	**4 368 087**

6.5 Performance and Expenditure Trends

The positive trend is due to the increasing demand for Tertiary and Central Hospital services, as well as the various OSDs, annual wage agreements, and related carry-through costs. The 2015/16 MTEF includes the carry-through costs of wage agreements, OSDs, and national priorities.

The increase in *Compensation of employees* in the 2014/15 Revised Estimate is due to the filling of critical posts to strengthen neonatal services. The 2015/16 MTEF comprises carry-through costs for previous wage agreements and national priorities and increases in the National Tertiary Services Grant.

The lower growth in *Goods and services* in 2012/13 and 2013/14 is attributed to efficiency gains from high cost drivers such as medicines, medical supplies and blood products. The increase in 2015/16 and negative growth in 2016/17 is due to the PPP payment and medical supplies payments that will be deferred from 2014/15 to 2015/16. Growth over the 2015/16 MTEF caters for inflation only.

The high expenditure against *Transfers and Subsidies to: Households* in 2014/15 relates to medico-legal claims against the Department. No provision was made for these claims in the 2015/16 MTEF period due to baseline budget cuts and hence a negative growth in 2015/16.

The increase in the 2015/16 MTEF against *Machinery and equipment* is a provision for the planned replacement and modernisation of tertiary services critical major medical equipment.

6.6 Risk Management – All Sub-Programmes

Table 94: Risk Management

Potential Risks	Mitigating Strategies
1. Poor information system, quality of data and information management which will impact on decision-making, planning and performance against targets. *(High Risk)*	• Patient-based information system (including cost centres) to align service delivery and expenditure. • Implementation of ICD 10 coding. • Alignment of classification with service package and leadership competencies.
2. Ineffective clinical governance resulting in high litigation costs and inadequate support services, e.g. maintenance/replacement of Medical Equipment and delays in SCM. *(High Risk)*	• Implementation of the Hospital Rationalisation Plan and National Core Standards.
3. Reduction of the tertiary services grant due to global economic crisis/National DOH historical allocation. *(High Risk)*	• Negotiations with the National Chief Financial Officer to review the Provincial allocation taking into consideration the burden of disease and service demands.
4. Increasing service demands without concomitant resources including equipment, human resources and finance. *(High Risk)*	• Re-prioritisation to ensure effective utilisation of existing resources.
5. Inadequate service delivery platform to accommodate the proposed decentralised training model (in early development phase). *(High Risk)*	• Included in the Business Plan for the Decentralised Training in a PHC Model. • Research being conducted to determine gaps that will inform the strategy for implementation.

7. PROGRAMME 6: HEALTH SCIENCES AND TRAINING

7.1 Programme Purpose

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

There are no changes to the structure of Programme 6.

Sub-Programme 6.1: Nurse Training College

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

Sub-Programme 6.2: EMS Training College

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

Sub-Programme 6.3: Bursaries

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

Sub-Programme 6.4: PHC Training

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

Sub-Programme 6.5: Training (Other)

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

7.2 Overview

Nurse Training College

The KZN College of Nursing maintained accreditation as a Nursing Institution for continued training with the South African Nursing Council (SANC).

The partnership with UKZN resulted in an increase in the intake of Advanced Midwives that will contribute towards improving maternal health outcomes and intake of an additional 200 PHC nurses in line with the prioritisation of PHC re-engineering. The College successfully introduced the training course for Ophthalmic Nursing at Edendale Campus (post-graduation qualification). Forty (40) students completed training and 20 will commence training on 1 March 2015.

Table 95: KZN Nursing College average annual graduation

Category	Course	Number per annum
Post-Graduation qualification	R212	200
Professional Nurses	R425	500
General Nurses	R683	350
Enrolled Nurses	R2175	620
Enrolled Nursing Auxiliary	R2176	100
Diploma in Midwifery	R254	350
Diploma in Psychiatry	R880	30
Clinical Nursing Science, Health	R48	50
Total number of students graduating	**-**	**2 200**

The aging infrastructure in most campuses and sub-campuses is a concern in spite of significant infrastructure investment over the last few years. To date, the Department has spent R46 million towards upgrading of Nursing Colleges at Charles Johnson Memorial (CJM), Edendale, Addington and the Greys Hospital Nursing Home, Benedictine and RK Khan campuses, Madadeni and Port Shepstone, Ceza, Manguzi, Nkonjeni, Mbongolwane, Eshowe, Rietvlei, Mseleni, Hlabisa and Bethesda sub-campuses.

There is a high vacancy rate at CJM, Mosvold, Bethesda, Manguzi, Ceza and Nkandla, while the lack of educational resources to meet the Higher Education needs for accreditation to Institution of Higher Education will receive attention over the MTEF. Inadequate ICT systems/ infrastructure to manage student affairs have been included in the ICT Strategic Plan.

EMS Training College

The KZN College of Emergency Care is responsible for developing and maintaining the knowledge and skills of EMS staff members. The College offers formal training programmes which are accredited by the Health Professional Council of South Africa which allows for professional registration. These are the Emergency Care Training (ECT) and Intermediate Life Support (ILS) programmes. The College is accredited to run three classes each year at the Northdale Campus in Pietermaritzburg and is accredited to complete the education and training for ECT level at the McCord Campus in Durban.

To maintain the skills and competencies of staff members the College offers refresher courses and updates at various venues throughout the Province. These training courses assist employees with maintaining their Continuing Professional Development portfolios. The refresher programmes conducted in all 11 health districts include one day updates for Basic and Intermediate Life Support staff members and 5 day refresher programmes for Basic Life Support (BLS) staff members. Week long refresher courses for Intermediate and Advanced Life Support staff members are conducted centrally at the McCord Campus of the College.

In addition to these programmes the College offers Driver Training, Emergency Medical Dispatch training and Management courses to employees of the KwaZulu-Natal Emergency Medical Services.

The Department is working with the Durban University of Technology (DUT) to roll out the Higher Education Qualification Sub Framework for Emergency Medical Care (Emergency Care Assistant (ECA), NQF level 5 and Emergency Care Technician (ECT), NQF level 6). These are scheduled to start in 2016.

Bursaries

There are currently 777 bursary holders studying in South African Universities, and 783 students studying medicine in Cuba (including the November 2014 intake). It is anticipated that the number of Cuban students will be reduced over the MTEF due to the high costs of the programme and the limited funding envelope. The Cuban programme comes at a high cost to the Department including direct academic costs, costs for goods and services such as flights, accommodation, processing of documents, and procurement of student support materials such as stethoscopes, BP Machines, uniform, stationery and medical books. The university charges additional fees for students on their return to South Africa due to the need of extra support and mentorship to adapt to the South African context and English language.

Scaling down of the Cuban programme will be substituted by an increased intake of medical students by UKZN as well as the new decentralised training model *(Community-Based Training in a PHC Model)* developed by UKZN in partnership with the Department. This will reduce cost of training and contribute towards an increase in locally trained health professionals. Development of the training model is at an advanced stage and it is anticipated that the pilot phase will commence in 2016/17 pending formal approval of the Business Plan. Funding will be required to create a suitable teaching platform to accommodate the huge contingent of Cuban students who will return in 2018/19 for completion of their final South African studies of 18 months.

Other bursary related activities such as specialisation in trauma, mammography, ultrasonography, etc. are already being implemented for in-service employees for both compliance with professional requirements and improved service delivery. New programmes in the form of Mid-Level Worker training are being augmented to ensure a continuous supply of skills to rural areas. Whilst efforts are being made to address the shortage of doctors, the other allied categories involved in the value chain e.g. pharmacists, sonographers, monographers, etc. could not be ignored as they play a pivotal role towards the trajectory of meeting the Millennium Development Goals. The Department has sent 30 Pharmacy students to India as part of a Public-Private Partnership arrangement. There is a need to support this initiative financially over the MTEF.

Table 96: Mid-Level Worker Training

Domain	Targeted for Training	Trained	In Training
Clinical Associates	200[83]	44	125
Occupational Therapist Technicians	58	16	42
Physiotherapist Technicians	63	43	0
Medical Orthotist and Prosthetist Technicians	30	0	0[84]
Health Promoters	100	0	0[85]

Training (Other)

Implementation of the Artisan Development Programme

There is a drastic shortage of artisans in the Department in especially in rural hospitals which places at risk the successful management of infrastructure maintenance and repair projects. The Department and the Technical Vocational Education and Training Colleges (TVET Colleges) have engaged to provide a platform for workplace learning programmes to address this need. A Memorandum of Agreement (MOA) with TVET has been drafted and the assessment of skills for recognition of prior learning has commenced.

Implementation of Sign Language Programmes

Sign language training was identified as an urgent need to address the challenges of people with disabilities in terms of accessing health services in a dignified manner. The training programme will be implemented over the MTEF at a decentralised level, which will culminate into identifying staff members at a district level to be appointed as champions for sign language. The implementation will be a consultative process with Societies for the Deaf and Blind to ensure appropriate training.

General Training

Most training programmes addressing soft skills are provided by the KZN Public Service Academy. The following decentralised training has taken place:

- Customer Care
- Supervisory
- Embracing Diversity
- Supervisory Skills
- Financial Literacy

Compulsory Induction Programme (CIP)

There are currently 7 700 employees (appointed from 01 July 2012 to 30 June 2014) that still need CIP training before their probation can be confirmed.

The programme has not yet commenced although the CIP Action Plan, human resources (CIP trainers) and equipment (laptops and data projectors) is in place. Laptops and data projectors have been allocated to all districts in preparation for the course. There are 21 qualified Assessors and 13 qualified Trainers to train staff at salary levels 1-12. A further 6 Trainers qualified as Assistant Trainers.

[83] Based on at least a minimum of two Clinical Associates per hospital/CHC
[84] First intake to be in January 2016
[85] Health Promoters will be recruited from Community Care Givers and Lay Counsellors to undergo a 12 month training programme at UKZN

The challenge with the roll-out of the training is due to a lack of funding for procuring the training material from the National School of Government (NSG). A letter was written to NSG requesting authority for the Department to utilize its own printing services however, the request was declined. DPSA has allowed for confirmation of probation without undergoing CIP for those departments with a huge backblock.

Performance Management and Development

The training priority is to align training to service delivery requirements. This could be achieved in part through effective implementation of the Performance Management Development System (PMDS). This system informs training needs through the Personal Development Plans or performance assessment reviews if it is adverse to the specific performance targets in agreements.

The reviewed policy to include timelines for submission and the forfeiting of pay progression has yielded good results in improved compliance. HRM circular 4 of 2015 was issued directing employees and managers to align Performance Agreements to strategic documents such as Annual Performance Plan, Operational Plans and Departmental strategic priorities, however there are still some challenges regarding the system itself as there is a perception that good performance should be compensated by means of a performance bonus over and above accelerated pay progression. Compliance amongst clinical staff is still a challenge and workshops have been conducted and PMDS tools for clinicians have been redesigned to address the challenges.

There are also challenges regarding the grading of certain categories such as Emergency Medical Services. This challenge is being addressed by means of an audit to ascertain which staff qualify for grade progressions and to determine the cost implications since it has a backdating effect. Backdated grade progressions have an effect on Compensation of Employees' budget. There will be a need for additional budget to implement the outcome of the audit.

7.3 2015/16 Priorities

1. Accreditation of KZNCN as an Institution of Higher Education.	• Accreditation Implementation Plan including amalgamation of Campuses and Sub-Campuses (infrastructure and resource allocation in line with requirements for accreditation). • Management information systems to improve management and monitoring.
2. Align student intake with service delivery demands and Provincial Long Term Plan.	• Align student intake with Human Resource Plan and identified service delivery needs.
3. Improve Emergency Training.	• Revitalise the College for Emergency Care and align training to the Higher Education Qualification Sub-Framework for Emergency Medical Care. Acquire suitable student accommodation. • New education and training courses (in partnership with DUT) including courses at entry level (Emergency Care Assistant) and mid-level qualification (Emergency Care Technician); refresher

		programmes for BLS, ILS and ALS. • EMS training on Management, Rescue, Driver Training, Emergency Medical Dispatcher, Motivation and Aviation Health Care Provider. • Complete relocation of Northdale Campus to McCord Central Campus.
4.	Implement the Provincial HRD Strategy.	• Workplace Skills Plan – aligned with HR Plan. • Decentralised sign language training. • Bursary Programme. • Innovations to accelerate training programmes e.g. E-learning. • Partnerships with Higher Education Institutions and other training providers to ensure relevance.
5.	Implement the Management Training and Leadership Development Strategy.	• Conduct skills/ competency audit for Managers to inform training programmes. • Analyse management assessments to inform interventions and to improve productivity.
6.	Implement the Mid-Level Worker strategy.	• Develop and implement Mid-Level training programmes in collaboration with UKZN.

7.4 Strategic Objectives, Indicators and Targets

Table 97: Strategic Plan 2015-2019 Targets

Strategic Goal	Strategic Objective	Strategic Objective Statement	Indicator	Target March 2020
Strategic Goal 4: Strengthen human resources for health	4.1) Improve human resources for health	4.1.4) Allocate 569 bursaries for first year medicine students between 2015/16 and 2019/20	• Number of bursaries awarded for first year medicine students	569
		4.1.5) Allocate 2 000 bursaries for fist year nursing students between 2015/16 and 2019/20	• Number of bursaries awarded for first year nursing students	2 000
		4.1.6) Increase intake of Mid-Level Workers with at least 10% per annum (based on need per category)	• Number of new students enrolled in Mid-Level Worker training courses	167
		4.1.7) Increase the EMS skills pool by increasing the number of EMS personnel trained in ILS and ECT	• Number of Intermediate Life Support graduates per annum	360
			• Number of Emergency Care Technician graduates per annum	150

Table 98: (HST2) Programme Performance Indicators

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 4.1: Improve human resources for health										
4.1.4) Allocate 569 bursaries for first year medicine students between 2015/16 and 2019/20	1. Number of bursaries awarded for first year medicine students	Bursary Register	Annual/ No	66 (54RSA + 12 Cuban)	405 (51RSA + 354 Cuban)	379 (77 RSA + 302 Cuban)	131 (35 RSA + 96 Cuban)	154 (54 RSA + 100 Cuban)	150 (50 RSA + 100 Cuban)	160 (60 RSA + 100 Cuban)
4.1.5) Allocate 2 000 bursaries for fist year nursing students between 2015/16 and 2019/20	2. Number of bursaries awarded for first year nursing students	Bursary Register	Annual/ No	New indicator	New indicator	New indicator	New indicator	450	450	450

Table 99: (HST1) Provincial Strategic Objectives and Targets

Strategic Objective Statement	Performance Indicator	Data source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 4.3: Accreditation of KZNCN as Institution of Higher Education										
4.3.1) KZNCN accredited as institution of Higher Education by March 2017	1. KZNCN accredited as Institution of Higher Education	Accreditation Certificate	Annual/ Categorical	New indicator	New indicator	New indicator	New indicator	Implement improvement plan	Accredited	Accredited
Strategic Objective 4.1: Improve human resources for health										
4.1.11) Increase enrolment of Advanced Midwives by at least 10% per annum	2. Number of Advanced Midwifes graduating per annum	KZNCN Database	Annual/ No	120	107	90	100	110	121	132

Strategic Objective Statement	Performance Indicator	Data source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
4.1.12) Improve access for people with disabilities by training 1 100 service providers in sign language by March 2020	3. Number of employees trained in sign language (cumulative)	Annual Training Report	Annual/ No	30	0	0	0	220	220	220
4.1.6) Increase intake of Mid-Level Workers with at least 10% per annum (based on need per category)	4. Number of new students enrolled in Mid-Level Worker training courses	Student Records	HRD Student Records	New indicator	New indicator	New indicator	New indicator	100	110	121
4.1.8) Increase the number of MOP's who successfully completed the degree course at DUT to 90 (cumulative) by March 2020	5. Number of MOP's that successfully completed the degree course at DUT	Student Records DUT	Annual/ No	New indicator	New indicator	0	0	30	30	30
4.1.6) Increase intake of Mid-Level Workers with at least 10% per annum (based on need per category)	7. Number of new Pharmacy Assistants enrolled in training courses	Annual Training Report	Annual/ No	New indicator	New indicator	New indicator	New indicator	50	55	61
	8. Number of new Clinical Associates enrolled in training courses	Annual Training Report	Annual/ No	New indicator	New indicator	New indicator	New indicator	150	165	182
Strategic Objective 4.1: Improve human resources for health										
4.1.7) Improve the EMS skills pool by increasing the number of EMS personnel trained in ILS and ECT	9. Number of Intermediate Life Support graduates per annum	EMS College register	Annual/ No	86	88	44	54	72	72	72
	10. Number of Emergency Care Technician graduates per annum	EMS College register	Annual/ No	0	0	0	17	19	30	30

7.5 2015/16 Targets

Table 100: (HST3) Quarterly and Annual Targets

Performance Indicators	Targets 2015/16	Targets			
		Q1	Q2	Q3	Q4
Annual Targets					
1. Number of bursaries awarded for first year medicine students	154 (54 RSA + 100 Cuban)				154 (54 RSA + 100 Cuban)
2. Number of bursaries awarded for first year nursing students	450				450
3. KZNCN accredited as Institution of Higher Education	Implement improvement plan				Implement improvement plan
4. Number of Advanced Midwifes graduating per annum	110			110	
5. Number of employees trained in sign language (cumulative)	220				220
6. Number of students enrolled in Mid-Level Worker training courses	100				100
7. Number of MOP's that successfully completed the degree course at DUT	30				30
8. Number of Pharmacy Assistants enrolled in training course	50				50
9. Number of Clinical Associates enrolled in training course	150				150
10. Number of Intermediate Life Support graduates per annum	72				72
11. Number of Emergency Care Technician graduates per annum	19				19

7.6 Reconciling Performance Targets with Expenditure Trends

Table 101: (HST4 a) Expenditure Estimates

Sub-Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised estimate	Medium-Term Expenditure Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Nurse training colleges	355 879	334 013	292 602	302 768	302 756	276 379	296 953	312 765	328 404
EMS training colleges	11 417	10 890	5 968	7 570	7 549	5 042	4 709	4 967	5 215
Bursaries	64 433	82 997	205 880	216 950	216 950	258 458	237 500	250 034	263 036
PHC training	58 922	54 574	47 043	52 172	52 172	43 481	49 610	52 256	54 869
Other training	369 780	419 461	447 858	471 940	471 940	468 008	466 478	515 388	541 158
Total	**860 431**	**901 935**	**999 351**	**1 051 400**	**1 051 367**	**1 051 368**	**1 055 250**	**1 135 410**	**1 192 681**

Table 102: (HST4 b) Summary of Provincial Expenditure Estimates by Economic Classification

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Current payments	**776 485**	**804 266**	**789 339**	**824 702**	**824 702**	**796 332**	**816 250**	**886 916**	**931 263**
Compensation of employees	720 257	746 254	736 405	766 143	766 143	737 958	743 354	810 108	850 613
Goods and services	**56 228**	**58 012**	**52 931**	**58 559**	**58 559**	**58 374**	**72 896**	**76 808**	**80 650**
Communication	1 181	1 201	1 054	1 650	1 650	1 064	1 210	1 275	1 339
Computer Services	-	-	2 126	-	-	45	-	-	-
Consultants, Contractors and special services	306	76	257	709	709	72	20	34	37
Inventory	4 431	4 301	3 162	5 550	5 550	3 323	3 532	4 040	4 243
Operating leases	1 249	1 168	1 221	1 850	1 850	1 415	1 580	1 665	1 749

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Travel and subsistence	8 297	18 048	15 471	12 136	12 136	26 601	32 410	33 542	35 219
Interest and rent on land	-	-	3	-	-	-	-	-	-
Maintenance, repair and running costs	-	-	-	-	-	-	-	-	-
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	40 764	33 217	29 637	36 664	36 664	25 854	34 144	36 252	38 063
Transfers and subsidies to	**83 335**	**96 105**	**208 586**	**220 698**	**220 665**	**251 069**	**230 000**	**242 173**	**254 782**
Provinces and municipalities	-	-	-	48	15	15	-	-	-
Departmental agencies and accounts	8 588	10 119	11 282	13 000	13 000	15 768	16 000	16 842	17 684
Higher Education institutions	-	57	498	-	-	16	-	-	-
Foreign governments and international organisations	-	-	-	-	-	-	-	-	-
Non-profit institutions	14 298	15 130	-	-	-	-	-	-	-
Households	60 449	70 799	196 806	207 650	207 650	235 270	214 000	225 331	237 098
Payments for capital assets	**610**	**1 564**	**1 426**	**6 000**	**6 000**	**3 963**	**9 000**	**6 321**	**6 636**
Machinery and equipment	610	1 564	1 426	6 000	6 000	3 963	9 000	6 321	6 636
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Land and sub-soil assets	-	-	-	-	-	-	-	-	-
Software and other tangible assets	-	-	-	-	-	-	-	-	-
Payment for financial assets	1	-	-	-	-	4	1	-	-
Total economic classification	**860 431**	**901 935**	**999 351**	**1 051 400**	**1 051 367**	**1 051 368**	**1 055 250**	**1 135 410**	**1 192 681**
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	**860 431**	**901 935**	**999 351**	**1 051 400**	**1 051 367**	**1 051 368**	**1 055 250**	**1 135 410**	**1 192 681**

7.7 Performance and Expenditure Trends

The increase in the 2012/13 budget relates to the increase in the number of medical officers in the Cuban Training Programme. This funding is evident in the trends in the Bursaries sub-programme.

The reduction in *Compensation of Employees* in 2013/14 was due to the movement of student nurses from the more expensive salary system to a system of stipends. Also contributing to the reduction was cost-cutting aimed at reducing training and travelling costs. The reduction in the 2014/15 Revised Estimate is due to the movement of Nutrition Advisors to Other Community Services in Programme 2: District Health Services. The training programme for these employees was under Programme 6 and after completion of training staff have been moved to Programme 2.

The significant increase in *Transfers and Subsidies to: Households* over the entire period is attributed to the pressures in bursary payments related to the increase in student numbers on the Cuban Training Programme. The trends over the 2015/16 MTEF are for inflationary purposes only.

In the sub-programme: Training Other, the increase over the seven-year period is due to the extension of the medical internship period to two years and the OSD for doctors. The 2015/16 MTEF increase provides for the carry-through costs of the various wage agreements.

The fluctuating trend in *Goods and Services* is attributed to the travelling costs related to the Cuban Training Programme as well as the training of personnel in health related fields. Growth over the 2015/16 MTEF addresses the related travelling costs of students in Cuban Training Programme and the inflationary pressures in the two outer years.

The increase against *Machinery and Equipment* in 2014/15 seeks to address shortages that have arisen in the past and grows marginally over the 2015/16 MTEF.

7.8 Risk Management

Table 103: Risk Management

Potential Risks	Mitigating Strategies
1. Non-accreditation of the KZN College of Nursing as Institution of Higher Education which will impact on available training courses and intake of students as planned. Funding constraints affect implementation of required strategies to comply with criteria including infrastructure constraints (both Colleges and student accommodation). *(High Risk)*	• Implementation of the Nursing College Accreditation Plan (funding allowed). • Include infrastructure requirements in Infrastructure Plan (U-AMP).
2. Ineffective information management system resulting in poor data to inform decision-making and planning. *(Medium Risk)*	• Develop appropriate information system (funding allowed) as part of the ICT strategy.
3. Breach of contracts by Bursary Holders. *(High Risk)*	• Refine comprehensive database for Bursary holders, and vigorously monitor student activity. • Analyse Persal service termination reports to enforce appropriate recoveries. • Annual review of Bursary Contracts.

Potential Risks	Mitigating Strategies
4. Students on the Cuban Training Programme not completing studies within the required timeframe. *(High Risk)*	• All students subjected to intense orientation programme before departure to Cuba, with annual engagement of parents and student guardians. • Regular engagement with the RSA mission in Cuba. • Students sign a contractual agreement including clause on behavioral issues. • Department sends a representative when a national delegation goes to Cuba as part of students support and mentoring.
5. Absorption of Interns and bursary holders in permanent posts post training jeopardised due to the lack of funded posts (affected by limited funding envelope. *(High Risk)*	• Long Term HR Plan informs bursary holders and makes provision for absorption of students post training.

8. PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

8.1 Programme Purpose

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

There are no changes to the structure of Programme 7.

Sub-Programme 7.1: Laundry Services

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

Sub-Programme 7.2: Engineering Services

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

Sub-Programme 7.3: Forensic Services

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

Sub-Programme 7.4: Orthotic and Prosthetic Services

Render specialised orthotic and prosthetic services.

Sub-Programme 7.5: Pharmaceutical Service (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.

8.2 Overview

Laundry Services

Laundry Services are managed through in-house capacity at the KwaZulu Central Provincial Laundry, regional laundries (Cato Manor, Durban and Coastal, and Northern Natal) and facility laundries and are dependent on available laundry machines and staff. Facilities that outsource services e.g. McCord, Addington, Prince Mshiyeni and Inkosi Albert Luthuli are indispensable to the Province if in-house capacity is compromised. Private laundries are under-utilised and inefficient; hence they have 'spare/idle capacity' used to accommodate Departmental linen.

The Laundry Policy and Guidelines has been approved and are being implemented. Six (6) laundry trucks, all meeting the infection prevention and control specifications, have been deployed at the Durban Regional Laundries to improve efficiencies. The 3 year tender for SABS approved detergents and chemicals are in place which will improve the lifespan of linnen. Installation of new laundry machines has been completed in 67% of hospitals with the outstanding 35 targeted for the second phase of installation, dependent on the funding envelope.

The functionality of most Regional Laundries is restricted as a result of old machinery (regular breakdowns and long turn-around times (±2 months) for repairs. Required upgrading is restricted as a result of the limited funding envelope which impacts negatively on efficiencies.

The shortage of qualified artisans to maintain and repair laundry machines result in extended turn-around times for repairs which in turn jeopardises availability of clean linen to facilities. This is further affected by extended SCM processes for laundry machine maintenance and repair and other laundry services improvement initiatives. The Department commenced with the development of a Laundry Machinery Maintenance Plan to address these challenges.

The lack of an appropriate laundry information management system challenges effective monitoring of performance and early identification of risks. This has been included in the ICT Strategic Plan

Construction of the Dundee Laundry was put on hold as a result of funding constraints, although equipment that had already been procured will be installed before completion of the laundry.

The regional laundries process an estimated 10.8 million pieces of linen per annum. The amount of linen processed depends on 'receipts' from facilities and the turn-around time for clean linen is an average of 48 hours. Due to the shortage of linen in circulation, most facilities request a 24 hour lead time. In light of the existing old and unreliable equipment with longer turnaround times for repairs, the average cost per piece is R8. This cost includes pieces processed, compensation of employees and cost of goods. Linen is currently procured at facility level.

Orthotic and Prosthetic Services

Orthotics and Prosthetics, dealing with physical rehabilitations as a result of trauma, deformities and loss of function, are considered one of the scares skills in the Department. The Wentworth Orthotics and Prosthetics Centre is the only operational center in KwaZulu-Natal. The Centre services 41 Clinics with 10 Medical Ortho/Prosthetists (MOP) on the establishment. Due to shortage of appropriately trained staff and inadequate facilities, most of the services are rendered as outreach programmes.

The Department plan to establish one MOP Center per district to improve access and reduce waiting times for services. To date, R 30 million has been spent on the upgrading of earmarked facilities in preparation of establishing these identified Centres. Capital Planning commenced for the

establishment of Centres in earmarked hospitals including: Port Shepstone (Ugu); Christ The King (Harry Gwala); Stanger (Ilembe); Ngwelezana (Uthungulu); Ladysmith (Uthukela); Dundee (Umzinyathi); Madadeni (Amajuba); Nongoma (Zululand); and Mseleni (Umkhanyakude).

In 2013/14, the 4-year MOP degree course through DUT (Durban University of Technology) commenced, with approximately R4 million spent on bursaries for these students. The 5-year contract signed between the Department and DUT makes provision for a minimum of 90 MOP's to be trained in 5 years. It is envisaged that qualified MOP's will be placed in established Centres throughout the Province.

Pharmaceutical Services

A total of 44 Pharmacy Managers successfully completed a leadership development programme to improve pharmaceutical management. Medicine availability is showing continuous improvement from 92% in 2013/14 to 93% in 2014/15 at the depot. Facilities tracer medicine stock out rate remained at 3% for both 2013/14 and 2014/15 period while for PHC decreased from 2% to 1.93%, which is attributed to more effective training programmes and improved monitoring.

