health

Department:
Health
PROVINCE OF KWAZULU-NATAL

ANNUAL PERFORMANCE PLAN FOR 2013/14 - 2015/16

ANNUAL PERFORMANCE PLAN 2013/14

MTEF: 2013-14 – 2015/16

FOREWORD BY THE MEC FOR HEALTH

The 2013/14 Annual Performance Plan summarises the Department's priorities which have been aligned with the five core outputs of the Negotiated Service Delivery Agreement and the broader vision and development goals encapsulated in the National Development Plan and Provincial Growth and Development Plan.

As a health sector, our fundamental priority remains the improvement of the health care system in pursuance of universal access to quality healthcare services to ultimately ensure "*A Long and Healthy Life for All South Africans*".

We acknowledge the critical contribution that has to be made by KwaZulu-Natal for the country to meet its goals as alluded to in a statement made by our Honourable Premier, Dr Zweli Mkhize, when he said: "*It is important to acknowledge that the burden of disease that is affecting South Africa has its epicentre in this Province. Similarly, to improve the overall health outcomes in South Africa, KwaZulu-Natal must first improve*."

As we therefore venture into the 2013/14 financial year, our contribution as a Health Sector will be firmly embedded in the KwaZulu-Natal Vision namely to ensure that: "*By 2030 the Province of KwaZulu-Natal will be a prosperous Province, with healthy, skilled and secure people, acting as a gateway to Africa and the world*".

The current fiscal constraints and increasing burden of disease and demand for equitable healthcare put unprecedented strain and pressure on the Department to achieve all its quantified objectives for the planning cycle. We are however committed and determined to shape a sustainable niche in the increasing demand for healthcare in the Province in spite of the restrictions brought about by global recessionary conditions. This plan therefore does not only respond to the strategic thrust and policy priorities of our current government, but continues to accelerate service delivery to build on successes of the past few years.

The 2013/14 Annual Performance Plan has been crafted to respond to the Department's strategic vision while at the same time giving credence to the socio-economic parameters impacting on service delivery and health outcomes. An added impetus is the growing scientific evidence of improved health outcomes in priority areas since 2009. Although a lot still needs to be done, evidence attest to the fact that the Province is beginning to reap positive results following concerted efforts to address the quadruple burden of disease and to improve the health care system in the Province.

I endorse this 2013/14 Annual Performance Plan as framework for the Department's performance targets within the available budget.

Dr SM Dhlomo

Member of the Executive Council (MEC) for Health

KwaZulu-Natal Department of Health

Date: 12/03/2013

MESSAGE BY THE HEAD OF DEPARTMENT

I am pleased to present the 2013/14 Annual Performance Plan for the KwaZulu-Natal Department of Health following widespread consultation at provincial and district levels.

The smooth transition from scoping and planning to service delivery and improved outcomes will form the core of our business in 2013/14. The clear performance standards and milestones in the plan will serve as compass to navigate rigorous monitoring, evaluation and reporting on performance and health outcomes.

During 2013/14, the Department's anchor priorities include:

- Implementation of CARMMA (Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa) to improve maternal, neonatal, child and women's health.
- Zero new STI, HIV and TB infections.
- Strengthening HIV, AIDS, STI and TB treatment and support programmes.
- Strengthening community-based management of MDR-TB.
- PHC re-engineering through innovative, cost effective and quick-win evidence-based interventions.
- Strengthening Human Resources for Health inclusive of the finalisation of the organisational review.
- Revitalisation of Emergency Medical Services and Forensic Pathology Services.
- Strengthening transversal services including Food Services and Laundry Services.
- Clean Audit 2014/15.
- Improving information technology, data quality, performance monitoring and reporting, and information management.
- Infrastructure for health.

Re-prioritisation, based on the available funding envelope, demand for services, and health system challenges will form part of improved oversight arrangements to ensure optimal service delivery and value for money.

I wish to express my gratitude to the Honourable Member of the Executive Council, Dr SM Dhlomo, for his continued leadership and support.

To all staff, remember that the change we want to see starts with all of us. Let us continue to serve our communities with commitment to make an impact where it matters most.

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Dr SM Zungu

Head of Department

KwaZulu-Natal Department of Health

Date: 11 . 03 . 2013

OFFICIAL SIGN-OFF OF THE KWAZULU-NATAL DEPARTMENT OF HEALTH ANNUAL PERFORMANCE PLAN 2013/14 – 2015/16

It is hereby certified that the 2013/14 – 2015/16 Annual Performance Plan for the KwaZulu-Natal Department of Health:

- Was developed by the Provincial Department of Health in KwaZulu-Natal with leadership from the MEC for Health and Head of Department.
- Complies with the National Framework, the National Health System 10 Point Plan, and reviewed Negotiated Service Delivery Agreement for Health, the 2010 – 2014 Strategic Plan of the KwaZulu-Natal Department of Health, the National Development Plan, Provincial Growth and Development Plan and other relevant planning documents.
- The Plan reflects the performance targets which the Department will endeavor to achieve given the resources and budget for the 2013/14 – 2015/16 MTEF.

Mr J Govender

Acting General Manager: Planning, Monitoring & Evaluation

Date: 11/03/2013

Mr M Ravhura

Chief Financial Officer

Date: 11.03.2013

Dr SM Zungu

Head of Department: KZN Department of Health

Date: 11.03.2013

Approved

Dr SM Dhlomo

MEC for Health: KZN Department of Health

Date: 12/03/2013

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NOTE

1. **Some indicator baselines and MTEF targets in the 2013/14 – 2015/16 Annual Performance Plan are based on Stats SA 2011 mid-year population estimates. Introduction of the 2011 Census population will have an impact on these indicators during the 2013/14 financial year. Baselines and targets will be reviewed once the official information system (DHIS) has been updated with the 2011 Census population.**
2. **Implementation of the 2013 National Indicator Data Set (NIDS) in April 2013 will impact on a number indicator names, definitions and in some instances methods of calculation of the indicators currently included in the 2013/14 APP. Changes have been highlighted in the APP.**
3. **The 2013 NIDS has not been finalised and approved at the time of printing of the 2013/14 APP. Indicators will be reviewed once the NIDS has been approved after which an addendum to the APP will be tabled by the MEC for Health.**

PART A: STRATEGIC OVERVIEW

1. STRATEGIC OVERVIEW

1.1. VISION

Optimal health status for all persons in KwaZulu-Natal

1.2. MISSION

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

1.3. VALUES

Trust built on truth, integrity and reconciliation

Open communication, transparency and consultation

Commitment to performance

Courage to learn, change and innovate

1.4. STRATEGIC GOALS

Table 1: (A1): KwaZulu-Natal Department of Health Strategic Goals

Strategic Goal	Goal Statement	Rationale	Expected Outcomes
1. Overhaul Provincial Health Services.	Transform the Provincial health care system through implementation of the Service Transformation Plan (STP) 10 core components to improve equity, access and availability, efficiency, quality and effective management that will enhance service delivery and improve the health outcomes of all citizens in the Province.	An efficient and well-functioning health care system with the potential to respond to the burden of disease and health needs in the Province.	• Transformation in line with STP imperatives and the National Health System 10-Point Plan. • Improved access, equity, efficiency, effectiveness and utilisation of health services. • Improved Human Resource Management Services including reconfiguration of organisational structures, appropriate placement of staff (appropriate skills mix and competencies), appropriate norms and standards to respond to burden of disease and package of services, strengthened performance management and decreased vacancy rates. • Improved Financial & Supply Chain Management efficiency and accountability to curb over-expenditure, improve return on investment and value for money, and budget aligned with service delivery priorities and needs. • Appropriate response to the burden of disease and consequent health needs. • Improved governance including regulatory framework, policies and delegations to facilitate implementation of the Strategic

Strategic Goal	Goal Statement	Rationale	Expected Outcomes
			Plan. • Decentralised delegations, controls and accountability. • Improved information systems and processes, data quality and information management and improved performance monitoring, evaluation and reporting. • Revitalisation of infrastructure to improve service delivery.
2. Improve the efficiency and quality of health services.	Achieving the best possible health outcomes through effective utilisation of resources within the funding envelope.	Improved compliance with legislative/ policy requirements and National Core Standards for Quality in order to improve clinical and health outcomes.	• Accreditation (certification) of health facilities in line with National Core Standards for Quality. • Improved management capacity. • Improved health outcomes and increased life expectancy. • Improved performance towards achieving the Millennium Development Goal (MDG) targets. • Patient satisfaction with public health services.
3. Reduce morbidity and mortality due to communicable diseases and non-communicable conditions and illnesses.	Implement integrated high impact strategies to improve prevention, detection, referral, management, follow-up and support of communicable diseases and non-communicable illnesses and conditions at all levels of care.	Reduction of preventable and modifiable causes of morbidity and mortality at community and facility level contributing to a reduction in morbidity and mortality.	• Decrease in morbidity and mortality – with specific reference to preventable causes. • Improved performance towards achievement of MDG and NSDA targets i.e. – HIV and AIDS; – TB; – Maternal & Child Health; – Malaria; and – Change in trends of non-communicable disease patterns.

Source: 2010-2014/15 Strategic Plan

PLANNING CYCLE FOR THE 2013/14 ANNUAL PERFORMANCE PLAN

Quarter One (April – June 2012)

- 2011/12 Annual Health Review(s)
  - Provincial 2011/12 review: 18 – 20 May 2012. Attendance: MEC for Health (Dr SM Dhlomo), Head of Department (Dr SM Zungu), 189 Provincial, District and Facility Managers, Portfolio Committee Members, Labour Unions, and the Office of the Auditor General.
  - District annual reviews: April and May 2012.
  - 2011/12 Annual Report (Draft 1) submitted to the Auditor General of South Africa (AGSA) on 31 May 2012.
- 2011/12 District Health Expenditure Reviews (DHERs) commenced in all districts with leadership and technical support provided by the Strategic Planning Component supported by a Provincial Task Team including the Budget Office, Human Resources Management Services, Data Management and Monitoring & Evaluation. Eight (8) decentralised DHER workshops were

conducted during June and July 2012 attended by district and facility management teams. Verification of data (Persal, BAS and District Health Information System - DHIS) and critical analysis and review of expenditure trends in relation to service delivery, equity, access, sustainability, efficiency and quality.

Quarter Two (July – September 2012)

- July/ August 2012: First draft of the Medium Term Expenditure Framework (MTEF) budget and provisional performance measures for service delivery submitted to Provincial Treasury.
- 10 August 2012: First draft of the 2013/14 Annual Performance Plan (APP) submitted to Provincial Treasury, Senior Management, Provincial Health Portfolio Committee and the National Department of Health for comment and input.
- 28 August and 21 September 2012: First draft of the 2013/14 APP submitted/ tabled at the Provincial Health Portfolio Committee meeting.
- August/ September 2012: 2011/12 DHER Reports (District and Provincial) finalised and submitted to the National Department of Health and Senior Management.
- 3 September 2012: Tele-Conference with District Planners to confirm the process for completion of 2013/14 DHPs and identification of gaps in planning capacity at district level.
- Strategic Planning workshop 19-20 September 2012 targeting District Deputy Managers Planning Monitoring and Evaluation and Deputy Managers Planning (26 participants) with focus on identified capacity gaps.
- Review of Integrated Planning Framework: Process commenced to improve alignment between Sector Departments and Integrated Development Plans (IDPs) at Municipal level.

Quarter Three (October – December 2012)

- 1 October 2012: Consultation meeting with Head Office Programme Managers to explore options for the development of the Provincial Planning Framework and alignment of sector plans and strategies.
- October 2012: First draft 2013/14 DHPs, aligned with 2011/12 DHER findings and analysis of historic data, submitted to Provincial Strategic Planning and District Health Services (DHS) for comment and technical support.
- 1-2 November 2012: Provincial Strategic Planning Workshop to confirm 2013/14 priorities and key focus areas. Workshop attended by the MEC for Health (Dr SM Dhlomo), the HOD (Dr SM Zungu), Senior Managers and 206 Provincial and District Managers. Priorities and key focus areas, identified at the workshop, will be reviewed in the 4th quarter of 2012/13 based on the final funding envelope.
- 23 November 2012: Second draft 2013/14 APP and MTEF budget submitted to Provincial Treasury and Provincial Planning Commission.
- 30 November 2012: Second draft of the 2013/14 APP circulated via departmental website for comments and contributions from all service providers at provincial and district level.
- Indicative budget (2013/14) and adjusted budget (2012/13) submitted to Provincial Treasury with adjusted service delivery measures. Submission not inclusive of new Census 2011 data.
- 30 November 2012: Workshop hosted by Provincial Treasury, Office of the Premier and Provincial Planning Commission focusing on alignment of APPs (all Sectors) with Provincial Growth and Development Plan (PGDP) and MTEF budgets. Improved oversight and support to improve alignment between sector plans.
- Second draft 2013/14 DHPs submitted to Strategic Planning, District Health Services and National Department of Health for comment.
- Budget bid consultations, under leadership of the Chief Financial Officer (CFO), commenced in December 2012 with the aim to develop district capacity and align draft DHPs with the funding envelope, provincial priorities and key focus areas.

Quarter Four (January – March 2013)

- 2013/14 Budget bid consultations conclude with final alignment of budget and service delivery priorities and key focus areas (relevant to APP, DHPs and Operational Plans).
- Implementation of budgets on BAS and final Budget Allocation Letters.
- Approved 2013/14 APP (aligned with the PGDP) tabled in the Legislature (as per schedule).
- Final approved 2013/14 DHPs and Operational Plans submitted to Strategic Planning, District Health Services, and the National Department of Health. Dissemination to all service providers.
- Finalise alignment of monitoring, evaluation and reporting systems and processes.

PRESENTATION OF CORE BUSINESS: 2013/14 ANNUAL PERFORMANCE PLAN

- The 2013/14 APP is the 3rd annual plan for the 2010-2014 strategic planning cycle and adheres to imperatives contained in the National Health Act (Act No. 61 of 2003); KZN Health Act (Act No. 1 of 2009) and Regulations; Public Finance Management Act (Act No. 1 of 1999) and Amendments; Treasury Regulations (amended February 2007); and Promotion of Access to Information Act, 2000. The plan covers the period 1 April 2013 to 31 March 2014 and has been aligned with Budget Programmes and Sub-Programmes strategic objectives.
- Part A provides an overview of the provincial health perspective; strategic goals and objectives; and details of changes to the 5-year Strategic Plan based on policy development, changes in the Departmental mandate, and changes in the disease profile and consequent service delivery approaches.
- Part B provides planning information on individual programmes and sub-programmes with related performance measures and targets.
- Part C details links with other relevant plans.
- The National Department of Health, through consultation with National Treasury and Provincial Departments of Health, customised the APP template within the framework of the updated *Framework for Strategic Plans and Annual Performance Plans of National and Provincial Government Departments* (National Treasury August 2010). The Framework ensures that plans are aligned with the revised Medium Term Strategic Framework (MTSF), Performance Agreements between Ministers and the President, and Sectoral Service Delivery Agreements.
- Universal performance indicators have been determined by the National Department of Health in consultation with Provinces and National Treasury (referred herein as "*Performance Indicators*" in Part B of the APP). These indicators will be monitored quarterly and formal progress reports "*Provincial Quarterly Performance Reports or PQRS*" will be submitted to Senior Management, Provincial Health Portfolio Committee, Provincial/ National Treasury and the National Department of Health. Provincial and National Treasury is providing oversight for completion of the PQRS, and reports will be published quarterly on the National Treasury website.
- The Department identified province specific indicators, based on provincial priorities and key focus areas (within the national framework) to ensure effective tracking of performance and health outcomes. Provincial indicators and targets are reflected in Part B of the APP as "*Provincial Strategic Objectives, Indicators and Performance Targets*". Indicators are linked with provincial strategic goals and objectives.
- Indicator definitions (included in the APP) are attached as Annexure 1.
- The APP reflects only core/ macro priorities and performance measures. Supporting

(secondary or sub-set) indicators and targets are included in Component, Programme, District and Institutional Operational Plans.

- All indicators and targets (APP and Operational Plans) are included in the Monitoring, Evaluation and Reporting Framework to ensure comprehensive monitoring, evaluation and reporting on performance output and health outcomes.
- The Public Audit Act, 2004 empowers the Auditor-General of South Africa (AGSA) to audit and report on the accounts, financial statements and financial information of all National and Provincial State Departments and Administrations. The formal audit opinion of the AGSA is expressed annually in the Annual Report.
- Quarterly performance targets (Part B) serve as a yardstick for quarterly reviews and reporting.

The 2013/14 APP has been aligned with a variety of plans and strategies to ensure optimum output

- Twelve Outcomes prioritised by Government for the current electoral cycle (2010-2014).
  - Outcome 1: Quality basic education.
  - Outcome 2: A long and healthy life for all South Africans.
  - Outcome 3: All people in South Africa are and feel safe.
  - Outcome 4: Decent employment through inclusive economic growth.
  - Outcome 5: Skilled and capable workforce to support an inclusive growth path.
  - Outcome 6: An efficient, competitive and responsive infrastructure network.
  - Outcome 7: Vibrant, equitable, sustainable, rural communities contributing towards security for all.
  - Outcome 8: Sustainable human settlements and improved quality of household life.
  - Outcome 9: Responsive accountable effective and efficient local government system.
  - Outcome 10: Protect and enhance our environmental assets and natural resources.
  - Outcome 11: Create a better South Africa, a better Africa and a better world.
  - Outcome 12: An efficient, effective and development oriented Public Service and an empowered, fair and inclusive citizenship.
- Medium Term Strategic Framework 2009-2014 - *Improve the health profile of all South Africans.*[22]
- National Health System 10 Point Plan (*Page 48*).
- Negotiated Service Delivery Agreement for Health - June 2012 (*Page 52*).
- Provincial Strategic Plan 2010 – 2014 (*available on http://www.kznhealth.gov.za)*
- National Health Insurance Policy.
- Millennium Development Goals (*Page 50*).
- National and Provincial Strategic Plans for HIV, AIDS, STIs and TB 2012 – 2016.
- National Development Plan (*Page 24*)
- Provincial Growth and Development Plan *(Page 24).*
- Funding envelope and "Non-Negotiable Budget Items" (*Page 68*).

UPDATED STRATEGIC OBJECTIVES, INDICATORS AND TARGETS PER BUDGET PROGRAMME

The Mission, Vision, Core Values and Strategic Goals published in the 2010-2014 Strategic Plan remains unchanged for this reporting period. Changes in Strategic Objectives, Indicators and Targets are recorded in the tables below.

Table 2: Programme 1: Administration

Page	Reviewed Strategic Objectives, Indicators and Targets with Comments
2010-2014 Strategic Plan - Updated Strategic Objectives, Indicators and Targets	
Strategic Objective: To finalise and implement Provincial Health Plans aligned with the NHS and MTSF priorities for 2010-2014.	
Page 52	Indicator: Approved Strategic Plan aligned with NHS and MTSF priorities. *Indicator removed 2011/12. Indicator refers to approval and publishing of the 2010-2014 Strategic Plan which has been achieved.*
Strategic Objective: To prepare and submit the KZN Health Act (1 of 2009) Regulations for promulgation in 2010. ***Removed 2012/13 - achieved.***	
Page 53	Indicator: Regulations for the KZN Health Act 2009 promulgated. *Strategic Objective and indicator removed 2012/13. Target achieved. The KZN Health Act, 2009 (Act No. 1 of 2009) has been promulgated with effect from 6 September 2012.*
Strategic Objective: To implement a Finance & SCM Turn-Around Strategy to improve compliance with the PFMA and Treasury Regulations, eliminate over-expenditure by 2012/13 and ensure an annual unqualified audit opinion on financial statements from the AGSA.	
Page 53	Indicator: Expenditure versus allocated budget. *Indicator removed 2011/12. Routine monitoring and reporting as part of financial oversight and turn-around strategy. Quarterly and annual reporting.*
Page 54	Indicator: Percentage procurement spent on specific and transversal contract management. *Indicator removed 2011/12. Reviewed strategy and performance measures as part of Clean Audit 2014/15.*
Page 54	Indicator: Percentage of assets accounted for in the composite Asset Register. *Indicator removed 2011/12. Reviewed strategy and performance measures as part of Clean Audit 2014/15.*
Strategic Objective: To align the Human Resources Plan with the Service Transformation Plan (STP) and implement as part of the Human Resources Turn-Around Strategy.	
Page 54	Indicator: Aligned Human Resource Plan (HRP) published and implemented. *Indicator removed 2011/12. HRP approved and submitted annually. Performance measures reviewed based on the reviewed HRMS strategy (including the National Human Resources for Health Strategy) and monitored as per identified outputs. STP requirements reviewed annually to incorporate into HRP.*
Page 54	Indicator: Persal data verified. *Indicator removed 2012/13. Indicator not SMART. Clean-up of Persal routinely performed and monitored.*
Strategic Objective: To implement an integrated Health Information Turn-Around Strategy to improve data quality and ensure an annual unqualified audit opinion on performance information from the AGSA from 2010/11 – 2014/15.	
Page 55	Indicator: Master System Plan (MSP) implemented. *Indicator removed 2012/13. Target achieved. Integrated information systems monitoring based on expected outcomes of Project Plans.*
Page 56	Indicator: Approved M&E Framework implemented. *Indicator removed 2011/12. Target achieved. Results-based performance monitoring as per M&E Framework.*
2012/13 Annual Performance Plan - Updated Strategic Objectives, Indicators and Targets for 2013/14	
Strategic Objective: To expand the Registrar training programme to increase the pool of Specialists by retaining 75% of qualified Registrars by 2014/15.	

Page	Reviewed Strategic Objectives, Indicators and Targets with Comments
Page 66	Indicator: Number of Medical Registrars graduating. *Indicator removed 2013/14. The data element (number of Medical Registrars graduated) is monitored and used as numerator to calculate retention of Registrars.*

Table 3: Programme 2: District Health Services

Page	Reviewed Strategic Objectives, Indicators and Targets with Comments
	2010-2014 Strategic Plan - Updated Strategic Objectives, Indicators and Targets
	Strategic Objective: Revitalise PHC as per STP Implementation Plan.
Page 86	Indicator: Provincial PHC Strategy implemented (Target: Implemented in 11 districts by 2010/11). *Indicator removed 2011/12. Target achieved. The PHC re-engineering Model has been approved and is being implemented in all districts.*
	Strategic Objective: Implementation of National Core Standards towards accreditation of 50% PHC clinics, 100% CHC's and 100% District Hospitals by 2014/15. ***Strategic Objective reviewed 2012/13: "Implementation of National Core Standards towards accreditation of 10% PHC clinics, 100% CHCs and 100% District Hospitals by 2014/15." Reviewed target based on current performance as well as available resources.***
Page 86	Indicator: Number of PHC clinics accredited (Target: 279/ 558 or 10% per year). *Indicator re-defined 2012/13: "Percentage of clinics fully compliant with the 6 priorities of the National Core Standards".* *Target reviewed 2012/13: 10% of clinics fully compliant by 2014/15. Review of targets based on current performance as well as availability of resources. Targets set in % to make provision for new clinics (change in denominator).*
Page 86	Indicator: Number of CHC's accredited (Target: 16/16). *Indicator re-defined 2012/13: "Percentage of CHCs fully compliant with the 6 priorities of the National Core Standards".* *Target reviewed 2012/13: 100% CHCs compliant by 2014/15. Review of target based on current performance as well as available resources. Target set as % to make provision for new CHCs (change in denominator).*
Page 86	Indicator: Number of District Hospitals accredited (Target: 37/37). *Indicator re-defined 2012/13: "Number of District Hospitals fully compliant with the 6 priorities of the National Core Standards".*
	Strategic Objective: Reduce morbidity and mortality by reducing the HIV incidence with 50% by 2011/12 and 60% by 2014/15. ***Strategic Objective reviewed 2012/13: "Reduce morbidity and mortality by reducing HIV incidence to <1% by 2014/15." The reviewed target has been aligned with the KZNPSP 2012-2016 and PGDP. Current incidence is based on ASSA projections.***
Page 86	Indicator: HIV incidence (Target: Reduce HIV incidence with 50% by 2014/15). *Indicator re-defined 2012/13: "HIV incidence in the general population."* *Target reviewed 2012/13: <1% (based on ASSA estimate and KZNPSP 2012-2016 targets).*
	Strategic Objective: Reduce morbidity and mortality by reducing mother to child transmission to ≤ 5% by 2014/15. ***Strategic Objective reviewed 2012/13: "Reduce morbidity and mortality by reducing mother to child transmission to <1% by 2014/15."***

Page	Reviewed Strategic Objectives, Indicators and Targets with Comments
Page 87	Indicator: Mother to Child Transmission of HIV (Target: ≤ 5%). *Indicator re-defined 2011/12: "Baby tested PCR positive six weeks after birth as proportion of babies tested at six weeks." Redefined in 2012/13: Infant 1st PCR test positive around 6 weeks rate to align with the National Indicator Data Set (NIDS)* *Target reviewed 2012/13: <1% by 2014/15. Review based on current performance, available resources, the KZNPSP 2012-2016 and PGDP.*
Strategic Objective: Reduce morbidity and mortality by improving the TB cure rate to 70% by 2014/15. ***Strategic Objective reviewed 2012/13: "Reduce morbidity and mortality by improving the TB (new pulmonary) cure rate to 85% by 2014/15."***	
Page 87	Indicator: TB cure rate (Target: 70%). *Indicator re-defined 2010/11: "New smear positive PTB cure rate."* *Indicator Redefined in 2012/13: "TB (New pulmonary) cure rate" to align with NIDS.* *Target reviewed 2012/13: 85% by 2014/15.*
Page 87	Indicator: TB treatment interruption rate (Target: <5%). *Indicator re-defined 2011/12: "New smear positive PTB defaulter rate."* *Indicator re-defined 2012/13: "TB (new pulmonary) defaulter rate"* *Reason: Alignment of indicator to NIDS (DHIS)*
2012/13 Annual Performance Plan - Updated Strategic Objectives, Indicators and Targets for 2013/14	
Strategic Objective: Revitalise PHC as per STP Imperatives and Implementation Plan.	
New indicator 2013/14 APP	Indicator: "Number of dental health visits (headcount)." *Reason: Indicator required for monitoring progress in improving access and utilisation of Oral Health services.*
Strategic Objective reviewed 2012/13: "Reduce morbidity and mortality by improving the new smear positive PTB cure rate to 85% by 2014/15."	
New indicators 2013/14 APP	1. *Number of MDR-TB cases registered* 2. *TB-MDR death rate* 3. *TB-MDR Treatment success rate* 4. *Number of XDR-TB cases registered* 5. *TB-XDR death rate* 6. *TB-XDR Treatment success rate* *Reason: Indicators added to improve active monitoring of drug-resistant TB outcomes.*
Strategic Objective: Reduce child mortality to 30-45/1000 live births by 2014/15.	
New indicators 2013/14 APP	1. *Child under 5 years with diarrhoea with dehydration incidence* (annualised) *(Target: -10% per year).* 2. *Child under 5 years pneumonia incidence (annualised) (Target: -10% per year).*
New indicator 2013/14 APP	*Indicator: Neonatal mortality in facility rate (annualised) (Target: 8.5/1000).*
Strategic Objective: Reduce morbidity and mortality by reducing mother to child transmission to ≤ 5% by 2014/15.	

Page	Reviewed Strategic Objectives, Indicators and Targets with Comments
***Strategic Objective reviewed 2012/13*: "Reduce morbidity and mortality by reducing mother to child transmission to <1% by 2014/15."**	
Page 111	Indicator: ANC Nevirapine uptake rate. *Indicator removed 2012/13. Indicator not monitored following a change in the reviewed PMTCT Policy.*

Table 4: Programme 3: Emergency Medical Services

Page	Reviewed Strategic Objectives, Indicators and Targets with Comments
2012/13 Annual Performance Plan - Updated Strategic Objectives, Indicators and Targets for 2013/14	
***Added: Strategic Objective*: To establish effective training programmes to provide an adequate skills base for EMS services in accordance with national norms.**	
New indicators 2013/14 APP	1. *Number of successfully trained ILS staff.* 2. *Number of successfully trained ECT staff.* 3. *Number of successfully trained ALS staff.* *Reason: Monitor supply of trained EMS staff.*

Table 5: Programme 4: Regional and Specialised Hospitals

Page	Reviewed Strategic Objectives, Indicators and Targets with Comments
2010-2014 Strategic Plan - Updated Strategic Objectives, Indicators and Targets	
Strategic Objective: To implement the nationally approved delegations for Hospital Managers by 2010/11. ***Strategic Objective removed in 2011/12*.**	
Page 102	Indicator: Number of CEO's who have signed the national delegation of authorities for Hospital CEO's (Target: 14). *Indicator not SMART and removed in 2012/13.*
Strategic Objective: To implement the Financial Turn-Around Strategy to eliminate over-expenditure in 100% Regional Hospitals by 2012/13.	
Page 102	Indicator: Number of Regional Hospitals with zero over-expenditure (Target: 14). *Indicator not SMART and removed in 2011/12. Expenditure actively monitored with monthly, quarterly and annual reporting.*
Strategic Objective: To rationalise hospital services in line with the approved STP and Service Delivery Plan.[1]	
Page 103	Indicator: Rationalisation of Regional Hospital services as per STP Implementation Plan. *Indicator not SMART and removed in 2011/12. Rationalisation as per Implementation Plan.*
Strategic Objective: To implement the National Core Standards in 100% Regional Hospitals by 2010/11 for accreditation of 14/14 Regional Hospitals by 2012/13. ***Strategic Objective reviewed 2012/13*: To implement the National Core Standards in 100% Regional Hospitals by 2010/11 for accreditation of 7/13 Regional Hospitals by 2014/15.**	
Page 102	Indicator: Number of Regional Hospitals accredited (Target: 14 by 2012/13).

[1] National processes (National Health Annual Plan 2010/11) to determine staffing norms, skills audit, infrastructure "Shock Treatment Plan" will inform the Provincial processes

Page	Reviewed Strategic Objectives, Indicators and Targets with Comments
	Indicator re-defined in 2012/13: "Number of Regional Hospitals compliant with the 6 priority areas of Core Standards." *Target reviewed in 2012/13: 7 Regional Hospitals accredited by 2014/15.*
Page 102	Indicator: Average patient waiting time at OPD (Target: ≤1 hour by 2014/15). *Indicator moved to the Operational Plan in 2012/13. Patient waiting times are routinely monitored as part of the National Core Standards and therefore not duplicated in the APP.*

Table 6: Programme 5: Central and Tertiary Services

Page	Reviewed Strategic Objectives, Indicators and Targets with Comments
2010-2014 Strategic Plan - Updated Strategic Objectives, Indicators and Targets	
Strategic Objective: To implement the nationally approved delegations for Hospital Managers by 2010/11. ***Strategic Objective removed in 2011/12.***	
Page 110	Indicator: Number of CEO's who have signed the national delegation of authorities for Hospital CEO's (Target: 2).
	Indicator not SMART and removed in 2012/13.
Strategic Objective: To implement the Financial Turn-Around Strategy to eliminate over-expenditure by 2012/13.	
Page 110	Indicator: Number of Tertiary/ Central Hospitals with zero over-expenditure (Target: 2).
	Indicator not SMART and removed in 2011/12. Expenditure actively monitored with monthly, quarterly and annual reporting.
Strategic Objective: To rationalise hospital services in line with the approved STP Implementation Plan.[2]	
Page 111	Indicator: Rationalisation of Tertiary/ Central Hospital services as per STP timelines.
	Indicator not SMART and removed in 2011/12.
Strategic Objective: To implement the National Core Standards in 2/2 Tertiary/ Central Hospitals by 2010/11 and accredit 2/2 hospitals by 2012/13.	
Page 110	Indicator: Number of Tertiary/ Central Hospitals accredited (Target: 1 Tertiary and 1 Central).
	Re-defined indicator in 2012/13: *"Number of Tertiary/Central Hospitals compliant with the 6 priority areas of the National Core Standards."*
Page 110	Indicator: Average patient waiting time at OPD (Target: ≤ 1 hour by 2014/15).
	Indicator moved to the Operational Plan in 2012/13. Patient waiting times are routinely monitored as part of the National Core Standards and therefore not duplicated in the APP.

Table 7: Programme 6: Health Sciences and Training

Page	Reviewed Strategic Objectives, Indicators and Targets with Comments
2010-2014 Strategic Plan - Updated Strategic Objectives, Indicators and Targets	
Strategic Objective: To develop and implement a Learning Strategy for Managers based on the skills audit results and enrol 100% Hospital Managers by 2012/13.	
Page 117	Indicator: Learning Strategy (Target: Strategy approved).

[2] National processes (National Health Annual Plan 2010/11) to determine staffing norms, skills audit, infrastructure "Shock Treatment Plan" will inform the Provincial processes

Page	Reviewed Strategic Objectives, Indicators and Targets with Comments
	Removed in 2011/12. Development and mentoring programmes forms part of the new Human Resources for Health Strategy and will be monitored as part of the strategy.
Page 117	Indicator: Number of Hospital Managers who completed the Masters for Public Health (75 Hospital Managers completed the Hospital Management Course). *Indicator removed in 2011/12. Managers completed the Masters Programme and no new intakes registered due to financial constraints.*

Table 8: Programme 7: Pharmaceutical Services

Page	Reviewed Strategic Objectives, Indicators and Targets with Comments
	2010-2014 Strategic Plan - Updated Strategic Objectives, Indicators and Targets
	Strategic Objective: Improve compliance with Pharmaceutical Regulations and legislation with 80% of pharmacies obtaining A or B grading on inspection by 2014/15 and PPSD being fully compliant with Regulations by 2012/13. ***Strategic Objective reviewed in 2012/13: Improve compliance with Pharmaceutical Regulations and legislation with 90% of pharmacies obtaining A or B grading on inspection by 2014/15 and PPSD being fully compliant with Regulations by 2012/13.***
Page 123	Indicator: Percentage of Pharmacies compliant with SAPC standards (Target: 80% of Pharmacies obtained A or B grading on inspection by 2014). *Indicator re-defined in 2011/12: "Percentage of Pharmacies that obtained A and B grading on inspection."* *Target reviewed 2012/13: 90% by 2014/15. Review based on current performance.*
Page 123	Indicator: PPSD building compliant with Good Manufacturing Practice Regulations (Target: PPSD 100% compliant with Good Manufacturing Practice Regulations by 2012/13). *Indicator re-defined in 2012/13: "PPSD compliant with Good Wholesaling Practice Regulations."*
	Strategic Objective: Reduce tracer medicine (including ARV and TB medicines) stock-out rate to <1% by 2014.
Page 123	Indicator: Tracer medicine stock-out rate (Target: Tracer medicines stock out rate <1% by 2014). *Indicator re-defined in 2011/12:* *1. Tracer medicine stock-out rate (PPSD).* *2. Tracer medicine stock-out rate (Institutions).*

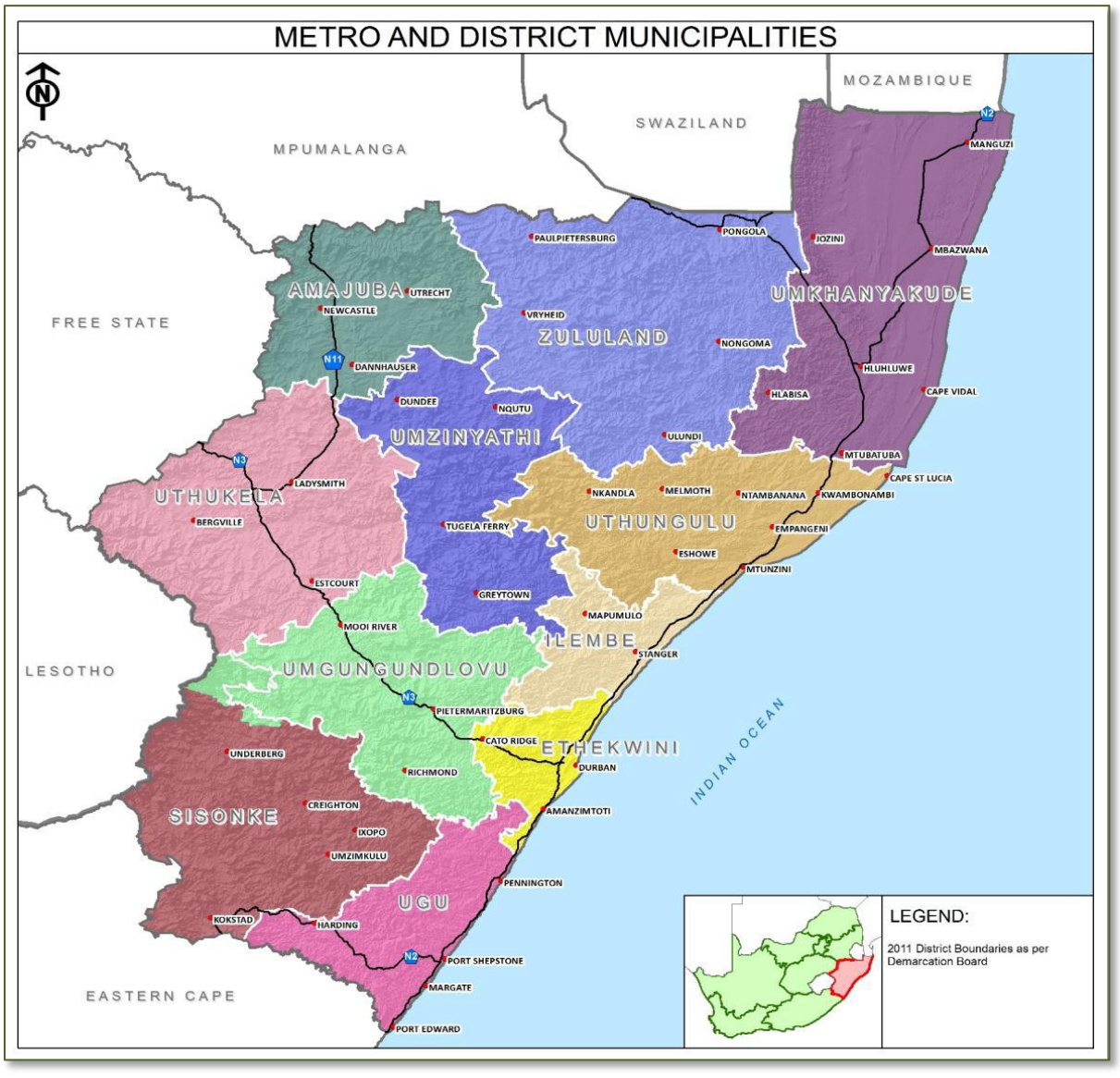
Table 9: Programme 8: Health Facilities Management

Page	Reviewed Strategic Objectives, Indicators and Targets with Comments
	2010-2014 Strategic Plan - Updated Strategic Objectives, Indicators and Targets
	Strategic Objective: To deliver new clinical infrastructure in line with the STP and approved Infrastructure Programme Implementation Plan (IPIP).
Page 128	Indicator: Infrastructure Programme (Target: Fully aligned IPIP). *Target achieved and removed in 2011/12.*
Page 128	Indicator: Number of projects for new clinical infrastructure fully commissioned (Target: 52 Projects). *Indicator and targets reviewed in 2011/12:* *1. Number of new clinical projects with completed construction (Target: 23).* *2. Number of new clinical projects where commissioning is completed (Target: 29).*

Page	Reviewed Strategic Objectives, Indicators and Targets with Comments
Strategic Objective: To upgrade and renovate existing clinical infrastructure in accordance with the STP and approved IPIP.	
Page 128	Indicator: Number of upgrade and renovation projects fully commissioned (Target: 89 Projects). *Indicator and targets reviewed in 2011/12:* *1. Number of upgrading and renovation projects with completed construction (Target: 106)* *2. Number of upgrading and renovation projects where commissioning is completed (Target: 184)*
Strategic Objective: To undertake the acquisition of properties including vacant land for building purposes.	
Page 128	Indicator: Implementation Plan to optimise Departmental accommodation needs (Target: Plan implemented). *Target achieved and indicator removed in 2011/12.*

1.5. SITUATION ANALYSIS

Map 1: Province of KwaZulu-Natal



Source: Extracted from Provincial Growth and Development Strategy

The Province of KwaZulu-Natal covers almost 8% of the country's geographic area and comprises 1 Metropol, 10 Districts, 50 Municipalities and 828 Wards. Health district boundaries are aligned with the municipal boundaries determined by the Municipal Demarcation Board.

Much of the provincial landscape is characterised by remote rural settlements in terrains where delivery of infrastructure is particularly challenging. *Integrated spatial planning and development, through the Provincial Growth and Development Plan, would contribute towards addressing this challenge*.

The Province shares borders with the Eastern Cape in the South, Free State and Lesotho in the West, Mpumalanga in the North West, and Swaziland and Mozambique in the North. Patients from Mpumalanga, Mozambique and Swaziland utilise health services in the northern districts of Umkhanyakude and Zululand, while patients from the Eastern Cape utilise health services in the southern districts of Ugu and Sisonke.

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

1. Lesotho: Sani Pass International Border Post within Sisonke District.
2. Swaziland: Golela International Border Post within Zululand District.
3. Mozambique: Manguze International Border Post within Umkhanyakude District.

POPULATION PROFILE

According to Census 2011, the total KZN population is 10,267,300 compared with 10,819,130 estimated in the 2011 StatsSA mid-year estimates [37] (*Table 10*).

Table 10: Census 2001 and 2011 Comparison

Item	Census 2001	Census 2011	2011 Estimates (P0302)
1. Total Population	9,584,146	10,267,300	10,819,130
2. Proportion of national population	21.3%	19.8%	21.39%
3. Proportion Males and Females	46.8% (M); 53.2% (F)	47.5% (M); 52.5% (F)	47.7% (M); 52.3% (F)
4. Population under 5 years	964,546 (10%)	1,198,134 (11.7%)	1,220,882 (11.3%)
5. Population 0-14 years	2,988,708 (31.2%)	3,279,519 (31.9%)	3,661,598 (33.8%)
6. Population between 15 – 34 years	3,041,516 (31.7%)	3,932,082 (38.3%)	4,114,155 (38%)

Source: Census 2001 and 2011; Statistical Release PO302 Mid-Year Population Estimates 2011

Note: Provincial proportion of the national population is indicated in brackets in the table above.

Population data for the calculation of performance indicators in the 2013/14 Annual Performance Plan is based on the nationally populated District Health Information System (DHIS) that still reflects StatsSA estimates to ensure consistency in reporting. The Census 2011 data (per district) is indicated in Table 11 for comparison and reference.

Current service delivery output is being reviewed in order to establish new baselines – especially relevant to indicators with population as denominator. The impact of the "reduced" population (Census 2011) on budget allocation will be closely monitored during 2013/14.

Table 11: Population per District and Sub-District

Districts and Sub-Districts	CENSUS 2001 AND 2011				STATSSA ESTIMATED DATA (DHIS)			% Uninsured Population
	Total Population	Growth Rate	Total Population	Uninsured Population	Total Population	Total Population	Uninsured Population	
	2001	2001-2011	2011	2011	2011	2012	2012 DHIS	
Ugu	**704,030**	**0.3%**	**722,484**	**679,477**	**764,577**	**767,999**	**721,919**	**94%**
% KZN Population	7.35%	-	7.04%	-	7.2%	7.17%	-	
Ezinqoleni	54,775	-0.4%	52,540	49,387	58,589	58,759	55,233	
Hibiscus Coast	217,824	1.6%	256,135	240,766	241,006	242,742	228,177	
Umdoni	62,375	2.3%	78,875	74,142	69,584	70,198	65,986	
uMuziwabantu	92,327	0.4%	96,556	90,762	98,643	98,383	92,480	
Umzumbe	193,768	-1.9%	160,975	151,316	207,026	207,475	195,026	
Vulamehlo	82,961	-0.7%	77,403	72,758	89,669	89,987	84,587	
Umgungundlovu	**932,121**	**0.9%**	**1,017,763**	**895,631**	**1,066,151**	**1,071,600**	**943,008**	**88%**
% KZN Population	9.68%	-	9.91%	-	10.04%	10.01%	-	
Impendle	37,844	-1.3%	33,105	29,132	38,264	38,376	37,992	
Mkhambathini	59,067	0.7%	63,142	55,564	67,911	68,160	59,980	
Mooi Mpofana	36,832	0.3%	38,103	33,530	42,478	42,679	37,557	
Richmond	63,223	0.4%	65,793	57,897	72,587	72,898	64,150	
Msunduzi	552,837	1.1%	618,536	544,311	636,081	639,577	562,827	
uMngeni	73,896	2.3%	92,710	81,584	84,887	85,439	75,186	
uMshwathi	108,422	-0.2%	106,374	93,609	124,006	124,471	109,534	
Uthukela	**657,736**	**0.2%**	**668,848**	**654,405**	**699,756**	**702,645**	**667,512**	**95%**
% KZN Population	6.85%	-	6.51%	-	6.59%	6.54%	-	
Emnambithi	225,459	0.5%	237,437	225,565	243,148	244,665	232,431	

Districts and Sub-Districts	CENSUS 2001 AND 2011				STATSSA ESTIMATED DATA (DHIS)			% Uninsured Population
	Total Population	Growth Rate	Total Population	Uninsured Population	Total Population	Total Population	Uninsured Population	
	2001	2001-2011	2011	2011	2011	2012	2012 DHIS	
Imbabazane	120,622	-0.6%	113,073	107,419	126,912	127,292	120,927	
Indaka	113,644	-1.0%	103,116	97,960	118,667	118,763	112,824	
Okhahlamba	137,924	-0.4%	132,068	125,464	146,280	146,724	139,387	
Umtshezi	60,087	3.2%	83,153	78,995	64,799	65,201	61,940	
Umzinyathi	**480,088**	**0.6%**	**510,838**	**485,296**	**514,838**	**517,807**	**491,916**	**95%**
% KZN Population	4.76%	-	4.98%	-	4.85%	4.84%	-	
Endumeni	51,101	2.4%	64,862	61,618	60,872	61,592	58,512	
Msinga	167,274	0.6%	177,577	168,698	184,719	185,328	176,061	
Nquthu	169,419	-0.2%	165,307	157,041	163,893	164,675	156,441	
Umvoti	92,294	1.1%	103,093	97,938	105,354	106,212	100,901	
Amajuba	**468,036**	**0.7%**	**499,839**	**464,850**	**514,313**	**517,284**	**481,074**	**93%**
% KZN Population	4.88%	-	4.87%	-	4.84%	4.83%	-	
Dannhauser	102,779	-0.1%	102,161	95,009	112,147	112,587	104,705	
Emadlangeni	32,954	0.6%	34,442	32,031	35,855	36,092	33,565	
Newcastle	332,981	0.9%	363,236	337,809	366,311	368,605	342,802	
Zululand	**780,069**	**0.3%**	**803,575**	**755,360**	**855,675**	**862,112**	**810,385**	**94%**
% KZN Population	8.39%	-	7.83%	-	8.06%	8.05%	-	
Abaqulusi	191,019	1.0%	211,060	198,396	207,089	209,072	196,527	
eDumbe	82,241	0%	82,053	77,129	87,938	88,654	83,336	
Nongoma	198,443	-0.2%	194,908	183,213	207,008	208,062	195,578	
Ulundi	188,585	0%	188,317	177,017	224,396	225,927	212,371	

Districts and Sub-Districts	CENSUS 2001 AND 2011				STATSSA ESTIMATED DATA (DHIS)			% Uninsured Population
	Total Population	Growth Rate	Total Population	Uninsured Population	Total Population	Total Population	Uninsured Population	
	2001	2001-2011	2011	2011	2011	2012	2012 DHIS	
uPhongolo	119,781	0.6%	127,238	119,603	129,244	130,397	122,573	
Umkhanyakude	**573,341**	**0.9%**	**625,846**	**594,553**	**660,351**	**666,521**	**633,194**	**95%**
% KZN Population	5.98%	-	6.1%	-	6.22%	6.23%	-	
Hlabisa	69,269	0.4%	71,925	68,328	102,018	102,875	97,731	
Jozini	184,206	0.1%	186,502	177,176	213,630	215,490	204,715	
Mtubatuba	145,987	1.8%	175,425	166,653	144,982	146,520	139,194	
The Big 5	31,482	1.1%	35,258	33,495	36,749	37,140	35,283	
Umhlabuyalingana	142,565	0.9%	156,736	148,899	162,972	164,496	156,271	
Uthungulu	**885,965**	**0.2%**	**907,519**	**798,616**	**972,850**	**979,513**	**861,971**	**88%**
% KZN Population	9.24%	-	8.84%	-	9.16%	9.15%	-	
Mbonambi	106,942	1.4%	122,889	108,142	116,839	117,552	103,445	
Mthonjaneni	50,382	-0.5%	47,818	42,079	55,317	55,698	49,014	
Nkandla	133,602	-1.6%	114,416	100,686	143,009	143,582	126,352	
Ntambanana	84,771	-1.3%	74,336	65,415	95,584	96,701	85,096	
uMhlathuze	289,190	1.5%	334,459	294,323	320,737	323,586	284,755	
uMlalazi	221,078	-0.3%	213,601	187,968	240,964	242,394	213,306	
Ilembe	**560,389**	**0.8%**	**606,809**	**558,264**	**629,625**	**632,453**	**581,856**	**92%**
% KZN Population	5.85%	-	5.91%	-	5.93%	5.90%	-	
KwaDukuza	167,805	3.2%	231,187	212,692	182,213	183,604	168,915	
Mandeni	127,327	0.8%	138,078	127,031	145,615	146,413	134,883	
Maphumulo	120,643	-2.2%	96,724	88,986	132,007	132,126	121,555	

Districts and Sub-Districts	CENSUS 2001 AND 2011				STATSSA ESTIMATED DATA (DHIS)			% Uninsured Population
	Total Population	Growth Rate	Total Population	Uninsured Population	Total Population	Total Population	Uninsured Population	
	2001	2001-2011	2011	2011	2011	2012	2012 DHIS	
Ndwedwe	144,615	-0.3%	140,820	129,554	169,790	170,310	156,685	
Sisonke	**452,231**	**0.2%**	**461,419**	**438,348**	**506,941**	**511,957**	**486,359**	**95%**
% KZN Population	4.76%	-	4.49%	-	4.77%	4.78%	-	
Greater Kokstad	56,528	1.5%	65,981	62,681	63,499	64,577	61,348	
Ingwe	107,558	-0.7%	100,548	95,520	114,229	115,142	109,384	
Kwa Sani	11,848	0.8%	12,898	12,253	17,647	17,875	16,981	
Ubuhlebezwe	101,959	0.0%	101,691	96,606	108,887	109,885	104,390	
Umzimkhulu	174,338	0.3%	180,302	171,286	202,679	204,498	194,273	
eThekwini	**3,090,122**	**1.1%**	**3,442,361**	**2,822,736**	**3,437,112**	**3,474,029**	**2,848,703**	**82%**
% KZN Population	32.24%	-	33.53%	-	32.36%	32.46%	-	
KwaZulu-Natal	**9,584,129**	**0.7%**	**10,267,300**	**9,137,897**	**10,622,189**	**10,703,920**	**9,526,488**	**89%**

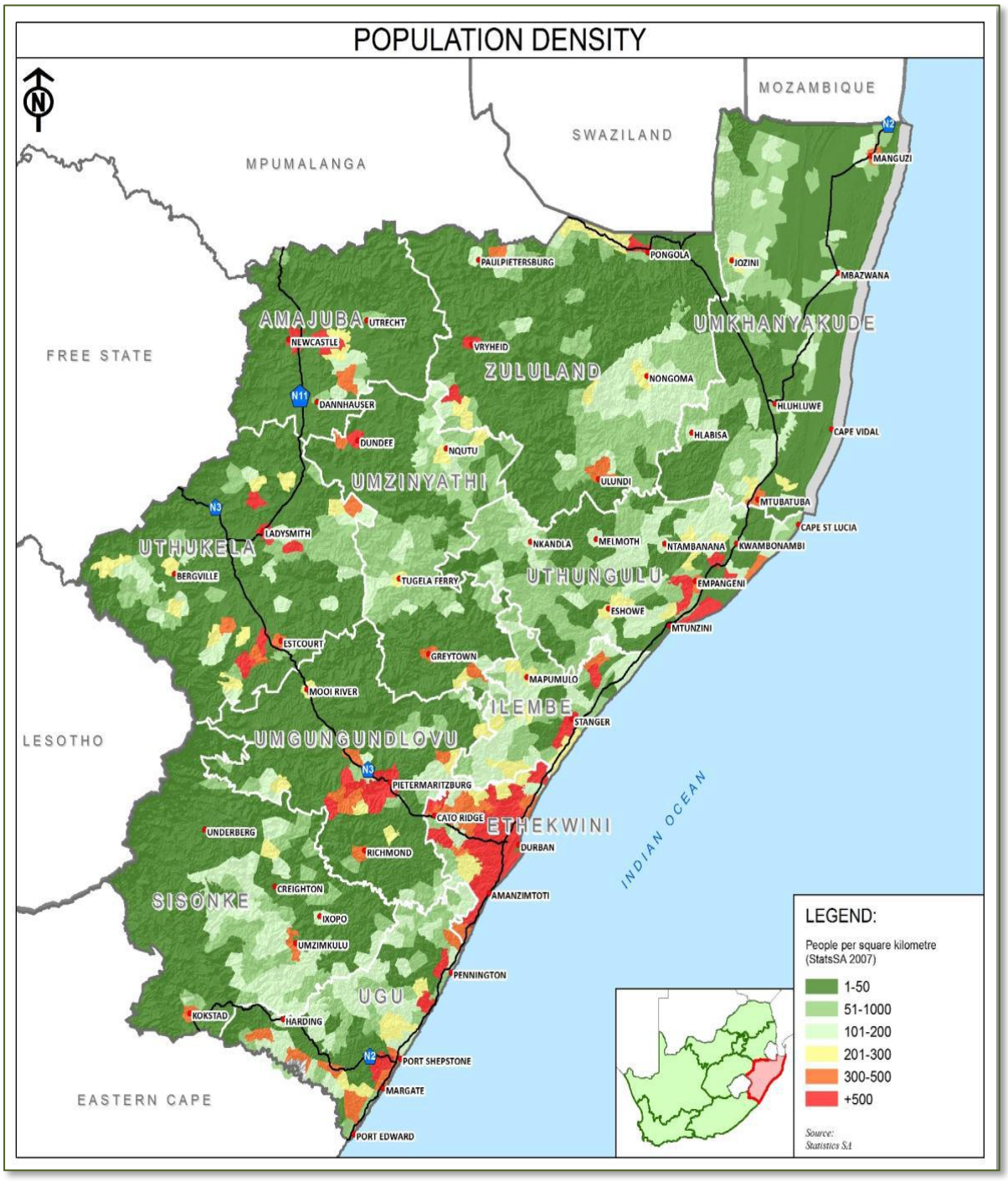
Source: DHIS (StatsSA projections) and Census 2011

Population distribution and density is exemplified in *Map 2* signifying significant implications for health planning and service delivery. Changes in the demography of communities due to migration patterns, the quadruple burden of disease, poverty and other social determinants of health require integrated and coordinated services at community and household level hence implementation of the Provincial Flagship Programme, Operation Sukuma Sakhe (OSS). The Department uses a geo-spatial model to contextualise and prioritise health service delivery within a broader context aligned with the National Growth Plan and Provincial Growth and Development Strategy and Plan.

The most densely populated areas (including the fast growing informal settlements) are mostly concentrated in eThekwini, Umgungundlovu and Uthungulu which are also considered the economic hubs of the Province.

Although very different in composition, urban/ rural and densely/ sparsely populated areas are presenting with similar challenges of access to facilities, poor access to essential services and inadequate road and transport facilities. This is further aggravated by the historical distribution (location) of health services and inequitable distribution of human and financial resources between the public and private sector.

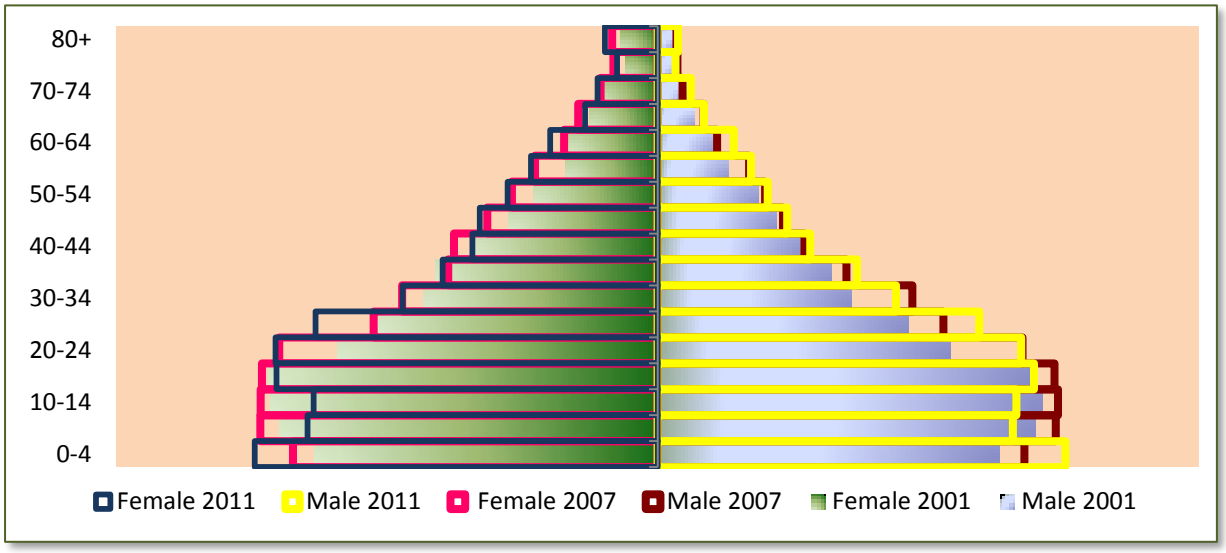
Map 2: Population Density



According to 2011 estimates (StatsSA) the fertility rate in KZN decreased from 3.21 to 2.81 between 2001 and 2011 compared with 2.81 and 2.52 nationally; and the life expectancy increased from 51.6 – 52.8 years for females and 47.4 – 48.4 years for males.

The population pyramid (*Figure 1*) illustrates the population trends between 2001 (Census), 2007 (Community Survey) and 2011 (Census). Of significance is the increase in the 0-4 cohort, generally ascribed to positive gains in the reduction of mother to child transmission of HIV. Further analysis is however essential to explain correlation between fertility, births and deaths

Figure 1: Provincial Population Pyramid 2001; 2007, 2011



Source: Census 2001 and 2011; 2007 Community Survey

Approximately one third of the KZN population is under 15 years and one third between 15-34 years (reproductive years). The broad base and tapering top is typical of a developing population and provide specific pointers to service delivery demands (gender and age) requiring a customised programme design to respond to health demand and need.

The demographic transition is explained by a drop in death rates resulting in an expanding population followed by a drop in fertility rates resulting in stabilisation of the population. The quadruple burden of disease, especially HIV and AIDS, has had a profound impact on the population structure since 2001 i.e. high mortalities of women especially of reproductive age and children under-5 years. This affected the normal trajectory of the demographic transition over the last decade, although more effective prevention and treatment programmes begin to change trends.

Increased demand and patient activity in health facilities is associated with population trends, the burden of disease, gradual change in health behaviour and increased access to health services. Between 2010/11 and 2011/12, the PHC utilisation rates increased from 2.5 to 2.7 visits per client per year, and 4.5 to 4.6 visits per year for children under-5 years. This is however still considered low taking into consideration the high burden of disease in the Province.

SOCIO-ECONOMIC PROFILE

Poverty and Deprivation

"Large-scale poverty within the rural areas and vulnerability to variable economic conditions, service delivery and climate variability suggests the necessity for increased focus on integrated strategies for rural development".[20]

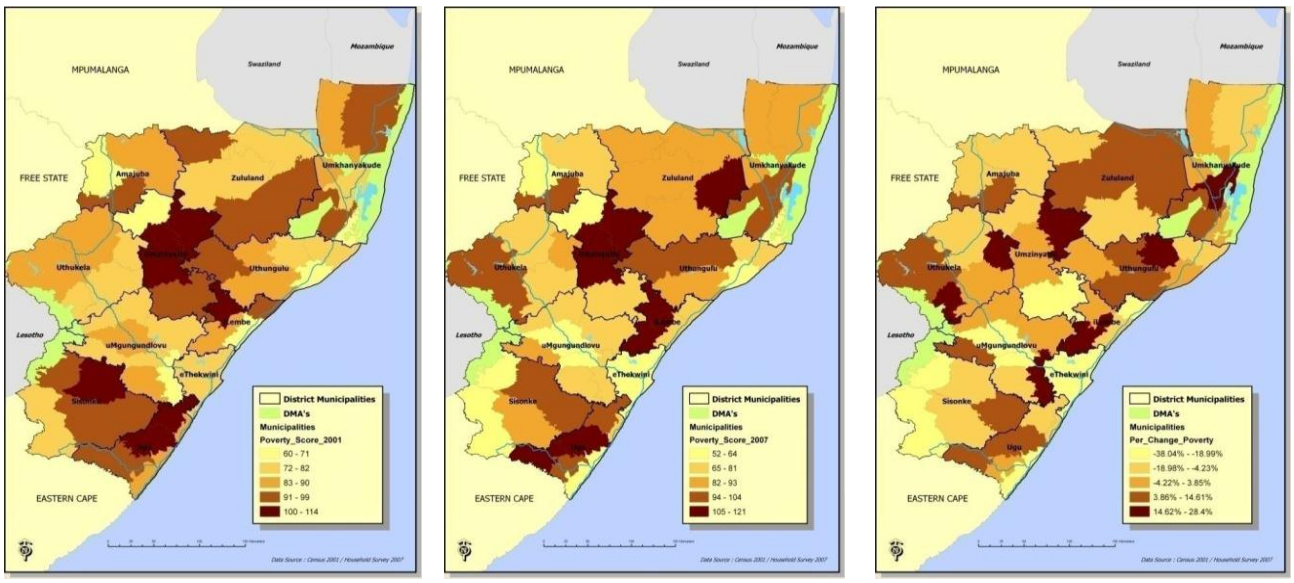
KZN bears a disproportionately high burden of poverty[3] with 63% to 82% of households living on less than R800 per month (*District Health Barometer*),[3] The average general household income in the Province however increased from R 38 905 in 2001 to R 83 053 in 2011 (*Census 2011*). The General Household Survey (*GHS*) indicates that 25% of recipients dependent on social grants and social relief packages live in KZN with more than half (53%) of the recipients female.[36]

Of the working age population in the Province, 33.7% are employed either formally or informally compared to almost 39% in South Africa (*Quantec Database – Standardised Regional Dataset*).

[3] Poverty refers to lack of material possessions or money and absolute poverty is a state where there is a lack of basic human needs such as clean/fresh water, nutrition, health care, education, clothing and shelter

Figure 2 illustrates district trends in the composite deprivation index between 2001 and 2007. Long-term health outcomes are, to a large extent, shaped by factors outside the health system and are therefore an integral part of the intention to bolster the social compact for health and social responsibility through active community participation in PHC re-engineering. Integrated action, using OSS, provides the foundation for this multi-sectoral action.

Figure 2: Trends in the Composite Deprivation Index of KZN 2001 - 2007



Source: Data from StatsSA

Poverty is inextricably associated with malnutrition and disease with a synergistic effect between malnutrition, HIV and Tuberculosis (TB). Food insecurity frequently leads to poor nutrition, which in turn affects the functioning of the immune system, leading to increased susceptibility to disease.[4]

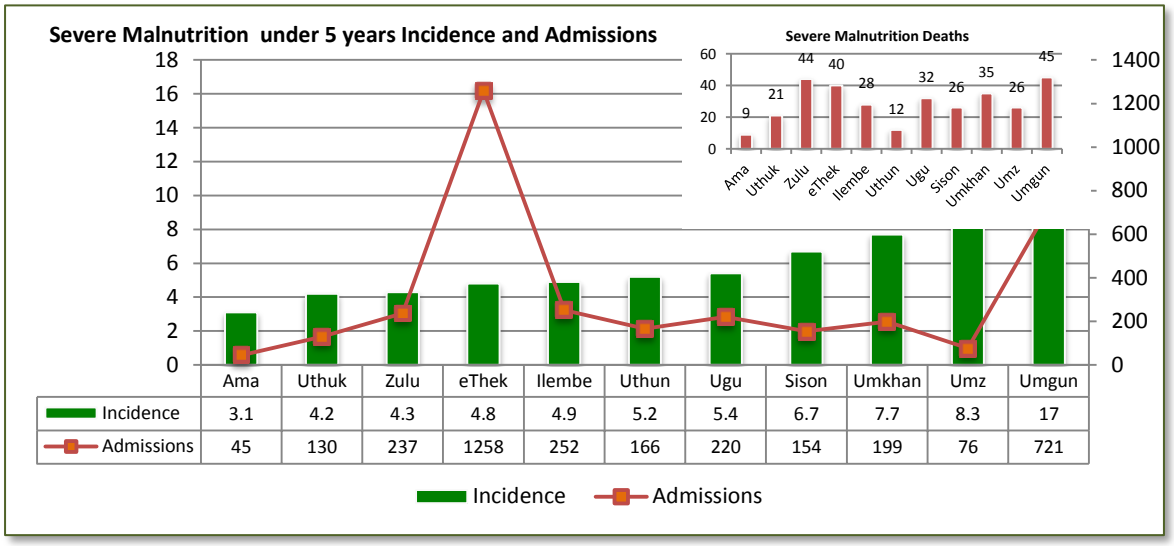
The inter-related complexities of poverty and deprivation compel multi-sectoral strategies and interventions actioned through OSS within the framework of the PGDP. This will serve to provide empirical evidence with regards to outcome of specific "inter/intra-departmental" interventions to reduce poverty and improve health outcome.

Malnutrition remains one of the leading co-morbidities for children under the age of 5 years. Between 2010/11 and 2011/12, the severe malnutrition under-5 year incidence decreased from 7/1000 to 6.7/1000 (*DHIS*). A total of 3,548 children were admitted to hospital with a diagnosis of severe malnutrition and 318 died during the same period (*Graph 1*).

The lack of community-based data and poor classification of malnutrition cases at facility level however imply under-reporting of the actual malnutrition incidence in the Province.

[4] Food insecurity is defined as the lack of "access to food, adequate in quantity and quality, to fulfil all nutritional requirements for all household members throughout the year" (Jonsson and Toole 1991).

Graph 1: Child under 5 years severe acute malnutrition incidence (annualised), admission and deaths



Source: DHIS

Note: Graph 1 reflects facility data only and is therefore not a reflection of all severe malnutrition cases in the Province.

Access to Basic Services

According to Census 2011 access to basic services increased significantly between 2001 and 2011:

- Access to piped water inside dwellings increased from 48.7% (1,031,206 households) to 63.6% (1,614,147 households);
- Access to flush toilets increased from 46.1% (976,398 households) to 53.2% (1,352,122 households);
- Access to electricity for cooking, heating and lighting increased from 47.6% (1,208,768 households) to 68.6% (1,742,048 households).

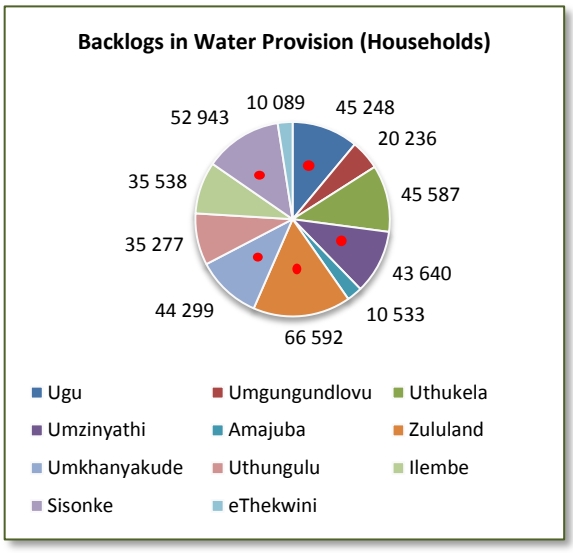
Figure 3 illustrates the backlogs in service delivery for basic services clearly illustrating inequities in access to basic services. Rural Development Nodes are marked with red dots (*COGTA Annual Report 2011/12*).

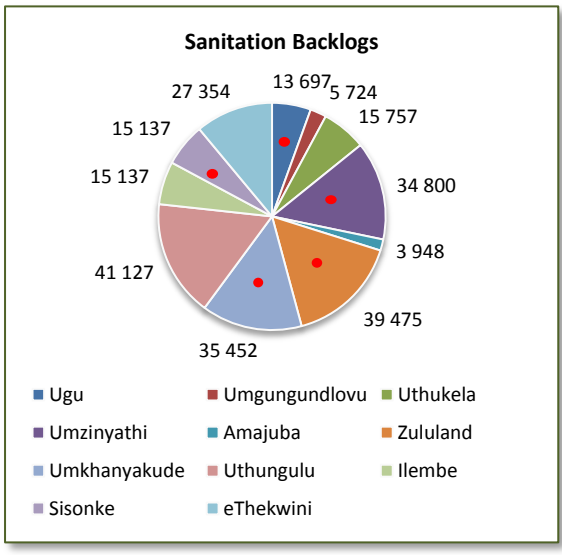
The Provincial "Blue Drop" score (measuring the management and processes to ensure acceptable drinking water quality) improved from 65% in 2010 to 80% in 2011 and 92.90% in 2012.[6] All Water Service Authorities reported a decline in unsafe water which is expected to have a positive impact on health outcomes.

Access to basic services is a challenge in informal settlements. According to the 2007 Community Survey, an estimated 306,076 households resided in informal settlements in KZN. The KZN Department of Human Settlement estimated that 78% of households in informal settlements are located in eThekwini Municipality (494 settlements comprising 239,436 households).[19]

Between 2001 and 2011, the number of households living in informal dwellings decreased from 271,718 to 210,772 (*Census 2011*).

Figure 3: Backlogs in Provisioning of Water and Sanitation – July 2011





Source: COGTA Report

Provincial Flagship Programme (Operation Sukuma Sakhe - OSS)

The Operation Sukuma Sakhe (OSS) integrated programme aims to address poverty and inequities through intensified and integrated sector strategies targeting individuals and households at community level (ward-based delivery model). The programme serves as vehicle for the implementation of the approved integrated community and facility-based PHC re-engineering model.

The broad aims of OSS include:

- Poverty eradication: Coordinated community-based interventions at household level.
- Community development with the primary focus on vulnerable groups e.g. women and youth.
- Rural development and food security.
- Integration and cooperative governance to improve service delivery.

Reporting forms part of the multi-sector reporting system developed and monitored by the Office of the Premier to ensure complete integration with the Provincial Growth and Development Plan.

National Development Plan (NDP)

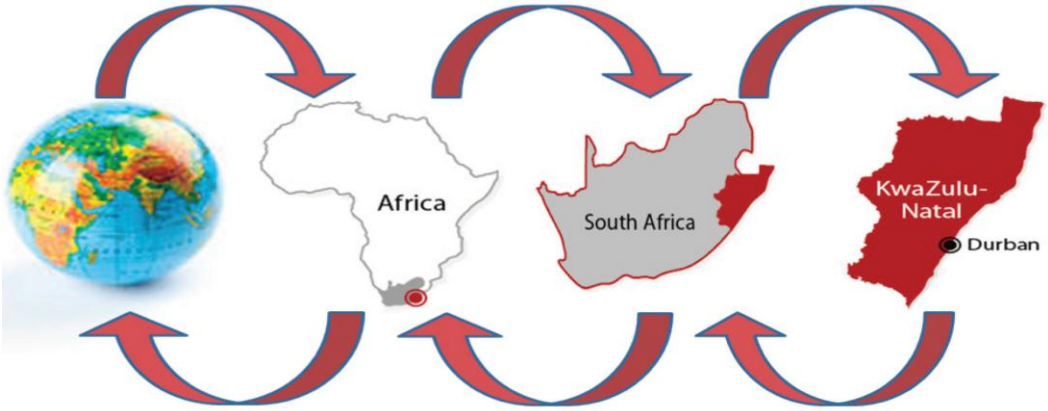
Provincial priorities and key focus areas are aligned with the NDP objectives including:

1. Increase life expectancy
2. Progressively improve TB prevention and cure
3. Reduce maternal and child mortality
4. Reduce prevalence of non-communicable diseases
5. Health systems reform
6. Community-based interventions including Community Care Givers, PHC Teams, School Health Teams and District Specialist Teams
7. Universal health coverage (NHI)
8. Health workforce aligned with demand and need
9. Improved management, leadership and oversight
10. Inter-sectoral collaboration

Provincial Growth and Development Strategy (PGDS) and Plan (PGDP) [20]

Vision: By 2030, the Province of KwaZulu-Natal should be a GATEWAY to South and Southern Africa, its human and natural resources maximized to create a safe, healthy and sustainable living environment.

Figure 4: KZN as Gateway to South Africa and Africa



Source: Extracted from the PGDS

The KwaZulu-Natal Provincial Planning Commission (PPC) was appointed by the Premier in February 2011 to serve for a period of 5 years. The PPC is constituted of nine Commissioners - eight part-time Commissioners and a fulltime Chairperson.

The KwaZulu-Natal Provincial Cabinet adopted the Provincial Growth and Development Plan in December 2012.

The Provincial Growth and Development Strategy (2030 Vision, Strategic Goals and Objectives) and Plan (desired outcomes) is aligned with provincial, national and global policy frameworks including the six Provincial Priorities, the Twelve National Outcomes, the New Growth Path, the National Planning Commission's Diagnostic Report and National Development Plan and the Millennium Development Goals (MDGs).

Provincial Growth and Development Plan Strategic Goals

Strategic Goal 1: Job creation (Expand Provincial economic output and employment).

Strategic Goal 2: Human resource development (To ensure human resource capacity is adequate, relevant and responsive to growth and development needs of KZN).

Strategic Goal 3: Human and community development (To support the constant improvement in the health and holistic growth and development of individuals and communities in KZN).

Strategic Goal 4: Strategic infrastructure (To provide infrastructure for the social and economic growth and development needs of KZN).

Strategic Goal 5: Environmental sustainability (To reduce global greenhouse gas emissions and create social-ecological capacity to adapt to climate change).

Strategic Goal 6: Governance and policy (The population of KZN is satisfied with the levels of government service delivery).

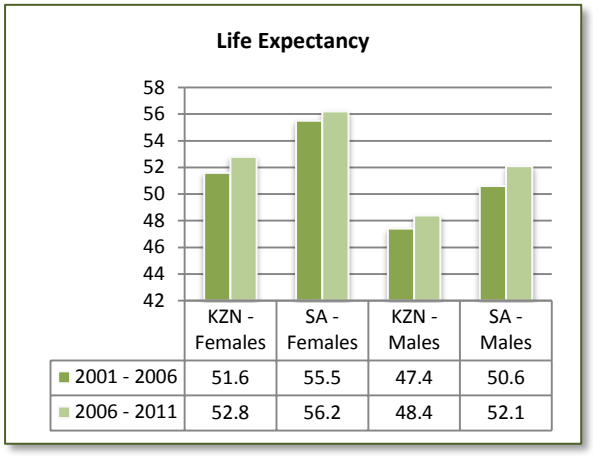
Strategic Goal 7: Spatial equity (To increase spatial access to goods and services)

The Annual Performance Plan and District Health Plans have been aligned with the vision and strategic goals and objectives contained in the PGDP.

EPIDEMIOLOGICAL PROFILE/ BURDEN OF DISEASE

Life expectancy for both males and females in KZN increased between 2001 and 2011 in spite of the increasing burden of disease in the province (*Graph 2*). Improved access to health services and appropriate response to the burden of disease contributed to improved health outcomes and improved life expectancy.

Graph 2: Life Expectancy in KwaZulu-Natal and South Africa

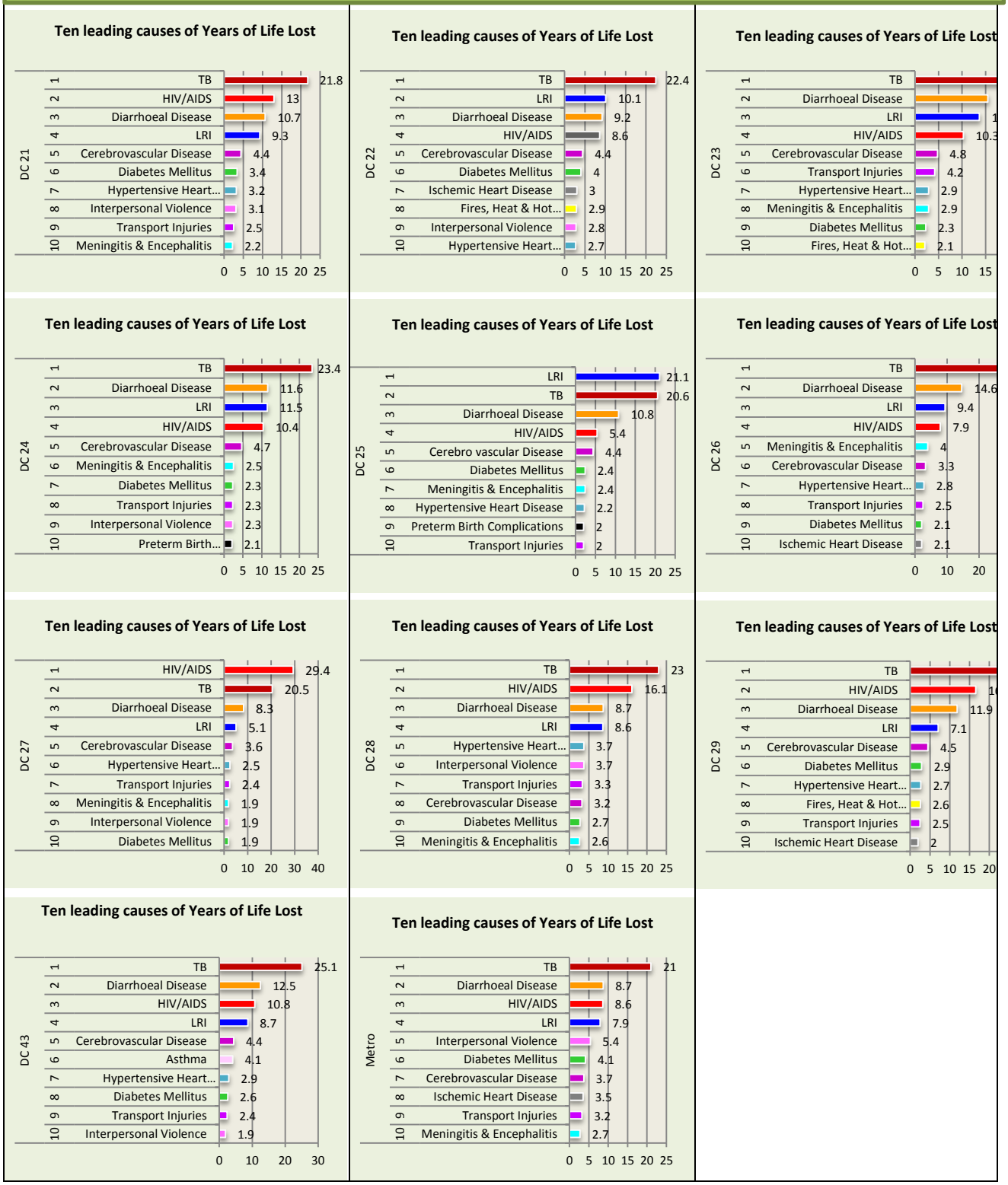


Source: Statistics South Africa

In South Africa infectious diseases are responsible for 25%; and non-communicable diseases 27% of years of life lost.[40] The ten leading causes of Years of Life Lost (YLL) in KwaZulu-Natal are depicted in Figure 5.[3] Three of the leading causes of YLL in the Province (TB, pneumonia, and diarrhoea) are directly related to HIV and might therefore suggest that HIV mortality is by far the leading cause of YLL in the province.