The Department is implementing the Centralised Chronic Medicine Dispensing and Distribution (CCMDD) Model in the NHI districts with the intention to roll it out to other districts over the MTEF. The total number of patients enrolled into the programme is 60 204 with 15 565 from Amajuba District, 30 511 from Umgungundlovu District, and 14 128 from Umzinyathi District as at December 2014. The Programme Monitoring System is currently focussing on enrolment and expansion data. As the programme matures, the impact on the health system will be measured.

The implementation of a pilot to test the Early Warning System for monitoring the stock levels of essential medicines at PHC clinics (Stock Visibility Solution) in partnership with the Vodacom Foundation (National initiative) is progressing well and lessons learned will be applied for rollout post pilot phase. The National Department of Health and KwaZulu-Natal Department of Health are working on the work-flows and processes to formalise them into Standard Operating Procedures, training manuals and change management documents for PHC clinics. The clinics were provided with mobile phone handsets with a software for capturing stock information for transmitting into a central database for use by managers at all levels. The information on the database is linked to the facilities map that uses colours to show the stock status at the clinic. When the stock level reaches a set point, a short message service (SMS) is sent to the supervising manager to alert for action. The system is still at an early piloting phase.

The Department increased the intake of candidates for the Pharmacist Assistant Courses including the enrolment of unemployed youth in an effort to improve the provision of pharmaceutical services. Seventy seven (7) candidates successfully completed the Post Basic course in November 2014. The graduation will take place in 2015. Seventy (70) of them are employed by the Department of Health and 7 by Private Sector. The output and outcome will be closely monitored to inform future decision-making.

The physical infrastructure of the Depot and some Pharmacies is dilapidated and requires urgent refurbishment and reconstruction. Due to financial constraints the required projects cannot be included over the MTEF. There has been newly built pharmacies and others were refurbished to improve their conditions.

The Department of Health is making good progress with implementing the reforms with regard to Pharmaceuticals Procurement and Distribution. The Depot systems and processes are strengthened to adequately respond to the needs of the Province. The Provincial Medicine Procurement Unit (PMPU), the "Control Tower" is being established to coordinate procurement and distribution of pharmaceuticals in the province. The Direct Deliveries and Cross-docking models are being

strengthened and introduced respectively. These models will relieve pressure on the Depot and allow the Depot to hold stock of a select number of items as buffer stock to ensure uninterrupted availability of essential medicines and related supplies.

The shortage of Pharmacists at Rural Districts and Hospitals is a major concern as the provision of Pharmaceutical Services is compromised. Increase in the uptake of Pharmacists forms part of the discussions between the Department and UKZN. District and Institutional Management is lagging behind with employing Pharmacists' Assistants for support of Primary Health Care Services. Some Community Health Centres and hospitals also do not have adequate number of Pharmacists' Assistants to provide Pharmaceutical Services. Training of Mid-Level Workers is being considered as one of the options to address the challenge.

Between 2013/14 and 2014/15, the vacancy rate for Pharmacists decreased from 28% to 16.1% and for Pharmacist Assistants from 30% to 9.8%.

8.3 2015/16 Priorities

1. Improve management of laundry services.
   - Suitable Laundry Management System to reduce breakdowns of laundry machinery.
   - Three year tender for linen procurement to ensure adequate linen supply that will eliminate clean linen stock outs.
   - Procurement of approved laundry chemicals/ detergents to reduce the damage to linen.
   - Design trolleys that cater for both dirty linen and clean linen.
   - Implement appropriate training for staff (in collaboration with UKZN) to improve efficient management of laundries.
2. Implement Rationalisation Plan for Mortuaries.
   - Phased implementation of the approved Mortuary Rationalisation Plan.
3. Repair of fridges in identified facilities.
4. Procurement of Lodox machines for Gale Street, Phoenix and Pietermaritzburg Mortuaries.
5. Approval of staff establishment and filling of identified posts.
6. Strengthen in-house training and mentoring of Forensic Pathology Officers.
7. Decentralisation of Orthotic and Prosthetic services.
   - Phased implementation of 9 decentralised Centres in line with the Infrastructure Plan, Provincial Long Term Plan and funding envelope.
8. Training of MOP's.
   - Agreement with DUT to train a minimum of 90 MOP's by March 2020.
9. Upgrading of equipment to all MOP centres.
   - Procurement of new machinery and equipment for earmarked Centers as per approved Procurement Plan.

10. Improve pharmaceutical services management.	• Revitalize the Provincial Pharmacy and Therapeutics Committee. • Electronic Stock Management System at PHC facilities, Hospitals and Depot to improve the Early Warning System for stock outs. • Pharmaceutical Procurement Reform to improve efficiencies and medicines availability.
11. Improve efficiencies and clinical governance.	• Community-based distribution of chronic medicines to improve access and reduce waiting times at pharmacies. • Training and development including training of Pharmacist Assistants to strengthen services at PHC.

8.4 Strategic Objectives, Indicators and Targets

Table 104: Strategic Plan 2015-2019 Targets

Strategic Goal	Strategic Objective	Strategic Objective Statement	Indicator	Target March 2020
		Orthotic and Prosthetic Services		
Strategic Goal 1: Strengthen health system effectiveness	1.9) Strengthen health system effectiveness	1.9.1) Increase the number of operational Orthotic Centres to 11 by March 2020	• Number of operational Orthotic Centres (cumulative)	11
Strategic Goal 4: Strengthen human resources for health	4.1) Improve human resources for health	4.1.8) Increase the number of MOP's who successfully completed the degree course at DUT to 90 (cumulative) by March 2020	• Number of MOP's that successfully completed the degree course at DUT *(Programme 6)*	90
		Laundry Services		
Strategic Goal 1: Strengthen health system effectiveness	1.9) Strengthen health system effectiveness	1.9.2) Decrease and maintain zero clean linen stock outs in facilities from March 2018 onwards	• Percentage of facilities reporting clean linen stock outs	Zero clean linen stock outs
		Pharmaceutical Services		
Strategic Goal 5: Improved quality of health care	5.2) Improve quality of care	5.2.1) Increase the percentage pharmacies that comply with the SA Pharmacy Council Standards (A or B grading) to 100% by March 2020	• Percentage of Pharmacies that obtained A and B grading on inspection	100%
		5.2.2) PPSD compliant with good Wholesaling Practice Regulations by March 2016	• PPSD compliant with good Wholesaling Practice Regulations	Compliant
		5.2.3) Decrease medicine stock-out rates to less than 1% in PPSD and all health facilities by March 2020	• Tracer medicine stock-out rate (PPSD)	Less than 1%
			• Tracer medicine stock-out rate (Institutions)	Less than 1%

Table 105: (HCSS1) Provincial Strategic Objectives and Targets

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 1.9: Strengthen health system effectiveness										
1.9.2) Decrease and maintain zero clean linen stock outs in facilities from March 2018 onwards	1. Percentage of facilities reporting clean linen stock outs	Laundry register	Quarterly/ %	New indicator	New indicator	10%	56%	30%	10%	0%
	Number of facilities reporting clean linen stock out	*Laundry register*	*No*	-	-	*7*	*40*	*22*	*7*	*0*
	Facilities total	*DHIS calculates*	*No*	-	-	*72*	*72*	*72*	*72*	*72*
1.9.5) Implement the approved Forensic Pathology Rationalisation Plan by March 2016	2. Forensic Pathology Rationalisation Plan	Rationalisation Plan	Annual/ Categorical	New indicator	New indicator	New indicator	New indicator	Plan approved & implemented	Implemented as per Plan	Implemented as per Plan
1.9.1) Increase the number of operational Orthotic Centres to 11 by March 2020	3. Number of operational Orthotic Centres - cumulative	Operational Centres reports	Annual/ No	New indicator	New indicator	New indicator	1	2	4	6
Strategic Objective 5.2: Improve quality of care										
5.2.1) Increase the percentage pharmacies that comply with the SA Pharmacy Council Standards (A or B grading) to 100% by March 2020	4. Percentage of Pharmacies that obtained A and B grading on inspection	Grading Certificates	Annual/ %	71%	80%	81%	90%	90%	90%	95%
	Pharmacies with A or B Grading	*Grading Certificates*	*No*	*61*	*71*	*71*	*80*	*80*	*80*	*84*
	Number of pharmacies	*Pharmacy records*	*No*	*86*	*89*	*88*	*89*	*89*	*89*	*89*
5.2.2) PPSD compliant with good Wholesaling Practice Regulations by March 2016	5. PPSD compliant with good Wholesaling Practice Regulations	License from Medicine Control Council	Annual/ Categorical	Not compliant	Not compliant	Not compliant	Not compliant	Compliant	Compliant	Compliant

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
5.2.3) Decrease medicine stock-out rates to less than 1% in all health facilities and PPSD by March 2020	6. Tracer medicine stock-out rate (PPSD)	DQPR	Quarterly/ %	13.2%	9%	5.7%	<5%	4% [86]	<3%	<2%
	Number of tracer medicine out of stock	*Pharmacy records*	*No*	*5*	*19*	*12*	*11*	-	-	-
	Total number of tracer medicine expected to be in stock	*Pharmacy records*	*No*	*38*	*220*	*212*	*159*	-	-	-
	7. Tracer medicine stock-out rate (Institutions)	Pharmacy records	Quarterly/ %	0.7%	1.4%	1.8%	<1%	<1%	<1%	<1%
	Number of tracer medicines stock out in bulk store	*Pharmacy records*	*No*	*1 951*	*3 638*	*4 476*	*Not available*	-	-	-
	Number of tracer medicines expected to be stocked in the bulk store	*Pharmacy records*	*No*	*277 020*	*255 220*	*251 125*	*Not available*	-	-	-

[86] Indicators 6 and 7: Numerators and denominators for MTEF targets could not be obtained from the Pharmacy Component before finalisation of the APP

8.5 015/16 Targets

Table 106: (HCSS2) Quarterly and Annual Targets

Performance Indicators	Targets 2015/16	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Percentage of facilities reporting clean linen stock outs	30% (or less)	50%	45%	35%	30% (or less)
2. Tracer medicine stock-out rate (PPSD)	<4%	<5%	<5%	<4.5%	<4%
3. Tracer medicine stock-out rate (Institutions)	<1%	<1.8%	<1.6%	<1.4%	<1%
Annual Targets					
4. Forensic Pathology Rationalisation Plan	Approved				Approved
5. Number of operational Orthotic Centres (cumulative)	2				2
6. Percentage of Pharmacies that obtained A and B grading on inspection	90%				90%
7. PPSD compliant with good Wholesaling Practice Regulations	Compliant				Compliant

8.6 Reconciling Performance Targets with Expenditure Trends

Table 107: (HCSS4 a) Expenditure Estimates

Sub-Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Laundries	13 971	15 170	-	-	-	-	-	-	-
Orthotic and prosthetic services	84 995	90 040	90 271	104 578	112 439	115 402	104 280	110 413	115 934
Medicines trading account	26 002	25 331	32 573	36 381	28 495	25 532	34 008	35 924	37 720
Total	124 968	130 541	122 844	140 959	140 934	140 934	138 288	146 337	153 654

Table 108: (HCSS4 b) Summary of Payments and Estimates by Economic Classification

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Current payments	**110 448**	**112 663**	**121 545**	**132 685**	**132 685**	**138 176**	**135 113**	**142 995**	**150 145**
Compensation of employees	75 511	78 745	81 357	89 900	89 900	85 596	95 700	100 895	105 940
Goods and services	**34 937**	**33 918**	**40 188**	**42 785**	**42 785**	**52 580**	**39 413**	**42 100**	**44 205**
Communication	563	384	399	598	598	458	428	451	473
Computer Services	-	-	-	-	-	-	-	-	-
Consultants, Contractors and special services	571	278	488	700	8 585	499	-	2	2
Inventory	24 016	22 845	22 363	29 797	21 912	14 953	20 871	22 469	23 593
Operating leases	45	26	97	105	105	111	104	109	114
Travel and subsistence	29	103	106	93	93	119	70	73	77
Interest and rent on land	-	-	-	-	-	-	-	-	-

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Maintenance, repair and running costs	-	-	-	-	-	-	-	-	-
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	9 713	10 282	16 737	11 492	11 492	36 440	17 940	18 996	19 946
Transfers and subsidies to	**14 483**	**16 493**	**1 285**	**674**	**649**	**1 032**	**575**	**606**	**637**
Provinces and municipalities	-	-	-	124	99	74	-	-	-
Departmental agencies and accounts	14 483	15 170	-	-	-	-	-	-	-
Higher Education institutions	-	-	-	-	-	-	-	-	-
Foreign governments and international organisations	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	-	1 323	1 285	550	550	958	575	606	637
Payments for capital assets	**35**	**1 385**	**14**	**7 600**	**7 600**	**1 726**	**2 600**	**2 736**	**2 872**
Machinery and equipment	35	1 385	14	7 600	7 600	1 726	2 600	2 736	2 872
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Land and sub-soil assets	-	-	-	-	-	-	-	-	-
Software and other tangible assets	-	-	-	-	-	-	-	-	-
Payment for financial assets	**2**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total economic classification	**124 968**	**130 541**	**122 844**	**140 959**	**140 934**	**140 934**	**138 288**	**146 337**	**153 654**
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	**124 968**	**130 541**	**122 844**	**140 959**	**140 934**	**140 934**	**138 288**	**146 337**	**153 654**

8.7 Performance and Expenditure Trends

In 2013/14, the Department centralised Laundry Services and Orthotic and Prosthetic Services as separate sub-programmes in Programme 7, which is in line with the budget and programme structure for the health sector. These functions were previously spread over Programmes 2, 4 and 5.

Expenditure against Medicine Trading Account was reduced in 2013/14 due to the account having sufficient funding for the supply of pharmaceuticals and medical sundries, with no top-up needed. This is carried through to 2015/16, but will be reviewed in-year for the next budget process. This also accounts for the trend against *Transfers and Subsidies to: Departmental Agencies and Accounts*.

The notable increase in 2014/15 against Laundry Services is due to additional laundry linen and laundry vehicles for the commissioning of the Prince Mshiyeni Central Laundry. The further increase in the 2014/15 Revised Estimate was as a result of the outsourcing of laundry services due to delays in the commissioning of Prince Mshiyeni Central Laundry service.

Compensation of Employees grows steadily driven mainly by the various higher than expected wage agreements.

The high growth in *Goods and services* in 2014/15 is due to the provision for the bulk purchase of linen for the commissioning of Prince Mshiyeni Central Laundry, the once-off procurement of laundry vehicles, as well the outsourcing of laundry services during this period.

Expenditure against *Machinery and Equipment* relates to office equipment and laundry vehicles. The increase in 2014/15 is due to the delivery of laundry vehicles ordered in 2013/14, as well as the planned once-off purchase of special/modified laundry vehicles, hence the drop in 2015/16. Provision is made for inflationary increases in 2016/17 and 2017/18.

8.8 Risk Management

Table 109: Risk Management

Potential Risks	Mitigating Strategies
1. Regular breakdown of laundry machines and extended repair turnaround times adding to the existing inadequate number of in-house laundry machinery to respond to demand – decrease linen supply in circulation and increase clean linen stock outs. *(High Risk)*	• Develop, implement and monitor the costed Maintenance Plan. • Increase laundry machinery capacity at strategically identified facilities and increase operating hours. • Centralise procurement of linen and develop linen distribution centres/ hubs.
2. Demand exceeds supply on availability of artisans in the laundry Industry. *(Medium Risk)*	• Explore in-house capacity for artisans to repair laundry machines.
3. Inadequate staffing and poor infrastructure increasing the inefficiencies of medico-legal mortuaries. *(High Risk)*	• Rationalisation of medico-legal mortuaries based on Rationalisation Plan. • Prioritise approval of establishment for filling of essential posts.
4. Inadequate facilities and appropriately trained MOP staff impacting on access to services and extended waiting times. *(High Risk)*	• Development of Orthotic Centres in identified hospitals. • Increase the pool of qualified professionals through partnership with DUT.

Potential Risks	Mitigating Strategies
5. Non-compliance of PPSD with the SAPC Regulations and inadequate storage facilities for medicines at PPSD and PHC facilities. *(High Risk)*	• Explore alternative medicine storage strategies for PHC clinics.
6. Insufficient Pharmaceutical Skills pool with high vacancy rates for Pharmacists. Add to extended waiting times at pharmaceutical facilities. *(High Risk)*	• Roll-out of Training Programme for Pharmacist Assistants. • Implement alternative chronic medicines access programme. • On-going Waiting Time Surveys as part of the national core standards and development of quality improvement plans to address identified gaps.
7. Poor medicine management resulting in shortage and/or expiry of medicines, theft, abuse and wastage. *(High Risk)*	• Review security management at institutions; and implement ICT system to track pharmaceutical management. • Develop and implement relevant policies and procedures for prevention and management of pharmaceutical stock outs. • Enforce the functionality of Board of Surveys. • Automation of Expired Medication Alerts - improve the Stock Management System. • Revise the Waste Management Policy. • Explore Use of Loss Control & Irregular Expenditure system.

9. PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

9.1 Programme Purpose

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

There are no changes to the structure of Programme 8.

Sub-Programme 8.1: Community Health Facilities

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

Sub-Programme 8.2: Emergency Medical Services

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

Sub-Programme 8.3: District Hospitals

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

Sub-Programme 8.4: Provincial (Regional) Hospital Services

Construction of new facilities and refurbishment, upgrading and maintenance of existing Provincial/ Regional Hospitals and Specialised Hospitals

Sub-Programme 8.5: Central Hospital Services

Construction of new facilities and refurbishment, upgrading and maintenance of existing Tertiary and Central Hospitals

Sub-Programme 8.6: Other Facilities

Construction of new facilities and refurbishment, upgrading and maintenance of other health facilities including forensic pathology facilities and nursing colleges and schools

9.2 Overview

During 2013/14 the Department completed 61 infrastructure projects to the total value of R 563 million. Ten new clinics were completed and commissioned in Amajuba, Harry Gwala, Umgungundlovu, Umzinyathi, and Zululand Districts.

Due to the reduction of budgets over the last few years, the Department was forced to "shelve" a number of planned projects to ensure that MTEF Plan(s) balances with allocated budget(s). There will however be a high risk for implementation processes over the next three years due to two big projects (the new Dr Pixley ka Isaka Seme Regional Hospital and the 192 bed multi-storey surgical block in the Ngwelezane Hospital) which will take at least one third of the total infrastructure budget annually. The

Department will implement vigorous project monitoring of these 2 projects to prevent over/ under expenditure through unforeseen circumstances.

The Department has developed a 10-year User Asset Management Plan (U-AMP) requesting an average annual budget of R1.9 billion over the next three years. This is based on service delivery pressures and a number of projects which have already been designed.

Accommodation

Upgrades of nurse accommodation at Charles Jonson Memorial and Christ the King Hospitals and doctor accommodation at Manguzi and Ceza Hospitals were completed which is hoped to assist in improving retention of staff in these rural areas.

Primary Health Care

Between 2009/10 to date, the Department commissioned 31 new clinics, while 12 new clinics are currently under construction. Four CHCs have been commissioned including KwaMashu (eThekwini), Turton and Gamalakhe Phase 1 (Ugu) and St Chads (Uthukela) at an average cost of R200 million per CHC. Three new CHCs are under construction namely Dannhauser (Amajuba), Pomeroy (Umzinyathi) and Jozini (Umkhanyakude) with expected completion in late 2014/15. Upgrades commenced at the Inanda and Phoenix CHCs (eThekwini) and Phase 2 construction commenced at the Gamalakhe CHC in Ugu.

Maternal, Neonatal, Child and Women's Health

To improve maternal and child health outcomes the following infrastructure projects have been completed: New maternity and paediatric wards at Untunjambili and Mosvold Hospitals; neonatal intensive care unit at Ladysmith Hospital; and Mother's Lodges at Niemeyer Memorial and Lower Umfolozi War Memorial (60 beds) Hospitals.

The following hospital projects are currently under construction: Greys (neonatal intensive care unit); Bethesda (new paediatric ward and 20-bed mother's lodge); Stanger (new labour and neonatal block); Church of Scotland (new paediatric ward); Prince Mshiyeni War Memorial (nursery); KwaMagwaza (maternity upgrade); and Emmaus (maternity and nursery).

Tuberculosis

The Department has built and upgraded a number of facilities to improve TB management and outcomes including 40-bed MDR-TB facilities at Catherine Booth and Manguzi Hospitals. A 60-bed Parkhome has been commissioned at Thulasizwe Hospital to replace the condemned buildings. The Department is completing a 97-bed TB ward at Murchison Hospital. Installation of new air conditioning for the new TB multi-storey block in King Dinuzulu Hospital (new TB complex) and the TB surgical OPD is planned for commissioning in late 2014/15. The Department continues to improve ventilation in all health facilities as part of infection prevention and control.

Forensic Pathology Services

The Greytown mortuary was commissioned. The following medico-legal mortuaries have been upgraded: Gale Street (eThekwini); Newcastle (Amajuba); Richards Bay (Uthungulu); and Port Shepstone (Ugu). The Department is in the process to commission the new Phoenix forensic mortuary (460-body storage) to a value of R92.9 million.

Emergency Medical Services

The Department built/ refurbished the Wentworth Emergency Management Centre and the base station and the KwaMashu base.

Nursing Colleges

To date, the Department has spent R46 million towards upgrading of the following Nursing Colleges: Charles Johnson Memorial, Edendale, Addington and the Greys Hospital Nursing Home.

Laundry Services

During 2013/14, the Department upgraded laundry equipment in 30 hospital on-site mini laundries, and invested R210 million on upgrading of the Prince Mshiyeni Laundry. The first line production is expected to open in August 2014 and second production line in 2015/16. This will improve service reach to 11 hospitals. Design of the Dundee Laundry is at an advanced stage.

Major Upgrades and Additions to Hospitals

The Department embarked on a process to upgrade and improve physical infrastructure of existing hospitals as part of the improved health service platform. Major projects include: Emmaus – new outpatient, casualty & related facilities (R132 237 million); GJ Crookes – casualty, trauma and admissions (R 138 000 million); Stanger – new labour and neonatal ward and upgrading of existing psychiatric ward (R 146 290 million); Rietvlei – Admin, kitchen audio, ARV and staff accommodation (R127 097 million); Edendale – OPD, accident and emergency, CDC/ARV and psychiatric ward (R178 383 million); Lower Umfolozi War Memorial – upgrade and additions (R500 743 million); and Addington – repair & upgrade core block facade, operating theatres and maintenance (R206 866 million).

Implementing Agents

The Department currently uses the following programme Implementing Agents (IA's) for health infrastructure namely the Department of Health, Department of Public Works (DoPW) and Independent Development Trust (IDT). Budgets have been allocated according to the "Nature of Investment" as defined by National Treasury (Table 110).

Table 110: Summary of Infrastructure Expenditure per Category

Total Infrastructure Project Cost per Category and Sub-Programme							
No	**Category and Sub-Programme**	**Assigned to PIA**	**MTEF Year 1**	**MTEF Year 2**	**MTEF Year 3**	**MTEF Year 4**	**MTEF Year 5**
			2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**
			R'000	**R'000**	**R'000**	**R'000**	**R'000**
Total Infrastructure Project Cost			**1 491 471**	**1 583 796**	**1 732 757**	**2 357 948**	**679 427**
1	**New Construction/ Acquisition**	**Total**	**557 356**	**730 754**	**821 709**	**1 502 493**	**51 500**
1.1		KZN DoPW	90 086	40 770	107 625	860 000	51 500
1.2		IDT	447 210	679 919	704 014	642 498	0
1.3		Health	20 060	10 065	10 070	0	0
2	**Refurbishment**	**Total**	**475 960**	**420 908**	**523 042**	**510 700**	**338 700**
2.1		KZN DoPW	388 495	285 908	415 130	405 000	270 700

Total Infrastructure Project Cost per Category and Sub-Programme							
No	**Category and Sub-Programme**	**Assigned to PIA**	**MTEF Year 1**	**MTEF Year 2**	**MTEF Year 3**	**MTEF Year 4**	**MTEF Year 5**
			2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**
			R'000	**R'000**	**R'000**	**R'000**	**R'000**
2.2		IDT	87 420	115 000	64 912	55 700	8 000
2.3		Health	45	20 000	43 000	50 000	60 000
3	**Maintenance**	**Total**	**438 155**	**412 134**	**363 006**	**314 750**	**259 227**
3.1		KZN DoPW	116 026	118 854	127 000	72 520	5 647
3.2		IDT	98 691	70 839	4 500	0	0
3.3		Health	223 438	222 441	231 506	242 230	253 580
4	**Organisation and Support**	**Total**	**20 000**	**20 000**	**25 000**	**30 000**	**30 000**
4.1		Health	20 000	20 000	25 000	30 000	30 000

The Department has allocated most of the funding to committed projects which highlighted the importance of effective management of the Implementing Agents (Table 111).

Table 111: Programme Maturity Level

No	**Category and Sub-Programme**	**Assigned to PIA**	**MTEF Year 1**	**MTEF Year 2**	**MTEF Year 3**	**MTEF Year 4**	**MTEF Year 5**
			2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**
			R'000	**R'000**	**R'000**	**R'000**	**R'000**
Total Infrastructure Project Cost			**1 491 471**	**1 583 796**	**1 732 757**	**2 357 948**	**679 427**
1	**Feasibility, Planning & Design**	**Total**	**42 386**	**222 980**	**554 325**	**1 359 700**	**354 200**
1.1		KZN DoPW	32 386	180 980	490 825	1 294 000	326 200
1.2		IDT	-	42 000	60 500	55 700	8 000
1.3		Health	10 000	-	3 000	10 000	20 000
2	**Tender**	**Total**	**46 500**	**53 970**	**2 600**	**-**	**-**
2.1		KZN DoPW	46 500	53 970	2 600	-	-
2.2		IDT	-	-	-	-	-
2.3		Health	-	-	-	-	-
3	**Construction**	**Total**	**1 298 962**	**1 298 944**	**1 175 832**	**998 248**	**325 227**
3.1		KZN DoPW	450 625	209 828	156 330	43 520	1 647
3.2		IDT	595 027	816 610	712 926	642 498	0
3.3		Health	253 310	272 506	306 576	312 230	323 580
4	**Retention**	**Total**	**103 623**	**7 902**	**-**	**-**	**-**
4.1		Health	65 096	754	-	-	-
4.2		Health	38 294	7 148	-	-	-
4.3		Health	233	-	-	-	-

Umgungundlovu and eThekwini continue to receive higher budgets based on the increasing demand as a result of fast increasing populations, population density and burden of disease (Table 112).

Table 112: Infrastructure Split per District

Total Infrastructure Cost Assignment per District						
Assigned to PIA		MTEF Year 1	MTEF Year 2	MTEF Year 3	MTEF Year 4	MTEF Year 5
		2015/16	2016/17	2017/18	2018/19	2019/20
		R'000	R'000	R'000	R'000	R'000
Total Infrastructure Cost		**1 491 471**	**1 583 796**	**1 732 757**	**2 357 948**	**679 427**
1	Amajuba	90 505	71 355	13 223	8 109	8 515
2	Ilembe	81 295	36 792	39 042	49 494	32 969
3	Harry Gwala	35 370	48 523	91 783	831 216	47 866
4	Ugu	34 039	22 549	47 485	38 785	17 623
5	Umgungundlovu	201 025	151 645	101 851	94 044	96 346
6	Umkhanyakude	30 053	59 836	55 407	59 751	21 754
7	Umzinyathi	59 952	21 929	60 258	66 021	27 322
8	Uthukela	8 846	8 239	11 651	19 083	29 537
9	Uthungulu	152 306	142 743	182 921	184 771	113 509
10	Zululand	53 740	38 212	20 255	56 109	71 915
11	eThekwini	657 840	905 473	1 032 881	902 045	207 424
12	KZN	86 500	76 500	76 000	48 520	4 647

The Department of Public Works is allocated 163 projects out of a total of 240 and IDT 28 projects. The Department of Health currently performs Institutional Maintenance through District Offices and Institutions. In terms of IDT, most of the budget is allocated for the construction of Dr Pixley ka Isaka Seme as the Department is phasing out the allocation of projects to IDT in line with the Provincial IDMS Framework (Table 113).