Figure 5: Ten Leading Causes of Years of Life Lost in KZN

DC 21: Ugu; DC 22: Umgungundlovu; DC 23: Uthukela; DC 24: Umzinyathi; DC 25: Amajuba; DC 26: Zululand; DC 27: Umkhanyakude; DC 28: Uthungulu; DC 29: Ilembe; DC 43: Sisonke; Metro: eThekwini



Source: District Health Barometer 2010/11 (Health Systems Trust)

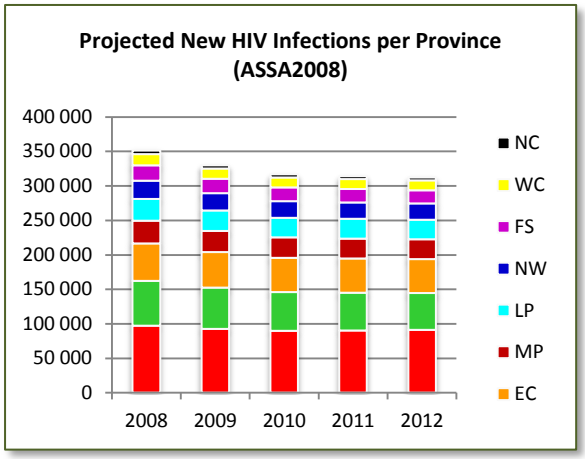
HIV AND AIDS

KZN has the highest burden of disease associated with under-development and poverty in the country, which includes HIV & AIDS, STIs and Tuberculosis.

The HIV epidemic is estimated to have reduced life expectancy in South Africa by about 13 years from 64 in 1990 to 51 years in 2005 (Dorrington et al. 2006), and although there has been a national reduction in the number of annual AIDS deaths (*ASSA 2011*), HIV and AIDS remains the dominant co-morbidity in KZN.

According to ASSA2008[5] estimates, the HIV incidence in KZN is 1.01% (2012) compared with 0.71% nationally.

Graph 3: Estimated new HIV infections per Province



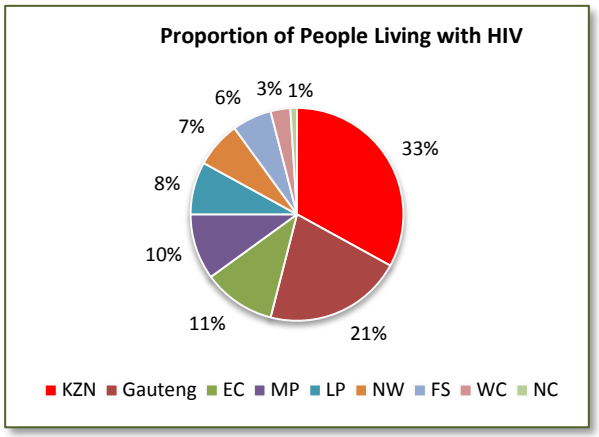
Source: ASSA2008 HIV estimates

KZN, comprising 19.8% of the total national population, carries the biggest burden of HIV as illustrated in Graph 4.

According to ASSA estimates, the number of people living with HIV in the Province increased from 1,576,025 in 2011 to 1,602,236 in 2012 (15.6% of total population).

If 40% of people living with HIV are presumed to have a CD4 count of 350 and below, roughly 640,894 people are in need of ART – compared with 641,198 patients on ART mid-year 2012/13.

Graph 4: Proportion of People Living with HIV per Province[6]



HIV prevalence data from the antenatal sentinel surveillance study shows significant variances between health districts (*Graph 5*) which can be explained in part by common high risk factors including localised high HIV transmission in areas close to national roads; and poverty and deprivation linked to significantly higher HIV prevalence. People working in the informal sector present overall the highest HIV prevalence among the different employment groups with almost one third of African informal workers HIV-positive; and women living in poverty more likely to be HIV-positive.

Several studies indicated that urban informal areas are linked to the highest HIV prevalence levels, compared to urban formal, rural informal and rural formal areas. In 2008, women living in urban informal areas were 57% more likely to be HIV infected than those in urban formal areas.[22]

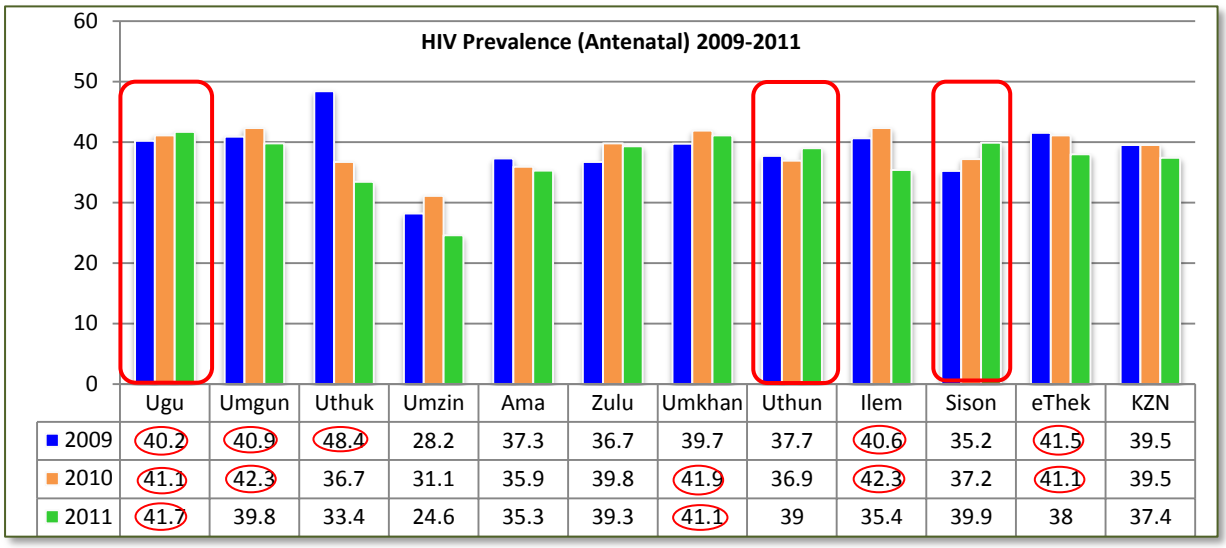
In rural areas HIV prevalence increased by over 5% between 2002 and 2008 (increase statistically significant for rural informal areas). This can be correlated with provincial trends hence integrated multi-sectoral approach through the Provincial Flagship Programme and PGDP.

The current prevalence trends are difficult to interpret, as it may be indicative of a positive change in incidence or improved management of people living with HIV. Graph 5 shows the general decrease in prevalence between 2010 and 2011 except in Ugu, Uthungulu and Sisonke where prevalence increased.

[5] AIDS Committee of Actuarial Society of South Africa

[6] Estimated population 15-49 years in mid-2008 from the SSA website times-series data – HIV prevalence in persons aged 15-49 years in 2008 from Shisana et al (2009) Table 3.10

Graph 5: HIV prevalence under antenatal women 2009 – 2011



	Ugu	Umgun	Uthuk	Umzin	Ama	Zulu	Umkhan	Uthun	Ilem	Sison	eThek	KZN
2009	40.2	40.9	48.4	28.2	37.3	36.7	39.7	37.7	40.6	35.2	41.5	39.5
2010	41.1	42.3	36.7	31.1	35.9	39.8	41.9	36.9	42.3	37.2	41.1	39.5
2011	41.7	39.8	33.4	24.6	35.3	39.3	41.1	39	35.4	39.9	38	37.4

Source: 2011 National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa

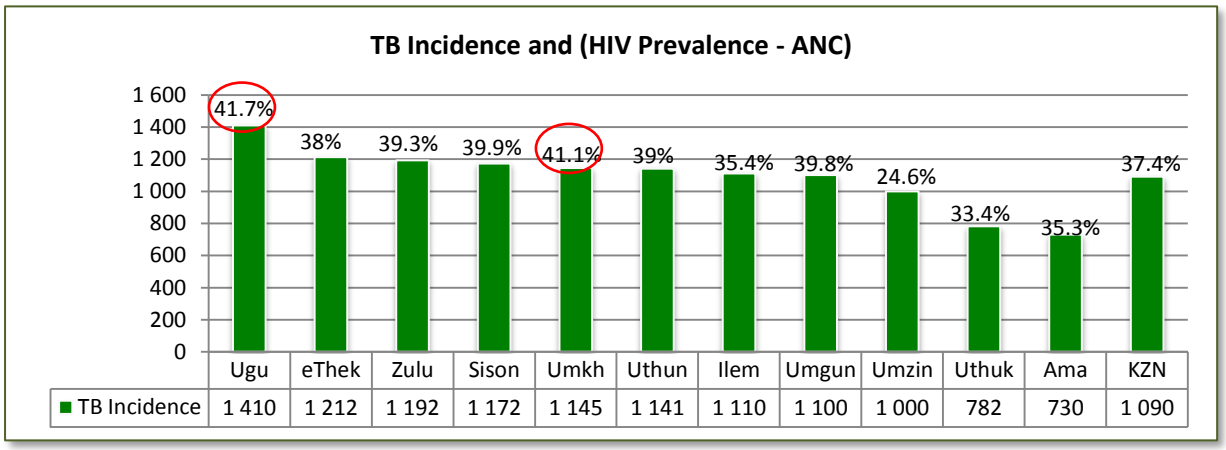
According to the Medical Research Council the early infant HIV infection prevalence in KZN was 1.9% in 2010 (1.5% nationally) and the mother to child transmission rate 2.9% at 4-8 weeks (3.5% nationally) reducing to 2.1% in 2011. The study sample used facility-based data of infants presenting for immunisation and therefore excluded all infants not presenting for immunisation and children who have died by 6 weeks which might have increased the under-estimation of infant HIV infection prevalence.[9]

According to DHIS data, the babies testing PCR positive at 6 weeks after birth (as proportion of babies tested at 6 weeks) was 4% in 2011/12.

TUBERCULOSIS

The TB incidence decreased slightly from 1161/100 000 in 2010 to 1090/100 000 in 2011 (*Graph 6*). The decrease in the incidence is mainly attributed to improved case finding; early initiation of treatment (rollout of rapid diagnostic technology (32 GeneXpert machines); initiating HIV positive patients without TB symptoms on Isoniazid Prophylactic treatment; improved infection prevention and control of airborne diseases; and early initiation of TB-HIV co-infected patients on ART.

Graph 6: TB Incidence and HIV (ANC) Prevalence per district 2011



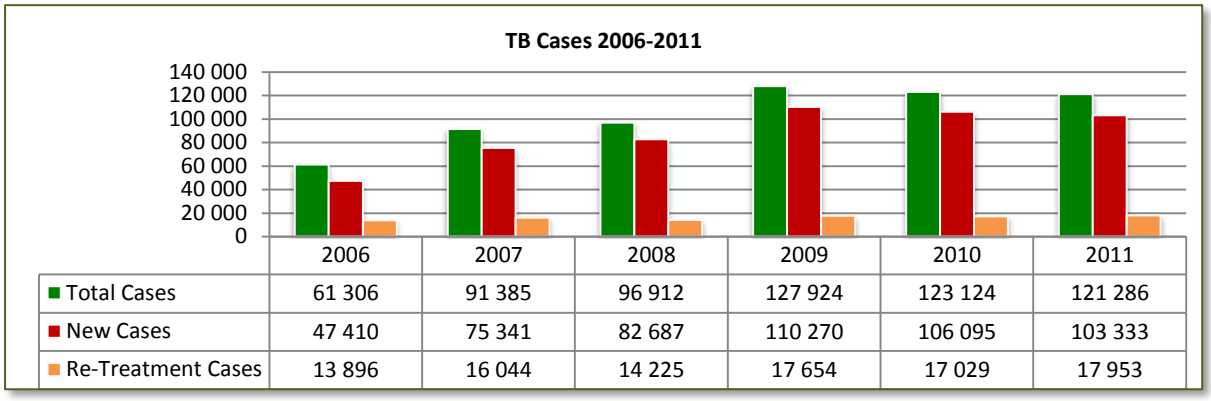
	Ugu	eThek	Zulu	Sison	Umkh	Uthun	Ilem	Umgun	Umzin	Uthuk	Ama	KZN
TB Incidence	1 410	1 212	1 192	1 172	1 145	1 141	1 110	1 100	1 000	782	730	1 090

Source: ETR.Net and 2011 National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa

Note: HIV prevalence per district (%) included in Graph 6, with specific relevance to the high HIV-TB co-infection rate (currently exceeding 70%). TB remains the most common opportunistic infection in KZN (*Figure 5*).

Graph 7 illustrates the number of TB cases reported to health facilities from 2006 to 2011. Improved surveillance programmes, as part of re-engineering of PHC and OSS, might see an increase in reported cases which will be monitored.

Graph 7: Total reported TB cases in health facilities 2006-2011

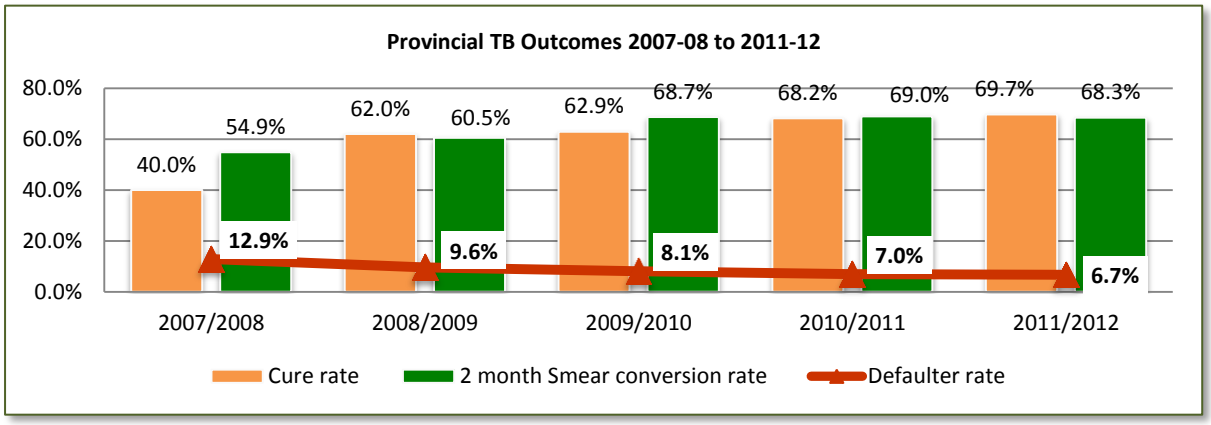


	2006	2007	2008	2009	2010	2011
Total Cases	61 306	91 385	96 912	127 924	123 124	121 286
New Cases	47 410	75 341	82 687	110 270	106 095	103 333
Re-Treatment Cases	13 896	16 044	14 225	17 654	17 029	17 953

Source: ETR.Net

The TB cure rate shows a year on year increase from 49% in 2006 to 69.7% in 2011/12 (*Graph 8)*. The improvement is ascribed to increased resource allocation in high burden facilities and the increase of outreach services; improved patients treatment adherence counseling using community care givers for directly observed treatment as part of OSS; community based management of TB and drug resistant TB; intensified TB defaulter tracing; improved systems for patient tracking and community awareness campaigns.

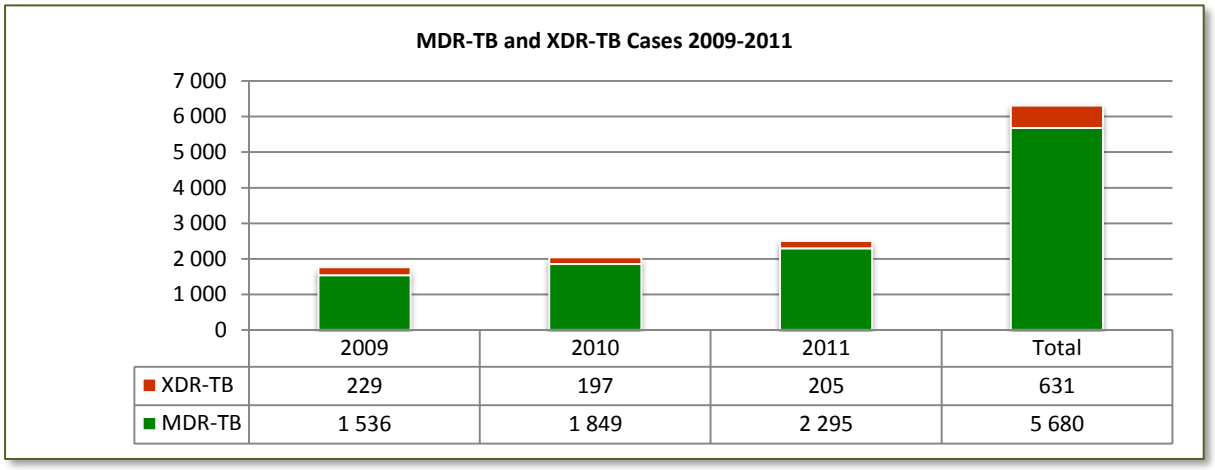
Graph 8: Provincial TB Outcomes 2007/08 to 2011/12



Source: ETR.Net

Drug-resistant forms of TB i.e. MDR-TB (multi-drug resistant TB) and XDR-TB (extensively drug resistant TB) have increased progressively over the last 3 years (*Graph 9*). Facility-based management of drug-resistant TB places considerable pressure on limited resources and has significant implications for patients e.g. length of stay in facilities for treatment. Community-based management of these cases was therefore piloted in KZN in 2007 with gradual rollout of the programme to date. The National Department of Health launched the *National Policy Framework on Decentralised and De-Institutionalised Management of Drug-Resistant TB for SA* in August 2011.

Graph 9: MDR-TB and XDR-TB 2009-2011



	2009	2010	2011	Total
XDR-TB	229	197	205	631
MDR-TB	1 536	1 849	2 295	5 680

Source: MDR-TB database

HIV, AIDS, STI and TB Focus for 2013/14

- ***Vision:*** *"A KwaZulu-Natal Province that is free of new HIV, STI and TB infections, free of deaths associated with HIV and TB and free of discrimination where all infected and affected enjoy a high quality of life."* [22]
- Implementation of the Multi-Sectoral Provincial Strategic Plan for HIV and AIDS, STI and TB 2012-2016 for KwaZulu-Natal.
  - **Priority Area 1: Prevention of HIV, STI and TB** (Male Medical Circumcision; Behaviour Change Communication; Prevention of Mother to Child Transmission; Treatment of Sexually Transmitted Infections; HIV & TB Screening; Condom distribution; Treatment of TB; Occupational exposure, sexual violence and discordance).
  - **Priority Area 2: Sustaining Health and Wellness** (Increased access to treatment and support, Adherence to treatment and optimum health for people living with HIV; Increased access to treatment and responsive services; Increased access to support for affected people; Quality care for orphaned and vulnerable children).
  - **Priority Area 3: Protection of Human Rights** (Strengthening leadership to speak out against stigma and discrimination; Adherence to legislation and policy on human rights).
  - **Priority Area 4: Reducing Structural Vulnerability** (Reducing poverty, unemployment and gender inequality; Improved involvement of stakeholders).
  - **Priority Area 5: Coordination, Monitoring & Evaluation** (Strengthening coordination and management; strengthening monitoring & evaluation systems at all levels; strengthening the research component of the response.

MATERNAL, NEONATAL, CHILD AND WOMEN'S HEALTH

Maternal and Neonatal Health

According to the Saving Mothers 2008-2010 Report, the KZN Institutional Maternal Mortality ratio (MMR) increased from 169.78/ 100 000 live births between 2005-2007 (961 reported deaths) to 192.31/100 000 live births between 2008-2010 (1,129 reported deaths). The case fatality rate (CFR) for HIV positive pregnant women was 389.99/ 100 000 (430.35/100 000 nationally); CFR for HIV negative pregnant women was 68.10/100 000 (75.46/100 000 nationally); and the CFR for HIV unknown pregnant women was 195.25/100 000 (179.80/100 000 nationally).[31]

Table 12 summarises the institutional mortality rates per district with districts exceeding the national average highlighted in tan.

Table 12: Mortality Rates (2008 – 2010)

District	Institutional Maternal Mortality Ratio (MMR) per 100 000 live births		Perinatal Mortality Rate (PNMR) per 1000 live births	Still Birth Rate (%)	Early Neo-Natal Death Rate (ENNDR) (%)	Baby tested PCR positive six weeks after birth as proportion of babies tested at six weeks
	MMR/100 000	Deaths/ Deliveries				
Ugu	299.5	126/ 42,077	25.9	22.9	3.2	3.2
Umgungundlovu	229.2	117/ 51,047	35.4	30.0	5.6	3.0
Uthukela	221.6	86/ 38,813	40.7	25.5	15.5	2.9
Umzinyathi	113.6	41/ 36,094	28.5	18.5	10.2	3.6
Amajuba	139.8	33/ 23,597	40.4	39.2	1.3	1.9
Zululand	150.1	74/ 49,296	30.7	21.3	9.7	3.7
Umkhanyakude	91.3	38/ 41,623	23.1	17.7	5.4	3.4
Uthungulu	266.6	154/ 57,760	39.5	25.2	14.7	2.9
Ilembe	180.9	56/ 30,955	37.6	26.0	11.9	2.9
Sisonke	40.7	11/ 27,007	24.2	20.4	4.0	3.0
eThekwini	217.3	391/ 179,976	31.0	24.2	7.0	6
National average	**179.5**		**32.7**	**23.3**	**9.7**	

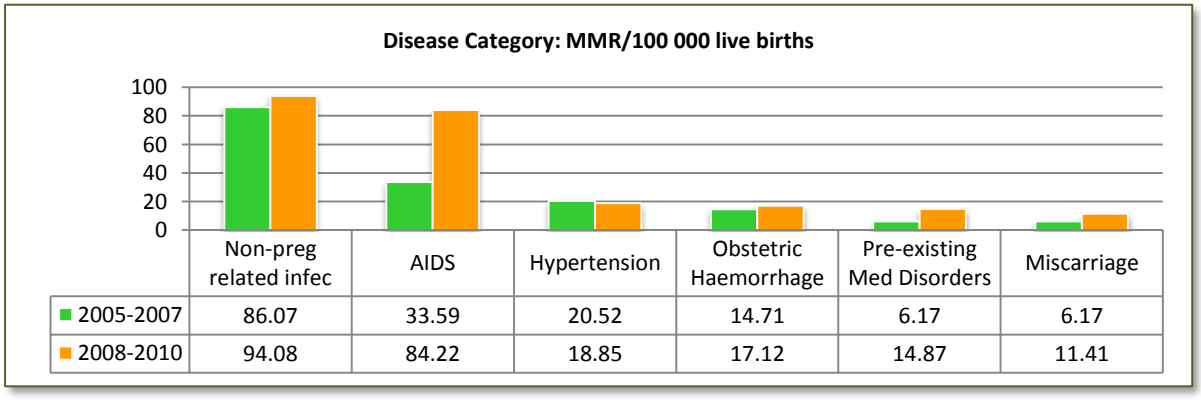
Source: Fifth Report on the Confidential Enquiries into Maternal Deaths in South Africa 2008-2010

Note: Rural Development Nodes indicated in light green (Umzimkhulu Municipality in Sisonke).

The mother to child transmission of HIV (PCR positive 6 weeks after birth) shows a significant decrease from 10.3% in 2009/10 to 4% in 2011/12 (*DHIS*). Research published by the Medical Research Council (MRC) in 2010 estimated the mother to child transmission at 6-8 weeks postpartum at 2.9% reducing to 2.1% in 2011.[9] Improved outcomes in mother to child transmission will have a positive impact on reduction of infant and child mortalities.

Between 2005-2007 and 2008-2010, the direct causes of MMR increased from 65.55/100 000 to 68.66/100 000 and the indirect causes from 92.24/100 000 to 108.95/100 000. The leading causes of MMR are illustrated in Graph 10.

Graph 10: Leading causes of Institutional Maternal Mortality 2005-2007 and 2008-2010



Source: Fifth Report on Confidential Enquiries into Maternal Deaths in South Africa 2008-2010

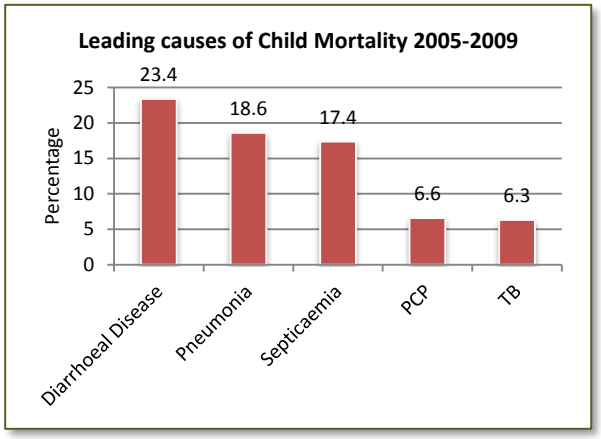
The biggest challenges remain the negative impact of HIV on maternal and neonatal health outcomes; late booking for antenatal care that compromise the ability of medical personnel to manage high-risk patients effectively; and delays in reaching health facilities during labour.

Infant and Child Health

According to ASSA 2008 projections, the infant mortality rate in KZN was 43/1000 live births in 2011, and the under-5 mortality rate (U5MR) 63/1000 live births during the same year.

Malnutrition and HIV infection are frequent co-morbidities in children dying of sepsis and according to the Saving Children Report, 49% of children who died of sepsis had severe malnutrition; 26% were underweight for age; and 55% were either HIV exposed (24%) or HIV infected (31%). This confirms the malign influence of poverty and nutritional deficiencies on child morbidity and mortality, and quantifies the complexities of service delivery.[39]

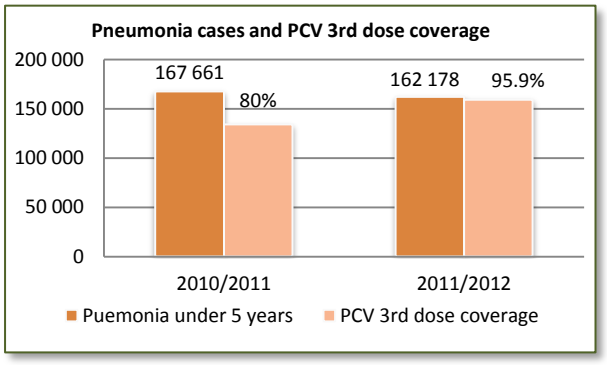
Graph 11: Main causes of death in children under-5 years 2005 - 2009



Source: Saving Children 2009

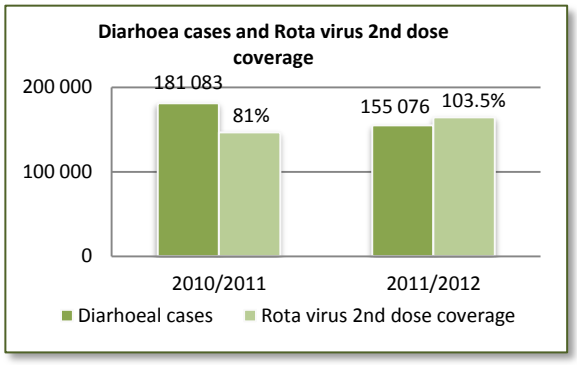
Pneumonia and diarrhoea, identified as two of the leading causes of morbidity and mortality, are still a challenge although a decline is evident since the introduction of the Rotavirus and Pneumococcal vaccines (*Graphs 12 and 13).*

Graph 12: Pneumonia and PCV 3rd dose coverage



Source: DHIS

Graph 13: Diarrhoea and Rotavirus 2nd dose coverage



Maternal, Neonatal, Child and Women's Health Focus for 2013/14

- Implementing CARMMA (Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa).
- Strengthening the Expanded Programme on Immunisation.
- Integration with PHC re-engineering to improve community-based strategies.

MALARIA

Malaria, mainly transmitted along the border areas of South Africa (Umkhanyakude District in KZN), constitutes a major barrier to social and economic development. According to national estimates approximately 4.9 million persons (or 10% of the population) are at risk of contracting malaria.

The number of reported malaria cases increased from 380 cases (5 deaths) in 2010/11 to 531 cases (4 deaths) in 2011/12. Malaria is not isolated to the Umkhanyakude District and calls for a high index of suspicion and preparedness.

The Department is in the process of reviewing the malaria strategy including the monitoring of the impact of climate change on malaria as it is suspected that an increase in the mean temperature may result in a "faster parasite development and a potentially higher incidence of malaria".

Malaria Focus for 2012/13

1. Surveillance: Scaling up surveillance and epidemiological case investigation.
2. Epidemic Preparedness and Response: Early detection and response of malaria outbreaks.
3. Vector control: Increase and maintain high coverage through integrated Vector Management.
4. Health Promotion: Ensure all groups are targeted with relevant message.
5. Programme management: Strengthen human resource capacity at all levels.
6. Monitoring and evaluation: Scale up entomological activities.

NON-COMMUNICABLE AND CHRONIC DISEASES

The most important risk factors for non-communicable diseases are the lack of regular physical exercise, long-term use of tobacco products and an unhealthy diet characterised by a high intake of fat, salt and sugar, and low intake of fibre, fruit and vegetables. The debilitating impact of these risk factors has been widely published, and concerted efforts are therefore being made, as part of PHC re-engineering, to scale up preventive and promotive strategies to address root causes.

Diabetes Mellitus and Hypertension

Kengne et al[13] estimated that by 2030, 81% of the global burden of diabetes will be in Sub-Saharan Africa – mainly in urban areas. In KZN, both diabetes mellitus and hypertension are in the top 10 causes of YLL in all districts (*Figure 4,- Ten leading causes of Years of Life Lost*).

According to DHIS data, the number of new diabetes mellitus cases that were put on treatment *(diabetes mellitus client treatment new)* decreased from 31,673 in 2010/11 to 23,307 in 2011/12; and the number of new hypertension cases put on treatment *(hypertension client treatment new)* marginally decreased from 70,973 to 70,821. Reasons for the decline in cases at facility level should be investigated as it is assumed that the case numbers will increase concurrent with improved case finding.

Data quality at source level must be verified to ensure accurate recording and reporting of these critical indicators.

Cancer

The most frequent cause of cancer deaths in men in KZN (2007) were malignant neoplasm of the bronchus and lung (16.27%) followed by cancer of the oesophagus (10.62%). This suggests that health promotion programmes to reduce smoking and alcohol abuse (high risk factors) may help to reduce the incidence of these cancers supporting scaled up prevention programmes as part of the re-engineering of PHC.

The most frequent causes of cancer deaths in women in KZN (2007) were malignant neoplasm of the cervix (18.21%) and breast cancer (15.21%). The Phila Ma campaign aims to improve screening for cervical cancer and breast self-examination and education.[35]

Eye Care

People with visual impairment, currently estimated at half a million South Africans or 10,000/1mil population, risk exclusion from basic health and education services and are more prone to suffering economic deprivation. According to RAAP [30] the Provincial prevalence of blindness is 2.8% in the 50+ year age group, with an estimated 63,482 blind people living in the Province.

Blindness due to treatable cataracts is estimated at 34,915 people of whom 1,270 are children. Approximately 2,539,280 people in the Province need spectacles while it is estimated that four out of five school children who need spectacles are unable to afford them.

Trauma

Trauma is the second most common cause of death in South Africa [32] and an important cause of

morbidity and mortality in KZN (*Figure 4, Years of Life Lost in KZN*).

Garrib et al reported an injury mortality rate of 142.2 per 100 000 person years of observation, which is almost twice the global estimate of 83.7 deaths per 100 000 population. Fifty percent of deaths were due to homicide and 26% to road traffic accidents. Statistics further shows that an estimated 1.5 million trauma cases present to major state facilities annually with more than half of these cases from interpersonal violence. Approximately 60,000 fatal injuries occur each year and are usually associated with alcohol abuse.[8]

Non-Communicable Diseases Focus for 2013/14

- Intensified healthy lifestyle campaign.
- Improved community-based services to improve surveillance, detection, referral, follow-up and support.
- Phila Ma campaign and improving screening of HIV positive women.

PROVINCIAL SERVICE DELIVERY ENVIRONMENT

There are 5 Rural Development Nodes in the Province i.e. Ugu, Umzinyathi, Zululand and Umkhanyakude Districts and Umzimkhulu Municipality in Sisonke District. The Municipalities of Nkandla (Uthungulu District) and Msinga (Umzinyathi District) are targeted for intensified strategies in terms of a Cabinet directive.

According to the District Health Barometer [3] approximately 15.7% of the KZN population had access to medical insurance in 2010 with variations between 4.9% in Umkhanyakude and 25.8% in eThekwini. Day and Grey estimated that approximately 9.2 million people in the Province are dependent on the public health service adding considerable pressure on scares resources e.g. human resources and infrastructure.[4] According to Kibel et al, there were 2,180,000 children in the Province living more than 30 minutes away from a clinic irrespective of the mode of transport they use.[14] Table 13 indicates the number of public health facilities in KZN (*DHIS*).

Table 13: Number of Public Health Facilities in KZN - 2012

District		Fixed PHC facilities	CHC's	District Hospitals	Regional Hospitals	Specialised Hospitals	Tertiary / Central Hospitals	Other
Ugu	Hibiscus Coast	17	1	1	1	1 (TB)	-	-
	Umdoni	6	-	1	-	-	-	-
	Umuziwabantu	11	-	1	-	-	-	-
	Ezinqoleni	4	-	-	-	-	-	-
	Umzumbe	13	1	-	-	-	-	-
	Vulamehlo	5	-	-	-	-	-	-
	Total	56	2	3	1	1 (TB)	0	0
Umgungundlovu	Richmond	5	-	-	-	1 (TB)	-	-
	Msunduzi	29	2	1	1	2 (Psych) 1 (TB)	1	1 (Special TB clinic)
	Umgeni	4	-	-	-	1 (Psych)	-	-
	uMshwathi	7	-	1	-	-	-	-
	Impendle	2	-	-	-	-	-	-
	Mkhambathini	4	-	-	-	-	-	-

District		Fixed PHC facilities	CHC's	District Hospitals	Regional Hospitals	Specialised Hospitals	Tertiary / Central Hospitals	Other
	Mooi Mpofana	2	1	-	-	-	-	-
	Total	53	3	2	1	2 (TB) 2 (Psych)	1	1
Uthukela	Emnambithi	12	1	-	1	-	-	-
	Okhahlamba	6	-	1	-	-	-	-
	Umtshezi	6	-	1	-	-	-	-
	Imbabazane	5	-	-	-	-	-	-
	Indaka	7	-	-	-	-	-	-
	Total	36	1	2	1	0	0	0
Umzinyathi	Endumeni	7	-	1	-	-	-	-
	Msinga	15	-	1	-	-	-	-
	Nquthu	12	-	1	-	-	-	-
	Umvoti	11	-	1	-	1 (TB)	-	-
	Total	45	0	4	0	1	0	0
Amajuba	Emadlangeni	2	-	1	-	-	-	-
	Newcastle	13	-	-	2	-	-	-
	Dannhauser	9	-	-	-	-	-	-
	Total	24	0	1	2	0	0	0
Zululand	Abaqulusi	14	-	1	-	-	-	-
	eDumbe	5	1	-	-	-	-	-
	Nongoma	11	-	1	-	-	-	1 (VCT)
	Ulundi	22	-	2	-	1 (Psych) 1 (TB)	-	-
	uPhongolo	10	-	1	-	-	-	-
	Total	62	1	5	0	1 (Psych) 1 (TB)	0	1
Umkhanyakude	Hlabisa	5	-	1	-	-	-	-
	Jozini	18	-	2	-	-	-	-
	Umhlabuyalingana	18	-	2	-	-	-	-
	Mtubatuba	12	-	-	-	-	-	-
	The Big 5	3	-	-	-	-	-	-
	Total	56	0	5	0	0	0	0
Uthungulu	Mthonjaneni	4	-	1	-	-	-	-
	Nkandla	19	-	2	-	-	-	-
	Umhlathuze	11	1	-	1	1	-	1 (VCT)
	Umlalazi	15	-	3	-	-	-	-
	Mbonambi	7	-	-	-	-	-	-

District		Fixed PHC facilities	CHC's	District Hospitals	Regional Hospitals	Specialised Hospitals	Tertiary / Central Hospitals	Other
	Ntambanana	5	-	-	-	-	-	-
	Total	61	1	6	1	1	0	1
Ilembe	KwaDukuza	9	-	-	1	-	-	-
	Mandeni	7	1	-	-	-	-	-
	Maphumulo	10	-	2	-	-	-	-
	Ndwedwe	7	1	1	-	-	-	-
	Total	33	2	3	1	0	0	0
Sisonke	Greater Kokstad	2	-	1	-	-	-	-
	Ingwe	8	1	1	-	-	-	-
	Ubuhlebezwe	9	-	1	-	-	-	-
	Umzimkhulu	15	-	1	-	1 (Psych) 1 (TB)	-	-
	Kwa Sani	2	-	-	-	-	-	-
	Total	36	1	4	0	1 (TB) 1 (Psych)	0	0
eThekwini	Total	101	8	2	6	2 (Chronic) 4 (TB) 1 (Psych)	1 (Central)	1 Rehab Centre 5 Specialised clinics
Total		**563**	**19**	**37**	**13**	**10 (TB) 6 (Psych) 2 (Chronic)**	**2 (Tertiary) 1 (Central)**	**See individual districts**

Source: DHIS

Although there has been extensive investment in the provisioning of PHC facilities and supporting mobile services there are still inequities in access to health facilities. Geographic and topographic landscapes in service areas clearly necessitate differentiation in determination of access (catchment) norms and standards including population thresholds per facility i.e. the minimum and/or maximum number of patients/clients that can be accommodated at such a facility in a given time. Table 14 includes the average clinic catchment population (per district) comparing catchment populations based on the estimated district populations for 2012 and recently released Census 2011 data.

Table 14: Average clinic catchment population per district

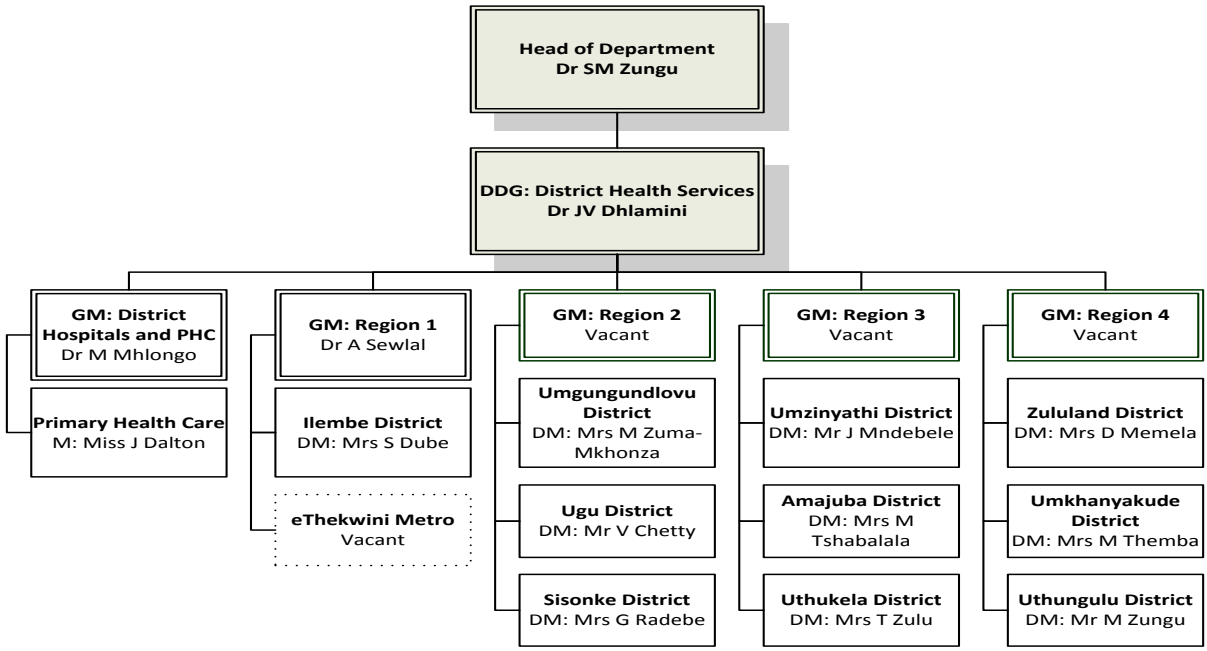
	KwaZulu-Natal	Ugu	Umgungundlovu	Uthukela	Umzinyathi	Amajuba	Zululand	Umkhanyakude	Uthungulu	Ilembe	Sisonke	eThekwini
Catchment (Projected 2012 Pop)	18,392	13,241	19,136	18,990	11,507	21,554	13,684	11,902	15,799	18,070	13,837	31,872

	KwaZulu-Natal	Ugu	Umgungundlovu	Uthukela	Umzinyathi	Amajuba	Zululand	Umkhanyakude	Uthungulu	Ilembe	Sisonke	eThekwini
Catchment (Census 2011 Pop)	17,641	12,457	18,174	18,077	11,352	20,827	12,755	11,176	14,637	17,337	12,471	31,581

Source: Projected 2012 data based on the estimated DHIS data (Statistical Release PO302 Mid-Year Population Estimates 2011); Census 2011 data

In 2012/13 the Department reviewed the service arrangements of the three (3) health service areas that were established in 2008/09 with the objective to improve management and oversight and refine organisational efficiency and continuum of care. Health districts were consolidated into 4 Service Delivery Management Regions (*Figure 6*).

Figure 6: Service Delivery Management Regions in KZN



Review of Sub-District service arrangements commenced in 2012/13 to further enhance service delivery in line with the vision to strengthen the District Health System through re-engineering of PHC.

Alignment of budget/expenditure with service delivery

Strategies commenced to resolve the inherent tension between strategic planning (long term) and budget allocation and planning (mostly short term MTEF). More sophisticated forms of activity-based costing, as opposed to pure population-based allocation, are being explored to strengthen the link between budget and performance targets.

Analysis of expenditure versus service delivery at PHC level showed vast improvement over the last 2 years as part of the integrated District Health Expenditure Reviews (DHERs). This process has been integrated with provincial and district planning processes which should contribute positively towards evidence-based planning.

There has been a substantial increase in PHC expenditure between 2009/10 and 2011/12.

Expenditure for District Management, Community Health Clinics and Community Health Centres shows real growth of 36.9%, 27.4% and 39.6% respectively, and the average PHC per capita spending increased by 34.6% (real terms). Part of this increase in funding has, however, been as a result of higher personnel costs after introduction of the Occupation Specific Dispensation (OSD). The impact of the OSD on health service quality has not yet been documented.

RE-ENGINEERING OF PHC

PHC is central to transformation of the health system and considered the backbone of health service delivery. The Provincial PHC re-engineering model complies with the national model as well as WHO recommendations for strengthening of the health system through PHC re-engineering:

- Coverage reforms to ensure universal access to services.
- Service delivery reforms to make services responsive to health needs and future demands.
- Public health policy reforms that foster inter-sectoral action for health.
- Leadership reforms that foster inclusive, participative, negotiation-based leadership to respond to the complexities of attaining health.

Supervision remains a challenge despite implementation of the Supervisory Manual. There are still wide variations in supervision coverage per month between and within districts ranging from 33.6% in Uthukela to 98.7% in Umkhanyakude. In 2011/12, six districts reported supervision rates below the Provincial average of 62.2% (*DHIS*). Quality of supervision (qualitative data) has not yet been analysed to determine the direct relation between improved supervision and improved clinical outcomes.

The positive impact of effective outreach services on clinical outcomes is clearly articulated in Perinatal Problem Identification Programme reports with reference to pregnancy outcomes e.g. stillbirths and neonatal deaths.[27] Current systems for oversight and clinical governance, including PHC outreach services from District and Regional Hospitals, are still inadequate and being addressed as part of PHC re-engineering.

Although considerable investments have been made in physical infrastructure for PHC, there are still major deficiencies exacerbated by the increasing burden of disease and consequent demand on existing services necessitating the introduction of additional services.

Inadequate information systems (especially systems for community-based data) and veracity of data is still a challenge affecting evidence-based planning and decision-making at all levels of care. According to a 2009 multi-sectoral health information system (HIS) assessment, South Africa scored 49% for overall availability of HIS resources including polices and processes, 48% for data management, and 39% for information use for planning and decision-making.[38] This is being addressed through implementation of the Information Technology and Data Management Turn-Around Strategies.

The Department started to spatially contextualise and prioritise interventions to harness greater spatial equity in the delivery of seamless health services based on the PHC approach. This includes clearly defined institutional arrangements to ensure an efficient health system and improved health outcomes. Analysis of historic and current trends commenced in 2011/12 to inform the ultimate context within which change will be managed over the coming years.

Human resources for health remain a serious challenge including insufficient human resource planning aligning resources with service delivery demands and the burden of disease; poor retention of community services officers; inequities in the distribution of human resources; high attrition rates in especially rural areas despite introduction of Occupation Specific Dispensation (OSD); inadequate staff accommodation in rural areas and inherent tensions between the current supply and demand. Renewed partnerships, including partnership with UKZN to review production of suitably trained professionals commenced in 2012/13.

All districts commenced with the appointment of District Specialist Teams to improve clinical governance and oversight (*Table 15*). Agreements between districts will ensure specialist coverage of all districts.

There are currently 35 Family Health (PHC Outreach) Teams and 137 School Health Teams that are aligned with OSS and linked with clinics from where oversight is provided. Expansion of coverage (increased number of teams) will be dependent on the funding envelope.

There are 168 mobile vehicles with 133 operational. The current fleet is aging and 13 replacement vehicles were purchased in 2012/13 (limited by budget constraints). New vehicles (with improved specifications to make provision for extended package of services and topography) will be prioritised in the MTEF.

Table 15 provides a breakdown of the necessary expansion of services to ensure adequate and equitable coverage at household level. Expansion will however be determined by the funding envelope and targets will be reviewed year on year.

Table 15: PHC Re-engineering Teams and Mobile Vehicles

District	District Specialist Teams	School Health Teams		Family Health Teams		Mobile Vehicles	
		2012/13	2014/15	2012/13	2014/15	2012/13[7]	2014/15[8]
Ugu	**Yes** (Family Health Specialist, Advanced Midwife, and Child Health Nurse Specialist)	11	34	0	20	15	7
Umgungundlovu	**Yes** (Family Health Specialist, Paediatrician, Obstetrician, Anaesthetist, PHC Nurse, Advanced Midwife and Child Nurse Specialist)	17	40	4	24	15	11
Uthukela	**Yes** (Advanced Midwife and PHC Nurse)	5	24	0	16	14	7
Umzinyathi	**Yes** (Family Health Specialist, Paediatrician, Obstetrician, PHC Nurse and Advanced Midwife)	11	31	9	20	11	12
Amajuba	**Yes** (Advanced Midwife and PHC Nurse)	9	21	0	14	7	2
Zululand	**Yes** (Family Health Specialist, Obstetrician, Child Health Nurse Specialist, PHC Nurse and Advanced Midwife)	14	36	5	22	18	16
Umkhanyakude	**Yes** (Family Health Specialist , PHC Nurse and Child Health Nurse Specialist)	5	27	0	18	18	9
Uthungulu	**Yes** (Obstetrician and PHC Nurse)	11	40	0	25	15	10
Ilembe	**Yes** (Family Health Specialist , PHC Nurse, Advanced Midwife, and Child Health Nurse Specialist)	12	29	0	18	10	5
Sisonke	**Yes** (Advanced Midwife and PHC Nurse)	12	22	5[9]	15	12	11

[7] According to DHIS – not including "out of service" vehicles
[8] Replacement and new mobile vehicles
[9] External funding for teams

District	District Specialist Teams	School Health Teams		Family Health Teams		Mobile Vehicles	
		2012/13	2014/15	2012/13	2014/15	2012/13[7]	2014/15[8]
eThekwini	**Yes** (Family Health Specialist, Advanced Midwife , PHC Nurse and Child Health Nurse Specialist)	30	41	12	28	33	24
Total		**137**	**345**	**35**	**220**	**168**	**114 (282)**

Source: PHC Directorate

Between 2010/11 and 2011/12 the PHC total headcount increased by 10.6% from 26,494,623 to 29,314,618 and the utilisation rate from 2.5 to 2.7 visits per person per year. In 2011/12, PHC patients visiting out-patient departments (without being referred) comprised 34.9% of the total outpatient headcount which indicates that a considerable number of patients still enter the health system at inappropriate levels (*DHIS*).

According to the 2011/12 DHER Reports, the PHC workload for Professional Nurses was 35.7 with variations between 28.9 in Zululand and 48.6 in Ilembe. There is a direct inverted relationship between the Professional Nurse clinical workload and the cost per headcount (*Table 16*).

Table 16: PHC Workload, PHC Cost and Utilisation Rate

District/ Metro	PN Workload - PHC	Cost per Headcount	Cost per Capita	Utilisation Rate - PHC
Amajuba	37.6	R 118	R 460	2.2
eThekwini	40.4	R 93	R 443	2.8
Ilembe	48.6	R 125	R 506	3.1
Sisonke	29.1	R 119	R 537	2.3
Ugu	34.9	R 125	R 556	2.7
Umgungundlovu	31.6	R 106	R 519	2.7
Umkhanyakude	39.7	R 128	R 608	3.0
Umzinyathi	30.9	R 119	R 554	2.8
Uthukela	33.9	R 110	R 426	2.1
Uthungulu	36.6	R 121	R 455	2.5
Zululand	28.9	R 149	R 526	2.0
KZN	**35.7**	**R 114**	**R 486**	**2.7**

Source: Provincial 2011/12 District Health Expenditure Review Report

HIV AND AIDS

As part of the prevention strategy, 124,517 male medical circumcisions were performed by the end of 2011/12 (124,406 adult and 111 neonatal). Between 2010/11 and 2011/12, the male condom distribution rate increased slightly from 8.1 to 9 condoms per person per year ranging from 5.2 in eThekwini to 14.8 in Zululand. The total number of male condoms distributed (public health) increased from 27,690,135 in 2010/11 to 31,914,706 in 2011/12. *Low condom distribution is a concern and the strategy has been reviewed to improve distribution.* A total of 2,511,872 clients

were tested for HIV in 2011/12 (*DHIS updated data*).

The number of patients on ART increased with 34% between 2010/11 and 2011/12 (from 408,238 to 547,411), and 282 Nurses and 120 Nurse Mentors were trained on Nurse Initiated and Managed ART (NIMART) to improve sustained access to ART at PHC level. Strategies to decongest PHC services will be explored in the coming MTEF including the review of HIV and AIDS policies and integration of follow-up and support of patients on treatment with PHC community-based services. Health system development will be an integral component of change.

TUBERCULOSIS

There are 7 functional Decentralized MDR TB Units (2012/13) and 98 Mobile Injection teams for community-based management of MDR-TB. Rollout of the GeneXpert commenced in eThekwini (13), Uthungulu (7), Sisonke (7), Zululand (1) and Umzinyathi (1) which will improve early initiation of treatment for MDR-TB patients.

Of the MDR-TB patients managed at community level, 67.8% (597) started on treatment 9 months back culture converted; 5.7% remained positive; 12.6% had no results; 8.4% died; 2.4% defaulted; and the same proportion was transferred out. Of all MDR-TB cases, 40.2% (462) of patients started on treatment 24 months ago were cured; 17.5% completed treatment giving a treatment success rate of 57.7%; 2.4% patients remained positive; 11% defaulted; 15% died; 5% were transferred out; and 10% remained on treatment (*TB Programme Report*).

Of the XDR-TB patients managed at community level, 38.9% (59) started on treatment 9 months back culture converted; 13.5% remained positive; 25.4% had no results; 20.3% patients died; zero defaulted; and 1.7% was transferred out. Of all XDR-TB cases, 17% (47) started treatment 24 months ago were cured; 4.2% completed treatment giving a treatment success of 21.2%; 6.3% defaulted; 51% died; one patient was transferred out; and 9 out of 47 patients remained on treatment (*TB Programme Report*).

MATERNAL, NEONATAL, CHILD AND WOMEN'S HEALTH

In 2011/12, the facility mortality ratio was 190.6/100 000 with variations ranging between 68.1/100 000 in Umkhanyakude and 332.5/100 000 in Uthungulu (*DHIS*). Higher mortality ratios were reported in districts with referral hospitals (*Part B – Sub-Programme MCWH*). A total of 28 additional Obstetric Ambulances (increasing from 12 – 40) were deployed in districts to improve service arrangements and access to maternal and neonatal care (*EMS Report*).

Postnatal follow-up (within 6 days of delivery) is still poor although it shows an upward trend between 2010/11 and 2011/12 from 31% to 58.3% for babies and 31% to 58.1% for mothers. Between 2010/11 and 2011/12, the antenatal visits before 20 weeks *(Antenatal 1st visit before 20 weeks rate)* increased slightly from 36% to 41% (*DHIS*).

The Prevention of Mother to Child Transmission (PMTCT) programme shows consistent progress year on year with mother to child transmission (babies tested PCR positive 6 weeks after birth) decreasing from 6.8% in 2010/11 to 4% in 2011/12 with variation between 1.9% in Amajuba and 6% in eThekwini (*DHIS*). Only eThekwini (6%) reported an outcome exceeding the Provincial average. The number of eligible women placed on HAART increased from 9,701 in 2010/11 to 19,574 in 2011/12 (*DHIS*).

The Expanded Programme on Immunisation (EPI) remains a key priority to reduce child morbidity and mortality. The immunisation coverage under 1 years increased from 86% in 2010/11 to 97% in 2011/12. The number of confirmed measles cases decreased from 3,662 in 2010 to 22 in 2011 (*EPI Line Listing database*) which correlates with the increase in the coverage for Measles 1st dose under 1 year from 88% in 2010/11 to 98.9% in 2011/12 (*DHIS*).

Between 2010/11 and 2011/12 the Rota Virus 2nd dose coverage (annualised) increased from 81% to 103.5%. During the same period, the number of diarrhoea cases for children under 5 years (both with and without dehydration) decreased from 181,083 to 155,076. The pneumococcal 3rd dose coverage increased from 80% to 95.9%. During the same period the number of pneumonia cases decreased from 167,661 to 162,178 (*DHIS*).

Weighing coverage increased from 75% in 2010/11 to 85% in 2011/12. The underweight for age rate decreased from 26.3/1000 in 2009/10 to 24/1000 in 2011/12 with more children detected through improved screening and weighing (*DHIS*). Detection of malnutrition at PHC level improved through improved growth monitoring using the Road to Health Chart, use of Mid-Upper Arm Circumference (MUAC) tapes by CCGs at household level, and ensuring that paediatric/ adult scales and length/height measures were purchased to ensure that all facilities have adequate anthropometric measures for improved growth monitoring and health/nutritional promotion.

Nutritional supplements were issued to 114,913 patients 15 years and older and 19,004 children under the age of 5 years (*Nutrition Report*). The Department is intensifying implementation of the Infant Youth and Young Child Feeding (IYCF) Policy and Guidelines to improve exclusive breastfeeding. There are 36 accredited Baby-Friendly Hospitals in the Province.

ORAL AND DENTAL HEALTH

Implementation of the reviewed Oral Health 10 Point Plan 2011-2015 commenced in 2011/12 making provision for the development of appropriate oral health services to address inequalities at all levels of care.

The Department strengthened the oral health screening programme through integration with school health services as component of PHC re-engineering; commissioned the Maxillofacial and Dental Laboratory and Maxillofacial and Oral Surgery Unit at Inkosi Albert Luthuli Central Hospital (IALCH); established regional denture services for pensioners at Ngwelezane and Greys Hospitals; and formalised contracts with private Specialists to provide sessional tertiary services at Greys and Ngwelezane Hospitals.

Plans commenced for the implementation of a Provincial Registrar Programme in Maxillofacial and Orthodontics (dental deformities) service for children. The programme will be implemented in collaboration with Medunsa and Wits Universities until a new Dental School, linked with the Medical School at University of KwaZulu-Natal (UKZN), has been established.

The implementation of comprehensive training and development courses in Grey's Hospital (Maxillofacial and Oral Surgery Department) and in-house programmes in Ngwelezane, IALCH and King Edward VIII Hospitals commenced.

HOSPITAL SERVICES

District Hospitals

There are 37 District Hospitals (5 Small, 25 Medium, and 7 Large) and 3 State Aided District Hospitals (2 in eThekwini and 1 in Zululand). There are 9,113 approved beds translating to 0.85 beds per 1000 people compared to the norm of 0.66/1000.

Regional Hospitals

There are 13 Regional Hospitals with no Regional Hospital in Umzinyathi, Zululand, Umkhanyakude and Sisonke Districts (all Rural Development Nodes). There are 7,613 approved beds translating to 0.71 beds per 1000 people compared to the norm of 0.23/1000.

Ngwelezane Hospital (Uthungulu District) has been re-classified as a Developing Tertiary Hospital in 2012 and reporting therefore changed from Programme 4 to Programme 5. The "new" King Edward Vlll Hospital (eThekwini) has been classified as a Central Hospital.[10]

Tertiary Hospitals

There are 2 Tertiary Hospitals in the Province including the reclassified Ngwelezane Hospital. There are 1,090 approved beds translating to 1.01 beds per 1000 people compared to the norm of 0.23/1000.

Central Hospital

Inkosi Albert Luthuli Central Hospital (IALCH) is the only Central Hospital currently. The hospital has 810 approved beds translating to 0.08 beds per 1000 people compared with the norm of 0.22/1000.

Table 17: Efficiency and Patient Activity 2010/11 – 2011/12

Indicators	2010/11				2011/12			
	District	Regional	Tertiary	Central	District	Regional	Tertiary	Central
Average length of stay	6.1 days	5.4 days	12 days	8.6 days	5.8 days	5.5 days	9.9 days	9.1 days
Bed utilisation rate	63.8%	63.6%	73.4%	66.7%	63.7%	78.4%	70.5%	72.5%
OPD total headcount	2,664,297	3,195,790	343,531	170,986	2,698,087	3,333.687	312,745	178,484
Separations	331,419	372,902	29,714	22,371	337,550	381,657	31,050	24,331

Source: DHIS

Note: Ngwelezane has been included as Tertiary Hospital in the table above.

- *Average length of stay*: The high burden of disease, late reporting to health facilities, inadequate step down facilities, high turnover rate of medical officers, and inadequate patient transport is considered the main contributors of extended length of stay.
- *Regional and Tertiary Hospitals:* Data is inclusive of changes due to re-classification of Ngwelezane Hospital and will therefore differ from data in the 2011/12 Annual Report.

Specialised TB Hospitals

There are 12 Specialised TB Hospitals, and 7 MDR-TB decentralised and 9 MDR-TB satellite units that are attached to hospitals. There are no Specialised TB Hospitals in Uthukela, Amajuba, Umkhanyakude, Uthungulu and Ilembe. There are 2,012 approved beds translating to 0.19 beds per 1000 people; and 410 MDR-TB beds in decentralised and satellite units.

In 2011/12 a total of 2,295 MDR-TB and 205 XDR-TB patients were registered in treatment programmes. Rollout of the GeneXpert is expected to increase MDR-TB numbers based on the average positivity rate of 5.8% of current screened clients. Current projections, based on data from the 7 pilot sites that initiated the GeneXpert in 2011/12, the Province would need 1,150 active beds for the management of MDR-TB (making provision for 2 month admission), as well as 262 Mobile Injection Teams for implementation of community management of MDR-TB patients indicating a current shortfall of 179 teams (*TB Draft Strategy*).

Specialised Psychiatric Hospitals

There are 6 Specialised Psychiatric Hospitals with 3,244 approved beds or 0.31 beds per 1000 people. Historical allocation of resources, including location of facilities, resulted in significant inequities in distribution and access to services. There is a significant shortfall of acute and forensic beds in Ugu, Ilembe and eThekwini, with Umkhanyakude, Zululand and Uthungulu being severely under-resourced in terms of both acute and chronic beds. Umgungundlovu has the highest number of the specialised beds (both acute and chronic). Access to both regional and tertiary psychiatric services is compromised in all districts.

The Mental Health Summit (19 – 20 March 2012) generated specific resolutions that were presented at the National Mental Health Summit in March 2012. The Summit provided valuable information that will be used in the review of the mental health strategy to improve services. A Provincial Mental Health Advisory Committee has been appointed to provide leadership and technical support in revitalisation of mental health services.

Chronic Hospitals

Hillcrest Hospital in eThekwini (212 approved beds) provides long-term chronic care. Services fall within the scope of practice of a Staff Nurse (under indirect supervision of a Professional Nurse and General Practitioner).

Clairwood Hospital in eThekwini (426 approved beds) provides palliative treatment and care for patients presenting with degenerative diseases.

Services fall within the scope of practice of a Professional Nurse under supervision of a General Practitioner.

Table 18: Efficiency and Patient Activity 2010/11 – 2011/12

Indicators	2010/11			2011/12		
	Specialised TB	Specialised Psychiatric	Chronic	Specialised TB	Specialised Psychiatric	Chronic
Average length of	25.9 days	37.9 days	24.3 days	39.9 days	32.1 days	22.1 days
Bed utilisation	58.1%	73.8%	63.4%	62.2%	83.3%	61.2%
OPD total headcount	136,853	7,994	136,951	206,452	15,425	157,386
Separations	9,289	2,945	3,591	10,662	2,531	5,934

Source: DHIS

KWAZULU-NATAL CHILDREN'S HOSPITAL

Phase 1 of the new KZN Children's Hospital commenced in June 2011. The Department has committed R50 million to the project payable in three installments, and the KZN Children's Trust is expected raise the balance of the funds required for the refurbishment of the site. Re-construction of the "Old Out-Patients Building" commenced in February 2012 and was completed on 30 November 2012 after which the site was handed over to the Trust. A Training Centre, Adolescent Clinic, Child Development Assessment Centre (including psychological support and allied health services) and temporary parking formed part of Phase 1.

A heritage impact assessment has been submitted to AMAFA (the Heritage Association) in preparation for commencement of Phase 2. Work commenced on the external facade and roof of the Old Children's Hospital building (Phase 2B) which is anticipated to take 12 months to complete.

The Department transferred the 2nd tranche of R20 million for the project, and a total amount of R 39 711 151 was raised (30 October 2012) for the project including contributions in cash and kind. Of this, R 26 882 807 has been received during 2012 and the remainder has been pledged for the outer years.

Phase 2A and 2B is expected to be completed in 18-24 months and will include:

1. Design and implementation of bulk services infrastructure for the entire site (including sewage, water supply, electrical sub-stations etc.) with an estimated cost of R7.5 million.
2. Renovation work on the roof and external facade of the Old Children's Hospital Building with an estimated cost of R17 million.
3. Renovation work to the roof and external facade of the Old Nurses Home with an estimated cost of R9 million.

EMERGENCY MEDICAL SERVICES (EMS)

EMS is operating as a hybrid model with elements of centralisation to standardise service delivery and improve equity and general management.

Ambulances: At the end of 2011/12 there were 185 operational ambulances (out of a total fleet of 501) which translated to 1 ambulance per 57,417 people (compared to the national norm of 1:10 000) indicating a shortfall of 855 ambulances (*EMS Programme Report*). Mid-year 2012/13, the operational ambulances increased to 214. Specialised obstetric ambulances increased from 12 to 40, and 38 inter-facility ambulances were deployed in districts. The total operational ambulances therefore increased to 290.

Patient Transport: Demand for inter-hospital patient transport currently supersedes supply which resulted in increased turn-around times, non-compliance to admission and discharge policies and additional cost to facilities (increased length of stay). The department placed an order for 12 new buses. Five (5) will be converted to carry seated and stretcher patients, and 7 to carry 60 seated patients. A total of 39 midi buses (23 seated) and 17 Planned Patient Transport (PPT) mini buses (16 seated) have been issued to

districts during the 2nd quarter of 2012/13 to strengthen PPT services (*EMS Programme Report*).

Air Medical Services: The National Treasury RT 79 Aeromedical contract was awarded to Air Mercy Services (AMS). This contract includes 2 rotor wing aircraft and 1 fixed wing aircraft with the first 30 hours of flying being exclusive of the contract amount (pre-paid) time per aircraft per month. All aircraft are operational on a 24 hour basis.

Communication Centres: A desk has been allocated in the eThekwini Communication Centre to coordinate PPT activities including patient repatriation. The intention is to strengthen communication between HUBS and institutions for coordination of patient transport.

PHARMACEUTICAL SERVICES

The Provincial Pharmaceutical Supply Depot (PPSD) has several infrastructural challenges. The warehouse does not comply with Pharmacy Regulations and failed to acquire a license from the Medicine Control Council to operate as a Pharmaceutical Wholesaler and to pre-pack and/or manufacture medicines. The Pharmacy Council gave the Department an exemption until alternative arrangements have been finalised.

In 2011/12, PPSD was able to supply directly to 78.1% of clinics thus capacity must be increased to accommodate the remaining 17% demanders (*2011/12 Pharmaceutical Services Report*). Due to the current infrastructural constraints the building has reached capacity and no further clinics can be added to the direct distribution system.

Many hospitals, CHCs and PHC clinics are challenged by poor, non-compliant, and inadequate infrastructure for the storage of pharmaceutical supplies and carrying out pharmaceutical operations. The Department has been upgrading infrastructure in various districts although the backlog emanating from previous dispensation is significant. Newly built facilities, designed before the current prescribed specifications, will need alterations to ensure compliance.

The management, security, and controls in Pharmaceutical services are inadequate leading to an increased risk of leakage of pharmaceutical supplies. Some pharmacies are managed by inexperienced junior personnel, often Community Service Pharmacists, due to the shortage of Pharmacists and difficulty to recruit and retain staff at rural facilities. The Pharmacy Stores Support Officers provide technical support and training to facilities with regard to pharmaceutical stock control.

The Central Chronic Medication Dispensing Unit (CCMDU) programme is implemented in eThekwini and Umgungundlovu, with the aim to roll it out to other districts in a phased approach. The infrastructure plan for the CCMDU has been approved and will share premises with the Provincial Pharmaceutical Supply Depot.

NATIONAL HEALTH INSURANCE (NHI)

Umgungundlovu and Umzinyathi Districts have been included in the 10 NHI pilot districts announced by the National Minister of Health. KwaZulu-Natal added Amajuba District as a third pilot district based on the provincial population size and burden of disease.

A NHI Conditional Grant of R33 million was allocated to the two official NHI pilot districts and two hospitals i.e. King Edward Vlll Hospital (KEH) and Inkosi Albert Luthuli Hospital (IALCH) while Amajuba District is supported through equitable share. Business Plans were approved for the 3 pilot districts in July 2012.

Phase one of the NHI rollout (first 5 years) includes:

- Strengthening of the health system and improving the service delivery platform.
- Policy and Legislative reform.
- Infrastructure development and maintenance (supported by Facilities Improvement Teams led by ManCo).
- Human Resources Planning, Development and Management.
- Improving the quality of health services by focusing on the National Core Standards (Cleanliness, Improved patient and staff safety, Positive and caring staff attitudes, Infection prevention and control, Availability of medicines and supplies, and Patient waiting times).
- Re-engineering of PHC including roll-out of School Health and PHC Outreach Teams

(Family Health/Ward-Based) linked with OSS; District Specialist Teams; and universal mobile units.
- Establishing contracts with General Practitioners (GPs) to render services in PHC facilities.
- Standardising the referral system in pilot districts using the proposed Benguela referral approach.
- Rolling out e-Health in support of community-based management of chronic diseases.
- Accreditation for CARMMA compliance.
- Regionalisation of administrative functions (previously in Head Office) to unblock bottlenecks and streamline HR, procurement and SCM processes.

The Department appointed a Provincial NHI Task Team to oversee preparatory work for the implementation of NHI in the Province, and 3 Facility Improvement Teams (1 per pilot district) were appointed in 2012/13 to support implementation of the National Core Standards and facility improvement plans at facility level.

CLEAN AUDIT 2014/15

Audit Improvement Plans and toolkits have been finalised and disseminated to districts and facilities to improve management effectiveness and controls. The Department commenced with re-engineering of supply chain management processes and structures to improve contract management and tender turnaround time. A review of organisational practices and structures will be finalised in 2013/14 to improve efficiency and effectiveness of the financial component.

The Provincial Data Management Policy was approved in 2012 and implementation and monitoring thereof is expected to strengthen information management processes. The Department commenced with regular data clean-up programmes and site visits to address audit queries and assist facilities/districts to develop improvement plans to address data challenges. District/facility planning processes place strong emphasis on veracity of data through critical analysis and interpretation.

The Medical Research Council (MRC) facilitated data management training with PHC Supervisors and commenced with a review of the current registers in facilities with a view to improve recording at source level.

PROVINCIAL AND DISTRICT HEALTH COUNCILS

The Provincial Health Council has been established and meeting convened on 14 September 2012. Establishment of District Health Councils commenced in 2012/13 in collaboration with COGTA. The annual Provincial Consultative Health Forum meeting was convened on 6 November 2012.

INSTITUTIONAL GOVERNANCE STRUCTURES

With the promulgation of the KwaZulu-Natal Health Act, 2009 (Act No. 1 of 2009) on 6 September 2012, all the Hospital Boards and Clinic Committees have been appointed in terms of section 36 of this Act and section 41 of the National Health Act, 2003 (Act No. 66 of 2003).

EPIDEMIOLOGY AND HEALTH RESEARCH

The Health Research and Knowledge Management Policy was finalised in 2012.

The KwaZulu-Natal Health Act, 2009 (Act No. 1 of 2009) mandated the extension of the Provincial Health Research Committee (PHRC) to serve a dual research and ethics function. The Department commenced with the process to establish the Provincial Health Research and Ethics Committee (PHREC) which is expected to conclude in 2013. The Health Research and Knowledge Management Policy (2012) guide the structure and functioning of the PHREC, which will seek to attain accreditation as a Level 1 and subsequently Level 2 Ethics Committee from the National Health Research Ethics Council.

The Provincial burden of disease study commenced in 2012 with the final report due in 2013

Table 19: (A2): Trends in key Provincial Service Volumes

Indicator	2009/10 Actual	2010/11 Actual	2011/12 Actual	2012/13 Estimate
1. PHC total headcount	25,921,993	26,494,623	29,314,618	31,252,624
2. *OPD new client not referred rate	New indicator	New indicator	941,805	979,454
3. Separations District Hospitals	350,524	331,419	337,550	352,958
4. Separations Regional Hospitals	355,231	372,902	381,657	368,862
5. Separations Tertiary Hospital	27,777	29,714	31,050	27,798
6. Separations Central Hospital	20,204	22,371	24,331	25,270

Source: DHIS

- Tertiary Hospital data includes data from Ngwelezane Hospital.

NATIONAL HEALTH SYSTEM PRIORITIES FOR 2009-2014

Table 20: (A4): National Health Systems priorities 2009-2014 (10 Point Plan)

Priority	Key Activities
1. Provision of strategic leadership and creation of social compact for better health outcomes	Ensure unified action across the health sector in pursuit of common goals
	Mobilise leadership structures of society and communities
	Communicate to promote policy and buy-in to support government programmes
	Review of policies to achieve goals
	Impact assessment and programme evaluation
	Development of a social compact
	Grass root mobilisation campaign
2. Implementation of National Health Insurance (NHI)	Finalisation of NHI policies and implementation plan
	Immediate implementation of steps to prepare the introduction of the NHI e.g. budgeting, initiation of the drafting of legislation
3. Improving the quality of health services	Focus on the 18 health districts
	Refine and scale up the detailed plan on the improvement of quality of services and directing its immediate implementation
	Consolidate and expand the implementation of the health facilities improvement plans
	Establish a national Quality management and Accreditation Body
4. Overhauling the health care system and improving its management	Identify existing constitutional and legal provision to unify the public health service
	Draft proposals for legal and constitutional reform
	Development of a decentralised operational model, including new governance arrangements
	Training managers in leadership, management and governance
	Decentralisation of management
	Development of an accountability framework for the public and private sectors
5. Improved human resources planning, development and management	Refinement of the HR plan for health
	Re-opening of nursing schools and colleges
	Recruitment and retention of professionals, including urgent collaboration with countries that have access of these professionals

Priority	Key Activities
	Specify staff shortages and training targets for the next 5 years
	Make an assessment of and review the role of Health Professional Training and Development Grant (HPTDG) and the National Tertiary Services Grant (NTSG)
	Manage coherent integration and standardisation of all categories of Community health Workers Correct
6. Revitalisation of infrastructure	Urgent implementation of refurbishment and preventative maintenance of all health facilities
	Submit a progress report on revitalisation
	Assess progress on revitalisation
	Review the funding of the revitalisation programme and submit proposals to get the participation of the private sector to speed up this programme
7. Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases	Implementation of PMTCT, paediatric treatment guidelines
	Implementation of adult treatment guidelines
	Urgently strengthen programmes against TB, MDR-TB and XDR-TB
8. Mass mobilisation for better health for the population	Intensify health promotion programmes
	Strengthen programmes focusing on Maternal, Child and Women's Health
	Place more focus on the programmes to attain the Millennium Development Goals (MDGs)
	Place more focus on non-communicable diseases and patients' rights, quality and provide accountability
9. Review of the drug policy	Complete and submit proposals and a strategy with the involvement of various stakeholders
	Draft plans for the establishment of a State-owned drug manufacturing entity
10. Strengthening research and development	Commission research to accurately quantify infant mortality
	Commission research into the impact of social determinants of health and nutrition
	Support research studies to promote indigenous knowledge systems and the use of appropriate traditional medicines

REVIEW OF PROGRESS TOWARDS THE HEALTH RELATED MILLENNIUM DEVELOPMENT GOALS

Table 21: (A3): Progress towards the Millennium Development Goals

Indicators	Data Source	Baseline 2009/10	Target 2014/15	Progress 2011/12	Comments
Goal 1: Eradicate extreme poverty and hunger					
Target: Halve, between 1990 and 2015, the proportion of people who suffer from hunger					
1. Prevalence of underweight children under 5 years	DHIS	26.3/1000	15/1000	24/1000	Data for severe malnutrition reflect facility data only which is not a true marker of actual malnutrition in the Province. In 2010/11, seven of the 10 districts with the worst malnutrition rates in SA were in KZN (DHB 2010/11).[3] Prevalence varies between 3.1/1000 in Amajuba to 17/1000 in Umkhanyakude which points to significant differences in poverty and deprivation in the Province.
2. Severe malnutrition under 5 years incidence *(Child under 5 severe acute malnutrition incidence (annualised))**	DHIS	9.5/1000	6/1000	6.7/1000	
Goal 4: Reduce child mortality					
Target: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate					
3. Under-5 mortality rate	ASSA[10] 2008	67/1000	27/1000 live births	62.7/1000 live births	Targets are based on the two third reduction between 1990 and 2015 and are based on the ASSA 1990 estimates for under 5 mortality rate (80/1000 live births) and infant mortality rate (58/1000 live births). According to the Child Problem Identification Programme data (2005-2009) most child deaths occurred in children under the age of one year (63.2%) and 34% occurred within 24 hours of admission which indicates poor health seeking behaviour. The impact of HIV and AIDS on child mortality is significant in spite of the mother to child transmission reduction over the last 3 years.
4. Infant mortality rate	ASSA 2008	45/1000	19/1000 live births	43.1/1000 live births	
5. Measles 1st dose under 1 year coverage *(Measles 1st dose under 1 year coverage (annualised))**[11]	DHIS	87.3%	90%	98.9%	The Immunisation Programme remains one of the core programmes to reduce child morbidity and mortality. Pneumonia and diarrhoea (two of the leading causes of mortality in children under 5 years) incidence shows a decrease since introduction of the Pneumococcal

[10] AIDS Committee of Actuarial Society of South Africa
[11] In the customised APP Template this indicator appears as the "Proportion of one year old children immunized against measles however for continuity the name of the indicator has been aligned to the NIDS 2013/14.

Indicators	Data Source	Baseline 2009/10	Target 2014/15	Progress 2011/12	Comments
6. Immunisation coverage under 1 year *(Immunisation coverage under 1 year (annualised))**	DHIS	84.9%	90%	97%	and Rotavirus vaccines although it still exceeds the national average. Child under 5 years pneumonia incidence: 145.5/1000 with variations between 78.9/1000 in Uthukela and 187.3/1000 in Ugu (national average 80.3/1000). Child under 5 years diarrhea with dehydration incidence: 139.1/1000 with variations between 84.7/1000 in Amajuba and 169.9 in eThekwini (national average 95.9/1000). (*DHIS*)
Goal 5: Improve maternal health					
Target: Reduce by three quarters, between 1990 and 2015, the maternal mortality rate					
7. Maternal mortality ratio	Confidential Enquiries into Maternal Deaths in SA 2005-2007 & 2008-2010	169.78/ 100 000 (2005-2007)	135 or less/ 100 000 live births	192.31/ 100 000 live births (2008-2010)	Non-pregnancy related infections and AIDS are still the major causes of maternal deaths increasing from 86.07% to 94.08% and 33.59% to 84.22% between 2005-2007 and 2008-2010.[31] The facility maternal mortality rate was 190.6/100 000 in 2011/12 (*DHIS*). Late booking for antenatal care (41% before 20 weeks) still compromise the effective management of pregnancy; postpartum care 6 days after delivery is still low at 57.3% (babies) and 58.6% (mothers) hence increasing the risk of complications after birth. Births to women under 18 years (17,933) are still a concern (*DHIS*).
8. Proportion of births attended by skilled health personnel	SADHS 2003	91.1%	100%	75.7% (proxy)	"Delivery rate in facility" used as proxy for progress (*SAHR 2011*).[4] Delays in reaching health facilities during labour is still one of the major challenges which is being addressed by establishing strategic MOUs, allocating obstetric ambulances and waiting mother's lodges.
Goal 6: Combat HIV and AIDS, Malaria and other diseases					
Target: Have halted by 2015, and begin to reverse the spread of HIV and AIDS and incidence of malaria and other major diseases					
9. HIV prevalence among 15-19 year old pregnant women	National HIV Syphilis Prevalence Survey of SA	22%	National Target: 22.8%	16.8%	Prevalence among 15-24 year old pregnant women decreased from 31% in 2009 to 25.5% in 2011; prevalence in the age group 35-39 years increased from 46.2% in 2009 to 53.1% in 2011; and in the 44-49 year age group increased from 25% in 2009 to 52.9% in 2011.[23]

Indicators	Data Source	Baseline 2009/10	Target 2014/15	Progress 2011/12	Comments
10. HIV prevalence among 20-24 year old pregnant women	National HIV Syphilis Prevalence Survey of SA	37.2%	National Target: 22.8%	33.3%	
11. Contraceptive prevalence rate	SADHS[12] 2003	76.8%	100%	Current prevalence not available	"Couple year protection rate" is monitored as proxy for this indicator (25.5%), although not considered as accurate marker of contraceptive prevalence.
12. Proportion of TB cases reported and cured under directly observed treatment short course (DOTS)	ETR.Net	62.9%	85%	69.7%	"New smear positive PTB cure rate" reported as proxy for progress.
13. Malaria incidence rate per 1000 people at risk	Malaria Database	0.11/1000	<1/1000	0.79/1000	The malaria case fatality rate was 0.75% in 2011/12 (*Malaria database*).

Colour coding: Green: Achieved; Orange: Likely to achieve; Red: Not likely to achieve

- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

PROVINCIAL CONTRIBUTION TO THE HEALTH SECTOR NEGOTIATED SERVICE DELIVERY AGREEMENT

The Department continues to focus on the strategies to fast track delivery on the NSDA Outputs as indicated below:

Output 1: Increasing life expectancy

Output 2: Decreasing maternal and child mortality

Output 3: Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis

Output 4: Strengthening health system effectiveness

Sub-Output 4.1: Re-engineering of PHC

Sub-Output 4.2: Improving patient care and satisfaction

[12] South African Demographic and Health Survey 2003

Sub-Output 4.3: Accreditation/ certification of health facilities for compliance

Sub-Output 4.4: Improved health infrastructure availability

Sub-Output 4.5: Improved human resources for health

Sub-Output 4.6: Strengthening financial management (monitoring and evaluation)

Sub-Output 4.7: Improving healthcare financing through implementation of NHI

Sub-Output 4.8: Strengthening health information systems

Output 5: Reducing Non-Communicable Diseases (Identified by the MEC for Health as additional output in 2012/13)

Table 22: (A6): Provincial contribution towards achievement of the NSDA Outputs

Provincial Priorities 2013/14	Provincial Strategies 2013/14	Service Delivery Targets 2009/10 - 2014/15 (unless otherwise indicated)	Progress (confirmed 2011/12 data unless otherwise indicated)
OUTPUT 1: INCREASING LIFE EXPECTANCY **NOTE: THE MEC FOR HEALTH (KZN) DECLARED NON-COMMUNICABLE AND CHRONIC DISEASES ONE OF THE CORE PRIORITIES FOR KZN - MONITORED AS OUTPUT 5 IN ROUTINE REPORTING**			
• *PHC re-engineering (including OSS) is the primary vehicle for integrated strategies to improve primary prevention of non-communicable and chronic diseases with a strong emphasis on health promotion and improved detection, screening, referral, follow-up and support.* • *Routine screening for chronic conditions during school health visits, health events, HCT campaigns and household visits (PHC/OSS outreach) will be up-scaled.*			
NSDA 2014/15 target: Increase life expectancy to 56 years for males and 61 years for females (increase of 2 years since 2009)			
1.1 Improve the social compact for health	• Establish Provincial and District Health Councils	• Provincial Health Council and 11 District Health Councils established and meet at least twice annually	• Provincial Health Council established and meeting convened on 14/09/2012 • Process to establish District Health Councils commenced – nil established to date
1.2 Decrease the incidence of non-communicable and chronic diseases	• Implement an integrated inter-sectoral healthy lifestyle strategy as part of PHC re-engineering and staff wellness	• Decrease new hypertension cases put on treatment *(hypertension client treatment new)* from 74,671 to 60,377	• Hypertension cases put on treatment (new): 70,821
		• Decrease new diabetes mellitus cases put on treatment *(diabetes mellitus client treatment new)* from 32,345 to 24,648	• Diabetes mellitus cases put on treatment (new): 23,307
		• Increase the number of accredited health promoting schools from 170 to 255	• 210 accredited health promoting schools

Provincial Priorities 2013/14	Provincial Strategies 2013/14	Service Delivery Targets 2009/10 - 2014/15 (unless otherwise indicated)	Progress (confirmed 2011/12 data unless otherwise indicated)
1.3 Prevention of blindness	• Integrate eye care services with PHC re-engineering • Improve cataract services	• Increase the cataract surgery rate *(cataract surgery rate (annualised))* from 1,003/1mil to 1,835/1mil (19,500 operations)	• Cataract surgery rate: 1,030.8/1mil (9,170 operations) • Commenced with the development of High Volume Refraction and Cataract Centres
1.4 Malaria elimination: Reducing malaria incidence and case fatality rate	• Reviewed malaria strategy: – Improve early diagnosis and treatment – Implement entomology vector and parasite surveillance programmes – Implement targeted indoor spraying	• Maintain malaria incidence at <1/1000 population at risk	• Malaria incidence: 0.79/1000 population at risk
		• Maintain malaria case fatality rate at <1%	• Malaria case fatality rate: 0.75%
		• Increase malaria spraying coverage from 83% to 95%	• Malaria spraying coverage: 93%
1.5 Reduce and manage intentional and unintentional injuries – *transversal across departments and sectors*	• Implement an integrated strategy to reduce alcohol and substance abuse	• Develop and implement an integrated mental health (including substance abuse) strategy	• Mental Health Summit in 2012/13 • Provincial Mental Health Advisory Committee established in 2012/13 to advise on the development of Mental Health services
	• Revitalisation of Emergency Medical Services	• Increase rostered ambulances from 0.24/10000 (217 ambulances) to 0.34/10 000 population (383 ambulances)	• Rostered ambulances: 0.17/10 000 population or 185 ambulances
		• Increase P1 calls with a response time <40 minutes in a rural area *(EMS P1 rural response under 40 minutes rat*e) from 36% to 80%	• P1 calls with a response time <40 minutes in an rural area: 36%
		• Increase P1 calls with a response time <15 minutes in an urban area *(EMS P1 urban response under 15 minutes rat*e) from 19% to 50%	• P1 calls with a response time <15 minutes in an urban area: 11%
		• Increase all calls with a response time within 60 minutes *(EMS P1 call response under 60 minutes rate)* from 53% to 70%	• Percentage of all calls with a response time within 60 minutes: 51%
OUTPUT 2: DECREASING MATERNAL AND CHILD MORTALITY			
2.1 Reduce child morbidity and	• Implement GOBIFFF (growth	• Reduce the under-5 mortality rate to 37/1000	• Under-5 mortality rate: 63/1000 (ASSA)

Provincial Priorities 2013/14	Provincial Strategies 2013/14	Service Delivery Targets 2009/10 - 2014/15 (unless otherwise indicated)	Progress (confirmed 2011/12 data unless otherwise indicated)
mortality	monitoring, oral rehydration therapy, breastfeeding, immunisation, family spacing, female education, food supplementation) through integrated strategies (PHC and OSS) • Implementation of the IYCF Policy; nutritional supplementation; Vitamin A supplementation; and the prevention/ management of (severe) malnutrition	• Reduce infant mortality rate to 30-45/1000	• Infant mortality rate: 43/1000 (ASSA)
		• Reduce the underweight for age under 5 years incidence from 26.3/1000 to 15/1000	• Underweight for age under 5 years incidence – annualised: 24/1000[13]
		• Reduce severe malnutrition under 5 years incidence *(Child under 5 years severe acute malnutrition incidence (annualised))* from 9.5/1000 to 6/1000	• Severe malnutrition under 5 years incidence: 6.7/1000 (facility data only)
		• Reduce children not gaining weight rate under 5 years from 1.3% to <1%	• Not gaining weight rate under 5 years: 1%
		• Increase the Vitamin A coverage 12-59 months *(Vitamin A 12 – 59 months coverage (annualised))* from 37.4% to 51% in all districts	• Vitamin A coverage 12-59 months: 42% • Only eThekwini (54.9%) achieved coverage over 50%.
	• Strengthen the Expanded Programme on Immunisation to reduce vaccine preventable morbidity and mortality	• Increase the immunisation coverage under-1 year *(Immunisation coverage under 1 year (annualised))* from 84.9% to 90% in all districts	• Immunisation coverage under-1 year: 97% • Coverage in 4 districts still under 90% i.e. Umgungundlovu (84.2%); Amajuba (77.7%); Zululand (78.7%); and Sisonke (82.3%)
		• Increase the measles 1st dose under 1 year coverage *(Measles 1st dose under 1 year coverage(annualised))* from 87.3% to 90% in all districts	• Measles 1st dose under 1 year coverage: 98.9% • Coverage in 4 districts still under 90% i.e. Umgungundlovu (85.6%); Amajuba (81.8%); Zululand (83.5%); and Sisonke (89.2%)
		• Increase the Pneumococcal (PCV) 3rd dose coverage *(PCV 3rd dose coverage (annualised))* from 75.9% to 90% in all districts	• Pneumococcal (PCV) 3rd dose coverage: 95.9% • Coverage in 4 districts still under 90% i.e. Umgungundlovu (79.9%); Amajuba (84.5%); Zululand (79.5%); and Sisonke (89.4%)

[13] Inconsistent trends (based on DHIS data) – will be closely monitred

Provincial Priorities 2013/14	Provincial Strategies 2013/14	Service Delivery Targets 2009/10 - 2014/15 (unless otherwise indicated)	Progress (confirmed 2011/12 data unless otherwise indicated)
		• Decrease the number of diarrhoea cases (children under-5) from 232,397 to 112,317 (10% reduction per year)	• Number of diarrhoea cases (children under-5): 155,076 • Child under 5 years diarrhea with dehydration incidence: 139.1/1000 with variations between 84.7/1000 in Amajuba and 169.9/1000 in eThekwini
		• Increase the Rota Virus 2nd dose coverage (annualised) from 58% to 90% in all districts	• Rota Virus 2nd dose coverage: 103.5% • Coverage in 3 districts still under 90% i.e. Amajuba (88.7%); Zululand (84.7%); and Sisonke (89.6%)
		• Decrease the number of pneumonia cases (children under-5) *(Child under 5 years with pneumonia new)* from 209,920 to 109,212 (10% reduction per year)	• Number of pneumonia cases (children under-5): 162,178 • Child under 5 years pneumonia incidence: 145.5/1000 with variations between 78.9/1000 in Uthukela and 187.3/1000 in Ugu
	• Expand the reach of perinatal and maternal mortality meetings to include community outreach teams to avert avoidable mortality	• Increase facilities that conduct perinatal and maternal mortality meetings from 93% to 100%	• All facilities conducting perinatal and maternal mortality meetings • Commenced with appointment of District Specialist Teams to improve clinical governance
2.2 Decrease maternal and neonatal morbidity and mortality	• Implement CARMMA (Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa)	• Reduce maternal mortality ratio (MMR) to 135 (or less) per 100 000 live births (National target)	• MMR 192.31/100 000 live births (*Saving Mothers 2008-2010: Fifth Report on the Confidential Enquiries into Maternal Deaths in South Africa*)
	• Improve access to comprehensive Sexual & Reproductive Health Services including the contraceptive 5-step campaign	• Increase the couple year protection rate *(couple year protection rate (annualised))* from 25.1% to 45%	• Couple year protection rate: 25.5% • Commenced with implementation of the Contraceptive Strategy

Provincial Priorities 2013/14	Provincial Strategies 2013/14	Service Delivery Targets 2009/10 - 2014/15 (unless otherwise indicated)	Progress (confirmed 2011/12 data unless otherwise indicated)
	• Implement the Phila Ma campaign (cervical cancer screening) and scale up routine screening of HIV positive women	• Increase cervical cancer screening coverage *(cervical cancer screening coverage (annualised))* from 57.4% (2010/11) to 75%[14]	• Cervical cancer screening coverage: 76.1%[15] • The Phila Ma campaign is ongoing
	• Improve early antenatal and post natal care through BANC and integration with PHC outreach services	• Increase ANC visits before 20 weeks *(Antenatal 1st visits before 20 weeks rate*) from 34.3% to 60%	• ANC 1st visits before 20 weeks rate: 41%
		• Increase the postnatal care baby visits within 6 days rate from 42% to 80%	• Postnatal care baby visits within 6 days rate: 58.3%
		• Increase the postnatal care mothers visit within 6 days rate *(Mother postnatal visit within 6 days rate)* from 42% to 80%	• Mother postnatal visit within 6 days rate: 58.1%
	• Improve access to skilled birth attendance: dedicated obstetric ambulances; maternity waiting homes; establishing strategically placed Basic Emergency Obstetric Care Units; and Kangaroo Mother Care	• Allocate obstetric ambulances in all municipalities (pending funding envelope)	• 40 Obstetric ambulances allocated to districts
		• Establish maternity waiting homes in all District Hospitals (pending funding envelope)	• 10 Maternity waiting homes functional (2012/13) - no waiting homes in Ugu, Umgungundlovu and Ilembe
		• Establish strategically placed MOUs pending availability of resources e.g. Advanced Midwifes and adequate number of deliveries to justify expenditure	• 18 Strategically placed MOUs established
	• Improve quality of care - implementation of ESMOE (Essential Steps in Management of Obstetric Emergencies); Midwifery Education & Training); District Specialist Teams	• 11 District Specialist Teams established (minimum composition of teams)	• All districts commenced with appointment of District Specialist Teams • Three districts comply with minimum criteria of staffing

[14] Calculation of this indicator changed in 2010/11 (DHIS) resulting in significant increase in coverage. Baseline therefore based on the 2010/11 baseline for trend analysis and year-on-year monitoring
[15] It is suspected that the data include ALL PAP SMEARS and not screening only

Provincial Priorities 2013/14	Provincial Strategies 2013/14	Service Delivery Targets 2009/10 - 2014/15 (unless otherwise indicated)	Progress (confirmed 2011/12 data unless otherwise indicated)
	• Improved management of HIV positive women and HIV infected/ affected children e.g. improved management of co-infections; scaling up NIMART; and scaling up PMTCT programmes as integrated component of PHC re-engineering	• Increase the percentage of eligible pregnant women placed on HAART *(Antenatal clients initiated on HAART)* from 52.7% to 98%	• Percentage of eligible pregnant women placed on HAART: 80%
		• Reduce Baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks *(infant 1st PCR test positive within 2 months rate*) from 10.3% to <1% (DHIS)	• Percentage of Baby tested PCR positive at six weeks as a proportion of babies tested at six weeks: 4% (*DHIS*)
OUTPUT 3: COMBATING HIV AND AIDS AND DECREASING THE BURDEN OF DISEASE FROM TUBERCULOSIS			
• *Implement and actively monitor the KwaZulu-Natal Multi-Sectoral Provincial Strategic Plan for HIV and AIDS, STIs and TB (KZNPSP) 2012-2016.*			
3.1 Decrease HIV incidence (Zero New Infections) and manage HIV prevalence	• Expand decentralisation of ART services to PHC to improve universal access and effective follow-up and support (PHC re-engineering)	• Reduce HIV incidence to less than 1% by 2016 (KZNPSP 2012-2016)	• Estimated HIV incidence: 1.01% (ASSA estimate)
		• Manage HIV prevalence	• HIV prevalence (antenatal women): 37.4% • HIV prevalence (ANC) in the 15-19 year age group: 16.8% • The HIV prevalence (ANC) shows an increase in the age groups 35-39 years (52.7% to 53.1%) and 45-49 years (38.5% to 52.9%)
		• Increase the total number of patients (children and adults) on ART *(Total clients remaining on ART (TROA) at end of month)* from 319,015 to 1,011,201	• Number of patients initiated on ART: 641,198 (*mid-year 2012/13*)
	• Strengthen HIV-TB integration	• Increase the percentage TB/HIV co-infected patients placed on ART rate *(HIV / TB co-infected patient initiated on ART rat*e) from 48% (2010/11) to 80%	• Percentage TB/HIV co-infected patients placed on ART rate: 32.5%[16]

[16] Data quality for this indicator is questionable and will be monitored during 2013/14. According to the data from the ART Register the TB/HIV co-infected patients on ART rate was 70% (third quarter 2012/13)

Provincial Priorities 2013/14	Provincial Strategies 2013/14	Service Delivery Targets 2009/10 - 2014/15 (unless otherwise indicated)	Progress (confirmed 2011/12 data unless otherwise indicated)
	• Scale up voluntary Male Medical Circumcision	• Increase the number of male medical circumcisions: Neonatal from 58 to 600; and adult males from 33,817 to 469,280	• Number of male medical circumcisions: 111 neonatal and 124,406 adult males
	• Expand the integrated HCT Campaign as integral component of PHC re-engineering at community and facility level	• Increase the number of people tested for HIV from 2,511,872 (2011/12 DHIS) to 4,489,193[17]	• 2,511,872 people tested for HIV in 2011/12
		• Increase the male condom distribution rate *(male condom distribution rate annualised))* from 8 to 25	• Male Condom distribution rate: 9
	• Scale up interventions in High Transmission Areas	• Increase the number of HTA sites from 53 (2011/12) to 105 (*DORA Business Plan*)	• Number of HTA sites: 40 (*DORA Business Plan*) • 7 Truck Stops operational
3.2 Reduce TB incidence and improve TB outcomes	• Strengthen TB ACSM (Advocacy, Communication and Social Mobilisation) and integrate TB DOTS support, surveillance for early detection of TB, and follow up of defaulters into activities of Operation Sukuma Sakhe and community-based strategies	• Increase the new smear positive PTB cure rate *(TB (new pulmonary) cure rate)* from 62.9% to 85%	• New smear positive PTB cure rate: 69.7%
		• Decrease new smear positive PTB defaulter rate *(TB (new pulmonary) defaulter rate)* from 8.1% to <5%	• New smear PTB defaulter rate: 6.7%
		• Increase the PTB two month smear conversion rate *(TB conversation success rate)* from 68.7% to 85%	• PTB two month smear conversion rate: 68.3%
3.3 Improve MDR-TB outcomes	• Expand the Community Management of MDR TB[18]	• TB-MDR Treatment success rate 65% (2013/14)	• TB-MDR Treatment success rate: 62%
		• TB-XDR Treatment success rate 35% (2013/14)	• TB-XDR Treatment success rate: 30%
OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVENESS			
SUB-OUTPUT 4.1: RE-ENGINEERING OF PHC			

[17] Targets have been aligned with the DORA Business Plan
[18] New indicators to monitor MDR-TB and XDR-TB - historic data not available hence targets set for 2013/14 and current performance reflecting 2012/13 mid-year data

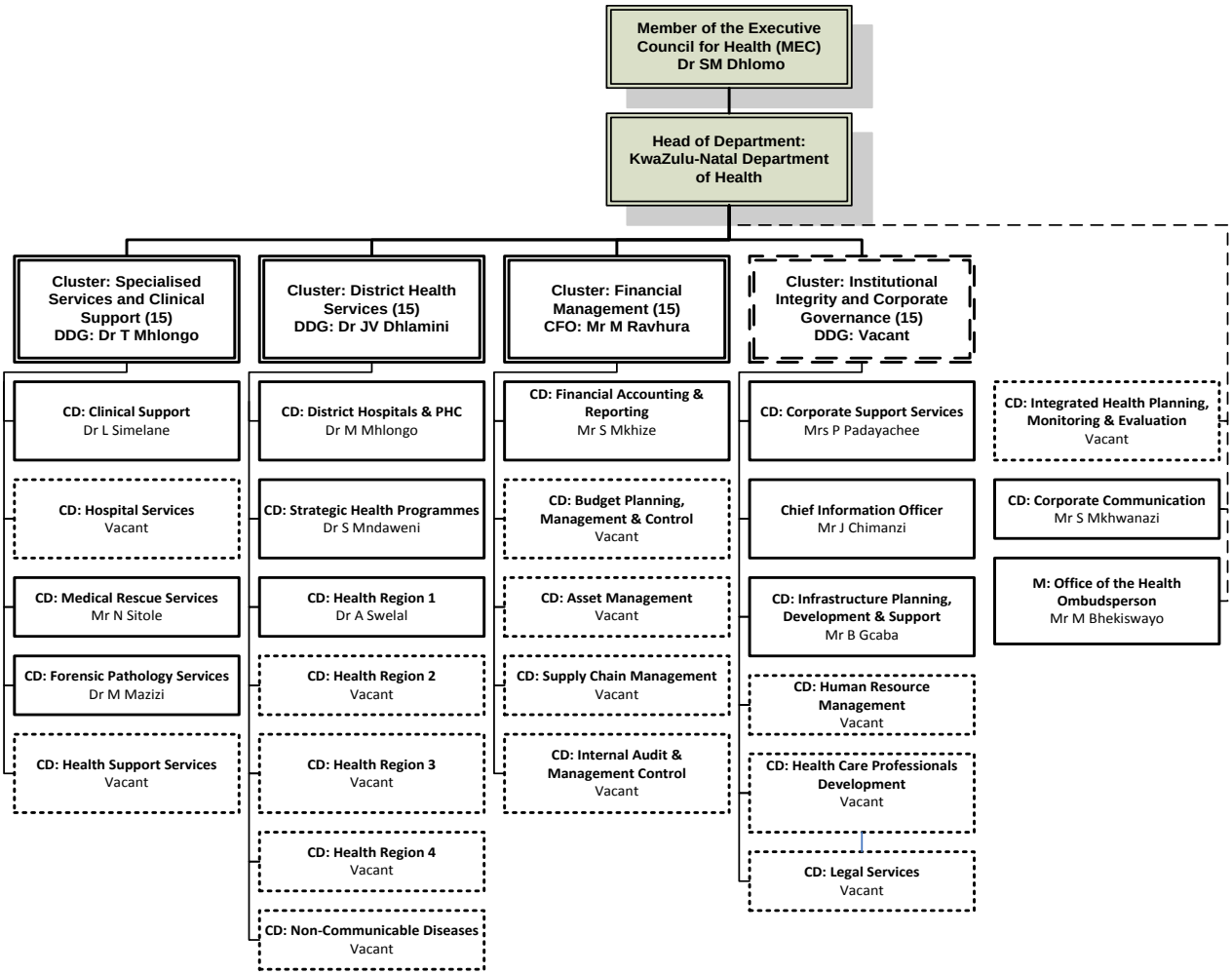
Provincial Priorities 2013/14	Provincial Strategies 2013/14	Service Delivery Targets 2009/10 - 2014/15 (unless otherwise indicated)	Progress (confirmed 2011/12 data unless otherwise indicated)
4.1.1 Strengthen the District Health System through PHC re-engineering	• PHC re-engineering using OSS as primary vehicle for integrated multi-disciplinary services	• Increase the utilisation rate - *PHC (PHC utilisation rate (annualised))* from 2.6 to 3.1	• Utilisation rate – PHC: 2.7 • PHC total headcount: 29,314,618
		• Increase the PHC Outreach (Family Health/Ward-Based) Teams from 12 (2011/12) to 137	• PHC Outreach Teams: 35 (mid-year 2012/13) • The target compares negatively with the national norm of 1 team per 7,660 persons or 1,619 households
		• Increase the number of School Health Teams from 86 (2011/12) to 196	• School Health Teams: 137 (mid-year 2012/13)
		• District Specialist Teams (minimum staff composition) established in all districts	• All districts commenced with appointment of District Specialist Teams
		• Decrease the OPD new cases not referred from 34.9% (2011/12) to 30% of the OPD total headcount *(OPD headcount – total)*	• OPD new cases not referred 34.9% of OPD total headcount
4.1.2 Improve governance and social compact for health	• Establish Provincial and District Health Councils	• Provincial and 11 District Health Councils established	• Provincial Health Council established and meetings conducted
	• Appoint Hospital Boards and Clinic Committees as per National Health Act, 2003 and KZN Health Act, 2009 (Act No. 1 of 2009)	• 100% Clinic Committees and Hospital Boards established	• Established Clinic Committees: 74% PHC clinics; 37% CHCs; and 90% Hospitals.
SUB-OUTPUT 4.2: IMPROVING PATIENT CARE AND SATISFACTION			
4.2.1 Improve the quality and efficiency of health services	• Improve clinical governance and supervision at all levels of the health care system	• Improve the PHC facilities monthly supervisory visit rate *(PHC supervisor visit rate*) from 68% to 70%	• Fixed PHC facilities monthly supervisory visit rate: 62.2%
		• 100% Hospitals conduct monthly mortality and morbidity review meetings	• 100% Hospitals conduct monthly mortality meetings
4.2.2 Strengthen Pharmaceutical Services	• Improve efficiency of Pharmaceutical services	• Reduce medicines stock out rate to <1%	• Medicine stock out rate in PPSD 13% and in institutions 1%

Provincial Priorities 2013/14	Provincial Strategies 2013/14	Service Delivery Targets 2009/10 - 2014/15 (unless otherwise indicated)	Progress (confirmed 2011/12 data unless otherwise indicated)
SUB-OUTPUT 4.3: ACCREDITATION/ CERTIFICATION OF HEALTH FACILITIES FOR COMPLIANCE			
4.3.1 Certification of health facilities	• Implement the National Core Standards and Make me Look Like a Hospital	• Accreditation/ certification of 10% PHC facilities and 100% Hospitals	• Zero facilities compliant with core standards • All health facilities assessed for compliance (HST) and Facility Improvement Plans implemented
SUB-OUTPUT 4.4: IMPROVED HEALTH INFRASTRUCTURE AVAILABILITY			
4.4.1 Improved physical infrastructure for health	• Implement the User Asset Management Plan (U-AMP) for 2013/14	• Complete projects as per U-AMP and funding envelope	• Developed Infrastructure Project Assemble Tool (IPAT) to monitor project readiness
SUB-OUTPUT 4.5: IMPROVED HUMAN RESOURCES FOR HEALTH			
4.5.1 Improve access to Human Resources for Health.	• Implement the Human Resource Plan (aligned with the Human Resources for Health Strategy): • *Leadership & Governance* • *Intelligence and Planning for HRM* • *A workforce for new service strategies* • *Upscale and revitalise Education Training and Research* • *Academic training and service platform interfaces* • *Professional HR Management* • *Quality professional care* • *Access in rural and remote areas*	• Implement the aligned Human Resources for Health Strategy	• Commence review of organisational structure • Workforce growth rate: 10.5% (70,913 to 78,394 between 2010/11 and 2011/12) • 351 Students selected for medical training in Cuba in 2012/13 • Sponsoring 30 students from Limpopo to participate in the Cuban programme - estimated cost of ±R 5 million for 2012/13
SUB-OUTPUT 4.6: STRENGTHENING FINANCIAL MANAGEMENT (MONITORING AND EVALUATION)			

Provincial Priorities 2013/14	Provincial Strategies 2013/14	Service Delivery Targets 2009/10 - 2014/15 (unless otherwise indicated)	Progress (confirmed 2011/12 data unless otherwise indicated)
4.6.1 Improve financial management and accountability.	• Implement the Financial Turn-Around Strategy • Address Auditor-General's (AGs) recommendations to improve financial management • Clean Audit 2014	• Annual unqualified audit opinion.	• Qualified audit opinion 2011/12 • Reviewed strategy for Clean Audit 2014
SUB-OUTPUT 4.7: IMPROVING HEALTHCARE FINANCING THROUGH IMPLEMENTATION OF NATIONAL HEALTH INSURANCE			
4.7.1 Implement NHI Pilot in Umgungundlovu, Umzinyathi and Amajuba Districts	• Baseline assessments to formulate strategic and operational interventions	• As per NHI Business Plans	• Commenced implementation of NHI strategies in 3 pilot districts
SUB-OUTPUT 4.8: STRENGTHENING HEALTH INFORMATION SYSTEMS			
4.8.1 Implement the integrated Information Management Strategy (including M&E Framework) to improve the quality of data and information management at all levels in the public health system	• Placement of information clerks in PHC facilities to collate and verify daily data	• Annual unqualified audit opinion for performance information	• Qualified audit opinion 2011/12 • Developed action plan following the 2011/12 audit report
	• Implement training programmes for PHC Supervisors and Operations Managers		
	• Increase M&E capacity at clinic and facility level		
	• Improve information systems and align with national initiatives		
	• Review and implement strategy to reduce the number of registers		

1.6. PROVINCIAL ORGANISATIONAL ENVIRONMENT

Figure 7: Macro Structure KZN Department of Health



Abbreviations in Figure 7: DDG: Deputy Director General; CD: Chief Director; M: Manager

The Department is awaiting final approval for the reviewed macro organisational structure from DPSA. This macro structure has been informed by core and support functions necessary to achieve the Department's mandate, strategic goals and objectives. Alignment of sub-structures and review of facility post establishments commenced although predicting future staffing requirements remains a challenge due to insufficient planning information pertaining to the impact of changing disease patterns, increasing burden of disease, poverty and socio-economic and demographic determinants on the future workforce.

Current human resource planning methodologies, including calculation of population-to-staff ratios and facility-based staffing standards, does not incorporate the significant local variations in service demand and actual workload per facility. To address that, the Department will pilot the Workload Indicators of Staffing Need (WISN) that is based on workload and activity (time) standards for each workload component to determine/ predict staffing needs per facility. Retrospective service delivery data will be used to determine gaps, supply and demand within the funding envelope. Operational efficiency (optimal spending between different categories of health workers and productivity of the existing workforce) will be monitored to ensure value for money.

The health workforce shows a 10.5% growth between 2010/11 and 2011/12 from 70,913 to 78,394 employees (*Persal*). Inequities in allocation and placement of staff remain a challenge which should be addressed through applying the preferred methodology to determine gaps.

Table 23: (A7): Public Health Personnel 2011/12

Categories	Number Employed	% of Total Employed	Number per 100 000 people	Number per 100 000 Uninsured People	Vacancy Rate (%)	% of Total Personnel Budget	Annual Cost per Staff Member
Medical Officers	2,455	3	26.18	26.98	34.7	5.29	R 479 392
Medical Specialists	572	0.7	5.34	6.29	64.1	2.97	R 813 775
Dentists	97	0.1	0.91	1.07	20.5	0.38	R 500 526
Dental Specialists	0	0	0	0	0	0	R 00
Professional Nurses	13,779	17	137.27	151.45	22.6	17.51	R 199 520
Staff Nurses	10,001	12.4	93.43	109.92	3.6	6.95	R 107 914
Nursing Assistant	6,465	8	60.4	71.06	4.8	3.67	R 86 715
Student Nurses	1,761	2.2	16.45	19.36	13.2	0.68	R 552 255
Pharmacists	552	0.7	5.61	6.07	32.2	1.58	R 415 059
Physiotherapists	206	0.3	1.92	2.26	23.4	0.32	R 213 819
Occupational Therapists	100	0.1	0.93	1.1	32	0.16	R 197 173
Radiographers	487	0.6	4.55	5.35	19.4	0.82	R 226 172
Emergency Medical Staff	2,994	3.7	27.97	32.91	13.1	2.38	R 117 384
Dieticians & Nutritionists	136	0.2	1.27	1.49	33.3	0.19	R 199 060
Community Care Givers	9,722	12	90.83	106.85	0.47	1.06	R 18 198

Source: Persal expenditure per staff member

Vacancy Rate

Between 2010/11 and 2011/12 the overall vacancy rate was reduced with 7.92% (from 31.45% to 23.45%) and the number of filled posts increased with 5% (from 76% to 81%). This was partly due to the Parliamentary Resolution to abolish unfilled posts that were vacant for periods exceeding 12 months. The use of vacancy rates as standard predictor of human resource gaps and prioritisation for filling of posts is a poor predictor of need as establishments are not currently aligned with service delivery demand and workload (*HRP 2012/13*).

Turnover Rate

The turnover rate, decreasing from 7.6% in 2009/10 to 5.3% in 2011/12, is largely influenced by the terminations and re-appointments of professional staff doing internships and community service as appointments are managed as contracts on the system (*HRP 2012/13*).

The average service range for health professionals is between 1 to 10 years which is concerning as attempts are being made to increase employment stability. The short service periods can be ascribed to health professionals exiting the Public Service after having served their compulsory services (internships and community service) and contract periods (bursary holders). It is anticipated that further training opportunities e.g. Registrar

training will serve as a means to retain these health professionals. The impact of Occupation Specific Dispensation still has to be measured to determine the impact on service delivery and stability rates.

Age Profile

There has been an increase of 4.96% (34.72% to 39.68%) in the age group 25 to 34 years over the previous 2 years. The dominant age group remains the group between 35 to 54 years (53.19%), and the most stable group between 55 to 64 years. This presents the ideal opportunity for mentoring and succession training to ensure sustainability and improved institutional memory.

Employment Equity

African females dominate the workforce (mostly employed within the Nursing category) followed by African males. Other race groups form a low percentage of the workforce and are not represented in especially deep rural areas. Current representation according to the HRP for 2012/13:

- African: 20.8% Males and 66.13% Females.
- Indian: 3.77% Males and 5.69% Females.
- White: 0.94% Males and 1.61% Females.
- Coloured: 0.37% Males and 1.36% Females.

The number of disabled employees in the Department (151) has shown no significant increase during the reporting year. The Department launched the Provincial Disabled Employees Forum to serve as the platform to address the stigma still associated with disability.

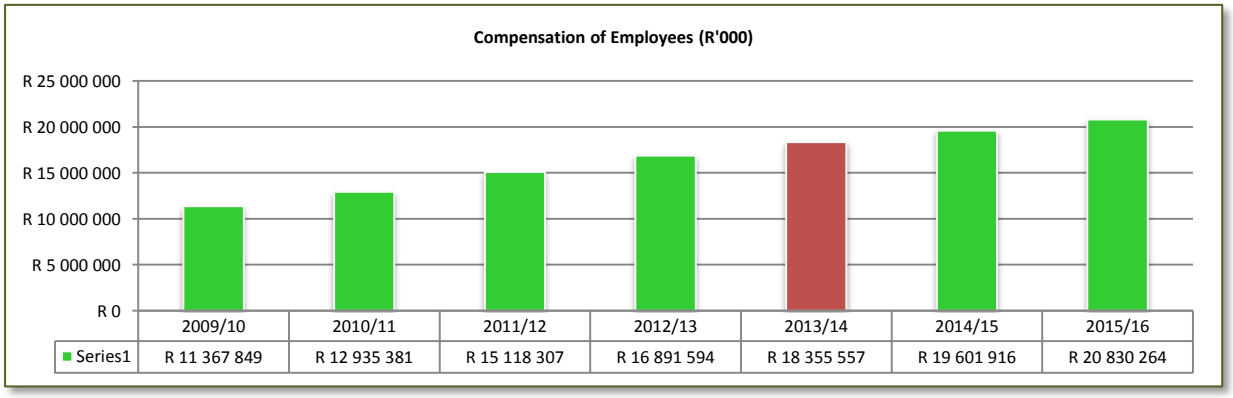
Incapacity Leave and Ill-health Retirement

The impact of ill-health on the workforce (directly and indirectly) has serious implications for service delivery including allocation/replacement of staff, distribution of responsibilities, increasing number of staff in acting positions, and critical posts not being filled for extended periods.

Compensation of Employees

Due to competing demands on the national fiscus, increases on the current budget spent on health are unlikely. New population data (Census 2011) further predicts a decrease in the Provincial health budget for the coming MTEF. The graph below illustrates the growth in compensation of employees between 2009/10 to 2015/16.

Graph 14: Compensation of Employees 2009/10 – 2015/16



Source: Budget Appropriation (Vote 7)

Organisational Factors Impacting on Service Delivery

1. Imbalance between human resources for health supply and demand. Retention strategy not effective e.g. no firm retention strategy to retain Interns as part of the Internship Programme.
2. Career pathing options limited although there is a strategy in place for career pathing of Community Care Givers.
3. Occupational Specific Dispensation in some professional occupation categories no

competitive to recruit and retain staff – specifically relevant to deep rural areas.

4. Lack of policy and strategy for succession training.
5. Imbalances in staff mix and placement of human resources based on the burden of disease and workload.
6. Delays in finalising post establishments and insufficient funding for the filling of critical posts. Non-filling of critical vacancies increasing workload with negative impact on staff wellbeing and absenteeism.
7. Poor management of sick leave remains a challenge which impacts on service delivery and quality of care.
8. Effective management and accountability at especially facility level.
9. Inadequate performance management and non-alignment of Performance Agreements with core priorities and service delivery output.
10. Poor quality of data which compromises monitoring, evaluation, reporting, planning and decision-making with negative impact on service delivery outcomes and utilisation of resources.
11. Inadequate information technology and infrastructure especially referring to collection of community-based data.
12. Non-compliance to basic standards of care (National Core Standards for Quality).
13. Dual authority of provincial and local government personal PHC services in Metro and bigger municipalities.

Health Sciences and Training

In 2012/13, the Cuban Medical Training Programme has been expanded to support PHC re-engineering and a total of 351 students commenced their studies in Cuba. The KZN Department of Health is in addition sponsoring 30 students from Limpopo to participate in the programme at an estimated cost of approximately R 5 million for the financial year. A total of 737 bursaries were awarded in 2012/13 inclusive of both local and Cuban training programmes.

In July 2011, a total of 179 Community Care Givers (CCGs) wrote the South African Nursing Council (SANC) first year external examination towards the qualification as Enrolled Nurse (Staff Nurse), with a further 450 selected for training according to the Training and Development Plan. In October 2011, a further 25 CCGs commenced with basic training to strengthen community-based health promotion, prevention and care programmes in support of PHC re-engineering.

There are currently 1,146 Community Service Officers rendering services in the Province as indicated in the table below.

Table 24: Community Services

Item	Total	Item	Total
Professional Nurses	667	Environmental Health Practitioners	34
Medical Officers	189	Occupational Therapists	32
Radiographers	55	Dieticians	25
hysiotherapists	37	Audio and Speech Therapists	28
Pharmacists	49	Psychologists	9
Dentists	21		
Total: 1,146			

Source: HRMS

There are currently 902 interns as indicated in the table below.

Table 25: Interns

Item	Total	Item	Total
Medical Orthotists & Prosthetics	1	Pharmacist	115
Medical Officer (old code)	42	Psychologist	18
Medical Officer	726	Other	656
Total: 902			

Source: HRMS

- A total of 31 *Physiotherapy Assistants* wrote their final examinations in 2012 and a further 29 students are expected to register in 2013.
- Seven *Clinical Associate* students completed training in 2011 with 6 placed in District

Hospitals (Charles Johnson Memorial, Greytown, Ceza, Mosvold, Hlabisa and Osindisweni) in January 2012. The 7th candidate is coordinating the Clinical Associate Programme at the University of Port Elizabeth.

- Between 2010/11 and 2012/13 a total of 62 students registered with the University of Pretoria and WITS for the Bachelor in *Medical Practice* Degree.
- The Department planned to enroll 40 *Dental Assistants* from the pool of 240 unemployed Assistants in the Internship Programme in 2013/14.
- The *Nutritional Advisor* one year course (UKZN) commenced in May 2012. A group of 400 students is currently in training with their final examination in February 2013. This group targeted CCGs and Youth Ambassadors with matric.
- There are currently 153 *Pharmacy Assistants* on training.
- A group of 51 *Occupational Therapy Technicians* will be trained over the next two years at UKZN.

The Strategic Plan identified the lack of management competencies and skills as one of the root causes of poor service delivery, especially at facility level. The Department entered into an agreement with the Provincial Training Academy in order to speed up training of SMS members.

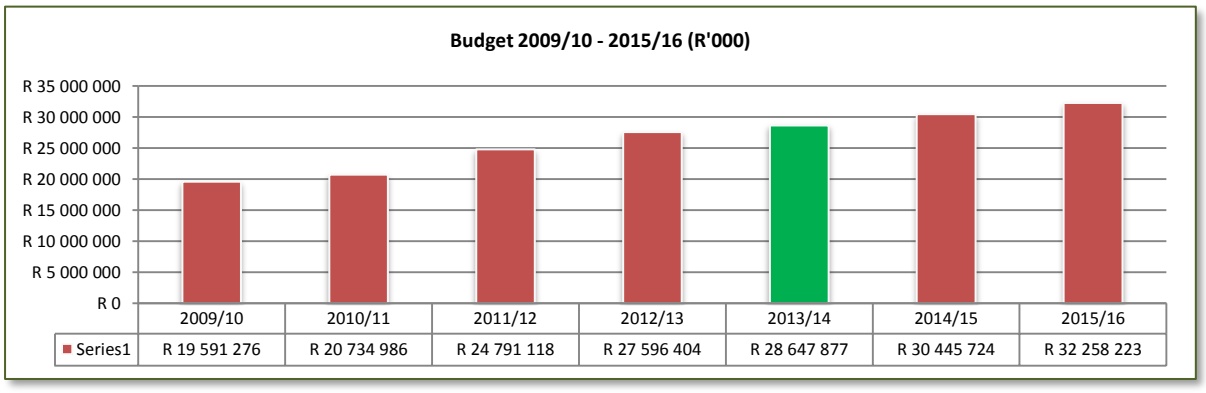
- Two Medical Managers enrolled in the OR Tambo Fellowship Programme for a Diploma in Health Management.
- Four District Managers are on the Population and Development post graduate training programme through UKZN/APSTAR.
- One Manager commenced with the Compulsory Ethics and Value Training Programme.

1.7. LEGISLATIVE MANDATES AND NEW POLICY INITIATIVES

- The KwaZulu-Natal Health Act, 2009 (Act No. 1 of 2009) has been promulgated with effect from 6 September. 2012.
- National School Health Services Policy (2012).

1.8. OVERVIEW OF THE 2013/14 BUDGET AND MTEF ESTIMATES

Graph 15: Health Budget 2009/10 – 2015/16

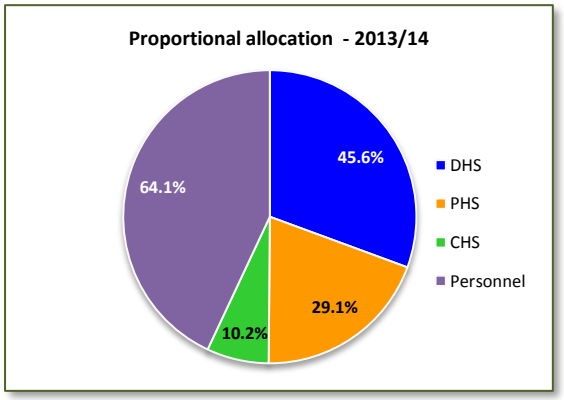


Source: Budget Appropriation (Vote 7)

Graph 16 shows the proportional allocation of the 2013/14 budget die District Health Services (DHS), Provincial Health Services (PHS), Central Health Services (CHS) and Personnel. Between 2012/13 and 2013/14, the proportional allocation for DHS increased from 44.05% to 45.59%; for PHS from 28.10% to 29.07%; for CHS from 9.93% to 10.2%, and for Personnel from 61.21% to 64.08%. Health,

as percentage of the total public health expenditure remains stable at 31.9% between 2012/13 and 2013/14.

Graph 16: Proportional budget allocation



Source: Budget Appropriation (Vote 7)

NON-NEGOTIABLE BUDGET ITEMS

Poor budget allocation for essential items and poor cash flow management and prioritisation regularly result in overspending and non/late payment of basic services and suppliers. The Health Sector budget for personnel has grown annually at the expense of Goods and Services due to increased appointments, and funds earmarked for priority/specific programmes (e.g. Maternal and Child Health, District Teams and Registrars) are not always allocated as intended by either Provincial Health Departments or Provincial Treasuries. The purpose of "non-negotiables" is to address these challenges with a system of continuous monitoring, reporting and accountability.

Key components have been identified as non-negotiable items with existing items within BAS to ensure uniform application of the process by all provinces. Existing information available from BAS and Persal will be used to monitor progress especially Budget versus Expenditure. National Treasury will be approached to assist in the creation of additional items in cases where this need has been identified.

The National Department of Health and National Treasury will revise the Health Sector Programme structure to assist in the uniform application of financial planning for priority areas. Provinces will include reporting on non-negotiables as part of the Monthly Budget and Conditional Grant reporting to the National Department of Health by the 15th of each month. There will be further engagement with National Treasury to ensure that Earmarked and Ring-Fenced budgets reach Provincial Departments of Health. Non-financial measures per non-negotiable and earmarked funds will be finalised by the National Department of Health.

The following items have been identified as non-negotiables.

Non-Negotiables

- Infection control and cleaning
- Medical waste
- Medicines, Medical Supplies including Dry Dispensary
- Laboratory services
- Blood supply services
- Food services and relevant supplies
- Laundry services
- Security services
- Essential equipment and maintenance of equipment
- Maintenance of Infrastructure
- Children's vaccines

Earmarked Funding

- Child health services (including neonatal/ perinatal)
- Maternal and Reproductive Health services
- NHI Pilot Districts (full complement of Teams)
- District Specialist Teams
- Registrars

EXPENDITURE ESTIMATES

Table 26: (A8): Summary of Payments and Estimates

Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Administration (1)	1 159 694	463648	576425	397 670	418 090	559 494	591 078	628 340	661 600
District Health Services (2)	9 095 886	9 729 299	10 692 335	11 953 719	11 986 929	12 156 931	13 063 776	14 211 182	15 188 628
Emergency Medical Services (3)	762 479	822 618	1070 387	1 045 888	973 431	949 390	972 362	1 063 938	1 126 728
Provincial Hospital Services (4)	5 002 719	5 584 757	7 058 831	7 568 389	7 827 233	7 753 449	8 326 401	8 845 275	9 395 878
Central Hospital Services (5)	2 059 124	2 103 382	2 512 654	2 659 359	2 742 074	2 741 097	2 922 125	3 098 392	3 288 335
Health Sciences and Training (6)	773 998	832 279	860 457	998 051	960 723	934 894	992 246	1 022 500	1 075 603
Health Care Support Services (7)	117 127	111 756	125 030	15 170	15 170	133 869	143 286	153 359	162 823
Health Facilities Management (8)	1 378 249	1 087 247	1 894 999	1 917 104	2 367 280	2 367 280	1 636 603	1 422 738	1 358 628
Sub-total	**20 349 276**	**20 734 986**	**24 791 118**	**26 555 350**	**27 290 930**	**27 596 404**	**28 647 877**	**30 445 724**	**32 258 223**
Direct charges against National Revenue Fund	-	-	-	-	-	-	-	-	-
Total	**20 349 276**	**20 734 986**	**24 791 118**	**26 555 350**	**27 290 930**	**27 596 404**	**28 647 877**	**30 445 724**	**32 258 223**
Unauthorised expenditure (1st charge)	**(758 000)**	-	-	-	-	-	-	-	-
Change to 2011/12 budget estimate	**19 591 276**	**20 734 986**	**24 791 118**	**26 555 350**	**27 290 930**	**27 596 404**	**28 647 877**	**30 445 724**	**32 258 223**

- Programme 1: Health Professions Training and Development Grant (R' million): R276 263 (2013/14); R292 837 (2014/15); R306 308 (2015/16)
- Programme 1: EPWP Integrated Grant for Provinces (R' million): R3 000 (2013/14)
- Programme 2: Comprehensive HIV and AIDS Grant (R' million): R2 652 072 (2013/14); R3 098 705 (2014/15); R3 512 927 (2015/16)
- Programme 2 and 5: National Health Insurance Grant (R' million): R9 700 (2013/14); R14 000 (2014/15); R14 793 (2015/16)
- Programme 5: National Tertiary Services Grant (R' million): R1 415 731 (2013/14); R1 496 427 (2014/15); R1 565 263 (2015/16)
- Programme 8: Health Facility Revitalisation Grant (R' million): R962 469 (2013/14); R1 090 431 (2014/15); R1 139 972 (2015/16)[19]

[19] The Health Infrastructure Grant, Nursing Colleges and Schools Grant and Hospital Revitalisation Grant have been merged into one Infrastructure Grant (Health Facility Revitalisation Grant)

Table 27: (A9): Summary of Provincial Expenditure Estimates by Economic Classification

Economic Classification	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Current payments	**17 547 270**	**18 985 210**	**22 364 652**	**24 121 856**	**24 537 676**	**24 843 150**	**26 585 714**	**28 488 374**	**30 378 686**
Compensation of employees	11 367 849	12 935 381	15 118 307	16 516 085	16 896 484	16 891 594	18 355 557	19 601 916	20 830 264
Goods and services	**6 179 421**	**6 049 829**	**7 246 325**	**7 605 771**	**7 641 192**	**7 951 527**	**8 230 157**	**8 886 458**	**9 548 422**
Communication	94 599	82 047	83 607	88 553	85 144	90 702	95 423	102 380	108 186
Computer Services	117 344	80 192	164 578	156 492	133 447	135 669	153 089	161 723	174 045
Consultants, Contractors and special services	1 613 606	1 331 508	1 792 985	1 818 086	1 629 968	1 629 902	1 725 734	1 832 760	1 986 263
Inventory	3420783	3469119	3758106	4092743	4214305	4519318	4587046	5042041	5433588
Operating leases	70 686	96 543	43 400	43 438	41 822	39 540	46 337	49 485	51 826
Rental and Hiring	59 048	55 796	65 974	70 010	-	-	-	-	-
Travel and subsistence	37 430	38 063	54 307	74 579	77 575	77 570	68 669	72 563	74 899
Interest and rent on land	-	-	20	-	-	-	-	-	-
Maintenance , repair and running costs	Included under Contractors and Inventory to avoid double counting								
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	765 925	896 561	1 283 368	1 261 870	1 458 931	1 458 826	1 553 859	1 625 506	1 719 615
Transfers and subsidies to	**498 292**	**562 374**	**515 846**	**562 780**	**542 709**	**542 738**	**655 168**	**650 155**	**673 063**
Provinces and municipalities	84 010	126 756	88 879	88 819	102 371	102 371	148 683	171 508	184 638
Departmental agencies and accounts	34 795	18 942	23 249	24 530	25 317	25 769	27 851	30 440	31 962
Non-profit institutions	278 846	289 009	273 487	296 679	281 361	281 361	274 168	241 750	248 960
Households	100 641	127 667	130 231	152 752	133 660	133 237	204 466	206 457	207 503
Payments for capital assets	**1 545 699**	**1 181 773**	**1 910 011**	**1 870 714**	**2 210 545**	**2 210 545**	**1 406 995**	**1 307 195**	**1 206 474**
Buildings and other fixed structures	1 005 258	778 749	1 048 172	1 085 471	1 492 131	1 492 131	864 152	903 641	813 796
Machinery and equipment	540 441	402 226	835 384	785 243	718 414	718 414	542 843	403 554	392 678
Land and sub-soil assets	-	798	26 455	-	-	-	-	-	-
Payment for financial assets	**758 015**	**5 629**	**609**	-	-	-	-	-	-
Total economic classification	**20 349 276**	**20 734 986**	**24 791 118**	**26 555 350**	**27 290 930**	**27 596 404**	**28 647 877**	**30 445 724**	**32 258 223**

Economic Classification	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Unauthorised expenditure (1st charge) not available for spending	(758 000)	-	-	-	-	-	-	-	-
Total	19 591 276	20 734 986	24 791 118	26 555 350	27 290 930	27 596 404	28 647 877	30 445 724	32 258 223

RELATING EXPENDITURE TRENDS TO SPECIFIC GOALS

Table 28: (A10): Trends in Provincial Public Health Expenditure (R'000)

Expenditure	Audited/ Actual			Estimate	Medium Term Projections		
	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
Current prices							
Total	19 591 276	20 734 986	24 791 118	27 596 404	28 643 027	30 438 724	32 250 820
Total per person	1 874.92	1 967.14	2 333.90	2 578.16	2 656.64	2 803.90	2 951.95
Total per uninsured person	2 142.77	2 248.16	2 667.31	2 946.47	3036.16	3 204.45	3 373.66
Constant (2012/13) Price							
Total	16 868 089	18 516 342	23 402 815	27 596 404	30 161 107	33 634 790	37 249 697
Total per person	1 614.31	1 756.66	2 203.20	2 578.16	2 797.45	3 098.31	3 409.51
Total per uninsured person	1 844.92	2 007.61	2 517.94	2 946.47	3 197.08	3 540.92	3 896.58
% of Total spent on:-							
DHS	46.43%	46.92%	43.13%	44.05%	45.59%	46.66%	47.07%
PHS	25.35%	26.93%	28.47%	28.10%	29.07%	29.06%	29.13%
CHS	10.51%	10.14%	10.14%	9.93%	10.20%	10.18%	10.20%
All personnel	58.03%	62.38%	60.98%	61.21%	64.08%	64.40%	64.59%
Capital	7.89%	5.70%	7.70%	8.01%	4.90%	4.27%	3.72%
Health as % of total public expenditure	31.9%	30.6%	30.9%	31.9%	31.9%	32.0%	31.7%

Table 29: (A11): Adjusted CPIX

Financial Year	Updated CPIX Multiplier 16 February 2009	CPIX
2006/07	1.20	5.2
2007/08	1.11	8.1
2008/09	1.00	10.8
2009/10	0.95	5.4
2010/11	0.90	5.1
2011/12	0.86	4.6
2012/13	0.86	4.6
2013/14	0.86	4.6
2014/15	0.86	4.6
2015/16	0.86	4.6

Source: Budget Office

Outlook for 2013/14

National Treasury took a decision to impose 1, 2 and 3 percent baseline cuts on all spheres of government over the MTEF to curb the national deficit as public spending is growing faster than revenue collection. In addition to that, KwaZulu-Natal received reduced equitable share allocations based on the Census 2011 results.

As a result of fiscal tightening over the MTEF, immediate expansion of services to accommodate the increasing demand (as a direct result of the burden of disease) is being delayed. Funding pressures necessitated unavoidable restrictions for separately funded projects and programmes including establishment of Outreach Teams and filling of vacant posts. Alternative innovative and cost effective interventions are being explored to ensure continuation and expansion of services (quick wins).

Expanded cost-cutting measures, as re-issued by Provincial Treasury, will be adhered to.

Strategies will be reviewed to improve alignment of budget with service delivery. Expenditure versus service delivery analysis and review will be strengthened at all levels of care.

Revenue enhancement programmes will continue to maximise revenue retention above provincial targets as agreed with Provincial Treasury.

Above inflation increase for Compensation of Employees makes provision for:

- Filling of critical Senior and District Management posts.
- Strengthening capacity in Malaria and Port Health, establishing community-based teams e.g. School Health, District Specialist, and TB Tracing and Injection.
- Carry through costs for health professionals appointed in January 2013.
- Final commissioning of King Dinuzulu Hospital and St. Chads, Gamalakhe and Turton CHCs.
- Commissioning of KwaZulu-Natal Children's Hospital out-patient services in June 2013.
- Appointment of Staff Nurses and Nutrition Advisors as part of the CCG career path programme that commenced in 2012/13.
- Commissioning of 20 new clinics in 2013/14.
- Clean Audit 2014/15: Human resource and system strengthening i.e. establishment of a dedicated Audit Unit to improve SCM and Asset Management functions.

Provision has been made for an above inflation increase for transfer payments to eThekwini and Umhlathuze Municipalities to increase access to PHC services. In addition to transfer payments, a provincial budget for medicines, vaccines, antiretroviral medication, test kits, medical surgical supplies, etc. is being kept under Goods and Services for both Municipalities.

- eThekwini Metro (R'000): R 238 395 (total).
- Umhlathuze (R'000): R35 945 (total).

Infrastructure Development (5.7% of the total Provincial budget) was subjected to substantial reprioritisation with a shift of funds from new building projects to maintaining and refurbishing existing facilities. Current priority projects e.g. the revitalisation of Addington Hospital, will not be affected by reprioritisation.

Provision has been made for the finalisation of costing of maternal and neonatal health services in 2013/14 including the development of staffing, equipment and facility norms, and additional obstetric ambulances and mother lodges for pregnant women.

Job creation will continue with small KZN companies and rural women being given an increasing share in market opportunities.

PART B: BUDGET PROGRAMMES

NOTE

Indicator baselines and MTEF targets will be reviewed once the following National processes have been finalised:

1. **Inclusion of the 2011 Census population in the National District Health Information System (DHIS). The current DHIS population is based on 2011 mid-year estimates using Stats SA 2001 projections.**
2. **Finalisation and approval of the 2013 National Indicator Data Set (NIDS) that will be implemented from April 2013.**

PROGRAMME 1: ADMINISTRATION

1.1. PROGRAMME PURPOSE AND STRUCTURE

Provides strategic and supportive leadership, management and overall administration for the Provincial Department of Health

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

Provides effective and efficient governance arrangements and systems to support the MEC for Health

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

Provides strategic leadership in creating an enabling environment for the delivery of quality health care services in line with legislative and governance mandates

There are no changes in the purpose of Programme 1 since tabling of the 2010 - 2014 Strategic Plan.

Performance of all administrative services or programmes, not specifically identified as core priorities in the APP, will be included in Operational Plans and will be monitored and reported on quarterly. Overall performance outputs and outcomes will be included in the 2013/14 Annual Report.

1.2. OVERVIEW

Review of the macro organisational structure, aligned with mandates, functions, and strategic goals and objectives of the Department, is in the final phase and should be finalised in early 2013. Filling of critical Senior Management posts commenced in 2012/13 to strengthen leadership and provide the impetus for service transformation in order to improve universal access to high quality public health services.

The role of Administration (Head Office) remains an enabling function with focus on policy making, planning, systems development, procedural design, setting of norms and standards, and monitoring and evaluation. Improved systems and processes will have an enabling function to navigate effective operationalisation of policies and strategies. Development of capacity, with increased focus on the strengthening of management capacity, has been prioritised in 2012 and will continue in 2013/14.

Administrative systems and processes, in response to service gaps and demands, are being put in place supported by review of policies, standard operating procedures and strategies to ensure continuity of care. Re-prioritisation of budget and core deliverables is high on the Department's agenda to ensure return in investment and the necessary controls are being put in place to ensure compliance to prescripts.

1.3. CHALLENGES

- Reconciling reduced budget with service demands and existing health system gaps.
- Human resource inequities and gaps exacerbated by the gap between supply and demand of certain occupations. Lack of norms and standards to determine real human resource gaps at facility level.
- Inadequate information systems and data quality (all information systems) and inadequate management of information to support evidence-based planning.
- Monitoring, evaluation and reporting.

1.4. 2013/14 PRIORITIES: ADMINSTRATION

PROVINCIAL PRIORITIES	PROVINCIAL KEY FOCUS AREAS
1. Provincial and District Service Transformation Plans (STPs).	• Finalise Provincial and District STPs.
2. Financial Turn-Around Strategy including Clean Audit 2014/15.	• Strengthen financial management and accountability.
	• Strengthen alignment between budget(s) and service delivery.
	• Clean Audit 2014/15.
3. Align the Human Resources Plan with Provincial priorities and strategies and Human Resources for Health SA Strategy.	• Finalise the organisational review, post establishments and expedite filling of identified critical posts (within funding envelope).
	• Leadership and governance: Implement the management training strategy including succession training and mentoring programmes.
	• Establish a Centre for Health Workforce Intelligence.
	• Review the recruitment and retention strategy.
	• Strengthen Academic Health Complexes and Nursing Colleges.
	• Implement appropriate training programmes including training of mid-level workers.
4. Health Information Turn-Around Strategy including Clean Audit 2014/15.	• Implement the Information Technology Communication Strategy including E-Health, M-Health and Telemedicine.
	• Implement an integrated Information Management strategy to improve data quality, monitoring & evaluation, reporting and information management.
	• Research for Health to improve evidence-based planning and practice.
5. National Health Insurance Pilot.	• Continue with NHI Phase 1 Pilot in Umgungundlovu, Umzinyathi and Amajuba Districts.

1.5. SITUATIONAL ANALYSIS AND PROJECTED PERFORMANCE FOR HUMAN RESOURCES

Table 30: (ADMIN1): Situation Analysis and Projected Performance for Human Resources[20]

Indicators	Data Source	Type	Audited/ Actual Performance			Mid-Year Performance[21]	Medium Term Targets		
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
1. Medical officers per 100,000 people	Persal	Ratio	26	24.4	26.18	**26.41**	27	27	28
2. Medical officers per 100,000 people in rural districts	Persal	Ratio	-	9.8	8	**11.44**	12	12	13
3. Professional nurses per 100,000 people	Persal	Ratio	111	130.1	137.27	**128.64**	130	135	140
4. Professional nurses per 100,000 people in rural districts	Persal	Ratio	-	95.6	81.3	**114.27**	116	120	125
5. Pharmacists per 100,000 people	Persal	Ratio	4	4.8	5.61	**5.97**	6	6	7
6. Pharmacists per 100,000 people in rural districts	Persal	Ratio	-	2.1	2.2	**3.70**	4	4	5
7. Vacancy rate for professional nurses	Persal	%	25.7%	28.6%	22.6%	**9.2%** *N: 1,394 D: 15,164*	9%	9%	8%
8. Vacancy rate for doctors	Persal	%	41.6%	28.7%	34.7%	**44%** *N: 2,223 D: 5,056*	42%	41%	40%
9. Vacancy rate for medical specialists	Persal	%	65.9%	41.6%	64.1%	**44.3%** *N: 460 D: 1,039*	44%	43%	42%
10. Vacancy rate for pharmacists	Persal	%	76.4%	36.2%	32.2%	**28.7%** *N: 257 D: 896*	28%	28%	27%

- Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Mid-year performance data (numerator and denominator) for 2012/13 is indicated in green italic in all tables.
- Abbreviations to indicate raw data in all tables: N = Numerator; D = Denominator

[20] Local Government personnel not included. Rural districts refer to Rural Development Notes i.e. Ugu, Umzinyathi, Zululand and Umkhanyakude Districts and Umzimkhulu Municipality in Sisonke District
[21] Estimated 2012/13 performance based on December 2012 Persal data

- Indicators 7-10: Unfunded vacant posts have been abolished in November 2011, January, July, August and November 2012 which affected vacancy rate trends. Review of the organisational structure and post establishments will provide a more accurate analysis of demand and gaps over the MTEF. Vacancy rates will therefore be reviewed in-year in response to reviewed post establishments and funding envelope.
- Census 2011: Changing population data (2011 Census) will impact on indicators 1-6 (using the total population as denominator). New baselines and targets will be determined once new 2011 Census data has been incorporated in the official data system. To ensure consistency in reporting, the population used for the 2013/14 APP is based on mid-year 2011 population estimates (StatsSA) to align with the official information system (DHIS) as prescribed by the National Department of Health.

1.6. PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR ADMINISTRATION

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 31: (ADMIN2): Provincial Strategic Objectives and Annual Targets for Administration

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
1.1) To finalise and implement Provincial Health Plans aligned with the NHS and MTSF priorities for 2010-2014.	1.1.1) Tabled Annual Performance Plan (APP)	Annual tabling of APP as per Regulations	APP sign-off documents	2010/11 APP tabled	2011/12 APP tabled	2012/13 APPP tabled on June 7 – Legislature sitting schedule	Tabled as per schedule	2014/15 APP tabled	2015/16 APP tabled	2016/17 APP tabled
	1.1.2) Number of approved District Health Plans	11 DHP's approved	DHP's sign-off documents	11	11	11	11	11	11	11
1.2) To finalise and implement the approved 2010-2020 KZN STP.	1.2.1) Published STP	Approved STP Implemented	STP	Draft 2 signed off by HOD and MEC	Draft 3	Draft 4	STP not finalised	STP approved	Annual review	Annual review
1.3) To implement the decentralised Operational Model in 11 districts	1.3.1) Number of Hospital Managers who have signed Performance Agreements (PA's)	71/ 71	Signed PA's	New Indicator	55/71	55/71	48/71	71 (100%)	71 (100%)	71 (100%)
	1.3.2) Number of District Managers who have signed PA's	11/11	Signed PA's	New Indicator	11	11	10/11	11	11	11

PROGRAMME 1: ADMINISTRATION

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
	1.3.3) Percentage of Head Office Managers (Level 13 and above) who have signed PA's	100%	Signed PA's	New Indicator	46% (18/39)	46% (18/39)	30% N: 15 D: 50	100%	100%	100%
1.4) To implement the Financial Turn-Around Strategy to improve financial management and accountability in compliance with the PFMA.	1.4.1) Annual unqualified audit opinion for financial statements	Unqualified audit opinion	Auditor-General's Report	Qualified audit opinion 2009/10	Qualified audit opinion 2010/11	Qualified audit opinion 2011/12	2012/13 Audit not yet done	Unqualified audit opinion	Unqualified audit opinion	Unqualified audit opinion
	1.4.2) Number of approved District Health Expenditure Reviews (DHER)	11/ 11	Approved DHER sign-off documents	11	11	11	11	11	11	11
1.5) To implement an integrated Health Information Turn-Around Strategy to improve data quality and ensure annual unqualified audit opinion on performance information from the AGSA from 2010/11 – 2014/15.	1.5.1) Annual unqualified audit opinion for performance information	Unqualified audit opinion	Auditor-General's Report	New indicator	Not officially audited	Qualified audit opinion	2012/13 Audit not yet done	Unqualified audit opinion	Unqualified audit opinion	Unqualified audit opinion
	1.5.2) Annual Report tabled	Tabled as per Regulations	Annual Report tabling documents	2008/09 Annual Report tabled	2009/10 Annual Report tabled	2010/11 Annual Report tabled	2011/12 Annual Report tabled	2012/13 Annual Report tabled	2013/14 Annual Report tabled	2014/15 Annual Report tabled
	1.5.3) Number of progress reports on implementation of the 10-Point Plan	Four progress reports	4 Reports	4 Reports	4 Reports	4 Reports	4 Reports	4 Reports	4 Reports	4 Reports
	1.5.4) Number of functional Tele-Medicine sites	37	IT Strategic Plan	New indicator	35	37	37	47	57	67
1.6) To expand the Registrar training programme to	1.6.1) Number of Registrars in training	720	Persal	272 (2 intakes)	567	610	608 (September 2012)	700	720	750

PROGRAMME 1: ADMINISTRATION

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
increase the pool of Specialists by retaining 75% of qualified Registrars by 2014/15.	1.6.2) Number of Registrars retained after qualifying	75% of total graduates by 2014/15	Persal	69/ 87 (79.3%)	134/ 200 (67%)	179	Not yet available	75% of total graduates	75% of total graduates	75% of total graduates
1.7) Improve governance structures and social compact for health.	1.7.1) Provincial Consultative Health Forum convened annually	Established and convened annually	Minutes of meetings	New indicator	Summit was held in the 3rd Quarter	The Provincial Health Summit was held in the 3rd Quarter of 2011/12	Convened on 6 November 2012	Convened annually	Convened annually	Convened annually
	1.7.2) Number of Provincial Health Council meetings	Established and convened annually	Minutes of meetings	Reporting not required	Nil	Established on 12 August 2011	Convened on 14 September 2012	Bi-annual meetings	Bi-annual meetings	Bi-Annual meetings
	1.7.3) Number of District Health Councils established	11	Departmental Records	Reporting not required	Nil	Nil	Nil	9/11	11/11	11/11
	1.7.4) Number of District Health Councils meetings convened annually	11	Minutes of meetings	New indicator	Nil	Nil	Nil	9/11	11/11	11/11

- Indicator 1.2.1: Incomplete chapters in the STP: Human Resources, Infrastructure, Information Technology, and Forensic Pathology. Costing of STP will be done once outstanding chapters have been approved.
- Indicator 1.1.2: 11 DHPs (draft 3) have been submitted to the National Department of Health as per official timeline – plans will be finalised by the end of March 2013 (official deadline).
- Indicator 1.5.3: Three reports have been submitted as per Treasury timelines. The final report will be submitted in May 2013.
- Indicator 1.6.2: Graduation results not yet available for reporting.
- Indicator 1.7.3: The process to establish District Councils commenced in 2012 in collaboration with COGTA.

1.7. QUARTERLY, BI-ANNUAL AND ANNUAL TARGETS FOR ADMINISTRATION – 2013/14

Table 32: (ADMIN3): Quarterly, Bi-Annual and Annual Targets for 2013/14

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Number of progress reports on implementation of the 10-Point Plan	4	1	1	1	1
2. Vacancy rate for Professional Nurses	9%	9.2%	9.2%	9%	9%
3. Vacancy rate for Doctors	42%	43.5%	43.5%	43%	42%
4. Vacancy rate for Medical Specialists	44%	44.2%	44.1%	44%	44%
5. Vacancy rate for Pharmacists	28%	28.5%	28.5%	28.3%	28%
6. Number of District Health Councils established	9	3	3 (6)	3 (9)	-
7. Number of District Health Councils Meetings convened annually	9	3	3 (6)	3 (9)	-
Bi-Annual Targets					
8. Number of Provincial Health Council meetings	2	1	-	1	-
Annual Targets					
9. Medical officers per 100,000 people	27				27
10. Medical officers per 100,000 people in rural districts	12				12
11. Professional nurses per 100,000 people	130				130
12. Professional nurses per 100,000 people in rural districts	116				116
13. Pharmacists per 100,000 people	6				6
14. Pharmacists per 100,000 people in rural districts	4				4
15. Tabled Annual Performance Plan	2013/14 APP tabled	2013/14 APP tabled			
16. Number of approved District Health Plans	11	11			
17. Published STP	STP approved				STP approved
18. Number of District Managers who have signed Performance Agreements	11	11			
19. Number of Hospital Managers/ CEO's who have signed Performance Agreements	71	71			

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
20. Percentage of Head Office Managers (Level 13 and above) who have signed Performance Agreements	100% level 13 and above	100% level 13 and above			
21. Annual unqualified audit opinion for financial statements	Unqualified audit opinion	Unqualified audit opinion			
22. Number of District Health Expenditure Reviews (DHER) completed	11	11			
23. Annual unqualified audit opinion on performance information	Unqualified audit opinion	Unqualified audit opinion			
24. Tabled Annual Report	2012/13 Annual Report tabled	Annual Report tabled			
25. Number of functional Tele-Medicine sites	47				47
26. Number of Registrars in training	700				700
27. Number of Registrars retained after qualifying	75% of total graduates				75% of total graduates
28. Provincial Consultative Health Forum meetings convened annually	Convened annually	-	-	Meeting convened	

- Indicators 2-5: Vacancy rates are affected by abolishment of vacant posts and review of post establishments. Vacancy rates (and quarterly targets) will be reviewed in-year.
- Indicators 9-14: Population-based indicators will be reviewed using Census 2011 data to establish new baselines and targets (not included in this plan). The 2013/14 APP uses Stats SA 2011 mid-year estimates (aligned with current information systems) as per national directive.
- Indicators 26-27: Final data on the number of students that have graduated will only be available after publishing of the APP and will be reported on in the Annual Report.

1.8. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 33: (ADMIN4 (a): Summary of Payments and Estimates: Programme 1

Sub-Programme R' thousand	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
MEC's Office	12 441	14 452	15 615	20 318	20 318	20 318	18 419	19 269	20 302
Management	1 147 253	449 196	560 810	377 352	397 772	539 176	572 659	609 071	641 298
Sub-Total	**1 159 694**	**463 648**	**576 425**	**397 670**	**418 090**	**559 494**	**591 078**	**628 340**	**661 600**
Unauthorized expenditure (1st charge)	**(758 000)**	-	-	-	-	-	-	-	-

Sub-Programme R' thousand	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
not available for spending									
Total	**401 694**	**463 648**	**576 425**	**397 670**	**418 090**	**559 494**	**591 078**	**628 340**	**661 600**

Table 34: (ADMIN4 (b): Summary of payments and estimates by economic classification: Programme 1

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Current payments	**396 741**	**454 816**	**463 100**	**379 513**	**390 205**	**471 434**	**559 879**	**596 915**	**629 664**
Compensation of employees	168 705	183 201	208 965	238 456	247 382	247 382	273 032	292 087	309 793
Goods and services	**228 036**	**271 615**	**254 115**	**141 057**	**142 823**	**224 052**	**286 847**	**304 828**	**319 871**
Communication	6 109	5 130	3 210	4 687	5 200	5 200	6 888	7 207	7 541
Computer Services	111 269	76 119	144 531	27 371	20 000	102 718	147 719	156 353	168 675
Consultants, Contractors and special services	23 049	16 236	39 184	22 277	11 462	11 462	17 670	18 329	16 515
Inventory	5 795	5 581	7 991	8 713	8 876	8 876	10 231	11 597	12 518
Operating leases	34 735	63 064	6 392	5 807	6 600	4 378	6 731	7 538	7 942
Travel and subsistence	9 521	13 038	16 312	16 115	19 500	19 500	19 823	20 922	20 842
Interest and rent on land	-	-	20	-	-	-	-	-	-
Maintenance , repair and running costs	Included under Contractors and inventory to prevent double counting								
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	37 558	92 447	36 495	56 087	71 185	71 918	77 785	82 882	85 838
Transfers and subsidies to	**2 311**	**1 750**	**3 392**	**3 157**	**2 426**	**2 426**	**3 549**	**3 675**	**3 676**
Provinces and municipalities	38	33	26	57	39	39	43	44	45
Households	2 273	1 717	3 365	3 100	2 387	2 387	3 500	3 630	3 630
Payments for capital assets	**2 642**	**6 702**	**109 386**	**15 000**	**25 459**	**85 634**	**27 650**	**27 750**	**28 260**

PROGRAMME 1: ADMINISTRATION

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Machinery and equipment	2 642	6 702	109 386	15 000	25 459	85 634	27 650	**27 750**	28 260
Payment for financial assets	758 000	380	547	-	-	-	-	-	-
Total economic classification	**1 159 694**	**463 648**	**576 425**	**397 670**	**418 090**	**559 494**	**591 078**	**628 340**	**661 600**
Unauthorised expenditure (1st charge) not available for spending	(758 000)	-	-	-	-	-	-	-	-
Total economic classification	**401 694**	**463 648**	**576 425**	**397 670**	**418 090**	**559 494**	**591 078**	**628 340**	**661 600**

1.9. PERFORMANCE AND EXPENDITURE TRENDS

It is the Department's policy to keep the allocation for this programme to 2% of the total budget. In 2013/14 the programme has been allocated 2.06% of the vote compared to 2.02% in the 2012/13 revised estimates with expenditure showing a nominal increase of R31.584 million between 2012/13 and 2013/14.

The significant increase in *Compensation of Employees* over the 2013/14 MTEF (from R16 891 594 000 to R18 355 557 000) relate to the need to improve Senior Management capacity at Head Office in order to strengthen leadership and oversight.

Clean Audit 2014/15 requires strengthening of SCM and Asset Management functions, hence establishment of the Asset Management Unit.

Additional funding in the form of the NHI Conditional Grant was provided since 2012/13 to build capacity for implementation of the first phase of NHI in Umgungundlovu and Umzinyathi Districts, with Amajuba District being funded through equitable share. The Grant decreased from R33 million in 2012/13 to R9.7 million in 2013/14.

The budget for improvement of information technology (R25 million for equipment) has been consolidated under Programme 1 (previously within all programmes).

1.10. RISK MANAGEMENT

POTENTIAL RISKS	MITIGATING FACTORS
1. Inadequate alignment and integration (High).	• Implement the integrated planning framework that commenced in 2013/14.
2. Reconciliation of reduced budget with increasing system challenges and service demands (High).	• Review and refine internal planning processes. Process commenced in 2012/13.
3. Inadequate human resources and capacity at service delivery level partly due to non-alignment of human resource plans with service delivery (High).	• Implementation of the Human Resources for Health Strategy. • Implementation of the integrated planning framework with emphasis on human resources alignment. • Review strategies for allocation of bursaries and training of mid-level workers. • Partnership with UKZN to address supply versus demand.
4. Poor data quality - all information systems (High).	• Persal clean-up continue. • Review policies and SOPs to improve data quality.
5. Inadequate financial management capacity (High).	• Capacity development and mentoring.

PROGRAMME 2: DISTRICT HEALTH SERVICES

2.1. PROGRAMME PURPOSE AND STRUCTURE

Comprehensive, integrated, and sustainable health care services (preventive, promotive, curative, and rehabilitative) based on Primary Health Care (PHC) approach through District Health System (DHS).