Table 113: Allocation per Implementing Agent

Total Infrastructure Cost Assignment per Organisation						
Assigned to PIA		MTEF Year 1	MTEF Year 2	MTEF Year 3	MTEF Year 4	MTEF Year 5
		2015/16	2016/17	2017/18	2018/19	2019/20
		R'000	R'000	R'000	R'000	R'000
Total Infrastructure Cost		**1 491 471**	**1 583 796**	**1 732 757**	**2 357 948**	**679 427**
1	DoPW	594 607	445 532	649 755	1 337 520	327 847
2	IDT	633 321	865 758	773 426	698 198	8 000
3	Health	263 543	272 506	309 576	322 230	343 580

9.3 2015/16 Priorities

1. Specialised TB Hospitals (including previous SANTA Hospitals); decentralised MDR-TB units; ventilation improvement projects (in all health facilities) to improve infection prevention and control.
   - New Master Plan for St Margaret Hospital: New MDR wards within existing premises; installation of new autoclaves and plans for upgrading of the sewer infrastructure commenced.
   - Hlengisizwe CHC: Provision of ARV-TB park homes.
   - Ndwedwe CHC: Construction of new HAST Unit/ TB Clinic and upgrade of the water and sewer system.
   - Osindisweni Hospital: Replacement of the old TB ward.
2. Accelerate provision of new clinical buildings and infrastructure.
   - Deliver new clinical Infrastructure as per approved U-AMP and Infrastructure Programme Management Plan (IPMP) in line with approved Infrastructure budget.
3. Upgrade and maintain existing infrastructure.
   - Upgrade and maintain existing infrastructure as per approved U-AMP, IPMP, and District Maintenance Plans in line with approved Infrastructure budget.
4. Effective Real Estate services and Property Management.
   - Hiring and letting of properties as well as acquisition of properties including vacant land required in accordance with the Strategic Plan.
5. Develop and implement a maintenance management system.
6. Filling of identified funded posts (Technical posts).

Note: See Part C for details of the Infrastructure Project Plan

9.4 Strategic Objectives, Indicators and Targets

Table 114: Strategic Plan 2015-2019 Targets

Strategic Goal	Strategic Objective	Strategic Objective Statement	Indicator	Target 2019/20
Strategic Goal 1: Strengthen health system effectiveness	3.2) Create job opportunities	3.2.1) Create 11 800 jobs through the Expanded Public Works Programme by March 2020 (cumulative)	Number of jobs created through the EPWP	11 800
	3.3) Improve health facility planning and infrastructure delivery	3.3.1) Commission 28 new projects by March 2020	Number of new clinical projects with completed construction	8
Strategic Goal 3: Universal health coverage			Number of new clinical projects where commissioning is complete	28
		3,3.2) Complete 35 upgrading & renovation projects by March 2018	Number of upgrading and renovation projects with completed construction	35

Table 115: (HFM2) Programme Performance Indicators

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 3.3: Improved health facility planning and infrastructure delivery										
3.3.5) Major and minor refurbishment completed at 37 health facilities by March 2018	1. Number of health facilities that have undergone major and minor refurbishment	IRM,PMIS and monthly reports	Annual/ No	New indicator	New indicator	New indicator	56	21	8	8
3.3.6) Annual SLA signed with the Department of Public Works to accelerate infrastructure delivery	2. Establish service level agreements (SLAs) with Departments of Public Works (and any other implementing agents)	SLA's	Annual/ No	New indicator	New indicator	New indicator	1	1	1	1

Table 116: (HFM1) Provincial Strategic Objectives and Targets - HFM

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 3.2: Create job opportunities										
3.2.1) Create 11 800 jobs through the Expanded Public Works Programme (EPWP) by March 2020 (cumulative)	1. Number of jobs created through the EPWP	IRS and EPWP Quarterly reports	Quarterly/ No	1 300	2 485	3398	2200	2 000	2 300	2400
Strategic Objective 3.3: Improved health facility planning and infrastructure delivery										
3.3.1) Commission 28 new projects by March 2020	2. Number of new clinical projects with completed construction	IRM, PMIS and monthly reports	Quarterly/ No	6	6	11	10	*8*	*0*	*0*
	3. Number of new clinical projects where commissioning is complete	IRM, PMIS and monthly reports	Quarterly/ No	24	6	6	14	*10*	*8*	*0*
3,3.2) Complete 35 upgrading & renovation projects by March 2018	4. Number of upgrading and renovation projects with completed construction	IRM, PMIS and monthly reports	Quarterly/ No	13	38	67	56	21	8	6
3.3.3) 100% of maintenance budget spent annually	*5.* Percentage of maintenance budget spent	IRM, PMIS and monthly reports	Quarterly/ %	54%	14%	100%	100% [87]	100%	100%	100%
	Maintenance budget spent	*BAS*	*R*	-	-	-	-	-	-	-
	Maintenance budget	*BAS*	*R*	-	-	-	-	-	-	-
3.3.4) Health Facilities Revitalisation Grant 85% of total annual budget by March 2018	6. Health Facilities Revitalisation Grant expenditure as percentage of total annual budget	IRM, PMIS and monthly reports	Quarterly/ %	33%	27%	100%	80%	83%	85%	85%

[87] Indicators 5 and 6: Expenditure data could not be obtained from the Infrastructure Programme before finalisation of the APP

Strategic Objective Statement	Performance Indicator	Data Source	Frequency/ Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	Hospital revitalisation expenditure	*BAS*	*R*	*624 099*	*652 041*	*-*	*1 362 469*	*1 090 432*	*1 239 974*	*1 239 974*
	Infrastructure budget	*BAS*	*R*	*1 894 999*	*2 373 597*	*-*	*-*	*1 287 471*	*287 802*	*-*

9.5 2015/16 Targets

Table 117: (HFM3) Quarterly and Annual Targets

Indicators	Targets 2015/16	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Number of jobs created through the EPWP	2 200	550	1100	1650	2200
2. Number of new clinical projects with completed construction	8	1	3	6	8
3. Number of new clinical projects where commissioning is complete	14	0	1	5	14
4. Number of upgrading and renovation projects with completed construction	21	2	6	12	21
5. Percentage of maintenance budget spent	100%	25%	50%	75%	100%
6. Health facilities Revitalisation Grant expenditure as percentage of total annual budget	83%	21%	42%	62%	83%
Annual Targets					
7. Number of health facilities that have undergone major and minor refurbishment	21				21
8. Establish service level agreements (SLAs) with Departments of Public Works (and any other implementing agent)	1				1

9.6 Reconciling Performance Targets with Expenditure Trends

Table 118: (HFM4 a) Expenditure Estimates

Sub-Programme R'000	Audited outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term expenditure estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Community Health Facilities	426 102	562 070	523 719	266 614	307 486	403 524	200 842	79 226	105 229
District Hospitals	720 786	651 614	588 488	461 884	540 694	526 685	159 266	165 428	165 508
EMS	3 285	5 377	1 328	1 737	694	-	2 381	2 413	27 413
Provincial Hospitals	531 961	812 898	600 958	607 395	539 311	522 422	941 445	918 712	967 110
Central Hospitals	4 720	28 598	24 396	12 230	18 362	15 149	11 897	11 235	11 234
Other facilities	208 145	313 041	261 917	129 497	274 000	212 767	235 521	222 207	193 187
Total	**1 894 999**	**2 373 597**	**2 000 806**	**1 479 357**	**1 680 547**	**1 680 547**	**1 551 352**	**1 399 221**	**1 469 681**

Table 119: (HFM4 b) Summary of Provincial Expenditure Estimates by Economic Classification

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Current payments	**522 372**	**463 510**	**349 449**	**169 774**	**328 279**	**377 450**	**405 904**	**374 441**	**329 006**
Compensation of employees	12 736	21 998	24 048	7 581	25 089	24 400	37 000	37 000	42 000
Goods and services	**509 636**	**441 511**	**325 401**	**162 193**	**303 190**	**353 050**	**368 904**	**337 441**	**287 006**
Communication	9	16	22	-	4	4	-	-	-
Computer Services	19 409	6 123	2 742	-	-	-	-	-	-
Consultants, Contractors and special services	53 260	79 173	87 239	24 915	99 666	105 694	137 664	114 773	87 358
Inventory	5 630	20 280	32 648	118	27 366	39 174	36 030	38 537	30 537

Economic Classification R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Operating leases	533	68 633	61 524	69 997	69 997	75 281	66 000	51 606	66 000
Travel and subsistence	-	358	242	-	-	138	-	-	-
Interest and rent on land	-	-	-	-	-	-	-	-	-
Maintenance, repair and running costs	-	-	-	-	-	-	-	-	-
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	430 795	266 929	140 984	67 163	106 157	132 759	129 210	132 525	103 111
Transfers and subsidies to	**10 783**	**20 000**	**20 022**	**-**	**14**	**36**	**-**	**-**	**-**
Provinces and municipalities	-	-	-	-	-	-	-	-	-
Departmental agencies and accounts	-	-	-	-	-	-	-	-	-
Higher Education institutions	-	-	-	-	-	-	-	-	-
Foreign governments and international organisations	-	-	-	-	-	-	-	-	-
Non-profit institutions	10 000	20 000	20 000	-	-	-	-	-	-
Households	783	-	22	-	14	36	-	-	-
Payments for capital assets	**1 361 844**	**1 890 088**	**1 631 335**	**1 309 583**	**1 352 254**	**1 303 061**	**1 145 448**	**1 024 780**	**1 140 675**
Machinery and equipment	287 217	227 152	100 442	59 810	82 399	83 386	1 789	10 000	10 000
Buildings and other fixed structures	1 048 172	1 662 936	1 530 893	1 249 773	1 269 855	1 219 675	1 143 659	1 014 780	1 130 675
Land and sub-soil assets	26 455	-	-	-	-	-	-	-	-
Software and other tangible assets	-	-	-	-	-	-	-	-	-
Payment for financial assets	-	-	-	-	-	-	-	-	-
Total economic classification	**1 894 999**	**2 373 597**	**2 000 806**	**1 479 357**	**1 680 547**	**1 680 547**	**1 551 352**	**1 399 221**	**1 469 681**
Unauthorised expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	**1 894 999**	**2 373 597**	**2 000 806**	**1 479 357**	**1 680 547**	**1 680 547**	**1 551 352**	**1 399 221**	**1 469 681**

9.7 Performance and Expenditure Trends

The declining trend in the two outer years of the 2015/16 MTEF (and 2016/17 in particular) in all sub-programmes and in *Buildings and other fixed structures*, as well as *Machinery and Equipment* relates to the decrease to zero of the Health Facility Revitalisation Grant in 2016/17.

The increase in *Compensation of Employees* from 2011/12 to 2014/15 is due to the implementation of the EPWP Integrated Grant for Provinces, which utilises local people to maintain grounds and clean buildings. The decrease from 2015/16 onward is due to the low level of funding from the Grant in 2015/16.

In 2014/15 the original allocation for *Goods and Services* was not sufficient to cover the Department's maintenance requirements hence an increase in the 2014/15 Adjusted Appropriation. The level of funding for maintenance decreases over the 2015/16 MTEF due to census-based base line budget cuts initiated in 2013/14, as well as the reduction to zero of the Health Facility Revitalisation Grant.

The Department transferred R10 million to Non-Profit Institutions in 2011/12 and R20 million in 2012/13, with a final transfer of R20 million in 2013/14 to the KZN Children's Hospital Trust for the development and refurbishment of the KZN Children's Hospital in the eThekwini Metro.

In the 2014/15 Adjusted Appropriation, R1.190 million was allocated to *Buildings and other fixed* structures within Programme 8 for various infrastructure changes that need to be made at the McCord Hospital to convert it to a Specialist Eye Hospital and R200 million was allocated to *Buildings and other fixed structures* for infrastructure pressures in the Health Revitalisation Grant.

9.8 Risk Management

Table 120: Risk Management

Potential Risks	Mitigating Strategies
1. Level of competency of service providers resulting in inferior work and delays in completion of projects with consequent increase in cost. *(High Risk)*	• Close monitoring of the appointed Service Providers and enforcement of penalties in cases of default.
2. Lack of capacity within the Implementing Agents (IA's) to deliver on infrastructure projects resulting in inability to complete projects on time. *(High Risk)*	• Close monitoring of the appointed IA's and enforcement of penalties in cases of default.
3. Lack of maintenance management systems. *(High Risk)*	• Develop and implement a maintenance management system.
4. Limited financial resources to meet the increasing infrastructure needs/ demands. *(High Risk)*	• Put construction of new facilities on hold with more emphasis on maintenance.
5. Shortages of technical skilled staff. *(High Risk)*	• Filling of all identified funded technical posts.

PART C: LINKS TO OTHER PLANS

- Long Term Infrastructure & Other Capital Plans
- Conditional Grants
- Public Entities
- Public Private Partnerships
- Conclusions

10. INFRASTRUCTURE PLAN

Table 121: Infrastructure Project List

No.	Project name	Type project details	Project status	Implementing Agent Name	District Municipality Name	Primary Source of funding	Total project Cost (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)
	Total						**R 9 527 595**	**R 1 491 471**	**R 1 583 796**	**R 1 732 757**
MAINTENANCE PROJECTS										
1	Acquisition of Land and Buildings	Real Estates - Acquisition of properties	Construction 1% - 25%	KZN-DoPW	KZN Province	Equitable Share	R 10 000	R 3 500	R 3 500	R 3 000
2	Addington Hospital	Upgrade / replace 5 Otis Lifts, 2 Kone Lifts and 7 Schindler Lifts	Construction 1% - 25%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 13 000	R 12 500	R 400	-
3	Addington Hospital	Replacement of 3 x Autoclaves	Retention	Health	eThekwini Metro	Equitable Share	R 986	R 24	-	-
4	Addington Hospital	Phase 3: Replacement of 1 x Autoclave	Retention	Health	eThekwini Metro	Equitable Share	R 350	R 9	-	-
5	Charles Johnson Memorial Hospital	Phase 3: Replacement of 1 x Autoclave	Retention	Health	Umzinyathi	Equitable Share	R 350	R 9	-	-
6	Charles Johnson Memorial Hospital	Upgrade / replace 2 Schindler Lifts	Retention	KZN-DoPW	Umzinyathi	Health Facility Revitalisation Grant	R 1 750	R 44	-	-
7	Church of Scotland Hospital	Phase 3: Replacement of 1 x Autoclave	Retention	Health	Umzinyathi	Equitable Share	R 350	R 9	-	-
8	Church of Scotland Hospital	Replacement of the Theatre and CSSD Chiller	Retention	KZN-DoPW	Umzinyathi	Health Facility Revitalisation Grant	R 1 000	R 100	-	-
9	E.G & Usher Memorial Hospital	Replacement of 2 x Autoclaves	Retention	Health	Harry Gwala	Equitable Share	R 658	R 16	-	-
10	Edumbe CHC	Replacement of 1 x Autoclave	Retention	Health	Zululand	Equitable Share	R 373	R 9	-	-
11	EPWP: Maintenance of Gardens/Grounds	EPWP Maintenance of Gardens and Grounds for Health Facilities (Co-Funded under Other/ Equitable Share)	Construction 1% - 25%	Health	Umgungundlovu	Equitable Share	R 64 000	R 17 000	R 17 000	R 17 000
12	Eshowe Hospital	Upgrade / Replace 4 Otis Lifts	Construction 1% - 25%	KZN-DoPW	Uthungulu	Health Facility Revitalisation Grant	R 5 000	R 4 850	R 150	-
13	Eshowe Hospital	Phase 3: Replacement of 1 x Autoclave	Retention	Health	Uthungulu	Equitable Share	R 350	R 9	-	-

No.	Project name	Type project details	Project status	Implementing Agent Name	District Municipality Name	Primary Source of funding	Total project Cost (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)
14	Feasibility Investigations	Feasibility Investigations, Multi Year Plans	Feasibility	KZN-DoPW	Umgungundlovu	Equitable Share	R 3 000	R 1 000	R 1 000	R 1 000
15	Food Services	Repair 56 and Replace 34 Cold Rooms (31 Institutions)	Feasibility	KZN-DoPW	KZN Province	Equitable Share	R 30 000	R 1 000	R 3 000	R 3 000
16	Food Services	Repair 19 and Replace 24 Freezers (17 Institutions)	Feasibility	KZN-DoPW	KZN Province	Equitable Share	R 7 000	R 1 000	R 2 000	R 2 000
17	Food Services	Replace 13 Stainless Steel Shelving for Cold Rooms and Freezers (10 Institutions)	Feasibility	KZN-DoPW	KZN Province	Equitable Share	R 1 000	R 1 000	-	-
18	Food Services	Replace 15 Stainless Steel for Dry Storerooms (10 Institutions)	Feasibility	KZN-DoPW	KZN Province	Equitable Share	R 1 000	R 1 000	-	-
19	Greys Hospital	Replacement of 11 lifts in the DQ and at Nurses Residents	Retention	KZN-DoPW	Umgungundlovu	Equitable Share	R 7 654	R 667	-	-
21	Greytown Hospital	Replacement of the Theatre and CSSD Chiller	Retention	KZN-DoPW	Umzinyathi	Health Facility Revitalisation Grant	R 1 000	R 100	-	-
22	Highway House : Mayville	Upgrading of A/C (Replacement of Cenral plant compressors)	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 7 500	R 7 320	R 104	-
23	Institutional Maintenance: Amajuba District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Amajuba	Health Facility Revitalisation Grant	R 77 710	R 2 810	R 2 950	R 3 098
24	Institutional Maintenance: Amajuba District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Amajuba	Equitable Share	R 52 894	R 4 325	R 4 405	R 4 625
25	Institutional Maintenance: eThekwini District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	eThekwini Metro	Health Facility Revitalisation Grant	R 280 756	R 19 511	R 20 426	R 21 447
26	Institutional Maintenance: eThekwini District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	eThekwini Metro	Equitable Share	R 345 642	R 26 979	R 28 196	R 29 550
27	Institutional Maintenance: Harry Gwala District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Harry Gwala	Health Facility Revitalisation Grant	R 194 146	R 4 561	R 4 789	R 5 029
28	Institutional Maintenance: Harry Gwala District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Harry Gwala	Equitable Share	R 64 499	R 5 128	R 5 384	R 5 654

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29	Institutional Maintenance: Head Office District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Umgungundlovu	Equitable Share	R 56 041	R 1 970	R 2 068	R 1 786
30	Institutional Maintenance: Head Office District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Umgungundlovu	Equitable Share	R 32 675	R 3 100	R 3 255	R 2 756
31	Institutional Maintenance: Ilembe District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Ilembe	Health Facility Revitalisation Grant	R 69 989	R 3 356	R 3 524	R 3 700
32	Institutional Maintenance: Ilembe District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Ilembe	Equitable Share	R 60 960	R 4 855	R 5 098	R 5 342
33	Institutional Maintenance: Ugu District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Ugu	Health Facility Revitalisation Grant	R 146 003	R 6 368	R 6 627	R 6 949
34	Institutional Maintenance: Ugu District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Ugu	Equitable Share	R 103 211	R 8 266	R 8 658	R 9 036
35	Institutional Maintenance: Umgungundlovu District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Umgungundlovu	Health Facility Revitalisation Grant	R 256 276	R 11 010	R 11 560	R 11 874
36	Institutional Maintenance: Umgungundlovu District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Umgungundlovu	Equitable Share	R 314 110	R 25 428	R 26 699	R 27 435
37	Institutional Maintenance: Umkhanyakude District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Umkhanyakude	Health Facility Revitalisation Grant	R 125 597	R 6 306	R 6 621	R 6 952
38	Institutional Maintenance: Umkhanyakude District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Umkhanyakude	Equitable Share	R 73 395	R 5 852	R 6 145	R 6 430
39	Institutional Maintenance: Umzinyathi District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Umzinyathi	Health Facility Revitalisation Grant	R 132 711	R 7 536	R 7 913	R 9 078

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40	Institutional Maintenance: Umzinyathi District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Umzinyathi	Equitable Share	R 70 337	R 5 628	R 5 699	R 6 180
41	Institutional Maintenance: uThukela District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Uthukela	Health Facility Revitalisation Grant	R 87 853	R 3 217	R 3 378	R 3 547
42	Institutional Maintenance: uThukela District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Uthukela	Equitable Share	R 58 227	R 4 629	R 4 861	R 5 104
43	Institutional Maintenance: Uthungulu District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Uthungulu	Health Facility Revitalisation Grant	R 118 584	R 9 428	R 9 899	R 10 394
44	Institutional Maintenance: Uthungulu District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Uthungulu	Equitable Share	R 150 769	R 12 071	R 12 674	R 13 197
45	Institutional Maintenance: Zululand District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Zululand	Equitable Share	R 81 077	R 6 446	R 6 768	R 7 107
46	Institutional Maintenance: Zululand District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Zululand	Equitable Share	R 93 957	R 7 470	R 7 844	R 8 236
47	King Edward VIII Hospital	Replacement of 1 x Autoclave	Retention	Health	eThekwini Metro	Equitable Share	R 350	R 9	-	-
48	Madadeni Hospital	Replacement of Boiler	Retention	KZN-DoPW	Amajuba	Health Facility Revitalisation Grant	R 9 800	R 100	-	-
49	Madadeni Hospital	Condition Assessment Maintenance	Construction 1% - 25%	IDT	Amajuba	Health Facility Revitalisation Grant	R 85 000	R 35 191	R 34 000	R 2 500
50	Mahatma Ghandhi Hospital	Replacement of 2 x Autoclaves	Retention	Health	eThekwini Metro	Equitable Share	R 704	R 18	-	-
51	Mbongolwane Hospital	Phase 3: Replacement of 1 x Autoclave	Retention	Health	Uthungulu	Equitable Share	R 350	R 8	-	-
52	Mosvold Hospital	Phase 3: Replacement of 1 x Autoclave	Retention	Health	Umkhanyakude	Equitable Share	R 350	R 9	-	-
53	Newcastle Hospital	Upgrade 7 lifts	Retention	KZN-DoPW	Amajuba	Equitable Share	R 6 818	R 170	-	-

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54	Newcastle Hospital	Replacement of 1 x Autoclave	Retention	Health	Amajuba	Equitable Share	R 353	R 9	-	-
55	Newcastle Hospital	Condition Assessment Maintenance	Construction 1% - 25%	IDT	Amajuba	Health Facility Revitalisation Grant	R 72 000	R 43 500	R 30 000	R 2 000
56	Northdale Hospital	Upgrade / Replace 4 Otis Lifts	Construction 1% - 25%	KZN-DoPW	Umgungundlovu	Health Facility Revitalisation Grant	R 4 000	R 3 900	R 100	-
57	Nseleni CHC	Replacement of 1 x Autoclave	Retention	Health	Uthungulu	Equitable Share	R 348	R 9	-	-
58	Office and residential Accommodation lease agreements	Manage 168 Lease Agreements For KZN - Health(Office and Residential Accommodation)	Construction 1% - 25%	KZN-DoPW	KZN Province	Health Facility Revitalisation Grant	R 332 033	R 66 000	R 66 000	R 66 000
59	PHC Clinics Planning	Grant budget for training	Feasibility	Health	KZN Province	Health Facility Revitalisation Grant	R 10 000	R 10 000	-	-
60	Phoenix Assessment Centre	Install 1 x 100 KVA with new unit	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 500	R 125	-	-
61	Port Shepstone Hospital	Replacement of 2 x Autoclaves	Retention	Health	Ugu	Equitable Share	R 618	R 15	-	-
62	R K Khan Hospital	Upgrading of 4 lifts: Nurses Home	Construction 1% - 25%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 2 000	R 1 500	R 500	-
63	Radio Repeater Site	Radio Repeater high sites throughout KZN: Maintenance and Licence Fees	Construction 1% - 25%	KZN-DoPW	KZN Province	Equitable Share	R 6 000	R 2 000	R 2 000	R 2 000
64	St Aidens Hospital	Replacement of 1 x Autoclave	Retention	Health	eThekwini Metro	Equitable Share	R 370	R 9	-	-
65	St Apollinaris Hospital	Replacement of 1 x Autoclave	Retention	Health	Harry Gwala	Equitable Share	R 353	R 9	-	-
66	St. Margaret's hospital	Replacement of 1 x Autoclave	Retention	Health	Harry Gwala	Equitable Share	R 342	R 8	-	-
67	Stanger Hospital	Replacement of 3 Chiller for the entire Hospital (Theatre/ Wards Chillers)	Retention	KZN-DoPW	Ilembe	Health Facility Revitalisation Grant	R 2 200	R 50	-	-
68	Stanger Hospital	Upgrade / replace 1 Otis Lifts and 1 Hoist	Construction 1% - 25%	KZN-DoPW	Ilembe	Health Facility Revitalisation Grant	R 2 200	R 2 150	R 50	-
69	Vryheid Hospital	Upgrade / replace 2 Otis Lifts	Construction 1% - 25%	KZN-DoPW	Zululand	Health Facility Revitalisation Grant	R 2 000	R 1 950	R 50	-

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REFURBISHMENT PROJECTS										
70	Addington Hospital	Replace and install 1 x 500kVA with larger unit	Construction 1% - 25%	KZN-DoPW	eThekwini Metro	Equitable Share	R 1 500	R 1 450	R 50	-
71	Addington Hospital	Upgrade 3rd Floor Theatres	Retention	IDT	eThekwini Metro	Health Facility Revitalisation Grant	R 30 000	R 350	-	-
73	Appelsbosch Hospital	New Staff Accommodation U.T.B Additions And Alterations to Staff & Nurses Accommodation	Retention	KZN-DoPW	Umgungundlovu	Health Facility Revitalisation Grant	R 17 495	R 610	-	-
74	Appelsbosch Hospital	Erect Lockable Garaging for 20 Vehicles	Retention	KZN-DoPW	Umgungundlovu	Equitable Share	R 2 058	R 110	-	-
75	Appelsbosch Hospital	Replace and install 1 x 300kVA with larger unit	Construction 1% - 25%	KZN-DoPW	Umgungundlovu	Health Facility Revitalisation Grant	R 1 000	R 975	R 25	-
76	Benedictine Hospital (Nursing College)	Student Nurses Accommodation (40 beds), Phase 1	Construction 1% - 25%	IDT	Zululand	Health Facility Revitalisation Grant	R 38 446	R 15 000	R 22 000	R 412
77	Bethesda Hospital	Demolish existing Nurses Units, Relocate Water Chlorifying Room & Extraction Room and Built New Paeds Ward and 20 Mother lodge ward	Retention	KZN-DoPW	Umkhanyakude	Health Facility Revitalisation Grant	R 25 004	R 1 131	-	-
78	Bruntville CHC	Construct sheltered walkways, Install ramps and waiting shelter. Extend pharmacy	Tender	KZN-DoPW	Umgungundlovu	Equitable Share	R 5 000	R 300	R 4 570	-
79	Catherine Booth Hospital	Demolish existing wards and Rebuild new Wards - 105 beds	Design	KZN-DoPW	Uthungulu	Equitable Share	R 95 000	-	R 10 000	R 40 000
80	Catherine Booth Hospital	Replace and Install 1 x 200kVA with larger unit	Construction 1% - 25%	KZN-DoPW	Uthungulu	Health Facility Revitalisation Grant	R 800	R 780	-	-
81	Catherine Booth Hospital	New water storage tank and Replacement of galvanised pipes.	Retention	KZN-DoPW	Uthungulu	Equitable Share	R 5 840	R 200	-	-
82	Ceza Hospital	New female & male ward and Replacement of burnt house	Feasibility	KZN-DoPW	Zululand	Equitable Share	R 50 000	-	-	R 2 500
83	Charles Johnson Memorial Hospital	Replace and Install 1 x 500kVA with larger unit	Construction 1% - 25%	KZN-DoPW	Umzinyathi	Health Facility Revitalisation Grant	R 1 500	R 1 450	R 500	-