Sub-Programme 2.1: District Management

To provide service planning, administration (including financial administration) managing personnel, coordination and monitoring of district health services, including those rendered by district councils and non-governmental organisations (NGO's).

Sub-Programme 2.2: Community Health Clinics

To render a nurse driven Primary Health Care services at the clinic level including visiting points, mobiles and Local Government clinics.

Sub-Programme 2.3: Community Health Centres

To render Primary Health Care services including Maternal, Child and Women's Health, Geriatrics, occupational therapy, physiotherapy, psychiatry, speech therapy, communicable diseases, oral and dental health, mental health, rehabilitation and disability and chronic health.

Sub-Programme 2.4: Community-Based Service

Render community based health services at non health facilities in respect of home based care, abuse, mental and chronic care, school health etc.

Sub-Programme 2.5: Other Community Services

To render health services at community level including environmental and port health services.

Programme 2.6: HIV and AIDS

To render Primary Health Care services related to comprehensive management of HIV and AIDS and other special projects.

Sub-Programme 2.7: Nutrition

To render nutrition services.

Sub-Programme 2.8: Forensic Pathology Services

To render forensic pathology and medico-legal services at district level.

Sub-Programme 2.9: District Hospitals

To render hospital services at General Practitioner level

There is no change in the purpose of Programme 2 since tabling of the 2010 - 2014 Strategic Plan.

Programme performance measures, not specifically identified as priority in the APP, are included in the Operational Plans and monitored quarterly to ensure effective performance monitoring. Specific output and outcomes will be included in the Annual Report.

2.2. PRIMARY HEALTH CARE

2.2.1. OVERVIEW

PHC services are provided by 582 fixed and 168 mobile clinics (Provincial and Local Government) in KwaZulu-Natal (*DHIS*). The distribution of these services (per Municipality) is reflected in Table 36.

Fifty six (56) Local Government (LG) clinics have been transferred to the Provincial Department of Health by the third quarter of 2012/13. Clinics in eThekwini Metro and Umhlathuze Municipality (Uthungulu) have not yet been provincialized. The Department will transfer R122 500 000 to eThekwini and R21 000 000 to Umhlathuze for the rendering of PHC services in 2013/14.

The PHC total headcount showed a 10.6% increase between 2010/11 and 2011/12 with more than 29.3 million clients visiting PHC services in 2011/12. The utilisation rate of 2.8 visits per client per year and 4.6 visits of children under 5 years is still considered low based on the increasing burden of disease in the Province (*DHIS*).

The positive growth in expenditure per headcount (from R86.90 to R106) and cost per uninsured person (from R222 to R350) shows a positive shift towards investment in PHC. There are however still significant variances between districts i.e. expenditure per headcount varied from R93 in eThekwini to R149 in Zululand and cost per capita from R426 in Uthukela to R608 in Umkhanyakude. The inverted relation between cost per headcount and Professional Nurse (PN) clinical workload is clear with PN workload fluctuating between 28.9 in Zululand and 40.4 in eThekwini (*DHER 2011*).

The Department commenced with the process to appoint District Health Councils and plans to finalise the appointment of 9 Councils by the end of 2013/14. Clinic Committees and Hospital Boards are appointed in terms of Section 41 of the National Health Act, 2003 (Act No. 63 of 2003) and Section 36 of the Provincial Health Act, 2009 (Act No. 1 of 2009).

District Health Plans have been aligned with the Annual Performance Plan to ensure appropriate allocation of resources and operationalisation of priority strategies and the Department is actively participating in the development of a Sector Integrated Planning Framework to improve integration of sector plans.

During 2012/13, the Department divided the 11 Districts into 4 geographic Regions to improve management and oversight.

Re-engineering of PHC, with the main focus on improving community-based services, was prioritised in 2012/13. The Department commenced with implementation of the four national pillars of PHC re-engineering i.e. PHC Outreach Teams, School Health Teams, District Specialist Teams and NHI pilots which will progressively increase over 2013/14. Mobile service coverage is currently jeopardised due to the ageing fleet of mobiles. Plans for the purchase of customised mobile clinics commenced in 2012/13 and was prioritised for 2013/14 MTEF.

Infrastructure Plans (maintenance, construction of new clinics and CHCs) have been reprioritised and aligned with Provincial and District Plans (within the funding envelope) to improve equity and access to PHC.

2.2.2. PHC CHALLENGES

- Inadequate integration of services.
- Lack of change management programmes to ensure the smooth transition from curative to community-based PHC.
- Inadequate infrastructure for health (space constraints impacting on pharmaceutical storage, access for people with disabilities, implementation of the full PHC package of services) and inadequate specialised rehabilitation Centre's in rural areas.
- Poor supervision and clinical governance.
- Human resource challenges including inequity in placement of staff, inadequate skills and competencies, shortage of critical skills e.g. Ophthalmologists, Therapists, etc.
- Inadequate, old and/or obsolete machinery and equipment and delays in repair and procurement.
- Considerable gaps in training and development including effective mentoring programmes and succession training; development of Operations Managers as first level managers (extended role in new PHC Model).
- Unintended consequences of OSD where PHC Supervisors opt for positions as Operational Managers and midwives prefer to work in hospitals.

2.2.3. 2013/14 PRIORITIES: PHC

PROVINCIAL PRIORITIES	PROVINCIAL KEY FOCUS AREAS
1. PHC re-engineering	• Finalise service arrangements for PHC re-engineering within the DHS Framework: – Finalise Regional Management service arrangements. – Strengthen NHI Phased roll-out in three pilot districts. – Finalise PHC post establishments and prioritise filling of critical posts. – Establish District Health Councils.
	• Expand implementation and integration of the three streams (pillars) of PHC re-engineering with other specialised teams e.g. Mobile Injection Teams, Roving Teams, Surveillance Teams, etc. • Scale up the integrated Healthy Lifestyle Strategy.
	• Conduct research (Epidemiology and Research Component): – Evaluate knowledge, attitudes and perceptions of clients and staff towards NHI in 3 pilot districts. Including components of PHC re-engineering. – Explore perceptions and experiences of Nurses and Community Care Givers about structure and functioning of district clinical support and PHC and School Health Teams (as part of PHC re-engineering).
	• Improve equity, access and efficiency of PHC services: – Infrastructure: Re-prioritisation of maintenance and new PHC facilities (within funding envelope). – Expand the mobile fleet and increase coverage of service points. – Allocation of basic essential equipment. – Human resources: Pilot WISN in NHI pilot districts to determine actual staffing gaps for prioritisation of critical posts. – Budget allocation: Improve alignment of service delivery and budget allocation, and sustain the integrated DHER process. Improve financial management at PHC level.
2. Improved Quality and Clinical Governance	• Implementation of the National Core Standards to improve: – Availability of medicines and supplies – Cleanliness – Patient safety – Infection prevention & control – Positive and caring staff attitudes – Patient waiting times
	• Improve clinical governance including supportive supervision and mentoring.

Table 35: (DHS1): District Health Service Facilities by Health Districts – 1 April 2012

Health District	Facility Types	Number Facilities	Sub-Districts Total fixed clinics in brackets	Total Population per Sub-District and District		Population per PHC Facility		Per capita utilisation
				DHIS Population	Census 2011 Population	DHIS Catchment	Census 2011 Catchment	
Ugu	Non-fixed Clinics [Mobiles]	15	Ezinqoleni (4)	58,759	52,540	14,690	13,135	2.8
	Fixed Clinics	56	Hibiscus Coast (18)	242,742	256,135	13,486	14,230	
	CHCs	2	Umdoni (6)	70,198	78,875	11,700	13,146	
	Total Fixed Clinics	***58***	uMuziwabantu (11)	98,838	96,556	8,985	8,778	
	District Hospitals	3	Umzumbe (14)	207,475	160,975	14,820	11,498	
			Vulamehlo (5)	89,987	77,403	17,997	15,481	
			Total Fixed Clinics (58)	**767,999**	**722,484**	**13,241**	**12,457**	
Umgungundlovu	Non-fixed Clinics [Mobiles]	15	Impendle (2)	38,376	33,105	19,188	16,553	2.7
	Fixed Clinics	53	Mkhambathini (4)	68,160	63,142	17,040	15,786	
	CHCs	3	Mooi Mpofana (3)	42,679	38,103	14,226	12,701	
	Total Fixed Clinics	***56***	Richmond (5)	72,898	65,793	14,580	13,159	
	District Hospitals	2	Msunduzi (31)	639,577	618,536	20,632	19,953	
			uMngeni (4)	85,439	92,710	21,360	23,178	
			uMshwathi (7)	124,471	106,374	17,782	15,196	
			Total Fixed Clinics (56)	**1,071,600**	**1,017,763**	**19,136**	**18,174**	
Uthukela	Non-fixed Clinics [Mobiles]	14	Emnambithi (13)	244,655	237,437	18,820	18,264	2.1
	Fixed Clinics	36	Imbabazane (5)	127,292	113,073	25,458	22,615	
	CHCs	1	Indaka (7)	118,763	103,116	16,966	14,731	
	Total Fixed Clinics	***37***	Okhahlamba (6)	146,724	132,068	24,454	22,011	
	District Hospitals	2	Umtshezi (6)	65,201	83,153	10,867	13,859	
			Total Fixed Clinics (37)	**702,645**	**668,848**	**18,990**	**18,077**	

Health District	Facility Types	Number Facilities	Sub-Districts Total fixed clinics in brackets	Total Population per Sub-District and District		Population per PHC Facility		Per capita utilisation
				DHIS Population	Census 2011 Population	DHIS Catchment	Census 2011 Catchment	
Umzinyathi	Non-fixed Clinics [Mobiles]	11	Endumeni (7)	61,592	64,862	8,799	9,266	2.7
	Fixed Clinics	45	Msinga (15)	185,328	177,577	12,355	11,838	
	CHCs	0	Nquthu (12)	164,675	165,307	13,723	13,776	
	Total Fixed Clinics	***45***	Umvoti (11)	106,212	103,093	9,656	9,372	
	District Hospitals	4	**Total Fixed Clinics (45)**	**517,807**	**510,838**	**11,507**	**11,352**	
Amajuba	Non-fixed Clinics [Mobiles]	7	Dannhauser (9)	112,587	102,161	12,510	11,351	4.1
	Fixed Clinics	24	Emadlangeni (2)	36,092	34,442	18,046	17,221	
	CHCs	0	Newcastle (13)	368,605	363,236	28,354	27,941	
	Total Fixed Clinics	***24***	**Total Fixed Clinics (24)**	**517,284**	**499,839**	**21,554**	**20,827**	
	District Hospitals	1						
Zululand	Non-fixed Clinics [Mobiles]	16	Abaqulusi (14)	209,072	211,060	14,934	15,076	2.3
	Fixed Clinics	62	eDumbe (6)	88,654	82,053	14,776	13,676	
	CHCs	1	Nongoma (11)	208,062	194,908	18,915	17,719	
	Total Fixed Clinics	***63***	Ulundi (22)	225,927	188,317	10,269	8,560	
	District Hospitals	5	uPhongolo (10)	130,397	127,238	13,040	12,724	
			Total Fixed Clinics (63)	**862,112**	**803,575**	**13,684**	**12,755**	
Umkhanyakude	Non-fixed Clinics [Mobiles]	16	Hlabisa (5)	102,875	71,925	20,575	14,385	3.2
	Fixed Clinics	56	Jozini (18)	215,490	186,502	11,972	10,361	
	CHCs	0	Mtubatuba (12)	146,520	175,425	12,210	14,619	
	Total Fixed Clinics	***56***	The Big 5 (3)	37,140	35,258	12,380	11,753	
	District Hospitals	5	UMhlabuyalingana (18)	164,496	156,736	9,139	8,708	
			Total Fixed Clinics (56)	**666,521**	**625,846**	**11,902**	**11,176**	

Health District	Facility Types	Number Facilities	Sub-Districts Total fixed clinics in brackets	Total Population per Sub-District and District		Population per PHC Facility		Per capita utilisation
				DHIS Population	Census 2011 Population	DHIS Catchment	Census 2011 Catchment	
Uthungulu	Non-fixed Clinics [Mobiles]	17	Mbonambi (7)	117,552	122,889	16,793	17,556	2.6
	Fixed Clinics	60	Mthonjaneni (4)	55,698	47,818	13,925	11,955	
	CHCs	1	Nkandla (19)	143,582	114,416	7,557	6,022	
	Total Fixed Clinics	***62***	Ntambanana (5)	96,701	74,336	19,340	14,867	
	District Hospitals	6	uMhlathuze (12)	323,586	334,459	26,966	27,872	
			uMlalazi (15)	242,394	213,602	16,160	14,240	
			Total Fixed Clinics (62)	**979,513**	**907,519**	**15,799**	**14,637**	
Ilembe	Non-fixed Clinics [Mobiles]	10	KwaDukuza (9)	183,604	231,187	20,400	25,687	3.1
	Fixed Clinics	33	Mandeni (8)	146,413	138,078	18,302	17,260	
	CHCs	2	Maphumulo (10)	132,126	96,724	13,213	9,672	
	Total Fixed Clinics	***35***	Ndwedwe (8)	170,310	140,820	21,289	17,603	
	District Hospitals	3	**Total Fixed Clinics (35)**	**632,453**	**606,809**	**18,070**	**17,337**	
Sisonke	Non-fixed Clinics [Mobiles]	12	Greater Kokstad (2)	64,557	65,981	32,279	32,991	2.2
	Fixed Clinics	36	Ingwe (9)	115,142	100,548	12,794	11,172	
	CHCs	1	Kwa Sani (2)	17,875	12,898	8,938	6,449	
	Total Fixed Clinics	***37***	Ubuhlebezwe (9)	109,885	101,691	12,209	11,299	
	District Hospitals	4	UMzimkhulu (15)	204,498	180,302	13,633	12,020	
			Total Fixed Clinics (37)	**511,957**	**461,419**	**13,837**	12,471	
eThekwini	Non-fixed Clinics [Mobiles]	35	**Total Fixed Clinics (109)**	**3,474,029**	**3,442,361**	**31,872**	**31,581**	3.1
	Fixed Clinics	101						
	CHCs	8						
	Total Fixed Clinics	***109***						

Health District	Facility Types	Number Facilities	Sub-Districts Total fixed clinics in brackets	Total Population per Sub-District and District		Population per PHC Facility		Per capita utilisation
				DHIS Population	Census 2011 Population	DHIS Catchment	Census 2011 Catchment	
	District Hospitals	2						
Province	**Non-fixed Clinics (Mobiles)**	**168**	**Total Fixed Clinics (582)**	**10,703,920**	**10,267,300**	**18,392**	**17,641**	**2.7**
	Fixed Clinics	**563**						
	CHCs	**19**						
	Total Fixed Clinics	***582***						
	District Hospitals	**37**						

Source: DHIS

- Rural Development Nodes are shaded in light tan (including Umzimkhulu Municipality in the Sisonke District).
- Facilities per district include Provincial and LG facilities as per DHIS to ensure consistent reporting. For purposes of planning, other services (including NGO's) are considered based on the package of services that are provided.
- Average catchment population per fixed facility is a broad measure to inform strategies targeting equity and access. This is however not an accurate measure of the actual catchment population.

2.2.4. SITUATION ANALYSIS INDICATORS FOR DISTRICT HEALTH SERVICES – 2011/12

Table 36: (DHS2): Situation Analysis Indicators for District Health Services – 2011/12

Indicators	Data Source	Type	Provincial 2011/12	Ugu 2011/12	Umgungundlovu 2011/12	Uthukela 2011/12	Umzinyathi 2011/12	Amajuba 2011/12	Zululand 2011/12	Umkhanyakude 2011/12	Uthungulu 2011/12	Ilembe 2011/12	Sisonke 2011/12	eThekwini 2011/12	National average 2011/12
1. Provincial PHC expenditure per uninsured person	BAS/ StatsSA	R	R 350	R 352	R 339	R 270	R 350	R 270	R 386	R 346	R 315	R 377	R 366	R 315	-
2. PHC Total Headcount	DHIS	No	29,314,618	2,095,450	2,924,108	1,476,892	1,418,983	1,111,253	1,954,753	2,097,010	2,555,330	1,941,212	1,167,686	10,571,941	-

Indicators	Data Source	Type	Provincial 2011/12	Ugu 2011/12	Umgungundlovu 2011/12	Uthukela 2011/12	Umzinyathi 2011/12	Amajuba 2011/12	Zululand 2011/12	Umkhanyakude 2011/12	Uthungulu 2011/12	Ilembe 2011/12	Sisonke 2011/12	eThekwini 2011/12	National average 2011/12
3. PHC total headcount under 5 years	DHIS	No	5,161,689	355,425	450,858	315,207	340,150	210,870	367,677	400,518	484,647	340,231	246,000	1,650,106	-
4. Utilisation rate - PHC	DHIS	Rate	2.7	2.8	2.7	2.1	2.7	4.1	2.3	3.2	2.6	3.1	2.2	3.1	2.5
5. Utilisation rate under 5 years - PHC	DHIS	Rate	4.6	4.5	4.2	4.1	5.1	2.2	3.5	4.8	4.5	5.3	3.7	5.4	4.7
6. Fixed PHC facilities monthly supervisory visit rate	DHIS	Rate	62.2%	59%	45%	33.6%	76.9%	62.5%	55.5%	98.7%	81.2%	60.1%	75.5%	50.6%	-
7. Expenditure per PHC headcount	BAS/ DHIS	R	R 106	R 113	R 109	R 112	R 112	R 110	R149	R 96	R 106	R 108	R 140	R 90	-
8. Percentage of complaints of users of PHC services resolved within 25 days.	DHIS	%	76%	74%	No data	53%	100%	78%	79%	83%	57%	85%	77%	78%	-
9. Number of PHC facilities assessed for compliance against the 6 priorities of the core standards	DQPR Assess-ment Reports	No	481	55	24	36	42	24	29	42	48	34	37	110	-

2.2.5. PERFORMANCE INDICATORS FOR DISTRICT HEALTH SERVICES

Table 37: (DHS4): Performance Indicators for District Health Services

Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2015/16
1. Provincial PHC expenditure per uninsured person[22]	BAS/ Stats SA	R	R 260.26	R 222	R 350 N: R3 113 614 D: 8,895,443	**R 320** *Mid-Year R 296* *N:R2 819 299 075* *D:9,526,488*	R 516 N: R4 918 922 000	R 562 N: R5 362 369 000	R 592 N: R5 647 974 000	-
2. PHC total headcount *(PHC Headcount total)**	DHIS	No	25,921,993	26,494,623	29,314,618	**31,256,624** *Mid-Year: 15,628,312*	34,032,545	36,755,141	39,695,560	-
3. PHC total headcount under 5 years *(PHC headcount under 5 years)**	DHIS	No	5,184,242	5,065,881	5,161,689	**5,252,160** *Mid-Year 2,626,080*	5,511,337	5,676,677	5,846,977	-
4. Utilisation rate – PHC *(PHC utilisation rate (annualised))**	DHIS	Rate	2.6	2.5	2.7 N:29,314,618 D:10,622,204	**2.9** *Mid-Year 2.9 (annualised)* *N:15,626,312* *D:10,703,920*	3	3.1	3.1	3.5
5. Utilisation rate under 5 years – PHC *(PHC utilisation rate under 5 years (annualized))**	DHIS	Rate	4.6	4.5	4.6 N: 5,161,689 D: 1,118,510	**4.8** *Mid-Year 4.8 (annualised)* *N: 2,626,080* *D: 1,104,898*	5	5	5	5.5
6. Fixed PHC facilities monthly supervisory visit rate *(PHC supervisor visit rate (fixed clinic / CHC / CDC))**	DHIS	Rate	68%	63.3%	62.2% N: 4,578 D: 7,356	**66%** *Mid-Year 64%* *N: 2,205* *D: 3,445*	68%	70%	73%	100%

[22] Included are clinics, CHC's, district management, community based services and other community based services

Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2015/16
7. Percentage of complaints of users of PHC services resolved within 25 days. *(Complaints resolution within 25 working days rate)**	DHIS	%	Not reported	Not reported	76% N: 2,389 D: 3,142	**72.5%** Mid-Year: 72.5% N: 2,921 D: 4,030	75%	80%	85%	-
8. Number of PHC facilities assessed for compliance against the 6 priorities of the core standards	Assessment Reports	No	Not reported	Not reported	481	**582** *Mid-Year 241* *N: 241* *D: 582*	582 (100% facilities)	582 (100% facilities)	582 (100% facilities)	All facilities

- Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Abbreviations to indicate raw data: N = Numerator; D = Denominator
- Indicator 1: Expenditure trends will be monitored in 2013/14 to establish new baselines based on improved methodology to determine actual cost
- Note: The use of 2011 mid-year population estimates (Stats SA) will have an impact on population-based indicators (baselines and targets) in 2013/14. Indicators will therefore be reviewed in-year using Census 2011 data.
- Note (*): Indicators indicted in italics (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current indicators from April 2013. Changes are in line with the reviewed national customised APP Template dated 18th February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

2.2.6. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR DISTRICT HEALTH SERVICES

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 38: (DHS3 (a)): Provincial Strategic Objectives, Indicators and Annual Targets for District Health Services

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Sources	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
1.9) Strengthen governance structures in line with the National Health Act, 2003 and social compact for health.	1.9.1) Percentage of clinics with functional Clinic Committees	50%[23] Target reviewed 2013/14	DQPR Clinic Records	82% N: 437 D: 533	56.9% N: 337 D: 592	74% N: 351 D: 470[24]	**80%** *Mid-Year 75.6%* *N: 440* *D: 582*	100%	100%	100%
	1.9.2) Percentage of CHCs with functional Clinic Committees	100%	DQPR Clinic Records	81% N: 14 D: 17[25]	43.7% N: 7 D: 16	37% N: 7 D: 19	**100%** *Mid-Year 84%* *N: 16* *D: 19*	100%	100%	100%
1.10) Revitalisation of PHC services as per STP imperatives and Implementation Plan[26]	1.10.1) Number of accredited Health Promoting Schools	APP	DQPR Health Promotion database	170 cumulative	188 cumulative	210 cumulative	**15 (225)** *Mid-Year 13 (223 cum)*	12 (240 cum)	15 (255 cum)	15 (285 cum)
	1.10.2) School Health Services coverage *(School ISHP Coverage (annualised))**	APP	DQPR DHIS from 2013/14	74%	50.3%	54.9% N: 2,268 D: 4,124	**64.9%** *Mid-Year 32.5%*[27] *N: 1,438* *D: 4,425*	70%	76%	76%
	1.10.3) Number of operational PHC Outreach Teams	APP	DQPR	N/A	N/A	12	**40** *Mid-Year 35*	46 (86 cum)	51 (137 cum)	51 (188 cum)

[23] The Strategic Plan targets (for both clinics and CHCs) were based on appointment of Committees as per National Health Act, 2003. Since promulgation of the KZN Health Act, 2009 (Act No. 1 of 2009) in September 2012, it is possible to comply with the Act and targets were therefore reviewed

[24] Provincial clinics and state-aided clinics have been included – Local Government clinics NOT INCLUDED in denominator

[25] Embo CHC reclassified as clinic in 2010/11 based on efficiency and utilisation measures

[26] All included indicators will serve to demonstrate the impact of revitalisation (and overhaul of health systems/services) on equity, availability, efficiency and quality of services. Improvement of routine PHC services e.g. immunisation coverage, management of chronic conditions, etc. will be monitored to determine the outcome of revitalisation. Timeframes will be determined by the PHC strategy and STP Implementation Plan

[27] Data for 2012/13 refers to quintile 1 and 2 schools only

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Sources	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
	1.10.4) Number of operational School Health Teams	APP	DQPR	N/A	N/A	86	**142 cum** *Mid-Year 137*	37 (179 cum)	37 (196 cum)	69 (265 cum)
	1.10.5) Number of operational District Specialist Teams	APP	DQPR	N/A	N/A	0	**11** *Mid-Year 11*[28]	11	11	11
	1.10.6) Dental extraction to restoration rate *(Dental extraction to restoration ratio)**	APP	DHIS	20:1	27:1	20:1	**15:1** *Mid-Year 15:1* *N: 229,319* *D: 15,057*	14:1	12:1	10:1
	1.10.7) Dental headcount	APP	DHIS	432,251	454,309	653,139	**546,730** *Mid-Year: 273,365*	557,664	568,817	580,193
	1.10.8) PHC budget as % of total budget[29]	49% Target reviewed (2013/14) based on inclusion criteria	BAS	25.1% N:R4 599 822 D: R18 329 163 (R'000)	23.7% N: R4 901 489 D: R20 678 687 (R'000)	23.3% N: R5 766 524 D: R24 791 118 (R'000)	**24.66%** N: R12 126 929 D: R27 430 930 (R'000)	26.11% N: R13 090 416 D: R28 765 677 (R'000)	27% N: R14 070 672 D: R30 544 555 (R'000)	36.54% N: R14 706 475 D: R31 810 184 (R'000)

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator
- Indicators 1.10.3 and 1.10.4: Targets for the appointment of teams will be reviewed based on the funding envelope (outer years) as well as availability of human and other resources. Targets are idealistic (taking into consideration progressive budget cuts over the MTEF) however justified as requirement for improved service delivery. Districts might however use existing staff members in new teams – which will not require additional funding for appointments.
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

[28] All districts commenced with the appointment of District Specialist Teams although all teams are not fully inclusive of the prescribed composition of teams. The estimated performance refers to "incomplete" teams. See Part A for details.

[29] Sub-programmes 2.2 (Clinics), 2.3 (CHC's), 2.4 (Community Services), 2.5 (Other Community Based Services), 2.6 (HIV & AIDS) & 2.7 (Nutrition) were included in the calculation. District Management (2.1), Forensic Pathology (2.8) and District Hospitals (2.9) were excluded from PHC budget

GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

Table 39: (DHS3 (b)): Provincial Strategic Objectives, Indicators and Annual Targets for District Health Services

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2016/16
2.1) To implement the National Core Standards for Quality in 100% of facilities towards accreditation of 10% PHC clinics and 100% CHC's and 100% District Hospitals by 2014/15[30]	2.1.1) Percentage of clinics fully compliant with the 6 priorities of the National Core Standards	10%	DQPR Quality Control database	Reporting not required	0%	0%	**0%** *Mid-Year 0%*	5%	10%	20%
	2.1.2) Percentage of CHCs fully compliant with the 6 priorities of the National Core Standards	100%	DQPR Quality Control database	Reporting not required	0%	0%	**0%** *Mid-Year 0%*	44%	100%	100%
	2.1.3) Percentage of CHCs conducting annual Patient Satisfaction Survey's	100%	DQPR Patient Satisfaction Survey	70.5% N: 12 D: 17[31]	62.5% N: 10 D: 16	89% N: 17 D: 19	**100%** *Mid-Year 79%* *N: 15* *D: 19*	100%	100%	100%

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator
- Indicators 2.1.1 and 2.1.2 are dependent on National processes (National Office of Standard Compliance). The Province ensures that local processes are in place to work towards full compliance with national norms and standards through on-going monitoring and assessment of compliance. The Core Standard Assessment Tools and Quality Improvement Plans form part of ongoing Quality Assurance activities and are monitored at facility, district and provincial levels

[30] Official aaccreditation of facilities is dependent on national processes i.e. establishment of the National Accreditation Board and capacity to comply with demand for accreditation
[31] Embo CHC was reclassified as a PHC clinic in 2010/11

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

Table 40: (DHS3 (c)): Provincial Strategic Objectives and Annual Targets for District Health Services

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
3.3) To prevent and manage non-communicable diseases with a focus on hypertension and diabetes	1.10.5) Diabetes mellitus patients on treatment – new *(Diabetes client treatment new)**	APP	DHIS	32,345	31,673	23,307	**25,664** *Mid-Year 12,832*	25,151	24,648	24,155
	1.10.6) Hypertension patients on treatment – new *(Hypertension client treatment new)**	APP	DHIS	74,671	70,973	70,821	**62,630** *Mid-Year 31,315*	61,377	60,377	58,947

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Diabetes and hypertension data will be closely monitored (as part of Output 5) to determine the impact of improved community-based PHC on disease trends and outcomes. Targets will be reviewed based on evidence.
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

2.2.7. QUARTERLY AND ANNUAL TARGETS FOR PHC – 2013/14

Table 41: (DHS5): Quarterly and Annual Targets for District Health Services 2013/14

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. PHC total headcount *(PHC headcount total)**	34,032,545	8,508,137	8,508,136	8,508,136	8,508,136

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
2. PHC total headcount under 5 years *(PHC headcount under 5)**	5,511,337	1,313,040	1,313,040	1,313,040	1,313,040
3. Provincial PHC expenditure per uninsured person	R 516[32]	R 516	R 516	R 516	R 516
4. Utilisation rate – PHC *(PHC utilisation rate (annualised))**	3	2.9	2.9	2.9	3
5. Utilisation rate under 5 years – PHC *(PHC utilisation rate under 5 (annualised))**	5	4.8	4.8	4.8	5
6. Fixed PHC facilities monthly supervisory visit rate *(PHC supervisor visit rate (fixed clinic / CHC / CDC))**	68%	64%	68%	72%	68%
7. Percentage of complaints of users of PHC services resolved within 25 days. *(Complaints resolution within 25 working days rate) **	75%	73%	73.5%	75%	75%
8. School health services coverage *(School ISHP coverage (annualised))**	70%	65%	67%	69%	70%
9. Dental extraction to restoration rate *(Dental extraction to restoration ratio)**	14:1	15:1	14.7:1	14.4:1	14:1
10. Dental headcount	557,664	139,416	139,416	139,416	139,416
11. Diabetes mellitus patients treatment – new *(Diabetes client treatment new)**	25,151	6,287	12,574	18,861	25,151
12. Hypertension patients treatment – new *(Hypertension client treatment new)**	61,377	15,344	30,688	46,032	61,377
Annual Targets					
13. Number of PHC facilities assessed for compliance against the 6 priorities of the Core Standards	582 (100%)				582 (100%)
14. Percentage of clinics with functional Clinic Committees	100%				100%
15. Percentage of CHCs with functional Clinic Committees	100%				100%
16. Number of accredited Health Promoting Schools	12 (240 cumulative)				12 (240 cumulative)

[32] Expenditure trends will be monitored in 2013/14 to confirm new baselines based on the improved methodology to determine actual cost. New Census 2011 data will inadvertently impact on baseline which will be adjusted

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
17. Number of operational PHC Outreach Teams	46				46
18. Number of operational School Health Teams	37				37
19. Number of operational District Specialist Teams	11				11
20. PHC budget as percentage of total budget	26.11%[33]				26.11%
21. Percentage of clinics fully compliant with the 6 priorities of the National Core Standards	5%				5%
22. Percentage of CHCs fully compliant with the 6 priorities of the National Core Standards	44%				44%
23. Percentage of CHCs conducting annual Patient Satisfaction Surveys	100%				100%

- Note: Baselines and targets have been based on mid-year 2011 population estimates. Census 2011 will have an impact on population-based data during 2013/14.
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

2.2.8. RISK MANAGEMENT – PHC

POTENTIAL RISKS	MITIGATING FACTORS
1. Inadequate integration of services at service delivery level (High).	• Implementation of integrated PHC re-engineering strategy.
2. Poor quality of data (all information systems) affecting planning, decision-making, budget allocation, and audit outcomes (High).	• Implementation of an integrated information management strategy linked with Clean Audit 2014/15.
3. Increasing burden of disease without concomitant allocation of resources (High).	• Alignment of service delivery and budget allocation. • Re-prioritisation and robust monitoring, evaluation and reporting to inform forward planning
4. Resource allocation not aligned with demand at service delivery level (High).	• Implementation of the Human Resources for Health Strategy (including alignment of HR Plan). • Re-prioritisation of budget allocation based on service demand and priority. • Partnership with UKZN to improve supply of health professionals according to need.

[33] Not including the complete Programme 2 budget (excluding District Hospitals and Coroner Services)

2.3. DISTRICT HOSPITALS

2.3.1. OVERVIEW

There are 37 Public District Hospitals in the Province supported by 3 State Aided District Hospitals (2 in eThekwini and 1 in Zululand). There are currently 9,113 approved district hospital beds translating to 0.85 beds per 1000 population (compared with the provincial STP norm of 0.66 beds per 1000 population).

The basic District Hospital package of services includes emergency medical services, adult and child in-patient and out-patient services as well as obstetric care. A number of hospitals provide varying general specialist services to improve access to services especially taking into consideration historic distribution of hospitals in the province.

Revitalisation of District Hospital services, as part of the strengthening of the District Health System, commenced in 2012/13 and has been prioritised for 2013/14.

King George V Hospital has been officially renamed to King Dinuzulu Hospital in January 2013.

2.3.2. CHALLENGES – DISTRICT HOSPITALS

- Inadequate human resource distribution and capacity impacting on availability of the full package of District Hospital services, inequities in workload, poor clinical governance, inadequate PHC outreach and support, and sub-optimal response to the burden of disease.
- Poor hospital efficiencies (including low inpatient bed utilisation) in the majority of District hospitals.
- Inadequate management capacity and development and mentoring programmes.

2.3.3. 2013/14 PRIORITIES: DISTRICT HOSPITALS

PROVINCIAL PRIORITIES	PROVINCIAL KEY FOCUS AREAS
1. Revitalisation of District Hospital services	• Finalise service delivery platform for District Hospitals including reviewed designation; post establishments; package of services; bed allocation; and referral arrangements. • Improved access to Step-Down Care. • Implement communication strategy to improve community consultation in transformation of services. • Critical review of efficiency indicators.
	• Improve human resources for health in District Hospitals – Gap analysis (WISN) to determine human resource needs and demands per facility. – Re-prioritisation of critical posts according to funding envelope. – Fast track management development programmes. – Partnership with UKZN to improve supply and development of critical occupations.
	• Fast-track infrastructure projects to improve functionality of facilities (within funding envelope).
	• Develop Vision Centres (high volume cataract and refraction services) at District Hospitals.
2. Improve quality and efficiency	• Implement the National Core Standards (including Make me Look Like a Hospital) to improve: – Availability of medicines and supplies. – Cleanliness. – Patient safety. – Infection prevention & control.

PROVINCIAL PRIORITIES	PROVINCIAL KEY FOCUS AREAS
	– Positive and caring staff attitudes. – Patient waiting times.
	• Institutionalise the Clinical Governance Policy and improve clinical support through Telemedicine and support from District Specialist Teams.
	• Improve service arrangements for outreach services to PHC facilities including Flying Doctors, Rehabilitation Teams, Social Workers, etc. and outreach from Regional to District Hospitals.

2.3.4. SITUATION ANALYSIS INDICATORS FOR DISTRICT HOSPITALS – 2011/12

Table 42: (DHS6): Situation Analysis Indicators for District Hospitals – 2011/12

Indicators	Data Source	Type	Provincial 2011/12	Ugu 2011/12	Umgungundlovu 2011/12	Uthukela 2011/12	Umzinyathi 2011/12	Amajuba 2011/12	Zululand 2011/12	Umkhanyakude 2011/12	Uthungulu 2011/12	Ilembe 2011/12	Sisonke 2011/12	eThekwini 2011/12	National 2011/12
1. Caesarean section rate	DHIS	Rate	26%	33.9%	23.5%	23.9%	23%	19.9%	22.1%	22.3%	25%	21.5%	26.9%	35.8%	15% or above
2. Separations - total	DHIS	No	337,550	33,468	28,795	18,949	41,391	3,714	48,304	43,327	33,647	12,095	29,667	44,171	-
3. Patient day equivalents	DHIS	No	2,990,662	304,910	244,860	156,223	355,140	31,312	389,572	388,612	352,406	124,507	247,649	390,856	-
4. OPD total headcount	DHIS	No	2,698,087	243,925	268,314	134,374	313,609	59,717	207,292	337,166	359,997	130,853	177,889	454,998	-
5. Average length of stay	DHIS	Days	5.8 Days	6.3 Days	4.6 Days	5.6 Days	5.7 Days	2.8 Days	6.4 Days	6.3 Days	6.7 Days	6.6 Days	5.9 Days	4.7 Days	3.5 Days
6. Bed utilisation rate	DHIS	Rate	63.7%	71.5%	69.1%	64.1%	55%	54.6%	68.9%	60.8%	51.5%	55.9%	65%	74.2%	75%
7. Expenditure per patient day equivalent	DHIS/ BAS	R	R 1 593	R 1 084	R 1 965	R 1 414	R 1 271	R 8 758	R 1 575	R 1 289	R 1 729	R 1 535	R 1 258	R 1 870	-
8. Percentage of complaints of users of District Hospitals services resolved within 25 days	DHIS	%	68.2%	39%	97%	48%	68%	94%	79%	81%	65%	90%	76%	96%	100%

Indicators	Data Source	Type	Provincial 2011/12	Ugu 2011/12	Umgungundlovu 2011/12	Uthukela 2011/12	Umzinyathi 2011/12	Amajuba 2011/12	Zululand 2011/12	Umkhanyakude 2011/12	Uthungulu 2011/12	Ilembe 2011/12	Sisonke 2011/12	eThekwini 2011/12	National 2011/12
9. Percentage of district hospitals with monthly mortality and morbidity meetings	DHIS	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-
10. District Hospital Patient satisfaction rate	Patient Satisfaction Module	Rate	78%[34]	89%	70%	No data	90%	100%	51%	90%	81%	No data	78%	No data	-
11. Number of District Hospitals assessed for compliance against the 6 Priorities of the core standards	DQPR Assess-ment Reports	No	37/37	3/3	2/2	2/2	4/4	1/1	5/5	5/5	6/6	3/3	4/4	2/2	-

[34] Data incomplete and based on information received from 8 districts

2.3.5. PERFORMANCE INDICATORS FOR DISTRICT HOSPITALS

Table 43: (DHS8): Performance Indicators for District Hospitals

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2015/16
1. Caesarean Section Rate *(Delivery by caesarean section rate)**	DHIS	Rate	26.5%	27.4% N: 23,461 D: 85,728	26% N: 22,819 D: 87,843	**26%** *Mid-Year 26.7%* *N: 12,200 D: 45,723*	25.5%	25%	24.5%	15% or above
2. Separation *(Inpatients Separations – total) **	DHIS	No	350,524	331,419	337,550	**352,958** *Mid-Year 176,479*	374,671	391,014	406,269	-
3. Patient day equivalents	DHIS	No	3,023,443	3,002,516	2,990,662	**2,946,168** *Mid-Year 1,473,084*	3,080,078	3,121,372	3,142,305	-
4. OPD total headcount *(OPD headcount – total)**	DHIS	No	3,069,671	2,664,297	2,698,087	**2,683,494** *Mid-Year 1,341,747*	2,738,534	2,754,015	2,767,953	-
5. Average length of stay *(Average length of stay – total)**	DHIS	Days	4.7 Days	6.1 Days[35]	5.8 Days	**5.5 Days** *Mid-Year 5.6 Days* *N: 982,361 D: 176,479*	5.4 Days	5.2 Days	5 Days	3.5 Days
6. Bed utilisation rate *(Inpatient Bed utilisation rate – total)**	DHIS	%	65.4%	63.8%	63.7%	**63%** *Mid-Year 62.7%* *N: 982,361 D: 1,566,215*	66%	69%	72%	75%
7. Expenditure per patient day equivalent (PDE)	DHIS/ BAS	R	R 1 639	R 1 668	R 1 593 N:R4 763 328 599 D: 2,990,662	**R1 650**[36] *Mid-Year R 1,517* *N: R2 235 029 411 D: 1,473,084*	R 1 714 N:R5 279 319 000 D: 3,080,078	R 1 788 N:R5 579 950 00 0 D: 3,121,372	R 1 873 N:R5 884 235 000 D: 3,142,305	-

[35] This data is questionable when reviewed in relation to the disruptions experienced by the Health Section during the Public Servants Strike
[36] Expenditure/cost will be closely monitored during 2013/14 to make provision for improved methodologies to determine actual cost

PROGRAMME 2: DISTRICT HEALTH SERVICES

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2015/16
8. Percentage of complaints of users of District Hospital services resolved within 25 days. *(Complaint resolution within 25 working days rate)**	DHIS	%	79%	78%	68.2% N: 1,585 D: 2,321	**69.5%** *Mid-Year 69.3%* *N: 746* *D: 1,077*	75%	80%	85%	100%
9. Percentage of District Hospitals with monthly mortality and morbidity meetings *(Mortality and morbidity review rate)**	DHIS	%	Reporting not required	93%	100% (37/37)	**100%** *Mid-Year 97.3%* *N: 36* *D: 37*	100%	100%	100%	All District Hospitals
10. District Hospital Patient Satisfaction Rate *(Patient Satisfaction Rate)**	DHIS	Rate	Reporting not required	Reporting not required	78%	**No data available**	100%	100%	100%	-
11. Number of District Hospitals assessed for compliance against the 6 priorities of the Core Standards *(Number of Hospitals assessed for compliance against the 6 priorities of the Core Standards)**	DQPR	No	Reporting not required	Reporting not required	37	**37** *Mid-Year 37*	37	37	37	-

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator
- There are still significant efficiency variances between individual hospitals which are being addressed as part of the strategy to strengthen the District Health System. Inequities in allocation of resources, utilisation and optimisation of existing resources, and capacity development forms part of strategy going forward.
- Indicator 1: The Caesarean section rate still exceeds the national target partly attributed to the high burden of disease necessitating the procedure. This is monitored as part of the MC&WH Programme strategy.
- Indicators 2-4: Trends in hospital activity is expected to change in line with improved access and quality of PHC services. This is closely monitored as part of PHC re-engineering to inform evidence-based targets.
- Indicator 7: Expenditure is more accurate than previous reporting cycles. Budget includes NHLS, NPI (Non-Profit Institutions), HTS (Health Technology Services) - done per budget allocation at sub-programme level "District Hospital".
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

2.3.6. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR DISTRICT HOSPITALS

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 44: (DHS7 (a)): Provincial Strategic Objectives and Annual Targets for District Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
1.9) Strengthen governance structures and social compact for health.	1.9.3) Percentage of District Hospitals with functional Hospital Boards	100%	DQPR	100% N: 37 D: 37	100% N: 37 D: 37	92% N: 34 D: 37	**100%** *Mid-Year 100%* *N: 37* *D: 37*	100%	100%	100%

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator

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

Table 45: (DHS7 (b)): Provincial Strategic Objectives and Annual Targets for District Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
2.2) To implement the National Core Standards in 100% of facilities towards accreditation of 100% District Hospitals by 2014/15[37]	2.2.1) Number of District Hospitals fully compliant with the 6 priorities of the National Core Standards	37/ 37	DQPR	Reporting not required	0	0	**0** *Mid-Year 0*	7/37	37/37	37/37

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.

[37] Official accreditation is dependent on national processes – province is monitoring compliance routinely

2.3.7. QUARTERLY AND ANNUAL TARGETS FOR DISTRICT HOSPITALS – 2013/14

Table 46: (DHS9): Quarterly and Annual Targets for District Hospitals 2013/14

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Caesarean Section Rate *(Delivery by caesarean section rate)**	25.5%	26 %	26%	25.5%	25.5%
2. Separations *(Inpatient separations – total)**	374,671	93,667	187,335	281,002	374,671
3. Patient day equivalents	3,080,078	770,019	1,540,039	2,310,057	3,080,078
4. OPD total headcount *(OPD headcount – total)**	2,738,534	684,633	1,369,266	2,053,899	2,738,534
5. Average length of stay *(Average length of stay – total)**	5.4 Days	5 .6 Days	5.4 Days	5.2 Days	5.4 Days
6. Bed utilisation rate *(Inpatient Bed utilisation rate – total)**	66%	63.5%	64.1%	66.1%	66%
7. Expenditure per patient day equivalent	R 1 714	R 1 714	R 1 714	R 1 714	R 1 714
8. Percentage of complaints of users of District Hospital services resolved within 25 days. *(Complaint resolution within 25 working days rate)**	75%	75%	75%	75%	75%
9. Percentage of District Hospitals with monthly mortality and morbidity meetings *(Mortality and morbidity review rate)**	100%	100%	100%	100%	100%
Annual Targets					
10. District Hospital Patient Satisfaction Rate *(Patient Satisfaction Rate)**	100%				100%
11. Number of District Hospitals assessed for compliance against the 6 priorities of the Core Standards *(Number of Hospitals assessed for compliance against the 6 priorities of the Core Standards)**	37				37
12. Percentage of District Hospitals with functional Hospital Boards	100%				100%
13. Number of District Hospitals compliant with the 6 priorities of the National Core Standards	7				7

- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

2.3.8. RISK MANAGEMENT – DISTRICT HOSPITALS

POTENTIAL RISKS	MITIGATING FACTORS
1. Inequities in resource allocation exacerbated by the limited funding envelope (High).	• Implementation of the Human Resources for Health Strategy. • Alignment of service delivery and budget allocation.
2. Challenges with service arrangements including referral, step-down facilities, human resources, etc. impacting on the quality of care and efficiency (High).	• Review service delivery platform and service arrangements as part of the long-term vision.
3. Inadequate management capacity (High).	• Implementation of management development and mentoring programmes.
4. Poor data quality and information management (High).	• Implementation of the Information Management Strategy including data quality, information systems, M&E and reporting.

2.4. HIV & AIDS, STI & TB CONTROL (HAST)

2.4.1. OVERVIEW

The Province aligned implementation plans with the integrated Multi-Sectoral Provincial Strategic Plan for HIV, AIDS, STI and TB 2012 – 2016. The strategy includes 5 focus areas with specific outcomes as indicated below.

Priority Area 1: Prevention of HIV, STI and TB

- Reduce HIV incidence in the general population to less than 1% by 2016.
- Zero HIV transmission to infants by 2016.
- Reduce HIV prevalence in the age group 15-24 years to 7.5% by 2016.
- Reduce TB infections to less than 200 new smear positive TB per 100,000 population by 2016.
- Reduce STI incidence to less than 0.5% by 2016.

Priority Area 2: Sustaining Health and Wellness

- Increase access to treatment & support, adherence (to treatment) and optimum health for people living with HIV.
- A reduction in TB associated mortality by 80% by 2016.

Priority Area 3: Protection of Human Rights

- Capacity building on policies and legislation relating to HIV, AIDS and TB.

Priority Area 4: Reducing Structural Vulnerability

- Reduce vulnerability to HIV, STI and TB due to poverty, socio-cultural norms and gender imbalance by 2016.

Priority Area 5: Coordination, Monitoring & Evaluation

- Strengthening coordination and management.
- Strengthening monitoring and evaluation systems at all levels.
- Strengthening the research component of the response to HIV.

2.4.2. CHALLENGES: HAST

- TB/HIV integration at service delivery level.
- Major space constraints in facilities to manage the increased number of patients on ART and TB treatment.
- Tracking and tracing of ART and TB clients remains a challenge resulting in high defaulter and loss to follow-up rates.
- Emerging HIV drug resistance.
- Failure to recruit ART Roving Teams for decentralised ART services which limits provision of Male Medical Circumcision and ART at PHC level.
- Infection prevention and control, including nosocomial transmission in facilities, remains a challenge with considerable cost implications and health risks for all clients (not limited to TB patients).
- Inadequate MDR-TB beds especially based on preliminary results of diagnosis using GeneXpert.
- Human resource constraints to manage increased patient numbers for HIV and TB.

2.4.3. 2013/14 PRIORITIES: HAST

PROVINCIAL PRIORITIES	PROVINCIAL KEY FOCUS AREAS
1. Decrease HIV incidence (Zero new infections) and Manage HIV prevalence.	• Implement and monitor the Multi-Sectoral Provincial Strategic Plan (KZNPSP) for HIV and AIDS, STIs and TB 2012 – 2016.
	• Increase access to ART through decentralisation to PHC. • Appointment of Roving Teams for initiation of patients on ART at PHC level. • Integration with PHC re-engineering to improve follow-up and support of patients on ART.
	• Review Protocol for the management of stable HIV positive patients – community management.
	• Scale up the Male Medical Circumcision Programmes (MMC).
	• Scale up HIV Counselling and Testing including follow-up and support at household level.
	• Increase condom distribution and expand education programmes.
	• Improve data quality, monitoring and evaluation, and reporting (3-TIER).
	• Scale up prevention strategies to reduce STI incidence.
	• Scale up the establishment of High Transmission Areas (HTAs).
2. Reduce TB incidence and improve TB outcomes.	• Implement and monitor the Multi-Sectoral Provincial Strategic Plan (KZNPSP) for HIV and AIDS, STIs and TB 2012 – 2016.
	• DOT support, surveillance for early detection of TB, follow-up of defaulters, contact tracing, and management of TB.
	• Expand Community-Based Management of MDR-TB (including review of service arrangements for MDR-TB including beds, decentralised units and Injection Teams).
	• Roll-out of GeneXpert.
3. Infection Prevention and Control and Quality Assurance.	• Facility audits for IPC, gap analysis and implementation of recommendations.

2.4.4. SITUATION ANALYSIS INDICATORS FOR HIV & AIDS, STI & TB CONTROL – 2011/12

Table 47: (HIV1): Situation Analysis Indicators for HIV & AIDS, STI's AND TB Control – 2011/12

Indicator	Data Source	Type	Provincial 2011/12	Ugu 2011/12	Umgungundlovu 2011/12	Uthukela 2011/12	Umzinyathi 2011/12	Amajuba 2011/12	Zululand 2011/12	Umkhanyakude 2011/12	Uthungulu 2011/12	Ilembe 2011/12	Sisonke 2011/12	eThekwini 2011/12	National 2013/14
1. Total number of patients (children and adults) on ART	DHIS	No	547,441	39,304	66,099	36,337	27,543	26,808	35,469	43,405	62,164	35,665	25,436	149,181	3.2 million
2. Male condom distribution rate	DHIS	Rate	9	7	6.9	10.4	13.1	13.7	14.8	13.9	11.5	8.9	14	5.2	60
3. New smear positive PTB defaulter rate	ETR.Net	Rate	6.7%	4.4%	6.8%	6.5%	1.5%	2.7%	3.6%	4.1%	4.8%	7.5%	5.9%	11.1%	<5%
4. TB AFB sputum result turn-around time under 48 hours rate	ETR.Net	Rate	81%	71%	93%	87%	89%	93%	59%	63%	42%	104%	36%	96%	-
5. PTB 2 month smear conversation rate	ETR.Net	Rate	68.3%	62.1%	80.5%	73.7%	75.1%	73%	84.3%	57.8%	75%	80.2%	56.6%	73%	75%
6. Percentage of HIV-TB co-infected patients placed on ART rate	ETR.Net	Rate	32.5%	28.7%	38.5%	41.9%	58.8%	53.2%	7.2%	29.8%	18.8%	28.4%	43.4%	33%	100%
7. HCT coverage	DHIS	%	86%	97%	98%	99%	98%	99%	94%	98%	64%	99%	95%	77%	-
8. New smear positive PTB cure rate	ETR.Net	%	69.7%	69.8%	76.8%	69.5%	84.8%	79.7%	75.8%	58.3%	78.2%	81.9%	70.2%	64.6%	85%

2.4.5. PERFORMANCE INDICATORS FOR HIV & AIDS, STI & TB CONTROL

Table 48: (HIV3): Performance Indicators for HIV & AIDS, STI's and TB Control

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2015/16
1. Total number of patients (children and adults) on ART *(Total clients remaining on ART (TROA) at end of the month)*	DHIS	No	319,015	408,238	547,411	**785,431** *Mid-Year 641,198*	846,919	1,011,201	1,172,397	3.2 million
2. Male condom distribution rate *(Male condom distribution rate (annualised))*	DHIS	Rate	8	8.1	9 N: 31,914,706 D: 3,440,461	**14** *Mid-Year 14.2 (annualised)* *N: 24,742,024 D: 3,493,699*	20	25	30	60
3. New smear positive PTB defaulter rate *(TB (new pulmonary) defaulter rate)*	ETR.Net	Rate	8.1%	7%	6.7% N: 2,075 D: 30,787	**6.1%** *Mid-Year 5.7%* *N: 947 D: 16,640*	5%	<5%	<5%	<5%
4. TB AFB sputum result turn-around time under 48 hours rate[38]	ETR.Net	Rate	58% (2009/10 Annual Report)	71% (2010/11 Annual Report)	81% N: 778,211 D: 961,874	**70%** *Mid-Year 70.1%* *N: 487,257 D: 694,643*	65%	70%	75%	-
5. PTB two month smear conversation rate *(TB new client treatment success rate)**	ETR.Net	Rate	68.7%	69%	68.3% N: 21,454 D: 31,366	**69%** *Mid-Year 60.5%* *N: 8,526 D: 14,093*	80%	85%	85%	75%
6. Percentage of HIV-TB co-infected patients placed on ART *(HIV/ TB co-infected patient initiated on ART rate)**	ETR.Net	%	Reporting not required	48%	32.5% N: 20,910 D: 64,325	**54%** *Mid-Year: 54%* *N: 17,710 D: 32,462*	70%	80%	90%	100%

[38] This data could not be verified before publishing of this plan and will be monitored in 2013/14. Note that data for 2011/12 and 2012 13 refers to calendar year reporting

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2015/16
7. HCT coverage *(HIV testing coverage)**	DHIS	%	Reporting not required	80%	86% N: 2,511,872 D: 2,892,810	**93%** *Mid-Year 91.8%* *N: 961,054 D: 1,047,171*	95%	95%	95%	-
8. New smear positive PTB cure rate *(TB (new pulmonary) cure rate)**	ETR.Net	Rate	62.9%	68.2%	69.7% N: 21,478 D: 30,787	**73.7%** *Mid-Year 73.7%* *N: 12,264 D: 16,640*	78.9%	85%	85%	85%

- Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Abbreviations to indicate raw data: N = Numerator; D = Denominator
- Performance indicator baselines and targets are currently based on mid-year 2011 population estimates (Stats SA). Census 2011 will have an impact on data during 2013/14.
- HAST indicators have been aligned with the DORA Business Plan although outer year targets (2014/15 and 2015/16) will have to be reviewed based on Census 2011 population.
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

2.4.6. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR HAST

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

Table 49: (HIV2): Provincial Strategic Objectives and Annual Targets for HIV and AIDS

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
3.1) To scale up implementation of the integrated HIV & AIDS, STI and	3.1.1) HIV incidence in the general population	0.85% [50% reduction] Reviewed 2012/13 (<1% by 2016)	ASSA and MRC	1.7% (MRC) 1.04% (ASSA)	1.7% (MRC) 1.01% (ASSA)	1.01% (ASSA)	**1.01%** (ASSA2008)	<1%	<1%	<1%

PROGRAMME 2: DISTRICT HEALTH SERVICES

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
TB Strategic Plan to reduce HIV incidence to less than 1% by 2014/5	3.1.2) Percentage qualifying HIV-positive patients on ART	90%	ART Register ASSA	±60%	81%	Not available	**88.9%** *Mid-Year 88.9%*[39] *N: 641,198 D: 721,006*	90%	90%	100%
	3.1.3) Number of neo-natal males circumcised (cumulative)	100% of target by 2014/15 Reviewed in 2011/12 and 2012/13	DHIS	Reporting not required	58	53 (111)	**80 (191 cum)** *Mid-Year 41 (152 cum)*	300 (cum)	600 (cum)	900 (cum)
	3.1.4) Number of adult males circumcised (cumulative)	100% of target by 2014/15 Reviewed in 2011/12 and 2012/13	DHIS	Reporting not required	33,817	90,589 (124,406)	**152,600 (277,006 cum)** *Mid-Year 76,300* *(200,706 cum)*	356,960 (cum)	469,280 (cum)	581,600 (cum)
	3.1.5) Percentage of HIV positive patients initiated on IPT rate *(HIV positive new client initiated on IPT rate)**	APP	DHIS	Reporting not required	Reporting not required	20%	**35%** *Mid-Year 17%*[40] *N: 29,781 D: 175,306*	70%	80%	85%

[39] According to ASSA estimates, the number of people living with HIV in the province increased from 1,576,025 in 2011 to 1,602,236 in 2012 (15.6% of total population). If 40% of people living with HIV are presumed to have CD4 counts of 350 and below, and an additional 5% of the population qualify for ART as per policy, roughly 721,006 people qualify for ART – compared with 641,198 patients on ART mid-year 2012/13 (estimate)

[40] Inconsistencies between HAST data and DHIS still persist. To ensure consistency in reporting DHIS data is quoted (where available). Data challenges are being addressed as part of the Data Management strategy

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	3.1.6) Percentage of TB-HIV co-infected patients initiated on CPT *(HIV/TB co-infected patient initiated on CPT rate)**	APP	DHIS	Reporting not required	Reporting not required	47% N: 46,194 D: 99,030	**50%** *Mid-Year 37.5%*[41] *N: 65,208* *D: 173,732*	90%	90%	95%
	3.1.7) STI treated new episode incidence *(STI treated new episode incidence (annualised))**	APP	DHIS	6.7%	6.5%	6.5%	**6.6%** *Mid-Year 6.6%*[42] *(annualised)* *N: 236,440* *D: 7,153,184*	2.4%	2%	1.5%
3.2) To scale up implementation of the integrated HIV & AIDS, STI and TB Strategic Plan to reduce TB associated mortality by 80% by 2016[43]	3.2.1) Number of MDR-TB cases registered	APP	MDR.Net	Not reported	Not reported	Not reported	**2,388** *Mid-Year 1,194*	2,600	Targets for outer years will be based on confirmed baseline	
	3.2.2) TB MDR death rate	APP	MDR.Net	Not reported	Not reported	Not reported	**13%** *Mid-Year 13%* *N: 118* *D: 923*	10%	Targets for outer years will be based on confirmed baseline	
	3.2.3) TB MDR treatment success rate	APP	MDR.Net	Not reported	Not reported	Not reported	**62%** *Mid-Year 62%* *N: 572* *D: 923*	65%	Targets for outer years will be based on confirmed baseline	
	3.2.4) Number XDR-TB cases registered	APP	MDR.Net	Not reported	Not reported	Not reported	**284** *Mid-Year 142*	300	Targets for outer years will be based on confirmed baseline	

[41] DHIS data quoted for consistency in reporting. The HAST indicator definition is unclear and being followed up
[42] DHIS data used for consistency in reporting – the different indicator definitions (DHIS and HAST) is being addressed
[43] KZNPSP Target

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	3.2.5) TB XDR death rate	APP	MDR.Net	Not reported	Not reported	Not reported	**36%** *Mid-Year 36%* *N: 33* *D: 92*	30%	Targets for outer years will be based on confirmed baseline	
	3.2.6) TB XDR treatment success rate	APP	MDR.Net	Not reported	Not reported	Not reported	**30%** *Mid-Year 30%* *N: 28* *D: 92*	35%	Targets for outer years will be based on confirmed baseline	

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator
- Indicators 3.1.1 and 3.1.2: Indicators are not routinely collected by the Department. Use ASSA projected data (preferred national source) for estimates.
- Indicator 3.1.4: Targets have been aligned with the HIV/AIDS Business Plan. The Department will however pursue the reviewed MMC Escalation Plan.
- Indicator 3.2.1 – 3.2.6: New indicators included to monitor MDR and XDR-TB outcomes. Historic data is not available to inform trend analysis and target setting. Estimated annual performance is therefore rough estimates based on mid-year 2012/13 data. Outer-year targets will be established once baselines have been established in 2013/14.
- Note: MDR and XDR-TB treatment outcomes include patients that were registered (started treatment) in 2010 - outcomes evaluated and reported in the first two quarters of 2012/13.
- Note: Performance indicator baselines and targets are based on mid-year 2011 population estimates. Census 2011 will have an impact on data and targets from 2013/14.
- Note: Indicators for 2013/14 are aligned with DORA targets however targets for the outer years (2014/15 and 2015/16) will be reviewed once new Census 2011 population has been determined for outer years.
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

2.4.7. QUARTERLY AND ANNUAL TARGETS FOR HAST – 2013/14

Table 50: (HIV4): Quarterly and Annual Targets for HIV & AIDS, STI's and TB Control for 2013/14

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Total number of patients (children and adults) on ART *(Total clients remaining on ART (TROA) at end of the month)*	846,919	211,729	423,458	635,187	846,919
2. Male condom distribution rate *(Male condom distribution rate (annualised))*	20	20	20	20	20
3. New smear positive PTB defaulter rate *(TB (new pulmonary) defaulter rate)*	5%	6.1%	5.8%	5.5%	5%
4. TB AFB sputum result turn-around time under 48 hours rate	65%	65%	65%	65%	65%
5. PTB two month smear conversation rate *(TB new client treatment success rate)**	80%	73%	75%	78%	80%
6. Percentage of HIV-TB co-infected patients placed on ART *(HIV / TB co-infected patient initiated on ART rate)**	70%	55%	60%	65%	70%
7. HCT Coverage *HIV testing coverage)**	95%	95%	95%	95%	95%
8. Number of neo-natal males circumcised (cumulative)	300	37 (189 cum)	37 (226 cum)	37 (263 cum)	37 (300 cum)
9. Number of adult males circumcised (cumulative)	356,960	269,240	298,480	327,720	356,960
10. Percentage of HIV positive patients initiated on IPT rate *(HIV positive new client initiated on IPT rate)**	70%	70%	70%	70%	70%
11. Percentage of TB / HIV co-infected patients initiated on CPT *(HIV/TB co-infected patient initiated on CPT rate)**	90%	75%	80%	85%	90%
12. Number of MDR-TB cases registered	2,600	650	650	650	650
13. TB MDR death rate	10%	10%	10%	10%	10%
14. TB MDR treatment success rate	65%	65%	65%	65%	65%
15. Number XDR-TB cases registered	300	75	75	75	75
16. TB XDR death rate	30%	30%	30%	30%	30%

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
17. TB XDR treatment success rate	35%	35%	35%	35%	35%
Annual Targets					
18. New smear positive PTB cure rate *(TB (new pulmonary) cure rate)**	78.9%				78.9%
19. HIV incidence in the general population	<1%				<1%
20. Percentage qualifying HIV-positive patients placed on ART	90%				90%
21. STI treated new episode incidence *(STI treated new episode incidence (annualised))**	2.4%				2.4%

- Note: Population-based indicator baselines and targets are based on mid-year population estimates. Census 2011 will have an impact on data during 2013/14.
- Note: Indicators for 2013/14 are aligned with DORA targets however targets for the outer years (2014/15 and 2015/16) will be reviewed once Census 2011 population has been determined for outer years.
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

2.4.8. RISK MANAGEMENT: HAST

POTENTIAL RISKS	MITIGATING FACTORS
1. Integration at service point (High).	• Integrated strategy with PHC re-engineering.
2. Increasing burden of disease without concomitant resources (High).	• Alignment of HAST strategies with PHC to ensure optimal use of existing resources.
3. Increasing burden of TB in children (High).	• Collabora • tion with School Health Services and Provincial Flagship Programme (OSS).
4. High numbers of ART patients lost to follow up (High).	• Strengthen alignment of HAST strategies with PHC re-engineering.

2.5. MATERNAL, NEONATAL, CHILD & WOMEN'S HEALTH

2.5.1. OVERVIEW

Strategies to improve maternal, newborn, child and women's health (MNC&WH) are dependent on a well-functioning health care system especially with reference to improved PHC services. The three pillars of PHC re-engineering therefore play a key role in improving MNC&WH outcomes.

The Province will continue to focus on implementation of the African Union's Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA) and the Strategic Framework for Reaching the MDGs on Child Survival in Africa, which calls on countries to increase efforts to strengthen health systems and to implement "at scale" integrated packages of high-impact and low-cost health and nutrition interventions to improve maternal;, neonatal, child and women's health services.[44]

The following will be prioritised as part of CARMMA and re-engineering of PHC:[45] [46]

Maternal Health

- Basic Antenatal Care (early booking before 14 - 20 weeks).
- HIV testing during pregnancy with initiation of ART and provision of other PMTCT services where indicated.
- Improved access to care during labour through introduction of dedicated obstetric ambulances and establishment of maternity waiting homes.
- Improved intra-partum care with specific focus on the correct use of the Partogram and protocols for managing complications.
- Post-natal care within six days of delivery.
- ESMOE (Essential Steps in Management of Obstetric Emergencies).

Newborn Health

- Promotion of early and exclusive breastfeeding including ensuring that breastfeeding is made as safe as possible for HIV-exposed infants.
- Provision of PMTCT.
- Resuscitation of newborns.
- Care for small/ ill newborns according to standardised protocols.
- Kangaroo Mother Care for stable low birth weight infants.
- Post-natal visit within six days which include newborn care and supporting mothers to practice exclusive breastfeeding.

Child Health

- Promotion of breastfeeding and appropriate complementary feeding practices for infants and young children.
- Provision of preventative services including immunisation, growth monitoring and promotion, vitamin A supplementation, and regular deworming.
- Correct management of common childhood illnesses using the Integrated Management of Childhood Illnesses (IMCI) case management protocol (including early identification and management of children with HIV and TB).
- Early identification of HIV-infected children and appropriate management including initiation of ART where indicated.
- Improved hospital care for ill children especially for those with common conditions i.e. pneumonia, diarrhoea and severe malnutrition.
- Expansion and strengthening of school health services.
- Developing services for children with long-term/ chronic health conditions.

Women's Health

- Access to contraceptive services including pregnancy confirmation, emergency

[44] African Union (2007) A Strategic Framework for Reaching the Millennium Development Goal on Child Survival in Africa
[45] Adam T et al (2005) Cost effectiveness analysis of strategies for maternal and neonatal health in developing countries British Medical Journal 331:1107
[46] The Partnership for Maternal, Newborn & Child Health (2011) A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health (RMNCH). Geneva, Switzerland: PMNCH.

contraception, choice on termination of pregnancy, and a full range of contraceptive methods.

- Post-rape care for adults and children.
- Improved reproductive health services for adolescents through provision of youth-friendly reproductive health services at health facilities and as part of school health services.
- Improved coverage of cervical screening and strengthening of follow-up.

Community Interventions

- Provision of a package of community-based maternal, child and women's health services by CCGs working as part of ward-based PHC outreach teams.
- Multi-sectoral action (through OSS) to reduce poverty and inequity and improve access to basic services especially improved water and sanitation.

2.5.2. CHALLENGES: MNC&WH

- The impact of HIV on maternal and child health outcomes.
- Late booking for antenatal care that compromise effective management of high risk patients.
- The delay in reaching health facilities during labour is a major concern.

2.5.3. 2013/14 PRIORITIES: MNC&WH

PROVINCIAL PRIORITIES	PROVINCIAL KEY FOCUS AREAS
1. Reduce neonatal and maternal morbidity and mortality.	• Implementation of CARMMA (Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa) package of care for neonates and pregnant women
	• Establish high care beds in all nurseries.
	• Establish neonatal resuscitation units in all labour wards.
2. Reduce child morbidity and mortality.	• Implementation of CARMMA package of services for children.
	• Back to the basics of GOBIFFF (growth monitoring, oral rehydration therapy, breastfeeding, immunisation, family spacing, female education, food supplementation) through Operation Sukuma Sakhe and PHC re-engineering.
3. Improve women's health.	• Implementation of CARMMA package of services for women and youth.
	• Scale up cervical cancer screening programme including routine screening of HIV positive women.
	• Intensify programmes for Post Exposure Prophylaxis (PEP).

2.5.4. SITUATION ANALYSIS INDICATORS FOR MC&WH AND NUTRITION – 2011/12

Table 51: (MCWH1): Situation Analysis Indicators for MCWH&N

Indicator	Data Source	Type	Provincial 2011/12	Ugu 2011/12	Umgungundlovu 2011/12	Uthukela 2011/12	Umzinyathi 2011/12	Amajuba 2011/12	Zululand 2011/12	Umkhanyakude 2011/12	Uthungulu 2011/12	Ilembe 2011/12	Sisonke 2011/12	eThekwini 2011/12
1. Immunisation coverage under 1 year	DHIS	%	97%	95.3%	84.2%	105.4%	104.1%	77.7%	78.7%	99%	105.9%	96.8%	82.3%	106.1%
2. Vitamin A coverage 12 – 59 months	DHIS	%	42.6%	45%	30.6%	32.8%	46.7%	37.3%	30.1%	29.5%	38.2%	49.6%	44.8%	54.9%
3. Measles 1st dose under 1 year coverage	DHIS	%	98.9%	98.6%	85.6%	106.1%	107.0%	81.8%	83.5%	103.2%	99.7%	99.8%	89.2%	107.6%
4. Pneumococcal vaccine (PCV) 3rd dose coverage	DHIS	%	95.9%	98.4%	79.9%	99.9%	108.3%	84.5%	79.5%	103.7%	103.7%	99.1%	89.4%	100%
5. Rota Virus (RV) 2nd dose coverage (annualised)	DHIS	%	103.5%	99.4%	90.5%	100.2%	108.3%	88.7%	84.7%	106.9%	105%	102.7%	89.6%	117.7%
6. Cervical cancer screening coverage	DHIS	%	76.1%	71.5%	70.6%	56.2%	139.5%	53.7%	82.5%	87%	54.9%	90%	60.8%	79.5%
7. Antenatal visits before 20 weeks rate	DHIS	Rate	41%	35.1%	48.3%	36.6%	44.0%	38.2%	42.3%	48.0%	39.6%	42.9%	37.4%	39.1%
8. Baby tested PCR positive six weeks after birth as proportion of babies tested at six weeks.	DHIS	%	4%	3.2%	3%	2.9%	3.6%	1.9%	3.7%	3.4%	2.9%	2.9%	3.0%	6.0%

Indicator	Data Source	Type	Provincial 2011/12	Ugu 2011/12	Umgungundlovu 2011/12	Uthukela 2011/12	Umzinyathi 2011/12	Amajuba 2011/12	Zululand 2011/12	Umkhanyakude 2011/12	Uthungulu 2011/12	Ilembe 2011/12	Sisonke 2011/12	eThekwini 2011/12
9. Couple year protection rate	DHIS	Rate	25.5%	26.9%	25.1%	25.2%	28.7%	28%	26%	28%	24.3%	25.6%	25.6%	24.4%
10. Facility Maternal mortality rate	DHIS	No per 100K	190.6	177.9	193.5	132.8	96.3	173.4	134	68.1	332.5	112.5	127.9	251.6
11. Delivery in facility under 18 years	DHIS	%	9.3%	11.2%	9.8%	8.9%	8.7%	9.2%	10.8%	10.5%	8.3%	11.0%	10.5%	8.0%
12. Facility infant mortality (under 1 year) rate	DHIS	Rate	7.0%	8.9%	7.4%	9.6%	8.9%	5.2%	7.5%	8.5%	7.4%	11.5%	15.1%	3.1%
13. Facility child mortality (under 5 years) rate	DHIS	Rate	4.8%	6.1%	5.6%	7.5%	6.7%	3.6%	7.6%	6.6%	5.3%	8.1%	10.1%	1.6%

2.5.5. PERFORMANCE INDICATORS FOR MC&WH AND NUTRITION

Table 52: (MCWH3): Performance Indicators for MCWH&N

Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	
1. Immunisation coverage under 1 year *(Immunisation coverage under 1 year (annualised))**	DHIS	%	84.9%	86%	97% N: 212,468 D: 219,033	**93.8%** *Mid-Year 93.8% (annualised)* *N: 99,946* *D: 213,214*	90%	90%	90%	90%

Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	
2. Vitamin A coverage 12 – 59 months *(Vitamin A 12 – 59 months coverage (annualised))**	DHIS	%	37.4%	32.6%	42% N: 769,685 D: 902,089*2	**42.6%** *Mid-Year 42.63% (annualised)* *N: 379,785* *D: 1,783,360*	45%	51%	55%	-
3. Measles 1st dose under 1 year coverage *(Measles 1st dose under 1 year coverage (annualised))**	DHIS	%	87.3%	88%	98.9% N: 216,704 D: 219,033	**95%** *Mid-Year 95% (annualised)* *N: 101,305* *D: 213,214*	90%	90%	90%	90%
4. Pneumococcal vaccine (PCV) 3rd dose coverage *(PCV 3rd dose coverage (annualised))**	DHIS	%	75.9%	80%	95.9% N: 210,097 D: 219,033	**95.7%** *Mid-Year 95.8% (annualised)* *N: 102,053* *D: 213,214*	90%	90%	90%	90%
5. Rota Virus (RV) 2nd dose coverage *(RV 2nd dose coverage (annualised))**	DHIS	%	58%	81%	103.5% N: 226,776 D: 219,033	**104.2%** *Mid-Year 104.2% (annualised)* *N: 111,120* *D: 213,214*	90%	90%	90%	90%
6. Child under 5 years diarrhea with dehydration incidence (annualised)	DHIS	No per 1000	41.8/1000	27/1000	20.7/1000	**125.6/1000** *Mid-Year 125.4/1000 (annualised)* *N: 69,331* *D: 1,104,898*	113/1000 (-10%)	102/1000 (-10%)	92/1000 (-10%)	-
7. Child under 5 years pneumonia incidence (annualised)	DHIS	No per 1000	178.7/1000	147/1000	143/1000	**122/1000** *Mid-Year 122.02/1000 (annualised)* *N: 67,414* *D: 1,104,898*	110/1000 (-10%)	99/1000 (-10%)	90/1000 (-10%)	-

Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	
8. Cervical cancer screening coverage *(Cervical cancer screening coverage (annualised))*	DHIS	%	5.9%[47]	57.4%	76.1% N: 159,096 D: 209,051	**83.1%** *Mid-Year 83.1% (annualised)* *N: 87,000* *D: 209,289*	75%	75%	75%	70%
9. Antenatal visit before 20 weeks rate *(Antenatal 1st visit before 20 weeks rate)**	DHIS	Rate	34.3%	36%	41% N: 91,525 D: 223,145	**45%** *Mid-Year 45.5%* *N: 49,746* *D: 109,243*	56%	60%	65%	80%
10. Baby tested PCR positive six weeks after births as proportion of babies tested at six weeks *(Infant 1st PCR test positive within 2 months rate)**	DHIS	Rate	10.3%	6.8%	4% N: 2,900 D: 73,193	**2.2%** *Mid-Year 2.5%* *N: 995* *D: 40,049*	<1.4%	<1%	<1%	-
11. Couple year protection rate *(Couple year protection rate (annualised))**	DHIS	Rate	25.1%	24.1%	25.5%	**29%** *Mid-Year 23.8% (annualised)* *N: 321,537* *D: 2,707,427*	40%	45%	50%	-
12. Facility Maternal mortality rate *(Maternal mortality in facility ratio (annualised))**	DHIS	No per 100k	169/100k	195/100k	190.6/100k N: 363 D: 190,452	**188/100k** *Mid-Year 160.5/100k* *N: 159* *D: 99,043*	180/100k	175/100k	170/100k	-
13. Delivery in facility under 18 years *(Delivery in facility under 18 years rate)**	DHIS	%	8.6%	8.9%	9.3% N: 17,933 D: 193,375	**9.1%** *Mid-Year 9.3%* *N: 9,331* *D: 100,469*	8.5%	8%	7.5%	-

[47] Calculation on the DHIS system changed after 2009/10 hence outlier in 2009/10

Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	
14. Facility infant mortality (under 1) rate *(Child under 1 year mortality in facility rate (annualised))**	DHIS	%	7.3%	9.1%	7% N: 2,342 D: 33,257	**6.5%** *Mid-Year 6.5%* *N: 1,357* *D: 20,619*	7%	7%	6.9%	-
15. Facility child mortality (under 5 years) rate *(Inpatient death under 5 years rate)**	DHIS	%	6.3%	7.6%	4.8% N: 2,779 D: 57,774	**5.4%** *Mid-Year 5.4%* *N: 1,772* *D: 32,667*	5.3%	5.2%	5%	-

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator
- Cervical cancer screening coverage is being investigated. It is suspected that it refers to total Pap smears including routine, diagnostic, repeats, etc. and not routine smears as per data definition and policy requirement.
- Note: Population-based baselines and targets are based on mid-year 2011 population (Stats SA) estimates. Census 2011 will have an impact on data in 2013/14.
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

2.5.6. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR MC&WH AND NUTRITION

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

Table 53: (MCWH2): Provincial Strategic Objectives and Annual Targets for MCWH&N

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Source	Audited/actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
3.2) To scale up implementation of the Accelerated Plan for PMTCT	3.2.1) % of pregnant women tested for HIV	100%	DHIS	93%	91.8% N: 224,196 D: 244,013	114.2% N: 218,049 D: 190,953	**96%** *Mid-Year 91.4%* *N: 99,822* *D: 109,243*	100%	100%	100%

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Source	Audited/actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
to reduce mother to child transmission to <1% by 2014/15	3.2.2) Percentage of eligible pregnant women placed on HAART. *(Antenatal client initiated on HAART rate)**	90% Reviewed 2012/13	DHIS	52.7%	75% N: 9,701 D: 12,911	80% N: 19,574 D: 24,468	**86%** *Mid-Year 85.4%* *N: 9,546* *D: 11,179*	95%	98%	100%
	3.2.3) Baby Nevirapine uptake rate (Infant given NVP within 72 hours after delivery uptake rate)[48]*	100%	DHIS	75.2%	78.6%	98% N: 66,262 D: 67,886	**98%** *Mid-Year 94.7%* *N: 33,013* *D: 34,861*	98%	100%	100%
3.3) Reduce child mortality to 30-45/1000 live births by 2014/15	3.3.1) Underweight for age under 5 years incidence - annualised[49]	Replaced – see footnote	DHIS	26.3/1000	19.4/1000	24/1000	**16.5/1000** *Mid-Year 16.5/1000 (annualised)* *N: 9,109* *D: 1,104,898*	16/1000	15/1000	14/1000
	3.3.2) Not gaining weight rate under 5 years	APP	DHIS	1.3%	1.1%	1%	**1%** *Mid-Year 1.2% (annualised)* *N: 12,287* *D: 2,219,532*	1%	<1%	<1%
	3.3.3) Severe malnutrition under 5 years incidence *(Child under 5 severe acute malnutrition incidence (annualised))**	6/1000	DHIS	9.5/ 1000	7/ 1000	6.7/1000	**6.2/1000** *Mid-Year 6.2/1000 (annualised)* *N: 3,427* *D: 1,104,898*	6.1/1000	6/1000	5.9/1000
3.4) Reduce maternal mortality to ≤100/ 100 000	3.4.1) Postnatal care baby visits within 6 days rate	80%	DHIS	42%	31%	58.3% N: 111,217 D: 190,452	**65%** *Mid-Year 69.1%* *N: 69,386* *D: 100,469*	70%	80%	85%

[48] Previously monitored "% of HIV exposed infants receiving ARV's for PMTCT" – indicator changed
[49] Replace "Reduce the prevalence of underweight children under-5 years" as the indicator is not included in DHIS. The new indicator is included in DHIS.