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84	Charles Johnson Memorial Hospital (Nursing Colleges)	New staff Accommodation for 40 staff (incl. Comm serve Doctors)	Design	IDT	Umzinyathi	Equitable Share	R 60 000	-	R 2 000	R 20 000
85	Church Of Scotland Hospital	Replace Paediatric Ward with Male and Female TB Ward	Construction 76% - 99%	KZN-DoPW	Umzinyathi	Health Facility Revitalisation Grant	R 56 110	R 2 500	R 1 500	-
86	Church Of Scotland Hospital	Install 1 x 200 KVA and 1x300 KVA with larger units	Retention	KZN-DoPW	Umzinyathi	Health Facility Revitalisation Grant	R 2 000	R 500	-	-
87	Clairwood Hospital	Repairs and Renovations to FM1 and FM2 for TB	Design	KZN-DoPW	eThekwini Metro	Equitable Share	R 22 000	-	R 2 000	R 13 000
88	Dunstan Farrell Hospital	Install 1 x 100 KVA with larger units	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 850	R 213	-	-
89	E.G & Usher Memorial Hospital	Replace and Install 1 x 500kVA with larger unit	Retention	KZN-DoPW	Harry Gwala	Health Facility Revitalisation Grant	R 1 500	R 1 450	R 50	-
90	Edendale Hospital	Implementation of a new CDC Clinic and ARV facility	Retention	KZN-DoPW	Umgungundlovu	Health Facility Revitalisation Grant	R 58 106	R 700	-	-
91	Edendale Hospital	Upgrade existing Accident & Emergency Unit and OPD	Construction 76% - 99%	KZN-DoPW	Umgungundlovu	Health Facility Revitalisation Grant	R 74 750	R 6 000	R 1 868	-
92	Edendale Hospital	Convert steam reticulation to electrical reticulation	Construction 76% - 99%	KZN-DoPW	Umgungundlovu	Health Facility Revitalisation Grant	R 21 180	R 4 000	-	-
93	Edendale Nursing College	Extensive Renovations and Additions to existing building	Retention	KZN-DoPW	Umgungundlovu	Health Facility Revitalisation Grant	R 48 963	R 700	-	-
94	Ekhombe Hospital	Complete Repairs and Renovations to Kitchen; Complete Repairs and Renovations to Doctors Flats; Complete Upgrades and Additions to Male and Female Wards; Replace existing CSSD and Theatre with new facility	Design	IDT	Uthungulu	Equitable Share	R 53 810	-	-	R 500
95	Ekhombe Hospital	New staff Accommodation for 38 staff (Nursing staff and Medical officers) and 3x3 bedroom Doctors house	Retention	IDT	Uthungulu	Equitable Share	R 17 729	R 443	-	-
96	Ekuhlengeni Life Care Centre	Complete Renovations of the Hospital	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 42 150	R 1 000	-	-
97	Ekuphumuleni Clinic	Upgrade and Additions (MOU) & minor Repairs to Kitchen roofs and ablutions	Feasibility	KZN-DoPW	Uthungulu	Equitable Share	R 8 000	R 1 000	R 3 000	R 4 000

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98	Emmaus Hospital	New OPD, Casualty/Trauma Unit, X-Ray and related facilities	Retention	KZN-DoPW	Uthukela	Health Facility Revitalisation Grant	R 132 236	R 1 000	-	-
99	Eshowe Hospital	Upgrade Maternity complex , Medical gas & Nursery	Feasibility	KZN-DoPW	uThungulu	Equitable Share	R 25 000	-	R 2 000	R 3 000
100	Eshowe Hospital	Construction of new roof for all Hospital buildings	Retention	KZN-DoPW	uThungulu	Health Facility Revitalisation Grant	R 11 400	R 285	-	-
101	Ex-Old Boys Model School - Offices	Conversion of existing building to new SCM offices	Construction 1% - 25%	KZN-DoPW	Umgungundlovu	Health Facility Revitalisation Grant	R 48 806	R 18 000	R 2 500	-
102	Food Services	Replace Flooring for Cold Rooms (5 Hospitals)	Feasibility	KZN-DoPW	KZN Province	Equitable Share	R 1 000	R 1 000	-	-
103	Fort Napier Hospital	Renovations to Peter De Vos Building Nurses Residence, Ward 3, Forensic Ward, Dining room, Jabula Ward and Laundry	Retention	IDT	Umgungundlovu	Equitable Share	R 17 188	R 375	-	-
104	G J Crookes Hospital	Construction of Redesigned access and traffic handling facility	Design	KZN-DoPW	Ugu	Equitable Share	R 20 000	-	-	R 5 000
105	G J Crookes Hospital	Phase 2-4 Casualty, Trauma, Admissions (Completion Contract)	Retention	KZN-DoPW	Ugu	Health Facility Revitalisation Grant	R 138 000	R 3 500	-	-
106	G J Crookes Hospital	Upgrade the roof and plumbing in maternity ward	Feasibility	KZN-DoPW	Ugu	Equitable Share	R 15 000	R 10 786	R 3 214	R 1 000
107	Gale Street Mortuary	Reconfigure 2nd floor to a new Forensic Pathology Lab for National Health	Construction 1% - 25%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 9 900	R 4 559	R 245	-
108	Gamalakhe CHC	Phase 2- HAST (including ARV) Unit, Admin, Child Health, CSSD, Special Clinics, Lab & Stores	Retention	KZN-DoPW	Ugu	Health Facility Revitalisation Grant	R 36 000	R 900	-	-
109	Greys Hospital	Conversion of M2 Ward into New NICU Facilities	Retention	KZN-DoPW	Umgungundlovu	Health Facility Revitalisation Grant	R 9 688	R 230	-	-
110	Greytown Hospital	Replace and Install 1 x 300kVA with larger unit	Construction 1% - 25%	KZN-DoPW	Umzinyathi	Health Facility Revitalisation Grant	R 1 000	R 975	R 25	-
111	Greytown TB Hospital	Replace and Install 1 x 50kVA with larger unit	Retention	KZN-DoPW	Umzinyathi	Health Facility Revitalisation Grant	R 250	R 6	-	-
112	Hillcrest Hospital	Replace and Install 1 x 200kVA with larger unit	Construction 1% - 25%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 750	R 730	R 20	-
113	Hlabisa Hospital	Replace and Install 1 x 500kVA with larger unit	Construction 1% - 25%	KZN-DoPW	Umkhanyakude	Health Facility Revitalisation Grant	R 1 500	R 1 450	R 50	-

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114	Hlabisa Hospital	Upgrade Pharmacy, OPD	Design	IDT	Umkhanyakude	Health Facility Revitalisation Grant	R 120 000	-	R 40 000	R 40 000
115	Hlengisizwe CHC	Provision of ARV-TB and MMC Parkhomes	Retention	Health	eThekwini Metro	Equitable Share	R 7 000	R 45	-	-
116	IDMS Posts	Programme Management	Construction 1% - 25%	Health	Umgungundlovu	Health Facility Revitalisation Grant	R 44 430	R 20 000	R 20 000	R 25 000
117	Imbalenhle CHC	Install 1 x 200 KVA with larger units	Retention	KZN-DoPW	Umgungundlovu	Health Facility Revitalisation Grant	R 950	R 238	-	-
118	Inanda C Clinic	Additions and Alterations to Administration block (and multi-year plan)	Retention	KZN-DoPW	eThekwini Metro	Equitable Share	R 27 210	R 2 121	R 600	-
119	Isithebe Clinic	Construction of Nurses Residents	Retention	KZN-DoPW	Ilembe	Equitable Share	R 18 700	R 900	-	-
120	Kilman Clinic	Security, General R & R To Clinic & Residences, Liliput Syst (Completion of Contract)	Retention	KZN-DoPW	Harry Gwala	Equitable Share	R 861	R 88	-	-
121	King Dinuzulu Hospital	Additional work to Level 1 Hospital	Construction 76% - 99%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 8 630	R 1 917	R 215	-
122	King Dinuzulu Hospital	New Psychiatric closed unit (Previously known as alterations and additions)	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 12 847	R 300	-	-
123	King Dinuzulu Hospital	TB Surgical Outpatients	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 32 322	R 800	-	-
124	King Dinuzulu Hospital	Initial Planning: Disbursement for resident personnel and other related costs	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 26 745	R 983	-	-
125	King Dinuzulu Hospital	New Aircon to TB Multi storey	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 23 012	R 893	-	-
126	King Dinuzulu Hospital	New Psychiatric Hospital Phase 2, Upgrade to existing water reservoir, new covered walkway, Helistop and Taxi Stop	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 68 544	R 1 730	-	-
127	King Dinuzulu Hospital	Provide roofs to TB Surgical wards, walkways and ramps, and Reconfigure used building to EMS Base	Design	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 13 000	-	R 7 000	R 1 000
128	King Dinuzulu Hospital	New TB complex	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 78 054	R 1 693	-	-
129	King Dinuzulu Hospital	Renovate staff accommodation	Feasibility	KZN-DoPW	eThekwini Metro	Equitable Share	R 80 000	R 2 000	R 30 000	R 46 000

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130	King Edward VIII Hospital	Unblocking and Repair of stormwater pipes (to include sub drainage)	Design	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 35 000	-	R 15 000	R 15 000
131	King Edward VIII Hospital	Health Technology Equipment	Retention	IDT	eThekwini Metro	Health Facility Revitalisation Grant	R 30 644	R 2 000	-	-
132	King Edward VIII Hospital	Repairs and Renovations to MOPD and Upgrade to Theatres, ICU, Nursery and High Care wards in Block 'S'	Design	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 248 000	-	R 20 341	R 80 000
133	King Edward VIII Hospital	Repairs and Renovations to Family Clinic, Male and Female Psychiatric patients wards and Kitchens in Theatre Block and Conversion of N Theatre Block Offices	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 37 407	R 935	-	-
134	King Edward VIII Hospital	Staff Residence Renovation Phase 2	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 73 211	R 1 830	-	-
135	Kwamagwaza Hospital (St Mary's)	Additions & Redesign to maternity	Retention	KZN-DoPW	Uthungulu	Health Facility Revitalisation Grant	R 9 400	R 350	-	-
136	KwaMagwaza Hospital (St Mary's)	Upgrade Kitchen Floor, Waterproofing Roof	Design	KZN-DoPW	Uthungulu	Equitable Share	R 4 000	-	-	R 500
137	KwaMashu CHC	Provision of new Kitchen and Tuckshop	Feasibility	KZN-DoPW	eThekwini Metro	Equitable Share	R 3 000	-	-	R 300
138	KwaShoba Clinic	Clinic Maintenance & Upgrading Programme Phase 1 (Completion of cancelled contract)	Retention	KZN-DoPW	Zululand	Equitable Share	R 5 700	R 135	-	-
139	KwaZulu Central Provincial Laundry	Shelving	Feasibility	KZN-DoPW	eThekwini Metro	Equitable Share	R 2 000	R 2 000		-
140	KwaZulu Provincial Central Laundry (PMMH)	Repair & Install Plant: Durban Regional Laundry (Co-funded from HIG)	Retention	KZN-DoPW	eThekwini Metro	Equitable Share	R 198 037	R 2 000	-	-
141	KZN Childrens Hospital	Refurbish : Phase 2A and Phase 2B	Construction 26% - 50%	Health	eThekwini Metro	Equitable Share	R 300 000	-	R 20 000	R 40 000
142	Ladysmith Provincial Hospital	Extension of OPD and Reconfiguration	Feasibility	Health	Uthukela	Equitable Share	R 40 000	-	-	R 3 000
143	LUWMH	Health Technology Equipment	Construction 76% - 99%	IDT	Uthungulu	Health Facility Revitalisation Grant	R 73 072	R 5 752	-	-

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144	LUWMH	Alteration and Additions to existing Hospital	Construction 76% - 99%	KZN-DoPW	Uthungulu	Health Facility Revitalisation Grant	R 427 521	R 24 955	-	-
145	LUWMH	Maternity ward -OT & Emergency unit	Identified	KZN-DoPW	Uthungulu	Equitable Share	R 50 000	-	-	R 5 000
146	Makhathini Clinic	Maintenance for 2001/2002 Programme (Completion contract)	Retention	KZN-DoPW	Umkhanyakude	Health Facility Revitalisation Grant	R 6 200	R 150	-	-
147	Mayor's Walk CPS	Upgrade / Replace 1 Hoist	Retention	KZN-DoPW	Umgungundlovu	Health Facility Revitalisation Grant	R 750	R 19	-	-
148	Mbongolwane Hospital	New Theatre & CSSD, Refurbish Existing Theatre Into New Male (Completion of Terminated Contract)	Retention	KZN-DoPW	Uthungulu	Equitable Share	R 20 662	R 200	-	-
149	Mbongolwane Hospital	Demolish existing houses at Jabulani Village, Rebuild with 6 single units, Repairs and Renovations to existing dormitories, R&R to existing 7 house at Hosp, new access roads/parking to staff accommodation	Retention	KZN-DoPW	Uthungulu	Health Facility Revitalisation Grant	R 20 100	R 1 364	-	-
150	Mbongolwane Hospital	Construction of a new Pharmacy	Retention	KZN-DoPW	Uthungulu	Equitable Share	R 15 700	R 2 151	-	-
151	McCords Hospital	Complete Renovations	Identified	KZN-DoPW	eThekwini Metro	Equitable Share	R 40 000	-	R 2 000	R 3 000
152	Mnqobokazi Clinic	Clinic Maintenance & Upgrading Programme : 2006-2007 Phase 1 (Completion contract)	Retention	KZN-DoPW	Umkhanyakude	Health Facility Revitalisation Grant	R 3 800	R 180	-	-
153	Montebello Hospital	Replace and Install 1 x 300kVA with larger unit	Construction 1% - 25%	KZN-DoPW	Ilembe	Health Facility Revitalisation Grant	R 1 000	R 975	R 25	-
154	Mosvold Hospital	Replace and Install 1 x 300kVA with larger unit	Construction 1% - 25%	KZN-DoPW	Umkhanyakude	Health Facility Revitalisation Grant	R 1 500	R 1 450	R 50	-
155	Mseleni Hospital	Install 1 x 250 KVA with larger units	Retention	KZN-DoPW	Umkhanyakude	Equitable Share	R 1 250	R 313	-	-
156	Murchison Hospital	General & TB Wards	Retention	KZN-DoPW	Ugu	Health Facility Revitalisation Grant	R 66 000	R 1 650	-	-
157	Murchison Hospital	Construction of new MDR unit	Feasibility	KZN-DoPW	Ugu	Equitable Share	R 20 000	-	R 3 000	R 10 000
158	Murchison Hospital	Construction of new OPD, casualty, x-ray etc.	Feasibility	KZN-DoPW	Ugu	Equitable Share	R 25 000	-		R 500
159	Mwolokohlo Clinic	Additions and Upgrading to the Clinic and construction of Nurses Residents	Retention	KZN-DoPW	Ilembe	Health Facility Revitalisation Grant	R 12 000	R 1 234	-	

No.	Project name	Type project details	Project status	Implementing Agent Name	District Municipality Name	Primary Source of funding	Total project Cost (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)
160	Natalia Building	Relocate EMS Provincial Health Operational Centre from 16th floor to Ground floor West Wing and Remove wall carpet on all floors	Construction 1% - 25%	IDT	Umgungundlovu	Health Facility Revitalisation Grant	R 110 000	R 48 000	R 50 000	R 4 000
161	Natalia Building	Phase 2 Electrical Upgrade	Construction 1% - 25%	IDT	Umgungundlovu	Health Facility Revitalisation Grant	R 15 000	R 13 000	R 1 000	-
162	Ndumo Clinic	Add consulting rooms, PMTCT, Ambulance Base to existing clinic and Build residences	Construction 76% - 99%	KZN-DoPW	Umkhanyakude	Health Facility Revitalisation Grant	R 33 000	R 3 000	R 500	-
163	Ndundulu Clinic	Replacement Clinic: K2, R2 X 3, R3x1,Guard House, Car Port, (Completion contract)	Retention	KZN-DoPW	Uthungulu	Health Facility Revitalisation Grant	R 16 325	R 447	-	-
164	Ndwedwe CHC	Replace and Install 1 x 200kVA with larger unit	Construction 1% - 25%	KZN-DoPW	Ilembe	Health Facility Revitalisation Grant	R 1 000	R 975	R 25	-
165	Ndwedwe CHC	Construction of new HAST Unit/ TB Clinic and Upgrade water and sewer system	Design	KZN-DoPW	Ilembe	Equitable Share	R 18 000	-	-	R 3 000
166	Newcastle Hospital	Construction of new VCT & ART	Retention	KZN-DoPW	Amajuba	Equitable Share	R 18 658	R 200	-	-
167	Newcastle Hospital	Construction of a new Pharmacy and Physio Department	Retention	KZN-DoPW	Amajuba	Equitable Share	R 11 808	R 200	-	-
168	Ngwelezane Clinic	Repairs and Renovations (Completion contract)	Retention	KZN-DoPW	Uthungulu	Equitable Share	R 2 500	R 153	-	-
169	Ngwelezane Hospital	Upgrade MV and LV electrical reticulation including generators, lighting protection to remaining building, Upgrade water reticulation and existing corridors	Retention	KZN-DoPW	Uthungulu	Health Facility Revitalisation Grant	R 125 000	R 4 823	-	-
170	Ngwelezane Hospital	Construct 2 new Wards (Demolish Wards A & B)	Retention	KZN-DoPW	Uthungulu	Health Facility Revitalisation Grant	R 55 000	R 200	-	-
171	Ngwelezane Hospital	Health Technology Equipment	Retention	IDT	Uthungulu	Health Facility Revitalisation Grant	R 60 771	R 2 000	-	-
172	Ngwelezane Hospital	Security Upgrade	Feasibility	KZN-DoPW	Uthungulu	Health Facility Revitalisation Grant	R 10 000	-	R 5 000	R 4 000
173	Ngwelezane Hospital	Construct new 192 beds medical wards to Replace wards E,F,G,H and Demolish the existing Crisis Centre Parkhome and construct new Crisis centre, Demolish old wards E,F,G,H.	Construction 1% - 25%	KZN-DoPW	Uthungulu	Health Facility Revitalisation Grant	R 320 000	R 80 000	R 100 000	R 80 330

No.	Project name	Type project details	Project status	Implementing Agent Name	District Municipality Name	Primary Source of funding	Total project Cost (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)
174	Ngwelezane Hospital	8 New Theatres, CSSD, 20 bed ICU, infectious disease isolation unit, 30 bed high care ward, theatre specialist offices, overnight doctors accommodation, IT training rooms and fencing of the remainder of the Ngwelezane site. Upgrades to kitchen, laundry, supplies department, cafeteria and occupational therapy department	Design	KZN-DoPW	Uthungulu	Health Facility Revitalisation Grant	R 360 000	-	-	R 20 000
175	Niemeyer Memorial Hospital	Re-design Upgrade of CCMT waiting area	Identified	KZN-DoPW	Amajuba	Equitable Share	R 10 000	-	-	R 1 000
176	Nkandla Hospital	Construction of a new pharmacy	Retention	KZN-DoPW	Uthungulu	Equitable Share	R 8 100	R 500	-	-
177	Nkonjeni Hospital	Reconfigure existing Neonatal Facility and Renovate existing Casualty and OPD	Design	KZN-DoPW	Zululand	Equitable Share	R 3 250	R 3 000	R 250	-
178	Nkonjeni Hospital	Renovate existing Casualty and OPD	Feasibility	KZN-DoPW	Zululand	Equitable Share	R 60 000	-	-	R 2 000
179	Nkonjeni-Ulundi Residential Accommodation	Renovations to 7 x 3 Bedrooms house with Double garages	Tender	KZN-DoPW	Zululand	Equitable Share	R 8 600	R 8 000	R 600	-
180	Ntambanana Clinic	Clinic Maintenance & Upgrading Programme : 2006-2007 Phase 2 (Completion of cancelled contract)	Retention	KZN-DoPW	Uthungulu	Health Facility Revitalisation Grant	R 6 500	R 328	-	-
181	Osindisweni Hospital	Replace and Install 1 x 200kVA with larger unit	Construction 1% - 25%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 1 000	R 975	R 25	-
182	Osindisweni Hospital	Replace TB ward	Design	KZN-DoPW	eThekwini Metro	Equitable Share	R 90 350	-	-	R 20 000
183	Phoenix CHC	Extension of patient waiting area (Rehabilitation of Community Health Centre	Retention	KZN-DoPW	eThekwini Metro	Equitable Share	R 21 620	R 1 014	-	-
184	Phoenix CHC	Install 1 x 200 KVA with larger units	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 750	R 187	-	-
185	Phoenix CHC	Construction of Admin Block, Block F, Parking - Phase2	Design	KZN-DoPW	eThekwini Metro	Equitable Share	R 15 000	-	-	R 7 500
186	Pholela CHC	Accommodation for 39 staff and provision for Parkhome	Retention	IDT	Harry Gwala	Equitable Share	R 26 107	R 500	-	-

No.	Project name	Type project details	Project status	Implementing Agent Name	District Municipality Name	Primary Source of funding	Total project Cost (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)
187	Port Shepstone Hospital	Repair roofing to kitchen and laundry area/Urgent structural evaluation of roofing to kitchen and adjacent area.(Completion contract)	Retention	KZN-DoPW	Ugu	Equitable Share	R 2 300	R 223	-	-
188	Port Shepstone Hospital	Conversion of A Ward to 15 bedded Psychiatric Unit	Design	KZN-DoPW	Ugu	Equitable Share	R 30 000	-	R 1 000	R 15 000
189	Prince Mshiyeni Memorial Hospital	Upgrade fire protection system and water reservoir	Tender	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 67 000	R 20 000	R 35 000	R 2 000
190	Prince Mshiyeni Memorial Hospital	Upgrade Maternity Ward and Nursery	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 19 614	R 218	-	-
191	Prince Mshiyeni Memorial Hospital	Upgrade fire system	Construction 1% - 25%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 64 000	R 40 000	R 1 600	-
192	R K Khan Hospital	Completion of P Block (Completion contract) including Repairs to collapsing bank	Construction 76% - 99%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 35 242	R 8 418	R 1 700	-
193	Rietvlei Hospital	Phase 3B : Admin, Kitchen, Audio, ARV, New Staff Accommodation, Renovate existing accommodation	Retention	KZN-DoPW	Harry Gwala	Health Facility Revitalisation Grant	R 127 097	R 3 178	-	-
194	Rietvlei Hospital	Connection of electricity to the sewer treatment works plant	Retention	KZN-DoPW	Harry Gwala	Health Facility Revitalisation Grant	R 614	R 20	-	-
195	Siphilile Clinic	Reconfigure existing Clinic, perimeter fence, double vehicle entrance and pedestrian gates	Identified	KZN-DoPW	Uthungulu	Equitable Share	R 18 000	-	-	R 2 000
196	St Andrews Hospital	Replace and install 1 x 300kVA with larger unit	Construction 1% - 25%	KZN-DoPW	Ugu	Health Facility Revitalisation Grant	R 1 500	R 1 450	R 50	-
197	St Apollinaris Hospital	Reconfigure existing building to provide for a neonatal nursery	design	KZN-DoPW	Harry Gwala	Equitable Share	R 2 500	R 2 000	R 500	-
198	St. Margaret's hospital	Building a new male/female TB Wards	Identified	KZN-DoPW	Harry Gwala	Equitable Share	R 50 000	-	R 4 000	R 20 000
199	St. Margaret's hospital	Sewer Reticulation	Feasibility	KZN-DoPW	Harry Gwala	Equitable Share	R 7 000	-	-	R 500
200	Stanger Hospital	Replacement of entire roof in OPD and Paeds Wards	Identified	KZN-DoPW	Ilembe	Equitable Share	R 18 000	-	-	R 1 000
201	Stanger Hospital	New Labour And Neo-Natal Ward	Construction 26% - 50%	KZN-DoPW	Ilembe	Health Facility Revitalisation Grant	R 155 000	R 65 000	R 25 000	R 5 000

No.	Project name	Type project details	Project status	Implementing Agent Name	District Municipality Name	Primary Source of funding	Total project Cost (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)
202	Sundumbili CHC	Maintenance	Retention	KZN-DoPW	Ilembe	Health Facility Revitalisation Grant	R 8 453	R 120	-	-
203	Sundumbili CHC	Replace and Install 1 x 100kVA with larger unit	Construction 1% - 25%	KZN-DoPW	Ilembe	Health Facility Revitalisation Grant	R 850	R 730	R 20	-
204	Tongaat CHC	Replace and Install 1 x 100kVA with larger unit	Construction 1% - 25%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 850	R 730	R 20	-
205	Townhill Hospital	Replacement or Renovations to Roof - Admin Block, North Park, Uitsag Wards, Hillside Wards, Occupational Therapy and Pharmacy	Retention	KZN-DoPW	Umgungundlovu	Equitable Share	R 50 000	R 2 100	-	-
206	Umphumulo Hospital	Install 1 x 300 KVA with larger units	Construction 1% - 25%	KZN-DoPW	Ilembe	Health Facility Revitalisation Grant	R 1 000	R 950	R 50	-
207	Umphumulo Hospital	Construction of OPD With X-Ray, Admin Block Pharmacy, neonatal and Physiotherapy	Design	KZN-DoPW	Ilembe	Equitable Share	R 45 000	-	-	R 1 000
208	Umzimkhulu Hospital	Install 1 x 100 KVA with larger units	Retention	KZN-DoPW	Harry Gwala	Health Facility Revitalisation Grant	R 850	R 212	-	-
209	Umzinyathi Clinics	Construction of Septic Tanks	Construction 1% - 25%	KZN-DoPW	Umzinyathi	Equitable Share	R 15 000	R 13 500	R 500	-
210	Vryheid Hospital	Reconfigure existing building to provide for a neonatal nursery	Design	KZN-DoPW	Zululand	Equitable Share	R 2 000	R 1 600	R 200	-
NEW FACILITIES PROJECTS										
211	Dannhauser CHC	Construction of a new CHC	Retention	IDT	Amajuba	Health Facility Revitalisation Grant	R 186 186	R 4 000	-	-
212	Dr Pixley Ka Isaka Seme Hospital	New 500 bed Regional Hospital	Construction 1% - 25%	IDT	eThekwini Metro	Health Facility Revitalisation Grant	R 2 912 459	R 400 000	R 673 127	R 704 014
213	Dr Pixley ka Isaka Seme Hospital	Payment for Levies	Construction 1% - 25%	Health	eThekwini Metro	Health Facility Revitalisation Grant	R 2 567	R 60	R 65	R 70
214	Dundee EMS	Construction of large EMS Base	Design	KZN-DoPW	Umzinyathi	Equitable Share	R 65 000	-	R 2 500	R 25 000
215	Emambedwini Clinic	New Clinic	Retention	KZN-DoPW	Umgungundlovu	Health Facility Revitalisation Grant	R 8 600	R 1 593	-	-

No.	Project name	Type project details	Project status	Implementing Agent Name	District Municipality Name	Primary Source of funding	Total project Cost (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)
216	Equiping of Completed New/Upgraded Facilities	Furniture and Equipment for New and Upgraded facilities	Construction 1% - 25%	Health	Umgungundlovu	Equitable Share	R 48 434	R 20 000	R 10 000	R 10 000
217	Groutville Clinic	Replacement of Clinic Phase 9 (including a separate PMTCT unit)	Design	KZN-DoPW	Ilembe	Equitable Share	R 55 000	-	R 3 000	R 20 000
218	Gwaliweni Clinic	Construction of a new clinic, guard house and repairs and renovations	Retention	KZN-DoPW	Umkhanyakude	Health Facility Revitalisation Grant	R 13 153	R 346	-	-
219	Hluhluwe Clinic	Construction of a new Clinic with residences	Retention	IDT	Umkhanyakude	Health Facility Revitalisation Grant	R 34 202	R 485	-	-
220	Jozini CHC	Construction of a new CHC	Construction 76% - 99%	IDT	Umkhanyakude	Health Facility Revitalisation Grant	R 268 502	R 5 000	R 5 000	-
221	Mahehle / Ncakubana Clinic	Construct New Clinic	Tender	KZN-DoPW	Harry Gwala	Health Facility Revitalisation Grant	R 18 000	R 9 200	R 6 500	R 100
222	Malaria Control Programme	Camp at Manguzi	Feasibility	KZN-DoPW	Umkhanyakude	Equitable Share	R 1 000	-	R 975	R 25
223	Manxili Clinic	Construction of a Medium clinic with Residence	Retention	IDT	Umzinyathi	Health Facility Revitalisation Grant	R 16 097	R 166	-	-
224	Mashona Clinic	Construction of a New Medium Clinic	Retention	IDT	Zululand	Equitable Share	R 23 160	R 200	-	-
225	Mkhuphula Clinic	Construction of a Small Clinic,B2 Residential Accommodation and Guard House (Completion contract)	Construction 26% - 50%	IDT	Umzinyathi	Equitable Share	R 10 235	R 7 500	R 250	-
226	Mkhuze Mortuary	New Forensic Mortuary	Design	KZN-DoPW	Umkhanyakude	Equitable Share	R 20 000	-	-	R 2 000
227	Mpophomeni Clinic	Phase 8 : New Clinic	Construction 76% - 99%	KZN-DoPW	Umkhanyakude	Equitable Share	R 11 126	R 4 381	R 495	-
228	Msizini Clinic	Construction of a Small Clinic,B2 Residential Accommodation and Guard House (Completion contract)	Construction 26% - 50%	IDT	Umzinyathi	Equitable Share	R 8 282	R 6 000	R 283	-
229	Muden Clinic	Construction of a New Medium Clinic with double accommodation	Construction 51% - 75%	IDT	Umzinyathi	Health Facility Revitalisation Grant	R 16 878	R 6 154	R 450	-
230	Ngabayena Clinic	Construction of a Small Clinic,B2 Residential Accommodation and Guard House (Completion Contract)	Retention	IDT	Umzinyathi	Equitable Share	R 5 059	R 3 750	R 309	-
231	Ofafa/ Ntakama Clinic	Construct New Clinic	Tender	KZN-DoPW	Harry Gwala	Health Facility Revitalisation Grant	R 18 000	R 9 000	R 7 300	R 500