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Source	Audited/actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
by 2014/15	3.4.2) Postnatal care mothers visit within 6 days rate *(Mother postnatal visit within 6 days rate)*	80%	DHIS	42%	31%	58.1% N: 112,418 D: 193,375	**58%** *Mid-Year 56.1%* *N: 56,586* *D: 100,469*	75%	80%	85%
	3.4.3) Neonatal mortality rate in facility *(Neonatal mortality in facility rate (annualised))**	APP	DHIS	Not collected	Not collected	Not collected	**9/1000** *Mid-Year 9.1/1000* *N: 900* *D: 99,043*	8.5/1000	8/1000	7.8/1000

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator
- Note: Population-based baselines and targets are based on mid-year 2011 population estimates (Stats SA). Census 2011 will have an impact on data in 2013/14.
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

2.5.7. QUARTERLY AND ANNUAL TARGETS FOR MCWH&N – 2013/14

Table 54: (MCWH4): Quarterly and Annual Targets for MCWH&N for 2013/14

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Immunisation coverage under 1 year *(Immunisation coverage under 1 year (annualised))**	90%	90%	90%	90%	90%
2. Vitamin A coverage 12 – 59 months *(Vitamin A 12 – 59 months coverage (annualised))**	45%	43.2%	43.7%	44.3%	45%
3. Measles 1st dose under 1 year coverage *(Measles 1st dose under 1 year coverage (annualised))**	90%	90%	90%	90%	90%
4. Pneumococcal vaccine (PCV) 3rd dose coverage *(PCV 3rd dose coverage (annualised))**	90%	90%	90%	90%	90%

PROGRAMME 2: DISTRICT HEALTH SERVICES

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
5. Rota Virus (RV) 2nd dose coverage 6. *(RV 2nd dose coverage (annualised))**	90%	90%	90%	90%	90%
7. Cervical cancer screening coverage *(Cervical cancer screening coverage (annualised))*	75%	75%	75%	75%	75%
8. Antenatal visit before 20 weeks rate *(Antenatal 1st visit before 20 weeks rate)**	56%	48%	51.5%	53.5%	56%
9. Baby tested PCR positive six weeks after births as proportion of babies tested at six weeks *(Infant 1st PCR test positive within 2 months rate)**	<1.4%	<1.4%	<1.4%	<1.4%	<1.4%
10. % of pregnant women tested for HIV	100%	98%	98%	98%	100%
11. Percentage of eligible pregnant women placed on HAART. *(Antenatal client initiated on HAART rate)**	95%	95%	95%	95%	95%
12. Baby Nevirapine uptake rate *(Infant NVP within 72 hours after delivery uptake rate)**	98%	98%	98%	98%	98%
13. Postnatal care baby visits within 6 days rate	70%	65%	67%	69%	70%
14. Postnatal care mothers visit within 6 days rate *(Mother postnatal visit within 6 days rate)*	75%	75%	75%	75%	75%
15. Child under 5 yeas diarrhea with dehydration incidence	113/1000	113/1000	113/1000	113/1000	113/1000
16. Child under 5 years pneumonia incidence (annualised)	110/1000	110/1000	110/1000	110/1000	110/1000
Annual Targets					
17. Couple year protection rate *(Couple year protection rate (annualised))**	40%				40%
18. Facility Maternal mortality rate per 100k *(Maternal mortality in facility ratio (annualised))**	180/100k				180/100k
19. Delivery in facility under 18 years *(Delivery in facility under 18 years rate)**	8.5%				8.5%
20. Facility infant mortality (under 1) rate *(Child under 1 year mortality in facility rate (annualised))**	7%				7%

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
21. Facility child mortality (under 5 years) rate *(Inpatient death under 5 years rate)*	5.3%				5.3%
22. Underweight for age under 5 years incidence - annualised	16/1000				16/1000
23. Not gaining weight rate under 5 years incidence	1%				1%
24. Severe malnutrition under 5 years incidence *(Child under 5 severe acute malnutrition incidence (annualised))**	6.1/1000				6.1/1000
25. Neonatal mortality rate in facility *(Neonatal mortality in facility rate (annualised))**	8.5/1000				8.5/1000

- Targets for immunisation remain 90% with the aim to improve immunisation in all districts to 90% and over. Decreasing population numbers (Census 2011) will increase the current baseline for immunisation coverage (all vaccines). Individual district targets will therefore be reviewed based on the new population which might result in coverage over 100% in some districts.
- Census 2011: New Census data impact on all indicators using population as denominator e.g. immunisation. All indicators will be reviewed to establish new baselines (based on 2011 Census). For purpose of this APP, projected StatsSA population has been used to enable national comparison. DHIS will be populated with updated population during 2013/14.
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed

2.5.8. RISK MANAGEMENT – MNC&WH

POTENTIAL RISKS	MITIGATING FACTORS
1. Continuing impact of HIV, AIDS and TB on maternal and child health (High).	• Integration strategy with other mainstream programmes.
2. Late booking for antenatal care (High).	• Improved community-based interventions in collaboration with OSS partners.
3. Insufficient funding for expansion of services (High).	• Costing of MNC&WH services.
4. Poor socio-economic determinants of health (High).	• Strengthening participation in OSS.
5. High HIV and TB prevalence in pregnant women (High).	• Strengthen integration with HIV and TB.

2.6. DISEASE PREVENTION AND CONTROL (DPC)

2.6.1. OVERVIEW

The appointment of Waste Management Officers commenced in 2012/13 in order to improve management, monitoring and evaluation of collections, storage and disposal of health care risk waste. The Department commenced with a review of implementation of the Health Care Risk Waste Policy.

Port Health has been prioritised during the MTEF in order to improve compliance to service standards.

2.6.2. CHALLENGES

- Delay with the devolution of Municipal Health Services (MHS) to Metropolitan and District Municipalities.
- Delay in the appointment of Waste Management Officers at health facilities which impacts negatively on the Department's responsibility to monitor and evaluate the safe collection, storage and final disposal of health care risk waste (HCRW).
- Delay in the implementation of the new malaria organisational structure to address the current shortage of Environmental Health Practitioners which is posing a risk to the resurgence of malaria in the Province.

2.6.3. 2013/14 PRIORITIES: DISEASE PREVENTION AND CONTROL

PROVINCIAL PRIORITIES	PROVINCIAL KEY FOCUS AREAS
1. Maintain malaria incidence at <1/1000 population and the malaria case fatality rate <1%.	• Review and cost the Malaria Strategy.
	• On-going research to monitor antimalarial drug efficacy.
	• Targeted indoor residual spraying.
	• Improve early diagnosis and treatment through integration with PHC re-engineering and OSS.
	• Implement Entomology Vector and parasite surveillance programmes.
2. Revitalisation of Environmental Health Services.	• Expedite the devolution of Environmental Health Services.
	• Port Health: Controlled ingress of Passengers and consignments into the Province.
	• Control Hazardous Substances (Green Economy): Licensing of all hazardous substance dealers/ importers.
	• Healthcare Risk Waste Disposal: Efficient collection and disposal of all health care risk waste from health facilities and generators.
3. Sustain Communicable Disease Control.	• Epidemic preparedness.
4. Prevention of blindness.	• Increase cataract surgeries. • Improve prevention programmes through integrated strategies and participation in OSS.

2.6.4. SITUATION ANALYSIS INDICATORS FOR DISEASE PREVENTION AND CONTROL – 2011/12

Table 55: (DCP1): Situation Analysis Indicators for Disease Prevention and Control – 2011/12

Indicator	Data Source	Type	Provincial 2011/12	Ugu 2011/12	UMgungundlovu 2011/12	Uthukela 2011/12	Umzinyathi 2011/12	Amajuba 2011/12	Zululand 2011/12	Umkhanyakude	Uthungulu 2011/12	Ilembe 2011/12	Sisonke 2011/12	eThekwini 2011/12	National 2011/12
1. Malaria fatality rate	Malaria Surveillance Programme	Rate	0.75%	0%	0%	0%	0%	0%	5.26%	1.30%	0%	0%	0%	0%	<1%
2. Cholera fatality rate	CDC database	Rate	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
3. Cataract surgery rate	DHIS	No per million population	1,030.8/ 1mil	328.6/ 1mil	1,414.1/ 1mil	395.3/ 1mil	680.5/ 1mil	759.2/ 1mil	497.9/ 1mil	1,088.7/ 1mil	1,274.6/ 1mil	1,451.7/ 1mil	1,541.6/ 1mil	1,209.0/ 1mil	2,000/ 1mil

2.6.5. PERFORMANCE INDICATORS FOR DISEASE PREVENTION AND CONTROL

Table 56: (DCP3): Performance Indicators for DPC

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2015/16
1. Malaria case fatality rate	Malaria database	Rate	0.9% N: 4 D: 428	1.3% N: 5 D: 380	0.75% N: 4 D: 531	**0.48%** *Mid-Year 0.48%* *N: 1* *D: 206*	<0.5%	<0.5%	<0%	<1%
2. Cholera fatality rate	CDC database	Rate	0%	0%	0%	**0%** *Mid-Year 0%*	0%	0%	0%	0%

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2015/16
3. Cataract surgery rate *(Cataract surgery rate (annualised))*	DHIS	No per 1mil population	1,003/ 1 mil	757/1mil	1,030.8/1 mil (9,170 operations)	**1,255/1mil** *Mid-Year 1.255.6/mil[50] (annualised)* *N: 6,720 D: 10,703,920*	1,430/1 mil	1,835/1mil	1,950/1mil	2,000/1 mil

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator
- Note: Population-based baselines and targets are based on mid-year 2011 population estimates. Census 2011 will have an impact on data in 2013/14.
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

[50] DHIS data reflects as 728.3/mil (numerator 3,898) as only operations performed in public facilities are recorded. Chronic Disease has supplied the numerator of 6,720 which includes operations performed at both private and public facilities however the incorrect denominator (population) was used in the calculation giving a cataract surgery rate (annualised) of 846/mil

2.6.6. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR DPC

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

Table 57: (DCP2): Provincial Strategic Objectives and Annual Targets for DPC

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
3.5) To maintain preventative strategies to reduce and maintain the malaria incidence at ≤ 1/1000 population	3.5.1) Malaria incidence per 1000 population at risk	<1/ 1000	Malaria database	0.11/1000	0.03/1000 N: 380 D: 10,540,960[51]	0.79/1000 N: 531 D: 666,524	**0.61/1000** *Mid-Year 0.62/1000[52] (annualised)* *N: 206* *D: 666,521*	<1/ 1000	<1/ 1000	<1/ 1000
	3.5.2) Indoor residual spraying coverage	APP	Malaria database	83%	88% N: 270 143 D: 305 259	93%	**95%** Seasonal spraying (Nov-Feb) – data not yet available	95%	95%	95%

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator
- Note: Population-based baselines and targets are based on mid-year 2011 population estimates. Census 2011 will have an impact on data in 2013/14.

2.6.7. QUARTERLY AND ANNUAL TARGETS FOR DPC – 2013/14

Table 58: (DPC4): Annual Targets for DPC for 2013/14

Performance Indicator	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4

[51] Provincial population was utilised in this calculation
[52] Umkhanyakude population was used as the denominator for this indicator "referring to population at risk"

Performance Indicator	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
1. Malaria case fatality rate	<0.5%				<0.5%
2. Cholera fatality rate	0%				0%
3. Cataract surgery rate *(Cataract surgery rate (annualised))*	1,430/1 mil				1,430/1 mil
4. Malaria incidence per 1,000 population at risk	<1/ 1000				<1/ 1000
5. Indoor residual spraying coverage	95%				95%

- Note: Population-based baselines and targets are based on mid-year 2011 population estimates. Census 2011 will have an impact on data in 2013/14.
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

2.6.8. RISK MANAGEMENT: DISEASE PREVENTION AND CONTROL

POTENTIAL RISKS	MITIGATING FACTORS
1. Rollout of Environmental Health Programmes within limitations of MTEF budget (High).	• Reprioritization and alignment of budget and service delivery demands.
2. Resource constraints jeopardizing eye care programmes (Medium).	• Partnerships with private health care providers.
3. Inadequate resources for implementation of the cataract programme (Medium).	• Strengthening partnerships.

2.7. FORENSIC PATHOLOGY SERVICES

2.7.1. STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR PHARMACEUTICAL SERVICES

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 59: Provincial Strategic Objectives and Annual Targets for FPS

Strategic Objective	Performance Indicator	Strategic Plan Target	Data source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
To revitalise Forensic Pathology Services (FPS) in alignment with the STP.	Percentage of paupers stored for longer than three months.	APP	FPS Register	New indicator	New indicator	New indicator	**60.4%** *N: 139 D: 230*	55%	Targets for outer years will be based on the confirmed baseline	
	Percentage of mortuary facilities that have been audited in terms of quality assurance.	APP	FPS Register	New indicator	New indicator	New indicator	**17.5%** *N: 7 D: 40*	80%	Targets for outer years will be based on the confirmed baseline	

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator

2.7.2. QUARTERLY AND ANNUAL TARGETS FOR DPC – 2013/14

Table 60: Annual Targets for FPS for 2013/14

Performance Indicator	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
1. Percentage of paupers stored for longer than three months.	55%				55%
2. Percentage of mortuary facilities that have been audited in terms of quality assurance.	80%				80%

2.8. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 61: (DHS11 (a)): Summary of payments and estimates Programme 2

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
R' thousands	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
District Management	121 855	133 675	165 967	200 149	228 554	208 427	201 548	209 565	221 402
Community Health Clinics	1 812 690	2 054 214	2 314 985	2 546 665	2 614 113	2 596 338	2 832 671	3 079 491	3 198 738
Community Health Centres	550 817	628 582	767 716	870 181	935 318	926 190	1 030 648	1 132 166	1 205 824
Community Based Services	98 850	101 399	25 774	-	-	-	-	-	-
Other Community Services	471 293	524 369	617 239	768 652	721 843	692 879	854 055	941 147	987 183
HIV and AIDS	1 534 546	1 500 250	1 914 057	2 225 423	2 343 916	2 649 390	2 652 072	3 079 376	3 491 245
Nutrition	90 637	36 614	65 237	47 642	47 642	47 642	49 348	51 490	53 809
Coroner Services	97 091	117 884	137 034	156 393	142 717	148 311	159 265	165 804	175 107
District Hospitals	4 314 113	4 627 858	4 680 514	5 138 614	4 952 826	4 887 754	5 284 169	5 552 143	5 855 320
Total economic classification	**9 095 886**	**9 729 299**	**10 692 335**	**11 953 719**	**11 986 929**	**12 156 931**	**13 063 776**	**14 211 182**	**15 188 628**

Table 62: (DHS11 (b)): Summary of payments and estimates by Economic Classification Programme 2

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Current payments	**8 722 956**	**9 297 816**	**10 201 342**	**11 532 669**	**11 490 212**	11 694 896	**12 532 421**	**13 621 729**	**14 622 059**
Compensation of employees	5 696 023	6 421 744	7 147 852	8 014 328	7 928 880	7 876 310	8 706 221	9 328 916	9 926 490
Goods and services	**3 026 933**	**2 876 072**	**3 053 490**	**3 518 341**	**3 561 332**	**3 818 586**	**3 826 200**	**4 292 813**	**4 695 569**
Communication	51 738	43 569	45 289	46 215	45 974	51 120	48 636	53 284	57 253
Computer Services	2 141	218	108	46 379	37 313	7537	-	-	-
Consultants, Contractors and special services	587 669	497 117	531 964	654 657	541 542	541 470	574 547	613 661	672 863

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Inventory	1 987 564	1 951 084	2 011 026	2 263 435	2 390 428	2 679 255	2 625 702	2 979 351	3 259 825
Operating leases	21 102	17 507	17 876	17 057	19 790	19 676	21 717	23 153	24 075
Travel and subsistence	12 811	13 021	17 903	18 640	19 291	19 241	19 582	21 119	22 134
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	363 867	353 536	429 324	471 958	506 994	500 520	536 016	602 245	659 419
Transfers and subsidies to	**344 748**	**398 922**	**338 236**	**345 980**	**338 334**	**338 186**	**408 044**	**423 935**	**445 179**
Provinces and municipalities	82 451	124 886	86 828	86 293	99 373	99 358	145 584	168 788	181 783
Departmental agencies and accounts	-	27	130	-	-	29	31	32	33
Non-profit institutions	237 438	247 899	213 387	223 807	208 437	208 437	225 339	213 209	220 705
Households	24 846	26 110	37 891	35 880	30 524	30362	37 090	41 906	42 658
Payments for capital assets	**28 182**	**29 586**	**152 714**	**75 070**	**158 383**	**123 849**	**123 311**	**165 518**	**121 390**
Machinery and equipment	28 182	29 586	152 714	75 070	158 383	123 849	123 311	165 518	121 390
Payment for financial assets	**-**	**2 972**	**43**	**-**	**-**	**-**	**-**	**-**	**-**
Total economic classification	**9 095 886**	**9 729 299**	**10 692 335**	**11 953 719**	**11 986 929**	**12 156 931**	**13 063 776**	**14 211 182**	**15 188 628**

2.9. PERFORMANCE AND EXPENDITURE TRENDS

Programme 2 is allocated 45.6% of the vote in 2013/14 compared with 44.05% in the 2012/13 revised estimate. The Programme 2 expenditure increased with R906 million between 2012/13 and 2013/14.

- *Sub-Programmes Community Health Clinics, CHCs, Community-Based Services, and Other Community Services:* Allocated 36.11% of the Programme 2 budget with an increase of R501 million in 2013/14. Additional allocations have been made for:
  - R57.8 million to strengthen the Malaria Programme including the appointment of an Entomologist and research.
  - R16.8 million for Port Health to improve staffing and implement new strategy.
  - R30 million to strengthen School Health Services and R6.6 million for vehicles.
  - R14.5 million for to expand the mobile fleet.
  - R7.7 million for vehicles to improve PHC out-reach services e.g. Specialist Teams, PHC Outreach Teams and PHC management/ supervision.
  - R45 million to strengthen community-based management of MDR-TB (TB Injection Teams and 92 vehicles).
  - R63.5 million for rollout of the GeneXpert.
- *Sub-Programme HIV and AIDS:* The steady growth relates mainly to the HIV and AIDS Conditional Grant for expansion of the ART programme.
- *Sub-Programme Nutrition:* Provision has been made for the appointment (R43.7 million) and training (R6 million) of Nutritional Advisors.
- *Sub-Programme Coroner Services:* Additional funds have been allocated for:
  - Training of professional staff as part of strategy to professionalise Forensic Pathology services.
  - Appointment of 28 Forensic Pathology Officers in the Phoenix, Gale Street and Pinetown mortuaries.
- *Sub-Programme District Hospitals:* Allocated 40.4% of the Programme 2 budget in 2013/14 compared to 40.2% in the 2012/13 revised estimate. The allocation includes funding to improve compliance to national norms and standards, as well as funding for the various OSDs, capacity building and general policy adjustment.
- *NHI Conditional Grant:* R9.7 million was allocated for the two pilot districts and 2 central hospitals to:
  - Enhance district capacity in the areas of planning and monitoring and evaluation.
  - Improve SCM systems and processes in support of efficient and effective health services delivery.
  - Strengthen referral systems based on the re-engineered PHC platform.
- Amounts of R122 500 million to eThekwini and R21 000 million to Umhlathuze Local Governments in 2013/14 is to scale up implementation of personal PHC services including HIV and TB services.
- The decrease in the *2012/13 Revised Estimate* relates primarily to rationalisation of costs at McCords Hospital following re-assessment of the SLA with the hospital. 2013/14 allocation provides for inflationary increases only.

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

3.1. PROGRAMME PURPOSE AND STRUCTURE

Provide emergency, medical, rescue & non-emergency (elective) transport and health disaster management services in the Province.

Sub-Programme 3.1: Emergency Patient Transport (EPT)

Provide emergency response (including the stabilisation of patients) and transport to all patients involved in trauma, medical/ maternal/ and other emergencies through the utilisation of specialised vehicles, equipment and skilled Emergency Care Practitioners.

Sub-Programme 3.2: Planned Patient Transport (PPT)

Provide transport services for non-emergency referrals between hospitals, and from PHC Clinics to Community Health Centres and Hospitals for indigent persons with no other means of transport.

Sub-Programme 3.3: Disaster Management

Mass casualty incident management. Conduct surveillance and facilitate action in response to Early Warning Systems for the Department and activate effective response protocols in line with the provisions of the Disaster Management Act, 2002.

There is no change in the purpose of Programme 3 since tabling of the 2010 - 2014 Strategic Plan.

Programme performance measures, not specifically identified as priority in the APP, are included in the Operational Plans and monitored quarterly to ensure effective performance monitoring. Specific output and outcomes will be included in the Annual Report.

3.2. OVERVIEW

During 2012/13 Emergency Medical Services increased the vehicle fleet to improve general response times and response outcomes. Operational ambulances increased from 185 to 290 (including 38 inter-facility ambulances and 28 additional specialised obstetric ambulances) which translated to 0.20 ambulances per 10 000 people compared to the national norm of 1 ambulance per 10,000 people.

Planned patient transport was strengthened by introducing 39 midi buses (23 seated) and 17 PPT mini buses (16 seated). Coordination of PPT services has been improved through implementation of a dedicated desk in the eThekwini Communication Centre to coordinate PPT activities including patient repatriation.

The programme has been prioritised for the coming MTEF.

3.3. CHALLENGES

- Inadequate infrastructure including staff accommodation, offices, vehicle bases, and customised wash bays and sluice facilities.
- Inadequate number of ambulances and skilled staff with particular reference to Intermediate and Advanced Life Support.
- Poor road infrastructure, long distances, high accident rates and shortage of service providers for fleet maintenance resulting in increased downtime of ambulances.
- Management of overtime ("compulsory overtime") remains a serious challenge.
- Revenue generation and collection.
- Patient safety.
- Risk management (fuel card fraud), and fraud and corruption.
- Ill-discipline and labour issues.
- Recruitment and retention of suitably qualified personnel.

3.4. 2013/14 PRIORITIES: EMS

PROVINCIAL PRIORITIES	STRATEGIES AND CORE ACTIVITIES
1. Revitalisation of EMS.	• Implement the new EMS Service Delivery Model for modernization of EMS. • Centralisation of administrative and support services - new Service Delivery Model.
2. Improve access to EMS.	• Establish Media Liaison and Publicity Section to improve public awareness, marketing and utilisation.
3. Improve quality of care and infection prevention and control.	• Recruitment of ILS, Mid–Level Workers (Emergency Care Technicians) and AL. – Ensure effective intervention (treatment) of pre-hospital emergencies. – Compulsory Continuing Medical Education for all personnel.
4. Improve human resource capacity.	• Implement development programmes for management and supervisory staff. • Finalise the staff establishment for EMS and prioritise filling of critical posts. • Appointment of executive management to improve leadership, clinical governance and risk management. • Training of 96 ECP in Basic Medical Rescue; 30 ECT with 30 qualifying end of 2015. • Development of First Line Managers in management skills.
5. Improve Patient Transport Services.	• Introduce downward and upward referral guidelines clearly defining Non-Emergency Patient Transport and Planned Patient Transport. • Establish Patient Transport Service Hubs at IALCH, Ngwelezane and Greys Hospitals.
6. Revitalisation of basic infrastructure.	• Commence with the construction of: Emergency Management Centre (Umgungundlovu), Large Base (Umzinyathi), and the King Dinuzulu Medium Base. • Commissioning of the Wentworth EMS Base Station in 2013/14.
7. Improve ambulance response times.	• Introduce a new fleet of ambulances including Rapid Response vehicles, Obstetric Ambulances, and Rescue Units. • Replace/add 15 Rescue Units to Local Municipalities that lack capacity in obtaining resources. • Procurement of new vehicles for conversion into ambulances, rapid response vehicles and psychiatric ambulances with requisite equipment. • Conduct training in ILS for 72 officials (anticipated throughput of 60 per year); negotiation with service provider for ALS training (throughput of 20); and negotiation with the Professional Board for Emergency Care Personnel to conduct 5 training courses per year. • Aviation Healthcare Provider course for 60 officials. • Clearly defined calls (call categorization).
8. Improve the existing Communications network.	• Finalise the rationalisation of Emergency Management Centres from 12 to 4. – Merge Provincial Health Operations Centre, and Umgungundlovu and Sisonke Emergency Management Centres to serve eThekwini, Ilembe, Ugu, Sisonke and Umgungundlovu. – Appoint 60 people with disabilities in Emergency Management Centres. – Replace the old Repeaters in “dead spot” areas.
9. Improve the management of vehicle and equipment.	• Introduce new Vehicle Monitoring Real-Time Tracking systems linked to Emergency Management Centres. – Employ suitably qualified Fleet Management Officers. – Introduce stringent control measures. – Driver training to minimize road accidents.

3.5. SITUATION ANALYSIS INDICATORS FOR EMERGENCY MEDICAL SERVICES – 2011/12

Table 63: (EMS1): Situation Analysis Indicators for EMS – 2011/12

Quarterly Indicators	Data Source	Type	Province 2011/12	Ugu 2011/12	UMgungundlovu 2011/12	UThukela 2011/12	UMzinyathi 2011/12	Amajuba 2011/12	Zululand 2011/12	UMkhanyakude 2011/12	UThungulu 2011/12	Ilembe 2011/12	Sisonke 2011/12	eThekwini 2011/12	National 2011/12
1. Rostered ambulances per 10,000 people	EMS Database	Ratio per 10000	0.17 (185)	0.19 (14)	0.17 (17)	0.20 (15)	0.29 (15)	0.23 (16)	0.17 (16)	0.18 (12)	0.17 (16)	0.17 (12)	0.25 (13)	0.11 (39)	1:10 000 (1,122)
2. P1 calls with a response time <15 minutes in an urban area	EMS Database	%	11%	6%	27%	7%	52%	78%	N/A	N/A	33%	7%	N/A	7%	80%
3. P1 calls with a response time <40 minutes in a rural area	EMS Database	%	36%	21%	17%	26%	36%	84%	48%	18%	34%	22%	18%	44%	80%
4. All calls with a response time within 60 minutes)	EMS Database	%	51%	39%	41%	46%	53%	91%	64%	32%	48%	35%	58%	48%	100%

3.6. PERFORMANCE INDICATORS FOR EMS AND PATIENT TRANSPORT

Table 64: (EMS3): Performance Indicators for EMS and Patient Transport

Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2015/16
1. Rostered ambulances per 10,000 people *(EMS operational ambulance coverage*	DHIS	Ratio per 10,000	0.24 (217)	0.20	0.17 (185)	**0.27** *Mid-Year 0.20*	0.28 (300)	0.34 (383)	0.43 (477)	1: 10,000

	Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2015/16
	*(annualised))**		population				*N: 214* *D: 10,703,920*				
2.	P1 calls with a response time <15 minutes in an urban area *(EMS P1 urban response under 15 minutes rate)**	DHIS	%	19%	29%	11% N: 16,242 D: 142,864	**19%** *Mid-Year 9.3%* *N: 5,553* *D: 81,514*	37%	50%	65%	80%
3.	P1 calls with a response time <40 minutes in a rural area *(EMS P1 rural response under 40 minutes rate)**	DHIS	%	36%	37%	36% N: 66,567 D: 185,479	**40%** *Mid-Year 32.7%* *N: 33,358* *D: 102,136*	50%	65%	80%	80%
4.	All calls with a response time within 60 minutes) *(EMS P1 call response under 60 minutes rate)**	DHIS	%	53%	53%	51% N: 259,496 D: 504,393	**45%** *Mid-Year 40.6%* *N: 104,095* *D: 256,672*	65%	70%	75%	100%

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator
- Note: Population-based baselines and targets are based on mid-year 2011 population estimates. Census 2011 will have an impact on data in 2013/14 for example Indicator 1.
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been approved, indicator baselines and MTEF targets will be reviewed.
- The response times are achievable only if the indicated number of rostered ambulances and additional obstetric and inter-facility transfer ambulances are operational. The intra-districts Planned Patient Transportation services must also be fully implemented.

3.7. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR EMS

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 65: (EMS2): Provincial Strategic Objectives, indicators and Annual Targets for EMS

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
1.12) To revitalise EMS and improve response times to ≥ 70% for rural and urban areas by 2014/15	1.12.1) Total number of EMS emergency cases (*EMS clients total)**	1,435,951 Reviewed 2012/13	EMS Database DHIS 2013/14	713,923	642,760	585,955	**568,522** *Mid-Year 284,261*	600,000	610,000	620,000
	1.12.2) Total number of inter-facility transfers (*EMS inter-facility transfer)**	187,224 Reviewed 2012/13	EMS Database DHIS 2013/14	116,253	122,337	171,868	**186,440** *Mid-Year 93,220*	200,000	220,000	230,000
1.13) Improve the quality of care rendered by Emergency Care Personnel	1.13.1) Locally based staff with training in BLS (BAA)	20% Reviewed 2012/13	EMS Database	71.5%	70.5%	70% N: 1,959 D: 2,795	**67.4%** *Mid-Year 67.4% N: 1,839 D: 2,728*	61%	56%	52%
	1.13.2) Locally based staff with training in ILS (AEA)	50% Reviewed 2012/13	EMS Database	25%	26%	26% N: 725 D: 2,795	**28.5%** *Mid-Year 28.5% N: 777 D: 2,728*	32%	35%	37%
	1.13.3) Locally based staff with training as ECT (Emergency Care Technician)	5% Reviewed 2012/13	EMS Database	0.5%	0.5%	1% N: 20 D: 2,795	**0.7%** *Mid-Year 0.7% N: 19 D: 2,728*	3%[53]	4%	6%

[53] Increase in the skills base will be through the recruitment of new staff (with appropriate qualifications) – not based on output of Training College

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
	1.13.4) Locally based staff with training in ALS (Paramedics)	25% Review 2012/13	EMS Database	3%	3%	3% N: 91 D: 2,795	**3.3%** *Mid-Year 3.3%* *N: 91* *D: 2,728*	4%[54]	5%	5%
1.14) To establish effective training programmes to provide an adequate skills base for EMS services in accordance with national norms	1.14.1) Number of successfully trained ILS staff	APP	EMS Database	16	42	86	**96** *Mid-Year 96*	144	144	144
	1.14.2) Number of successfully trained ECT staff	APP	EMS Database	20	0	0	**0** *Mid-Year 0*	0	30[55]	60
	1.14.3) Number of successfully trained ALS staff	APP	EMS Database	16	26	0	**0** *Mid-Year 0*	0[56]	0	0

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator

3.8. QUARTERLY AND ANNUAL TARGETS FOR EMS – 2013/14

Table 66: (EMS4): Quarterly and Annual Targets for EMS - 2013/14

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. P1 calls with a response time <15 minutes in an urban area *(EMS P1 urban response under 15 minutes rate)**	37%	25%	32%	37%	37%

[54] The increase in skills will be through the recruitment of new staff with appropriate qualifications
[55] The Emergency Care Training College is being accredited by the Health Professionals Council of South Africa to lecture the ECT course in 2013/14 with students graduating in 2014/15
[56] The Emergency Care Training College is not accredited to teach this course and also does not have the capacity

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
2. P1 calls with a response time <40 minutes in a rural area *(EMS P1 rural response under 40 minutes rate)**	50%	40%	45%	50%	50%
3. All calls with a response time within 60 minutes) *(EMS P1 call response under 60 minutes rate)**	65%	46%	53%	59%	65%
4. Total number of EMS emergency cases (*EMS clients total)**	600,000	150,000	150,000	150,000	150,000
5. Total number of inter facility transfers (*EMS inter-facility transfer)**	200,000	50,000	50,000	50,000	50,000
Annual Targets					
6. Rostered ambulances per 10,000 people *(EMS operational ambulance coverage (annualised))**	0.28 (300)				0.28 (300)
7. Locally based staff with training in BLS (BAA)	61%				61%
8. Locally based staff with training in ILS (AEA)	32%				32%
9. Locally based staff with training in ALS (Paramedics)	4%				4%
10. Locally based staff with training as ECT (Emergency Care Technician)	3%				3%
11. Number of successfully trained ILS staff	144				144
12. Number of successfully trained ECT staff	0				0
13. Number of successfully trained ALS staff	0				0

- Note: Population-based baselines and targets are based on mid-year 2011 population estimates (Stats SA). Census 2011 will have an impact on data in 2013/14.
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

3.9. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS – 2012/13

Table 67: (EMS5 (A)): Expenditure estimates for Emergency Medical Services

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R' thousands	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Emergency Transport	721 478	790 015	1 032 954	1 007 942	933 012	908 971	907 217	994 518	1 053 444
Planned Patient Transport	41 001	32 603	37 433	37 946	40 419	40 419	65 145	69 420	73 284
Total	**762 479**	**822 618**	**1 070 387**	**1 045 888**	**973 431**	**949 390**	**972 362**	**1 063 938**	**1 126 728**

Table 68: (EMS5 (b)): Summary of Provincial Expenditure estimates by Economic Classification

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Current payments	**690 875**	**733 709**	**856 411**	**971 966**	**889 428**	**872 403**	**936 252**	**1 019 378**	**1 081 940**
Compensation of employees	486 534	521 434	595 253	691 586	638 830	638 830	702 642	758 261	804 617
Goods and services	**204 341**	**212 275**	**261 158**	**280 380**	**250 598**	**233 573**	**233 610**	**261 117**	**277 323**
Communication	12 940	9 786	9 574	9 911	9 710	**9 710**	11 654	12 167	12 507
Computer Services	-	-	-	25 394	17 000	-	-	-	-
Consultants, Contractors and special services	67 787	69 158	86 220	80 748	7 188	7 188	7 292	7 753	8 075
Inventory	74344	83717	106933	99835	108958	108958	128278	140095	152514
Operating leases	4 231	4 722	4 469	4 672	2 277	2 277	3 138	3 306	3 471
Travel and subsistence	4 999	3 266	4 936	5 158	6 840	6 840	6 211	6 522	6 848
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	40 040	41 626	49 026	54 662	98 625	98 600	77 037	91 274	93 908

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Transfers and subsidies to	**2 260**	**2 966**	**3 230**	**3 922**	**5 892**	**5 892**	**6 110**	**4 560**	**4 788**
Provinces and municipalities	1 232	1 461	1 842	1 832	2 400	2 400	2 415	2 040	2 142
Households	1 028	1 505	1 388	2 090	3 492	3 492	3 695	2 520	2 646
Payments for capital assets	**69 344**	**85 673**	**210 745**	**70 000**	**78 111**	**71 095**	**30 000**	**40 000**	**40 000**
Buildings and other fixed structures	-	19	-	-	-	-	-	-	-
Machinery and equipment	69 344	85 654	210 745	70 000	78 111	71 095	30 000	40 000	40 000
Payment for financial assets	-	270	1	-	-	-	-	-	-
Total economic classification	**762 479**	**822 618**	**1 070 387**	**1 045 888**	**973 431**	**949 390**	**972 362**	**1 063 938**	**1 126 728**

3.10. PERFORMANCE AND EXPENDITURE TRENDS

The reduction in the *2012/13 Adjusted Appropriation and Revised Estimates* is attributed to savings from the replacement process of the ageing emergency fleet as repair and fuel costs of new ambulances are lower, as well as the slower than expected process to fill vacant posts.

Funding increase in the *2013/14 MTEF* period provides for inflationary adjustment and the gradual filling of vacant posts that is dependent upon availability of skilled candidates and the number of ambulances in the fleet.

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

The increase in *Compensation of Employees in* 2013/14 is for the filling of essential posts, both in management and at operational level.

The main cost drivers under *Goods and Services* are fuel and repairs to emergency vehicles, the latter being related to the rough terrain in the rural areas of the province. These costs will increase as the service expands with a related increase in the size of the fleet.

The inflated amount in 3023/24 in *Transfers and Subsidies to: Households Adjusted Appropriation and Revised Estimates* pertain to a legal claim against the department by the First Aid League and the increase in staff exit costs.

Construction of the Emergency Communication Centre in Umgungundlovu, large ambulance base in Umzinyathi, medium base at King Dinuzulu (King George V) Hospital, and commissioning of the Wentworth EMS base station in 2013/14 will have cost implications during the MTEF.

R30 million has been allocated for the purchase of new ambulances in 2013/14.

3.11. RISK MANAGEMENT

POTENTIAL RISKS	MITIGATING FACTORS
1. Infrastructure backlogs including accommodation, office space, ambulance bases, customised wash bays and sluice facilities (High).	• Prioritisation in U-AMP.
2. Perpetuating backlog/ shortage of ambulances and trained staff with a limiting funding envelope for the MTEF (High).	• Implementation of the reviewed EMS strategy.
3. Skills pool (EMS qualifications) inadequate therefore impacts on the quality of EMS services (High).	• Review training strategy.
4. Cross infection to EMS clinical staff and patients (High).	• Implementation of Infection Prevention and Quality Control Policy.
5. Delayed or non-response to emergency calls (High).	• Improvement of call categorization/ prioritization.
6. Sexual and physical assault to EMS personnel (High).	• Community awareness campaigns.
7. Delays with disciplinary cases of personnel (High).	• Recruit labour specialists.
8. High number of vehicle accidents caused by staff (High).	• Institute driver training programmes.

PROGRAMME 4: REGIONAL AND SPECIALISED HOSPITALS

4.1. PROGRAMME PURPOSE AND STRUCTURE

Sub-Programme 4.1: Regional Hospitals

Render Regional Hospital Services at specialist level

Sub-Programme 4.2: Specialised TB Hospitals

Render Hospital services for TB, including Multi-Drug Resistant TB

Sub-Programme 4.3: Specialised Mental Health Hospitals

Render Hospital services for Mental Health

Sub-Programme 4.4: Oral and Dental Training Centre

Render comprehensive Dental Health services and provide training for Oral Health personnel

Sub-Programme 4.5: Step-Down and Rehabilitation Hospitals

Render Step-Down and Rehabilitation services to the chronically ill

There is no change in the purpose of Programme 4 since tabling of the 2010 - 2014 Strategic Plan.

Programme performance measures, not specifically identified as priority in the APP, are included in the Operational Plans and monitored quarterly to ensure effective performance monitoring. Specific output and outcomes will be included in the Annual Report.

4.2. REGIONAL HOSPITALS

4.2.1. OVERVIEW

There are 13 Regional Hospitals in the Province, of which 11 are rendering some tertiary services to improve equity and access. All Regional Hospitals render level one services as part of their package of services although it is not possible to quantify the actual breakdown of level 1 and 2 services.

One of the main aims of PHC re-engineering and strengthening of the District Health System (DHS) is to improve the management of patients at primary care level thereby decongesting hospitals (including regional hospitals) at the same time.

Ngwelezane Hospital in Uthungulu (previously classified as a Regional Hospital) has been re-classified as a Developing Tertiary Hospital (Government Notice No. R185).[10] For reporting purposes, this hospital has therefore been moved to Programme 5: Tertiary and Central Hospitals.

King Edward VIII Hospital in eThekwini has been re-classified as a Central Hospital (Government Notice No. R185).[10] The classification is relevant to the "new" King Edward Hospital that will be part of the new academic complex with Inkosi Albert Luthuli Central Hospital and the University of KZN (UKZN).

There are currently 7,613 approved level 2 beds in the province, translating to 0.71 beds per 1000 population (compared with the national norm of 0.23 beds per 1000 population).

4.2.2. CHALLENGES

- Efficient management of the acute caseload in hospitals, exacerbated by congestion due to patients bypassing PHC or District Hospital services. In some districts this is specifically relevant due to poor access to District Hospitals.

- Improving access to specialist ambulatory care through appropriate devolution to DHS – change management.
- Hospital efficiency and quality of patient care.
- Effective financial management and compliance to the Public Finance Management Act (PFMA).
- Information systems and management including poor quality of data and use of information for planning and decision-making.
- Inadequate human resources for health (supply versus demand) within the current funding envelope. Alignment of Human Resource Plans to service delivery demand.
- Referral arrangements including up/down referral and provision of step-down beds.

4.2.3. 2013/14 PRIORITIES: REGIONAL HOSPITALS

PROVINCIAL PRIORITIES	STRATEGIES AND CORE ACTIVITIES
1. Overhauling Regional Hospital services.	• Finalise reviewed service delivery platform and service arrangements. • Human Resources for Health Strategy in line with service delivery platform (gaps and demand). Determine human resource gaps using WISN and finalising customised post establishments to speed up filling of critical posts. • Develop one High Volume Cataract Surgery Unit. • Strengthen management capacity and accountability. • Improve access to Forensic Psychiatry i.e. observation units at Madadeni and Umzimkhulu Hospitals. • Critical review of efficiency indicators.
2. Improve the quality and efficiency of Regional Hospital services.	• Implement the National Core Standards in all facilities to improve: – Availability of medicines and supplies – Cleanliness – Patient safety – Infection prevention & control – Positive and caring staff attitudes – Patient waiting times • Institutionalise clinical governance and improve clinical support through Telemedicine and support. • Improve service arrangements for outreach services to District Hospitals including Flying Doctors.

4.2.4. PERFORMANCE INDICATORS FOR REGIONAL HOSPITALS

Table 69: (PHS2): Performance Indicators for Regional Hospitals

Indicator	Data Source	Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2015/16
1. Caesarean Section Rate *(Delivery by caesarean section rate)**	DHIS	Rate	38.8%	38.8%	38.2% N: 31,259 D: 81,790	**39%** *Mid-Year 39.4%* *N: 15,745* *D: 39,919*	37.5%	37%	37%	>25%
2. Separations *(Inpatient separations – total)**	DHIS	No	355,231	372,902	381,657	**368,862** *Mid-Year 180,076*	376,239	383,764	391,439	-
3. Patient day equivalents	DHIS	No	2,903,847	3,238,319	3,343,858	**3,240,454** *Mid-Year 1,538,520*	3,305,263	3,371,368	3,438,796	-
4. OPD total headcount *(OPD headcount – total)**	DHIS	No	2,673,272	3,195,790	3,336,687	**3,107,680** *Mid-Year 1,553,840*	3,231,987	3,361,267	3,495,717	-
5. Average length of stay *(Average length of stay – total)**	DHIS	Days	5 Days	5.4 Days	5.5 Days	**5.4 Days** *Mid-Year 5.4 Days* *N: 973,200* *D: 180,076*	5 Days	5 Days	5 Days	4.8 Days
6. Bed utilisation rate *(Inpatient Bed utilisation rate – total)**	DHIS	Rate	72.8%	63.6%	78.4%	**77%** *Mid-Year 76.5%* *N: 973,200* *D: 1,272,755*	75%	75%	75%	75%
7. Expenditure per patient day equivalent(PDE)[57]	BAS/ DHIS	R	R 1 421	R 1 380	R 2 134 N: R7 136 117 884 D: 3,343,858	**R 2 100**[58] *Mid-Year R 2116* *N: R3 255 997 471* *D:1 538 820*	R 2 047 N: R6 766 177 000 D: 3,305,263	R 2 122 N: R7 153 795 000 D: 3,371,368	R 2 202 N: R7 570 647 000 D: 3,438,796	-

[57] For planning purposes, budget for NPI's, Fleet, NHLS, registrars, radiological services, HTS, JME and Flying Doctors has been included in the budget projections
[58] Expenditure/cost will be closely monitored to determine a more reliable baseline (using new improved methodology to calculate actual cost)

PROGRAMME 4: REGIONAL AND SPECIALISED HOSPITALS

Indicator	Data Source	Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2015/16
8. Percentage of complaints of users of Regional Hospital services resolved within 25 days. *(Complaint resolution within 25 working days rate)**	DHIS	%	84%	79%	66% N: 534 D: 807	**70%** *Mid-Year 62.9%* *N: 266* *D: 423*	75%	80%	85%	-
9. Percentage of Regional Hospitals with monthly mortality and morbidity meetings *(Mortality and morbidity review rate)**	DQPR	%	100%	100%	100%	**100%** *Mid-Year 100%* *N: 13* *D: 13*	100%	100%	100%	100%
10. Regional Hospital Patient Satisfaction rate *(Patient Satisfaction Rate)**	DQPR	Rate	Reporting not required	Reporting not required	60%	**Data incomplete**	80%	90%	90%	90%
11. Number of Regional Hospitals assessed for compliance against the 6 Priorities of the core standards *(Number of Hospitals assessed for compliance against the 6 Priorities of the core standards)**	DQPR	No	Reporting not required	Reporting not required	14	**13** *Mid-Year 12*	13	13	13	-

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator
- Indicator 6: Target kept at 75% (considered as appropriate efficiency measure) based on current availability of resources.
- Ngwelezane Hospital, previously classified as Regional Hospital, has been reclassified as a Developing Tertiary Hospital and moved from Programme 4 to Programme 5. This inevitably affects the trends/targets.
- Indicator 7: Expenditure trends will be monitored in 2013/14 to establish new baselines based on improved methodology to determine actual cost.
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

4.2.5. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR REGIONAL HOSPITALS

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 70: (PHS1 (a)): Provincial Strategic Objectives and Annual Targets for Regional Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
1.14) To rationalize hospital services in line with service delivery needs and STP imperatives[59]	1.14.5) Number of Regional Hospitals designated as Ophthalmic Centres of Excellence	APP	DQRS	Reporting not required	Reporting not required	Nil	**0** *Mid-Year 0*	3 (3)	1 (4)	1 (5)

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.

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

Table 71: (PHS1 (b)): Provincial Strategic Objectives and Annual Targets for Regional Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
2.3) To implement the National Core Standards in 100% of Regional Hospitals for accreditation of 7/13 Regional Hospital by 2014/15[60]	2.3.1) Number of Regional Hospitals compliant with the 6 priority areas of Core Standards	7/13	DQPR	Reporting not required	Nil	Nil	**0** *Mid-Year 0*	3 (3)	4 (7)	6 (13)

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.

[59] Rationalisation of hospital services will be aligned with the STP (all components), NHS 10-Point Plan and informed by current service delivery needs, disease profile and funding envelope – assessment and output will be informed by the STP Implementation Plan

[60] Accreditation is dependent on the National processes

4.2.6. QUARTERLY AND ANNUAL TARGETS FOR REGIONAL HOSPITALS

Table 72: (PHS4 (a): Quarterly and Annual Targets for Regional Hospitals - 2013/14

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Caesarean Section Rate *(Delivery by caesarean section rate)**	37.5%	38.5%	38%	38%	37.5%
2. Separations *(Inpatient separations – total)**	376,239	94,059	188,118	282,177	376,239
3. Patient day equivalents	3,305,263	826,315	1,652,630	2,478,945	3,305,263
4. OPD total headcount *(OPD headcount – total)**	3,231,987	807,996	1,615,992	2,423,988	3,231,987
5. Average length of stay *(Average length of stay – total)**	5 Days	5.4 Days	5.3 Days	5.2 Days	5 Days
6. Bed utilisation rate *(Inpatient Bed utilisation rate – total)**	75%	75%	75%	75%	75%
7. Expenditure per patient day equivalent	R 2 047	R 2 047	R 2 047	R 2 047	R 2 047
8. Percentage of complaints of users of Regional Hospital services resolved within 25 days. *(Complaint resolution within 25 working days rate)**	75%	70%	75%	75%	75%
9. Percentage of Regional Hospitals with monthly mortality and morbidity meetings *(Mortality and morbidity review rate)**	100%	100%	100%	100%	100%
Annual Targets					
10. Regional Hospital Patient Satisfaction rate *(Patient Satisfaction Rate)**	80%				80%
11. Number of Regional Hospitals assessed for compliance against the 6 Priorities of the core standards *(Number of Hospitals assessed for compliance against the 6 Priorities of the core standards)*	13				13

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
12. Number of Regional Hospitals compliant with the 6 priority areas of the Core Standards	3				3
13. Number of Regional Hospitals designated as Ophthalmic Centres of Excellence	3				3

- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

4.2.7. RISK MANAGEMENT

POTENTIAL RISKS	MITIGATING FACTORS
1. Recruitment and retention of appropriate numbers of appropriately qualified and experienced professional health workers and support staff (High).	• Align HR Plan(s) (approved posts based on WISN) and fast track filling of critical posts. • Improve collaboration between UKZN and other Higher Education Institutions to improve long-term supply of health workforce. • Review retention packages especially relevant to rural/periphery areas.
2. Increasing workload within resource constrained environment compromise quality of care (High).	• Strengthen clinical governance and quality control. • Institutionalise clinical audits and mortality/ morbidity meetings within institutions and surrounds. • Improve service arrangements to make provision for out-reach and support services. • Active implementation of the National Core Standards and Quality Improvement Plans to improve compliance to core standards.
3. Revitalisation of hospital services within budget constraints (High).	• Re-prioritisation and optimisation of current resources.
4. Ineffective information management (including quality of data, M&E, and reporting) compromising planning and decision-making) (High).	• Implement the Information Turn-Around Strategy. • Strengthen information reviews involving all staff from source.

4.3. SPECIALISED TB HOSPITALS

4.3.1. OVERVIEW

There are 12 Specialised TB Hospitals (2 State Aided) and 7 decentralised MDR-TB Units in the Province, with no Specialised TB Hospitals in Uthukela, Amajuba, Umkhanyakude, Uthungulu, and Ilembe. There are 2,012 approved TB beds in Specialised Hospitals translating to 0.19 beds per 1000 population. There are 410 MDR-TB beds in decentralised and satellite MDR-TB Units, while acute beds are available in District Hospitals. Referral arrangements have been determined for referral of TB patients.

King Dinuzulu (George V) Hospital (eThekwini) remains the Centre of Excellence for MDR-TB services. Philanjalo, a NGO assisting the Department with the development of a community-based model for MDR-TB management, has been tasked to establish norms for the allocation of the Mobile Injection Teams.

4.3.2. CHALLENGES

- Equitable distribution of TB beds (including beds for drug-resistant TB).
- Growing numbers of drug-resistant TB without concomitant increase in resources.
- Integration of TB services with mainstream PHC services specifically referring to transfer of stable TB patients to community-based services.
- Human Resources constraints especially relevant to the management of drug-resistant TB.
- Infrastructure constraints (all facilities and not exclusive to TB hospitals) jeopardising effective Infection Prevention and Control practices.

4.3.3. 2012/13 PRIORITIES FOR SPECIALISED TB HOSPITALS

PROVINCIAL PRIORITIES	STRATEGIES AND CORE ACTIVITIES
1. Decentralised and Satellite MDR TB Units.	• Review service platform for the management of MDR-TB. • Community-based management of MDR-TB linked with in-patient care and PHC re-engineering. • Review of post establishments (based on gap analysis using WISN) and fast track filling of critical posts.
2. Overhauling Specialised TB Hospitals.	• Revitalisation of Specialised TB Hospitals informed by the TB burden of disease. • Implement the National Core Standards to improve: – Availability of medicines and supplies. – Cleanliness. – Patient safety. – Infection prevention & control. – Positive and caring staff attitudes. – Patient waiting times. • Improved management capacity and accountability. • Critical review of efficiency indictors.

4.3.4. PERFORMANCE INDICATORS FOR SPECIALISED TB HOSPITALS

Table 73: (PHS2 (b)): Performance Indicators for Specialised TB Hospitals

Indicator	Data Source	Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
1. Separations *(Inpatient separations – total)**	DHIS	No	9,113	9,289	10,662	**13,354** *Mid-Year 6,677*	13,775	14,167	14,592
2. Patient day equivalents	DHIS	No	518,685	482,323	491,803	**501,192** *Mid-Year 250,596*	511,216	521,440	531,869
3. OPD total headcount *(OPD headcount – total)**	DHIS	No	64,853	136,853	206,452	**235,248** *Mid-Year 117,624*	244,658	254,444	264,622
4. Average length of stay *(Average length of stay – total)**	DHIS	Days	54.5 Days	25.9 Days	39.9 Days	**32 Days** *Mid-Year 31.1 Days* *N: 207,409 D: 6,677*	30 Days	30 Days	30 Days
5. Bed utilisation rate *(Inpatient Bed utilisation rate – total)* *	DHIS	Rate	70.1%	58.1%	62.2%	**62%** *Mid-Year 59.9%* *N: 207,409 D: 346,507*	68%	72%	75%
6. Expenditure per patient day equivalent (PDE)[61]	DHIS/ BAS	R	R 1 516	R 1 750	R 1 814 N: 892,013,737 D: 491,803	**R 1 100**[62] *Mid-Year R 960* *N:R240 537 006 D:250,596*	R 1 221 N: R624 381 000 D: 511,216	R 1 301 N: R678 302 000 D: 521,440	R 1 406 N: R747 904 000 D: 531,869

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

[61] For planning purposes, NHLS costs for Genie Expert and NPI's have been included in the projected budget figures
[62] New baselines will be determined using a new methodology to calculate expenditure per PDE

4.3.5. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND TARGETS FOR SPECIALISED TB HOSPITALS

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

Table 74: (PHS1 (d)): Provincial Strategic Objectives and Annual Targets for Specialised TB Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
2.4) To implement the National Core Standards in 100% of Specialised TB Hospitals for accreditation of 100% hospitals by 2014/15[63]	2.4.1) Number of Specialised TB Hospitals compliant with the 6 priorities of the Core Standards	10 / 10 Reviewed 2012/13	National database	Reporting not required	Reporting not required	Nil	**0** *Mid-Year 0*	3 (6)	4 (10)	5 (10)

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.

4.3.6. QUARTERLY AND ANNUAL TARGETS FOR SPECIALISED TB HOSPITALS

Table 75: (PHS4 (b)): Quarterly and Annual Targets for Specialised TB Hospitals for 2013/14

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Separations *(Inpatient separations – total)**	13,755	2,480	4,961	7,440	13,755
2. Patient day equivalents	511,216	127,804	255,608	383,412	511,216
3. OPD total headcount *(OPD headcount – total)**	244,658	61,164	122,328	183,492	244,658
4. Average length of stay *(Average length of stay – total)**	30 Days	29 Days	29.5 Days	30 Days	30 Days

[63] Official accreditation is dependent on establishment of the National Accreditation Body. Compliance to standards are monitored at provincial level continuously

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
5. Bed utilisation rate *(Inpatient Bed utilisation rate – total)**	68%	64%	66%	67%	68%
6. Expenditure per patient day equivalent	R 1 221	R 1 221	R 1 221	R 1 221	R 1 221
Annual Targets					
7. Number of Hospitals compliant with the 6 priorities of the Core Standards	3				3

- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.
- Indicator 6: Expenditure is currently being reviewed and will be adjusted in-year

4.3.7. RISK MANAGEMENT

POTENTIAL RISKS	MITIGATING FACTORS
1. Psycho-social factors associated with TB negatively impacting on successful completion of treatment (High).	• Provincial response to HIV and AIDS (KZNPSP) and OSS.
2. Integration of the TB Programme with PHC i.e. PHC Family Health Teams, School Health Teams, etc. to improve prevention and support programmes (High).	• Implementation of an integrated PHC strategy.
3. Poor infection prevention and control mechanisms (infrastructure backlogs, M&E) (High).	• Re-prioritise infrastructure requirements (not related to specialised hospitals only). • Improved clinical governance, Quality Assurance, and Supervision to ensure sustained good practice. • Implementation of the National Core Standards.

4.4. SPECIALISED PSYCHIATRIC HOSPITALS

4.4.1. OVERVIEW

There are 6 Specialised Psychiatric Hospitals in the Province with the biggest number of hospitals (beds) in the Umgungundlovu District. Access to regional and tertiary psychiatric services are severely under-resourced in all the districts.

There are 3,244 approved beds translating to 0.31 beds per 1000 population with a significant shortfall of acute beds in eThekwini, Ugu, and Ilembe. Region 4 is severely under-resourced in terms of both acute and chronic beds.

4.4.2. CHALLENGES

- Increasing demand for mental health services without concomitant increase in resources.
- Extended waiting list for awaiting trial prisoners due to inadequate forensic services.
- Staff shortages of all categories of staff e.g. Psychiatrists, Psychologists, and Psychiatric Nurses.
- Inadequate infrastructure for mental health care users including, but not limited to, seclusion rooms.
- Delays in the full commissioning of King Dinuzulu (George V) Hospital pose a challenge in terms of the support that the Hospital should be offering to District Hospitals. The hospital is currently operating with 60 instead of 130 beds.
- Poor integration of services at PHC level (including District Hospitals) resulting in congestion of regional/ specialised hospitals with level-1 patients.

4.4.3. 2012/13 PRIORITIES: SPECIALISED PSYCHIATRIC HOSPITALS

PROVINCIAL PRIORITIES	STRATEGIES AND CORE ACTIVITIES
• Revitalisation of Psychiatric services.	• Review service delivery platform of Ekuhlengeni and Umgeni Waterfall Institute and develop an appropriate service delivery plan for revitalization. • Critical review of efficiency indicators.
	• Expedite full commissioning of King Dinuzulu (George V) Psychiatric Hospital.
	• . Implement the National Core Standards to improve: – Availability of medicines and supplies. – Cleanliness. – Patient safety. – Infection prevention & control. – Positive and caring staff attitudes. – Patient waiting times.
	• Improve hospital management and accountability.
	• Finalise service arrangements for Child and Adolescent services.

4.4.4. PERFORMANCE INDICATORS FOR SPECIALISED PSYCHIATRIC HOSPITALS

Table 76: (PHS2 (c)): Performance Indicators for Specialised Psychiatric Hospitals

Indicator	Data Source	Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
1. Patient day equivalents	DHIS	No	628,878	644,750	626,312	**640,140** *Mid-Year 320,070*	652,943	666,002	679,322
2. Separations *(Inpatient separations – total)**	DHIS	No	1,965	2,945	2,531[64]	**2,358** *Mid-Year 1,179*	2,429	2,502	2,577
3. OPD total headcount *(OPD headcount – total)**	DHIS	No	14,409	7,994	15,425	**13,840** *Mid-Year 6,920*	14,117	14,399	14,687
4. Average length of stay *(Average length of stay – total)**	DHIS	Days	1,315 Days	37.9 Days[65]	32.1 Days	**269 Days** *Mid-Year 269.5 Days N: 317,761 D: 1,179*	269 Days	269 Days	269 Days
5. Bed utilisation rate *(Inpatient Bed utilisation rate – total)**	DHIS	Rate	71.6%	73.8%	83.3%	**72%** *Mid-Year 68.8% N: 317,761 D: 461,543*	75%	75%	75%
6. Expenditure per patient day equivalent	DHIS/ BAS	R	R 811	R 864	R 924 N: 578,716,787 D: 626,312	**R 1 050** *Mid-Year R 912 N:R 292 015 768 D:320,070*	R 1 073 N: R 700 652 000 D: 652,943	R 1 131 N: R 752 946 000 D: 666,002	R 1 179 N: R 800 722 000 D: 679,322

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Historic data for specialized hospitals is a challenge. Data will be verified and discussed with both district and facility management which should resolve the data quality issues.
- Indicator 6: Expenditure trends will be monitored in 2013/14 to establish new baselines based on improved methodology to determine actual cost

[64] Data has been corrected since publishing of the Annual Report 2011/12

[65] The 2010/11 and 2011/12 data for Average Length of Stay – total is not comparable to previous years for specialized hospitals due to a formula change which now includes the Day patients as part of the denominator (Separations). This was previously excluded.

- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

4.4.5. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND TARGETS FOR SPECIALISED PSYCHIATRIC HOSPITALS

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

Table 77: (PHS1 (f)): Provincial Strategic Objectives and Annual Targets for Specialised Psychiatric Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
2.5) To implement the National Core Standards in 100% of Specialised Psychiatric Hospitals for accreditation of 100% hospitals by 2014/15[66]	2.5.1) Number of Specialised Psychiatric Hospitals compliant with the 6 priorities of the Core Standards	6/ 6	DQPR	Reporting not required	Reporting not required	Nil	**0** *Mid-Year 0*	2	3 (5)	1 (6)

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.

4.4.6. QUARTERLY AND ANNUAL TARGETS FOR SPECIALISED PSYCHIATRIC HOSPITALS

Table 78: (PHS4 (c)): Quarterly and Annual Targets for Psychiatric Hospitals for 2013/14

Performance Indicator	Target 2013/14	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Patient day equivalents	652,943	163,235	326,470	490,413	652,943
2. Separations *(Inpatient separations – total)**	2,429	927	927	927	2,429

[66] Accreditation is dependent on the National processes

Performance Indicator	Target 2013/14	Targets			
		Q1	Q2	Q3	Q4
3. OPD total headcount *(OPD headcount – total)**	14,119	3,529	7,058	10,587	14,119
4. Average length of stay *(Average length of stay – total)**	269	269 Days	269 Days	269 Days	29 Days
5. Bed utilisation rate *(Inpatient Bed utilisation rate – total)**	75%	71%	75%	75%	75%
6. Expenditure per patient day equivalent	R 1 073	R 1 073	R 1 073	R 1 073	R 1 073
Annual Targets					
7. Number of Hospitals compliant with the 6 priority areas of the Core Standards	2				2

- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

4.4.7. RISK MANAGEMENT

POTENTIAL RISKS	MITIGATING FACTORS
1. Poor integration of services especially at PHC level increase in-patient services without concomitant increase in resources (Medium).	• Implement the integrated PHC re-engineering strategy. • Make provision for appropriate allocation of beds based on disease burden and demand for services.
2. Human resources for health – shortage of appropriately trained staff (Medium).	• Align HR Plan with service gaps (WISN gap analysis). • Scale up training and development plan.

4.5. ORAL AND DENTAL TRAINING CENTRE

The Oral and Dental Training Centre (ODTC) is currently part of the King Dinuzulu (George V) Hospital in eThekwini and has two main functions namely training of Dental Therapist and Oral Hygienists and Public Health service delivery. The Centre is linked to the training programme for Dental Therapy and Oral Hygiene students at UKZN and produces an average of 30 students per year for combined degrees. The Centre also provides basic dental services, specialised dental services, as well as limited tertiary services for teaching purposes – average patient headcount is 2,200 per month.

The package of services at the centre includes:

- Primary Health Care: examination and patient charting, education, and management of pain and sepsis.
- Secondary and Tertiary Services: prosthodontics, Orthodontics, Periodontics and Maxillofacial and Oral Surgery.

The Department, in partnership with UKZN, is developing a long-term strategy to improve output of the ODTC including training and service delivery.

4.5.1. CORE CHALLENGES

- High patient demand for extractions instead of preventive and restorative work.
- Long waiting time for dentures which is expected to improve with the opening of the dental laboratory at IALCH.
- Shortage of dental chairs and lack of working stations for staff. UKZN procured and replaced 22 new dental chairs in 2011 which will improve service delivery.

4.5.2. 2012/13 PRIORITIES: ORAL & DENTAL TRAINING CENTRE

PROVINCIAL PRIORITIES	STRATEGIES AND CORE ACTIVITIES
1. Revitalisation of the Oral and Dental Training Centre.	• Expand specialised treatment services i.e. Prosthodontics and Orthodontics. • Revitalisation Plan in collaboration with UKZN.

4.6. ADDINGTON CHILDREN'S HOSPITAL

Phase 1 of the new Children's Hospital commenced in June 2011, and the re-construction of the "Old Outpatients Building" commenced in February 2012.

A training Centre, Adolescent Clinic Child Development Assessment Centre (including psychological support, allied health services) and temporary parking is planned for completion of Phase 1 in the 2012/13 financial year.

The service delivery platform will be aligned with the new King Edward VIII Hospital and Inkosi Albert Luthuli Central Hospital.

4.7. STEP-DOWN, REHABILITATION & CHRONIC HOSPITALS

Clairwood Hospital in eThekwini provides long term residential care to patients with degenerative diseases. The hospital provides palliative treatment and care within the scope of practice of a Professional Nurse under supervision of a General Practitioner. In instances where more specialized treatment is required patients are referred. The hospital has 426 approved beds translating to 0.04 beds per 1000 population. Ntambanana in Uthungulu District is not functional due to the high crime incidence in the area.

Hillcrest Hospital in eThekwini provides long term chronic care. Due to poor support at community level, the hospital length of stay is extended to sustain treatment gains and prevent costly relapses. Due to the low level of acuity of patients, treatment procedures falling within the scope of practice of a Staff Nurse (under the indirect supervision of a Professional Nurse and General Practitioner) are provided. There are 212 approved beds in the institution which translates to 0.02 beds per 1000 population.

4.7.1. CHALLENGES

- Inadequate provision for step-down and rehabilitative care in all districts.

4.7.2. 2012/13 PRIORITIES CHRONIC/ SUB-ACUTE HOSPITALS

PROVINCIAL PRIORITIES	STRATEGIES AND CORE ACTIVITIES
1. Revitalisation of Chronic and Sub-Acute Hospital services.	• Review service delivery platform of all institutions. • Implement the national core standards to improve efficiency and quality. • Improve management capacity and accountability. • Critical review of efficiency indicators.

4.7.3. PERFORMANCE INDICATORS AND TARGETS FOR CHRONIC HOSPITALS

Table 79: (PHS2 (d)): Performance Indicators for Chronic Hospitals

Indicator	Data Source	Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
1. Separations *(Inpatient separations – total)**	DHIS	No	4,344	3,591	5,934	**3,636** *Mid-Year 1,818*	3,745	3,857	3,973
2. Patient day equivalents	DHIS	No	150,513	174,525	181,411	**134,546** *Mid-Year 67,273*	137,237	139,982	142,781
3. OPD total headcount *(OPD headcount – total)**	DHIS	No	Not available	136,951	157,386	**156,306** *Mid-Year 78,153*	162,558	169,061	175,823
4. Average length of stay *(Average length of stay – total)**	DHIS	Days	27 Days	24.3 Days[67]	22.1 Days	**34 Days** *Mid-Year 36.4 Days N: 66,233 D: 1,818*	30 Days	30 Days	30 Days
5. Bed utilisation rate *(Inpatient Bed utilisation rate – total)**	DHIS	Rate	82.5%	63.4%	61.2%	**65.2%** *Mid-Year 65% N: 66,233 D: 101,835*	70%	75%	75%
6. Expenditure per patient day equivalent (PDE)	DHIS/ BAS	R	R 662.08	R 574	R 602 N: 109 131 253 D: 181,411	**R 1 500**[68] *Mid-Year R 1 486 N: R 99 974 797 D:67,273*	R 1 596 N: R 219 021 000 D: 137,237	R 1 738 N: R 243 323 000 D: 139,982	R 1 811 N: R 258 694 000 D: 142,781

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator
- Indicators 1 to 6: Historic data for these indicators is questionable with no correlation between indicators and data elements. Verification will form part of the M & E and Data Turn-Around Strategy.

[67] The 2010/2011 figure for Average Length of Stay is not comparable to previous years for specialized hospitals due to a formula change which now includes the Day patients as part of the denominator (Separations). This was previously excluded.

[68] The cost per PDE will be significantly lowered to about R 1000 / PDE when the PDE (OPD Headcount) is resolved in Clairwood Hospital and correct methodology for costing can be employed to determine expenditure

- Indicator 3: Mid-year data (DHIS) includes data for Hillcrest Hospital (3,153) only. Clairwood Hospital (with an average 150,000 headcount annually) reported no data for the same period. Whilst data is being verified, the estimated performance has been calculated using an average 75,000 mid-year headcount for Clairwood Hospital.
- Indicator 6: Expenditure trends will be monitored in 2013/14 to establish new baselines based on improved methodology to determine actual cost Expenditure/cost will be monitored to establish new baselines based on improved calculation
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

4.7.4. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND TARGETS FOR CHRONIC HOSPITALS

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

Table 80: (PHS1 (h)): Provincial Strategic Objectives and Annual Targets for Chronic Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
2.6) To implement the National Core Standards in 100% of Specialised Chronic Hospitals for accreditation of 100% hospitals by 2011/12[69]	2.6.1) Number of Chronic Hospitals compliant with the 6 priority areas of the Core Standards	2/ 2	DQPR	Reporting not required	Reporting not required	Nil	**0** *Mid-Year 0*	1	1 (2)	2

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.

[69] Accreditation is dependent on the National processes

4.7.5. QUARTERLY AND ANNUAL TARGETS FOR CHRONIC HOSPITALS

Table 81: (PHS4 (d)): Quarterly and Annual Targets for Chronic Hospitals for 2013/14

Performance Indicator	Target 2013/14	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Separations *(Inpatient separations – total)**	3,745	1,056	2,110	3,165	4,223
2. Patient day equivalents	137,237	54,028	108,056	162,085	216,114
3. OPD total headcount *(OPD headcount – total)**	162,558 1	40,639	81,278	121,917	162,558
4. Average length of stay *(Average length of stay – total)**	24 Days	28.5 Days	26 Days	25.5 Days	24 Days
5. Bed utilisation rate *(Inpatient Bed utilisation rate – total)**	70%	68%	69%	70%	70%
6. Expenditure per patient day equivalent	R 1 596	R 1 596	R 1 596	R 1 596	R 1 596
Annual Targets					
7. Number of Hospitals compliant with the 6 priority areas of the Core Standards	1				1

- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

4.7.6. RISK MANAGEMENT

POTENTIAL RISKS	MITIGATING FACTORS
1. Inadequate step-down facilities to make provision for burden of disease (High).	• Review step-down allocation per district to decongest active hospital beds.
2. Poor data quality (High).	• Implement data management strategy.

4.8. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 82: (PHS4 (a)): Summary of payments and estimates Programme 4

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R' thousands	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
General [Regional] Hospitals	3 605 690	4 103 981	5 472 515	5 989 701	6 362 044	6 296 009	6 766 177	7 153 795	7 570 647
Tuberculosis Hospitals	783 099	832 030	891 705	787 875	592 578	592 578	624 381	678 302	747 904
Psychiatric Hospitals	503 667	533 949	570 999	655 155	650 141	642 392	700 652	`755 946	800 722
Sub-acute, step-down and chronic medical hospitals	99 578	102 531	109 131	119 006	207 406	207 406	219 021	240 323	258 694
Dental training hospital	10 685	12 266	14 481	16 652	15 064	15 064	16 170	16 909	17 911
Other specialised hospitals	-	-	-	-	-	-	-	-	-
Total	**5 002 719**	**5 584 757**	**7 058 831**	**7 568 389**	**7 827 233**	**7 753 449**	**8 326 401**	**8 845 275**	**9 395 878**

Table 83: (PHS4 (b)): Summary of payments and expenditure by Economic Classification Programme 4

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Current payments	**4 926 492**	**5 494 350**	**6 939 951**	**7 490 163**	**7 706 040**	**7 644 679**	**8 220 260**	**8 719 487**	**9 243 792**
Compensation of employees	3 486 099	4 074 121	5 203 373	5 531 354	5 901 669	5 863 667	6 288 416	6 684 105	7 074 666
Goods and services	**1 440 393**	**1 420 229**	**1 736 578**	**1 958 809**	**1 804 371**	**1 781 012**	**1 931 844**	**2 035 382**	**2 169 126**
Communication	18 171	18 284	20 376	22 355	19 625	19 482	22 009	23 200	24 063
Computer Services	811	1 425	108	26 032	22 224	8 294	-	-	-
Consultants, Contractors and special services	422 815	255 560	369 742	411 043	323 453	323 103	327 518	356 260	408 167
Inventory	804 238	898 662	1 038 769	1 129 668	1 101 389	1 096 406	1 196 693	1 251 948	1 319 489
Operating leases	8 281	9 267	11 023	10 839	10 839	10 839	11 734	12 320	13 013
Travel and subsistence	3 715	3 827	5 492	6 166	6 166	6 127	5 724	6 010	6 311
Other including Assets<5000, training and	182 362	233 204	291 068	352 706	320 675	316 971	368 166	385 644	398 083

PROGRAMME 4: REGIONAL AND SPECIALISED HOSPITALS

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
development, property payments, operating expenditure and venues and facilities									
Transfers and subsidies	**58 328**	**70 918**	**60 042**	**58 726**	**63 194**	**62 873**	**51 441**	**54 088**	**55 376**
Provinces and municipalities	137	193	91	600	529	469	525	526	553
Departmental agencies and accounts	-	54	47	-	42	42	56	60	63
Non-profit institutions	30 051	32 600	35 802	37 742	37 794	37 794	28 829	28 541	28 255
Households	28 140	38 071	24 102	20 384	24 829	24 568	22 031	24 961	26 505
Payments for capital assets	**17 884**	**17 572**	**58 823**	**19 500**	**57 999**	45 897	54 700	71 700	96 710
Machinery and equipment	17 884	17 572	58 823	19 500	57 999	45 897	54 700	71 700	96 710
Payment for financial assets	**15**	**1 917**	**15**	-	-	-	**-**	**-**	**-**
Total economic classification	**5 002 719**	**5 584 757**	**7 058 831**	**7 568 389**	**7 827 233**	**7 753 449**	**8 326 401**	**8 845 275**	**9 395 878**

4.9. PERFORMANCE AND EXPENDITURE TRENDS

Programme 4 received 29.06% of the vote in 2013/14 compared with 28.09% in 2012/13.

The funding provided in the *2013/14 MTEF* includes the carry-through costs for previous wage agreements, OSD and increase in equipment following the decentralisation of funding from Programme 8.

Sub-Programme Tuberculosis Hospitals: Increase relates to treatment of MDR/XDR-TB including the establishment of specialised MDR-TB units. The reduction in *2012/13* relates mainly to the decision to move funding to other categories of hospitals also managing TB including District and Regional Hospitals and the reduction of laboratory costs in TB Hospitals due to flat fee arbitration.

*Sub-Programme Psychiatric Hospitals: T*he *2013/14 MTEF* includes the carry-through costs of previous wage agreements, OSD and inflationary increases.

Sub-Programme Chronic Hospitals: The significant increase in the *2012/13 Adjusted Appropriation* is attributed to the re-classification of Clairwood Hospital to this Sub-Programme. The *2013/14 MTEF* includes the carry-through costs of previous wage agreements, OSD and inflationary increases.

The significant reduction in the *2012/13 Adjusted Appropriation* is as a result of the reduced laboratory costs as well as efficiency savings against medicine and medical supplies. Included from 2012/13 onward is national priority funding for improving compliance with national norms and standards, additional capacity for purchasing *Goods and Services* and funding for general policy adjustment.

Due to an amendment of the SCOA classification for motor vehicle licences in 2011/12 the Department shifted funds in respect of motor vehicle licences from *Goods and Services* to *Transfers and Subsidies to: Provinces and Municipalities* in the 2011/12 Adjusted Appropriation. The Department has adjusted the historical figures for comparative purposes.

The increase in *Transfers and Subsidies to: Households* (*2012/13 Adjusted Appropriation)* provides for the increased staff exit costs and medico-legal claims against the department.

PROGRAMME 5: CENTRAL AND TERTIARY HOSPITALS

5.1. PROGRAMME PURPOSE AND STRUCTURE

Rendering Quaternary and other Tertiary Health Services

Rendering Central and Quaternary Hospital Services

Sub-Programme 5.1: Central Hospitals

Sub-Programme 5.2: Tertiary Hospitals

Rendering Tertiary Hospital services

There is no change in the purpose of Programme 5 since tabling of the 2010 - 2014 Strategic Plan.

Programme performance measures, not specifically identified as priority in the APP, are included in the Operational Plans and monitored quarterly to ensure effective performance monitoring. Specific output and outcomes will be included in the Annual Report.

5.2. OVERVIEW

Inkosi Albert Luthuli Central Hospital (IALCH) is the only Central Hospital in the Province and has 810 approved beds. Design of the new King Edward Hospital (NKEH) commenced in 2012.

Grey's Hospital (530 approved beds) and Ngwelezane Hospital (current 560 approved beds and 859 after revitalisation) are classified as Tertiary Hospitals (Government Notice No. R185 of 2 March 2012). There are currently 1,090 beds translating to 1.01 beds per 1000 population compared with the national norm of 0.23 beds per 1000 population.

Currently only IALCH in eThekwini provides 100% tertiary services. Grey's Hospital in Umgungundlovu provides 80% tertiary services; Ngwelezane Hospital in Uthungulu 33% and Lower Umfolozi War Memorial Hospital in Uthungulu (Specialised Mother and Child Hospital) 37%. Review of the service delivery platform commenced in 2011/12.

5.3. CHALLENGES

- Lack of an appropriate costing model to ensure linkage of expenditure with service delivery.
- Poor data quality and inadequate data systems.
- Inadequate human resources for health – supply and demand.

5.4. 2013/14 PRIORITIES: TERTIARY AND CENTRAL HOSPITALS

PROVINCIAL PRIORITIES	STRATEGIES AND CORE ACTIVITIES
1. Revitalisation of Tertiary and Central Hospital services.	• Review the service delivery platform for Tertiary and Central Hospitals. • Develop a competent and sustainable workforce through improved Human Resource Planning, Development and Management. • Review and establish effective referral systems. • Monitor the implementation of the National Tertiary Services Grant (NTSG) Business

PROVINCIAL PRIORITIES	STRATEGIES AND CORE ACTIVITIES
	Plan.
2. Improve quality and efficiency.	• Implement the National Core Standards to improve: – Availability of medicines and supplies. – Cleanliness. – Patient safety. – Infection prevention & control. – Positive and caring staff attitudes. – Patient waiting times. • Strengthen clinical governance and leadership. • Strengthen management in all clinical disciplines. • Improve facility management competencies and accountability. • Improve clinical governance including training and development (Regional Hospitals). • Critical review of efficiency indicators.
3. Provide appropriate health technology and infrastructure.	• Establish appropriate hospital information systems. • Establish effective training/ mentoring programmes through Telemedicine.