No.	Project name	Type project details	Project status	Implementing Agent Name	District Municipality Name	Primary Source of funding	Total project Cost (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)
232	Phoenix Mortuary	New M6 Forensic Mortuary	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 92 925	R 2 500	-	-
233	Pisgah Clinic	Internal & External R & R, New Roof Sheeting, Upgrade Pathways/Driveway (2nd Completion Contract)	Retention	KZN-DoPW	Ugu	Health Facility Revitalisation Grant	R 4 500	R 881	-	-
234	Pomeroy CHC	Construction of a New CHC with Residence	Retention	IDT	Umzinyathi	Health Facility Revitalisation Grant	R 188 593	R 4 025	-	-
235	Shongweni Dam Clinic	Construction of a New Clinic (Phase 9)	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 11 209	R 2 185	-	-
236	St Aidens Hospital	Purchase of Hospital	Construction 51% - 75%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 60 000	R 60 000	-	-
237	Umzimkhulu CHC	Construct new CHC	Design	KZN-DoPW	Harry Gwala	Equitable Share	R 200 000	-	R 20 000	R 60 000
238	Usuthu Clinic	Replacement of Medium Clinic	Construction 51% - 75%	IDT	Zululand	Equitable Share	R 20 970	R 9 930	R 500	-

11. CONDITIONAL GRANTS

Table 122: Conditional Grants 2015/16

Purpose of the Grant	Performance Indicators 2015/16	Targets 2015/16
Comprehensive HIV and AIDS Conditional Grant		
1. To enable the health sector to develop an effective response to HIV and AIDS including universal access to HIV Counselling and Testing. 2. To support implementation of the National Operational Plan for Comprehensive HIV and AIDS Treatment and Care. 3. To subsidise in-part funding for the Antiretroviral Treatment Plan.	1. Total number of fixed public health facilities offering ART services	632
	2. Total clients started on ART during this month - naïve	229 650
	3. Number of beneficiaries served by Home-Based Carers	3 million
	4. Number of active Home-Based Carers receiving stipends	11 121
	5. Number of male condoms distributed	212 million
	6. Number of female condoms distributed	3.5 million
	7. Number of High Transmission Area intervention sites (new and old)	120
	8. Number of HIV positive clients screened for TB	310 060
	9. Number of HIV positive clients started on IPT	217 042
	10. Number of Lay Counsellors receiving stipends	2 199
	11. Number of clients pre-test counselled on HIV testing (including antenatal)	2 273 771
	12. Number of clients tested for HIV (including antenatal)	2 067 065
	13. Number of fixed health facilities offering MMC services	78
	14. Number of public health facilities offering Post Exposure Prophylaxis for sexual assault cases	160
	15. Number of sexual assault cases offered ARV prophylaxis (new)	10 000
	16. Number of Step Down Facilities/ Units	4
National Tertiary Services Grant		
1. To ensure provision of tertiary health services for all South African citizens. 2. To compensate tertiary facilities for the costs associated with provision of these services including cross border patients.	1. Number of National Central and Tertiary Hospitals providing components of Tertiary services	4
Health Professional Training and Development Grant		
1. Support provinces to fund service costs associated with training of health science trainees on the public service platform. 2. Co-funding of the National Human Resources Plan for Health in expanding undergraduate medical education for 2012 and beyond (2025).	1. Number of Registrars supervised	Not available at time for finalisation of APP
National Health Grant		
1. To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health, including inter alia, health technology, organisational systems (OD) and quality assurance (QA). 2. Supplement expenditure on health infrastructure delivered through public-private partnerships	1. Number of new clinical projects with completed construction	8
	2. Number of new clinical projects where commissioning is complete	14
	3. Number of upgrading and renovation projects with completed construction	21
National Health Insurance Grant		

Purpose of the Grant	Performance Indicators 2015/16	Targets 2015/16
• Develop frameworks and models that can be used to roll out the National Health Insurance (NHI) pilots in districts and central hospitals critical to achieving the phased implementation of NHI	1. Review referral systems 2. Medical equipment procured	Referral project Medical equipment procured as per Procurement List

12. PUBLIC ENTITIES

Table 123: Public Entities

Name of Public Entity	Mandate	Current Annual Budget (R'000)
1. Austerville Halfway House	2.2: Community Health Clinics	520
2. Azalea House	2.2: Community Health Clinics	480
3. Bekimpelo Bekulwandle Trust Clinic	2.2: Community Health Clinics	7 904
4. Benedictine Clinic	2.2: Community Health Clinics	175
5. Budget Control Holding Funds	2.2 Community Health Clinics	52 092
6. Claremont Day Care Centre	2.2: Community Health Clinics	367
7. Day Care Club 91	2.2: Community Health Clinics	100
8. Ekukhanyeni Clinic (AIDS Step-Down Care)	2.2: Community Health Clinics	911
9. Elandskop Clinic	2.2: Community Health Clinics	449
10. Enkumane Clinic	2.2: Community Health Clinics	270
11. Ethembeni Step-Down Centre	2.6: HIV and AIDS	4 881
12. Genesis Care Centres	2.6: HIV and AIDS	2 919
13. Happy Hour Amaoti	2.2: Community Health Clinics	490
14. Happy Hour Durban North	2.2: Community Health Clinics	245
15. Happy Hour Kwaximba	2.2: Community Health Clinics	392
16. Happy Hour Marianhill	2.2: Community Health Clinics	123
17. Happy Hour Mpumalanga	2.2: Community Health Clinics	392
18. Happy Hour Ninikhona	2.2: Community Health Clinics	245
19. Happy Hour Nyangwini	2.2: Community Health Clinics	257
20. Happy Hour Overport	2.2: Community Health Clinics	184
21. Happy Hour Phoenix	2.2: Community Health Clinics	245
22. Hlanganani Ngothando DCC	2.2: Community Health Clinics	208
23. Humana People to People	2.2: Community Health Clinics	2 828
24. Ikwezi Cripple Care	2.2: Community Health Clinics	1 136
25. John Peattie House	2.2: Community Health Clinics	1 335
26. Jona Vaughn Centre	2.2: Community Health Clinics	2 335
27. KwaZulu-Natal Childrens Hospital	Programme 4.1: Hospital Services	20 000
28. Lynn House	2.2: Community Health Clinics	584
29. Madeline Manor	2.2: Community Health Clinics	841
30. Masada Workshop	2.2: Community Health Clinics	74

Name of Public Entity	Mandate	Current Annual Budget (R'000)
31. Masibambeni Day Care Centre	2.2: Community Health Clinics	147
32. Matikwe Oblate Clinic	2.2: Community Health Clinics	491
33. McCords Hospital	4.1: Hospital Services	52 765
34. Mountain View Specialised TB	4.2: Specialised TB	9 871
35. Noyi Bazi Oblate Clinic	2.2: Community Health Clinics	496
36. Philanjalo Hospice (Step-Down Centre)	2.6: HIV and AIDS	2 551
37. Prenaid ALP NGO	2.2: Community Health Clinics	100
38. Pongola Hospital	Programme 2.7: District Hospitals	2 300
39. Rainbow Haven	2.2: Community Health Clinics	385
40. Scadifa Centre	2.2: Community Health Clinics	949
41. Siloah Hospital	4.2: Specialised TB	18 958
42. St Luke Home	2.2: Community Health Clinics	430
43. St Mary's Hospital Marianhill	2.7: District Hospitals	117 046
44. Sunfield Home	2.2: Community Health Clinics	303
45. Umlazi Halfway House	2.2: Community Health Clinics	260

13. PUBLIC PRIVATE PARTNERSHIPS

Table 124: Public Private Partnership

Name of PPP	Purpose	Outputs	2015/16 Annual Budget (R'000)	Date of Termination	Measures to ensure smooth transfer of responsibilities
Inkosi Albert Luthuli Central Hospital The Department in partnership with Impilo Consortium (Pty) Ltd and Cowslip Investments (Pty) Ltd	Supply equipment and information management and technology (IM&T) systems and replace the equipment and IM&T systems to ensure that they remain state of the art. Supply and replace non-medical equipment. Services necessary to manage Project Assets in accordance with Best Industry Practice. Maintain and replace Departmental Assets in terms of the replacement schedules. Provide or procure Utilities, Consumables and Surgical Instruments. Facility Management Services.	Delivery of non-clinical services to IALCH	965 976	The 15 year contract with Impilo Consortium (Pty) Ltd will terminate in 2016/17.	Termination arrangements are detailed in the project agreement in clauses 35, 36, 37 and the penalty regime (Schedule 15). The Provincial Treasury PPP Unit is rendering assistance to the Department of Health regarding its exit strategy.

14. CONCLUSION

The Annual Performance Plan presents the priorities, strategic goals, objectives and targets that the KwaZulu-Natal Department of Health will be pursuing during 2015/16 – 2017/18. The Plan has been aligned with the National Development Plan 2030, the Medium Term Strategic Framework 2014-2019, the Provincial Growth and Development Plan 2030, other sector priorities and needs in the Province.

The Plan reflects on the strategic priorities of the Department while Operational and District Health Plans will provide the detail of operationalising the strategic priorities. Head Office, as strategic enabler, will provide the necessary support to ensure that systems and processes are in place to execute the Plan, and discipline will be exercised to ensure that services are provided in line with service obligations and mandates for delivery of health care.

Long Term Plans, targeted for the first year in the coming MTEF will provide the detail for Implementation Plans that will be unpacked during the outer years. Ongoing performance monitoring at all levels of care will be strengthened to ensure pro-active response to service delivery challenges. Quarterly in-depth reviews and outcomes-based reporting and feedback will form an integral part of improved accountability for service delivery and health outcomes.

The Department remains committed to improved service delivery and all partners and stakeholders are invited to be part of the process in taking health service delivery to the next level.

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16. ABBREVIATIONS

Abbreviation	Description
A	
AIDS	Acquired Immune Deficiency Syndrome
ALOS	Average Length of Stay
ALS	Advanced Life Support
AMS	Air Mercy Services
ANC	Antenatal Care
APP	Annual Performance Plan
APSTAR	Applied Population Science and Research Programme
ART	Anti-Retroviral Therapy
ARV(s)	Anti-Retroviral(s)
ASSA	AIDS Committee of Actuarial Society of South Africa
ASELPH	Albertina Sisulu Executive Leadership Programme
B	
BAS	Basic Accounting System
BLS	Basic Life Support
C	
CARMMA	Campaign on Accelerated Reduction of Maternal and child Mortality in Africa
CCG(s)	Community Care Giver(s)
CCMDD	Centralised Chronic Medicine Dispensing and Distribution
CDC	Communicable Disease Control
CEO(s)	Chief Executive Officer(s)
CHC(s)	Community Health Centre(s)
CHS	College of Health Science
CIP	Compulsory Induction Programme
COE	Compensation of Employees
CPS	Central Provincial Stores
CSO(s)	Community Service Officer(s)
CTOP	Choice on Termination of Pregnancy
CVA	Cardiovascular Accident
D	
DCST(s)	District Clinical Specialist Team(s)
DHER(s)	District Health Expenditure Review(s)
DHIS	District Health Information System
DHP's	District Health Plans
DHS	District Health System
DoPW	Department of Public Works
DOT	Directly Observed Treatment

Abbreviation	Description
DPC	Disease Prevention and Control
DPME	Department Performance Monitoring and Evaluation
DR-TB	Drug Resistant Tuberculosis
DUT	Durban University of Technology
E	
ECP	Emergency Care Practitioner
ECT	Emergency Care Technician
EMS	Emergency Medical Services
EMS P1 Calls	Emergency Medical Services Priority 1 calls
EPWP	Expanded Public Works Programme
ESMOE	Essential Steps in Management of Obstetric Emergencies
ETBR	Electronic Tuberculosis Register
ETR.net	Electronic Register for TB
F	
FDC	Fixed Dose Combination (ARV)
FP	Family Planning
FPS	Forensic Pathology Services
FTF	First Things First
G	
GE	Gastroenteritis
GHS	General Household Survey
GIS	Geographic Information System
GPAA	Government Pension Administration Agency
H	
HAART	Highly Active Ante-Retroviral Therapy
HAST	HIV, AIDS, STI and TB
HCSS	Health Care Support Services
HCT	HIV Counselling and Testing
HEARD	Health Economics and HIV & AIDS Research Division
HEM	Helicopter Emergency Services
HIV	Human Immuno Virus
HPV	Human Papilloma Virus
HR	Human Resources
HRD	Human Resource Development
HTA's	High Transmission Areas
I	
IA(s)	Implementing Agent(s)
IALCH	Inkosi Albert Luthuli Central Hospital
ICD10	International Classification of Diseases

Abbreviation	Description
ICRM	Ideal Clinic Realisation and Maintenance
ICT	Information Communication Technology
ICU(s)	Intensive Care Unit(s)
IDT	Independent Development Trust
IDMS	Infrastructure Delivery Management Programme
IFT	Inter Facility Transfer
ILS	Intermediate Life Support
IMCI	Integrated Management of Childhood Illnesses
iMMR	Institutional Maternal Mortality Ratio
IMR	Infant Mortality Rate
IPMP	Infrastructure Programme Management Plan
IPT	Ionized Preventive Therapy
K	
KZN	KwaZulu-Natal
KZNCN	KwaZulu-Natal College of Nursing
L	
LG	Local Government
M	
MaMMAS	Maternal Morbidity and Mortality Assessment Records
M&E	Monitoring and Evaluation
MDG(s)	Millennium Development Goal(s)
MDR-TB	Multi Drug Resistant Tuberculosis
MEC	Member of the Executive Council
MgSO4	Magnesium Sulphate
MMC	Medical Male Circumcision
MMR	Maternal Mortality Rate
MNC&WH	Maternal, Neonatal, Child & Women's Health
MOA	Memorandum of Agreement
MOP	Medical Ortho Prosthetics
MOU(s)	Midwifery Obstetric Unit(s)
MOU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework
N	
NCS	National Core Standards
NCD(s)	Non-Communicable Disease(s)
NDP	National Development Plan
NGO(s)	Non-Governmental Organisation(s)
NHI	National Health Insurance

Abbreviation	Description
NHISSA	National Health Information System of South Africa
NIMART	Nurse Initiated and Managed Antiretroviral Therapy
NSDA	Negotiated Service Delivery Agreement
NSG	National School of Government
O	
OES	Occupation Efficiency Service
OHH	Outreach Households
OPD	Out-Patient Department
OSS	Operation Sukuma Sakhe
P	
PA(s)	Performance Agreement(s)
PC101	Primary Care 101
PCR	Polymerase Chain Reaction
PCV	Pneumococcal Vaccine
PDE	Patient Day Equivalent
PDOH	Provincial Department of Health
PEC	Patient experience of Care
PEP	Post Exposure Prophylaxis
PERSAL	Personnel and Salaries System
PGDP	Provincial Growth and Development Plan
PHC	Primary Health Care
PIA	Provincial Implementing Agents
PHREC	Provincial Health Research and Ethics Committee
PLWHA	People Living with HIV/AIDS
PMDS	Performance Management and Development System
PMPU	Provincial Medicine Procurement Unit
PMTCT	Prevention of Mother to Child Transmission
PN	Professional Nurse
PostMI	Post Myocardial Infarction
PPSD	Provincial Pharmaceutical Supply Depot
PPT	Planned Patient Transport
PTB	Pulmonary Tuberculosis
Q	
QIP(s)	Quality Improvement Plan(s)
R	
RSA	Republic of South Africa
S	
SA	South Africa
SABS	South African Bureau of Standards

Abbreviation	Description
SANC	South African Nursing Council
SANHANES	South African National Health and Nutrition Survey
SANTA	South African National Tuberculosis Association
SANTACO	South African National Taxi Council
SCM	Supply Chain Management
SHS	School Health Services
SLA	Service Level Agreement
SOP(s)	Standard Operating Procedure(s)
StatsSA	Statistics South Africa
STI(s)	Sexually Transmitted Infection(s)
T	
TB	Tuberculosis
TVET	Technical Vocational Education Training Colleges
U	
U5MR	Under 5 Mortality Rate
UKZN	University of KwaZulu-Natal
UNAIDS	United Nations Programme on HIV/AIDS
U-AMP	User–Asset Management Plan
W	
WBOT(s)	Ward Based Outreach Team(s)
WHO	World Health Organisation
WISN	Workload Indicators of Staffing Need
X	
XDR-TB	Extreme Drug Resistant Tuberculosis

17. ANNEXURE

Table 125: Wards worst affected by poverty (SAMPI)

			Census 2001			Census 2011			
District	Local Municipality	Ward Code	Headcount	Intensity	SAMPI Index Score	Headcount	Intensity	SAMPI Index Score	Deprived Ward Ranking Number
Umzinyathi	Msinga	52404016	64.0%	43.0%	0.28	50.7%	45.0%	0.23	1
Umzinyathi	Endumeni	52402001	76.3%	46.9%	0.36	51.2%	41.5%	0.21	2
Umzinyathi	Msinga	52404006	65.9%	43.0%	0.28	47.1%	45.1%	0.21	3
Umzinyathi	Msinga	52404008	76.4%	44.7%	0.34	51.0%	40.9%	0.21	4
Umzinyathi	Msinga	52404003	63.1%	45.8%	0.29	45.2%	45.1%	0.20	5
Umzinyathi	Msinga	52404015	66.9%	45.0%	0.30	45.2%	44.1%	0.20	6
Umkhanyakude	Umhlabuyalingana	52701013	64.2%	43.7%	0.28	41.9%	44.6%	0.19	7
Umkhanyakude	Umhlabuyalingana	52701006	61.2%	44.1%	0.27	40.9%	45.0%	0.18	8
Umkhanyakude	Umhlabuyalingana	52701009	65.5%	45.8%	0.30	42.6%	42.7%	0.18	9
Ugu	Vulamehlo	52101005	44.4%	40.5%	0.18	42.7%	41.5%	0.18	10
Uthukela	Umtshezi	52304007	68.9%	48.6%	0.33	39.8%	44.3%	0.18	11
Umzinyathi	Msinga	52404010	55.5%	44.1%	0.25	40.1%	43.9%	0.18	12
Uthungulu	Nkandla	52806007	56.6%	43.1%	0.24	41.4%	42.5%	0.18	13
Uthukela	Umtshezi	52304005	39.3%	46.6%	0.18	38.9%	43.9%	0.17	14
Umzinyathi	Umvoti	52405006	51.1%	41.4%	0.21	41.2%	41.4%	0.17	15
Umkhanyakude	Umhlabuyalingana	52701014	60.1%	45.9%	0.28	39.5%	42.9%	0.17	16
Uthukela	Indaka	52303009	57.6%	43.7%	0.25	39.1%	43.0%	0.17	17
Ugu	Umzumbe	52103001	41.3%	42.1%	0.17	37.2%	43.4%	0.16	18
Harry Gwala	Ubuhlebezwe	54304005	38.5%	40.8%	0.16	39.5%	40.8%	0.16	19
Umgungundlovu	Mpofana	52203004	53.2%	48.2%	0.26	39.1%	41.2%	0.16	20

			Census 2001			Census 2011			
District	Local Municipality	Ward Code	Headcount	Intensity	SAMPI Index Score	Headcount	Intensity	SAMPI Index Score	Deprived Ward Ranking Number
Umzinyathi	Msinga	52404002	65.0%	43.3%	0.28	36.7%	43.6%	0.16	21
Zululand	Abaqulusi	52603004	43.2%	41.5%	0.18	35.7%	44.1%	0.16	22
Harry Gwala	Ingwe	54301001	55.6%	42.5%	0.24	37.4%	41.8%	0.16	23
Umzinyathi	Msinga	52404007	63.9%	43.6%	0.28	37.0%	41.6%	0.15	24
Ugu	Umzumbe	52103008	50.2%	41.9%	0.21	36.7%	41.6%	0.15	25
Umzinyathi	Msinga	52404013	66.8%	44.8%	0.30	36.4%	41.9%	0.15	26
Umzinyathi	Msinga	52404009	52.0%	41.1%	0.21	36.3%	42.0%	0.15	27
Umzinyathi	Msinga	52404014	58.3%	46.4%	0.27	34.9%	43.4%	0.15	28
Uthukela	Indaka	52303010	70.3%	46.3%	0.33	34.9%	43.4%	0.15	29
Umzinyathi	Msinga	52404018	66.7%	43.1%	0.29	35.0%	43.2%	0.15	30
Umzinyathi	Msinga	52404005	47.5%	45.2%	0.21	34.7%	43.4%	0.15	31
Uthukela	Indaka	52303007	53.6%	42.8%	0.23	34.8%	42.9%	0.15	32
Uthungulu	Nkandla	52806002	53.2%	44.8%	0.24	37.9%	39.2%	0.15	33
Uthungulu	Nkandla	52806014	45.8%	42.4%	0.19	34.4%	42.8%	0.15	34
Ugu	Umzumbe	52103007	50.0%	43.6%	0.22	35.2%	41.6%	0.15	35
Ugu	Vulamehlo	52101007	47.8%	44.1%	0.21	35.2%	41.4%	0.15	36
iLembe	Maphumulo	52904003	48.6%	43.2%	0.21	35.6%	40.8%	0.15	37
Harry Gwala	Umzimkhulu	54305003	42.1%	43.0%	0.18	33.4%	43.4%	0.14	38
Umzinyathi	Msinga	52404001	60.1%	42.2%	0.25	34.1%	42.4%	0.14	39
Umkhanyakude	Umhlabuyalingana	52701012	53.2%	44.0%	0.23	34.6%	41.7%	0.14	40
Amajuba	Emadlangeni	52503001	47.2%	42.2%	0.20	33.6%	42.8%	0.14	41
Umkhanyakude	Umhlabuyalingana	52701016	60.6%	44.8%	0.27	34.3%	41.7%	0.14	42
Umgungundlovu	Mkhambathini	52206005	36.5%	42.9%	0.16	34.9%	40.4%	0.14	43
Uthukela	Indaka	52303008	47.4%	43.2%	0.21	31.6%	44.2%	0.14	44

			Census 2001			Census 2011			
District	Local Municipality	Ward Code	Headcount	Intensity	SAMPI Index Score	Headcount	Intensity	SAMPI Index Score	Deprived Ward Ranking Number
Umkhanyakude	Jozini	52702010	49.4%	41.7%	0.21	32.2%	43.2%	0.14	45
Zululand	Ulundi	52606007	49.2%	41.6%	0.20	30.6%	44.5%	0.14	46
iLembe	Maphumulo	52904002	57.6%	42.0%	0.24	35.2%	38.5%	0.14	47
Uthungulu	Nkandla	52806009	71.6%	43.7%	0.31	33.1%	41.0%	0.14	48
iLembe	Ndwedwe	52903016	58.4%	44.0%	0.26	32.4%	41.9%	0.14	49
Harry Gwala	Umzimkhulu	54305001	53.7%	43.1%	0.23	32.8%	41.2%	0.14	50
Harry Gwala	KwaSani	54302001	41.7%	41.3%	0.17	32.5%	41.6%	0.14	51
iLembe	Ndwedwe	52903004	40.7%	40.9%	0.17	31.7%	42.4%	0.13	52
Umkhanyakude	Jozini	52702013	50.9%	43.2%	0.22	29.4%	45.7%	0.13	53
Harry Gwala	Umzimkhulu	54305006	53.6%	43.2%	0.23	30.9%	43.3%	0.13	54
Umzinyathi	Msinga	52404017	47.3%	44.6%	0.21	31.5%	42.3%	0.13	55
Ugu	Umuziwabantu	52104009	53.1%	42.4%	0.23	32.6%	40.8%	0.13	56
Umkhanyakude	Jozini	52702012	54.7%	44.6%	0.24	29.9%	44.3%	0.13	57
Ugu	Umdoni	52102009	29.0%	42.3%	0.12	29.5%	44.7%	0.13	58
Ugu	Vulamehlo	52101010	57.6%	43.0%	0.25	32.1%	40.8%	0.13	59
Uthukela	Okhahlamba	52305004	43.1%	43.3%	0.19	30.5%	43.0%	0.13	60
Umzinyathi	Endumeni	52402009	42.1%	43.1%	0.18	31.0%	42.2%	0.13	61
Ugu	Umzumbe	52103006	43.2%	41.8%	0.18	31.8%	41.1%	0.13	62
Ugu	Umzumbe	52103009	43.0%	40.7%	0.18	31.2%	41.9%	0.13	63
Umzinyathi	Msinga	52404004	53.8%	45.5%	0.24	30.5%	42.7%	0.13	64
Uthungulu	Umlalazi	52804001	45.4%	41.2%	0.19	31.2%	41.7%	0.13	65
Umzinyathi	Endumeni	52402002	54.7%	42.3%	0.23	30.9%	42.1%	0.13	66
Zululand	Nongoma	52605002	44.0%	43.6%	0.19	30.1%	43.1%	0.13	67
Uthungulu	Umlalazi	52804006	45.2%	42.0%	0.19	32.2%	40.3%	0.13	68

			Census 2001			Census 2011			
District	Local Municipality	Ward Code	Headcount	Intensity	SAMPI Index Score	Headcount	Intensity	SAMPI Index Score	Deprived Ward Ranking Number
Umkhanyakude	Umhlabuyalingana	52701008	44.7%	45.2%	0.20	30.4%	42.6%	0.13	69
Umkhanyakude	Jozini	52702015	57.0%	43.6%	0.25	30.3%	42.7%	0.13	70
Umzinyathi	Umvoti	52405008	50.0%	44.6%	0.22	31.4%	41.2%	0.13	71
Ugu	Vulamehlo	52101008	45.4%	42.6%	0.19	32.6%	39.6%	0.13	72
Zululand	Nongoma	52605001	54.1%	42.5%	0.23	29.5%	43.0%	0.13	73
Harry Gwala	Umzimkhulu	54305018	41.9%	44.2%	0.18	29.5%	43.0%	0.13	74
Ugu	Umzumbe	52103002	40.8%	42.2%	0.17	30.8%	41.0%	0.13	75
Uthungulu	Mthonjaneni	52805003	49.1%	42.4%	0.21	31.1%	40.4%	0.13	76
Umkhanyakude	Jozini	52702004	46.7%	43.3%	0.20	30.0%	41.8%	0.13	77
Umkhanyakude	The Big 5 False Bay	52703002	50.6%	44.7%	0.23	29.3%	42.7%	0.13	78
Ugu	Vulamehlo	52101004	37.0%	40.4%	0.15	29.9%	41.7%	0.12	79
Ugu	Umzumbe	52103012	45.6%	41.6%	0.19	30.6%	40.2%	0.12	80
Harry Gwala	Umzimkhulu	54305015	47.2%	42.2%	0.20	28.5%	43.1%	0.12	81
Umzinyathi	Msinga	52404012	59.0%	44.4%	0.26	29.8%	41.1%	0.12	82
Uthungulu	Umlalazi	52804014	40.1%	42.4%	0.17	30.8%	39.6%	0.12	83
Umzinyathi	Umvoti	52405005	35.9%	42.0%	0.15	28.0%	43.3%	0.12	84
iLembe	Ndwedwe	52903002	34.5%	41.2%	0.14	30.0%	40.1%	0.12	85
Umkhanyakude	Jozini	52702017	63.5%	44.3%	0.28	28.5%	42.2%	0.12	86
iLembe	Maphumulo	52904011	48.2%	43.2%	0.21	29.1%	41.3%	0.12	87
Zululand	Ulundi	52606001	52.8%	41.9%	0.22	30.1%	39.9%	0.12	88
iLembe	Ndwedwe	52903018	32.6%	42.2%	0.14	30.1%	39.8%	0.12	89
Uthungulu	Nkandla	52806013	46.0%	41.4%	0.19	29.7%	40.1%	0.12	90
Umzinyathi	Msinga	52404019	48.6%	41.2%	0.20	28.2%	42.3%	0.12	91
iLembe	Maphumulo	52904005	46.0%	42.9%	0.20	27.9%	42.3%	0.12	92