5.5. CENTRAL HOSPITALS

5.5.1. PERFORMANCE INDICATORS FOR CENTRAL HOSPITALS

Table 84: (CHS2): Performance Indicators for Central Hospitals (IALCH)

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2015/16
1. Caesarean Section Rate *(Delivery by caesarean section rate)**	DHIS	Rate	74%	70.5%	74.7% N: 355 D: 475	**76%** *Mid-Year 76.6%* *N: 183* *D: 239*	74%	74%	74%	30%
2. Separations *(Inpatient separations – total)**	DHIS	No	20,204	22,371	24,331	**25,370** *Mid-Year 12,685*	27,014	28,310	29,411	-
3. Patient day equivalents	DHIS	No	253,344	250,387	280,971	**280,182** *Mid-Year 140,091*	282,383	284,086	285,235	-
4. OPD total headcount *(OPD headcount – total)**	DHIS	No	182,688	170,986	178,484	**181,638** *Mid-Year 90,819*	183,192	184,903	187,911	-
5. Average length of stay *(Average length of stay – total)**	DHIS	Days	9.1 Days	8.6 Days	9.1 Days	**8.6 Days** *Mid-Year* *8.6 Days* *N: 108,971* *D: 12,685*	8.4 Days	8.2 Days	8 Days	5.5 Days
6. Bed utilisation rate *(Inpatient Bed utilisation rate – total)**	DHIS	Rate	66.2%	66.7%	72.5%	**71.1%** *Mid-Year 71.5%* *N: 108,971* *D: 152,388*	75%	75%	75%	75%

PROGRAMME 5: CENTRAL AND REGIONAL HOSPITALS

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2015/16
7. Expenditure per patient day equivalent (PDE)	BAS/DHIS	R	R 8 396	R 9 171	R 8 942 N: R2 512 653 984 D: 280,971	**R 6 200** *Mid-Year R 6 034* *N: R845 372 355* *D:140,091*	R 6 337 N: R1 789 537 000 D: 282,383	R 6 662 N: R1 892 634 000 D: 284,086	R 7 044 N: R2 009 304 000 D: 285,235	-
8. Percentage of complaints of users of Central Hospitals resolved within 25 days *(Complaints resolution within 25 working days rate)**	DHIS	%	72%	75%	85.7% N: 36 D: 42	**83%** *Mid-Year 82.6%* *N: 19* *D: 23*	90%	90%	90%	-
9. Percentage of Central Hospitals with monthly mortality and morbidity meetings *(Mortality and morbidity review)**	Meeting minutes	%	100%	100%	100% N: 1 D: 1	**100%** *Mid-Year 100%* *N: 1* *D: 1*	100%	100%	100%	100%
10. Central Hospital Patient Satisfaction rate *(Patient Satisfaction Rate)*	Survey	Rate	Reporting not required	Reporting not required	96%	**No data available**	100%	100%	100%	100%
11. Number of Central Hospitals assessed for compliance against the 6 Priorities of the core standards *(Number of Hospitals assessed for compliance against the 6 Priorities of the core standards)*	Assessment records	No	Reporting not required	Reporting not required	1	**1** *Mid-Year 1*	1	1	1	-

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator

- Indicator 1: The Caesarean section rate exceeds the national target. High rate expected due to high level referral, the high burden of disease as well as relative small patient numbers.
- Indicator 7: Expenditure trends will be monitored in 2013/14 to establish new baselines based on improved methodology to determine actual cost.
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

5.5.2. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND TARGETS FOR CENTRAL HOSPITALS

STRATEGIC GOAL 2: IMPROVE THE EFFICICENCY AND QUALITY OF HEALTH SERVICES

Table 85: (CHS1 (b)): Provincial Strategic Objectives and Annual Targets for Central Hospital (IALCH)

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
2.8) To implement the National Core Standards in 100% of Central Hospitals for accreditation of 100% facilities by 2010/11[70]	2.8.1) Number of Central Hospitals that comply with the 6 core priorities of the core standards	1 / 1	DQPR	Reporting not required	Nil	Nil	**0** *Mid-Year 0*	1	1	1

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.

[70] Accreditation is dependent on the National processes

5.5.3. QUARLTERLY AND ANNUAL TARGETS FOR CENTRAL HOSPITALS

Table 86: (CHS3): Quarterly and Annual Targets for Central Hospital (IALCH)

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Caesarean Section Rate *(Delivery by caesarean section rate)**	74%	76%	75%	75%	74%
2. Separations *(Inpatient separations – total)**	27,014	6,753	13,506	20,259	27,014
3. Patient day equivalents	282,383	70,595	141,190	211,785	282,383
4. OPD total headcount *(OPD headcount – total)**	183,192	45,798	91,596	137,394	183,192
5. Average length of stay *(Average length of stay – total)**	8.4 Days	8.7 Days	8.6 Days	8.5 Days	8.4 Days
6. Bed utilisation rate *(Inpatient Bed utilisation rate – total)**	75%	75%	75%	75%	75%
7. Expenditure per patient day equivalent (PDE)	R 6 337	R 6 337	R 6 337	R 6 337	R 6 337
8. Percentage of complaints of users of Central Hospitals resolved within 25 days *(Complaints resolution within 25 working days rate)**	90%	90%	90%	90%	90%
9. Percentage of District Hospitals with monthly mortality and morbidity meetings *(Mortality and morbidity review rate)**	100%	100%	100%	100%	100%
Annual Targets					
10. Number of Hospitals assessed for compliance against the 6 Priorities of the Core Standards	1				1
11. Central Hospital Patient Satisfaction rate *(Patient Satisfaction Rate)*	100%				100%

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
12. Number of Central Hospitals assessed for compliance against the 6 Priorities of the core standards *(Number of Hospitals assessed for compliance against the 6 Priorities of the core standards)*	1				1

- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

5.6. TERTIARY HOSPITALS

5.6.1. PERFORMANCE INDICATORS FOR TERTIARY HOSPITALS

Table 87: (THS2): Performance Indicators for Tertiary Hospitals (Greys and Ngwelezane Hospitals)

Performance Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13[71]	2013/14	2014/15	2014/15	2015/16
1. Caesarean Section Rate *(Delivery by caesarean section rate)**	DHIS	%	62,6%	69.3%	69% N:1,093 D:1,585	**71.5%** *Mid-Year 72.2%* *N: 500* *D: 693*	69%	69%	68%	30%
Greys Hospital	*DHIS*	*%*	*62,6%*	*69.3%*	*69%*	*Mid-Year 72.2%* *N: 500* *D: 639*	*67.7%*	*67.2%*	*67%*	
Ngwelezane Hospital	*DHIS*	*%*	*N/A*[72]	*N/A*	*N/A*	*N/A*[73]	*N/A*	*N/A*	*N/A*	

[71] Reclassification of Ngwelezane into Developing Tertiary in July 2012, hence mid-year year data reflect both hospitals.
[72] Patients referred to Lower Umfolozi War Memorial Hospital (Mother and Child Hospital)
[73] Caesarean sections are being referred to Lower Umfolozi War Memorial Hospital (Mother & Child Hospital)

Performance Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13[71]	2013/14	2014/15	2014/15	2015/16
2. Separations *(Inpatient separations – total)**	DHIS	No	27,777	29,714	31,050	**27,798** *Mid-Year 13,899*	32,603	34,233	35,944	-
Greys Hospital	*DHIS*	*No*	*10,755*	*12,633*	*12,785*	*Mid-Year 5,287*	*13,425*	*14,095*	*14,800*	
Ngwelezane Hospital	*DHIS*	*No*	*17,022*	*17,081*	*18,265*	*Mid-Year 8,612*	*19,178*	*20,136*	*21,144*	
3. Patient day equivalents	DHIS	No	362,567	392,791	388,214	**397,064** *Mid-Year 198,532*	407,625	428,006	449,406	-
Greys Hospital	*DHIS*	*No*	*180,119*	*191,274*	*191,113*	*Mid-Year 98,152*	*200,669*	*210,702*	*221,237*	
Ngwelezane Hospital	*DHIS*	*No*	*182,448*	*201,517*	*197,101*	*Mid-Year 100,380*	*206,956*	*217,304*	*228,169*	
4. OPD total headcount *(OPD headcount – total)**	DHIS	No	353,453	343,531	312,745	**302,552** *Mid-Year 151,276*	328,382	344,801	362,041	-
Greys Hospital	*DHIS*	*No*	*203,358*	*208,223*	*188,637*	*Mid-Year 91,893*	*198,069*	*207,972*	*218,371*	
Ngwelezane Hospital	*DHIS*	*No*	*150,095*	*135,308*	*124,108*	*Mid-Year 59,383*	*130,313*	*136,829*	*143,672*	
5. Average length of stay *(Average length of stay – total)**	DHIS	Days	10.4 Days	12 Days	9.9 Days	**10.1 Days** *Mid-Year 10.3 Days* *N: 142,778* *D: 13,899*	10 Days	9 days	9 Days	5.5 Days
Greys Hospital	*DHIS*	*Days*	*10.4 Days*	*12 Days*	*9.9 Days*	*Mid-Year 12.6 Days* *N: 66,696* *D: 5,287*	*12.3 Days*	*11.8 Days*	*10.8 Days*	
Ngwelezane Hospital	*DHIS*	*Days*	*8.1 Days*	*8.6 Days*	*8 Days*	*Mid-Year 8.8 Days* *N: 76,082* *D: 8,612*	*8.6 Days*	*8.5 Days*	*8.1 Days*	

Performance Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13[71]	2013/14	2014/15	2014/15	2015/16
6. Bed utilisation rate *(Inpatient Bed utilisation rate – total)**	DHIS	Rate	65.4%	73.4%	70.5%	**82%** *Mid-Year 84.8%* *N: 142,778* *D: 168,448*	75%	75%	75%	75%
Greys Hospital	*DHIS*	*Rate*	*65.4%*	*73.4%*	*70.5%*	*Mid-Year 82.1%* *N: 66,696* *D: 81,213*	*75%*	*75%*	*75%*	
Ngwelezane Hospital	*DHIS*	*Rate*	*74%*	*79.5%*	*76.2%*	*Mid-Year 87.2%* *N: 76,082* *D: 87,235*	*75%*	*75%*	*75%*	
7. Expenditure per patient day equivalent (PDE)	BAS/DHIS	R	R 2 601[74]	R 7 644	R3 490 N:R667,079,054 D: 191,113	***R 3 050*** *Mid-Year R2 888* *N:R573,413,811* *D: 198,532*	R 3 064 N:R1,249,202,000 D: 407,625	R 3 151	R 3 258	-
Greys Hospital	*BAS/DHIS*	*R*	*R 2 601*	*R 7 644*	*R3 490 (667,079,054/ 191,113)*	*Mid-Year R3 596* *N:R352 936 751* *D: 98,152*	*R 3 924* *N: R787 501 000* *D: 200,669*	*R 3 951* *N:R832 425 000* *D: 210,702*	*R 4 015* *N:R888 160 000* *D: 221,237*	
Ngwelezane Hospital	*BAS/DHIS*	*R*	*Not available*	*Not available*	*Not available*	*Mid-Year R2 055* *N:R206 310 488* *D: 100,380*	*R 2 231* *N: R461 701 000* *D: 206,956*	*R 2 350*[75]	*R 2 500*[76]	
8. Percentage of complaints of users of Tertiary services resolved within 25 days. *(Complaint resolution within 25 working days rate)**	DHIS	%	100%	100%	92% N: 199 D: 216	**85%** *Mid-Year 84.6%* *N: 143* *D: 169*	90%	90%	90%	-

[74] Historic data represents Greys Hospital (Ngwelezane data not available)
[75] This will be reviewed once a baseline for Ngwelezana Hospital has been established and confirmed in 2013/14
[76] This will be reviewed once a baseline for Ngwelezana Hospital has been established and confirmed in 2013/14

PROGRAMME 5: CENTRAL AND REGIONAL HOSPITALS

Performance Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13[71]	2013/14	2014/15	2014/15	2015/16
Greys Hospital	*DHIS*	*%*	*100%*	*100%*	*92% (199/216)*	*Mid-Year 92%* *N: 81* *D: 88*	*90%*	*90%*	*90%*	
Ngwelezane Hospital	*DHIS*	*%*	*No data available*	*No data available*	*74.3%*	*Mid-Year 76.5%* *N: 62* *D: 81*	*90%*	*90%*	*90%*	
9. Percentage of Tertiary Hospitals with monthly mortality and morbidity meetings *(Mortality and morbidity review rate)**	DQPR DHIS 2013/14	%	100%	100%	100% N: 1 D: 1	**100%** *Mid-Year 100%* *N: 2* *D: 2*	100%	100%	100%	100%
Greys Hospital	*DQPR* *DHIS 2013/14*	*%*	*100%*	*100%*	*100% (1/1)*	*Mid-Year 100%* *N: 1* *D: 1*	*100%*	*100%*	*100%*	
Ngwelezane Hospital	*DQPR* *DHIS 2013/14*	*%*	*100%*	*100%*	*100%*	*Mid-Year 100%* *N: 1* *D: 1*	*100%*	*100%*	*100%*	
10. Tertiary Hospital Patient Satisfaction rate *(Patient Satisfaction Rate)*	DQPR DHIS 2013/14	Rate	Reporting not required	Reporting not required	80%	No data available	90%	90%	90%	100%
Greys Hospital	*DQPR* *DHIS 2013/14*	*Rate*	*Reporting not required*	*Reporting not required*	*80%*	No data available	*90%*	*90%*	*90%*	
Ngwelezane Hospital	*DQPR* *DHIS 2013/14*	*Rate*	*Reporting not required*	*Reporting not required*	*80%*	No data available	*90%*	*90%*	*90%*	

Performance Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2009/10	2010/11	2011/12	2012/13[71]	2013/14	2014/15	2014/15	2015/16
11. Number of Tertiary Hospitals assessed for compliance against the 6 Priorities of the core standards *(Number of Hospitals assessed for compliance against the 6 Priorities of the core standards)*	DQPR	No	New indicator	New indicator	1	**2** *Mid-Year 2*	2	2	2	-
Greys Hospital	*DQPR*	*No*	*New indicator*	*New indicator*	*1*	*Mid-Year 1*	*1*	*1*	*1*	
Ngwelezane Hospital	*DQPR*	*No*	*New indicator*	*New indicator*	*1*	*Mid-Year 1*	*1*	*1*	*1*	

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator
- Note: Expenditure trends will be monitored in 2013/14 to establish new baselines based on improved methodology to determine actual cost
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

5.6.2. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR TERTIARY HOSPITALS

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

Table 88: (THS1 (b)): Provincial Strategic Objectives and Annual Targets for Tertiary Hospitals (Greys and Ngwelezane Hospitals)

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
2.7) To implement the National Core Standards in 100% of Tertiary Hospitals for accreditation of 100% facilities by 2011/12[77]	2.7.1) Number of Tertiary Hospitals that comply with the 6 priorities of the core standards	1/ 1	DQPR	Reporting not required	0	0	**0** *Mid-Year 0*	1	1	2
Greys Hospital		*1*	*DQPR*	*Reporting not required*	*0*	*0*	*Mid-Year 0*	*1*	*1*	*1*
Ngwelezane Hospital		*0*	*DQPR*	*Reporting not required*	*0*	*0*	*Mid-Year 0*	*0*	*0*	*1*

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.

[77] Accreditation is dependent on the National processes

5.6.3. QUARTERLY AND ANNUAL TARGETS FOR TERTIARY HOSPITALS

Table 89: (THS3): Quarterly and Annual Targets for Tertiary Hospitals – 2013/14

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Caesarean Section Rate *(Delivery by caesarean section rate)**	69%	71%	70%	69%	69%
2. Separations *(Inpatient separations – total)**	32,603	8,150	16,300	24,450	32,603
3. Patient Day Equivalents	407,625	101,906	203,812	305,718	407,625
4. OPD total headcount *(OPD headcount – total)**	328,382	82,095	164,190	246,285	328,382
5. Average length of stay *(Average length of stay – total)**	10 Days	10.3 Days	10.2 Days	10.1 Days	10 Days
6. Bed utilisation rate *(Inpatient Bed utilisation rate – total)**	75%	75%	75%	75%	75%
7. Expenditure per patient day equivalent (PDE)	R 3 064	R 3 064	R 3 064	R 3 064	R 3 064
8. Percentage of complaints of users of Tertiary services resolved within 25 days *(Complaint resolution within 25 working days rate)**	90%	90%	90%	90%	90%
9. Percentage of Tertiary Hospitals with monthly mortality and morbidity meetings *(Mortality and morbidity review rate)**	100%	100%	100%	100%	100%
Annual Targets					
10. Tertiary Hospital Patient Satisfaction rate *(Patient Satisfaction Rate)*	90%				90%
11. Number of Tertiary Hospitals assessed for compliance against the 6 Priorities of the core standards *(Number of Hospitals assessed for compliance against the 6 Priorities of the core standards)*	2				2
12. Number of Tertiary Hospitals that comply with the 6 priorities of the core standards	1				1

- Indicator 5: The target has been maintained at 75% which is considered a standard norm for measurement of efficiency. This is especially relevant to the current shortage of human resources.
- Indicator 6: Expenditure per PDE calculation being reviewed and will be closely monitored to inform targets for outer years.
- Note: Indicators indicated in italic (*) denotes "new/renamed" indicators as per draft 2013 National Indicator Data Set (dated 28 January 2013), which will replace the current DHIS indicators from April 2013. Changes are in line with the reviewed national customised APP template dated 18 February 2013. Once the 2013 National Indicator Data Set (NIDS) has been finalised and approved, indicator baselines and MTEF targets will be reviewed.

5.7. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 90: (CH7 (a)): Summary of payments and estimates Programme 5

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R' thousands	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Central Hospitals	506 857	689 717	758 623	873 229	873 229	873 129	834 199	888 645	932 870
Tertiary Hospitals	1 552 267	1 413 665	1 754 031	1 786 130	1 868 845	1 867 968	2 087 926	2 209 747	2 355 465
Total	**2 059 124**	**2 103 382**	**2 512 654**	**2 659 359**	**2 742 074**	**2 741 097**	**2 922 125**	**3 098 392**	**3 288 335**

Table 91: (CH7 (b)): Summary of payments and estimates by Economic Classification Programme 5

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Current payments	**1 747 554**	**1 882 818**	**2 494 543**	**2 410 552**	**2 713 399**	**2 712 521**	**2 898 365**	**3 074 503**	**3 262 302**
Compensation of employees	802 490	942 537	1 154 360	1 228 839	1 390 054	1 390 054	1 515 000	1 619 167	1 737 689
Goods and services	**945 064**	**940 281**	**1 340 183**	**1 181 713**	**1 323 345**	**1 322 467**	**1 383 365**	**1 455 336**	**1 524 613**
Communication	3 398	3 106	3 405	3 672	3 411	3 411	3 300	3 465	3 638
Computer Services	251	251	422	778	12 231	11 453	-	-	-
Consultants, Contractors and special services	435 214	431 930	711 738	530 988	672 199	672 199	727 468	764 422	802 201
Inventory	473 216	459 172	559 310	579322	575 530	575 530	588 815	620 223	648 842

PROGRAMME 5: CENTRAL AND REGIONAL HOSPITALS

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Operating leases	512	430	1 813	2 789	480	480	1 300	1 365	1 433
Travel and subsistence	589	701	1 338	1 610	1 418	1 418	1 592	1 672	1 756
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	31 884	44 691	62 157	62 554	58 076	57 976	60 890	64 189	66 743
Transfers and subsidies to	**2 661**	**7 817**	**2 257**	**8 807**	**1 675**	**1 675**	**2 760**	**2 889**	**3 033**
Provinces and municipalities	8	6	4	7	8	8	10	4	4
Households	2 653	7 811	2 253	8 800	1 667	1 667	2 750	2 885	3 029
Payments for capital assets	**308 909**	**212 692**	**15 854**	**240 000**	**27 000**	**26 901**	**21 000**	**21 000**	**23 000**
Machinery and equipment	308 909	212 692	15 854	240 000	27 000	26 901	21 000	21 000	23 000
Payment for financial assets	-	**55**	-	-	-	-	-	-	-
Total economic classification	**2 059 124**	**2 103 382**	**2 512 654**	**2 659 359**	**2 742 074**	**2 741 097**	**2 922 125**	**3 098 392**	**3 288 335**

5.8. PERFORMANCE AND EXPENDITURE TRENDS

Programme 5 constitutes 10.20% of vote 7 in 2013/14 compared with 9.93% in 2012/13.

The *2013/14 MTEF* allocations include the carry-through costs of previous wage agreements, OSDs, and national priorities. Funding was also provided to both Inkosi Albert Luthuli Central Hospital and King Edward Vlll Hospital from the NHI Conditional Grant as part of the first phase pilot project in Umgungundlovu, Umzinyathi and Amajuba.

The increasing trend in *Compensation of Employees* includes funding for the higher than expected 2012 wage agreement and the re-classification of Ngwelezane Hospital as Developing Tertiary Hospital.

The increase in the 2012/13 Adjusted Appropriation in *Goods and Services* relates to the ruling by the Auditor General that all equipment expenditure incurred against the PPP agreement with Inkosi Albert Luthuli Central Hospital should be paid from current expenditure. Funding was therefore shifted from *Machinery and Equipment* to this item category. The allocations for the *2013/14 MTEF* include the carry-through costs for the national priorities and funding from the NHI Grant for the two pilot hospitals.

Due to an amendment of the SCOA classification for motor vehicle licences in 2011/12, the Department shifted funds in respect of motor vehicle licences from *Goods and Services* to *Transfers and Subsidies to: Provinces and Municipalities* in the 2011/12 Adjusted Appropriation. The Department has adjusted the historical figures for comparative purposes. The inflated figures in *Transfers and Subsidies to: Households* in 2010/11 relate to medico-legal claims against the Department.

The notable increase in *Machinery and Equipment* in *2014/15* relates to the decision by the Department to shift machinery and equipment funding from Programme 8 to individual programmes.

Additional allocation was made for IALCH to develop capacity in intensive care and high care for maternal and neonatal services, and to increase revenue capacity.

R21 million has been allocated for machinery and equipment to comply with national norms.

5.9. RISK MANAGEMENT

POTENTIAL RISKS	MITIGATING FACTORS
1. Increasing service demands due to high burden of disease (High).	• Support the delivery of district health services through outreach, support and clinical governance.
2. Limitation in recruitment and retention of key health professionals resulting in critical gaps in human resources (High).	• Prioritise critical posts for filling and use bursary system to attract possible candidates for scarce categories.
3. Ineffective information systems and management of information for decision-making (High).	• Enhance compliance through standard operating procedures, checklists and improved training to staff involved in processes.

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

6.1. PROGRAMME PURPOSE AND STRUCTURE

The provisioning of training and development opportunities for existing and potential employees of the department

Sub-Programme 6.1: Nurse Training College

Training of Nurses at both undergraduate and postgraduate level

Sub-Programme 6.2: EMS Training College

Training of Emergency Care Practitioners

Sub-Programme 6.3: Bursaries

Provision of bursaries for students studying in health science programmes at undergraduate levels

Sub-Programme 6.4: PHC Training

Provision of PHC related training for Professional Nurses working in a PHC setting

Sub-Programme 6.5: Training (Other)

Provision of skills development interventions for all occupational categories

There is no change in the purpose of Programme 6 since tabling of the 2010 - 2014 Strategic Plan.

Programme performance measures, not specifically identified as priority in the APP, are included in the Operational Plans and monitored quarterly to ensure effective performance monitoring. Specific output and outcomes will be included in the Annual Report.

6.2. OVERVIEW

The Human Resource and Training and Development Plans are based on the provincial priorities and aim to address the scarce and critical skills gaps of the current and future workforce. Programmes facilitate the recruitment, education, training and development of appropriate numbers of health workers with appropriate competencies to provide services determined by current and future requirements across all levels of care.

Within the framework of the Workplace Skills Plan, the Department provides skills development for all occupational categories in the Department, for example, management development.

Training of Clinical Technicians to improve medical equipment auditing, repairs and to reduce down-time with minor and major repairs is being undertaken by the Tshwane University and targets youth with a Diploma in Light Current Engineering. To date, 38 have been trained and a further 20 students selected for training in 2013/14.

The current laundry being commissioned at Prince Mshiyeni Hospital will employ youth with technical skills on the EPWP.

The partnership with the University of KwaZulu-Natal is being strengthened to improve supply/ production of scarce skill categories of staff.

6.3. CHALLENGES

1. Physical infrastructure in some Nursing Campuses / Sub-Campuses no longer meets SANC training standards.
2. The new Nursing Qualifications Framework affects the current status of the Nursing College and nursing schools and will result in the re-curriculation of programmes.

3. Training gap and inadequate capacity for mentorship programmes.
4. Non-alignment of training programmes with core service delivery challenges.
5. Follow-up and support after training programmes.

6.4. 2013/14 PRIORITIES: HEALTH SCIENCES & TRAINING

PROVINCIAL PRIORITIES	PROVINCIAL KEY FOCUS AREAS
1. Align training with service delivery requirements as an integral part of the HR Plan and maintain an updated skills database.	• Align training and development plans with core business of the Department including training for EMS, Forensic Pathology, ESMO, NIMART, PHC, and Advanced Midwifery. • Accreditation of the KZN College of Nursing (Higher Education Act).
2. Implement Management training and mentoring strategy.	• Develop and implement a Management training strategy including mentoring and succession training.
3. Implement a Mid-Level Worker strategy.	• Develop and implement a Mid-level Worker Strategy in line with service delivery needs.

6.5. PERFORMANCE INDICATORS FOR HEALTH SCIENCES AND TRAINING

Table 92: (HST2): Performance Indicators for Health Sciences and Training

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
1. Intake of nurse students	KZNCN Database	No	2,842	1,968	2,438	**1,200** *Mid-Year : 1,200*	1,500[78]	Dependent on accreditation	Dependent on accreditation
2. Students with bursaries from the province	Bursary Database	No	896	601	929	**737** *Mid-Year : 737*	770	800	830
3. Basic nurse students graduating	KZNCN Database	No	1,477	846	1,597	**1,639** *Mid-Year : 1,639*	1,000	1,500	1,500

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.

6.6. STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR HEALTH SCIENCES & TRAINING

STRATEGIC GOAL 2: IMPROVE THE EFFICICENCY AND QUALITY OF HEALTH SERVICES

Table 93: (HST1 (b)): Provincial Strategic Objectives and Annual Targets for Health Sciences and Training

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
2.9) To implement a Training	2.9.1) Number of Professional Nurses graduating	560 Review 2012/13	KZNCN Database	792	846	972	**1,006** *Mid-Year: 1,006*	820	820	850

[78] Dependent on the accreditation of the KZNCN as an Institute of Higher Education

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Strategy aligned with the core functions of the Department	2.9.2) Number of Advanced Midwifes graduating per annum	50 Review 2013/14	KZNCN Database	46	105	120	**44** *Mid-Year: 44*	100	Dependent on accreditation	Dependent on accreditation
	2.9.3) Number of Managers accessing the Management Skills Programmes.	120 Review 2012/13	Internal database	80	28	102	**7** *Mid-Year: 7*	550	600	650
	2.9.4) Number of SMS members trained on MIP	20	Internal database	5	0	2	**10** *Mid-Year: 10*	20	20	25

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.

6.7. ANNUAL TARGETS FOR HEALTH SCIENCES AND TRAINING

Table 94: (HST3): Annual Targets for 2013/14

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
Annual Targets					
1. Intake of nurse students	1,500				1,500
2. Students with bursaries from the province	770				770
3. Basic nurse students graduating	1,000			1,000	
4. Number of Professional Nurses graduating	820				820
5. Number of advanced midwifes graduating per annum	100				100
6. Number of Managers accessing the Management Skills Programmes.	550				550
7. Number of SMS members trained on Massification Implementation Plan (MIP)	20				20

6.8. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 95: (HST4 (a)): Summary of payments and estimates Programme 6

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised estimate	Medium-Term Expenditure Estimates		
R' thousands	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Nurse training colleges	343 531	367 268	355 905	415 128	379 409	353 580	348 035	367 056	385 441
EMS training colleges	19 338	14 118	11 417	19 842	14 889	14 889	12 453	13 179	14 112
Bursaries	42 454	54 272	64 433	107 738	90 138	90 138	138 000	133 285	131 902
PHC training	76 238	73 061	58 922	67 925	53 038	53 038	57 912	60 216	63 226
Other training	292 437	323 560	369 780	387 418	423 249	423 249	435 846	448 764	480 922
Total	**773 998**	**832 279**	**860 457**	**998 051**	**960 723**	**934 894**	**992 246**	**1 022 500**	**1 075 603**

Table 96: (HST4 (b)): Summary of payments and estimates by Economic Classification Programme 6[6]

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Current payments	**708 757**	**763 205**	**776 485**	**885 365**	**853 248**	**834 416**	**839 509**	**877 041**	**930 919**
Compensation of employees	662 000	717 464	720 257	783 252	761 399	761 399	763 333	809 135	860 037
Goods and services	**46 757**	**45 741**	**56 228**	**102 113**	**91 849**	**73 017**	**76 176**	**67 906**	**70 882**
Communication	1 559	1 424	1 181	1 302	1 203	1 203	1 842	1 934	2 030
Computer Services	-	-	-	25 829	21 970	3 138	-	-	-
Consultants, Contractors and special services	15 952	8 120	306	346	1 285	1 285	1 550	1 628	1 715
Inventory	4 704	3 996	4 431	5 886	5 548	5 548	7454	7827	8217
Operating leases	1 757	1 508	1 249	1 622	1 836	1 836	1 640	1 723	1 809
Rental and Hiring	-	-	6	-	-	-	-	-	-
Travel and subsistence	4 880	3 799	8 297	26 180	23 950	23 950	14 951	15 528	16 213

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	17 905	26 894	40 758	40 948	36 057	36 057	48 739	39 266	40 888
Transfers and subsidies	**59 843**	**68 625**	**83 361**	**107 018**	**96 018**	**96 018**	**146 737**	**142 459**	**141 534**
Provinces and municipalities	14	25	26	30	22	22	22	23	24
Departmental agencies and accounts	6 784	7 637	8 588	9 360	10 105	10 105	11 315	11 881	12 475
Non-profit institutions	11 357	8 510	14 298	15 130	15 130	15 130	0	0	0
Households	41 688	52 453	60 449	82 498	70 761	70 761	135 400	130 555	129 035
Payments for capital assets	5 398	427	610	5 668	11 457	4 460	6 000	3 000	3 150
Machinery and equipment	5 398	427	610	5 668	11 457	4 460	6 000	3 000	3 150
Payments for financial assets	0	22	1	-	-	-	-	-	-
Total economic classification	**773 998**	**832 279**	**860 457**	**998 051**	**960 723**	**934 894**	**992 246**	**1 022 500**	**1 075 603**

6.9. PERFORMANCE AND EXPENDITURE TRENDS

The increasing trend in *Programme 6* can largely be attributed to the training drive, increased bursary allocation and provision for the intake of medical interns, dentists, pharmacists and other interns.

Sub-Programmes Nurse Training Colleges and Primary Health Care Training: The *2013/14 MTEF* reflects inflationary increases only.

Sub-Programme EMS Training Colleges: The *2013/14 MTEF* includes inflationary increases only.

Sub-Programme Bursaries: R133 million has been allocated for the Cuban Programme in 2013/14 and R2.2 million for Bursaries to employees to improve capacity at service delivery level.

Sub-Programme Training Other: Additional funding has been provided for training in *2013/14* with a funding shift from staff nurse and nursing assistant training to primary health care training. Excess staff nurses and nursing assistants will be employed. There is a significant reduction in budget for intern training. Hospital Management and Hospital Board continue to receive allocation.

The significant increase in *Goods and Services* over the MTEF relates mainly to the provision of funding for travel and subsistence costs for the additional students in the Cuban Doctor Programme.

The *Transfers and Subsidies to: Departmental Agencies and Accounts* show a high growth in 2010/11 through to 2013/14 and 2015/16 to provide for the HWSETA levy in line with the growth in compensation of employees.

The subsequent increase in the allocation to *Transfers and Subsidies to: Non-Profit Institutions* in 2011/12 supports the Department's commitment to provide funding that will allow NGOs to increase their medical salaries in line with the Province. The negative growth in *2013/14* and 2014/15 are mainly attributed to a reduction in funding following the reassessment of the SLA with NGOs.

The decrease in *Machinery and Equipment* in 2013/14 relates to reprioritisation of funding, which will be reviewed during 2013/14.

6.10. RISK MANAGEMENT

POTENTIAL RISKS	MITIGATING FACTORS
1. A fragmented human resource information system or skills database (Medium).	• Development of an integrated information system (health sciences and training) linked to PERSAL.
2. Poor physical infrastructure in some Nursing Campuses/ Sub-Campuses (High).	• Infrastructure projects prioritised in the 2013/14 U-AMP.
3. Inadequate accommodation for learners and staff (High).	

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

7.1. PROGRAMME PURPOSE AND STRUCTURE

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

Sub-Programme 7.5: Medicine Trading Account

Managing the supply of pharmaceuticals and medical sundries to hospitals, community Health Centres, clinics and Local Authorities via the Medicine Trading Account

There is no change in the purpose of Programme 7 since tabling of the 2010 - 2014 Strategic Plan.

Programme performance measures, not specifically identified as core priority in the APP, are included in the Operational Plans and monitored quarterly to ensure effective performance monitoring. Specific output and outcomes will be included in the Annual Report.

7.2. MEDICINE TRADING ACCOUNT (SUB-PROGRAMME 7.5)

7.2.1. OVERVIEW

The provincial Pharmaceutical Supply Depot (PPSD) is the only trading entity operating within the administration of KwaZulu-Natal Department of Health. It is responsible for the procurement and delivery of pharmaceuticals (as listed by National and Provincial Health Pharmaceutical Services), procured from suppliers after which it is distributed to the various institutions as required.

The PPSD does not comply with legislative standards due to space constraints and challenges with temperature control. As an interim arrangement two wards in Clairwood Hospital have been allocated to PPSD to alleviate space constraints although wards are unsuitable for summer storage.

Following the national pronouncement on the future of Provincial Pharmaceutical Depots (PPSDs) in the country, the plan to build a new PPSD to address space and structural constraints had to be reviewed. A new distribution system (Just in Time) will be implemented in response to the growing demand for delivery of supplies to facilities.

Considering the topography and location of clinics the Department may consider keeping small scale operations for clinics at the current Depot as well as keeping safety stock in this warehouse to cater for stock-out situations.

Revitalisation of the current Depot will be explored.

7.2.2. CHALLENGES

- There are significant space constraints in health facilities for the storage of pharmaceuticals.
- Shortage of pharmacy personnel, including Pharmacists and Pharmacist Assistants, which jeopardise quality of care.
- The post for Manager for Technical and Essential Medicines Programme Support is vacant since June 2012 having a negative impact on planned training and support activities. Through a partnership with Systems for Improved Access to Pharmaceuticals and Services Project of Management Sciences for Health (SIAPS/MSH) the Department was able to offer the Pharmaceutical Leadership Development Programme.

7.2.3. 2013/14 PRIORITIES: PHARMACEUTICAL SERVICES

PROVINCIAL PRIORITIES	PROVINCIAL KEY FOCUS AREAS
1. Improve compliance with Pharmaceutical legislation.	• Improve the percentage of pharmacies compliant with SAPC standards.
	• PPSD 100% compliant with Good Wholesaling Practice Regulations.
2. Improve availability of medicines.	• Reduce tracer medicine stock-out rate in bulk stores (PPSD and Institutions).
	• Implement new distribution system (JIT – Just in time).
3. Improve quality of Pharmaceutical services.	• Reduce the average patient waiting time at pharmacies.
	• Improved capacity to improve oversight and quality e.g. training of Pharmacy Assistants and Roving Teams.
	• Filling of critical posts to improve clinical governance at PHC and hospital levels.
	• Policy review and monitoring implementation.

7.2.4. STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR PHARMACEUTICAL SERVICES

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 97: (HCSS1): Provincial Strategic Objectives and Annual Targets for Health Care Support Services

Strategic Objective	Performance Indicator	Strategic Plan Target	Data source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
1.13) Ensure compliance with Pharmaceutical Legislation with 90% pharmacies compliant by 2014/15 and PPSD 100% compliant by 2012/13	1.13.1) Percentage of Pharmacies that obtained A and B grading on inspection[79]	80%[80]	DQPR	Reporting not required	Reporting not required	71% N: 61 D: 86	**73. 32%** *Mid-Year 73%*[81] *N: 65* *D: 89*	80%	90%	90%
	1.13.2) PPSD compliant with Good Wholesaling Practice Regulations	100% compliant	License from MMC	Reporting not required	Reporting not required	Not compliant	**Non-compliant**	100% compliant	100% compliant	100%

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator

[79] Refers to being compliant with SAPC standards
[80] The target has been reviewed (90%) based on performance since publishing of the Strategic Plan
[81] Pharmacy records reflect as 72.1% (62/86)

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

Table 98: (HCSS1): Provincial Strategic Objectives and Annual Targets for Health Care Support Services

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15	2015/16
2.3) To improve medicine supply management systems at PPSD and facility level	2.3.1) Tracer medicine stock-out rate (PPSD)	<1%	DQPR	New indicator	No data for PPSD	13% N: 5 D: 38	**5%** *Mid-Year 6.58%* *N: 5* *D: 76*	<2%	<1%	<1%
	2.3.2) Tracer medicine stock-out rate (Institutions)	<1%	Pharmacy Records	New indicator	0.17% N: 416 D: 249,696	1% N: 1,951 D: 277,020	**2%** *Mid-Year 2%* *N: 728* *D: 33,071*	<2%	<1%	<1%

- Note: Estimated annual performance data for 2012/13 is indicated in bold in all tables.
- Note: Mid-year performance data for 2012/13 is indicated in green italic in all tables.
- Note: Abbreviations to indicate raw data: N = Numerator; D = Denominator

7.2.5. QUARTERLY AND ANNUAL TARGETS – 2013/14

Table 99: (HCSS2): Quarterly and Annual Targets for 2013/14

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Tracer medicine stock-out rate (PPSD)	<2%	4%	4%	3%	<2%
2. Tracer medicine stock-out rate (Institutions)	<2%	7%	5%	3%	<2%

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
Annual Targets					
3. Percentage of Pharmacies that obtained A and B grading on inspection[82]	80%				80%
4. PPSD compliant with Good Manufacturing Practice Regulations	100% compliant				100% compliant

7.3. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 100: (HCSS3 (a)): Summary of payments and estimates Programme 7

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
R' thousands	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Laundries	69 412	77 550	84 268	-	-	95 329	102 246	108 908	116 007
Orthotic and prosthetic services	20 187	23 442	26 005	-	-	23 370	25 036	26 451	27 916
Medicines trading account	27 528	10 764	13 971	15 170	15 170	15 170	16 004	18 000	18 900
Total	**117 127**	**111 756**	**125 030**	**15 170**	**15 170**	**133 869**	**143 286**	**153 359**	**162 823**

Table 101: (HCSS3 (b)): Summary of payments and estimates by Economic Classification Programme 7

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Current payments	**88 986**	**100 327**	**110 448**	**-**	**-**	**117 628**	**126 157**	**134 178**	**142 683**
Compensation of employees	62 550	69 843	75 511	-	-	85 682	92 285	98 617	105 344
Goods and services	**26 436**	**30 484**	**34 937**	**-**	**-**	**31 946**	**33 872**	**35 561**	**37 339**

[82] Refers to being compliant with SAPC standards

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Communication	456	415	563	-	-	555	583	612	643
Computer Services	-	1	-	-	-	-	-	-	-
Consultants, Contractors and special services	446	1 098	571	-	-	352	374	392	412
Inventory	18768	20933	24016	0	0	21169	22554	23681	25387
Operating leases	27	25	45	-	-	54	57	60	63
Travel and subsistence	22	26	29	-	-	84	88	92	97
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	6717	7995	9 713	-	-	9728	10 216	10 724	11 260
Transfers and subsidies to	**28 141**	**11 376**	**14 545**	**15 170**	**15 170**	**15 668**	**16 527**	**18 549**	**19 477**
Provinces and municipalities	130	152	62	-	-	75	79	83	87
Departmental agencies and accounts	28 011	11 224	14 483	15 170	15 170	15 593	16 448	18 466	19 390
Payments for capital assets	-	40	35	-	-	573	602	632	663
Machinery and equipment	-	43	35	-	-	573	602	632	663
Payments for financial assets	-	13	2	-	-	-	-	-	-
Total economic classification	**117 127**	**111 756**	**125 030**	**15 170**	**15 170**	**133 869**	**143 286**	**153 359**	**162 823**

7.4. PERFORMANCE AND EXPENDITURE TRENDS

The increase makes provision for higher stock levels needed to provide for the increased demand for ARV medication and turn-over of medicines, as well as for the provision of vaccines required for the reduction of child morbidity and mortality. The trend over the 2013/14 MTEF reflects inflationary increases only.

An amount of R 102 million was allocated to Laundry services for equipment and linen. R 50.8 million was allocated for the modernization of the Dundee Laundry in 2013/14, while the Midlands Laundry will be prioritised in the outer-years pending availability of funding.

Additional provision has been made for Chillers (R 15 million); Equipment (R 10 million); Autoclaves (R 5 million); and Generators (R 5 million).

7.5. RISK MANAGEMENT

POTENTIAL RISKS	MITIGATING FACTORS
9. Poor data quality, monitoring, evaluation and reporting (High).	• Integrated strategy with M&E and Data Management to improve data quality and reporting.
10. Shortage of pharmaceutical workforce including Pharmacists and Pharmacist Assistants (High).	• Review training strategy for mid-level workers (including training of Pharmacist Assistants). • Review recruitment and retention strategy for Pharmacists. • Pharmacy Technicians and Technical Assistants training programme will be fast tracked as soon as the National Legislative Framework has been finalised and Training institutions have established capacity. Currently training Pharmacists Assistants for both Basic and Post-basic Course are being trained.
11. Inadequate infrastructure (shortage of space) for the storage of pharmaceuticals in warehouse and facilities compounded by infrastructure backlog (High).	• Alignment and prioritization of pharmaceutical infrastructure requirements with service delivery and U-AMP.
12. Inadequate support arrangements at PHC level due to shortage of staff (High).	• Review outreach strategy and integration with Roving Teams.

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT (HFM)

8.1. PROGRAMME PURPOSE AND STRUCTURE

To provide new health facilities, upgrade and maintain existing health facilities, and manage the Hospital Revitalisation Programme and Conditional Grant.

Sub-Programme 8.1: Community Health Services including PHC clinics and Community Health Centres

Construction of new, and upgrading and maintenance of community Health Centres, Primary Health Care Clinics and other Community - based PHC Centres.

Sub-Programme 8.2: District Hospitals

Construction of new, and upgrading and maintenance of District Hospitals

Sub-Programme 8.3: Emergency Medical Services

Construction of new, and upgrading and maintenance of Emergency Medical Service facilities

Sub-Programme 8.4: Provincial/ Regional and Specialised Hospital Services

Construction of new, and upgrading and maintenance of Provincial/Regional and Specialised Hospitals

Sub-Programme 8.5: Tertiary and Central Hospital Services

Construction of new, and upgrading and maintenance of Tertiary and Central Hospitals

Sub-Programme 8.6: Other Facilities

Construction of new, and upgrading and maintenance of other health facilities

There is no change in the purpose of Programme 8 since tabling of the 2010 - 2014 Strategic Plan.

Performance measures, not specifically prioritised in the 2013/14 Annual Performance Plan, will be included in Operational Plans and monitored quarterly. Annual performance outcomes will be reported in the Annual Report.

8.2. OVERVIEW

Maintenance Programme

Maintenance of facilities, as per approved District Maintenance Plans, is undertaken by districts and the Independent Development Trust (IDT). Monthly reporting, guided by a customised reporting template making provision for actual and projected expenditure per project, improved the management of projects.

The Department appointed two Maintenance Project Managers to improve project management. Key management posts have been identified and submitted to the National Department of Health (NDOH) for approval.

Institutional maintenance has been under-spending in the first half of 2012/13 and intervention strategies have been put in place to ensure that expenditure is improved in the next six months.

Additional Funding

The Department has submitted the 2012/13 User Asset Management Plan (U-AMP) to the National Department of Health (NDOH) at the beginning of 2012/13, indicating a planned over-expenditure in the 2012/13 financial year.

In October 2012/13 the Department received additional funding of R200 million from National Treasury and R185 million from Provincial Treasury. The total additional funding received equates to R385 million in which the Department will prioritise this additional funding to committed projects only.

Infrastructure Project Assemble Tool (IPAT)

The Infrastructure Unit has appointed a Service Provider who is working closely with the Departmental Infrastructure Delivery Improvement Programme (IDIP) Technical Advisor (TA) on the development of a computer-based Project Packaging Tool. The departmental TA identified the need for improved project preparation so that fundamentals for implementation are secured at an early stage of a project in order to reduce risks.

The tool will provide a system for effective communication between key role-players and entities and will ensure that relevant information is highlighted and saved electronically for later use in the project implementation cycle. The tool will be applied prior to projects being introduced into the U-AMP and will provide 'project-readiness' reports to assist management in making project related resource allocation decisions and ensure that approvals are obtained such as land issues, feasibility studies, environmental assessments, services confirmations and ensure that each department has approved this project from moving forward.

This tool has been tested and has been submitted to the NDOH who requested roll out of tool nationally under the Infrastructure Delivery Management System (IDMS) system.

Management of Implementing Agents

The Province has a good working relationship with its two implementing agents namely Department of Public Works (DoPW) and IDT. The implementing agents are required to utilise the Standard Monthly Progress Reporting Format in which a hard and soft copy are forwarded to the Department of Health on the 10th of each month.

The Department uses this information to update the Infrastructure Reporting Model (IRM) which is then submitted on the 15th of each month to the NDOH and National Treasury.

Progress review of each project is undertaken in the Provincial Infrastructure Delivery Committee (PIDC) meeting held every month in which all Implementing Agents and Project Managers report on progress, actual expenditure and projected expenditure. This forms an effective and efficient communication mechanism of providing project information, challenges, project issues and resolutions to ensure that projects continue to improve so that service delivery can be met.

Financial and Physical Progress Monitoring

The Department has spent R 1,133 804 billion in the first half of 2012/13 with all four programmes spending above 58% versus time lapse of 50%. The table below indicates the actual expenditure versus the projections per month. The main reason for the Equitable Share under achieving is due to projects in the planning and design stage being put on hold due to the over commitment in this financial year coupled with the slow expenditure in the maintenance programme but the programme has spent 59% of its overall allocated budget.

Table 102: Actual Expenditure versus Projected Expenditure

Programme	Actual Expenditure April - September 2012	Projected Expenditure April – September 2012	Percentage Spent April – September 2012
Equitable Share	R 531 981.33	R 712 242.70	59%
Health Infrastructure Grant	R 260 262.68	R 255 259.00	60%
Hospital Revitalisation	R 327 117.47	R 313 065.67	58%
Nursing Colleges and Schools Grant	R 14 442.51	R 6 076.68	88%
Grand Total	**R 1 133 803.99**	**R 1 286 644.05**	**59%**

Source: Infrastructure Development (BAS)

8.3. CHALLENGES

- Inadequate capacity at Head Office, Districts and Institutions to manage the maintenance of infrastructure.
- Insufficient funding for addressing maintenance/ new infrastructure backlogs.
- Tender appeals continue to cause delays although there is a tremendous improvement compared to previous years.
- Appointment of incompetent contractors by the Department of Public Works, especially in new construction and upgrades to clinics, continue to cause problems. A solution is being sought to deal with this on-going problem.
- Unsuccessful termination of projects by Public Works, where contractors challenge the state through the courts. Contractors filing for liquidation in critical projects e.g. Durban Regional Laundry, Phoenix Mortuary and Port Shepstone core block.
- Budget constraints have caused the Department to put on hold a number of projects where design and documentation is complete. These critical projects include Dr Pixley kalsaka, Estcourt OPD, and Clairwood Replacement of Wards.

8.4. 2013/14 PRIORITIES: INFRASTRUCTURE DEVELOPMENT

PROVINCIAL PRIORITIES	PROVINCIAL KEY FOCUS AREAS
1. Create an enabling environment to support service delivery – approved Infrastructure Programme Implementation Plan (IPIP)	• New clinical infrastructure: IPIP aligned with STP and National Health Infrastructure Plan.
	• Maintenance, upgrading and renovation of existing infrastructure as per IPIP.
	• Office accommodation (Provincial and District).
2. Hospital Revitalisation Programme	• Improvement of facilities - upgrading and renovation of existing infrastructure.
	• Provide new infrastructure to improve service delivery.
	• Commence construction of the main building for Dr Pixley kalsaka Seme.
	• Continuation of Business Cases: Madadeni, Edendale and Dr John Dube Hospital.
	• New King Edward Central Hospital - National Department of Health.

8.5. STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR HFM

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 103: (HFM1): Provincial Strategic Objectives and Annual Targets for Health Care Support Services

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Mid-Year Performance	Medium Term Targets		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
1.19) Delivery of new clinical infrastructure in line with the approved IPIP (Infrastructure Programme Implementation Plan)	1.19.1) Number of new clinical projects with completed construction	52 Reviewed 2012/13	IRM; Draft 2013/14 U-AMP	Not reported	14	10	**10**	14	2	9
	1.19.2) Number of new clinical projects where commissioning is complete		IRM; Draft 2013/14 U-AMP	Not reported	23	22	**1**	6	17	14
1.20) Upgrading & renovation of existing clinical infrastructure in line with approved IPIP	1.20.1) Number of upgrading and renovation projects with completed construction	89 Reviewed 2012/13	IRM; Draft 2013/14 U-AMP	Not reported	41	27	**63**	45	23	12
	1.20.2) Number of upgrading and renovation projects where commissioning is complete		IRM; Draft 2013/14 U-AMP	Not reported	3	54	**0**	125	45	23

8.6. ANNUAL TARGETS FOR HFM 2013/14

Table 104: (HFM3): Annual Targets for Health Facilities Management for 2013/14

Performance Indicators	Targets 2013/14	Targets			
		Q1	Q2	Q3	Q4
Annual Targets					
1. Number of new clinical projects with completed construction	14				14
2. Number of new clinical projects where commissioning is complete	6				6
3. Number of upgrading and renovation projects with completed construction	45				45
4. Number of upgrading and renovation projects where commissioning is complete	125				125

8.7. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 105: (HFM4 (a)): Summary of payments and estimates for Programme 8

Sub-programme	Audited outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term expenditure estimates		
R' thousands	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Community Health Facilities	552 924	347 565	426 102	483 582	554 693	554 693	162 723	223 427	150 328
District Hospitals	482 159	424 314	720 786	600 408	624 482	624 482	519 777	487 365	402 498
EMS	1 201	428	3 285	6 460	8 091	8 091	9 679	1 737	19 846
Provincial Hospitals	187 320	204 691	531 961	568 303	869 566	869 566	514 276	482 621	587 977
Central Hospitals	35 161	11 982	4 720	51 763	32 410	32 410	25 281	25 652	34 518
Other facilities	119 484	98 267	208 145	206 588	278 038	278 038	404 867	201 936	163 461
Total	**1 378 249**	**1 087 247**	**1 894 999**	**1 917 104**	**2 367 280**	**2 367 280**	**1 636 603**	**1 422 738**	**1 358 628**

Table 106: (HFM4 (b)): Summary of payments and estimates by Economic Classification Programme 8

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2009/10	2010/11	2011/12	2012/13			2013/14	2014/15	2015/16
Current payments	**264 909**	**258 169**	**522 372**	**451 628**	**495 144**	**495 144**	**472 871**	**445 143**	**465 327**
Compensation of employees	3 448	5 037	12 736	28 270	28 270	28 270	14 628	11 628	11 628
Goods and services	**261 461**	**253 132**	**509 636**	**423 358**	**466 874**	**466 874**	**458 243**	**433 515**	**453 699**
Communication	228	333	9	411	21	21	**511**	**511**	**511**
Computer Services	2 872	2 178	19 409	4 709	2 709	2 709	**5 370**	**5 370**	**5 370**
Consultants, Contractors and special services	60 674	52 298	53 260	118 027	72 839	72 839	**69 315**	**70 315**	**76 315**
Inventory	52154	45974	5630	5884	23576	23576	**7319**	**7319**	**7319**
Operating leases	-	-	533	652	-	-	**20**	**20**	**20**
Rental and hiring	59 048	55 796	65 968	70 010	-	-	-	-	-
Travel and subsistence	893	385	-	710	410	410	698	698	698
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	85 592	96 168	364 827	222 955	367 319	367 319	375 010	349 282	363 466
Transfers and subsidies to	-	-	10 783	20 000	20 000	20 000	20 000	-	-
Non-profit institutions	-	-	10 000	20 000	20 000	20 000	20 000	-	-
Households	-	-	783	-	-	-	-	-	-
Payments for capital assets	**1 113 340**	**829 078**	**1 361 844**	**1 445 476**	**1 852 136**	**1 852 136**	**1 143 732**	**977 595**	**893 301**
Buildings and other fixed structures	1 005 258	778 730	1 048 172	1 085 471	1 492 131	1 492 131	864 152	903 641	813 796
Machinery and equipment	108 082	49 550	287 217	360 005	360 005	360 005	279 580	73 954	79 505
Land and sub-soil assets	-	798	26 455	-	-	-	-	-	-
Total economic classification	**1 378 249**	**1 087 247**	**1 894 999**	**1 917 104**	**2 367 280**	**2 367 280**	**1 636 603**	**1 422 738**	**1 358 628**

8.8. PERFORMANCE AND EXPENDITURE TRENDS

Programme 8 received 5.7% of the overall Provincial budget allocation, declining to 4.21% over the MTEF period.

The reduction in Programme 8 allocation over the 2013/14 MTEF is due to the baseline cuts, as well as funding being reprioritised 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 e.g. King Dinuzulu Hospital, clinics and CHCs. The shifting of *Machinery and equipment* funding from this programme (for established facilities) to the relevant service delivery programmes has also contributed to this reduction.

Provision has been made for the following in 2013/14:

- R401 million for Goods and Services (maintenance of facilities).
- Special allocations have been made for Chillers (R15 Million); Laundry (R10 Million); Autoclaves (R5 Million); Generators (R5 Million); Kitchen Equipment (R15 Million).

The three Infrastructure Grants have been combined to form the Health Facility Revitalisation Grant (R 962,499 Million) broken down as follows:

- Hospital Revitalisation component: R 560,104 Million
- Health Infrastructure component: R 373,969 Million
- Nursing Colleges and Schools component: R 28,396 Million
- The Equitable Share allocation is R 674,134 Million (41.1% of Health Facility Management budget from Equitable Share)

Additional funding is provided in the 2013/14 MTEF for the refurbishment of nurses training colleges and additional funding allocated under *Current payments* to enable the Department to address capacity issues in order to provide better support to infrastructure management.

The increasing trend in *Programme 8: Health Facilities Management* from 2009/10 to 2012/13 is largely the result of a drive to improve and maintain health infrastructure. The significant increase over the seven-year period comprises increasing amounts of Conditional Grant funding, especially the Hospital Revitalisation and the Health Infrastructure Grants, as well as the Department's Equitable Share.

8.9. RISK MANAGEMENT

POTENTIAL RISKS	MITIGATING FACTORS
13. Insufficient funding for maintenance and other infrastructure priorities/ backlogs (High).	• Re-prioritizing projects as per approved plans.
14. Inadequate project supervision (High).	• Appointment of Project Managers. • Implementation of IPAT.

PART C: LINKS TO OTHER PLANS

LINKS TO THE LONG-TERM INFRASTRUCTURE AND OTHER CAPITAL PLANS

Table 107: New and Replacement Assets

No	Project Name	Nature of Investment/ Project	Municipality	District	Project Expenditure for Previous years	Projected Expenditure by 31 March 2013	Medium Term Estimates			Total Project Cost
							2013/14	2014/15	2015/16	
1.	Babanango	New Clinic (Construction)	Ulundi	Zululand	R 2 053	R 11 757	R 4 354	R 270	-	**R 18 434**
2.	Bethesda Gateway	New Gateway Clinic (Design)	Jozini	Umkhanyakude	-	R 783	-	-	R 13 247	**R 14 405**
3.	Elandskraal	New Clinic (Construction)	Dannhauser	Umzinyathi	R 2 364	R 2 726	R 150	-	-	**R 5 240**
4.	Emambedwini	New Clinic (Construction)	uMshwathi	Umgungundlovu	R 2 013	R 7 499	R 1 552	R 582	-	**R 11 646**
5.	Enhlekiseni	New Clinic (Construction)	Abaqulusi	Zululand	R 1 721	R 7 653	R 3 863	R 919	-	**R 14 156**
6.	Ezimwini	New Clinic (Construction)	Mkhambathini	Umgungundlovu	R 7 590	R 13 911	R 817	-	-	**R 22 318**
7.	Ezwenelisha	New Clinic (Design)	Hlabisa	Umkhanyakude	-	R 250	-	-	R 9 020	**R 12 000**
8.	Groutville	Replacement Clinic (Design)	KwaDukuza	Ilembe	R 170	R 1 275		R 11 000	R 2 180	**R 15 000**
9.	Gwaliweni	New Clinic (Construction)	Jozini	Umkhanyakude	R 1 544	R 4 670	R 6 809	R 856	-	**R 13 879**
10.	Hluhluwe	New Clinic (Construction)	Jozini	Umkhanyakude	R 1 437	R 7 023	R 24 892	R 850	-	**R 34 202**
11.	Hopewell	New Clinic (Feasibility)	Richmond	Umgungundlovu	R 499	R 1 000	-	-	R 13 151	**R 15 000**
12.	Ingogo	New Clinic (Construction)	Newcastle	Amajuba	R 4 458	R 6 932	R 3 367	R 400	-	**R 15 157**
13.	Ikhwezi Lokusa	New Clinic Tender (Tender)	Ubuhlebezwe	Sisonke	R 1 170	R 1 178	-	R 12 695	R 350	**R 15 393**
14.	KwaHhemlana	New Clinic (Construction)	Nongoma	Zululand	R 1 923	R 5 706	R 647	R 521	-	**R 14 297**
15.	KwaJoni	New Clinic (Identified)	Umzumbe	Ugu	R 3 649	R 500	-	-	-	**R 18 000**
16.	KwaMakhutha	New Clinic (Tender)	eThekwini	eThekwini	R 1 670	-	-	R 7 000	R 10 404	**R 19 587**
17.	KwaMpande	New Clinic (Tender)	Msunduzi	Umgungundlovu	R 1 555	R 30	-	R 10 000	R 3 455	**R 15 425**
18.	Madundube	Replacement (Feasibility)	Maphumulo	Ilembe	-	-	-	-	R 21 450	**R 22 000**
19.	Mahlutshini	New Clinic (Construction)	Impendle	Umgungundlovu	R 1 133	R 6 202	R 3 279	R 275	-	**R 10 889**
20.	Manxili	New Clinic (Feasibility)	Msinga	Umzinyathi	R 34	R 300	-	-	-	**R 15 034**
21.	Maphumulo	New Clinic (Construction)	Maphumulo	Ilembe	R 8 446	R 12 280	R 500	-	-	**R 21 226**
22.	Mashona	New Clinic (Construction)	Ulundi	Zululand	R 620	R 7 571	R 10 791	R 426	-	**R 19 408**
23.	Mbabane/ Sukumani	New Clinic (Construction)	Dannhauser	Amajuba	R 9 005	R 1 463	R 339	-	-	**R 10 807**
24.	Mbotho	New Clinic (Retention)	UMuziwabantu	Ugu	R 4 938	R 72	R 150	-	-	**R 5 160**
25.	Mkhuphula	New Clinic (Construction)	Msinga	Umzinyathi	R 4 792	R 2 100	R 1 576	-	-	**R 8 468**
26.	Mosvold Gateway	New Gateway Clinic (Construction)	Jozini	Umkhanyakude	R 210	R 4 804	R 5 860	R 275	-	**R 11 149**
27.	Mpophomeni	New Clinic (Tender)	Umhlabuyalingana	Umkhanyakude	R 2 878	R 900		R 8 000	R 7 792	**R 19 800**
28.	Mqatsheni	New Clinic (Construction)	Underberg	Sisonke	R 870	R 8 235	R 4 440	R 600	-	**R 14 145**
29.	Mseleni Gateway	New Clinic (Design)	Umhlabuyalingana	Umkhanyakude	R 177	R 672	-	-	R 11 051	**R 12 130**

No	Project Name	Nature of Investment/ Project	Municipality	District	Project Expenditure for Previous years	Projected Expenditure by 31 March 2013	Medium Term Estimates			Total Project Cost
							2013/14	2014/15	2015/16	
30.	Msizini	New Clinic (Construction)	Msinga	Umzinyathi	R 6 926	R 1 192	R 850	-	-	**R 8 968**
31.	Muden	New Clinic (Awarded)	Msinga	Umzinyathi	R 493	R 3 200	R 12 385	R 800	-	**R 16 878**
32.	Ndelu	New Clinic (Design)	Umzumbe	Ugu	R 132	R 500		R 10 000	R 5 943	**R 17 000**
33.	Ndlozana	New Clinic (Construction)	Nongoma	Zululand	R 4 016	R 11 237	R 401	-	-	**R 15 654**
34.	Ndundulu	Replacement Clinic (Construction)	Mthonjaneni	Uthungulu	R 726	R 4 839	R 10 475	R 500	-	**R 16 540**
35.	Ngabayena	New Clinic (Construction)	Msinga	Umzinyathi	R 10 308	R 600	-	-	-	**R 10 908**
36.	Nkanini Health Centre	New Clinic (Awarded)	Nkandla	Uthungulu	R 575	R 191	-	-	-	**R 766**
37.	Nhlababo	New Clinic (Identified)	Nkandla	Uthungulu	-	R 500	-	-	-	**R 16 000**
38.	Nhlopheni	New Clinic (Construction)	Abaqulusi	Zululand	R 1 861	R 8 754	R 7 986	R 389	-	**R 18 990**
39.	Nogajuluka	New Clinic (Construction)	Mthonjaneni	Uthungulu	R 4 141	R 6 892	R 300	-	-	**R 11 333**
40.	Nxamalala	Replacement Clinic (Construction)	Impendle	Umgungundlovu	R 1 182	R 502	R 656	-	-	**R 2 340**
41.	Okhukho	New Clinic (Construction)	Ulundi	Zululand	R 1 574	R 8 642	R 10 138	R 550	-	**R 20 904**
42.	Rosary	New Clinic (Design)	Newcastle	Amajuba	R 2 127	-	-	-	R 9 000	**R 22 122**
43.	Sandlwana	New Clinic (Identified)	Umtshezi	Uthukela	-	R 100	-	-	-	**R 18 000**
44.	Shayamoya	New Clinic (Design)	Greater Kokstad	Sisonke	R 69	R 800	-	R 9 000	R 5 558	**R 15 858**
45.	Shongweni Dam	New Clinic (Construction)	eThekwini	eThekwini	R 833	R 7 394	R 5 073	R 350	-	**R 13 650**
46.	Sokhela	New Clinic (Construction)	Impendle	Sisonke	R 884	R 4 997	R 2 077	R 188	-	**R 8 146**
47.	Thathezakhe	New Clinic (Construction)	Nquthu	Umzinyathi	R 2 913	R 8 157	R 894	R 307	-	**R 12 271**
48.	Dannhauser	New CHC (Construction)	Dannhauser	Amajuba	R 8 257	R 41 511	R 50 000	R 54 827	R 2 789	**R 157 384**
49.	Jozini	New CHC (Awarded)	Jozini	Umkhanyakude	R 14 719	R 9 000	R 70 000	R 71 281	R 5 000	**R 170 000**
50.	Pomeroy	New CHC (Construction)	Msinga	Umzinyathi	R 11 794	R 53 468	R 65 000	R 34 712	R 4 026	**R 169 000**
51.	Umbumbulu	New CHC (Feasibility)	eThekwini	eThekwini	R 5 184	R 1 096	-	-	-	**R 160 000**
52.	Umzimkhulu	New CHC (Design)	Umzimkhulu	Sisonke	R 5 653	R 1 037	-	-	-	**R 200 000**
53.	Usutu	Replacement Clinic (Feasibility)	Nongoma	Zululand	-	R 600	-	-	-	**R 18 000**
54.	Vumani	New Clinic (Construction)	Abaqulusi	Zululand	R 2 847	R 7 609	R 5 117	R 400	-	**R 15 973**
55.	Wosiyane	Replacement Clinic (Construction)	Ndwedwe	Ilembe	R 3 039	R 3 586	R 455	-	-	**R 7 080**
56.	Zululand EMS	New large EMS station (Design)	Municipality	Zululand	R 458	R 225	-	-	-	**R 63 167**
57.	Dr John Dube Memorial Hospital	New District Hospital (Design)	eThekwini	eThekwini	R 10 230	R 8 000	-	-	-	**R 1 800 000**
58.	Ekhombe Hospital	New Staff Accommodation (Awarded)	Nkandla	Uthungulu	R 1 678	R 4 800	R 20 000	R 7 103	R 850	**R 34 431**
59.	King George V Hospital	New Hospital (Retention)	eThekwini	eThekwini	R 462 200	R 4 380	R 322	-	-	**R 466 902**
60.	Madadeni Psychiatric Hospital	New Psychiatric Hospital (Design)	Newcastle	Amajuba	R 9 501	R 16 589	-	-	-	**R 1 000 000**
61.	Pixley KaSeme Hospital	New Hospital (Design)	eThekwini	eThekwini	R 67 971	R 41 618	-	R 258 786	R 315 176	**R 2 642 522**

No	Project Name	Nature of Investment/ Project	Municipality	District	Project Expenditure for Previous years	Projected Expenditure by 31 March 2013	Medium Term Estimates			Total Project Cost
							2013/14	2014/15	2015/16	
62.	Pixley KaSeme Hospital	Phase 2 Below ground infrastructure (Construction)	eThekwini	eThekwini	R 21 530	R 13 403	R 875	-	-	**R 35 808**
63.	eThekwini EMS	New large EMS Station (Feasibility)	eThekwini	eThekwini	-	-	-	-	-	**R 20 000**
64.	Ugu EMS Base	New large EMS base (Design)	Municipality	Ugu	R 53	-	-	-	-	**R 157 115**
65.	Umgungundlovu EMS	New large EMS station (Design)	Municipality	Umgungundlovu	R 1 019	R 1 557	-	-	-	**R 70 000**
66.	Umzinyathi EMS	New large EMS station (Design)	Municipality	Umzinyathi	R 864	R 5 207	-	-	-	**R 74 390**
67.	Greytown Mortuary	New Forensic Mortuary (Design)	Greytown	Umzinyathi	R 27 204	R 11 033	R 1 000	-	-	**R 39 237**
68.	Ladysmith Forensic Mortuary	New Mortuary (Identified)	Emnambithi	Uthukela	-	R 500	-	-	R 31 867	**R 45 000**
69.	Phoenix Mortuary	New M6 Forensic Mortuary (Construction)	eThekwini	eThekwini	R 15 140	R 24 215	R 36 645	R 2 000	-	**R 78 000**
70.	Eshowe Nursing College	New Nursing College and Student Accommodation (Design)	Umlalazi	Uthungulu	R 417	-	-	-	-	**R 255 000**
71.	Madadeni Nursing College 'Core Block'	New Nursing College (Design)	Newcastle	Amajuba	R 428	R 500	-	-	-	**R 154 269**
72.	Madadeni Nursing College Student Accommodation	New Nursing College (Design)	Newcastle	Amajuba	R 2 280	R 538	-	R 13 104	R 23 191	**R 39 113**
Total New and Replacement Assets					**R 778 143**	**R 5 276 461**	**R 403 553**	**R 518 966**	**R 495 500**	**R 8 563 074**

Table 108: Maintenance and Repairs

No	Project Name	Nature of Investment/ Project	Municipality	District	Project Expenditure for Previous years	Projected Expenditure by 31 March 2013	Medium Term Estimates			Total Project Cost
							2013/14	2014/15	2015/16	
1.	Institutional Maintenance	Various Projects, Hospital - District	All	Amajuba	-	R 39 510	R 19 949	R 19 449	R 20 421	**R 479 140**
2.	Institutional Maintenance	Various Projects, Hospital - District	All	eThekwini	-	R 76 590	R 61 549	R 61 549	R 64 626	**R 1 466 278**
3.	Institutional Maintenance	Various Projects	Pietermaritzburg	Head Office	-	R 2 561	R 2 510	R 2 510	R 2 636	**R 59 233**
4.	Institutional Maintenance	Clinics	All	Ilembe	R 10 178	R 27 541	R 25 369	R 25 369	R 26 637	**R 610 515**
5.	Institutional Maintenance	Various Projects, Clinics	All	Sisonke	-	R 16 067	R 27 527	R 27 527	R 28 903	**R 637 587**
6.	Institutional Maintenance	Various Projects	All	Ugu	-	R 18 385	R 37 112	R 33 450	R 35 123	**R 777 300**
7.	Institutional Maintenance	Clinics	All	Umgungundlovu	-	R 52 118	R 58 808	R 58 808	R 61 748	**R 1 379 927**
8.	Institutional Maintenance	Clinics	All	Umkhanyakude	-	R 10 847	R 42 039	R 42 039	R 44 141	**R 960 027**
9.	Institutional Maintenance	Clinics	All	Umzinyathi	-	R 11 586	R 26 194	R 26 194	R 27 504	**R 603 009**
10.	Institutional Maintenance	Various Projects, Clinics	All	Uthukela	-	R 10 207	R 20 785	R 13 135	R 13 792	**R 314 336**
11.	Institutional Maintenance	Clinics, Hospital - District	All	Uthungulu	-	R 43 901	R 41 161	R 33 816	R 35 507	**R 814 763**
12.	Institutional Maintenance	Clinics, Hospital Specialised	All	Zululand	-	R 13 075	R 29 912	R 29 912	R 31 408	**R 688 445**
Total Maintenance and Repairs					**R 10 178**	**R 322 388**	**R 392 915**	**R 373 758**	**R 392 446**	**R 8 790 560**

Table 109: Upgrades and Additions

No	Project Name	Nature of Investment/ Project	Municipality	District	Project Expenditure for Previous years	Projected Expenditure by 31 March 2013	Medium Term Estimates			Total Project Cost
							2013/14	2014/15	2015/16	
1.	Acquisition Land/ Buildings	Various Upgrades	Head Office	Head Office	-	-	R 4 000	R 3 000	R 40 800	**R 125 800**
2.	Addington	Upgrade: Regional Hospital	eThekwini	eThekwini	R 3 211	R 1 000	-	R 30 000	R 45 289	**R 81 600**
3.	Appelsbosch	Additions: District Hospital	uMshwathi	Umgungundlovu	R 20 888	R 9 021	R 7 085	R 450	R 20 000	**R 83 719**
4.	Benedictine	Additions: District Hospital			-	R 500	-	-	R 40 000	**R 66 734**
5.	Bethesda	Upgrade: District Hospital	Jozini	Umkhanyakude	R 2 113	R 1 861	R 14 000	R 4 686	R 2 340	**R 25 000**
6.	Bruntville	Additions: CHC	Mpofana	Umgungundlovu	-	R 150	-	R 550	-	**R 700**
7.	Catherine Booth	Upgrade: District Hospital	Umlalazi	Uthungulu	R 983	R 4 490	R 125	-	-	**R 5 598**
		Additions			R 2 114	R 1 000	-	-	R 25 000	**R 49 388**
8.	Charles Johnson Memorial	Upgrade: District Hospital	Nquthu	Umzinyathi	-	R 2 000	-	R 3 772	R 100	**R 5 872**
		Additions			R 9 678	R 14 018	R 3 961	-	R 26 250	**R 55 406**
9.	Ceza	Additions: District Hospital	Nongoma	Zululand	R 1 949	R 4 963	R 10 929	R 400	-	**R 18 241**
10.	Chibini Clinic	Upgrade: Clinic	Ndwedwe	Ilembe	R 675	R 1 664	R 75	-	-	**R 2 414**
		Additions			-	R 200	-	-	-	**R 4 000**
11.	Christ the King	Upgrade: District Hospital	Ubuhlebezwe	Sisonke	-	R 619	R 25	-	-	**R 644**
12.	Church of Scotland	Upgrade: District Hospital	Msinga	Umzinyathi	R 2 901	R 4 050	R 28 650	R 20 537	R 772	**R 56 910**
		Additions			-	R 2 000	-	-	R 37 000	**R 40 000**
13.	Clairwood	Upgrade: Chronic Hospital	eThekwini	eThekwini	R 7 340	R 137	-	R 29 290	R 30 710	**R 90 040**
14.	Dr Pixley Ka Seme	Upgrade: New Regional Hospital	eThekwini	eThekwini	R 776	R 400	R 1 000	R 1 000	R 1 116	**R 4 292**
15.	Dundee	Additions: District Hospital	Endumeni	Umzinyathi	R 11 277	R 3 155	R 25	-	R 22 475	**R 41 957**
16.	Edendale	Upgrade: Regional Hospital	Msunduzi	Umgungundlovu	R 32 959	R 89 190	R 53 398	R 54 828	R 1 600	**R 2 616 463**
		Additions			R 2 572	R 13 500	R 27 013	R 15 000	R 594	**R 58 679**
17.	Ekhombe	Upgrade: District Hospital	Nkandla	Uthungulu	R 633	R 4 637	R 97	-	-	**R 5 367**
18.	Emmaus	Additions: District Hospital	Okhahlamba	Uthukela	R 7 765	R 22 478	R 57 600	R 41 093	R 3 300	**R 132 236**
19.	Eshowe	Upgrade: District Hospital	Umlalazi	Uthungulu	R 6 561	R 7 663	R 4 283	R 220	-	**R 18 727**
20.	Esikhawini	Upgrade: CHC	uMhlathuze	Uthungulu	R 102	R 500	-	-	-	**R 187 040**
21.	Estcourt	Additions: District Hospital	Umtshezi	Uthukela	R 7 223	R 1 000	-	-	R 65 000	**R 140 511**
22.	Ex Boys Model School	Upgrade: Clinic	Msunduzi	Umgungundlovu	R 871	R 3 400	R 4 504	R 225	-	**R 9 000**
23.	Fort Napier	Upgrade: Specialised Psychiatric Hospital	Msunduzi	Umgungundlovu	-	R 780	R 20	-	-	**R 800**
24.	Gamalakhe	Additions: CHC	Hibiscus Coast	Ugu	R 3 750	R 3 348	R 14 124	R 13 878	R 900	**R 36 000**
25.	G J Crookes	Upgrade: District Hospital	Umdoni	Ugu	-	R 600	-	-	-	**R 600**
26.	Greys	Upgrade: Tertiary Hospital	Msunduzi	Umgungundlovu	R 1 180	R 14 998	R 2 585	R 485	R 46 300	**R 66 748**
		Additions			R 1 415	R 1 800	R 5 000	R 6 310	R 375	**R 14 900**

PART C

No	Project Name	Nature of Investment/ Project	Municipality	District	Project Expenditure for Previous years	Projected Expenditure by 31 March 2013	Medium Term Estimates			Total Project Cost
							2013/14	2014/15	2015/16	
27.	Greytown	Upgrade: District Hospital	Msinga	Umzinyathi	R 981	-	R 25	-	-	**R 1 006**
		Additions			R 1 682	R 3 566	R 2 735	-	-	**R 37 363**
28.	Highway House	Upgrade: District Office	eThekwini	eThekwini	-	-	-	-	-	**R 1 800**
		Additions			R 3 334	R 7 390	R 1 500	R 500		**R 12 724**
29.	Hlabisa	Upgrade: District Hospital	Hlabisa	Umkhanyakude	R 49 640	R 13 134	R 9 448	R 36 500	R 20 445	**R 130 917**
30.	IDT Projects	Upgrades	Head Office	Head Office	-	R 4 500	R 18 000	R 18 000	R 13 500	**R 54 000**
31.	Inanda C	Additions: Clinic	eThekwini	eThekwini	R 3 936	R 5 839	R 12 235	R 4 600	R 600	**R 27 210**
32.	Injisuthi	Upgrade: Clinic	Imbabazane	Uthukela	R 783	-	R 117	-	-	**R 900**
33.	Isiboniso	Additions: Clinic	uMhlathuze	Uthungulu	R 453	R 3 932	R 200	-	-	**R 4 585**
34.	Isithebe	Additions: Clinic	Mandeni	Ilembe	R 1 372	R 4 749	R 10 501	R 419	-	**R 17 041**
35.	Jozini	Convert Old Jozini Complex into Offices	Jozini	Umkhanyakude	R 734	R 1 749	R 2 867	R 250	-	**R 5 600**
36.	King Edward VIII	Upgrade: Regional Hospital	eThekwini	eThekwini	R 11 826	R 20 758	R 58 000	R 50 319	R 2 800	**R 143 703**
37.	King George V	Upgrades: Regional Hospital	eThekwini	eThekwini	R 1 058 313	R 81 404	R 98 689	R 11 635	R 7 326	**R 1 257 368**
		Additions			R 14 160	R 27 289	R 34 339	R 1 917	-	**R 77 705**
38.	KwaMagwaza	Upgrades: District Hospital	Mthonjaneni	Uthungulu	R 957	R 4 973	R 4 400	R 10 230	R 5 391	**R 26 375**
		Additions			R 1 069	R 3 544	R 4 532	R 355	-	**R 9 500**
39.	Ladysmith	Upgrades: Regional Hospital	Emnambithi	Uthukela	R 1 735	R 3 927	R 748	R 125	-	**R 11 435**
		Additions			R 1 169	R 798	R 30	-	-	**R 21 497**
40.	Lower Umfolozi War Memorial	Upgrade: Regional M&C Hospital	uMhlathuze	Uthungulu	R 23 620	R 17 985	R 32 400	R 25 595	R 63 865	**R 163 465**
		Additions			R 124 533	R 81 556	R 55 000	R 65 000	R 21 785	**R 347 874**
41.	Madadeni	Upgrade: Regional Hospital	Newcastle	Amajuba	R 485	R 10 364	-	-	-	**R 33 849**
42.	Mahatma Ghandi	Additions			R 149	R 500	-	-	R 21 776	**R 23 000**
43.	Mambulu (Kranskop)	Upgrade: Clinic	Maphumulo	Ilembe	R 53	R 1 307	-	R 5 600	R 4 740	**R 12 000**
44.	Manguzi	Additions: District Hospital	Umhlabuyalingana	Umkhanyakude	R 12 014	R 27 150	R 4 809	-	R 575	**R 44 548**
45.	Mbongolwane	Upgrade: District Hospital	Umlalazi	Uthungulu	R 124	R 612	R 147	-	-	**R 883**
46.	Mkhontokayise	Upgrade: Clinic	uMhlathuze	Uthungulu	R 521	R 2 483	R 2 541	R 350	-	**R 5 895**
		Additions			R 5 146	R 13 621	R 16 296	R 1 299	-	**R 36 362**
47.	Montebello	Upgrade: District Hospital	Ndwedwe	Ilembe	-	R 343	-	-	R 14 282	**R 15 000**
48.	Mosvold	Upgrades: District Hospital	Jozini	Umkhanyakude	R 2 466	R 10 973	R 3 337	R 191	-	**R 16 947**
49.	Mseleni	Additions: District Hospital	Umhlabuyalingana	Umkhanyakude	R 2 782	R 17 204	R 11 022	R 751	-	**R 31 759**
50.	Murchison	Upgrades: District Hospital	Hibiscus Coast	Ugu	R 368	R 963	R 26	-	-	**R 1 357**
		Additions			R 7 032	R 9 165	R 22 393	R 25 760	R 1 650	**R 76 000**
51.	Mwolokohlo	Additions: Clinic	Ndwedwe	Ilembe	R 1 575	R 1 039	-	R 9 119	R 2 000	**R 14 083**
52.	Natalia Building	Upgrades: Head Office	Head Office	Head Office	R 10 822	R 12 559	R 70 100	R 70 000	R 26 976	**R 191 457**

No	Project Name	Nature of Investment/ Project	Municipality	District	Project Expenditure for Previous years	Projected Expenditure by 31 March 2013	Medium Term Estimates			Total Project Cost
							2013/14	2014/15	2015/16	
53.	Ndwedwe	Additions CHC	Ndwedwe	Ilembe	-	R 300	-	-	R 6 500	**R 9 000**
54.	Newcastle SAPS Mortuary	Upgrades: Mortuary	Newcastle	Amajuba	R 10 003	-	R 243	-	-	**R 10 246**
55.	Newcastle	Additions: Regional Hospital	Newcastle	Amajuba	R 2 690	R 11 343	R 21 380	R 1 353	-	**R 36 766**
56.	Newtown A	Upgrade CHC	eThekwini	eThekwini	-	R 100	-	-	-	**R 10 000**
57.	Ngwelezane	Upgrade: Tertiary Hospital	uMhlathuze	Uthungulu	R 66 370	R 55 861	R 84 495	R 14 068	R 13 500	**R 234 294**
		Additions			R 27 697	R 18 739	R 6 866	R 10 500	R 60 000	**R 299 367**
58.	Nhlabane	Additions: Clinic	Umlalazi	Uthungulu	R 1 972	R 461	R 413	-	-	**R 2 846**
59.	Niemeyer Memorial	Upgrade: District Hospital	Emadlangeni	Amajuba	R 569	R 92	R 25	-	-	**R 686**
60.	Nkandla	Upgrade: District Hospital	Nkandla	Uthungulu	R 6 463	R 19 606	R 454	-	-	**R 26 523**
		Additions			R 888	R 8 003	R 2 000	R 749	-	**R 11 640**
61.	Nkandla Nursing College	Additions: Nursing College	Nkandla	Uthungulu	R 1 927	R 600	-	R 14 350	R 6 263	**R 56 113**
62.	Northdale	Upgrade: District Hospital	Msunduzi	Umgungundlovu	-	R 700	-	-	-	**R 5 000**
63.	Ntinini	Additions: Clinic	Nquthu	Umzinyathi	R 584	R 595	R 50	-	-	**R 1 229**
64.	Office and residential accommodation lease agreements	Manage 168 Lease Agreements for KZN Health (Office and Residential Accommodation)	Head Office	Head Office	-	R 67 045	R 67 000	R 71 000	R 76 000	**R 954 045**
65.	Pholela	Additions: CHC	Umzimkhulu	Sisonke	-	R 5 978	R 20 000	R 8 522	R 500	**R 35 000**
66.	Port Shepstone	Upgrade: Regional Hospital	Hibiscus Coast	Ugu	R 465	R 3 501	R 80	R 20 418	R 8 087	**R 33 650**
		Additions			R 152 001	R 2 235	R 4 000	-	R 25 000	**R 198 236**
67.	Prince Mshiyeni Memorial	Upgrade: Regional Hospital	eThekwini	eThekwini	R 6 445	R 8 409	R 500	-	-	**R 15 354**
68.	Programme Management	Programme Management	Head Office	Head Office	-	R 14 816	R 12 000	R 12 000	R 12 000	**R 50 816**
69.	R K Khan	Upgrade: Regional Hospital	eThekwini	eThekwini	R 23 912	R 500	R 9 347	R 4 406	-	**R 38 165**
70.	Rietvlei	Upgrade: District Hospital	Umzimkhulu	Sisonke	R 79 547	R 51 229	R 81 675	R 52 526	R 53 000	**R 444 402**
		Additions			-	R 8 500	R 25 000	R 2 500	-	**R 36 000**
71.	St Andrews	Upgrade: District Hospital	UMuziwabantu	Ugu	R 7 804	R 1 234	R 240	-	-	**R 9 278**
72.	Stanger	Upgrade: Regional Hospital	KwaDukuza	Ilembe	R 1 537	-	-	-	R 4 300	**R 5 937**
		Additions			R 8 635	R 1 750	R 15 000	R 60 000	R 49 516	**R 138 351**
73.	Thafamasi	Additions: Clinic	Ndwedwe	Ilembe	R 2 089	R 388	R 20	-	-	**R 2 497**
74.	Umgeni	Upgrade: Specialised Psychiatric Hospital	Umsunduzi	Umgungundlovu	R 2 579	R 8 851	R 537	-	-	**R 11 967**
75.	Umphumulo	Upgrade: District Hospital	Maphumulo	Ilembe	R 860	R 300	-	-	R 21 000	**R 45 300**
76.	Umzimkhulu	Upgrade: District Hospital	Umzimkhulu	Sisonke	R 645	R 1 326	-	R 7 393	R 220	**R 10 658**
		Additions			R 7 748	-	-	-	R 80 000	**R 163 793**
77.	Umzimkhulu Forensic Mortuary	Upgrade: Mortuary (M1)	Umzimkhulu	Sisonke	R 352	-	-	-	R 11 000	**R 25 000**
78.	Underberg	Upgrade: Clinic	KwaSani	Sisonke	R 274	R 60	R 265	-	-	**R 599**

No	Project Name	Nature of Investment/ Project	Municipality	District	Project Expenditure for Previous years	Projected Expenditure by 31 March 2013	Medium Term Estimates			Total Project Cost
							2013/14	2014/15	2015/16	
79.	Untunjambili	Upgrade: District Hospital	Maphumulo	Ilembe	R 3 207	R 8 676	R 24 204	R 1 000	-	**R 37 087**
80.	Vryheid	Upgrade: District Hospital	Abaqulusi	Zululand	R 164	R 50	R 971	R 130	-	**R 1 315**
		Additions			R 895	R 1 140	R 80	-	-	**R 2 115**
81.	Wentworth	Upgrade: District Hospital	eThekwini	eThekwini	R 206	-	-	-	-	**R 3 168**
82.	Umgeni	Upgrade: Specialised Psychiatric Hospital	Msunduzi	Umgungundlovu	-	R 918	-	-	-	**R 918**
Total upgrades and additions					**R 1 891 298**	**R 913 784**	**R 1 091 781**	**R 845 154**	**R 1 044 518**	**R 9 864 955**

Table 110: Rehabilitation, Renovations and Refurbishments

No	Project Name	Nature of Investment/ Project	Municipality	District	Project Expenditure for Previous years	Projected Expenditure by 31 March 2013	Medium Term Estimates			Total Project Cost
							2013/14	2014/15	2015/16	
1.	Addington	regional Hospital	eThekwini	eThekwini	R 13 263	R 30 331	R 60 115	R 60 547	R 2 600	**R 166 856**
2.	Addington Nursing College	Nursing College	eThekwini	eThekwini	R 2 758	R 2 642	R 18 975	R 624	-	**R 25 000**
3.	Altona	Clinic	UPhongolo	Zululand	R 608	R 2 844	R 2 148	R 200	-	**R 5 800**
4.	Appelsbosch	District Hospital	uMshwathi	Umgungundlovu	R 13 024	R 4	R 1 058	-	-	**R 14 086**
5.	Bethesda	District Hospital	Jozini	Umkhanyakude	R 606	R 5 769	R 125	-	-	**R 6 500**
6.	Bhekabantu	Clinic	Umhlabuyalingana	Umkhanyakude	R 2 840	R 1 530	R 130	-	-	**R 4 500**
7.	Bhobhoyi	Clinic	Hibiscus Coast	Ugu	R 2 150	R 2 695	R 105	-	-	**R 4 950**
8.	Bhomela	Clinic	Hibiscus Coast	Ugu	R 4 187	-	R 150	-	-	**R 4 337**
9.	Ceza	District Hospital	Nongoma	Zululand	R 2 733	R 3 400	R 600	-	-	**R 6 733**
10.	Edendale	Regional Hospital	Msunduzi	Umgungundlovu	R 1 112	R 536	R 100	-	-	**R 1 748**
11.	Edendale Nursing College	Nursing College	Msunduzi	Umgungundlovu	R 11 596	R 20 708	R 12 092	R 2 000	-	**R 46 396**
12.	Ekhombe	District Hospital	Nkandla	Uthungulu	R 575	R 1 874	-	R 30 000	R 19 861	**R 53 810**
13.	Ekuhlengeni	Specialised Psychiatric Hospital	eThekwini	eThekwini	R 2 677	R 4 841	R 17 000	R 11 232	R 1 000	**R 36 750**
14.	Eshowe	District Hospital	Umlalazi	Uthungulu	R 432	R 1 617	R 7 841	R 250	-	**R 10 140**
15.	Estcourt	District Hospital	Umtshezi	Uthukela	R 6 703	R 432	R 3 232	R 100	-	**R 10 467**
16.	Fort Napier	Specialised Psychiatric Hospital	Msunduzi	Umgungundlovu	R 3 359	R 250	R 181	R 8 000	R 6 375	**R 18 540**
17.	G J Crookes	District Hospital	Umdoni	Ugu	R 9 267	R 20 669	R 50 000	R 68 325	R 14 678	**R 162 939**
18.	Gcilima	Clinic	Hibiscus Coast	Ugu	R 1 916	R 777	R 70	-	-	**R 2 763**
19.	Greys	Tertiary Hospital	Umsunduzi	Umgungundlovu	R 1 900	R 1 469	R 125	-	R 15 000	**R 33 000**
20.	Hartland	Clinic	eDumbe	Zululand	R 715	R 3 643	R 110	-	-	**R 4 468**
21.	Hillcrest	Chronic Hospital	eThekwini	eThekwini	R 891	R 368	R 38	-	-	**R 1 297**
22.	Ixopo	Clinic	Ubuhlebezwe	Sisonke	R 8 211	R 214	R 250	-	-	**R 8 675**

No	Project Name	Nature of Investment/ Project	Municipality	District	Project Expenditure for Previous years	Projected Expenditure by 31 March 2013	Medium Term Estimates			Total Project Cost
							2013/14	2014/15	2015/16	
23.	Jozini Malaria Health Complex	Malaria Complex	Jozini	Umkhanyakude	R 67	R 741	-	R 2 432	R 83	**R 3 323**
24.	Kilman Clinic	Clinic	Ingwe	Sisonke	R 1 951	-	R 489	R 60	-	**R 2 500**
25.	King Edward VIII Hospital	Regional Hospital	eThekwini	eThekwini	R 36 998	R 15 966	R 1 836	R 20 050	R 12 125	**R 87 850**
26.	King George V Hospital	District Hospital	eThekwini	eThekwini	R 6 938	R 313	R 248	R 1 408	R 800	**R 9 707**
27.	KwaJali Clinic	Clinic	UMuziwabantu	Ugu	R 1 300	R 650	R 50	-	-	**R 2 000**
28.	Kwashoba Clinic	Clinic	UPhongolo	Zululand	R 1 146	R 4 813	R 150	-	-	**R 6 109**
29.	KwaZulu Provincial Central Laundry (PMMH)	Laundry	eThekwini	eThekwini	R 6 000	R 90 778	R 2 000	R 2 000	R 2 000	**R 102 778**
30.	KZN Children's Hospital	Children's Hospital	eThekwini	eThekwini	R 10 000	R 10 000	R 20 000	R 10 000	-	**R 50 000**
31.	Ladybank Clinic	Clinic	Dannhauser	Amajuba	R 208	R 818	R 30	-	-	**R 1 056**
32.	Lomo	Clinic	Ulundi	Zululand	R 2 795	R 4 045	R 150	-	-	**R 6 990**
33.	Ludimala (Mlondi)	Clinic	Hibiscus Coast	Ugu	R 1 051	R 947	R 50	-	-	**R 2 048**
34.	Macambini	Clinic	KwaDukuza	Ilembe	R 3 909	R 2 688	R 103	-	-	**R 6 700**
35.	Madadeni Clinic No 7	Clinic	Newcastle	Amajuba	R 2 052	R 1 149	R 82	-	-	**R 3 283**
36.	Makhathini	Clinic	Jozini	Umkhanyakude	R 2 896	R 572	R 1 848	R 100	-	**R 5 416**
37.	Mathungela	Clinic	Umlalazi	Uthungulu	R 1 840	R 2 383	R 80	-	-	**R 4 303**
38.	Mbongolwane	District Hospital	Umlalazi	Uthungulu	R 932	R 6 670	R 12 495	R 5 696	R 600	**R 26 393**
39.	Mbuthisweni (Inhlazuka)	Clinic	Richmond	Umgungundlovu	R 773	R 768	R 50	-	-	**R 1 591**
40.	Mhlekazi	Clinic	Jozini	Umkhanyakude	R 3 743	R 170	R 322	-	-	**R 4 235**
41.	Mnqobokazi	Clinic	The Big 5 False Bay	Umkhanyakude	R 832	R 2 292	R 3 924	R 180	-	**R 7 228**
42.	Mosvold	District Hospital	Jozini	Umkhanyakude	R 2 220	R 7 199	R 10 253	R 550	-	**R 20 222**
43.	Ndulinde	Clinic	KwaDukuza	Ilembe	R 2 862	R 2 672	R 90	-	-	**R 5 624**
44.	Newcastle	Regional Hospital	Newcastle	Amajuba	R 1 136	R 940	R 2 560	R 427	-	**R 5 063**
45.	Ngwelezane	Clinic	uMhlathuze	Uthungulu	R 2 152	R 909	R 2 155	R 130	-	**R 5 346**
46.	Northdale	District Hospital	Msunduzi	Umgungundlovu	R 4 450	R11 309	R 623	-	-	**R 17 382**
47.	Ntambanana	Clinic	Ntambanana Clinic	Uthungulu	R 1 795	R 8 130	R 2 918	R 280	-	**R 13 123**
48.	Osindisweni	District Hospital	eThekwini	eThekwini	-	R 1 828	-	-	R 500	**R 4 000**
49.	Phelandaba	Clinic	Umhlabuyalingana	Umkhanyakude	R 380	R 1 506	R 300	-	-	**R 2 186**
50.	Phoenix	CHC	eThekwini	eThekwini	R 5 076	R 6 363	R 5 541	R 400	R 400	**R 17 780**
51.	Pholela	CHC	Ingwe	Sisonke	R 997	R 5 000	R 429	-	-	**R 6 426**
52.	Pisgah	Clinic	UMuziwabantu	Ugu	R 3 659	R 691	R 115	-	-	**R 4 465**
53.	Songozima	Clinic	Msunduzi	Umgungundlovu	R 2 798	R 374	R 35	-	-	**R 3 207**
54.	Stedham	Clinic	Ulundi	Zululand	R 281	R 1 501	R 155	-	-	**R 1 937**

No	Project Name	Nature of Investment/ Project	Municipality	District	Project Expenditure for Previous years	Projected Expenditure by 31 March 2013	Medium Term Estimates			Total Project Cost
							2013/14	2014/15	2015/16	
55.	Sundumbili	CHC	Mandeni	Ilembe	R 614	R 1 000	-	R 4 052	R 250	**R 5 916**
56.	Thalaneni	Clinic	Nkandla	Uthungulu	R 7 123	R 2 119	R 200	-	-	**R 9 442**
57.	Thokozani	Clinic	uMhlathuze	Uthungulu	R 1 540	R 1 982	R 80	-	-	**R 3 602**
58.	Townhill	Specialised Psychiatric Hospital	Msunduzi	Umgungundlovu	R 19 182	R 15 053	R 32 556	R 1 500	-	**R 68 290**
59.	Umbonambi	Clinic	Mfolozi	Uthungulu	R 9 787	R 4 862	R 340	-	-	**R 14 989**
60.	Vryheid	District Hospital	Abaqulusi	Zululand	R 295	R 3 460	R 100	-	-	**R 3 855**
61.	Wentworth	District Hospital	eThekwini	eThekwini	R 535	R 5 088	R 225	-	-	**R 5 848**
62.	Wentworth	EMS	eThekwini	eThekwini	-	R 2 200	R 9 308	R 300	-	**R 11 808**
Total rehabilitation, renovations and refurbishments					**R 67 714**	**R 86 478**	**R 71 907**	**R 7 819**	**R 1 150**	**R 237 739**

1.1.1. CONDITIONAL GRANTS

Table 111: Conditional Grants

Name of Conditional Grant	Purpose of the Grant	Performance Indicators 2013/14	Targets for 2013/14
Health Facility Revitalisation Grant **(R 962 499 million)** Consisting of: 1. Health Infrastructure Component (R 373 969 million) 2. Hospital Revitalisation Component (R 560 104 million) 3. Nursing College and Schools Component (R 28 396 million)	To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health is including, inter alia, health technology, organisational systems (OD) and quality assurance (QA). Supplement expenditure on health infrastructure delivered through public-private partnerships	Number of health facilities planned	13
		Number of health facilities designed	13
		Number of health facilities constructed	54
		Number of health facilities equipped	51
		Number of health facilities operationalised	51
		Number of health facilities maintained	37
Comprehensive HIV and AIDS Grant (R 2 652 072 billion)	To enable the health sector to develop an effective response to HIV and AIDS including universal access to HIV Counselling and Testing To support the implementation of the National Operational Plan for Comprehensive HIV and AIDS Treatment and Care To subsidise in-part funding for the antiretroviral treatment plan	Total number of fixed public health facilities offering ART services	615
		Number of new patients that started on ART	170,000
		Total number of ART patients remaining in care – adults and children (current active)	846,919
		Number of patients (beneficiaries) served by Home-Based Carers	154,000
		Number of active Home-Based Carers receiving stipends	10,337
		Number of male condoms distributed	212,000,000
		Number of female condoms distributed	2,800,000
		Number of High Transmission Areas (HTA) intervention sites (new & old)	80
		Number of antenatal care (ANC) clients initiated on lifelong ART	25,000
		Number of babies Polymerase Chain Reaction (PCR) tested at six weeks	70,000
		Number of HIV positive clients screened for TB	462,324
		Number of HIV positive client started IPT	300,512
		Number of lay counsellors receiving stipends	2,621
		Number of clients pre-test counselled on HIV testing (including antenatal)	3,178,475
		Number of clients tested for HIV (including antenatal)	2,889,522
		Number of health facilities offering MMC services	72

Name of Conditional Grant	Purpose of the Grant	Performance Indicators 2013/14	Targets for 2013/14
		Number of male medical circumcisions performed	356,960
		Number of sexual assault cases offered ARV prophylaxis	4,200
		Number of Step Down Facilities/ Units	4
		Number of Doctors and Professional Nurses (PNs) trained on HIV/AIDS, STIs, TB and Chronic Diseases and other related programmes	Doctors: 30 PNs: 300
National Tertiary Services Grant (R 1 415 731 billion)	To ensure provision of tertiary health services for all south African citizens To compensate tertiary facilities for the costs associated with provision of these services including cross border patients	Number of National Central and Tertiary hospitals providing components of Tertiary services	3 Hospitals
Health Professions Training & Development Grant (R 276 262 million)	Support provinces to fund service costs associated with training of health science trainees on the public service platform Co-funding of the National Human Resources Plan for Health in expanding undergraduate medical education for 2012 and beyond (2025) *A decision was taken in 2011/12 to use the Grant to fund the personnel costs of registrars only.*	Number of undergraduate health sciences trainees supervised	Not funded by Grant
		Number of postgraduate health sciences trainees (excluding registrars) supervised	Not funded by Grant
		Number of registrars supervised	700
		Number of community services health professionals and other health sciences trainees supervised	Not funded by Grant
National Health Insurance Grant (R 9 700 million)	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	***Central Hospitals:*** 1. Strengthening revenue collection and development of alternative hospital reimbursement tools. ***NHI Pilot Districts:*** 1. Strengthening M&E capacity. 2. Improved supply chain processes to enhance district health system performance (ordering systems, etc.). 3. Strengthening referral systems with linkages to PHC streams.	Business Plans not yet finalised for 2013/14

1.1.2. PUBLIC ENTITIES

Table 112: Public Entities

Name of Public Entity	Sub-Programme and Mandate	Annual Budget 2012/13 (R'000)
1. Austerville Halfway House	2.2: Community Health Clinics	R 525
2. Azalea House	2.2: Community Health Clinics	R 485
3. Bekulwandle Bekimpelo	2.2: Community Health Clinics	R 7 600
4. Benedictine Clinic	2.2: Community Health Clinics	R 350
5. Claremont Day Care Centre	2.2: Community Health Clinics	R 371
6. Careways Mental Health	2.2: Community Health Clinics	R 20
7. Day Care Club 91	2.2: Community Health Clinics	R 101
8. Durban School for the Deaf	2.2: Community Health Clinics	R 203
9. Ekukhanyeni Clinic (AIDS Step-Down)	2.2: Community Health Clinics	R 891
10. Elandskop Clinic	2.2: Community Health Clinics	R 458
11. Enkumane Clinic	2.2: Community Health Clinics	R 276
12. Happy Hour Various	2.2: Community Health Clinics	R 2 598
13. Hlanganani Ngothando	2.2: Community Health Clinics	R 210
14. Ikwezi Cripple Care	2.2: Community Health Clinics	R 1 515
15. Ikwezi District Nursing Services	2.2: Community Health Clinics	R 175
16. Jewel House	2.2: Community Health Clinics	R 337
17. John Peattie House	2.2: Community Health Clinics	R 1 348
18. Jona Vaughn Centre	2.2: Community Health Clinics	R 2 359
19. Lynn House	2.2: Community Health Clinics	R 590
20. Madeline Manor	2.2: Community Health Clinics	R 849
21. Masada Workshop	2.2: Community Health Clinics	R 75
22. Masibambeni Day Care Centre	2.2: Community Health Clinics	R 148
23. Matikwe Oblate Clinics	2.2: Community Health Clinics	R 496
24. Mhlumayo Clinic	2.2: Community Health Clinics	R 588
25. Noyi Bazi Oblate Clinic	2.2: Community Health Clinics	R 501
26. Place of Restoration	2.2: Community Health Clinics	R 200
27. Prenaid A LP	2.2: Community Health Clinics	R 101
28. Rainbow Haven	2.2: Community Health Clinics	R 393
29. Scadifa Centre	2.2: Community Health Clinics	R 959
30. Sparkes Estate	2.2: Community Health Clinics	R 1 067
31. St Luke Home	2.2: Community Health Clinics	R 730
32. Sunfield Home	2.2: Community Health Clinics	R 309
33. Umlazi Halfway House	2.2: Community Health Clinics	R 263
34. Ethembeni Care Centre	2.6: HIV and AIDS	R 4 820

Name of Public Entity	Sub-Programme and Mandate	Annual Budget 2012/13 (R'000)
35. Genesis Care Centres	2.6: HIV and AIDS	R 2 948
36. Philanjalo Hospice (Step-Down Centre)	2.6: HIV and AIDS	R 2 677
37. Pongola Hospital	2.9: District Hospitals	R 3 436
38. Montebello Chronic Sick Home	4.3: Psychiatric/ Mental Hospital	R 4 969
39. KZN Children's Hospital Trust	5.6: Other Facilities	R 20 000
40. McCords Hospital	Various	R 70 461
41. Mountain View Hospital	Various	R 9 971
42. Siloah Hospital	Various	R 19 149
43. St Mary's Hospital Marianhill	Various	R 113 637
44. Earmarked for further negotiations	Various	R 2 202
Total		**R 281 361**

Source: Budget Appropriation Statement, Vote 7

There was a reduction in the 2012/13 Adjusted Appropriation as a result of the active re-assessment of NGOs which resulted in a reduction in allocations to some NGOs. This trend will continue over the 2013/14 MTEF with a significant reduction from 2014/15 mainly driven by the planned provincialisation of the McCords Hospital with the budget for the hospital moved to *Current Payments*. This process will be reviewed during 2013/14 and formalised in the 2013/14 Adjustment Estimate.

From 2011/12 to 2013/14 the Department will transfer funds to the KZN Children's Hospital Trust for the development and refurbishment of the Children's Hospital in the eThekwini Metro, hence a decline in the overall baseline in 2014/15.

Private entities provide general (PHC) and community-based services including promotion and prevention services, HIV, AIDS and TB services, and district and general hospital services.

All public entities are evaluated and re-assessed annually to determine future funding based on output as per provincial priorities. Formal applications are presented to the Provincial Committee for consideration before recommendation to the Head of Department for approval.

Budget limitations require strict control. For this reason, delegation for oversight and reporting has been decentralised to District Management to ensure active monitoring of output and value for money.

1.1.3. PUBLIC-PRIVATE PARTNERSHIPS

Table 113: Public Private Partnership

Name of PPP	Purpose	Output	2012/13 Budget (R'000)	Date of Termination	Measures for Transfer
Inkosi Albert Luthuli Central Hospital The Department in	The Impilo Consortium is responsible for the provision of the following goods and services: Supply equipment and information management and technology (IM&T) systems and replace the equipment and IM&T	Delivery of non-clinical services to IALCH	R 657 435	15 Year Contract terminating in 2017	Termination arrangements are detailed in the project agreement in clauses 35,36,37 and the penalty regime (Schedule 15)

Name of PPP	Purpose	Output	2012/13 Budget (R'000)	Date of Termination	Measures for Transfer
partnership with Impilo consortium (Pty) Ltd and Cowslip Investments (Pty) Ltd	systems to ensure that they remain state of the art. Supply and replace non-medical equipment. Provide all services necessary to manage Project Assets in accordance with Best Industry Practice. Maintain and replace Departmental Assets in terms of the replacement schedules. Provide or procure Utilities, Consumables and Surgical Instruments. Provide Facility Management Services.				

Source: Budget Appropriation Statement, Vote 7

CONCLUSION

The 2013/14 Annual Performance Plan presents the strategic goals, objectives, priorities and targets that the KwaZulu-Natal Department of Health will be pursuing during the 2013/14 – 2015/16 MTEF. The Plan is aligned with National priorities as expressed in the National Health System 10 Point Plan, Negotiated Service Delivery Agreement, the National Development Plan and State of the Nation address. It makes provision for support of strategies included in the Provincial Growth and Development Plan as well as priorities highlighted in the State of the Province Address, Vote 7 priorities as well as priorities identified during Strategic Planning workshops.

The Annual Performance Plan reflects the strategic priorities with primary indicators while sub-set or secondary indicators are included in Operational Plans to ensure comprehensive recording, analysis and reporting against national and provincial priorities. Great discipline will be exercised to ensure that all health services are provided in line with service obligations and mandates for delivery of quality health care.

District Health Plans have been aligned with the Annual Performance Plan to ensure that strategic priorities are translated into service delivery at operational level. Supporting operational indicators have been included in the quarterly reporting system through the Monitoring & Evaluation Framework and quarterly reporting system. Quarterly in-depth reviews are being formalized to navigate improved analysis of performance information and expenditure. This will assist with improved accountability in service delivery.

The Negotiated Service Delivery Agreement will serve as framework within which the Department will monitor progress towards achieving the national priorities and in so doing contributing to “A healthy life for all South Africans”.

The commitment of the Department is unwavering and every effort will be made to achieve the goals and objectives set in the 5-year Strategic Plan and the 2012/13 Annual Performance Plan.

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ABBREVIATIONS

Abbreviations	Full Description
ACSM	Advocacy, Communication and Social Mobilisation
AGSA	Auditor General of South Africa
AIDS	Acquired Immune Deficiency Syndrome
ALS	Advanced Life Support.
AMS	Air Mercy Services
ANC	Ante Natal Care
APP	Annual Performance Plan
APEX	Refers to core priorities – not abbreviation
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
ASSA	AIDS Committee of Actuarial Society of South Africa
BANC	Basic Ante Natal Care
BAS	Basic Accounting System
BLS	Basic Life Support
BUR	Inpatient Bed Utilisation Rate - total
CARMMA	Campaign on Accelerated Reduction of Maternal and child Mortality in Africa
CCG's	Community Care Givers
CCMDU	Central Chronic Medication Dispensing Unit
CDC	Communicable Disease Control
CEO(s)	Chief Executive Officer(s)
CFO	Chief Financial Officer
CFR	Case Fatality Rate
CHC(s)	Community Health Centre(s)
Child PIP	Child Problem Identification Programme
COE	Compensation of Employees
COEC	College of Emergency Care.
COGTA	Cooperative Governance and Traditional Affairs
CPSS	Central Pharmaceutical Supply Store
CPT	Cotrimoxazole Preventive Treatment
DHER(s)	District Health Expenditure Review(s)
DHIS	District Health Information System
DHP's	District Health Plans
DHS	District Health System
DOE	Department of Education
DOH	Department of Health
DOTS	Directly Observed Treatment Short Course
DPC	Disease Prevention and Control

ABBREVIATIONS

Abbreviations	Full Description
DPSA	Department of Public Service and Administration
DQPR	District Quarterly Progress Report
ECP	Emergency Care Practitioner
ECT	Emergency Care Technician
EDL	Essential Drug List
EH	Environmental Health
EHP	Environmental Health Practitioner
EMS	Emergency Medical Services
EPI	Expanded Programme on Immunisation
EPT	Emergency Patient Transport
EPWP	Expanded Public Works Programme
ESMOE	Essential Steps in Management of Obstetric Emergencies
ETBR	Electronic Tuberculosis Register
ETR.net	Electronic Register for TB
FPS	Forensic Pathology Services
GHS	General Household Survey
GIS	Geographic Information System
GOBIFFF	Growth monitoring, Oral rehydration therapy, Breast feeding, Immunisation, Family spacing, Family education, Food supplementation
HAART	Highly Active Ante-Retroviral Therapy
HAST	HIV, AIDS, STI and TB
HCSS	Health Care Support Services
HCT	HIV Counselling and Testing
HCRW	Health Care Risk Waste
HIV	Human Immuno Virus
HFM	Health Facilities Management {APP)
HOD	Head of Department
HPS	Health Promoting Schools
HPTDG	Health Professionals Training and Development Grants
HR	Human Resources
HRMS	Human Resources Management Services
HRP	Human Resource Plan
HST	Health Systems Trust
HTA's	High Transmission Areas
IALCH	Inkosi Albert Luthuli Central Hospital
IDT	Independent Development Trust
IDIP	Infrastructure Delivery Improvement Programme
IDMS	Infrastructure Delivery Management Programme
IDP(s)	Integrated Development Plan(s)
ILS	Intermediate Life Support

ABBREVIATIONS

Abbreviations	Full Description
IMCI	Integrated Management of Childhood Illnesses
IPAT	Infrastructure Project Assemble Tool
IPC	Infection Prevention & Control
IPIP	Infrastructure Programme Implementation Plans
IPT	Ionized Preventive Therapy
IRM	Infrastructure Reporting Model
IUCD	Intra Uterine Contraceptive Device
IT	Information Technology
IYCF	Infant, Youth, Child Feeding
JIT	Just In Time
KZN	KwaZulu-Natal
KZNPSP	KwaZulu-Natal Provincial Strategic Plan for HIV, AIDS, STI and TB
LG	Local Government
M&E	Monitoring and Evaluation
MC&WH	Maternal Child & Women's Health
MDG	Millennium Development Goals
MDR-TB	Multi Drug Resistant Tuberculosis
MEC	Member of the Executive Council
MIP	Massification Implementation Plan
MMC	Medical Male Circumcision
MMR	Maternal Mortality Rate
MNC&WH	Maternal, Neonatal, Child & Women's Health
MOU	Maternity Obstetric Unit
MRC	Medical Research Council
MSP	Master Systems Plan
MTEF	Medium Term Expenditure Framework
MTS	Modernisation of Tertiary Services
MTSF	Medium Term Strategic Framework
MTCT	Mother To Child Transmission
MUAC	Mid-Upper Arm Circumference
NCE	National Confidential Enquiries
NDOH	National Department of Health
NGO's	Non-Governmental Organisations
NHC	National Health Council
NHI	National Health Insurance
NHIS	National Health Information System.
NHLS	National Health Laboratory Services
NHS	National Health System.
NIMART	Nurse Initiated and Managed Antiretroviral Therapy

ABBREVIATIONS

Abbreviations	Full Description
NIP	National Integrated Nutrition Programme.
NSDA	Negotiated Service Delivery Agreement
NSP	National Strategic Plan.
NTSG	National Tertiary Services Grant
NVP	Nevirapine
ODTC	Oral and Dental Training Centre
OPD	Out-Patient Department.
OSD	Occupation Specific Dispensation.
OSS	Operation Sukuma Sakhe
OTP	Office of the Premier
PA(s)	Performance Agreement(s)
P1 Calls	Priority 1 calls
PCR	Polymerase Chain Reaction
PCV	Pneumococcal Vaccine
PDE	Patient Day Equivalent
PEP	Post Exposure Prophylaxis.
Persal	Personnel and Salaries System.
PFMA	Public Finance Management Act
PGDS	Provincial Growth and Development Strategy
PGDP	Provincial Growth and Development Plan
PHC	Primary Health Care
PHRC	Provincial Health Research Committee
PHREC	Provincial Health Research and Ethics Committee
PPIP	Perinatal Problem Identification Programme
PITC	Patient Initiated Testing & Counselling
PICT	Provider Initiated Counselling & Testing
PIDC	Provincial Infrastructure Delivery Committee
PMDS	Performance Management and Development System
PMSC	Provincial Medical Supply Centre
PMTCT	Prevention of Mother to Child Transmission
PN	Professional Nurse
PPIP	Peri-Natal Problem Identification Programme
PPSD	Provincial Pharmaceutical Supply Depot
PPT	Planned Patient Transport
PQRS	Provincial Quarterly Reporting System
PTB	Pulmonary Tuberculosis
PwC	Price water house Coopers
RAAP	Rapid Assessment of Avoidable Factors of Blindness
RV	Rota Virus

ABBREVIATIONS

Abbreviations	Full Description
SANC	South African Nursing Council
SAPC	South African Pharmacy Council
SADHS	South African Demographic & Health Survey
SCM	Supply Chain Management.
SHS	School Health Services
SITA	State Information and Technology Agency
SMS	Senior Management Service
Stats SA	Statistics South Africa
STI's	Sexually Transmitted Infections
STP	Service Transformation Plan
TB	Tuberculosis
UKZN	University of KwaZulu-Natal
U-AMP	User –Asset Management Plan
VCT	Voluntary Counseling and Testing
WISN	Workload Indicators of Staffing Need
XDR-TB	Extreme Drug Resistant Tuberculosis
YLL	Years of Life Lost

ANNEXURES

ANNEXURE 1: NON-NEGOTIABLES

Table 114: Non-Negotiables

Non-Negotiable Items	Estimated Expenditure 2012/13 (R'000)	Estimated Budget 2013/14 (R'000)	% Increase based on projected expenditure	Non-Financial Measures/ Indicators
Infection Control and Cleaning	R 470 722	R 490 000	9%	1. Nosocomial infection rate
				2. Neonatal nosocomial infection rate
				3. Proportion of clients not satisfied with cleanliness as per the client satisfaction survey
				4. Proportion of facilities that score at least 80% compliance with cleanliness as per core standards
Medicines,[83] Medical Supplies including Dry Dispensary	R 1 288 281 (medicines)	R 1 418 778 (medicines)	10%	5. Proportion of health facilities with tracer drugs out of stock
				6. Drug stock-out rate at drug depots
	R 895 427 (medical supplies)	R 941 318 (medical supplies)	5%	7. Total Rand value of disposed/ expired drugs
				8. Total Rand value of drugs that had to be bought out of contract
Medical Waste	R 56 784	R 59 693	5%	9. Proportion of SLAs for waste management contracts that were monitored for compliance regulations
Laboratory Services: National Health Laboratory Services (NHLS)[84]	R 528 487	R 632 224	16%	10. Proportion of hospitals (district, regional, tertiary and central) implementing Electronic Gate Keeping system within the Province.
				11. Percentage of selected tests (CD4, HIV PCR, HIV VL, TB Directs and cervical smears) performed and results available within the agreed turn-around times
Blood Supply Services	R 307 675	R 337 072	5%	12. Percentage of hospitals (district, regional, tertiary and central) having emergency fridges with emergency blood stock available on site
				13. Proportion of blood units (RBC) ordered that was not transfused and discarded
Food Services[85] and Relevant Supplies	R 293 576	R 302 920	9%	14. Proportion of facilities with food service units that were monitored (using the Food Service Management Monitoring Tool)

[83] Medicines: Increasing service delivery pressures might necessitate a review of the current allocation
[84] NHLS: The increase of 16% is based on current and projected expenditure
[85] Food Services: Allocation makes provision for inflationary cost as well as increase in beds/patient activity e.g. commissioning of additional beds in King Dinuzulu Hospital.

Non-Negotiable Items	Estimated Expenditure 2012/13 (R'000)	Estimated Budget 2013/14 (R'000)	% Increase based on projected expenditure	Non-Financial Measures/ Indicators
				15. Proportion of facilities that scored >75% on the food service Monitoring Standard Grading System
Laundry Services	R 29 714	R 26 000	0%	16. Average cost per piece laundered (in-house)
				17. Average cost per piece laundered (outsourced)
				18. Value of linen procured
Security Services	R 319 131	R 357 511	10%	19. Number of districts with operational security committees
				20. Proportion of health facilities fenced with access control at the gate
				21. Number of safety and security audits conducted annually
Essential Equipment and Maintenance of Equipment[86]	R 410 393	R 220 000	-35%	22. Proportion of facilities operating with 100% of essential equipment (as per checklist on Essential Equipment)
				23. Proportion of facilities with an essential equipment maintenance plan
				24. Number of facilities monitoring Service Level Agreements (SLAs) with service providers appointed to maintain all essential equipment
Maintenance of Infrastructure	R 384 297	R 352 647	9%	25. Number of districts spending more than 90% of maintenance budget
				26. Proportion of infrastructure budget allocated to maintenance
				27. Proportion of infrastructure budget spent on maintenance (preventative and scheduled)
Children vaccines	R 342 844	R 351 355	5%	28. Immunization coverage
				29. Vitamin A coverage 12 – 59 months *(Vitamin A 12 – 59 months coverage (annualised))**
				30. Measles 1st dose under 1 year coverage *(Measles 1st dose under 1 year coverage (annualised))**
				1. Pneumococcal Vaccine (PCV) 3rd dose coverage *(PCV 3rd dose coverage (annualised))**
				31. Rota Virus (RV) 2nd dose Coverage *(RV 2nd dose coverage(annualised))**

[86] The equipment audit has not been finalised to inform allocation for Medical Equipment. Machinery and Equipment makes provision for vehicles and IT equipment to support outreach teams and make provision for replacement of mobile vehicles to strengthen PHC

National Health Laboratory Services (NHLS)

The Department is scaling up strategies to improve oversight and controls in the management of NHLS. Training of Medical and Systems Managers on the NHLS billing system (Thusano) commenced in 2012 with the aim to improve financial efficiency and value for money.

The Department will monitor service delivery versus expenditure in 2013/14 as indicated in Table 114: Non-Negotiables. Baselines and targets will be determined in 2013/14 through consultation.

Health Technology Services

Health Technology, as critical enabler for quality clinical service delivery, has been prioritised in 2013/14. A health technology medical equipment audit commenced at institutions in 2012 with the aim to compile a comprehensive Medical Equipment Asset Register. To date, 17% of institutions have been audited. The updated Asset Register will inform the Medical Equipment Replacement Plan that will be used to track and replace equipment.

To enhance efficiencies, the Department is planning to appoint 20 Clinical Engineering Technicians in early 2013. Funds have been allocated to close the gap for essential equipment. Processes are in place to procure a defined list of equipment through an implementing agent with an amount of R62.8 million allocated for this purpose.

The Department will implement a pilot project to improve Radiology Technical Services using "Cloud Technology" to minimise physical media such as CDs and X-ray films. This technology, when implemented, will improve diagnosis and lead to improved clinical outcomes.

Performance measures, baselines and targets will be confirmed in 2013/14 to ensure robust monitoring and evaluation of this service.

Food Services

A major shift in the recent years has been the phasing in of a new model for the provisioning of food services at health institutions. The new approach lends itself to moving away from reliance on external caterers, instituting a food distribution mechanism, in support of in-house catering services. All hospitals appointed Food Services Managers and qualified personnel to manage food services which should improve controls and efficiencies.

Implementation of in-house services is in the first phase of implementation with 23 hospitals operating with in-house food services. In the second phase, 62 institutions will be enrolled in the new model. Performance measures and targets will be confirmed in 2013/14.

Laundry Services

The Department is in the process to review the Laundry Strategy to make provision for critical interventions to address current gaps and challenges including (but not exclusive to) poor management of laundry services, shortage of clean linen, poor quality of linen, ageing machinery and equipment, regular breakdowns that render the laundries inefficient, staff shortages and other operational challenges.

The new strategy, supported by an updated policy, will inform performance measures going forward. Stringent monitoring, evaluation and reporting will be implemented to ensure cost effective outcomes.

The commissioning of the KwaZulu-Natal Central laundry will take place on the 1st of April 2013 and the upgrade of the Northern Natal laundry is in the initial phase.

The Department will confirm performance measures and targets in 2013/14.

ANNEXURE 2: DEFINITIONS

TRENDS IN KEY PROVINCIAL SERVICE VOLUMES

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
PHC total headcount	Number of PHC patients seen during the reporting period. Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen	Tracks the uptake of PHC services at each PHC site for the purposes of allocating staff and other resources.	DHIS	**Sum** Sum total of PHC headcounts during the reporting period	Accuracy of headcount depends on the reliability of PHC record management at facility level	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	DHS Programme Manager
OPD new client not referred	Number of General OPD clinic new cases (seeking medical attention for a condition for the first time) that report to the General OPD department without being referred from a PHC facility or doctor during the reporting period in all Hospitals (district, regional, tertiary and central) as a percentage of the OPD General headcount new visits total. **Relevant to all hospitals**	Tracks the utilisation of Hospitals by patients to access PHC services, which in fact should be accessed at PHC services. This could also points to the needs for PHC services or gaps in PHC service delivery	DHIS	**Sum** Sum total of OPD headcount not referred new during the reporting period	Accuracy of headcount depends on the reliability of district hospital record management at facility level	Output	Sum	Quarterly	Yes	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	Programme Manager
Total separations in District/ Regional/ Tertiary/ Central Hospitals	Recorded completion of treatment and/or accommodation of patients in hospitals. Separations include inpatients who were discharged, transferred out to other hospitals or patients who died - includes day patients. **Relevant to all hospitals**	Monitoring the service volumes and patient activity in all hospitals	DHIS	**Sum** • Inpatient deaths • Inpatient discharges • Inpatient transfer out • Day patients	Accuracy dependant on quality of data from reporting facility	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	DHS & Specialised & Clinical Support Services

ANNEXURE 2: DEFINITIONS

MILLENNIUM DEVELOPMENT GOALS

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Prevalence of underweight children under 5	A child under 5 years identified as being BELOW the third centile but EQUAL TO or OVER 60% of Estimated Weight for Age (EWA) on the Road-to-Health chart. Include any such child irrespective of the reason for the underweight - malnourishment, premature birth, genetic disorders etc.	Essential for growth monitoring in children and the early detection of malnourished children	DHIS	**Numerator** Number of children underweight for age during the reporting period **Denominator** Number of children weighed during the reporting period x100	Accuracy dependent on quality of data from reporting facility	Outcome	% (prevalence)	Quarterly	No	Lower levels of prevalence of underweight (children under 5) are desired	Epidemiology, DHS, Specialised & Clinical Services
Severe malnutrition under 5 years incidence	Severely malnourished children detected per 1000 children under-5 years in the population	Monitors the nutritional status of children less than 5 years as critical component of child health.	DHIS	**Numerator** Severe malnutrition under 5 years – new ambulatory **Denominator** Population under 5 years x 1000	Data quality	Outcome	Number per 1000	Annual	Yes	Reduced incidence may be an indication of improved socio-economic conditions, prevention and promotion and improved management of malnutrition.	DHS, Specialised & Clinical Support Services
2013 NIDS: *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*	*Monitors 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 should not be counted here*	*DHIS*	***Numerator*** *SUM([Child under 5 years with severe acute malnutrition new])* ***Denominator*** *SUM([Female under 5 years]) + SUM([Male under 5 years]) x1000*	*Accuracy dependent on quality of data from reporting facility*	*Outcome*	*Number per 1000*	*Quarterly* *(Indicator annualised in system)*	*No*	*Lower levels of prevalence of underweight (children under 5) are desired*	*Epidemiology, DHS, Specialised & Clinical Support Services*
Under-5 mortality rate	Number of children less than five years old who die in one year per 1000 live births during that same year	Monitors trends in under 5 mortality	South African Demographic and Health Survey (SADHS)	**Numerator** Number of children less than five years who die in one year **Denominator** Total number of live births during that year x 1000	Data are not frequently available. Empirical data are available from the SADHS, which is conducted every 5 years	Outcome	Number per 1000	Empirical data are provided by the SADHS every 5 years	No	Lower Infant Mortality Rates are desired	Maternal, Child and Women's Health Programme
Infant mortality rate	Number of children less than one year old who die in one year, per 1000 live births during that year	Monitors trends in infant mortality	South African Demographic and Health Survey (SADHS)	**Numerator** Number of children less than one year old who die in one year **Denominator** Total number of live births during that year x 1000	Data are not frequently available. Empirical data are available from the SADHS, which is conducted every 5 years	Outcome	Number per 1000	Empirical data are provided by the SADHS every 5 years	No	Lower Infant Mortality Rates are desired	Maternal, Child and Women's Health Programme

ANNEXURE 2: DEFINITIONS

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Measles 1st dose under 1 year coverage	Percentage of children under 1 year who received the 1st measles dose before their first birthday.	Monitors success in elimination of measles.	DHIS	**Numerator** Number of measles 1st dose under 1 year **Denominator** Total population under 1 year	Reliant on under 1 population estimates from StatsSA	Output	% (annualised)	Quarterly	No	Higher coverage will support elimination of measles.	DHS, Specialised & Clinical Support Services
2013 NIDS: *Measles 1st dose under 1 year coverage (annualised)*	*Proportion children under 1 year who received measles 1st dose, normally at 9 months*	*Monitors protection of children under-1 year of age against measles. Vaccines given as part of mass vaccination campaigns not included for indicator*	*DHIS*	***Numerator*** *SUM([Measles 1st dose under 1 year])* ***Denominator*** *SUM([Female under 1 year]) + SUM([Male under 1 year])*	*Reliant on under 1 population estimates from StatsSA*	*Output*	*% (annualised)*	*Quarterly*	*No*	*Higher percentage indicate better Measles coverage*	*EPI Programme Manager*
Immunisation coverage under 1 year	Percentage of all children in the target area under one year who complete their primary course of immunisation during the month (annualised). A Primary Course includes BCG, OPV 1,2 & 3, DTP-Hib 1,2 & 3, Hep B 1,2 & 3, and 1st measles at 9 month.	Reduce vaccine preventable diseases.	DHIS	**Numerator** Immunised fully under 1 year **Denominator** Total population under 1 year	Reliant on under-1 population estimates from StatsSA	Output	% (annualised)	Quarterly	No	Improved coverage to reduce disease preventable diseases.	DHS
2013 NIDS: *Immunisation coverage under 1 year (annualised)*	*Proportion children under 1 year who completed their primary course of immunisation* *The child should only be 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*	*Reduction of vaccine preventable diseases*	*DHIS*	***Numerator*** *SUM([Immunised fully under 1 year new])* ***Denominator*** *SUM([Female 1 year]) + SUM([Male under 1 year])*	*Reliant on under 1 population estimates from StatsSA*	*Output*	*% (annualised)*	*Quarterly*	*No*	*Higher percentage indicate better immunisation coverage*	*EPI Programme Manager*
Maternal mortality ratio	The number of women who die as a result of childbearing, during pregnancy, within 42 days of delivery, or termination of pregnancy in one year per 100 000 live births during that same year	Monitors trends in maternal mortality	South African Demographic and Health Survey (SADHS)	**Numerator** Number of women who die as a result of childbearing, during pregnancy, within 42 days of delivery, or termination of pregnancy in one year **Denominator** Total number of live births during that year x 100 000	Data is not frequently available. Empirical data are available from the SADHS, which is conducted every 5 years	Outcome	Ratio per 100 000 live births	Empirical data are provided by the SADHS every 5 years	No	Lower Maternal Mortality Ratios are desired Lower	Health Information, Epidemiology and Research Programme MCWH Programme

ANNEXURE 2: DEFINITIONS

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Proportion of births attended by skilled health personnel	Percentage of women who gave birth in the 5 years preceding the South African Demographic Survey (SADHS) who reported medical assistance at delivery from either a doctor, nurse or midwife	Monitors availability of skilled attendance during delivery	South African Demographic and Health Survey (SADHS)	**Numerator** Number of women who gave birth in the 5 years preceding the survey who reported medical assistance at delivery from either a doctor, nurse or midwife **Denominator** Total number of women who gave birth in the 5 years preceding the survey x 100	Data are not frequently available. Empirical data are available from the SADHS, which is conducted every 5 years	Output	% (proportion)	SADHS every 5 years	No	Higher levels of skilled births attended by skilled health personnel are desired	Epidemiology, HRMS, DHS, Specialised & Clinical Support Services
HIV prevalence among 15 to 19 year-old pregnant women	Percentage of pregnant women aged 15- 19 years surveyed testing positive for HIV	Tracks prevalence of HIV and AIDS in younger women of reproductive age, and the success of efforts to combat HIV and AIDS in South Africa	National Annual Antenatal and HIV Surveillance Survey	**Numerator** Pregnant women aged 15 – 19 years who tested HIV positive during the survey **Denominator** Pregnant women aged 15 – 19 years who were tested for HIV during the survey	Reflects prevalence in surveyed pregnant women, not the entire population.	Outcome	% (prevalence)	Annual	No	Lower levels of HIV and AIDS prevalence are desired	DHS & Specialised & Clinical Support Services
HIV prevalence among 20 to 24 year-old pregnant women	Percentage of pregnant women aged 20- 24 years surveyed testing positive for HIV	Tracks prevalence of HIV and AIDs in younger women of reproductive age, and the success of efforts to combat HIV and AIDS in South Africa	National Annual Antenatal and HIV Surveillance Survey	**Numerator** Pregnant women aged 20 – 24 years who tested HIV positive during the survey **Denominator** Pregnant women aged 20 – 24 years who were tested for HIV during the survey	Reflects prevalence in surveyed pregnant women, not entire population.	Outcome	% (prevalence)	Annual	No	Lower levels of HIV and AIDS prevalence are desired	DHS & Specialised & Clinical Support Services
Contraceptive prevalence rate	Percentage of women of reproductive age (15-44 years) who are using (or whose partner is using) a modern contraceptive method. Contraceptive methods include female and male sterilisation, injectable and oral hormones, intrauterine devices, diaphragms, spermicides and condoms, natural family planning lactational amenorrhoea.	Track the extent of the use of modern contraception (any method) amongst women of child bearing age	South African Demographic and Health Survey (SADHS)	Data available from the 5-year SADHS. The indicator is not monitored routinely.	Data is not frequently available. Empirical data are available from the SADHS, which is conducted every 5 years	Output	Rate (prevalence)	SADHS every 5 years	No	Higher Contraceptive prevalence levels are desired	DHS & Specialised & Clinical Support Services

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Proportion of TB cases reported and cured under directly observed treatment short course (DOTS)	The proportion of reported TB cases, with DOTS support, that were cured within 2 months of treatment. The WHO definition for DOTS refers to external treatment support for patients on treatment. The Department consider DOT support inclusive of family, etc.	Monitors the success of the TB treatment with DOTS	ETR.Net	**Numerator** New smear positive cured **Denominator** New smear positive newly registered	Accuracy dependant on quality of data from reporting facility	Outcome	%	Annual	No	Higher percentage indicate better cure rate for the province	DHS
2013 NIDS: *"TB (new pulmonary) cure rate" – as proxy*	*Percentage of new smear positive PTB cases cured at first attempt*	*Monitor the TB Cure rate*	*ETR.Net*	***Numerator*** *New smear positive cured* ***Denominator*** *New smear positive newly registered*	*Accuracy dependant on quality of data from reporting facility*	*Outcome*	*Rate*	*Annual*	*No*	*Higher percentage indicate better cure rate for the province*	*DHS*
Malaria incidence rate per 1000 population at risk	New malaria cases as proportion of 1000 population at risk.	Monitor the new malaria cases as proportion of the population at risk to monitor performance in relation to MDG 6.	Malaria Surveillance Database	**Numerator** Number of new malaria cases reported. **Denominator** Population at risk x 1000.	Accuracy dependant on quality of data and effective information systems.	Outcome	Rate per 1000 population at risk	Annual	No	Reduced incidence indicates improved prevention strategies.	DHS

- Note: The province reported "TB (new pulmonary) cure rate" as proxy to "Proportion of TB cases reported and cured under DOTS" as DOT supporters are defined as volunteers as well as household members (different to WHO definition).
- Note: Indicators captured in the Negotiated Service Delivery Agreement (Table A6) are included in Programme Indicator Definitions under Programmes/Sub-Programmes

ANNEXURE 2: DEFINITIONS

PROGRAMME 1: ADMINISTRATION

HUMAN RESOURCES

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Medical officers per 100 000 population	The number of medical officers in posts on the last day of March per 100 000 population.	Tracks the number of filled medical officer's posts as part of monitoring availability of Human Resources for Health	Persal & StatsSA mid-year estimates	**Numerator** Number of Medical Officers in posts on the 31st of March **Denominator** Total population X 100 000	Dependant on accuracy of Persal system.	Input	Number per 100 000 population	Annual	No	Increase in the number of medical officers contributes to improving access to and quality of clinical care	HRMS, DHS & Specialised & Clinical Support Services
Medical officers per 100 000 population in rural districts	The number of medical officers in posts in Rural Development Nodes on the last day of March per 100 000 population.	Tracks the number of medical officers employed in rural districts, as part of monitoring equity and access to human resources.	Persal & StatsSA mid-year estimates	**Numerator** Number of Medical Officers in posts on the 31st of March in Rural Development Nodes **Denominator** Total population in Rural Development Nodes X 100 000	Dependant on accuracy of Persal system.	Input	Number per 100 000 population in rural districts	Annual	No	Increase in the number of medical officers in rural districts i contributes to improving access to and quality of clinical care n rural district.	HRMS, DHS & Specialised & Clinical Support Services
Professional nurses per 100 000 population	The number of professional nurses in posts on the last day of March per 100 000 population.	Tracks the number of filled professional nurses posts, as part of monitoring availability of Human Resources for Health	Persal & StatsSA mid-year estimates	**Numerator** Number of Professional Nurses in posts on the 31st of March **Denominator** Total population X 100 000	Dependant on accuracy of Persal system.	Input	Number per 100 000 population	Annual	No	Increase in the number of professional nurses contributes to improving access to and quality of health services	HRMS, DHS & Specialised & Clinical Support Services
Professional nurses per 100 000 population in rural districts	The number of professional nurses in posts in Rural Development Nodes on the last day of March per 100 000 population.	Tracks the number professional nurses employed in rural districts, as part of monitoring equity and access to human resources.	Persal & StatsSA mid-year estimates	**Numerator** Number of Professional Nurses in posts on the 31st of March in Rural Development Nodes **Denominator** Total population in Rural Development Nodes X 100 000	Dependant on accuracy of Persal system.	Input	Number per 100 000 population in rural districts	Annual	No	Increase in the number of professional nurses in rural districts contributes to improving access to and quality of health services rural districts	HRMS, DHS & Specialised & Clinical Support Services
Pharmacists per 100 000 population	The number of pharmacists in posts on the last day of March per 100 000 population.	Tracks the number of filled pharmacists posts to monitor availability of Human Resources	Persal & StatsSA mid-year estimates	**Numerator** Number of Pharmacists in posts on the 31st of March **Denominator** Total population X 100 000	Dependant on accuracy of Persal system.	Input	Number per 100 000 population	Annual	No	Increase in the number of Pharmacists lead to better quality of care	HRMS, DHS & Specialised & Clinical Support Services

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Pharmacists per 100 000 population in rural districts	The number of pharmacists in posts in Rural Development Nodes on the last day of March per 100 000 population.	Tracks the number of pharmacists employed in rural districts to monitor equity and access to human resources.	Persal & StatsSA mid-year estimates	**Numerator** Number of Pharmacists in posts on the 31st of March in Rural Development Nodes **Denominator** Total population in Rural Development Nodes X 100 000	Dependant on accuracy of Persal system.	Input	Number per 100 000 population in rural districts	Annual	No	Increase in the number of Pharmacists in rural districts lead to better quality of care in these rural districts	HRMS, DHS & Specialised & Clinical Support Services
Vacancy rate for professional nurses	Percentage of vacant funded professional nurses posts on the last day of the reporting period	Tracks the number of vacant funded Professional Nurses posts to monitor availability of Human Resources	Persal	**Numerator** Total number of vacant funded Professional Nurses posts **Denominator** Total number of funded professional nurse posts in the province	Dependant on accuracy of Persal data	Process	Rate	Quarterly	No	Increase in the number of professional nurses lead to better quality of care	HRMS, DHS & Specialised & Clinical Support Services
Vacancy rate for doctors	Percentage of funded vacant doctors posts on the last day of the reporting period	Tracks the number of funded vacant Doctors posts to monitor availability of Human Resources	Persal	**Numerator** Total number of funded vacant doctors posts on the last day of the reporting period **Denominator** Total number of doctors funded posts in the province	Dependant on accuracy of Persal data	Process	Rate	Quarterly	No	Decrease in the vacancy rate lead to better quality of care	HRMS, DHS & Specialised & Clinical Support Services
Vacancy rate for medical specialists	Percentage of funded vacant medical specialists posts on the last day of the reporting period	Tracks the number of funded vacant medical specialists posts to monitor availability of Human Resources	Persal	**Numerator** Total number of funded vacant medical specialists posts on the last day of the reporting period **Denominator** Total number of medical specialists funded posts in the province	Dependant on accuracy of Persal data	Process	Rate	Quarterly	No	Decrease in the vacancy rate lead to better quality of care	HRMS, DHS & Specialised & Clinical Support Services
Vacancy rate for pharmacists	Percentage of funded vacant pharmacists posts on the last day of the reporting period	Tracks the number of **funded** vacant pharmacists posts to monitor availability of Human Resources	Persal	**Numerator** Total number of funded vacant Pharmacists posts on the last day of the reporting period **Denominator** Total number of funded pharmacists posts in the province	Dependant on accuracy of Persal data	Process	Rate	Quarterly	No	Decrease in the vacancy rate lead to better quality of care	HRMS, DHS & Specialised & Clinical Support Services

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ADMINISTRATION

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Tabled Annual Performance Plan (APP)	Annual APP aligned with Strategic Plan, NHS 10-Point Plan and MTSF Priorities signed off and tabled annually as per National Health Act 2003 and Treasury Regulations.	Monitor compliance with National Health Act 2003 and Treasury Regulations.	Registration records of submission Legislative records	Approved APP tabled as per Treasury Regulations.	None.	Process	Yes/ No	Annual	No	Provide necessary leadership in implementation and monitoring of national and provincial priorities based on evidence-based needs.	Strategic Planning
Number approved District Health Plans	Annual DHP's developed and approved in line with National Health Act 2003 requirements and incorporating Provincial priorities as per APP officially approved by CFO and HOD.	Monitor compliance with National Health Act 2003 and National DOH requirements.	Officially signed-off DHP's	Approved DHP's as per National Health Act 2003 requirements and National DOH submission dates.	None.	Process	Yes/ No	Annual	No	Unified action in addressing health priorities and needs.	Strategic Planning, DHS & Specialised & Clinical Support Services
Published STP	Service Transformation Plan signed off by HOD and MEC and published	Inform medium and long-term planning and ensure adequate provision of resources for revitalisation of health services	Signed off STP	Signed off STP.	None.	Process	Yes/ No	Annual	No	Integrated planning and performance monitoring and evaluation	Strategic Planning, ManCo
Number of Hospital Managers who have signed Performance Agreements (PA's).	The number Hospital Managers who have signed Performance Agreements for the reporting period with Supervisors.	Improve performance monitoring, development and accountability	Signed PA's	**Sum** Number of Hospital Managers with signed Performance Agreements for the reporting period.	None.	Input	Number	Annual	No	Improve accountability for service delivery outcomes as per Performance Agreements at operational level.	HRMS, DHS & Specialised & Clinical Support Services
Number of District Managers who have signed PA's.	The number of District Managers who have signed Performance Agreements for the reporting period with supervisors.	Improve performance monitoring, development and accountability	Signed PA's	**Sum** Number of District Managers with signed Performance Agreements for the reporting period.	None.	Input	Number	Annual	No	Improve accountability for service delivery outcomes as per Performance Agreements at operational level.	HRMS, DHS & Specialised & Clinical Support Services
Percentage of Head Office Managers (Level 13 and above) who have signed PA's.	The proportion of Senior Managers (level 13 and above) who have signed Performance Agreements for the reporting period with supervisors.	Improve performance monitoring, development and accountability	Signed PA's	**Numerator** Number of Head Office Managers (level 13 and above) with signed Performance Agreements for reporting period. **Denominator** Total number of Head Office Managers (level 13 and above) on Persal	None.	Input	%	Annual	No	Improve accountability for service delivery outcomes as per Performance Agreements.	HRMS

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Annual unqualified audit opinion for financial statements.	The Auditor General of South Africa (AGSA) declares the Annual Financial Statements compliant with the PFMA and Treasury Regulations.	Monitor improved financial management and compliance with the PFMA.	Auditor-General's Audit Report	Audit opinion of the AGSA expressed in tabled Annual Report.	Accuracy of financial data (especially at district/ facility level).	Outcome	AGSA audit opinion	Annual	No	Improved financial management and compliance with PFMA.	CFO, DHS & Specialised Clinical Support Services
Number of approved District Health Expenditure Reviews.	Analysis and review of expenditure trends at district/ facility level in compliance with the National Health Act 2003 and PFMA imperatives.	Monitor compliance with the National Health Act 2003 and PFMA imperatives in respect of DHER submissions.	Approved DHER's	**Sum** Number of approved DHER's submitted.	Limited technical support at Provincial level. Being addressed by partnership with Health Systems Trust (HST).	Input	Number	Annual	No	Annual review and analysis of expenditure trends at district & facility levels.	CFO, DHS, Specialised & Clinical Support Services
Annual unqualified audit opinion on performance information.	The AGSA declare the performance information in published reports accurate and a true reflection of performance.	Monitor quality and accuracy of performance information.	AGSA opinion in Annual Report	Unqualified audit opinion by the AGSA.	Effective systems and processes to ensure data completeness and quality at all levels of service delivery.	Outcome	AGSA audit opinion	Annual	No	Improved information management and reporting.	Data Management, M&E
Annual Report tabled	Annual Report as per National Health Act 2003 to report on performance information relevant to the strategic goals, objectives and targets set in the Provincial Strategic Plan and APP.	Monitor compliance with the National Health Act of 2003.	Registration records of submission Legislative records	Approved and tabled Annual Report.	None.	Output	Yes/ No	Annual	No	Compliance with National Health Act 2003 and Treasury timelines for submission of reports.	Strategic Planning
Number of progress reports on implementation of the 10-Point Plan	Quarterly performance reports based on performance targets in APP	Performance monitoring to inform planning	Signed off reports	**Sum** Number of reports submitted	No limitations for submission of reports, although quality of data may impact on reporting against targets.	Output	Number	Quarterly	No	Quarterly reports based on NSDA requirements	M&E, DHS & Specialised & Clinical Support Services
Number of functional Tele-medicine sites	Electronic media to improve training and development	Improve availability of mentoring, training & development	IT database	**Sum** Number of functional tele-medicine sites	None	Input	Number	Annual	No	Improved access to training & development	IT
Number of Registrars in training	Number of registrars who are in training with the DOH.	Track number of registrar's in training	Persal	**Sum** Number of registrar's in training	Data quality depends on good record keeping of the Department	Input	Number	Annual	No	Increased number of medical registrars in training.	HRMS, DHS, Specialised & Clinical Support Services

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of Medical Registrars who graduated	Total number of Medical Registrars, from the same intake, that successfully completed the degree.	Increased number of Specialists	HSPSA	**Sum** Total number of students successfully completing the degree	None	Output	Number	Annual	No	Increased pool of Specialists	HRMS, DHS, Specialised & Clinical Support Services
Number of Registrars retained after qualifying.	Number of Medical Specialists that stays in the public health service after graduation.	Track retention of Registrars after graduation.	Persal	**Sum** The total number of Medical Specialists, from Registrar intake group, that remain in the public health sector after graduation.	Records of students and retention.	Outcome	Number	Annual	No	Increased pool of Medical Specialists.	HRMS, DHS, Specialised & Clinical Support Services
Number of Provincial Consultative Health Forum meetings	Provincial governance structure convened as per National Health Act 2003 to improve social compact for health through participation and consultation.	Monitor consultative meetings with stakeholders in the province.	Corporate Governance database	**Sum** Number of Provincial Consultative Health Forum meetings during reporting year	None.	Output	Number	Annual	No	Improved social compact for better health outcomes.	Corporate Governance
Number of Provincial Health Council meetings	Provincial governance structure convened as per National Health Act 2003 to improve social compact for health through participation and consultation.	Monitor meetings with Provincial Health Council as per KZN Health Act (1 of 2009).	Corporate Services database	**Sum** Number of Provincial Health Council meetings convened.	None.	Output	Number	Annual	No	Improved social compact for better health outcomes.	Corporate Governance
Number of District Health Councils established	District governance structure to improve public consultation in health	Improved consultation and collaboration.	Corporate Governance records	**Sum** Number of District Health Councils established	None.	Process.	Number	Annual	No	Improved collaboration	Corporate Governance
Number of District Health Council meetings convened annually.	District governance structure convened as per National Health Act 2003 to improve social compact for health through participation and consultation.	Monitor meetings with District Health Councils as per KZN Health Act (1 of 2009).	Corporate Services database	**Sum** Number of District Health Council meetings convened.	None.	Output	Number	Annual	No	Improved social compact for better health outcomes.	Corporate Governance

PROGRAMME 2: DISTRICT HEALTH SERVICES

District Health Services

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Provincial PHC expenditure per uninsured person	Total expenditure by the Provincial DOH on PHC services	To monitor adequacy of funding levels for PHC services	BAS & StatsSA	**Numerator** Total expenditure of the Province on PHC services (Programme 2) **Denominator** Number of uninsured people in the Provinces as indicated in StatsSA	Accuracy of data	Input	Rand	Annual	No	Higher levels of expenditure reflect prioritisation of PHC services	DHS, CFO, Specialised & Clinical Support services
Utilisation rate - PHC	The average number of visits to a PHC facility per person per year in the population.	Tracks the utilisation of PHC services; inform allocation of staff and other resources; and measuring equity & access to PHC services.	DHIS	**Numerator** PHC total headcount **Denominator** Total Population	Dependant on the accuracy of estimated total population from StatsSA	Output	Rate annualised	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	DHS
2013 NIDS: *PHC utilisation rate (annualised)*	*Average number of PHC visits per person per year in the population*	*Monitors PHC access and utilisation*	*DHIS*	***Numerator*** *SUM([PHC headcount under 5 years]) + SUM([PHC headcount 5 years and older])* ***Denominator*** *SUM([Total population])*	*Dependant on the accuracy of estimated total population from StatsSA*	*Output*	*Rate annualised*	*Quarterly*	*No*	*Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system*	*Programme Manager*
Utilisation rate - PHC under 5 years	The average number of PHC visits per year per person under the age of 5 years in the population	Tracks the uptake/ utilisation of PHC services by children under the age of 5 years.	DHIS StatsSA	**Numerator** PHC headcount under 5 years **Denominator** Population under 5 years	Dependant on the accuracy of estimated population 5 years an under from StatsSA	Output	Rate annualised	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	DHS
2013 NIDS: *PHC utilisation rate under 5 years (annualised)*	*Average number of PHC visits per year per person under 5 years of age in the population*	*Monitors PHC access and utilisation by children under 5 years of age*	*DHIS*	***Numerator*** *SUM([PHC headcount under 5 years])* ***Denominator*** *SUM([Female under 5 years]) + SUM([Male under 5 years])*	*Dependant on the accuracy of estimated population under 5 years from StatsSA*	*Output*	*Rate annualised*	*Quarterly*	*No*	*Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system*	*Programme Manager*

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
PHC total headcount	Number of PHC patients seen during the reporting period. Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen	Tracks the uptake of PHC services at each PHC site for the purposes of allocating staff and other resources.	DHIS	Sum total of PHC headcounts during the reporting period	Accuracy of headcount depends on the reliability of PHC record management at facility level	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	DHS Programme Manager
2013 NIDS: *PHC headcount total*	*Clients of all ages attending the facility for Primary Health Care. Each client is counted once a day regardless of the number of services provided on that day*	*Tracks the uptake of PHC services at each PHC site for the purposes of allocating staff and other resources*	*DHIS*	*Sum of PHC headcount under 5 years and PHC 5 years and older. Each client is counted once a day regardless of the number of services provided on that day. Auto-calculated by DHIS*	*Accuracy of headcount depends on the reliability of PHC record management at facility level*	*Output*	*Sum*	*Quarterly*	*No*	*Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system*	*DHS Programme Manager*
PHC total headcount – under 5 years	Number of PHC patients under the age of 5 years seen during the reporting period. Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen	Tracks the children under 5 uptakes of PHC services at each PHC site for the purposes of allocating staff and other resources.	DHIS	Sum of PHC headcount under 5 years during the reporting period	Accuracy of headcount depends on the reliability of PHC record management at facility level	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease amongst children, or greater reliance on public health system	DHS Programme Manager
2013 NIDS: *PHC headcount under 5 years*	*Client under 5 years of age attending the facility for Primary Health Care*	*Tracks the children under 5 uptake of PHC services at each PHC site for the purposes of allocating staff and other resources*	*DHIS*	*Each client is counted once a day regardless of the number of services provided on that day*	*Accuracy of headcount depends on the reliability of PHC record management at facility level*	*Output*	*Sum*	*Quarterly*	*No*	*Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system*	*DHS Programme Manager*
Fixed PHC facilities monthly supervisory visit rate	Percentage of fixed PHC facilities that were visited by a supervisor at least once every month (official supervisor report completed)	Tracks the supervision rate of all PHC facilities as part of clinical governance to improve quality of care and patient satisfaction.	DHIS	**Numerator** Number of fixed PHC facilities that were visited by a supervisor at least once this month **Denominator** Total number of fixed PHC facilities	Dependant on accurate reporting and interpretation of supervisory visit.	Quality	Rate	Quarterly	No	Higher levels indicate better support to staff at PHC level and consequent improved quality of care	DHS and QA
2013 NIDS: *PHC supervisor visit rate (fixed clinic/CHC/CDC)*	*Proportion fixed clinics, CHCs and CDCs visited by a dedicated supervisor according to the PHC Supervision Manual*	*Monitors supervision according to the PHC Supervision manual (once a month) in clinics, CHCs and CDCs*	*DHIS*	***Numerator*** *SUM([PHC supervisor visit (fixed clinic/CHC/CDC)])* ***Denominator*** *SUM([Fixed clinic]) + SUM([Fixed CHC/CDC])*	*Dependant on the reporting of the purpose of the visit by the supervisor to the PHC facility*	*Quality*	*Rate*	*Quarterly*	*Yes*	*Higher levels indicate better support to the facility*	*QA Programme Manager*

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Expenditure per PHC headcount	Expenditure per PHC headcount by the Provincial DOH at provincial PHC facilities.	Tracks the expenditure of Provincial PHC services	DHIS: PHC total headcount BAS: Expenditure on PHC by provincial DOH	**Numerator** Expenditure on PHC services by the Provincial DOH **Denominator** PHC total headcount	Accuracy of data depends on the reliability of PHC record management at facility level and accuracy of expenditure depends on the accuracy of correct expenditure allocation	Efficiency	Rand	Quarterly	No	Lower expenditure could indicate efficient use of financial resources, or incomplete provision of the comprehensive PHC package	DHS & Finance (CFO)
Number of PHC facilities (OR CHCs) assessed for compliance against the 6 priorities of the core standards **The same indicator is relevant to PHC facilities and CHCs**	Total number of fixed PHC facilities (OR CHCs) assessed for compliance against the national core standards for the 6 priority areas using customised assessment tools.	Tracks the levels of compliance against the national core standards for the identified 6 priorities using standardised national assessment tools	DQPR Quality Assurance Database	Total number of fixed PHC facilities (OR CHCs) assessed for compliance against the 6 priorities of the core standards using the customised assessment tools	None	Process	Number	Annual	No	Accreditation (certification) of facilities that comply with norms	QA & DHS
Percentage of Clinics/CHCs with functional Clinic Committees[87] **The same indicator is relevant to PHC clinics and CHCs**	The proportion of PHC clinics (OR CHCs) with established and functional Clinic Committees	Improve community consultation and participation and improved information sharing	DQPR Clinic records of meetings	**Numerator** Total number of clinics (OR CHCs) with established and functional Clinic Committees **Denominator** Total number of clinics (OR CHCs)	None.	Output	%	Annual	No	All clinics/ CHCs have functional Clinic Committees to improve community consultation & participation	DHS

[87] Clinic Committees and Hospital Boards refer to Interim Committees and Boards – Strategic Plan targets reviewed

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of accredited Health Promoting Schools	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.	DQPR Health Promoting Schools Database	**Sum** Total number of schools formally accredited by an external assessment authority as a HPS.	Accuracy and completeness of the HPS database.	Output	Number	Quarterly	No	Increase community participation in health programmes through partnerships and active community involvement.	DHS
School Health Services coverage	The proportion of schools visited by a School Health Team rendering the package of services as per School Health Services Policy in a specific reporting period.	Monitors implementation of school health services as part of PHC re-engineering and equitable distribution and access to PHC services at community level.	DQPR	**Numerator** Number of schools visited by a school health team during the reporting period. **Denominator** Total number of schools.	Accurate reporting at district level.	Output	%	Quarterly	No	Improved school health coverage as per Provincial School Health Services Policy Implementation Plan.	DHS
2013 NIDS: *School Integrated School Health Programme (ISHP) coverage (annualised)*	*The proportion of schools in which the Integrated School Health Programme (ISHP) service package was provided in specific reporting period. This refers to service package as per School Health Service Policy.*	*Monitors implementation of the Integrated School Health Programme (ISHP) and equitable coverage with services for learners.*	*DHIS*	***Numerator*** *COUNT([School learners screened - total])* ***Denominator*** *COUNT([Schools total])*	*Accurate reporting at district level.*	*Output*	*%*	*Monthly*	*Yes*	*Improved school health coverage as per Provincial School Health Services Policy Implementation Plan.*	*DHS*
Number of operational PHC Outreach Teams	Number of established PHC Outreach Teams, rendering PHC services at household level	Re-engineering of PHC to improve equity, access and health promotion & education at household level	DQPR	Number of PHC Outreach Teams rendering community-based PHC services.	None.	Output	Number	Annual	No	Improved PHC at household level	DHS
Number of operational School Health Teams	Number of established School Health Teams rendering services at schools clustered to a PHC clinic as part of PHC re-engineering.	Increase access to health services for learners as component of PHC re-engineering.	DQPR	Number of School Health Teams rendering school health services.	None.	Output	Number	Annual	No	Improved PHC at community level (targeting learners)	DHS
Number of operational District Specialist Teams	Number of established District Specialist Teams providing clinical mentorship and oversight at district level (community-based and facility-based)	Improved clinical governance and clinical care	DQPR	Number of District Specialist Teams functional at district level.	None.	Output	Number	Annual	No	Improved mentoring and oversight; improved clinical governance & quality of care.	DHS