			Census 2001			Census 2011			
District	Local Municipality	Ward Code	Headcount	Intensity	SAMPI Index Score	Headcount	Intensity	SAMPI Index Score	Deprived Ward Ranking Number
Harry Gwala	Umzimkhulu	54305004	47.9%	43.2%	0.21	27.5%	43.0%	0.12	93
Umzinyathi	Msinga	52404011	50.0%	45.4%	0.23	27.3%	43.3%	0.12	94
Umkhanyakude	Hlabisa	52704006	39.9%	42.3%	0.17	26.8%	44.0%	0.12	95
Umkhanyakude	Jozini	52702018	43.3%	43.9%	0.19	27.5%	42.9%	0.12	96
Zululand	Abaqulusi	52603002	38.9%	43.7%	0.17	27.7%	42.4%	0.12	97
Uthungulu	Umlalazi	52804005	43.9%	41.3%	0.18	29.6%	39.6%	0.12	98
Uthungulu	Ntambanana	52803001	40.4%	41.5%	0.17	27.5%	42.4%	0.12	99
iLembe	Maphumulo	52904008	36.8%	42.5%	0.16	28.6%	40.7%	0.12	100
Umkhanyakude	Umhlabuyalingana	52701010	45.7%	43.1%	0.20	28.2%	41.3%	0.12	101
Umkhanyakude	Umhlabuyalingana	52701007	51.4%	43.6%	0.22	27.7%	41.9%	0.12	102
iLembe	Maphumulo	52904006	50.6%	42.8%	0.22	28.7%	40.4%	0.12	103
iLembe	Ndwedwe	52903019	40.3%	42.8%	0.17	27.8%	41.7%	0.12	104
Uthukela	Okhahlamba	52305005	50.5%	47.0%	0.24	26.1%	44.4%	0.12	105
Harry Gwala	Ingwe	54301002	41.5%	42.9%	0.18	28.8%	40.0%	0.12	106
Umgungundlovu	Umngeni	52202001	28.8%	45.3%	0.13	25.2%	45.6%	0.11	107
Harry Gwala	Umzimkhulu	54305005	45.9%	42.4%	0.19	26.7%	42.9%	0.11	108
Umkhanyakude	Jozini	52702009	44.8%	41.4%	0.19	26.9%	42.5%	0.11	109
Uthukela	Okhahlamba	52305007	34.4%	44.8%	0.15	26.3%	43.4%	0.11	110
Umkhanyakude	Umhlabuyalingana	52701015	46.5%	43.7%	0.20	27.4%	41.4%	0.11	111
Umgungundlovu	Mkhambathini	52206007	43.3%	41.9%	0.18	28.4%	39.9%	0.11	112
Zululand	Abaqulusi	52603003	51.2%	45.3%	0.23	26.1%	43.0%	0.11	113
Uthukela	Imbabazane	52306008	52.9%	42.5%	0.22	26.6%	42.2%	0.11	114
Amajuba	Emadlangeni	52503004	42.1%	42.2%	0.18	27.3%	40.9%	0.11	115
Umkhanyakude	Jozini	52702001	43.4%	43.6%	0.19	25.7%	42.8%	0.11	116

			Census 2001			Census 2011			
District	Local Municipality	Ward Code	Headcount	Intensity	SAMPI Index Score	Headcount	Intensity	SAMPI Index Score	Deprived Ward Ranking Number
Ugu	Vulamehlo	52101009	30.6%	42.3%	0.13	27.2%	40.4%	0.11	117
Umkhanyakude	Jozini	52702019	52.4%	42.9%	0.23	26.1%	42.1%	0.11	118
Zululand	Nongoma	52605003	47.6%	44.1%	0.21	26.5%	41.5%	0.11	119
Uthukela	Okhahlamba	52305003	55.5%	47.1%	0.26	25.1%	43.7%	0.11	120
iLembe	Ndwedwe	52903010	37.3%	43.1%	0.16	26.3%	41.5%	0.11	121
Umkhanyakude	Umhlabuyalingana	52701011	41.0%	46.5%	0.19	25.7%	42.5%	0.11	122
Harry Gwala	Ubuhlebezwe	54304003	40.2%	41.5%	0.17	27.4%	39.6%	0.11	123
Umkhanyakude	Umhlabuyalingana	52701002	35.1%	41.5%	0.15	24.9%	43.6%	0.11	124
Harry Gwala	Ubuhlebezwe	54304001	38.6%	44.6%	0.17	24.8%	42.9%	0.11	125
Uthungulu	Mthonjaneni	52805006	50.2%	41.8%	0.21	25.1%	42.4%	0.11	126
iLembe	Maphumulo	52904007	41.3%	40.5%	0.17	26.1%	40.6%	0.11	127
Uthungulu	Nkandla	52806012	41.7%	44.0%	0.18	26.9%	39.4%	0.11	128
Umkhanyakude	Jozini	52702003	55.1%	44.2%	0.24	25.5%	41.3%	0.11	129
Zululand	Abaqulusi	52603005	48.6%	43.1%	0.21	25.3%	41.4%	0.10	130
Ugu	Umdoni	52102006	31.5%	49.0%	0.15	22.5%	46.7%	0.10	131
Ugu	Umzumbe	52103013	36.7%	42.1%	0.15	25.6%	40.9%	0.10	132
Umkhanyakude	Umhlabuyalingana	52701004	46.0%	45.0%	0.21	24.4%	42.8%	0.10	133
Umkhanyakude	The Big 5 False Bay	52703004	49.5%	45.1%	0.22	25.0%	41.7%	0.10	134
eThekwini	eThekwini	59500089	38.4%	46.3%	0.18	23.6%	43.6%	0.10	135
Uthukela	Umtshezi	52304006	36.8%	46.7%	0.17	22.9%	44.6%	0.10	136
Umkhanyakude	Jozini	52702006	42.1%	42.9%	0.18	23.8%	42.7%	0.10	137
Ugu	Vulamehlo	52101006	30.0%	40.4%	0.12	24.8%	40.8%	0.10	138
Uthungulu	Nkandla	52806006	54.9%	42.5%	0.23	24.4%	41.4%	0.10	139
iLembe	Ndwedwe	52903008	38.1%	41.8%	0.16	23.9%	42.0%	0.10	140

			Census 2001			Census 2011			
District	Local Municipality	Ward Code	Headcount	Intensity	SAMPI Index Score	Headcount	Intensity	SAMPI Index Score	Deprived Ward Ranking Number
iLembe	Ndwedwe	52903007	36.0%	41.8%	0.15	24.8%	40.2%	0.10	141
iLembe	Kwadukuza	52902001	35.5%	42.7%	0.15	24.3%	41.0%	0.10	142
Harry Gwala	Ingwe	54301007	38.5%	44.6%	0.17	23.7%	41.9%	0.10	143
Ugu	Umzumbe	52103011	42.3%	43.0%	0.18	25.0%	39.5%	0.10	144
Uthungulu	Nkandla	52806008	39.9%	43.5%	0.17	23.5%	42.1%	0.10	145
Umzinyathi	Endumeni	52402008	37.3%	42.1%	0.16	24.6%	39.9%	0.10	146
Ugu	Vulamehlo	52101002	19.2%	45.8%	0.09	22.6%	43.4%	0.10	147
Zululand	UPhongolo	52602006	40.0%	42.5%	0.17	22.8%	43.0%	0.10	148
Umzinyathi	Endumeni	52402004	37.8%	42.2%	0.16	23.7%	41.3%	0.10	149
Harry Gwala	Umzimkhulu	54305013	42.2%	44.5%	0.19	23.2%	41.9%	0.10	150
Harry Gwala	Umzimkhulu	54305009	49.1%	45.1%	0.22	23.1%	42.0%	0.10	151
Harry Gwala	Ingwe	54301003	46.7%	42.4%	0.20	23.5%	41.4%	0.10	152
Uthukela	Emnambithi	52302019	34.3%	45.2%	0.16	22.9%	42.3%	0.10	153
Umzinyathi	Endumeni	52402010	40.0%	43.2%	0.17	22.6%	42.8%	0.10	154
Umzinyathi	Endumeni	52402003	35.8%	42.1%	0.15	22.8%	42.3%	0.10	155
iLembe	Ndwedwe	52903011	31.7%	43.7%	0.14	23.0%	41.9%	0.10	156
Zululand	Abaqulusi	52603007	39.4%	45.5%	0.18	22.5%	42.6%	0.10	157
Uthungulu	Ntambanana	52803003	40.8%	40.0%	0.16	23.3%	40.9%	0.10	158
Uthungulu	Umlalazi	52804003	47.2%	42.1%	0.20	25.0%	38.0%	0.10	159
Harry Gwala	Ubuhlebezwe	54304009	40.1%	43.2%	0.17	22.4%	42.3%	0.09	160
Zululand	UPhongolo	52602001	46.6%	45.4%	0.21	23.4%	40.5%	0.09	161
Zululand	Ulundi	52606002	47.3%	47.0%	0.22	24.0%	39.3%	0.09	162
Harry Gwala	Ubuhlebezwe	54304008	35.7%	43.9%	0.16	23.0%	41.1%	0.09	163
Harry Gwala	Ubuhlebezwe	54304004	33.4%	44.7%	0.15	21.0%	44.7%	0.09	164

			Census 2001			Census 2011			
District	Local Municipality	Ward Code	Headcount	Intensity	SAMPI Index Score	Headcount	Intensity	SAMPI Index Score	Deprived Ward Ranking Number
Harry Gwala	Umzimkhulu	54305002	40.9%	43.8%	0.18	22.5%	41.7%	0.09	165
Harry Gwala	Umzimkhulu	54305019	38.6%	43.0%	0.17	22.1%	42.6%	0.09	166
Uthungulu	Nkandla	52806011	44.7%	42.7%	0.19	22.9%	41.1%	0.09	167
Umzinyathi	Umvoti	52405001	54.1%	40.1%	0.22	23.0%	40.8%	0.09	168
Ugu	Hibiscus Coast	52106015	29.8%	45.2%	0.13	22.4%	41.6%	0.09	169

INDICATOR DEFINITIONS

Annual Performance Plan 2015/16 – 2017/18

National customised indicators are highlighted in light green for ease of reference

Programme 1: Administration

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Audit opinion from Auditor-General	Outcome of the audit conducted by Office of the Auditor General of South Africa (AGSA)	Monitor effective and efficient financial and information management	Annual Report-AGSA Findings	Annual Report – AGSA Findings	**Categorical**	Categorical	Annual	None	Unqualified opinion	CFO; all Managers
Percentage of hospitals with broadband access ***New indicator***	Proportion of Hospitals that have access to at least 2 Mbps connection	Monitor broadband connectivity	Evidence of connectivity	ICT database	**Numerator** Total number of hospitals with minimum 2 Mbps connectivity **Denominator** Total number of hospitals	%	Quarterly	None	Increased percentage indicates improved access to broadband connectivity	ICT Manager
Percentage of fixed PHC facilities with broadband access ***New indicator***	Proportion of PHC facilities (including PHC clinics and CHCs) that have access to at least 512 Kbps connection	Monitor broadband connectivity	Evidence of connectivity	ICT database	**Numerator** Proportion of PHC facilities that have access to at least 512 Kbps connectivity **Denominator** Total number of fixed PHC facilities	%	Quarterly	None	Increased percentage indicates improved access to broadband connectivity	ICT Manager
Percentage over/ under expenditure ***New indicator***	Expenditure within 1% of the annual budget allocation per classification based on BAS expenditure reports	Monitor financial management and expenditure	BAS Reports	BAS Reports	**Numerator** Expenditure **Denominator** Annual allocated budget	%	Quarterly	None	Lower deviation indicates more effective financial management	CFO, DDG's, District and Facility Managers
Annual costed Procurement Plan ***New indicator***	A costed Procurement Plan making provision for minor and major assets for a specific reporting cycle (referring to financial years)	Inform budget allocation and effective management of budgets	Procurement Plan	Procurement Plan	**Categorical**	Categorical	Annual	None	Annual costed Procurement Plan	CFO and District/ Facility Managers

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of registered sites performing monthly asset reconciliation reports ***New indicator***	Sites, registered on the electronic finance system, report and account for all assets under their control by completing monthly reconciliation reports	Improve financial and supply chain management	Monthly reconciliation reports	Monthly reconciliation reports	Number of registered sites submitting monthly reconciliation reports on assets	No	Quarterly	None	High number indicates compliance	CFO and District/ Facility Managers
Long Term Human Resource Plan ***New indicator***	Ten year Human Resources Plan estimating HR needs/ demands over the next 10 years taking into consideration current gaps and service demands. The Plan will inform short, medium and long term planning and decision-making	Evidence-based decision-making for human resources for health	Long Term Human Resource Plan	Long Term Human Resource Plan	**Categorical**	Categorical	Annual	None	Approved Long Term HR Plan	HRMS Manager
Number of organisational structure finalised ***New indicator***	The number of organisational and post structures developed, costed and implemented	Monitor effective provision for human resource needs	Organisational and post structures	Organisational and post structures	Number of organisational and post structures developed, costed and implemented. The number includes structures for Head Office, Regional and District Offices, Programmes (e.g. Emergency Medical Services, Forensic Pathology Services), PHC clinics, CHCs and Hospitals	No	Annual	None	The ideal is to have all structures costed and implemented	HRMS Manager
Community Based Training in a PHC Model ***New indicator***	New decentralised and community based training model for Health Sciences Students (doctors, nurses and allied workers) change the focus from hospicentric to a PHC approach in line with the re-engineering of PHC. Partnership between the Department of Health (DOH) and the University of KwaZulu-Natal (UKZN) to ensure the training and service delivery platform is aligned	Monitor progress in implementation of the new model and the production of health care providers over time	Business Plan, Training Model and Task Team Reports (DOH/UKZN)	Business Plan, Training Model and Task Team Reports (DOH/UKZN)	**Categorical**	Categorical	Annual	None	Model approved and implemented	Provincial Task Team (DOH/UKZN)

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Medical officers per 100,000 people	The number of medical officers in posts on the last day of March (of reporting year) per 100,000 population	Track the number of medical officers (in posts in the public health sector) in relation to the total population in the province	Persal (Medical Officers) DHIS (StatsSA population)	Persal (Medical Officers) DHIS (StatsSA population)	**Numerator** Number of Medical Officer posts filled **Denominator** Total population	Number per 100 000 pop	Annual	Dependant on accuracy of Persal data and StatsSA estimates. There are no standard SA norms to measure against	Increase in the number of Medical Officers contributes to improving access to and quality of clinical care	HRMS Manager
Professional nurses per 100,000 people	The number of professional nurses in posts on the last day of March (of reporting year) per 100,000 population	Track the number of professional nurses (in posts in the public health sector) in relation to the total population in the province	Persal (Professional Nurses) DHIS (StatsSA population)	Persal (Professional Nurses) DHIS (StatsSA population)	**Numerator** Number of Professional Nurse posts filled **Denominator** Total population	Number per 100 000 pop	Annual	Dependant on accuracy of Persal data and StatsSA estimates. There are no standard SA norms to measure against	Increase in the number of Professional Nurses contributes to improving access to and quality of clinical care	HRMS Manager
Pharmacists per 100,000 people	The number of pharmacists in posts on the last day of March (of reporting year) per 100,000 population	Track the number of pharmacists (in posts in the public health sector) in relation to the total population in the province	Persal (Pharmacists) DHIS (StatsSA population)	Persal (Pharmacists) DHIS (StatsSA population)	**Numerator** Number of Pharmacist posts filled **Denominator** Total population	Number per 100 000 pop	Annual	Dependant on accuracy of Persal data and StatsSA estimates. There are no standard SA norms to measure against	Increase in the number of Pharmacists contributes to improving access to and quality of clinical care	HRMS Manager
Number of Hospital Managers who have signed Performance Agreements (PAs)	The number of Hospital Managers who have signed Performance Agreements with their supervisors at the beginning of the reporting year	Improve performance monitoring, development and accountability	Signed PAs	Performance Management records (HRMS)/ Signed PAs	Number of Hospital Managers with signed Performance Agreements for the reporting period	Number	Annual	None	All staff sign annual PAs - aligned with Departmental priorities in Strategic, Annual Performance, District and Institutional Plans	HRMS Manager
Number of District Managers who have signed PAs	The number of District Managers who have signed Performance Agreements with their supervisors at the beginning of the reporting year	Improve performance monitoring, development and accountability	Signed PAs	Performance Management records (HRMS)/ Signed PAs	Number of District Managers with signed Performance Agreements for the reporting period	Number	Annual	None	All staff sign annual PAs - aligned with Departmental priorities in Strategic, Annual Performance, District and Institutional Plans	HRMS Manager
Percentage of Head Office Managers (Level 13 and above) who have signed PAs	The proportion of Senior Managers (level 13 and above) who have signed Performance Agreements with supervisors at the beginning of the reporting year	Improve performance monitoring, development and accountability	Signed PAs	Performance Management records (HRMS)/ Signed PAs	**Numerator** Head Office Managers (level 13 and above) who signed PA's for the period under review **Denominator** Number of Head Office Managers (level 13 and above)	%	Annual	None	All staff sign annual PAs - aligned with Departmental priorities in Strategic, Annual Performance, District and Institutional Plans	HRMS Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Provincial Long Term Plan	Ten year plan making provision for service transformation, system strengthening, service provision and clinical care. The Plan provides the blue print for short, medium and long term plans in the Department	Inform service transformation/ delivery and resource allocation over a ten year period	Long Term Plan	Long Term Plan	**Categorical**	Categorical	Annual	None	Long Term Plan approved	Strategic Planning Manager
Approved revised M&E Framework ***New indicator***	Review of the current M&E Framework that provides the parameters for monitoring, evaluation and reporting against performance targets	Improve evidence-based M&E, decision-making and planning	Revised M&E Framework	Revised M&E Framework	**Categorical**	Categorical	Annual	None	Revised M&E Framework approved to regulate monitoring, evaluation and reporting	M&E Manager
Data submission rate ***New indicator***	All public health facilities submit prioritised performance data as per stipulated timelines for collation of district and provincial data	Monitor data completeness and submission rates	Standardised facility submission tool	Standardised facility submission tool	**Numerator** Number of facilities submitting complete performance data as per stipulated timeline **Denominator** Number of facilities	%	Quarterly	Record keeping at district level using standardised data submission tool	Improved data completeness and quality	Data Management Manager
Audit error rate (PHC clinics and CHC's) ***New indicator***	Deviation between data collection tools at PHC and CHC level and DHIS	Monitor data accuracy and quality	Internal audit reports	Internal audit reports	**Numerator** Sum of variance between data collection tools and DHIS at audited PHC facilities and CHCs **Denominator** Number of PHC facilities and CHCs audited	%	Quarterly	Sample of audited facilities by internal teams might be inadequate to generalise	Lower deviation indicates improved data quality	Data Management Manager
Audit error rate (Hospitals) ***New indicator***	Deviation between the data collection tools at hospital level and DHIS	Monitor data accuracy and quality	Internal audit reports	Internal audit reports	**Numerator** Sum of variance between data collection tools and DHIS during audit at hospitals **Denominator** Number of hospitals audited	%	Quarterly	Sample of audited facilities by internal teams might be inadequate to generalise Provincial error rate	Lower deviation indicates improved data quality	Data Management Manager
Percentage of public health hospital with functional health information committees ***New indicator***	Appointment of Health Information Committees at hospitals - composition as per Provincial Data Management Policy	Monitor the establishment of Information Committees to improve data quality at facility level	Minutes of meetings	District & Facility Reports	**Numerator** Number of public health hospitals with a functional health information committee **Denominator** Number of public health hospitals	%	Annual	None	All hospitals have functional Information Committees	Data Management Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of Level 1 Health Ethics Review Boards established (cumulative)	Official Health Ethics Board(s) established to approve and monitor research for health. Composition as prescribed in the Provincial Health Research & Knowledge Management Policy	Monitor establishment of Research Boards to improve research processes and systems	Appointment letters of Health Ethics Review Board Members	Appointment letters of Health Ethics Review Board Members	Established Level 1 Ethics Review Boards (as per Provincial Health Research & Knowledge Management Policy)	Number	Annual	None	Increase in the number of Boards will reduce turn-around time for approval of research proposals	Epidemiology & Health Research Manager
Stakeholder analysis ***New indicator***	Identification and analysis of internal and external stakeholders to improve stakeholder involvement and participation in health matters	Identify stakeholders to improve consultation, participation and feedback on health related matters	Stakeholder analysis	Stakeholder analysis	**Categorical**	Categorical	Annual	None	Internal and external stakeholders identified	Corporate Communications Manager
Social media platforms ***New indicator***	Social media platforms including blog, twitter, etc. activated to create interactive communication and consultation on health matters and to inform health messaging	Monitor and analyse responses of stakeholders to enrich service delivery	Social media platform	Social media platform	**Categorical**	Categorical	Annual	None	Interactive social media established	Corporate Communications Manager
Number of corporate events conducted ***New indicator***	The number of health events conducted by the Department	Monitor the number of health events	Communication database	Communication database	Number of health events conducted	Number	Quarterly	None	Health events as per health calendar	Corporate Communications Manager
ICT Governance Policy and Framework ***New indicator***	Appropriate ICT Governance Framework developed to regulate the ICT environment	Monitor implementation of the ICT Governance Policy Framework	ICT Governance Policy & Framework	ICT Governance Policy & Framework	**Categorical**	Categorical	Annual	None	ICT Governance Policy & Framework developed and implemented	ICT Manager
Percentage of health facilities with stable bandwidth connectivity ***New indicator***	Proportion of public health facilities with stable bandwidth connectivity	Monitor facility connectivity	Evidence of connectivity	ICT database	**Numerator** Total number of public health facilities with stable bandwidth connectivity **Denominator** Total number of public health facilities	%	Annual	None	Increased access to bandwidth connectivity	ICT Manager
ICT Backup solution installed ***New indicator***	ICT backup solution installed	Monitor upgrade of ICT infrastructure in public health facilities	Evidence of ICT backup system	ICT database	**Categorical**	Categorical	Annual	None	Secured ICT backup system	ICT Manager
ICT security Infrastructure ***New indicator***	Reliable ICT security system installed and functional	Monitor the ICT security system	Evidence of security system	ICT database	**Categorical**	Categorical	Annual	None	Security system installed and functional	ICT Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Percentage of public health facilities with a web-based health information system ***New indicator***	Implementation of a web-based system for a National Integrated Patient-Based Information System at PHC level	Monitor integrated reporting on web-based patient information system	Web-based reporting	Web-based reporting	**Numerator** Number of public health facilities submitting reports on the web-based reporting system **Denominator** Number of public health facilities	%	Annual	None	Higher percentage an indication of improved information reporting system	ICT and Data Management Managers
Percentage of public health facilities with an Enterprise Content Management system ***New indicator***	Enterprise content management system installed to improve information management	Monitor improved information management	Evidence of content management system	ICT database	**Numerator** Number of public health facilities with enterprise content management system **Denominator** Number of public health facilities	%	Annual	None	Higher percentage indicates improved performance	ICT Manager
Number of functional Tele-medicine sites	Connectivity established to enable electronic communication through e-health, m-health and telemedicine	Improve availability of mentoring, training & development	Actual functional telemedicine sites	Telemedicine database	Number of functional tele-medicine sites	Number	Quarterly	None	Improved access to training & development	Telemedicine Manager
Hospital Rationalisation Plan ***New indicator***	Hospital Rationalisation Plan making provision for rationalisation and optimisation of hospital services (all classifications) including classification, package of services, staffing (according to staffing norms), bed allocation per clinical domain, specialities, complexes and centres of excellence, etc.	Improve hospital efficiencies and quality as per plan	Approved Plan	Approved Plan	**Categorical**	Categorical	Annual	None	Plan approved and implemented	Specialised Services , DHS and Strategic Planning Managers
Proportion of public health facilities that scored >75% on the Food Service Monitoring Standards Grading System	The proportion of facilities that comply with more than 75% of the food service standards using a customised grading system	Monitor the quality of Food Services	Food Services monitoring reports	Food Services Grading Register	**Numerator** Public health facilities that score more than 75% on the Food Service Monitoring Standards Grading System **Denominator** Number of public health facilities	%	Annual	Accurate and updated reports	Higher percentage desired indicating higher standard of food services	Food Services Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of public health facilities compliant with 2 priority Food Safety Standards	Public health facilities that implement the food safety standards and comply with priority standards	Monitor the quality of Food Services	Food Services monitoring reports	Food Services Register	Public health facilities that comply with 2 priorities of Food Safety Standards	Number	Annual	Accurate and updated reports	Higher number desired indicating higher standard of services	Food Services Manager
Percentage public health facilities with access control at the gate	Public health facilities that comply with standard fencing and gate control requirements	Monitor safety and security at public health facility level	Security audit results	Security reports	**Numerator** Fenced public health facilities with gate access control **Denominator** Total public health facilities	%	Annual	None	Higher percentage desired indicating improved security	Security Manager

Programme 2: (District Health Services)

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of districts piloting NHI interventions ***New indicator***	Total number of Districts piloting NHI interventions as per NHI White Paper	Track implementation of NHI Phase 1 implementation	Documented evidence	Documented evidence	Number of Districts piloting NHI interventions	Number	Annual	None	Three districts piloting NHI	NHI Manager
Established NHI Consultation Forum ***New indicator***	Provincial NHI Consultative Forum established to consult non-state actors, patient and non-patient groups on NHI. The forum will consist of stakeholders and interest groups	Track consultation with stakeholders in health service delivery in NHI districts	Letters of appointment	Letters of appointment	**Categorical**	Categorical	Annual	None	NHI Forum established	NHI Manager
Percentage of fixed PHC facilities scoring above 80% on the ideal clinic dashboard ***New indicator***	Percentage of fixed PHC facilities that score above 80% on the Ideal Clinic Dashboard (PHC essential standards and criteria) – tool available	Monitor compliance to Ideal Clinic standards	Ideal Clinic assessment records	Ideal Clinic assessment records	**Numerator** Number of fixed PHC facilities scoring above 80% on the ideal clinic dashboard **Denominator** Number of fixed PHC facilities that conducted an assessment using the Ideal Clinic Dashboard to date in the current financial year	%	Quarterly	Poor reporting using the Ideal Clinic Dashboard tool	Higher scores show compliance to Ideal Clinic standards	PHC and QA Managers

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Patient experience of care survey rate (fixed PHC facilities) ***New indicator***	Fixed PHC facilities that have conducted patient experience of care (PEC) surveys as a proportion of fixed PHC facilities	Monitor whether health establishments are conducting PECs to monitor patient satisfaction with health services	PEC Survey evidence	PEC Survey Reports - QA	**Numerator** Total number of fixed PHC facilities that conducted a patient experience of care survey to date in the current financial year **Denominator** Total number of fixed PHC facilities	%	Quarterly	Poor reporting of PEC surveys	All health facilities conduct PEC surveys to monitor patient satisfaction with services and to address concerns	QA and PHC Managers
Patient experience of care rate at PHC facilities	Average percentage of PHC patient experience of care scores in all PHC facilities that conducted annual PEC surveys	Track patient satisfaction with public health services	PEC satisfaction scores	QA database/ PEC results	**Numerator** Sum of patient experience of care scores of all fixed PHC facilities that conducted a patient experience of care survey to date in the current financial year **Denominator** Total number of fixed PHC facilities that conducted a patient experience of care survey to date in the current financial year	%	Annual	Poor monitoring and reporting of surveys and survey data	Improved satisfaction with health services	QA and PHC Managers
Outreach Household registration visit coverage (annualised)	Outreach households (OHH) registered by Ward Based Outreach Teams as a proportion of OHH in the population. The population is divided by 12 in the formula to make provision for annualisation	Monitor PHC re-engineering with a focus on community-based outreach and household visits and services	Outreach registers (households registered) StatsSA (households)	DHIS StatsSA (households)	**Numerator** Outreach households registration visits **Denominator** Outreach households in the catchment population	%	Quarterly (annualised)	Poor record keeping and reporting especially in the DHIS Module. Accurate household data from StatsSA	All households covered by community outreach teams	PHC Manager
Number of districts with district clinical specialist teams (DCST's)	Number of Districts that have DCSTs with the full composition of team members as defined by the Ministerial Task Team report (Specialist PHC Nurse, Advanced Midwife, Paediatric Nurse, Gynaecologist, Paediatrician, Family Medicine, and Anaesthetist)	Improve clinical governance and clinical care at district level	Documented evidence – appointment on Persal	DHIS - Documented evidence – appointment on Persal	Number of fully fledged District Clinical Specialist Teams (Due to the difficulty in recruiting Anaesthetists in the Province, the minimum requirement for "fully fledged" teams exclude Anaesthetists although the Department continues to recruit)	Number	Quarterly	Documented evidence	Specialist teams operational as per role and functions	DHS Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
PHC utilisation rate	Average number of PHC visits per person per year in the population. The population is divided by 12 in the formula to make provision for annualisation	Monitor PHC access and utilisation	PHC tick registers DHIS (StatsSA population estimates)	DHIS	**Numerator** PHC headcount total **Denominator** Total population	Rate	Quarterly	Dependant on the accuracy of reporting and estimated population from StatsSA	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system	PHC Manager
Complaint resolution rate	Complaints resolved as a proportion of complaints received	Monitor the response to customer concerns/ complaints	Complaint register/ documented evidence at facility level	DHIS	**Numerator** Complaint resolved **Denominator** Complaint received	%	Quarterly	Accuracy of reporting at facility level	Higher percentage suggest improved response to complaints	QA Manager
Complaints resolution within 25 working days rate	Complaints resolved within 25 working days as proportion of all complaint resolved	Monitor public health system response to customer concerns (turn-around time)	Complaints register/ documented evidence	DHIS	**Numerator** Complaints resolved within 25 working days **Denominator** Number of complaints resolved	%	Quarterly	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Higher percentage suggest better management of complaints	QA Manager
Life expectancy at birth – Total ***New indicator***	The average life expectancy at birth (age from birth to death)	Track improved quality of life – people living longer	StatsSA Mid-Year Estimates	StatsSA Mid-Year Estimates	Quote from the published StatsSA mid-year population estimates – Life expectancy at birth	Years	Annual	None	Increase in life expectancy indicates improved quality of life	Planning, M&E Managers
Life expectancy at birth – Male ***New indicator***	The expected life expectancy at birth for males (age from birth to death)	Track improved quality of life - people living longer	StatsSA Mid-Year Estimates	StatsSA Mid-Year Estimates	Quote from the published StatsSA mid-year population estimates – Life expectancy at birth for males	Years	Annual	None	Increase in life expectancy indicates improved quality of life	Planning, M&E Managers
Life expectancy at birth – Female ***New indicator***	The expected life expectancy at birth for females (age from birth to death)	Track improved quality of life - people living longer	StatsSA Mid-Year Estimates	StatsSA Mid-Year Estimates	Quote from the published StatsSA mid-year population estimates – Life expectancy at birth for females	Years	Annual	None	Increase in life expectancy indicates improved quality of life	Planning, M&E Managers
PHC utilisation rate under 5 years (annualised)	Average number of PHC visits per year per person under 5 years in the population. The population is divided by 12 in the formula to make provision for annualisation	Monitor PHC access and utilisation by children under 5 years	PHC tick register/ DHIS (StatsSA population estimates)	DHIS	**Numerator** PHC headcount under 5 years **Denominator** Population under 5 years	Rate	Quarterly (annualised)	Dependant on the accuracy of collected data and estimated population under 5 years from StatsSA	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	PHC Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Expenditure per PHC headcount	Provincial expenditure per person visiting public health PHC services	Monitor PHC expenditure trends and economy of scale	BAS (expenditure) PHC Tick Register	DHIS (headcount) BAS (expenditure)	**Numerator** Total expenditure in PHC (Sub-Programmes 2.2-2.7) **Denominator** Provincial PHC total headcount	Rand	Quarterly	Efficient record management at facility level and accuracy of BAS	Lower expenditure may indicate efficient use of resources; higher expenditure may indicate improved access to PHC	PHC and Budget Control Managers
Number of School Health Teams (cumulative)	Number of School Health Teams appointed to render services at schools as part of PHC re-engineering. Composition of teams (minimum requirement): Professional Nurse, Staff Nurse and Enrolled Nursing Assistant – may include additional members	Monitor school health services as part of PHC re-engineering	Persal and District Management	PHC database	School Health Teams appointed (cumulative)	Number (cumulative)	Annual	School Health Teams not correctly linked on BAS or Persal	Higher number desired for improved school coverage	PHC Manager
Number of Ward-Based Outreach Teams (WBOTs) in the 169 wards worst affected by poverty (cumulative) ***New indicator***	The number of ward-based outreach teams in the 169 wards with the highest poverty levels in the SAMPI Index Score as part of the Provincial Poverty Eradication Master Plan (List attached as Annexure in APP)	Monitor household coverage in the 169 wards worst affected by poverty (SAMPI Index Score)	Ward-based data – DHIS GIS (mapping of wards)	Ward-based data - DHIS	Number of Ward Based Outreach Teams (including PHC Outreach, School Health, TB, HIV/ AIDS Teams) in the identified 169 wards (cumulative)	Number (cumulative)	Annual	Accuracy of reporting	Ward Based Outreach Teams deployed in all 169 identified wards	PHC Manager
Number of accredited Health Promoting Schools (cumulative)	The number of schools that have been officially accredited as Health Promoting Schools by an external Assessment Authority. Accreditation is based on full compliance to the national norms and standards for Health Promoting Schools	Monitor implementation of community ownership for health promotion at schools in line with the Ottawa Charter's 5 Action Areas to expand the role of learners as partners in health and to improve accountability for health at household level	School accreditation certificate	Health Promotion database	Number of schools accredited as Health Promoting Schools by an external assessment authority	Number (cumulative)	Quarterly	Accuracy and completeness of the HPS database	Higher number desired to support community ownership for health promotion	PHC Manager
Dental extraction to restoration ratio	The ratio between the number of teeth extracted and the number of teeth restored	Monitor overall quality of dental services	Dental records/ register at facility level	DHIS	**Numerator** Tooth extraction **Denominator** Tooth restoration	Ratio	Quarterly	Reliant on accurate reporting at facility level	Decreased ratio indicates improvement in dental health services (lower ratio indicate improved management)	Oral Health Manager

Programme 2: (HIV, AIDS, STI and TB Control)

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Total clients remaining on ART (cumulative)	Cumulative total of patients on any ARV regimen	Track the number of patients on ARV treatment	ART Register	TIER.Net/ DHIS	Clients remaining on ART equals Naïve [including PEP and PMTCT] + experienced + Transfer-in + Restart minus [Died + lost to follow-up + Transfer-out]	Number (cumulative)	Quarterly	Dependent on accurate reporting	Higher total indicates a larger population on ART treatment – positive response to managing the prevalence of HIV	HIV/AIDS Manager
Client tested for HIV (incl. ANC)	Number of clients tested for HIV including under 15 years and antenatal clients	Monitor annual testing of persons who are not known HIV positive to increase the proportion of the population with known HIV status. It also inform resource allocation e.g. test kits and staffing	HIV Register	DHIS	Client tested for HIV (Incl ANC)	Number	Quarterly	Record keeping at facility level while non-reporting of testing outside public health facilities skew total testing numbers	Higher number indicated better response to increased "know your status" initiative	HIV/AIDS Manager
TB symptom 5 years and older screened rate ***New indicator***	Clients 5 years and older screened for TB symptoms as a proportion of PHC headcount 5 years and older	Monitor trends in early identification of TB suspects in health care facilities	TB register/ PHC tick register	DHIS	**Numerator** Clients 5 years and older screened for TB symptoms **Denominator** PHC headcount 5 years and older	%	Quarterly	Accuracy of recording and reporting at facility level	Higher percentage indicates improved screening and surveillance	TB Manager
Male condom distribution coverage (annualised)	Male condoms distributed from a primary distribution site to health facilities or points in the community (e.g. campaigns, non-traditional outlets, etc.). The population will be divided by 12 in the formula to make provision for annualisation	Monitor distribution of male condoms as dual protection i.e. prevention of sexually transmitted infections and unplanned pregnancy	Condom distribution records	DHIS	**Numerator** Male condoms distributed **Denominator** Male population 15 years and older	Rate	Quarterly (annualised)	Indicator reliant on accuracy of population estimates and record keeping	Higher rate indicates improved access to dual protection and prevention of STI's and HIV	HIV/AIDS Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Female condom distribution rate (annualised) ***New indicator***	Female condoms distributed from a primary distribution site to health facilities or points in the community (e.g. campaigns, non-traditional outlets, etc.). The population will be divided by 12 in the formula to make provision for annualisation	Monitor distribution of female condoms as dual protection i.e. prevention of sexually transmitted infections and unplanned pregnancy	Condom distribution records	DHIS	**Numerator** Female condoms distributed **Denominator** Female population 15 years and older	Rate	Quarterly (annualised)	Indicator reliant on accuracy of population estimates	Higher rate indicates improved access to dual protection and prevention of STI's and HIV	HIV/AIDS Manager
Medical male circumcision performed – Total (cumulative)	Total medical male circumcisions (MMCs) performed under medical supervision for males 10 years and older	Monitor medical male circumcision as component of the HIV prevention strategy	MMC Register	DHIS	Males 10 years and older circumcised under medical supervision	Number (cumulative)	Quarterly	Poor reporting in DHIS	Higher number of MMCs indicates increased uptake of the prevention strategy for males	HIV/AIDS Manager
TB new client treatment success rate	TB clients successfully completed treatment as proportion of TB clients who started on treatment	Monitor successful completion of TB treatment for all types of TB	TB Register	ETR.Net	**Numerator** TB client successfully completed treatment **Denominator** TB client start on treatment	%	Quarterly	Accuracy dependent on quality of data from reporting facilities	Higher percentage indicate better treatment success rate	TB Manager
TB client lost to follow up rate ***New indicator***	Proportion of TB clients who were lost to follow up as a proportion of TB client who started on treatment	Monitor the effectiveness of the TB retention in care strategies	TB Register	ETR.Net	**Numerator** TB client lost to follow up **Denominator** TB client start on treatment	%	Quarterly	Accuracy dependent on quality of data from reporting facility	Reduced percentage indicates improved compliance to treatment	TB Manager
TB death rate ***New indicator***	TB clients who died during treatment as a proportion of TB clients that started on treatment	Monitor death of clients on TB treatment. The cause of death may not necessarily be due to TB	TB Register	ETR.Net	**Numerator** TB client died during treatment **Denominator** TB client start on treatment	%	Quarterly	Accuracy dependent on quality of data from reporting facility	Reduced percentage indicates better treatment success	TB Manager
MDR-TB confirmed treatment initiation rate ***New indicator***	MDR-TB confirmed clients started on treatment as a proportion of confirmed MDR-TB clients	Monitor initial loss to follow up and the effectiveness of linkage to care strategies	MDR-TB Register	ETR.Net	**Numerator** MDR-TB confirmed client start on treatment **Denominator** MDR-TB confirmed client	%	Annual	Accuracy dependent on quality of data from reporting facility	Increased percentage indicates improved response to initiation of treatment for eligible clients	TB Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
MDR-TB treatment success rate	MDR-TB client successfully treated as a proportion of MDR-TB confirmed clients started on treatment	Monitor success of MDR-TB treatment	MDR-TB Register	ETR.Net	**Numerator** MDR-TB client who successfully completed treatment **Denominator** MDR-TB confirmed client start on treatment	%	Annual	Accuracy dependent on quality of data from reporting facility	Increased percentage indicates improved management of MDR-TB	TB Manager
MDR-TB six months interim outcome	The proportion of patients that culture converted at 6 months who have had 9 months of treatment	Monitor management and outcomes of drug-resistant TB	MDR-TB Register	ETR.Net	**Numerator** Number of patients who started treatment for 9 months with a negative culture at 6 months **Denominator** Total patients who started treatment in the same period	%	Annual	Dependent on data completeness and accuracy at facility level	Higher percentage desired indicative of good case holding practices	TB Manager
Number of patients that started XDR-TB treatment	The number of XDR-TB cases registered for treatment in a specific time period (incl. new+ previously treated)	Monitor management and outcomes of drug-resistant TB	XDR-TB Register	ETR.Net	Number of patients that started on the XDR-TB treatment regime	Number	Annual	Dependent on data completeness and accuracy at facility level	A higher number might indicate good case finding while lower number, regardless of intensified case finding, may indicate decreasing XDR-TB incidence	TB Manager
XDR-TB six month interim outcome	The proportion of patients that culture converted at 6 months who have had 9 months of treatment	Monitor management and outcomes of drug-resistant TB	XDR-TB Register	ETR.Net	**Numerator** Number of clients with a negative culture at six months who has had started treatment for 9 months **Denominator** Total of patients who started treatment in the same period	%	Annual	Dependent on data completeness and accuracy at facility level	Higher percentage desired - good case holding practices	TB Manager
TB incidence	The number of new TB infections per 100 000 population	Monitor new TB infections	TB Register	ETR.Net (patients) DHIS (StatsSA population)	**Numerator** New confirmed TB cases **Denominator** Total population	Number per 100,000 population	Annual	Dependent on accuracy of data from reporting facilities	Reduced incidence desired – improved prevention of TB	TB Manager
HIV incidence	New HIV infections in the general population	Monitor new infections as part of monitoring impact of prevention strategies	ASSA2008 projections	ASSA2008 projections	Quote from ASSA2008 published projections (the Department is not collecting this indicator – dependent on research and projections)	%	Annual	Not routinely collected therefore using ASSA2008 or Stats SA projections	Reduced incidence desired – effective prevention programmes	HIV/AIDS Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
STI treated new episode incidence (annualised)	Patients treated for a new STI episode as a proportion of population 15 years and older. The population will be divided by 12 in the formula to make provision for annualisation	Monitor the incidence of STI and effectiveness of prevention and treatment programmes for STI's	PHC Tick Register	DHIS	**Numerator** STI treated new episode **Denominator** Population 15 years and older	Number per 1000	Quarterly (annualised)	Data quality – data only refers to clients treated at public health facilities	Decrease in STIs might indicate success in prevention programmes	HIV/AIDS Manager
HIV testing coverage (15-49years) (annualised)	Clients tested for HIV as proportion of population 15-49 years. The population will be divided by 12 in the formula to make provision for annualisation	Monitor testing of persons 15-49 years who are not known HIV positive	Tick Register PHC Counsellor Tick Register StatsSA (population)	DHIS	**Numerator** HIV test client 15 to 49 years **Denominator** Population 15 to 49 years	%	Quarterly (annualised)	Accuracy dependent on quality of data from reporting entity	Higher coverage desired – more people knowing their HIV status	HIV/AIDS Manager
HIV prevalence among 15 to 24 year old pregnant women ***New indicator***	The HIV positive pregnant women 15 to 24 years as proportion of the total number of pregnant women 15 to 24 years tested for HIV	Monitor the HIV prevalence rate of pregnant women between 15 and 24 years (MDG Target)	National Antenatal Sentinel HIV & Herpes Simplex Type-2 Prevalence Survey in South Africa	National Antenatal Sentinel HIV & Herpes Simplex Type-2 Prevalence Survey in South Africa	Quote from the National Antenatal Sentinel HIV & Herpes Simplex Type-2 Prevalence Survey in South Africa	%	Annual	None	Reduced prevalence over time	HIV/AIDS Manager
TB AFB sputum result turn-around time under 48 hours rate	Proportion of TB test results received within 48 hours of submitting sample to Laboratory for testing	Monitor the effectiveness of both the facility and laboratory systems in ensuring that results are received by facilities (SMS or printed report) within 48 hours from when specimen was collected	TB Register/ Lab records	ETR.Net	**Numerator** TB AFB sputum result received within 48 hours **Denominator** TB AFB sputum sample sent	%	Quarterly	Reliant on accuracy of data at facility level	Higher percentage indicates efficiency in managing results	TB Manager
TB (new pulmonary) cure rate	New smear positive pulmonary TB clients cured as a proportion of new smear positive pulmonary TB clients started on TB treatment	Monitor cure of new pulmonary TB clients. This follows a cohort analysis therefore the clients would have been started on treatment at least 6 months prior	TB Register	ETR.Net	**Numerator** TB (new pulmonary) client cured **Denominator** TB (new pulmonary) client initiated on treatment	%	Quarterly	Accuracy dependent on quality of data from reporting facility	Higher percentage indicate better TB outcomes	TB Manager

Programme 2: (Maternal, Neonatal, Child & Women's Health and Nutrition)

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Antenatal 1st visit before 20 weeks rate	Women who have a booking visit (first visit) before they are 20 weeks into their pregnancy as proportion of all antenatal 1st visits	Monitor early utilisation of antenatal services	PHC Tick Register	DHIS	**Numerator** Antenatal 1st visit before 20 weeks **Denominator** Antenatal 1st visit - total	%	Quarterly	Reliant on accuracy of number of weeks the client is pregnant	Higher percentage indicates better access to antenatal care	MNCWH Manager
Mother postnatal visit within 6 days rate	Mothers who received postnatal care within 6 days after delivery as proportion of deliveries in public health facilities	Monitor access and utilisation of postnatal services. May be more than 100% in areas with low deliveries in facilities if mothers who delivered outside health facilities use these facilities for postnatal visits within 6 days after delivery	PHC Register	DHIS	**Numerator** Mother postnatal visit within 6 days after delivery **Denominator** Delivery in facility total	%	Quarterly	Accuracy of reporting at facility level	Higher percentage indicates improved post natal care	MC&WH Manager
Antenatal client initiated on ART rate	Antenatal clients who started on ART as a proportion of the total number of antenatal clients who are HIV positive and not previously on ART	Monitor implementation of PMTCT guidelines in terms of ART initiation of eligible HIV positive antenatal clients. From 2015/01/01 all HIV positive antenatal clients go onto lifelong treatment regardless of their CD4 status	ART Register	DHIS	**Numerator** Antenatal client start on ART **Denominator** Antenatal client eligible for ART initiation	%	Annual	Reliant on accuracy of reporting at facility level	Increased percentage indicates improved response to management of eligible clients	MC&WH and HIV/AIDS Managers
Infant 1st PCR test positive around 6 weeks rate	Infants tested PCR positive for the first time around 6 weeks after birth as proportion of Infants PCR tested around 6 weeks	Monitor positivity in HIV exposed infants around 6 weeks	ART Register	DHIS	**Numerator** Infant 1st PCR test positive around 6 weeks **Denominator** Infant 1st PCR test around 6 weeks	%	Quarterly	Accuracy of reporting at facility level	Reduced percentage indicates improved outcomes of PMTCT	MC&WH Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Immunisation coverage under 1 year (annualised)	Children under 1 year who completed their primary course of immunisation as a proportion of population under 1 year. The population will be divided by 12 in the formula to make provision for annualisation	Monitor immunisation coverage as part of child health. Child counted once as fully immunised when receiving the last vaccine in the course (usually the 1st measles and PCV3 vaccines) and if there is documented proof of all required vaccines (BCG, OPV1, DTaP-IPV/Hib 1, 2, 3, HepB 1, 2, 3, PCV 1,2,3, RV 1,2 and measles 1) on the Road to Health Card/Booklet and the child is under 1 year old	PHC Tick Register	DHIS (StatsSA population in DHIS)	**Numerator** Immunised fully under 1 year new **Denominator** Population under 1 year	%	Quarterly (annualised)	Reliant on accurate reporting and under 1 population estimates from StatsSA	Higher percentage indicate better immunisation coverage	MC&WH Manager
Measles 2nd dose coverage (annualised)	Children of 1 year (12-23 months) who received measles 2nd dose, normally at 18 months, as a proportion of population under 1 year. The population will be divided by 12 in the formula to make provision for annualisation	Monitor protection of children against measles. Because the 1st measles dose is only around 85% effective the 2nd dose is important as a booster. Vaccines given as part of mass vaccination campaigns not included	PHC Tick Register	DHIS	**Numerator** Measles 2nd dose **Denominator** Population 1 year	%	Quarterly (annualised)	Reliant on accurate reporting and estimates of population (StatsSA)	Higher percentage indicates better immunisation coverage	MC&WH Manager
DTaP-IPV/Hib3 - measles1st dose drop-out rate ***New indicator***	Children who dropped out of the immunisation schedule between DTaP-IPV-HepB-Hib 3rd dose, normally at 14 weeks and measles 1st dose, normally at 9 months as a proportion of population under 1 year	Monitor children who drop out of the vaccination program after 14 week vaccination. DTaP-IPV-HepB-Hib (also known as Hexaxim) will be implemented in 2015 and DTaP-IPV/Hib (Pentaxim) will be phased out as stocks are replaced with Hexaxim	PHC Tick Register	DHIS	**Numerator** DTaP-IPV-HepB-Hib 3 to Measles 1st dose drop–out **Denominator** DTaP-IPV-HepB-Hib 3rd dose	%	Quarterly	Reliant on accurate reporting at facility level	Reduced percentage indicates improved response to the immunisation schedule	MC&WH Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Child under 5 years diarrhoea case fatality rate	Children under 5 years admitted with diarrhoea who died as a proportion of children under 5 years admitted with diarrhoea	Monitor treatment outcome for children under-5 years who were admitted with diarrhoea	Inpatient under-5 year death records Admission records children under 5 years	DHIS	**Numerator** Child under 5 years with diarrhoea death **Denominator** Child under 5 years with diarrhoea admitted	%	Quarterly	Accuracy of reporting at facility level	Decreased percentage indicates improved quality of care and/or improved early management of diarrhoea	MC&WH Manager
Child under 5 years pneumonia case fatality rate	Children under 5 years admitted with pneumonia who died as a proportion of children under 5 years admitted with pneumonia	Monitor treatment outcome for children under-5 years who were admitted with pneumonia	Inpatient under 5 year death records Admission records children under 5 years	DHIS	**Numerator** Child under 5 years with pneumonia death **Denominator** Child under 5 years with pneumonia admitted	%	Quarterly	Accuracy of reporting at facility level	Decreased percentage indicates improved quality of care and/or improved early management of pneumonia	MC&WH Manager
Child under 5 years severe acute malnutrition case fatality rate	Children under 5 years admitted with severe acute malnutrition who died as a proportion of children under 5 years admitted with severe acute malnutrition	Monitor treatment outcome for children under-5 years who were admitted with severe acute malnutrition. Includes all under 1 year severe acute malnutrition deaths as defined in the IMCI guidelines	Inpatient under 5 years death records Admission records children under 5 years	DHIS	**Numerator** Child under 5 years with severe acute malnutrition death **Denominator** Child under 5 years with severe acute malnutrition admitted	%	Quarterly	Reliant on accurate reporting at facility level	Reduced percentage indicates improved response to severe acute malnutrition	Nutrition Manager
School Grade R learners screening coverage (annualised) ***New indicator***	Proportion of Grade R learners screened by a nurse in line with the Integrated School Health Programme (ISHP) service package. The population will be divided by 12 in the formula to make provision for annualisation	Monitor implementation of the ISHP	School Health Services Register	DHIS	**Numerator** School Grade R learners screened **Denominator** School Grade R learners	%	Quarterly (annualised)	Reliant on accuracy of reporting in DHIS as well as number of learners (Department of Basic Education)	Increased percentage indicates improved coverage and community PHC	PHC Manager
School Grade 1learners screening coverage ***New indicator***	Proportion of Grade 1 learners screen by a nurse in line with the ISHP service package. The population will be divided by 12 in the formula to make provision for annualisation	Monitor implementation of the ISHP	School Health Services Register	DHIS	**Numerator** School Grade 1 learners screened **Denominator** School Grade 1 learners	%	Quarterly (annualised)	Reliant on accuracy of reporting in DHIS as well as number of learners (Department of Basic Education)	Increased percentage indicates improved coverage and community PHC	PHC Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
School Grade 8 learners screening coverage ***New indicator***	Proportion of Grade 8 learners screened by a nurse in line with the ISHP service package. The population will be divided by 12 in the formula to make provision for annualisation	Monitor implementation of the ISHP	School Health Services Register	DHIS	**Numerator** School Grade 8 learners screened **Denominator** School Grade 8 learners	%	Quarterly (annualised)	Reliant on accuracy of reporting in DHIS as well as number of learners (Department of Basic Education)	Increased percentage indicates improved coverage and community PHC	PHC Manager
Couple year protection rate (annualised)	Women protected against pregnancy by using modern contraceptive methods, including sterilisations, as proportion of female population 15-49 year. The population will be divided by 12 in the formula to make provision for annualisation	Monitor access to and use of modern contraceptives to prevent unplanned pregnancies. Serves as proxy for the indicator "contraceptive prevalence rate" by monitoring trends between official surveys	PHC Tick Register	DHIS	**Numerator** Contraceptive years dispensed: Total of (Oral pill cycles/13) + (Medroxyprogesterone injection/4) + (Norethisterone enanthate injection/6) + (IUCD x4) + (Subdermal implant x3) + (Male condoms distributed/200) + (Female condoms distributed/200) + (Male sterilisation x20) + (Female sterilisation x10). **Denominator** Female population 15-49 years	%	Quarterly (annualised)	Reliant on accuracy of data collection and reporting	Higher protection levels are desired – increased percentage	MNCWH Manager
Cervical cancer screening coverage (annualised)	Cervical smears in women 30 years and older as a proportion of 10% of the female population 30 years and older. The population will be divided by 12 in the formula to make provision for annualisation	Monitor implementation of the policy on cervical cancer screening (3 free Pap smears per lifetime from 30 years and older)	PHC Tick Register	DHIS	**Numerator** Cervical cancer screening in women 30 years and older **Denominator** Female population 30 years and older female/10	%	Quarterly (annualised)	Reliant on accuracy of reporting and population estimates (StatsSA)	Higher percentage indicates better coverage of screened women – reduced cervical cancer	MC&WH Manager
Human papilloma virus vaccine 1st dose coverage	Proportion of girls 9 years and older that received HPV 1st dose	Monitor impact of HPV vaccination on incidence of cervical cancer	School Health Services Register	DHIS	**Numerator** Girls 9 years and older that received HPV 1st dose **Denominator** Grade 4 girl learners ≥ 9 years	%	Annual	Reliant on the accuracy of reporting	Higher percentage indicates improved response to prevention strategies for cervical cancer	PHC Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Vitamin A dose 12-59 months coverage (annualised)	Children 12-59 months who received vitamin A 200,000 units, every six months as a proportion of population 12-59 months. The denominator is multiplied by 2 because each child should receive supplementation twice a year. The population will be divided by 12 in the formula to make provision for annualisation	Monitor vitamin A supplementation to children aged 12-59 months	PHC Tick Register	DHIS	**Numerator** Vitamin A dose 12-59 months **Denominator** Population 12-59 months *2	%	Quarterly (annualised)	Reliant on accuracy of reporting and child population estimates from StatsSA	Higher percentage indicate better Vitamin A coverage, and better nutritional support to children	Nutrition Manager
Maternal mortality in facility ratio (annualised)	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 a facility	Proxy for the population-based maternal mortality rate, aimed at monitoring trends in health facilities between official surveys	Maternity Register/ Death records	DHIS	**Numerator** Maternal death in facility **Denominator** Live birth in facility	Number per 100 000 live births	Annual (annualised)	Reliant on accuracy of classification of inpatient death	Lower institutional rate indicate fewer avoidable deaths	MNCWH Manager
Inpatient early neonatal death rate ***New indicator***	Early neonatal deaths (0-7 days) as a proportion of infants who were born alive in public health facilities	Monitor trends in early neonatal deaths in public health facilities as well as effectiveness of health system and services for antenatal, delivery and early neonatal care	Inpatient records (death) Maternity Register	DHIS	**Numerator** Inpatient death early neonatal (0-7 days) **Denominator** Live birth in facility	Number per 1000	Annual	Reliant on accuracy of reporting at facility level	Reduced deaths indicates improved management of pregnancy, delivery and management of neonate	MC&WH Manager
Infant mortality rate ***New indicator***	Proportion of children less than one year old who died in one year per 1000 population under 1 year	Monitor trends in infant mortality (MDG 4)	StatsSA and Rapid Mortality Surveillance (RMS) from 2012 onwards	StatsSA and RMS from 2012 onwards.	**Numerator** Children less than 1 year that died in one year **Denominator** Total population under 1 year Quote estimates from StatsSA and Rapid Mortality Surveillance as the Department is not routinely monitoring this population-based indicator	Number per 1000 population	Annual	Empirical population-based data are not frequently available – reporting estimates	Lower mortality rate desired	MNCWH Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Under 5 mortality rate ***New indicator***	Proportion of children less than five years old that died in one year per 1000 population under 5 years	Monitor trends in under-5 mortality (MDG 4)	StatsSA and Rapid Mortality Surveillance (RMS) from 2012 onwards	StatsSA and RMS from 2012 onwards.	**Numerator** Children less than five years that die in one year in the province **Denominator** Total population under 5 years Quote estimates from StatsSA and Rapid Mortality Surveillance as the Department is not routinely monitoring this population-based indicator	Number per 1000 population	Annual	Empirical population-based data are not frequently available – reporting estimates	Lower mortality rate desired	MNCWH Manager
Child under 5 years diarrhea with dehydration incidence (annualised)	Children under 5 years newly diagnosed with diarrhoea with dehydration per 1000 children under-5 years in the population. The population will be divided by 12 in the formula to make provision for annualisation	Monitor prevention of diarrhoea with dehydration (IMCI classification) in children under-5 years. Count only once when diagnosed. Follow-up visits for the same episode of diarrhoea will not be counted here	PHC Tick Register/ DHIS (StatsSA)	DHIS	**Numerator** Child under 5 years diarrhoea with dehydration new **Denominator** Population under 5 years	Number per 1000	Quarterly (annualised)	Reliant on accuracy of reported data at facility level and population estimates by StatsSA	Lower incidence indicates improved health outcomes	MC&WH Manager
Child under 5 years pneumonia incidence (annualised)	Children under 5 years newly diagnosed with pneumonia per 1000 children under-5 years in the population. The population will be divided by 12 in the formula to make provision for annualisation	Monitor prevention and diagnosis of pneumonia (IMCI definition) in children under-5 years. Count only once when diagnosed. Follow-up visits for the same episode of pneumonia will not be counted here	PHC tick register/ DHIS (StatsSA)	DHIS	**Numerator** Child under 5 years with pneumonia new **Denominator** Population under 5 years	Number per 1000	Quarterly (annualised)	Reliant on accuracy of reported data at facility level and population estimates by StatsSA	Lower incidence indicates improved health outcomes	MC&WH Manager
Child under 5 years severe acute malnutrition incidence (annualised)	Children under 5 years newly diagnosed with severe acute malnutrition per 1000 children under-5 years in the population. The population will be divided by 12 in the formula to make provision for annualisation	Monitor prevention and diagnosis of severe acute malnutrition in children under-5 years. Count only once when diagnosed. Follow-up visits for the same episode of malnutrition will not be counted here	PHC tick register/ DHIS (StatsSA)	DHIS	**Numerator** Child under 5 years with severe acute malnutrition new **Denominator** Population under 5 year	Number per 1000	Quarterly (annualised)	Reliant on accuracy of reported data at facility level and population estimates by StatsSA	Lower incidence indicates improved health outcomes	Nutrition Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Child under 1 year mortality in facility rate (annualised)	Proportion of children under-1 year who died while admitted in public health facilities	Monitor treatment outcomes of children under-1 year in public health facilities	Midnight census	DHIS	**Numerator** Inpatient death under 1 year **Denominator** Inpatient death under-1 year + Inpatient discharge under 1 year + Inpatient transfer out under 1 year	%	Quarterly (annualised)	Dependant on the accuracy of data at facility level	Lower rate desired – fewer children under-1 year dying in public health facilities	MNCWH Manager
Inpatient death under 5 years rate (annualised)	Percentage of children under 5 years who died while admitted in public health facilities	Monitor treatment outcome for admitted children under-5 years - includes under 1 year deaths	Midnight census	DHIS	**Numerator** Inpatient death under 5 years **Denominator** Inpatient death under 5 years + Inpatient discharge under 5 years + Inpatient transfer out under 5 years	%	Quarterly (annualised)	Dependant on the accuracy of data at facility level	Lower rate desired – fewer children under-5 years dying in public health facilities	MNCWH Manager

Programme 2: (Disease Control and Prevention)

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Clients screened for hypertension – 25 years and older ***New indicator***	Number of clients not on treatment for hypertension screened for hypertension in PHC clinics and OPD	Monitor increase in the number of clients screened for hypertension at PHC level and OPD	PHC register/ OPD register	DHIS	Number of clients (25 years and older), not on treatment for hypertension, screened for hypertension at PHC and OPD	Number	Quarterly	Reliant on accurate reporting. Under-reporting as it does not make provision for community-based screening	Increased screening indicates improved detection of clients with hypertension	NCD Manager
Clients screened for diabetes – 5 years and older ***New indicator***	Number of clients not on treatment for diabetes screened for diabetes in PHC clinics and OPD	Monitor increase in the number of clients screened for diabetes at PHC level and OPD	PHC register/ OPD register	DHIS	Number of clients (5 years and older), not on treatment for diabetes, screened for diabetes at PHC and OPD	Number	Quarterly	Reliant on accurate reporting. Under-reporting as it does not make provision for community-based screening	Increased screening indicates improved detection of clients with diabetes	NCD Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Clients screened for mental disorders ***New indicator***	Clients screened for mental disorders at PHC facilities. Screening for depression, anxiety, dementia, psychosis, mania, suicide, developmental disorders, behavioural disorders and substance use disorders	Monitor access to and quality of mental health services in PHC facilities	PHC register	DHIS	**Numerator** PHC client screened for mental disorders **Denominator** PHC headcount total	%	Quarterly	Reliant on accurate reporting. Under-reporting as it does not make provision for community-based screening	Increased percentage indicates improved mental health screening and detection	NCD Manager
Clients treated for mental disorders new ***New indicator***	Clients treated for mental disorders at PHC level including depression, anxiety, dementia, psychosis, mania, suicide, developmental disorders, behavioural disorders and substance use) as a proportion of clients screened for mental disorders at PHC	Monitor access to mental health services	PHC Tick Register	DHIS	**Numerator** Client treated for mental disorders at PHC level **Denominator** Clients screened for mental disorders at PHC level	%	Quarterly	Reliant on accuracy of reporting at facility level	Increase in percentage might either indicate improved access to services, improved detection or increasing burden of disease related to mental health	Mental Health Manager
Number of district mental health teams established (cumulative) ***New indicator***	Number of Mental Health Teams established as per Mental Health Policy requirements	Monitor establishment of Mental Health Teams to provide the necessary support and oversight at district/ facility level	Evidence of appointment of team members	Mental Health Programme Report	Number of mental health teams established as per Mental Health Policy	Number	Quarterly (cumulative)	None	Increased number of Mental Health Teams per District	Mental Health Manager
Cataract surgery rate (annualised)	Clients who had cataract surgery per 1 million uninsured population. The population will be divided by 12 in the formula to make provision for annualisation	Monitor access to cataract surgery and utilisation of resources	Theatre register / General Household Survey (uninsured population)	DHIS	**Numerator** Cataract surgery total **Denominator** Uninsured population	Rate per 1 million uninsured people	Quarterly (annualised)	Reliant on accuracy of reporting and estimated uninsured population	Increased rate indicates improved response to need	NCD Manager
Malaria case fatality rate	Deaths from malaria as a proportion of the number of cases reported	Monitor the number deaths caused by malaria	Malaria database	Malaria database	**Numerator** Deaths from malaria **Denominator** Total number of Malaria cases reported	%	Quarterly	Accuracy dependant on quality of data	Lower percentage indicates a decreasing burden of malaria and improved management of malaria cases	Malaria Control Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Malaria incidence per 1000 population at risk	New malaria cases as proportion of 1000 population at risk (high-risk areas based on malaria cases)	Monitor the new malaria cases in endemic areas as proportion of the population at risk - MDG 6	Tick Register PHC CDC Surveillance database StatsSA	Malaria database	**Numerator** Number of malaria cases (new) **Denominator** Umkhanyakude population [1]	Number per 1000 population	Annual	Dependent on accuracy of reporting	Lower incidence desired – improved prevention towards elimination of malaria	Malaria Control Manager
Hypertension incidence (annualised)	Newly diagnosed hypertension cases initiated on treatment per 1000 population 40 years and older. The number of hypertension clients under 40 years is very small hence monitoring population 40 years and older who is the main risk group	Monitor hypertension trends to inform preventative strategies	Tick Register PHC Register OPD StatsSA	DHIS	**Numerator** Hypertension client treatment new **Denominator** Population 40 years and older	Number per 1000 population	Quarterly (annualised)	Accuracy is dependent on quality of data from reporting facility	Lower incidence desired – improved management of hypertensive patients	NCD Manager
Diabetes Incidence (annualised)	Newly diagnosed diabetes clients initiated on treatment per 1000 population	Monitor diabetes trends to inform preventative strategies	Tick Register PHC Register OPD Stats SA	DHIS	**Numerator** Diabetes clients treatment new **Denominator** Population total	Number per 1000 population	Quarterly (annualised)	Accuracy is dependent on quality of data from reporting facility	Lower incidence desired – improved management of diabetic patients	NCD Manager
Number of clients accessing rehabilitation services ***New indicator***	The number of clients accessing rehabilitation services at public health facilities	Monitor access to rehabilitative services	Tick register PHC	DHIS	Number of clients accessing rehabilitation services at public health facilities	Number	Quarterly	Dependent on accurate reporting at facility level	Increased number indicates improved accessibility	Rehab & Disability Manager

[1] (Population at risk referring to endemic areas – Umkhanyakude District in KZN identified as endemic district

Programmes 2, 4 and 5 (All Hospital Services)

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
National core standards self-assessment rate	Total number of (Category) Hospitals that have conducted annual National Core Standard (NCS) self-assessments as a proportion of the total number of (Category) Hospitals	Monitor whether public health hospitals are measuring their level of compliance to standards of the NCSs in order to close the identified gaps in preparation for the external assessments by the Office of Health Standards Compliance	Self-assessment records	DHIS – NCS Module	**Numerator** Number of (Category) Hospitals that conducted NCS self-assessments to date in the current financial year **Denominator** (Category) Hospitals total	%	Quarterly	Accuracy of reporting in the NCS Module	Higher percentage indicates active monitoring of performance against NCS	Hospital Managers
Quality Improvement Plan after self-assessment rate	Total number of (Category) Hospitals that have developed a Quality Improvement Plan (QIP) after self-assessment as a proportion of the total number of (Category) Hospitals	Monitor whether health facilities are developing an improvement plan to address gaps identified during self-assessments	Quality Improvement Plans	DHIS – NCS Module	**Numerator** Number of (Category) Hospitals that developed a QIP to date in the current financial year **Denominator** Number of (Category) Hospitals that conducted NCS self-assessment to date in the current financial year	%	Quarterly	Accuracy of reporting in the NCS Module	Increased percentage indicates improved response to addressing identified gaps	Hospital/ DHS Managers
Percentage of hospital compliant with all extreme and vital measures of the National Core Standards ***New indicator***	Total number of (Category) Hospitals that are compliant to all extreme measures and at least 90% of vital measures of NCS in self-assessment as a proportion of the total number of (Category) Hospitals that conducted NCS self-assessments to date in the current financial year	Track compliance to the NCSs	Assessment records	DHIS – NCS Module	**Numerator** Total number of (Category) Hospitals that are compliant to all extreme measures and at least 90% of vital measures of NCSs **Denominator** Number of (Category) Hospitals that conducted NCS self-assessment to date in the current financial year	%	Quarterly	Accuracy of reporting in the NCS Module	Higher percentage indicates active implementation of the NCS	Hospital & DHS Managers
Patient experience of care survey rate ***New indicator***	Total number of (Category) Hospitals that have conducted patient experience of care (PEC) surveys as a proportion of the total number of (Category) Hospitals	Monitor whether health facilities are conducting PEC surveys	PEC surveys	DHIS – NCS Module	**Numerator** Total number of (Category) Hospitals that conducted a PEC survey to date in the current financial year **Denominator** Total number of (Category) Hospitals	%	Quarterly	Accuracy of reporting in NCS Module	Increased percentage indicates improved client involvement in service improvement	DHS/ QA Managers

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Patient experience of care rate ***New indicator***	The average patient satisfaction score of all (Category) Hospitals that conducted annual PEC surveys	Track patient satisfaction with public health services	PEC survey results	DHIS – NCS Module	**Numerator** Sum of patient experience of care scores in (Category) Hospitals that conducted a PEC survey to date in the current financial year **Denominator** Total number of (Category) Hospitals that conducted a PEC survey to date in the current financial year	%	Annual	Generalised - depends on the number of users participating in the survey	Increased patient satisfaction with public health services	QA Manager
Average length of stay – total	The average number of client days an admitted client spends in hospital before separation (the total of day clients, inpatient discharges, inpatient deaths and inpatient transfer outs)	Monitor efficiency of Inpatient management. Proxy indicator as ideally it should only include inpatient days for those clients separated during the reporting month (the indicator is also relevant to CHCs with inpatient beds)	Midnight census	DHIS calculates	**Numerator** Inpatient days total + Day patients **Denominator** Inpatient separations	Number	Quarterly	Accuracy dependent on data quality	A low average length of stay reflects high levels of efficiency. High efficiency levels might in turn compromise quality of hospital care	Hospital Managers
Inpatient bed utilisation rate – total	Inpatient bed days used as proportion of maximum inpatient bed days available (number of inpatient beds X days in period)	Monitor effectiveness and efficiency of inpatient management	Midnight census	DHIS calculates	**Numerator** Inpatient days total + Day patients **Denominator** Inpatient bed days available	%	Quarterly	Accurate reporting sum of daily usable beds	Higher bed utilisation indicates efficient use of beds and/ or higher burden of disease and/ or better service levels	Hospital Managers
Expenditure per patient day equivalent	Average cost per patient day equivalent (PDE) - PDE is the inpatient days total + day patients * 0.5 + (emergency headcount + OPD headcount total) * 0.33333333	Monitor effective and efficient management of inpatient facilities. Note that multiplied by 0.5 is the same as division by 2, and multiplied by 0.33333333 is the same as division by 3	BAS (Finance) DHIS (PDE)	DHIS calculated BAS (Finance)	**Numerator** Expenditure - total **Denominator** Patient Day Equivalent	R	Quarterly	Accuracy dependent on data quality	Lower cost indicating efficient use of financial resources.	CFO and Hospital Managers
Complaints resolution rate	Client complaints resolved as proportion of complaints received	Monitor response to complaints received from clients using public health services	Complaints Register	DHIS	**Numerator** Complaints resolved **Denominator** Complaints received	%	Quarterly	Accuracy of data in complaints registers and reporting in DHIS	Higher percentage desired – better management of complaints and compliance to Batho Pele	QA Manager & Ombudsperson

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Complaint resolution within 25 working days rate	Client complaints resolved within 25 working days as proportion of all complaints resolved	Monitor management and response to complaints including turnaround time of resolving complaints	Complaints Register	DHIS	***Numerator*** Complaint resolved within 25 working days ***Denominator*** Complaints resolved	%	Quarterly	Accuracy of data in the complaints registers and DHIS	Higher percentage desired – better management of complaints and compliance to Batho Pele	QA Manager & Ombudsperson
Number of fully functional District Caesarean Section Centres (cumulative) ***New indicator (District Hospitals only)***	Creating caesarean section centres in identified district hospitals to improve maternal health outcomes	Monitor maternal and neonatal health outcomes with specific reference to caesarean section outcomes	Caesarean Section Centres	Caesarean Section Centres	Number of operating District Caesarean Section Centres	Number (cumulative)	Annual	None	Functional District Caesarean Section Centres	MC&WH Manager
Delivery by caesarean section rate	Delivery by caesarean section as proportion of total deliveries in (Category) Hospitals	Monitor caesarean section trends in all categories of hospitals	Delivery Register/ Theatre Register	DHIS	**Numerator** Delivery by caesarean section **Denominator** Delivery in facility total	%	Quarterly	Accuracy dependant on quality of data from reporting facility	Reduction in caesarean section rates depending on burden of disease	MC&WH Manager
OPD headcount – total	Total clients attending general or specialist outpatient clinics	Monitor patient activity (numbers) at outpatient clinics partly to track burden of disease trends, workload and utilisation/ allocation of resources	Tick register OPD DHIS calculates	DHIS calculated	OPD specialist clinic headcount + OPD general clinic headcount (including follow-up and new cases not referred)	Number	Quarterly	Dependant on quality of data from reporting facility	Higher patient numbers may indicate an increased burden of disease, increased reliance on public health services or lacking PHC system. Reduction in OPD headcount expected as PHC services improve	DHS and Hospital Managers
OPD headcount not referred new	New OPD clients without a referral letter to (Category) Hospitals	Monitor utilisation trends of PHC clients at both hospital and PHC level - not including OPD follow-up and emergency clients	OPD records	DHIS	OPD headcount not referred new	Number	Quarterly	Reliant on accuracy of facility records	Decrease in number of un-referred cases indicates improved efficiency and access at PHC level	PHC and Hospital Managers

Programme 3: Emergency Medical Services

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
EMS P1 urban response under 15 minutes rate	Emergency P1 calls in urban locations with response times under 15 minutes as a proportion of all P1 urban call outs. Response time is calculated from the time the call is received to the time of the first dispatched medical resource arrival on scene	Monitor compliance with the norm for critically ill or injured patients to receive EMS within 15 minutes in urban areas	EMS Registers	DHIS	**Numerator** EMS P1 urban response under 15 minutes **Denominator** EMS P1 urban calls	%	Quarterly	Accuracy dependant on quality of data from reporting EMS station	Higher percentage indicate improved efficiency and quality	EMS Manager
EMS P1 rural response under 40 minutes rate	Emergency P1 calls in rural locations with response times under 40 minutes as a proportion of all P1 rural call outs. Response time is calculated from the time the call is received to the time of the first dispatched medical resource arrival on scene	Monitor compliance with the norm for critically ill or injured patients to receive EMS within 40 minutes in rural areas	EMS Registers	DHIS	**Numerator** EMS P1 rural response under 40 minutes **Denominator** EMS P1 rural calls	%	Quarterly	Accuracy dependant on quality of data from reporting EMS station	Higher percentage indicate improved efficiency and quality	EMS Manager
EMS inter-facility transfer rate ***New indicator***	Inter-facility transfers (from one inpatient facility to another inpatient facility) as proportion of total EMS patients transported	Monitor use of ambulances for inter-facility transfers as opposed to emergency responses	EMS inter-facility register	DHIS	**Numerator** EMS inter-facility transfer **Denominator** EMS clients total	%	Quarterly	Reliant on accuracy of reporting	Increase percentage might be an indication of effective referral system or increasing burden of disease	EMS Manager
Revised EMS Model	Evidence-based EMS Model to inform short, medium and long-term operational plans to improve EMS efficiencies	Monitor short, medium and long term EMS plan(s)	EMS Model	EMS Model	**Categorical**	Categorical	Annual	None	Revised EMS Model approved and operationalised	EMS Manager
Number of obstetric ambulances – cumulative ***New indicator***	Number of customised obstetric ambulances used to prioritise obstetric cases (maternal and child)	Monitor access and response for obstetric cases	Transport asset register	EMS database	Number of existing + new operational obstetric ambulances	Number	Annual	None	Higher number indicates improved access	EMS Manager
Number of Inter Facility Transport ambulances – cumulative ***New indicator***	Inter Facility Transport (IFT) ambulances deployed to improve patient transport between facilities	Monitor efficiencies of inter facility transport	Transport asset register	EMS database	Number of existing + new inter facility transport operational ambulances	Number (cumulative)	Annual	None	Higher number indicates improved access	EMS Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Average number of daily operational ambulances ***New indicator***	The average number of ambulances available per day to respond to call outs	Monitor the number of operational ambulances versus the number of available ambulances	EMS database EMS call centre records EMS tick register	EMS database	Average number of daily operational ambulances (average of total number of ambulances available per day)	Number	Annual	Data completeness at EMS Stations	Higher number indicates improved management of available ambulances	EMS Manager
Number of clustered communication centres established and operational ***New indicator***	Clustering identified Communication Centres to improve optimisation of scarce resources	Monitor optimisation of resources	Infrastructure Project Records Com Centre	EMS database	Operational clustered Communication Centres	Number	Annual	None	Clustered centres optimise utilisation of resources	EMS Manager
Number of purpose built wash bays with sluice facilities	Construction of wash bays and sluice facilities that comply with EMS and infection prevention and control specifications	Monitor quality standards for EMS	Infrastructure project records Wash Bays	EMS database	Number of purpose built wash bays with sluice facilities	Number	Annual	None	Higher number indicates improved compliance with EMS standards	EMS Manager
Revenue generated	Revenue generated through fees from private EMS users	Monitor revenue collection	BAS	EMS database	EMS revenue generated	R	Annual	None	Increased revenue desired	EMS Manager
Number of bases with access to computers and intranet/ e-mail	The number of EMS bases with connectivity and computers	Monitor connectivity and improved information management	IT database	IT database	Number of EMS bases with access to computers and intranet	Number	Annual	Data completeness	Higher number indicates improved information management	EMS Manager

Programme 6: Health Sciences and Training

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of bursaries awarded for first year medicine students ***New indicator***	Number of bursaries awarded for first year medicine students	Monitor bursary allocation in relation to need and demand	Bursary records	Bursary records	Number of bursaries awarded to first year medicine students	Number	Annual	None	Increased number indicates appropriate response to need/ demand	HRMS Manager
Number of bursaries awarded for first year nursing student ***New indicator***	Number of bursaries awarded for first year nursing students	Monitor bursary allocation in relation to need and demand	Bursary records	Bursary records	Number of bursaries awarded to first year nursing students	Number	Annual	None	Increased number indicates appropriate response to need/ demand	HRMS Manager
KZNCN accredited as Institution of Higher Education ***New indicator***	KZNCN accredited by external Accreditation Body as compliant to standards for Institution of Higher Education	Monitor compliance with Regulations	Accreditation certificate	Accreditation certificate	**Categorical**	Categorical	Annual	None	KZNCN accredited	KZNCN Principal
Number of advanced midwifes graduating per annum	Number of students that obtained a post basic nursing qualification in Advanced Midwifery	Monitor production of Advanced Midwifes	Student registration	KZNCN student records	Number of Advanced Midwife graduates per annum	Number	Annual	None	Increased number implies increased human resources for health	KZNCN Principal
Number of employees trained in sign language (cumulative) ***New indicator***	The number of employees to completed a course in sign language	Monitor training in sign language	HRD Records	In-service records (HRD)	Number of employees who completed the course on sign language	Number (cumulative)	Annual	Reporting through training centres and in-service training	Increased number implies improved access for people with disability	Rehab & Disability Manager
Number of new students enrolled in Mid-Level Worker training courses ***New indicator***	Number of Mid-Level Workers that enrol for one of the available training courses at Institutions of Higher Learning	Monitor intake of Mid-Level Workers in response to identified human resources gap	Student enrolment register	HRD student enrolment register	Sum of the total number of new Mid-Level Worker students enrolled in training courses	Number	Annual	None	Higher number implies increase in pool of human resources for health	HRD Manager
Number of Medical Orthotic and Prosthetic students that successfully completed the degree course at DUT ***New indicator***	Medical Orthotic and Prosthetic (MOP) students that completed the prescribed training course successfully	Monitor pool of resources	Qualification	Training register – Qualification	Number of MOP students that successfully completed the prescribed training course at Institution of Higher Education	Number	Annual	Reporting of completion of courses	Increase in students who completed course indicate increased in resource pool	Orthotic and Prosthetic Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of new Pharmacy Assistants enrolled in training courses ***New indicator***	The number of Pharmacy Assistant students enrolled for training	Monitor human resources for health	HRD Training Records	HRD Training Records	Number of Pharmacy Assistants enrolled in training courses	Number	Annual	Dependent on reporting of students	Improved human resources for health	Pharmacy Manager
Number of new Clinical Associates enrolled in training courses ***New indicator***	The number of Clinical Associate students enrolled for training	Monitor human resources for health	HRD Training Records	HRD Training Records	Number of Clinical Associates enrolled in training courses	Number	Annual	Dependent on reporting of students	Improved human resources for health	HRMS Manager
Number of Intermediate Life Support graduates per annum ***New indicator***	Number of students that obtained a qualification in Intermediate Life Support	Monitor production of EMS personnel	Student registration	EMS College	Intermediate Life Support students graduated	Number	Annual	None.	Higher number desired – improved EMS capacity.	EMS Unit
Number of Emergency Care Technician graduates per annum ***New indicator***	Number of students obtaining the qualification of Emergency Care Technician	Monitor production of EMS personnel	Student registration	EMS College	Emergency Care Technician students graduating	Number	Annual	None.	Higher number desired – improved EMS capacity.	EMS Unit

Programme 7: Health Care Support Services

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Percentage of facilities reporting clean linen stock outs ***New indicator***	The number of facilities reporting clean linen stock outs as proportion of the total number of facilities	Monitor availability of clean linen at facility level	Linen register at facility level	Provincial Laundry Reports	**Numerator** Number of facilities reporting clean linen stock out **Denominator** Facilities total	%	Quarterly	Accuracy of reporting at facility level and lack of appropriate data information system for laundry services	Lower percentage indicates improved availability and management of linen	Laundry Manager
Forensic Pathology Rationalisation Plan ***New indicator***	Long term plan making provision for rationalisation of existing mortuaries and services to improve efficiency and cost benefit. The plan will make provision for a detailed Implementation Plan including allocation of relevant resources	Monitor efficiencies and cost benefit	Rationalisation Plan	Rationalisation Plan	**Categorical**	Categorical	Annual	None	Rationalisation Plan approved and implemented	Forensic Pathology Service Manager
Number of operational Orthotic Centres (cumulative) ***New indicator***	Orthotic centres providing the package of services for Orthotic and Prosthetic services	Monitor access to Orthotic and Prosthetic services	Orthotic Centre data	Orthotic and Prosthetic database	Number of Orthotic Centres providing the basic package of services	Number (cumulative)	Annual	None	Decentralised access to the complete package of services	Orthotic and Prosthetic Manager
Percentage of Pharmacies that obtained A or B grading on inspection	The number of Pharmacies that comply with Pharmaceutical prescripts on inspection as proportion of the total number of pharmacies	Track compliance with Pharmaceutical prescripts	Certificates	Certificates	**Numerator** Number of Pharmacies with A or B grading on inspection **Denominator** Number of Pharmacies	%	Annual	Accurate records of inspections conducted	Improved compliance will improve quality and efficiency of Pharmaceutical services	Pharmacy Manager
PPSD compliant with good Wholesaling Practice Regulations	Provincial Pharmaceutical Supply Deport Warehouse compiles with Pharmacy Regulations and is licensed by Medicine Control Council to operate as Pharmaceutical	Monitor safe warehousing practice	Certificate of compliance	Certificate of compliance	**Categorical**	Categorical	Annual	None	PPSD compliant with good wholesaling practice regulation	Pharmacy Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Tracer medicine stock-out rate (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 balance in the Bulk Store on a Stock Control System	Monitor shortages in tracer medicines	Pharmacy records	DHIS	**Numerator** Number of tracer medicines out of stock **Denominator** Total number of medicines expected to be in stock	%	Quarterly	Accuracy of reporting at facility level	Targeting zero stock-out	Pharmacy Manager
Tracer medicine stock-out rate (Institutions)	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 balance in Bulk Store (facilities) on the Stock Control System)	Monitor shortages in Tracer medicines	Pharmacy records	DHIS	**Numerator** Number of tracer medicines stock out in bulk store **Denominator** Number of tracer medicines expected to be stocked in the bulk store	%	Quarterly	Accuracy of reporting at facility level	Targeting zero stock-out of all tracer medicines	Pharmacy Manager

Programme 8: Health Facilities Management

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of Health facilities that have undergone major and minor refurbishment ***New indicator***	The number of facilities improved through minor or major refurbishment	Monitors status of infrastructure	IPIP – Infrastructure database	IPIP – Infrastructure database	Number of health facilities that have undergone major and minor refurbishment	Number	Annual	None	Well maintained infrastructure	Infrastructure Manager
Establish service level agreements with Department of Public Works (and any other implementing agents) ***New indicator***	Signed service level agreements (SLAs) with Implementing Agents that participate in infrastructure development projects in the province	Formalise service arrangements with Implementing Agents	Signed Service Level Agreement	Signed Service Level Agreement	Number of Service Level Agreements signed	Number	Annual	None	Service level agreement established	Infrastructure Manager
Number of jobs created through the EPWP	The number of jobs creation through EPWP	Track job creation	Project reports/ plan	IRS and EPWP Quarterly reports	Jobs created through EPWP in reporting period	Number	Quarterly	None	Higher number – improved job opportunities	Infrastructure Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of new clinical projects with completed constructed	New clinical projects with completed construction	Monitor project plans and delivery of infrastructure as per U-AMP	Project reports/ plan	IRM, PMIS and monthly reports	New clinical projects with completed construction in reporting period	Number	Quarterly	None	As per project plan	Infrastructure Manager
Number of new clinical projects where commissioning is compete	New clinical projects commissioned	Monitor project plans and delivery of infrastructure as per U-AMP	Project reports/ plan	IRM, PMIS and monthly reports	New clinical projects commissioned during reporting period	Number	Quarterly	None	As per project plan	Infrastructure Manager
Number of upgrading and renovation projects with completed construction	Upgrading and renovation projects with completed construction	Monitor project plans and delivery of infrastructure as per U-AMP	Project reports/ plan	IRM, PMIS and monthly reports	Number upgrading and renovation projects completed during reporting period	Number	Quarterly	None	As per project plan	Infrastructure Manager
Percentage of maintenance budget spent	Percentage of maintenance budget spent	Monitor financial management and service delivery	BAS	APP: IRM, PMIS and monthly reports	**Numerator** Maintenance budget spent **Denominator** Maintenance budget	%	Quarterly	None	100% budget spent	Infrastructure Manager
Health Facilities Revitalisation Grant expenditure as percentage of total annual budget	Proportion of infrastructure budget spent on maintenance.	Monitor financial management.	BAS	BAS/ Infrastructure database	**Numerator** Hospital revitalisation expenditure **Denominator** Infrastructure budget	%	Annual	None.	100% of allocation.	Infrastructure Development Unit

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