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Dental extraction to restoration ratio	The ratio between the number of dental extractions in relation to the number of dental restorations in a specific reporting period	To monitor the effective implementation and quality of the oral health programme with emphasis on prevention	DHIS	**Numerator** The total number of tooth extractions **Denominator** The total number of tooth restorations	Data quality	Output	Ratio	Quarterly	No	Decrease in the number of dental extractions in relation to dental restorations indicates improvement in dental health services	DHS
2013 NIDS: *Dental extraction to restoration ratio*	*The ratio between the number of teeth extracted and the number of teeth restored*	*Monitors overall quality of dental services. Poor quality dental services if many extractions and few restorations*	*DHIS*	***Numerator*** *SUM([Tooth extraction])* ***Denominator*** *SUM([Tooth restoration])*	*Data quality*	*Output*	*Ratio*	*Quarterly*	*No*	*Decrease in the number of dental extractions in relation to dental restorations indicates improvement in dental health services*	*DHS*
Dental headcount	The number of clients visiting PHC services for dental or oral health care in a specific period.	Monitors access to oral health services. Include clients seen by dentist and other oral health care staff. Count each client only once a day regardless of the number of services provided on that day. Include clients seen at a facility by a Doctor or Professional Nurse with a tooth abscess	DHIS	**Sum** Number of clients who received dental/oral care in public health facilities	Accuracy of data	Output	Sum	Quarterly	Yes	Increased number of patients refers to improved access	DHS
PHC Budget as a % of total budget	The proportion of the total health budget allocated for rendering of PHC services (excluding District Hospitals).	Monitoring investment in PHC.	BAS	**Numerator** Total budget allocation for Sub-Programmes 2.2; 2.3; 2.4; 2.5; 2.6; and 2.7 **Numerator** Total Provincial budget allocation (all Programmes)	None.	Input	%	Annual	No	Increased investment in PHC in support of better health for all	DHS; Finance; Planning
Percentage of (Clinics or CHCs) fully compliant with the 6 priorities of the National Core Standards **Same indicator for Clinics and CHCs**	The percentage of clinics (OR CHCs) that is fully compliant with the core standards of the 6 priority areas in the National Core Standards after assessment using the customised assessment tool.	Improved quality of health care.	DQPR Quality Assurance Database	**Numerator** Number of (Clinics OR CHCs) fully compliant with the norms and standards of the 6 priorities of the core standards **Denominator** Total number of (Clinics OR CHCs)	Accuracy dependant on quality of data from reporting facility	Output	%	Quarterly	No	Compliance to core standards improve patient satisfaction, efficiency and quality of healthcare – universal access to healthcare	DHS; QA, IPC

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Percentage of CHC's conducting annual Patient Satisfaction Survey's	The percentage of CHC's that conducted a Patient Satisfaction Survey (using the standard national template) in the last 12 months.	Measure patient satisfaction with health services.	DQPR	**Numerator** Number of CHC's that conducted a Patient Satisfaction Survey in the reporting year. **Denominator** Total number of CHCs x 100	Limitation not related to number of surveys conducted – rather the response to surveys and monitoring of outcomes.	Output	%	Annual	No	Annual surveys inform Quality Improvement Plans and track performance towards improved quality and patient satisfaction.	DHS & QA
Percentage of complaints of users of PHC services resolved within 25 days	Percentage of complaints of users of PHC Services resolved within 25 days	To monitor the management of the complaints in the PHC services	DQPR	**Numerator** Total number of complaints resolved within 25 days during the quarter **Denominator** Total number of complaints during the quarter	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	%	Quarterly	Yes	Higher percentage suggest better management of complaints in PHC Services	Quality Assurance
2013 NIDS: *Complaint resolution within 25 working days rate*	*Proportion of complaints resolved within 25 working days out of all complaints resolved*	*Monitors public health system response to customer concerns*	*DHIS*	***Numerator*** *SUM([Complaint resolved within 25 working days])* ***Denominator*** *SUM([Complaint resolved])*	*Accuracy of information is dependent on the accuracy of time stamp for each complaint*	*Quality*	*%*	*Quarterly*	*Yes*	*Higher percentage suggest better management of complaints in PHC facilities*	*Quality Assurance*
Hypertension case put on treatment - new	Newly diagnosed hypertension patients put on treatment	Monitor new cases of Hypertension	DHIS	Hypertension case put on treatment - new	Accurate reporting at District level	Output	Number	Quarterly	No	Improved education, training, screening and detection reduce incidence	DHS
2013 NIDS: *Hypertension client treatment new*	*Number of clients initiated on hypertension treatment for the first time*	*Monitors trends in clients initiated on hypertension treatment. Exclude clients who were initiated on hypertension treatment at another health facility*	*DHIS*	*Clients initiated on hypertension treatment for the first time*	*Accurate reporting at District level*	*Output*	*Number*	*Quarterly*	*No*	*Improved education, training, screening and detection reduce incidence*	*DHS*
Diabetes Mellitus case put on treatment - new	Newly diagnosed patients with diabetes mellitus put on treatment	Monitor new cases (incidence) of Diabetes Mellitus	DHIS	Diabetes mellitus case put on treatment - new	Accurate reporting at District level	Output	Number	Quarterly	No	Improved education, training, screening and detection reduce incidence	DHIS

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
2013 NIDS: *Diabetes client treatment new*	*Number of clients initiated on diabetes treatment for the first time*	*Monitors trends in clients initiated on diabetes treatment. Exclude clients who were initiated on diabetes treatment at another health facility. Auto-calculated by DHIS*	*DHIS*	*Clients initiated on diabetes treatment for the first time*	*Accurate reporting at District level*	*Output*	*Number*	*Quarterly*	*No*	*Improved education, training, screening and detection reduce incidence*	*DHIS*

Hospital Services (Indicators are relevant to all hospitals in Programme 2, 4 and 5)

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Caesarean section rate	Caesarean section deliveries in hospitals expressed as a percentage of all deliveries in hospitals.	Track the performance of obstetric care of the hospitals	DHIS	**Numerator** Number of Caesarean Sections performed **Denominator** Total number of deliveries in facility	Accuracy dependant on quality of data from reporting facility	Output	Rate	Quarterly	No	Reduction in caesarean section rate as promotive and preventive PHC improve as part of PHC re-engineering	DHS, Specialised & Clinical Support Services
2013 NIDS: *Delivery by caesarean section rate*	*Delivery by caesarean section as proportion of total deliveries in health facilities*	*Monitors access to caesarean section (and other surgery) as well as use of resources at delivery facilities. Differs between types of hospitals, for example 2011/12 values for DH: 15 % RH: 25 % TH: 30% CH: 50 %.*	*DHIS*	***Numerator*** *SUM([Delivery by caesarean section])* ***Denominator*** *SUM([Delivery in facility total])*	*Accuracy dependant on quality of data from reporting facility*	*Output*	*Rate*	*Monthly*	*No*	*Reduction in caesarean section rate as promotive and preventative PHC improve as part of PHC re-engineering*	*DHS, Specialised & Clinical support services*
Total separations	Recorded patient stay in hospital and include inpatients who were discharged, transferred out to other hospitals or who died and day patients.	Monitoring the service volumes to inform resource allocation, management and service delivery.	DHIS	**Sum** • Inpatient deaths • Inpatient discharges • Inpatient transfer out • Day patient	Accuracy dependant on quality of data from reporting facility	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, greater reliance on public health system, or ineffective PHC system	DHS and Specialised & Clinical Support Services
2013 NIDS: *Inpatient separations – total*	*Sum of inpatient deaths, inpatient discharges and inpatient transfers out*	*Monitors patients who left an inpatient facility by calculating inpatient deaths, inpatient discharges and inpatients transferred out*	*DHIS*	***Sum*** • *Inpatient deaths* • *Inpatient discharges* • *Inpatient transfer out*	*Accuracy dependant on quality of data from reporting facility*	*Output*	*Sum*	*Monthly*	*No*	*Higher levels of uptake may indicate an increased burden of disease, greater reliance on public health system, or ineffective PHC system*	*DHS and Specialised & Clinical Support Services*

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Patient Day Equivalent	A weighted combination of inpatient days, day-patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All hospital activity expressed as a equivalent to one inpatient day	Monitoring the service volumes to inform resource allocation, management and service delivery.	DHIS	**Sum** • Inpatient days -total • 1/2 Day patients • 1/3 OPD headcount - total • 1/3 Emergency Headcount **OPD Headcount total = sum** • OPD specialist clinic headcount + • OPD general clinic headcount	Accuracy dependant on quality of data from reporting facility	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system or ineffective PHC system	*DHS and Specialised & Clinical Support Services*
2013 NIDS: *Patient Day Equivalent*	*Weighted data element as proxy for estimating resources for all types of patients in terms of inpatient days*	*The sum of inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5, and OPD/Emergency total headcount multiplied by a factor of 0.33333333 (divided by 3). Auto-calculated by DHIS*	*DHIS*	***Sum*** • *Inpatient days -total* • *1/2 Day patients* • *1/3 OPD headcount - total* • *1/3 Emergency Headcount* ***OPD Headcount total = sum*** • *OPD specialist clinic headcount +* • *OPD general clinic headcount*	*Accuracy dependant on quality of data from reporting facility*	*Output*	*Sum*	*Monthly*	*No*	*Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system or ineffective PHC system*	*DHS and Specialised & Clinical Support Services*
OPD Headcount – Total	Total number of all out-patients attending an out-patient clinic.	Monitoring the service volumes to inform resource allocation, management and service delivery.	DHIS	**Sum** • OPD specialist clinic headcount • OPD general clinic headcount	Accuracy dependant on quality of data from reporting facility	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system or ineffective PHC system	DHS, Specialised & Clinical Support Services
2013 NIDS: *OPD headcount – total*	*Total clients attending general or specialist Outpatient clinics*	*Sum of new and follow-up clients attending general and specialist Outpatient clinics. Validation: should be equal to sum of OPD general and OPD specialist headcounts. Auto-calculated by DHIS*	*DHIS*	***Sum*** • *OPD specialist clinic headcount* • *OPD general clinic headcount (including follow-up and new cases not referred)*	*Accuracy dependant on quality of data from reporting facility*	*Output*	*Sum*	*Monthly*	*No*	*Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system or ineffective PHC system*	*DHS, Specialised & Clinical Support Services*

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Average length of stay	Average number of days that a patient stays in hospital before separation.	To monitor the efficiency of the hospital to inform resource allocation, management and service delivery.	DHIS	**Numerator** Inpatient days + 1/2 day patients **Denominator** Separations	Accuracy dependent on data quality	Efficiency	Number of days	Monthly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care	DHS, Specialised & Clinical Support Services
2013 NIDS: *Average length of stay – total*	*The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of day clients, Inpatient discharges, Inpatient deaths and Inpatient transfer outs*	*Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it should only include Inpatient days for those clients separated during the reporting month. Use in all hospitals ad CHCs with Inpatient beds*	*DHIS*	***Numerator*** *SUM([Inpatient days - total]) + (SUM([Day patients - total]) * 0.5)* ***Denominator*** *SUM([Inpatient deaths - total]) + SUM([Inpatient discharges - total]) + SUM([Inpatient transfers out - total])*	*Accuracy dependent on data quality*	*Outcome*	*Number of days*	*Monthly*	*No*	*A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care*	*DHS, Specialised & Clinical Support Services*
Bed utilisation rate (based on usable beds)	Patient days during the reporting period, expressed as a percentage of the sum of the daily number of usable beds.	Track the over/under utilisation of hospital beds	DHIS	**Numerator** Inpatient days + 1/2 Day patients **Denominator** Number of usable bed days	Accurate reporting sum of daily usable beds	Efficiency	Rate	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels	DHS, Specialised & Clinical Support Services
2013 NIDS: *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)*	*Monitors effectiveness and efficiency of Inpatient management. Baselines for 2011/12 were DH: 67.1, RH: 76.9, TH:73.6, CH: 75.3*	*DHIS*	***Numerator*** *SUM([Inpatient days - total]) + (SUM([Day patients - total]) * 0.5)* ***Denominator*** *SUM([Inpatient beds - total]) *30.42*	*Accurate reporting sum of daily usable beds*	*Efficiency*	*Rate*	*Quarterly*	*No*	*Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels*	*DHS, Specialised & Clinical Support Services*
Expenditure per patient day equivalent (PDE)	Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All hospital activity expressed as a equivalent to one inpatient day	Track the expenditure per PDE in hospitals to determine efficiency	BAS / DHIS	**Numerator** Total expenditure in hospitals **Denominator** Patient Day Equivalent (PDE)*	Accuracy dependent on data quality	Efficiency	Rand	Quarterly	No	Lower rate indicating efficient use of financial resources.	DHS, Specialised and Clinical Support Services

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Percentage of complaints of users of (category) hospital resolved within 25 days	The proportion of complaints of users of hospital services resolved within 25 days	To monitor the management of patient complaints in hospitals	M&E Framework	**Numerator** Total number of patient complaints resolved within 25 days during the reporting period **Denominator** Total number of patient complaints received during the reporting period	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	%	Quarterly	No	Higher percentage suggest better management of complaints in hospitals	DHS, Specialised & Clinical Support Services
2013 NIDS: Complaint resolved within 25 working days	*Total number of client / client complaints resolved within 25 working days*	*Monitors complaint resolution turnaround time measured against a standard. Although all complaints should be resolved, count only those that were resolved during the reporting month (even if reported the previous month)*	*DHIS*	***Numerator*** *SUM([complaint resolved within 25 working days])* ***Denominator*** *SUM([Complaint resolved])*	*Accuracy of information is dependent on the accuracy of time stamp for each complaint*	*Quality*	*%*	*Monthly*	*No*	*Higher percentage suggest better management of complaints in hospitals*	*DHS, Specialised & Clinical Support Services*
Percentage of (Category) hospitals with monthly mortality and morbidity meetings **Relevant to all categories of hospitals**	Percentage of (Category) hospitals conducting monthly mortality and morbidity meetings (3 per quarter or 12 per year).	Reduction of (preventable) morbidity and mortality; improved quality of care; mentoring	DQPR	**Numerator** Number of (Category) hospitals that conducted a mortality and morbidity meeting every month **Denominator** Total number of (Category) hospitals	Accuracy dependant on quality of data from reporting facility	Quality	%	Quarterly	No	Higher percentage suggests better clinical governance	DHS, Specialised & Clinical Support Services
2013 NIDS: Mortality and morbidity review rate **Relevant for all categories of hospitals**	*Frequency of holding mortality and morbidity reviews that should include, but not be limited to, (a) maternal deaths, (b) neonatal deaths, (c) wrong site surgery and (d) anaesthetic death. The same indicator is being used for all hospital categories.*	*Demonstrates facility's aim of ensuring quality healthcare service provision. Guideline to be developed to include among other things measures such as c/s infection rate, anaesthetic death rate, maternal and paediatric deaths and wrong site surgery*	*DHIS*	***Numerator*** *SUM([Mortality and morbidity review conducted])* ***Denominator*** *SUM([Planned mortality and morbidity review])*	*Accuracy dependant on quality of data from reporting facility*	*Quality*	*Rate*	*Quarterly*	*No*	*Higher percentage suggests better clinical governance*	*DHS, Specialised & Clinical Support Services*

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
(Category) Hospital patient satisfaction rate **Relevant for all categories of hospitals**	The percentage of users that participated in the Patient Satisfaction Survey that were satisfied with hospital services. The indicator is similar for all hospitals, referring to each category separately.	Tracks patient satisfaction with public health services	DQPR	**Numerator** Total number of survey participants that were satisfied with the services rendered in (Category) Hospitals **Denominator** Total number of users that participated in the Client Satisfaction Survey for (Category) Hospitals.	Generalised - depends on the number of users participating in the survey.	Output	Rate	Annual	No	Increased patient satisfaction with public health services	DHS, Specialised & Clinical Support Services
2013 NIDS: *Patient satisfaction rate* **Relevant to all categories of hospitals**	*The percentage of users that participated in the Patient Satisfaction Survey that were satisfied with the services.*	*Tracks patient satisfaction with public health services*	*DHIS* *Patient Satisfaction Module*	***Numerator*** *Total number of survey participants that were satisfied with the services rendered in (Category) Hospitals* ***Denominator*** *Total number of users that participated in the Client Satisfaction Survey for (Category) Hospitals.*	*Generalised - depends on the number of users participating in the survey.*	*Output*	*Rate*	*Annual*	*No*	*Increased patient satisfaction with public health services*	*DHS, Specialised & Clinical Support Services*
Number of (Category) Hospitals assessed for compliance against the 6 priorities of the core standards	Number of (Category) Hospitals assessed for compliance against the core standards	Tracks performance and compliance of hospitals to the core standards and criteria of the 6 priority areas	DQPR Assessment Reports	Total number of (Category) Hospitals assessed against the standards of the 6 priority areas of the core standards.	Recording of findings	Process	Number	Annual	No	Improved quality and patient satisfaction	DHS, Specialised & Clinical Support Services
2013 NIDS: Number of Hospitals assessed for compliance against the 6 priorities of the core standards	*Number of Hospitals assessed for compliance against the core standards of the 6 priority areas in the national core standards using the official assessment tools*	*Tracks performance and compliance to the core priority standards*	*DHIS* *Assessment Reports*	*Total number of (Category) Hospitals assessed against the standards of the 6 priority areas of the core standards.*	*Recording of findings*	*Process*	*Number*	*Annual*	*No*	*Improved quality and patient satisfaction*	*DHS, Specialised & Clinical Support Services*
Percentage of (Category) Hospitals with functional Hospital Boards	Measuring the proportion of hospitals (relevant to all categories) with appointed and functional Hospital Boards.	Improve community consultation and participation and improved information sharing.	DQPR	**Numerator** Total number of (Category) Hospitals with functional Hospital Boards **Denominator** Total number of (Category) Hospitals	Interpretation of "functional" Boards and active participation of board members	Output	%	Annual	No	Improved community consultation and information sharing	DHS, Specialised & Clinical Support Services

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of (Category) Hospitals compliant with the 6 priorities of the National Core Standards	Number of hospitals that comply 100% with the minimum standards for the 6 priority areas contained in the National Core Standards and using the customised core standard assessment tool for evaluation.	Improved quality, efficiency, patient satisfaction	DQPR Assessment Records	The total number of (Category) hospitals scoring 100% compliance to the National Core Standards for the 6 priority areas	Record keeping	Output	Number	Annual	No	100% Compliance to core standards	DHS, Specialised and Clinical Support Services
Number of District Hospitals with high-volume cataract centres	Number of high-volume cataract centres in District Hospitals	Intensifying strategies and services for the prevention of blindness	DQPR	**Sum** Number of high -volume cataract centres	None	Input	Number	Annually	Yes	Reduced cataract surgery backlog and improved access to prevent blindness	DHS & Specialised and Clinical Support Services

SUB-PROGRAMME: HIV AND AIDS, TB AND STI CONTROL

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Total number of patients (Children and Adults) on ART	Number of patients on an ARV regimen	Track the number of qualifying patients on ARV treatment	DHIS	**Sum** Cumulative total of the number of patients on an ARV regimen	Data quality	Output	Number Cumulative	Quarterly	No	Effective management of prevalence and increasing life expectancy	DHS, Specialised & Clinical Support Services
2013 NIDS: Total clients remaining on ART(TROA) at the end of the month	*Cumulative total of the number of patients on an ARV regimen*	*Track the number of patients on ARV Treatment*	*CCMT*	*Total clients remaining on ART(TROA) are the sum of the following:* *Any client that has a current regimen in the column designating the month you are reporting on* *Any client that has a star without a circle (someone who is not yet lost to follow-up[LTF] in the column designating the month you are reporting on)* *Clients remaining on ART equals (Naïve [including PEP and PMTCT] + experienced (EXP) + Transfer-in (TFI) + Restart] minus [Died (RIP) + lost to follow-up(LTF) + Transfer-out (TFO)]*	*Data quality*	*Input*	*Cumulative total*	*Quarterly*	*No*	*Higher total indicates a larger population on ART treatment*	*HIV/AIDS Programme Manager*

ANNEXURE 2: DEFINITIONS

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Male condom distribution rate.	Number of male condoms per male population 15 years and older distributed at public health facilities	Decrease HIV/ STI infections and unwanted pregnancies.	DHIS	**Numerator** Male condoms distributed at public health facilities **Denominator** Male population 15 and older	Data quality and population estimates from StatsSA – distribution not a reflection of actual use.	Process	Rate	Quarterly	No	Decrease HIV/STI incidence and unwanted pregnancies.	DHS, Specialised & Clinical Support Programmes
***2013 NIDS*:** Male condom distribution rate (annualised)	*Number of male condoms distributed to clients via the facility or via factories, offices, restaurants, NGOs or other outlets - per male 15 years and older*	*Monitors distribution of male condoms for prevention of HIV and other STIs, and for contraceptive purposes. Note that research indicates only around 60% of distributed condoms are used for the intended purpose*	*DHIS*	***Numerator*** *SUM([Male condoms distributed])* ***Denominator*** *SUM([Male 15-44 years]) + SUM([Male 45 years and older])*	*Indicator reliant on accuracy of population estimates from StatsSA*	*Output*	*Rate*	*Quarterly*	*No*	*Higher rate indicates better contraceptive measures which should lead to decrease in HIV/AIDS incidence*	*HIV/AIDS Programme Manager*
New smear positive PTB defaulter rate.	New smear positive PTB cases where patients defaulted from treatment as proportion of all smear positive PTB cases.	Monitor effectiveness of TB management	ETR.Net	**Numerator** New smear positive TB cases defaulted from treatment. **Denominator** New smear positive TB cases total.	Accuracy of data	Outcome	Rate	Quarterly	No	Lower levels of interruption reflect improved case holding, which is important for facilitating successful TB treatment.	DHS, Specialised & Clinical Support Programmes
***2013 NIDS*:** *TB (new pulmonary) defaulter rate*	*Proportion new smear positive (pulmonary) TB clients who defaulted treatment*	*Monitors TB clients who do not take their treatment as prescribed*		***Numerator*** *SUM([TB (new pulmonary) treatment defaulter])* ***Denominator*** *SUM([TB (new pulmonary) client initiated on treatment])*	Accuracy of data	*Output*	*Rate*	*Quarterly*	*No*	*Lower levels of interruption reflect improved case holding, which is important for facilitating successful TB treatment*	*TB Programme Manager*
PTB two month smear conversion rate.	The proportion of new smear positive PTB clients who converted to smear negative after being on treatment for 2 months.	Track the morbidity and mortality due to TB and the routine sputum collection in all TB patients at 2 months.	ETR.Net	**Numerator** New smear positive PTB clients who converted to smear negative at 2 months. **Denominator** New smear positive PTB clients registered.	Accuracy is dependent on accurate completion of the ETBR at facility level.	Outcome	Rate	Quarterly	No	Higher smear conversion rates will lead to improved TB outcomes.	DHS, Specialised & Clinical Support Services

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
2013 NIDS: *TB new client treatment success rate*	*Proportion TB patients (ALL types of TB) cured plus those who completed treatment*	*Monitors success of TB treatment for ALL types of TB*	*ETR.Net*	***Numerator*** *SUM([TB client cured OR completed treatment])* ***Denominator*** *SUM([TB (new pulmonary) client initiated on treatment])*	*Accuracy dependent on quality of data from reporting facility*	*Outcome*	*Rate*	*Annual*	*Yes*	*Higher percentage indicate better treatment success rate for the Province*	*TB Programme Manager*
TB AFB sputum result turn-around time under 48 hours rate	Proportion TB Acid Fast Bacilli (AFB) results received within 48 hours	Monitors TB AFB sputum results received by facility (SMS or printed report) within 48 hours from when specimen was collected. Include pre-treatment and follow-up specimens. EXCLUDE samples sent for culture and sensitivity	DHIS	**Numerator** SUM([TB AFB sputum result received within 48 hours]) **Denominator** SUM([TB AFB sputum sample sent])	Accuracy of capturing the date/time sampled dispatched and/or received	Quality	Rate	Quarterly	Yes	Higher percentage indicates faster turnaround	*TB Programme Manager*
Percentage of HIV-TB Co-infected patients placed on ART.	Percentage of HIV and TB co-infected patients placed on Ante Retrovirus Treatment (ART).	Monitors the coverage of ART among co-infected population.	ETR.Net	**Numerator** Total number of HIV and TB co-infected people on ART. **Denominator** Total number of co-infected people with a CD4 count of 350 or less.	Dependant on the accuracy of the Electronic TB Register.	Output	%	Quarterly	No	Improved TB and HIV outcomes	DHS, Specialised & Clinical Support Services
2013 NIDS: *TB/HIV co-infected client initiated on ART rate*	*Proportion of TB/HIV co-infected clients initiated on ART*	*Monitors TB/HIV co-infection at point of ART initiation*	*DHIS*	***Numerator*** *SUM([HIV/TB co-infected client initiated on ART])* ***Denominator*** *SUM([HIV/TB co-infected client - total])*	*Dependant on the accuracy of the Electronic TB Register.*	*Process*	*Rate*	*Monthly*	*Yes*	*Higher percentage indicate better coverage*	*TB Programme Manager*
HCT testing rate.	Percentage of clients tested for HIV to those pre-counselled.	Monitors the number of people knowing their HIV status.	DHIS	**Numerator** Total number clients tested for HIV. **Denominator** Total number of clients pre-test counselled	Dependant on the accuracy of tick and tally sheets.	Output	Rate	Quarterly	Yes	Increase in number of people knowing their HIV status to improve prevention and treatment programmes.	DHS, Specialised & Clinical Support Services

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
2013 NIDS: *HIV testing coverage*	*Clients HIV tested as proportion of population 15-49 years*	*Monitors annual testing of persons 15-49 years who are not known HIV positive*	*DHIS*	***Numerator*** *SUM([HIV test client 15-49 years])* ***Denominator*** *SUM([Female 15-44 years]) + SUM([Male 15-44 years]) + SUM([Female 45-49 years]) + SUM([Male 45-49 years])*	*Dependant on the accuracy of tick and tally sheets.*	*Process*	*%*	*Quarterly*	*Yes*	*Higher percentage indicate increased population knowing their HIV status*	*HIV/AIDS Programme Manager*
New smear positive PTB cure rate.	Percentage of new smear positive PTB cases cured at first attempt.	Monitor successful TB treatment outcomes.	ETR.Net	**Numerator** New smear positive TB cases cured **Denominator** New smear positive TB cases newly registered	Accuracy dependant on quality of data from reporting facility	Outcome	Rate	Annual	No	Higher percentage indicates improved TB outcomes.	DHS, Specialised & Clinical Support Services
2013 NIDS: *TB (new pulmonary) cure rate*	*Proportion new TB smear positive and culture positive (pulmonary TB) clients cured*	*Monitors cure of new pulmonary TB clients*	*ETR.Net*	***Numerator*** *SUM([TB (new pulmonary) client cured])* ***Denominator*** *SUM([TB (new pulmonary) client initiated on treatment])*	*Accuracy dependent on quality of data from reporting facility*	*Outcome*	*Rate*	*Quarterly*	*No*	*Higher percentage indicate better cure rate for the Province*	*TB Programme Manager*
HIV incidence	New HIV infections.	Monitor the impact of HIV & AIDS Programmes on new infections (effectiveness of prevention programmes)	ASSA2008 projections	**Numerator** New HIV infections in specific period. **Denominator** Total population.	Not routinely collected therefore dependent on research and annual projections. As per National Health recommendation, ASSA2008 projections will be used.	Impact	%	Annual projections	No	Reduction in HIV incidence will indicate positive behaviour change.	DHS, Specialised & Clinical Support Services
Percentage qualifying HIV-positive patients on ART	The percentage of HIV-positive clients who qualify for ART based on the HIV policy on the appropriate treatment regime.	Track performance against the National Strategic Plan targets and monitor the effectiveness of the HIV & AIDS Programme.	Currently based on projections (ASSA2008)	**Numerator** The number of HIV-positive qualifying patients on a treatment regime. **Denominator** The total number of HIV-positive clients qualifying for treatment.	Data quality and completeness from reporting facilities.	Output	%	Annual	No	HIV-positive qualifying patients have access to appropriate treatment.	DHS, Specialised & Clinical Support Services

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of neo-natal males circumcised	The number of neonatal males circumcised in a specific period and cumulative over time.	Monitor male medical circumcision prevention strategy to reduce HIV incidence.	DHIS	The number of neonatal males circumcised in a specified period	Data quality and completeness.	Output	Number	Quarterly	No	Reduce HIV incidence.	DHS, Specialised & Clinical Support Services
Number of adult males circumcised	The number of adult males circumcised in a specific period and cumulative over time.	Strategy to reduce HIV incidence.	DHIS	The number of adult males (15 years and older) circumcised in a specific period.	Data quality and completeness from reporting facilities.	Output	Number	Quarterly	No	Reduce HIV incidence.	DHS, Specialised & Clinical Support Services
Percentage of HIV positive patients initiated on IPT	The proportion of clients newly eligible for INH that started treatment during the reporting period.	Preventive therapy for TB.	DHIS	**Numerator** HIV positive new patients started on IPT **Denominator** HIV test positive new (excluding ANC) + ANC client test positive new + ANC re-test positive.	Data quality.	Output	%	Quarterly	No	Reduction of TB incidence	DHS, Specialised & Clinical Support Services
2013 NIDS: *HIV positive new client initiated on IPT rate*	*Proportion of eligible clients initiated on IPT*	*Monitors initiation of Isoniazid preventive therapy (IPT) to prevent TB*	*DHIS*	***Numerator*** *SUM([HIV positive client initiated on IPT])* ***Denominator*** *SUM([HIV positive client eligible for IPT])*	*Data quality.*	*Output*	*Rate*	*Quarterly*	*No*	*Reduction of TB incidence*	*DHS, Specialised & Clinical Support Services*
Percentage of TB/HIV co-infected patients initiated on CPT	The proportion of TB/HIV positive clients' newly eligible started co-trimoxazole prophylaxis during the reporting period.	Preventive therapy	DHIS	**Numerator** TB/HIV positive new patients started on co-trimoxazole prophylaxis **Denominator** HIV test positive new (excluding ANC) + ANC client tested HIV positive new	Data quality	Output	%	Quarterly	Yes	Manage TB/HIV prevalence	DHS, Specialised & Clinical Support Services
2013 NIDS: *TB/HIV co-infected client initiated on CPT rate*	*Proportion of TB/HIV co-infected clients initiated on co-trimoxazole prophylaxis therapy (CPT)*	*Monitors CPT initiation for TB/HIV co-infected clients to prevent opportunistic infections*	*DHIS*	***Numerator*** *SUM([HIV/TB co-infected client initiated on CPT])* ***Denominator*** *SUM([HIV/TB co-infected client - total])*	*Data quality*	*Output*	*Rate*	*Quarterly*	*Yes*	*Manage TB/HIV prevalence*	*DHS, Specialised & Clinical Support Services*
STI treated new episode incidence	The proportion of people 15 years and older that have been treated for a new episode of an STI.	Monitor spread, identification, treatment of STIs, and effectiveness of prevention programmes.	DHIS	**Numerator** STI treated new episode **Denominator** Population 15 years and older	Data quality – data only refers to clients treated at public health facilities.	Outcome	%	Annual	No	Decrease in STIs	DHS, Specialised & Clinical Support Services

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
2013 NIDS: *STI treated new episode incidence (annualised)*	*Proportion of people 15 years and older treated for a new episode of STI (annualised)*	*Monitors treatment of STIs, which include HIV and more than 20 disease-causing organisms and syndromes, of which some also can cause cancer (NSP 2012/2016:7)*	*DHIS*	***Numerator*** *SUM([STI treated new episode])* ***Denominator*** *SUM([Female 15-44 years]) + SUM([Male 15-44 years]) + SUM([Female 45 years and older]) + SUM([Male 45 years and older])*	*Data quality – data only refers to clients treated at public health facilities.*	*Outcome*	*%*	*Annual*	*No*	*Decrease in STIs*	*DHS, Specialised & Clinical Support Services*
Number of MDR-TB cases registered	*The number of MDR-TB cases registered in a specific time period (incl. new + previously Treated)*	*MDR-TB surveillance*	*EDR Web; Surveys*	*Total number of MDR-TB patients that have registered on treatment.*	*Data quality*	*Quality; Output*	*Number*	*Quarterly*	*Yes*	*A higher figure might indicate good case finding while lesser figure regardless of intensified case finding may indicate decreasing disease incidence*	*DHS, Specialised & Clinical Support Programmes*
2013 NIDS: *TB MDR Death Rate*	*Proportion MDR-TB patients who died during treatment period.*	*Monitors death during MDR TB treatment period. The casue of death may not necessarily be due to TB.*	*EDR Web*	***Numerator*** *SUM([TB MDR client death during treatment])* ***Denominator*** *SUM([TB MDR confirmed client initiated on treatment])*	*Data quality*	*Quality; Output*	*%*	*Quarterly*	*Yes*	*A lower figure indicates good treatment success.*	*DHS, Specialised & Clinical Support Programmes*
2013 NIDS: *TB MDR treatment success rate*	*Proportion MDR-TB patients successfully treated (cured and completed treatment)*	*Monitors success of MDR TB treatment*	*ETR.Net*	***Numerator*** *SUM ([TB MDR client successfully treated]).* ***Denominator*** *SUM([TB MDR confirmed client initiated on treatment])*	*Data quality*	*Quality; Outcome*	*Rate*	*Quarterly*	*Yes*	*A higher figure indicates good treatment success.*	*DHS, Specialised & Clinical Support Programmes*
Number of XDR-TB cases registered	*The number of XDR-TB cases registered in a specific time period (incl. new + previously Treated)*	*XDR-TB surveillance*	*EDR Web; Surveys*	*Total number of XDR-TB patients registered on treatment.*	*Data quality*	*Quality, Output*	*Number*	*Quarterly*	*Yes*	*A higher figure might indicate good case finding while lesser figure regardless of intensified case finding may indicate decreasing disease incidence.*	*DHS, Specialised & Clinical Support Programmes*
2013 NIDS: *TB XDR death rate*	*Proportion XDR-TB patients who died during treatment.*	*Monitors death during XDR TB treatment period. The casue of death may not necessarily be due to TB.*	*EDR Web*	***Numerator*** *SUM([TB XDR client death during treatment])* ***Denominator*** *SUM([TB XDR confirmed client initiated on treatment])*	*Data quality*	*Quality, Outcome*	*Rate*	*Quarterly*	*Yes*	*A lower figure indicates good treatment success.*	*DHS, Specialised & Clinical Support Programmes*

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
2013 NIDS: *TB XDR treatment success rate*	*Proportion XDR-TB patients successfully treated (cured and completed treatment)*	*Monitors success of XDR TB treatment*	*ETR.net*	***Numerator*** *SUM([TB XDR client successfully treated])* ***Denominator*** *SUM([TB XDR confirmed client initiated on treatment])*	*Data quality*	*Quality, Outcome*	*Rate*	*Quarterly*	*Yes*	*A higher figure indicates good treatment success.*	*DHS, Specialised & Clinical Support Programmes*

SUB-PROGRAMME: MATERNAL, CHILD AND WOMAN HEALTH

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Immunisation coverage under 1 year	Percentage of all children in the target area under one year who complete their primary course of immunisation during the month (annualised). A Primary Course includes BCG, OPV 1,2 & 3, DTP-Hib 1,2 & 3, Hep B 1,2 & 3, and 1st measles at 9 month.	Reduce vaccine preventable diseases.	DHIS	**Numerator** Immunised fully under 1 year **Denominator** Population under 1-year	Reliant on under 1 population estimates from StatsSA	Output	% (annualised)	Quarterly	No	Improved coverage to reduce disease preventable diseases.	DHS
2013 NIDS: *Immunisation coverage under 1 year (annualised)*	*Proportion children under 1 year who completed their primary course of immunisation*	*The child should only be 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*	*DHIS*	***Numerator*** *SUM([Immunised fully under 1 year new])* ***Denominator*** *SUM([Female 1 year]) + SUM([Male under 1 year])*	*Reliant on under 1 population estimates from StatsSA*	*Output*	*% (annualised)*	*Quarterly*	*No*	*Higher percentage indicate better immunisation coverage*	*EPI Programme Manager*
Vitamin A coverage under 12 – 59 months	Percentage of children 12-59 months receiving vitamin A 200,000 units twice a year.	Monitor the Vitamin A supplementation as part of child health strategy to reduce morbidity and mortality. The denominator is multiplied by 2 to make provision for the 2 doses per year.	DHIS	**Numerator** Total Vitamin A supplement to 12-59 months children **Denominator** Target population 1-4 years x2	*Reliant on child population estimates from StatsSA*	Output	% (annualised)	Quarterly	No	Higher percentage indicates better Vitamin A coverage, supporting child health strategies.	DHS, Specialised & Clinical Support Services
2013 NIDS: *Vitamin A 12-59 months coverage (annualised)*	*Proportion of children 12-59 months who received vitamin A 200,000 units every six months*	*Monitors vitamin A supplementation to children aged 12-59 months. The denominator is multiplied by 2 because each child should receive supplementation twice a year*	*DHIS*	***Numerator*** *SUM([Vitamin A 12-59 months])* ***Denominator*** *(SUM([Female 1 year]) + SUM([Female 02-04 years]) + SUM([Male 1 year]) + SUM([Male 02-04 years])) * 2*	*Reliant on child population estimates from StatsSA*	*Output*	*% (annualised)*	*Quarterly*	*No*	*Higher percentage indicate better Vitamin A coverage, and better nutritional support to children*	*Nutrition Programme Manager*

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Measles 1st dose under 1 year coverage	Percentage of children under 1 year who received the 1st measles dose before their first birthday.	Elimination of measles.	DHIS	**Numerator** Measles 1st dose before 1 year **Denominator** Population under 1 year	Data quality and population estimate	Output	% (annualised)	Quarterly	No	Higher coverage will support elimination of measles.	DHS, Specialised & Clinical Support Services
2013 NIDS: *Measles 1st dose under 1 year coverage (annualised)*	*Proportion children under 1 year who received measles 1st dose, normally at 9 months*	*Monitors protection of children less than 1 year of age against measles. Vaccines given as part of mass vaccination campaigns should not be counted here*	*DHIS*	***Numerator*** *SUM([Measles 1st dose under 1 year])* ***Denominator*** *SUM([Female under 1 year]) + SUM([Male under 1 year])*	*Reliant on under 1 population estimates from StatsSA*	*Output*	*% (annualised)*	*Quarterly*	*No*	*Higher percentage indicate better Measles coverage*	*EPI Programme Manager*
Pneumococcal vaccine (PCV) 3st dose coverage	Percentage of children under 1 year who received Pneumococcal 3st dose	Monitor the Pneumococcal coverage in relation to reduction of pneumonia incidence in children less than 5 years.	DHIS	**Numerator** Pneumococcal 3rd doses before 1 year **Denominator** Population under 1 year	Data quality and population estimates.	Output	% (annualised)	Quarterly	No	Higher coverage supporting reduced pneumonia incidence under-5 years.	DHS, Specialised & Clinical Support Services
2013 NIDS: *PCV 3rd dose coverage (annualised)*	*Proportion children under 1 year who received PCV 3rd dose, normally at 9 months*	*Vaccines given as part of mass vaccination campaigns should not be counted here*	*DHIS*	***Numerator*** *SUM([PCV 3rd dose under 1 year])* ***Denominator*** *SUM([Female under 1 year]) + SUM([Male under 1 year])*	*Reliant on under 1 population estimates from StatsSA*	*Output*	*% annualised*	*Quarterly*	*No*	*Higher percentage indicate better Pneumococcal coverage*	*EPI Programme Manager*
Rota Virus (RV) 2nd dose coverage	Percentage of children under 1 year who received Rota Virus 2nd dose	Monitor coverage in relation to reduction in diarrhoea incidence in children under-5 years.	DHIS	**Numerator** Rota Virus 2nd doses before 1 year **Denominator** Population under 1 year	Data quality and population estimates	Output	% (annualised)	Quarterly	No	Higher coverage supporting reduced diarrhoea incidence in children under-5 years.	DHS, Specialised & Clinical Support Services
2013 NIDS: *RV 2nd dose coverage (annualised)*	*Proportion children under 1 year who received RV 2nd dose, normally at 14 weeks but NOT later than 24 weeks*	*Monitors protection of children against rota virus. Vaccines given as part of mass vaccination campaigns should not be counted here*	*DHIS*	***Numerator*** *SUM([RV 2nd dose under 1 year])* ***Denominator*** *SUM([Female under 1 year]) + SUM([Male under 1 year])*	*Reliant on under 1 population estimates from StatsSA*	*Output*	*% Annualised*	*Quarterly*	*No*	*Higher percentage indicate better Rota Virus coverage*	*EPI Programme Manager*

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Cervical cancer screening coverage	Percentage of women from 30 years and older who received a routine Pap smear to screen for abnormal cells of the cervix.	Improved screening and management of abnormal smears that will contribute to the reduction in cervical cancer incidence.	DHIS	**Numerator** Cervical smear in woman 30-years and older **Denominator** 10% of female population 30-59 years	Data quality (including differentiation between routine and diagnostic smears) and population estimates.	Output	% (annualised)	Quarterly	No	Improved screening coverage (70% of target population) reduce cervical cancer incidence.	DHS, Specialised & Clinical Support Services
2013 NIDS: *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*	*Monitors implementation of policy on cervical screening*	*DHIS*	***Numerator*** *SUM([Cervical cancer screening 30 years and older])* ***Denominator*** *(SUM([Female 30-34 years]) + SUM([Female 35-39 years]) + SUM([Female 40-44 years]) + SUM([Female 45 years and older])) / 10*	*Reliant on population estimates from StatsSA for women in age category 30 – 59 years*	*Output*	*% (annualised)*	*Quarterly*	*No*	*Higher percentage indicates better cervical cancer screening coverage*	*MNCWH Programme Manager*
Antenatal visits before 20 weeks rate	The percentage of pregnant women who have an antenatal care booking (first visit) before their 20th week of pregnancy.	Early antenatal care (ANC) ensures early intervention and appropriate management of high risk pregnancies.	DHIS	**Numerator** Antenatal 1st visits before 20 weeks **Denominator** Antenatal 1st visits	Data quality	Process	Rate	Quarterly	No	Early ANC attendance and more effective management of high risk pregnancies to reduce morbidity and mortality.	DHS, Specialised & Clinical Support Services
2013 NIDS: *Antenatal 1st visit before 20 weeks rate*	*Women who have a booking visit (first visit) before they are 20 weeks (about half way) into their pregnancy as proportion of all antenatal 1st visits*	*Monitors early utilisation of antenatal services*	*DHIS*	***Numerator*** *SUM([Antenatal 1st visit before 20 weeks])* ***Denominator*** *SUM([Antenatal 1st visit 20 weeks or later]) + SUM([Antenatal 1st visit before 20 weeks])*	*Reliant on accuracy of number of weeks the client is pregnant*	*Process*	*Rate*	*Quarterly*	*No*	*Higher percentage indicates better access to antenatal care*	*MNCWH Programme Manager*
Baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks	The number of babies who test positive for HIV at 6 weeks as a proportion of the total number tested at 6 weeks.	Track mother to child transmission of HIV.	DHIS	**Numerator** Number of babies who tested PCR positive at 6 weeks after birth **Denominator** Total number of babies tested at 6 weeks after birth	Quality of data – poor reporting/ recording	Outcome	%	Quarterly	No	Lower % indicates that PMTCT programme is working	DHS, Specialised & Clinical Support Services

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
2013 NIDS: *Infant 1st PCR test positive within 2 months rate*	*Infants tested PCR positive for the first time within 2 months after birth as proportion of Infants PCR tested within 2 months*	*Monitors positivity in HIV exposed Infants within 2 months*	*DHIS*	***Numerator*** *SUM([Infant 1st PCR test positive within 2 months])* ***Denominator*** *SUM([Infant 1st PCR test within 2 months])*	*Quality of data – poor reporting/ recording*	*Outcome*	*Rate*	*Quarterly*	*Yes*	*Lower*	*PMTCT Programme*
Couple Year Protection Rate	Percentage of women of reproductive age (15-44) who are using (or whose partner is using) a modern contraceptive method. Contraceptive methods include female and male sterilisation , injectable, and oral hormones, intrauterine devices, diaphragms, spermicides and condoms. Contraceptive years are the total of (Oral pill cycles / 13) + (Medroxyprogesterone injection / 4) + (Norethisterone Enanthate injection / 6) + (IUCD x 4) +)Male condoms distributed / 200) + (Male sterilisation x 20) + (Female sterilisation x 10)	Track contraception use as part of prevention programmes to reduce morbidity and mortality.	DHIS SADHS	**Numerator** Contraceptive years equivalent = Sum: • Male sterilisations x 20 • Female sterilisations x10 • Medroxyprogesterone injection /4 • Norethisterone Enanthate injection /6 • Oral pill cycles /13 • IUCD x 4 • Male condoms /500 **Denominator** Female target population 15-44 years	Reliant on accuracy of data collection	Output	Rate	Annual	No	High rate indicating improved protection against high risk pregnancies and reduction in morbidity and mortality.	DHS, Specialised & Clinical Support Services
2013 NIDS: *Couple year protection rate (annualised)*	*Women protected against pregnancy by using modern contraceptive methods, including sterilisations, as proportion of female population 15-44 year. Contraceptive years are the total of (Oral pill cycles / 13) + (Medroxyprogesterone injection / 4) + (Norethisterone Enanthate injection / 6) + (IUCD x 4) +)Male condoms distributed / 200) + (Male sterilisation x 20) + (Female sterilisation x 10)*	*Monitors access to and utilisation of modern contraceptives to prevent unplanned pregnancies. Serves as proxy for the indicator contraceptive prevalence rate by monitoring trends between official surveys*	*DHIS*	***Numerator*** • *(SUM([Oral pill cycle]) / 13) +* • *(SUM([Medroxyprogesterone injection]) / 4) +* • *(SUM([Norethisterone Enanthate injection]) / 6) +* • *(SUM([IUCD inserted]) * 4) +* • *(SUM([Male condoms distributed]) / 200) +* • *(SUM([Sterilisation - male]) * 20) +* • *(SUM([Sterilisation - female]) * 10)* ***Denominator*** *SUM([Female 15-44 years])*	*Reliant on accuracy of data collection*	*Outcome*	*Rate*	*Annual*	*No*	*Higher protection levels are desired*	*MNCWH Programme Manager*

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Facility Maternal Mortality Ratio	Number of maternal deaths in facility expressed per 100 000 live births. A maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (as cited in ICD 10).	Monitoring and assessing causes of reported maternal deaths to reduce preventable causes of death and reduce maternal and neonatal mortality.	DHIS	**Numerator** Number maternal deaths in facility **Denominator** Number of live births in facility	Effective reporting of maternal deaths including reporting from private facilities and community.	Outcome	Ratio per 100 000 live births	Annual	No	Effective reporting and assessment reduce avoidable causes of death and reduce maternal and neonatal morbidity and mortality.	DHS, Specialised & Clinical Support Services
2013 NIDS: *Maternal mortality in facility ratio (annualised)*	*Women who died in hospital as a result of childbearing, during pregnancy or within 42 days of delivery or termination of pregnancy, per 100,000 live births in facility*	*This is a proxy for the population-based maternal mortality ratio, aimed at monitoring trends in health facilities between official surveys. Focuses on obstetric causes (around 30% of all maternal mortality). Provides indication of health system results in terms of prevention of unplanned pregnancies, antenatal care, delivery and postnatal services*	*DHIS*	***Numerator*** *SUM([Maternal death in facility])* ***Denominator*** *SUM([Live birth in facility])*	*Reliant on accuracy of classification of inpatient death*	*Outcome*	*Ratio per 100 000 live births*	*Annual*	*No*	*Lower institutional rate indicate fewer avoidable deaths*	*MNCWH Programme Manager*
Delivery rate for women under 18 years	Percentage of deliveries where the mother is under 18 years on the day of delivery.	Monitor teenage pregnancies/ deliveries to inform prevention strategies.	DHIS	**Numerator** Total number of deliveries to woman under 18 years **Denominator** Total deliveries in facilities	Data quality and accuracy	Outcome	Rate	Annual	No	Delivery rate will provide an indication of effectiveness of prevention programmes.	DHS, Specialised & Clinical Support Services
2013 NIDS: *Delivery in facility under 18 years rate*	*Deliveries to women under the age of 18 years as proportion of total deliveries in health facilities*	*Monitors success in prevention of teenage pregnancies*	*DHIS*	***Numerator*** *SUM([Delivery in facility under 18 years])* ***Denominator*** *SUM([Delivery in facility total])*	*Data completeness, quality and accuracy*	*Outcome*	*Rate*	*Annual*	*No*	*Higher percentage indicates increase in the number of deliveries among teenagers*	*MNCWH Programme Manager*

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Facility Infant mortality (under 1 years) rate	The number of children who have died in a health facility between birth and their first birthday, expressed per thousand live births in facility	Monitor trends to determine effectiveness of prevention and promotion strategies, health behaviour and burden of disease.	DHIS	**Numerator** Total number of inpatient deaths under one year **Denominator** Inpatients separations under 1 year (Sum of Inpatient discharge < 1 year and Inpatient transfer out < 1)	Data quality	Outcome	Rate	Annual	No	Lower infant mortality rate	DHS, Specialised & Clinical Support Services
2013 NIDS: *Child under 1 year mortality in facility rate*	*Admitted children under 1 year of age who died per estimated 1,000 live births. Estimated live births in population are calculated by multiplying estimated population under 1 year by 1.03 to compensate for infant mortality.*	*Includes neonatal deaths. Estimated live births in population is calculated by multiplying estimated population under 1 year by 1.03 to compensate for infant mortality. This indicator will be useful at a national, provincial and district level.*	*DHIS*	***Numerator*** *SUM([Inpatient death under 1 year])* ***Denominator*** *SUM([Female under 1 year])+SUM([Male under 1 year])*1.03*	*Data completeness, quality and accuracy*	*Impact*	*Rate*	*Monthly*	*Yes*	*Lower infant mortality rate*	*DHIS, Specialised & Clinical support services*
Facility neonatal mortality rate	The number of neonates who have died in a health facility between birth and 28 days, expressed per thousand live births in facility	Monitor trends to determine effectiveness of prevention and promotion strategies, health behaviour and burden of disease.	DHIS	**Numerator** Number of inpatient deaths- neonatal **Denominator** Number of live births	Data quality	Outcome	Rate	Annual	No	Lower neonatal mortality rate	DHS, Specialised & Clinical Support Services
2013 NIDS: *Neonatal mortality in facility rate (annualised)*	*Inpatient deaths within the first 28 days of life per 1,000 estimated live births. Estimated live births in population is calculated by multiplying estimated population under 1 year by 1.03 to compensate for infant mortality*	*Proxy indicator for the population based Neonatal Mortality Rate. Monitors trends in neonatal mortality in health facilities between official surveys. Indication of health system results in terms of antenatal, delivery and neonatal care*	*DHIS*	***Numerator*** *SUM([Inpatient death early neonatal])* ***Denominator*** *(SUM([Female under 1 year]) + SUM([Male under 1 year])) * 1.03*	*Data quality*	*Outcome*	*Rate (annualised)*	*Annual*	*Yes*	*Lower neonatal mortality rate*	*DHS, Specialised & Clinical Support Services*

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Facility child mortality (under 5 years) rate	The number of children who have died in a health facility between birth and their fifth birthday, expressed per thousand live births in facility	Monitor trends to determine effectiveness of prevention and promotion strategies, health behaviour and burden of disease.	DHIS	**Numerator** Total number of inpatient deaths under 5 years **Denominator** Inpatients separations under 5 year (Sum of Inpatient discharge < 5 year and Inpatient transfer out < 5)	Data quality	Outcome	Rate	Annual	No	Lower children mortality rate	DHS, Specialised & Clinical Support Services
2013 NIDS: *Inpatient death under 5 year rate*	*Proportion of children under 5 years admitted/separated who died during their stay in the facility. Inpatient separations under 5 years is the total of inpatient discharges, inpatient deaths and inpatient transfer outs*	*Monitors treatment outcome for admitted children under 5 years. Includes under 1 year deaths*	*DHIS*	***Numerator*** *SUM([Inpatient death under 5 years])* ***Denominator*** *SUM([Inpatient death under 5 years]) + SUM([Inpatient discharge under 5 years]) + SUM([Inpatient transfer out under 5 years])*	*Data quality*	*Outcome*	*Rate*	*Annual*	*No*	*Lower children mortality rate*	*DHS, Specialised & Clinical Support*
% of pregnant women tested for HIV	The proportion of pregnant women who are tested for HIV during the ANC period.	Track the number of ANC clients tested for HIV in support of improved PMTCT Programme and reduction of maternal mortality.	DHIS	**Numerator** Number of ANC clients tested for HIV. **Denominator** Number of ANC clients 1st visit	Data quality and completeness from reporting facilities.	Output	%	Quarterly	No	Increased testing will have an impact on the success of the PMTCT and HIV Programme.	DHS, Specialised & Clinical Support Services
% of eligible pregnant women placed on HAART	HIV-positive antenatal (ANC) clients initiated on HAART as a proportion of HIV-positive antenatal clients with CD4 count under the specified threshold and/or WHO staging of 4.	Monitor the effective implementation of the PMTCT Programme.	DHIS	**Numerator** Number of Antenatal client initiated on HAART **Denominator** Number of Antenatal clients eligible for HAART	Data quality and completeness from reporting facilities.	Output	%	Quarterly	No	Improved PMTCT outcomes	DHS, Specialised & Clinical Support Services
2013 NIDS: *Antenatal client initiated on ART rate*	*HIV positive antenatal clients initiated on ART as proportion of HIV positive antenatal clients with CD4 counts under the specified threshold and/or WHO staging of 4*	*Monitors implementation of PMTCT guidelines in terms of ART initiation*	*DHIS*	***Numerator*** *SUM([Antenatal client INITIATED on ART])* ***Denominator*** *SUM([Antenatal client eligible for ART])*	*Data quality and completeness from reporting facilities.*	*Output*	*Rate*	*Quarterly*	*No*	*Improved PMTCT outcomes*	*DHS, Specialised & Clinical Support Services*
Baby Nevirapine uptake rate	Babies (including born before arrival and known home deliveries) given Nevirapine within 72 hours after birth as proportion to live births to HIV positive women.	Improved PMTCT outcomes.	DHIS	**Numerator** Babies given Nevirapine within 72 hours after birth **Denominator** Live births to HIV positive women	Data quality	Output	Rate	Quarterly	Yes	Improved PMTCT outcomes.	DHS, Specialised & Clinical Support Services

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
2013 NIDS: *Infant given NVP within 72 hours after birth uptake rate*	*Babies given NVP within 72 hours of birth as proportion of live births to HIV positive women*	*Monitors implementation of the PMTCT guidelines in terms of NVP for HIV exposed babies*	*DHIS*	***Numerator*** *SUM([Infant given NVP within 72 hours after birth])* ***Denominator*** *SUM([Live birth to HIV positive woman])*	*Data quality*	*Output*	*Rate*	*Quarterly*	*Yes*	*Improved PMTCT outcomes.*	*DHS, Specialised & Clinical Support Services*
Number of diarrhoea cases – children under-5 years	The total number of diarrhoea cases (children under 5 years) seen in public health facilities. (Formally defined as 3 or more watery stools in 24 hours – but any episode diagnosed or treated is counted).	Monitor the trend in diarrhoea cases – link with rotavirus vaccine coverage and child mortality (MDG 4).	DHIS	Number of diarrhoea cases in children under 5 years – new ambulatory (including diarrhoea with and without dehydration)	Quality of data from reporting facility and effective reporting system.	Outcome	Number	Quarterly	No	Reduction in reported cases of diarrhoea.	DHS, Specialised & Clinical Support Services
Child under 5 years diarrhoea with dehydration incidence (annualised)	Children under 5 years newly diagnosed with diarrhoea with dehydration per 1,000 children under 5 years in the population	Monitors 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 should not be counted here	DHIS	**Numerator** SUM([Child under 5 years diarrhoea with dehydration new]) **Denominator** SUM([Female under 5 years]) + SUM([Male under 5 years])	Data quality	Outcome	Number per 1000 population	Quarterly	Yes	Improved coverage of Rotavirus vaccine reduce incidence	DHS, Specialised & Clinical Support Services
Number of pneumonia cases – children under-5 years	The total number of pneumonia cases (children under 5 years) seen in public health facilities.	Monitor the trend in pneumonia cases – link with pneumococcal vaccine coverage and child mortality (MDG 4).	DHIS	Number of children under 5 years reporting with pneumonia in reporting period. Number of pneumonia cases – new ambulatory in children under 5 years	Quality of data from reporting facility and effective reporting system.	Outcome	Number	Quarterly	No	Track progress towards MDG's.	DHS, Specialised & Clinical Support Services
2013 NIDS: *Child under 5 years with pneumonia new*	*Child under 5 years newly diagnosed with pneumonia. EXCLUDE referrals from other state health facilities*	*Monitor the trend in pneumonia cases – link with pneumococcal vaccine coverage and child mortality (MDG 4).*	*DHIS*	*Child under 5 years newly diagnosed with pneumonia. EXCLUDE referrals from other state health facilities*	*Quality of data from reporting facility and effective reporting system.*	*Outcome*	*Number*	*Quarterly*	*No*	*Track progress towards MDG's.*	*DHS, Specialised & Clinical Support Services*
Child under 5 years pneumonia incidence (annualised)	Children under 5 years newly diagnosed with pneumonia per 1,000 children under 5 years in the population	Monitors 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 should not be counted here	DHIS	**Numerator** SUM([Child under 5 years with pneumonia new]) **Denominator** SUM([Female under 5 years]) + SUM([Male under 5 years])	Data quality	Outcome	Number per 1000 population	Quarterly	Yes	Improved coverage of Pneumococcal vaccine reduce incidence	DHS, Specialised & Clinical Support Services

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Underweight for age under 5 years incidence - annualised	The proportion of all children under 5 years weighed who were identified as being below the third centile but equal to or over 60% of estimated weight for age on the Road to Health Chart (excluding newborn babies).	Early detection and treatment of malnutrition.	DHIS	**Numerator** Underweight for age under 5 years – new cases **Denominator** Catchment population under 5 years	Data quality	Outcome	%	Annual	Yes	Improved detection of nutritional deficiencies as part of prevention and management to improve child health outcomes.	DHS, Specialised & Clinical Support Services
Not gaining weight rate under 5 years	The proportion of children weighed who has had an episode of growth faltering or failure during the same period.	Early detection and treatment of malnutrition.	DHIS	**Numerator** Number of children under 5 years not gaining weight **Denominator** Children under 5 years weighed	Data quality	Outcome	Rate	Quarterly	Yes	Improved detection of nutritional deficiencies as part of prevention and management to improve child health outcomes	DHS, Specialised & Clinical Support Services
Severe malnutrition under 5 years incidence	The number of severely malnourished children detected as per 1000 population under 5 years.	Monitor nutritional status of children as critical component of child health.	DHIS	**Numerator** Severe malnutrition under 5 years – new ambulatory **Denominator** Population under 5 years	Data quality	Outcome	%	Annual	Yes	Reduced incidence may be an indication of improved socio-economic conditions, prevention and promotion and improved management of malnutrition.	DHS, Specialised & Clinical Support Services
2013 NIDS: *Child under 5 years severe acute malnutrition incidence (annualised)*	*Children under 5 years newly diagnosed with severe acute malnutrition per 1,000 children under 5 years in the population*	*Monitors prevention and diagnosis of severe acute malnutrition in children less than 5 years. Count only once when diagnosed. Follow-up visits for the same episode of malnutrition should not be counted here*	*DHIS*	***Numerator*** *SUM([Child under 5 years with severe acute malnutrition new])* ***Denominator*** *SUM([Female under 5 years]) + SUM([Male under 5 years])*	*Accuracy dependent on quality of data from reporting facility*	*Outcome*	*Number per 1000 children under 5 yearrs*	*Quarterly* *(Indicator must be annualised)*	*No*	*Lower levels of prevalence of underweight (children under 5) are desired*	*Epidemiology, DHS, Specialised & Clinical Support Services*
Postpartum care baby visits within 6 days rate	The proportion of mothers and babies, compared to total deliveries that receive a follow-up visit at a health facility within 6 days of delivery.	Monitor the access and utilisation of postpartum health services as part of effective maternal care.	DHIS	**Numerator** Postnatal care baby within 6 days of birth **Denominator** Total deliveries in facility	Reliant on accuracy of gestation period as well as reporting from facilities and reliable information systems.	Output	Rate	Quarterly	No	Increased utilisation of postpartum services will improve maternal & infant health outcomes (MDG 4 and 5). Reduced morbidity & mortality	DHS, Specialised & Clinical Support Services

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Postnatal care mothers visit within 6 days rate	The proportion of mothers and babies, compared to total deliveries that receive a follow-up visit at a health facility within 6 days of delivery.	Monitor the access and utilisation of postpartum health services as part of effective maternal care.	DHIS	**Numerator** Postnatal care mother within 6 days of delivery **Denominator** Total deliveries in facility	Reliant on accuracy of gestation period as well as reporting from facilities and reliable information systems.	Output	Rate	Quarterly	No	Increased utilisation of postpartum services will improve maternal & infant health outcomes (MDG 4 and 5). Reduced morbidity & mortality	DHS, Specialised & Clinical Support Services
2013 NIDS: *Mother postnatal visit within 6 days rate*	*Mothers who received postnatal care within 6 days after delivery as proportion of deliveries in health facilities*	*Monitors access to and utilisation of postnatal services. May be more than 100% in areas with low delivery in facility rates if many mothers who delivered outside health facilities used postnatal visits within 6 days after delivery*	*DHIS*	***Numerator*** *SUM([Mother postnatal visit within 6 days after delivery])* ***Denominator*** *SUM([Delivery in facility total])*	*Reliant on accuracy of gestation period as well as reporting from facilities and reliable information systems.*	*Output*	*Rate*	*Quarterly*	*No*	*Increased utilisation of postpartum services will improve maternal & infant health outcomes (MDG 4 and 5).* *Reduced morbidity & mortality*	*DHS, Specialised & Clinical Support Services*

SUB-PROGRAMME: DISEASE CONTROL AND PREVENTION

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Malaria case fatality rate (annual)	Deaths from malaria as a percentage of the number of cases reported	Monitor the number deaths caused by Malaria	DHIS	**Numerator** Deaths from malaria **Denominator** Total number of Malaria cases reported	Accuracy dependant on quality of data from health facilities	Outcome	Rate	Annual	No	Lower percentage indicates a decreasing burden of malaria	DHS, Specialised & Clinical Support Services
Cholera fatality rate (annual)	Deaths from cholera as a percentage of the number of cases reported	Monitor the number deaths caused by Cholera	CDC	**Numerator** Deaths from Cholera **Denominator** Total number of cholera cases reported	Accuracy dependant on quality of data from health facilities	Outcome	Rate	Annual	No	Lower percentage indicates a decreasing burden of cholera	DHS, Specialised & Clinical Support Services
Cataract surgery rate (annual)	Cataract operations completed per 1,000,000 population	Monitor the number of cataract surgery	DHIS	**Numerator** Cataract operations completed **Denominator** Total population	Accuracy dependant on quality of data from health facilities	Outcome	Rate per 1mil population	Annual	No	Higher levels reflects a good contribution to sight restoration, especially amongst the elderly population	DHS, Specialised & Clinical Support Services

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
2013 NIDS: *Cataract surgery rate (annualised)*	*Clients who had cataract surgery per 1 million uninsured population*	*Monitors access to cataract surgery. A client with surgery on both eyes within a short time period should be counted as one case*	*DHIS*	***Numerator*** *SUM([Cataract surgery total])* ***Denominator*** *SUM([Total population]) - SUM([Total population (Medical Aid)])*	*Accuracy dependant on quality of data from health facilities*	*Outcome*	*Rate per 1mil population*	*Annual*	*No*	*Higher levels reflects a good contribution to sight restoration, especially amongst the elderly population*	*Non-communicable diseases*
Malaria incidence per 1000 population at risk.	New malaria cases as proportion of 1000 population at risk.	Monitor the new malaria cases as proportion of the population at risk to monitor performance in relation to MDG 6.	DQPR	**Numerator** Number of new malaria cases reported. **Denominator** Population at risk.	Accuracy dependant on quality of data and effective information systems.	Outcome	Number per 1000 population	Annual	No	Reduced incidence indicates improved prevention strategies.	DHS, Specialised & Clinical Support Services .
Indoor residential spraying coverage	Proportion of houses sprayed as strategy to prevent malaria.	Monitor spraying as part of prevention strategy.	CDC	**Numerator** Number of residences sprayed **Denominator** Total number of residences	Data quality	Output	%	Annual	Yes	Improved spraying contributing to maintaining prevention strategies.	DHS, Specialised & Clinical Support Services

SUB-PROGRAMME: FORENSIC PATHOLOGY SERVICES

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Percentage of paupers stored for longer than three months	Percentage of unclaimed / un identified bodies that have been stored in the mortuary for longer than 3 months as a proportion of total number of paupers in the mortuary	To monitor compliance with National legislation regarding pauper burials, OHS, QA, and IPC	FPS	**Numerator** Number of paupers stored for longer than 3 months **Denominator** Total number of paupers in the mortuary	Data quality	Quality	%	Quarterly	Yes	Lower % indicates an improved standard of compliance	General manager FPS
Percentage of mortuary facilities that have been audited in terms of quality assurance	Percentage of mortuary facilities that have been audited in terms of quality assurance as a proportion of the total number of mortuary facilities in the province	To fast rack the implementation of the National Core Standards and monitor compliance	FPS	**Numerator** Number of mortuary facilities that have been audited **Denominator** Total number of mortuary facilities in the Province	None	Quality	%	Quarterly	Yes	Higher % indicates increased standard of compliance	Clinical Forensic Manager

PROGRAMME 3: EMERGENCY MEDICAL & PATIENT TRANSPORT SERVICES

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Rostered ambulances per 10 000 population	Number of all rostered ambulances per 10 000 people	Monitor availability of resources to render effective EMS.	EMS Information Systems	**Numerator** Total number of roistered ambulances **Denominator** Total population	Data quality	Input	Ratio per 10,000 people	Quarterly	No	Higher number of rostered ambulances will improve efficiency and effectiveness of EMS.	Specialised & Clinical Support Services, DHS
2013 NIDS: *EMS operational ambulance coverage (annualised)*	*Number of operational ambulances per 10 000 population*	*Monitors compliance with the norm for operational ambulances to meet population needs. This includes obstetric ambulances*	*EMS Information Systems*	***Numerator*** *SUM([EMS operational ambulances])* ***Denominator*** *SUM([Total population])*	*Data quality*	*Input*	*Ratio per 10,000 people*	*Quarterly*	*No*	*Higher number of rostered ambulances will improve efficiency and effectiveness of EMS.*	*Specialised & Clinical Support Services, DHS*
P1 calls with a response of time <15 minutes in an urban area	Percentage of P1 call outs to urban locations with response times within national urban target (15 min)	Monitor response times to determine efficiency and quality of EMS.	EMS Information Systems	**Numerator** Number of P1 urban call outs with response time under 15 minutes **Denominator** Total number of P1 call outs in urban areas	Accuracy dependant on quality of data from reporting EMS station	Quality	%	Quarterly	No	Higher percentage indicate better response times in the urban area	Specialised & Clinical Support Services, DHS
2013 NIDS: *EMS P1 urban response under 15 minutes rate*	*Proportion P1 calls in urban locations with response times under 15 minutes*	*Monitors compliance with the norm for critically ill or injured clients to receive EMS within 15 minutes in urban areas*	*EMS Information Systems*	***Numerator*** *SUM([EMS P1 urban response under 15 minutes])* ***Denominator*** *SUM([EMS P1 urban calls])*	*Accuracy dependant on quality of data from reporting EMS station*	*Output*	*%*	*Quarterly*	*No*	*Higher percentage indicate better response times in the urban area*	*Specialised & Clinical Support Services, DHS*
P1 calls with a response time of <40 minutes in a rural area	Percentage of P1 call outs to rural locations with response times within national rural target (40 min)	Monitor response times within national rural target. Monitor response times to determine efficiency and quality of EMS.	EMS Information Systems	**Numerator** Number of P1 rural call outs with response time under 40 minutes **Denominator** Total number of P1 call outs in rural areas	Accuracy dependant on quality of data from reporting EMS station	Quality	%	Quarterly	No	Higher percentage indicates improved efficiency.	Specialised & Clinical Support Services, DHS
2013 NIDS: *EMS P1 rural response under 40 minutes rate*	*Proportion P1 calls in rural locations with response times under 40 minutes*	*Monitors compliance with the norm for critically ill or injured clients to receive EMS within 40 minutes in rural areas*	*EMS Information Systems*	***Numerator*** *SUM([EMS P1 rural response under 40 minutes])* ***Denominator*** *SUM([EMS P1 rural calls])*	*Accuracy dependant on quality of data from reporting EMS station*	*Output*	*%*	*Quarterly*	*No*	*Higher percentage indicates improved efficiency.*	*Specialised & Clinical Support Services, DHS*

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
All calls with response time within 60 minutes	Percentage of all call-outs with response times within 60 minutes.	Monitor response times to determine efficiency and quality of EMS.	EMS	**Numerator** Number of call outs with a response time under 60min **Denominator** Total number of call outs	Data quality	Quality	%	Quarterly	No	Higher percentage indicates improved efficiency.	Specialised & Clinical Support Services, DHS
2013 NIDS: *EMS P1 call response under 60 minutes rate*	*Proportion of all P1 calls with response times under 60 minutes*	*Monitors compliance with the norm for all critically ill or injured clients to receive EMS within 60 minutes. This includes P1 urban responses under 15 minutes and P1 rural calls under 40 minutes. Low rates indicate inadequate resources*	*EMS Information Systems*	***Numerator*** *SUM([EMS P1 response under 60 minutes total])* ***Denominator*** *SUM([EMS P1 calls total])*	*Data quality*	*Output*	*Rate*	*Quarterly*	*No*	*Higher percentage indicates improved efficiency.*	*Specialised & Clinical Support Services, DHS*
Total number of EMS emergency cases	Number of patients transported by ambulance for emergency cases.	Monitor service volumes and capacity.	EMS	Number of patients transported by ambulance for emergency cases	Data quality	Output	Number	Quarterly	No	Increasing numbers may indicate increased dependence on public health services or more efficient EMS.	Specialised & Clinical Support Services, DHS
2013 NIDS: *EMS Clients total*	*Total number of clients transported by an ambulance during reporting period*	*Total number of emergency clients (all priorities) transported by ambulance, irrespective of the number of calls or trips. Include P1, P2 and P3 patients*	*EMS Information System*	***SUM*** – *Total number of emergency clients (all priorities) transported by ambulance* – *Include P1, P2 and P3 patients*	*Data quality*	*Output*	*Number*	*Quarterly*	*No*	*Increasing numbers may indicate increased dependence on public health services or more efficient EMS.*	*Specialised & Clinical Support Services, DHS*
Total number of inter facility transfers	The number of patients transferred between facilities by appointment.	Track patient activity between facilities.	EMS	Number of patients transported between facilities by appointment	Data quality	Output	Number	Quarterly	No	Increasing number might be indication of effective referral system or increasing burden of disease.	Specialised & Clinical Support Services, DHS
2013 NIDS: *EMS inter-facility transfer*	*Number of clients transferred between health facilities by an ambulance (from one inpatient facility to another inpatient facility)*	*Track patient activity between facilities*	*EMS Information System*	***SUM*** – *Number of clients transferred between health facilities by an ambulance (from one inpatient facility to another inpatient facility)*	*Data quality*	*Output*	*Number*	*Quarterly*	*No*	*Increasing number might be indication of effective referral system or increasing burden of disease.*	*Specialised & Clinical Support Services, DHS*

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of staff trained in BLS	The number of Emergency Medical Services (EMS) staff that completed an accredited training course for BLS.	Monitor allocation of appropriate Human Resources for Health to ensure effective EMS.	HPCSA	Number of EMS staff with BLS qualification.	Data quality depends on record keeping of training college.	Input	Number	Annual	No	Appropriate allocation of staff improves efficiency and quality of EMS.	Specialised & Clinical Support Services, DHS
Number of staff trained in ILS (AEA)	The number of Emergency Medical Services (EMS) staff that completed accredited an accredited training course for ILS.	Monitor allocation of appropriate Human Resources for Health to ensure effective EMS.	HPCSA	Number of EMS staff with ILS qualification.	Data quality depends on record keeping of training college.	Input	Number	Annual	No	Appropriate allocation of staff improves efficiency and quality of EMS.	Specialised & Clinical Support Services, DHS
Locally based staff with training in ALS (Paramedics)	The number of Emergency Medical Services (EMS) staff that completed an accredited training course for ALS.	Monitor allocation of appropriate Human Resources for Health to ensure effective EMS.	HPCSA	Number of EMS staff with ALS qualification.	Data quality depends on record keeping of training college.	Input	Number	Annual	No	Appropriate allocation of staff improves efficiency and quality of EMS.	Specialised & Clinical Support Services, DHS

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Intake of nurse students	Number of nurses entering the first year of nursing college	Tracks the training of nurses to manage Human Resources for Health.	HRMS	Total intake of student nurses	None.	Input	Sum	Annual	No	Higher levels of intake are desired, to increase the availability of nurses in future	HRMS, DHS, Specialised & Clinical Support Services
Students with bursaries from the province	Number of students provided with bursaries by the Provincial Department of Health	Tracks the numbers of health science students sponsored by the Province to undergo training as future health care providers	Human Resources Development	Number of students with bursaries from the Provincial Department of Health	Data quality depends on good record keeping by both the Provincial DOH and Health Science Training institutions	Input	Sum	Annual	No	Higher numbers of students provided with bursaries are desired, as this has the potential to increase future health care providers	HRMS, DHS, Specialised & Clinical Support Services
Basic nurse students graduating	Number of students who graduate from the basic nursing course	Tracks the production of nurses	Human Resources Development	Number of students graduating	Data quality depends on good record keeping by both the Provincial DOH and nursing colleges	Output	Sum	Annual	No	Desired performance level is that higher numbers of nursing students should be graduating	HRMS, DHS, Specialised & Clinical Support Services
Number of Professional Nurses graduating	Number of Professional Nurses who graduate from the basic nursing course.	Tracks the production (supply) of Professional Nurses	SANC / Persal	Professional Nurses graduating.	Data quality depends on good record keeping by both the Provincial DOH and nursing colleges.	Output	Number cumulative	Annual	No	Desired performance level is that the number of student nurses graduating should be in direct response to Provincial needs.	HRMS, DHS, Specialised & Clinical Support Services

ANNEXURE 2: DEFINITIONS

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of advanced midwifes graduating per annum	Number of Advanced Midwifes who graduate with a post basic nursing qualification in Advanced Midwifery.	Monitor training of Advanced Midwifes in response to NSDA priority of MC&WH.	SANC / Persal	Number of Advanced Midwifes graduating.	Data quality depends on good record keeping by the Provincial DOH and Training College.	Output	Number cumulative	Annual	No	Training more Advanced Midwifes in response to MC&WH Strategy to improve maternal health.	HRMS, DHS, Specialised & Clinical Support Services.
Number of Managers accessing the Management Skills Programmes.	Managers attending Leadership & Management training programmes.	Track the number of Managers that attend Leadership & Management training programmes.	Internal database	Number of Managers attending Leadership & Management training programmes.	Data quality depends on record keeping by HRD and external service providers.	Output	Number cumulative	Quarterly	No	Training will improve governance, leadership and management competencies.	HRMS, DHS, Specialised & Clinical Support Services
Number of SMS members trained on Massification Implementation Plan (MIP)	SMS members attending the MIP for Senior Managers.	Track the number of Senior Managers attending the MIP.	Internal database	Number of SMS members attending MIP.	Data quality depends on record keeping by HRD and the external training provider.	Output	Number cumulative	Annual	No	Higher attendance will improve service delivery.	HRMS, DHS, Specialised & Clinical Support Services

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Percentage of Pharmacies that obtained A or B grading on inspection[88]	The proportion of Pharmacies that comply with Pharmaceutical prescripts on inspection.	Track compliance with Pharmaceutical prescripts.	Pharmacy database	**Numerator** Number of Pharmacies with A or B grading on inspection. **Denominator** Total number of Pharmacies.	Accurate records of inspections conducted.	Quality	%	Annual	No	Improved compliance will improve quality and efficiency of Pharmaceutical services.	Specialised & Clinical Support Services, DHS
PPSD compliant with Good Wholesaling Practice Regulations	Provincial Pharmaceutical Supply Depot Warehouse complies with Pharmacy Regulations and is licensed by the Medicine Control Council to operate as a Pharmaceutical Wholesaler.	Safe warehousing practice	License	License issued by the Medicine Control Council	None	Output	Yes/No	Annual	No	Licensed	Specialised & Clinical Support Services
Tracer medicine stock-out rate (PPSD)	Any item on the Tracer Medicine List that had a zero balance in the Bulk Store (PPSD) on a Stock Control System.	Monitor shortages in tracer medicines.	Pharmacy	**Numerator** Any tracer medicine stock-out in bulk store (PPSD) **Denominator** Number of tracer medicine expected to be in bulk store (PPSD)	Data quality	Efficiency	Rate	Quarterly	No	Targeting zero stock-out.	Specialised & Clinical Support Services

[88] Refers to being compliant with SAPS standards

ANNEXURE 2: DEFINITIONS

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Tracer medicine stock-out rate (Institutions)	Any item on the Tracer Medicine List that had a zero balance in Bulk Store (facilities) on the Stock Control System. Percentage of fixed facilities with tracer medicine stock-outs (>0) during the reporting period. A facility should be counted once as having a stock-out during the reporting period.	Monitor shortages in Tracer medicines.	DQPR	**Numerator** Any tracer medicine stock-out in facilities **Denominator** Number of tracer medicine expected to be in bulk store (institution)	Data quality	Efficiency	rate	Quarterly	No	Targeting zero stock-out of all tracer medicines.	Specialised & Clinical Support Services

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
New infrastructure construction completed	The number of new clinical infrastructure (clinics, etc.) completed.	Monitor progress with projects for new clinical infrastructure.	2010: IRM 2010: IPMP 2010: Optimisation Plan 2011/12: U-Amp	Number of new infrastructure projects with construction completed	None	Process	Number	Quarterly	No	Effective monitoring of performance and progress.	Health Facility Maintenance Programme.
New infrastructure Commissioning completed	The number of new clinical infrastructure (clinics, etc.) fully commissioned.	Monitor progress with projects for new clinical infrastructure.	2010: IRM 2010: IPMP 2010: Optimisation Plan 2011/12: U-Amp	Number of new infrastructure projects commissioned.	None	Process	Number	Quarterly	No	Effective monitoring of performance and progress.	Health Facility Maintenance Programme.
Upgrading and renovation construction completed	The number of upgrading and renovation projects constructed.	Monitor progress with upgrading and renovation projects.	2010: IRM 2010: IPMP 2010: Optimisation Plan 2011/12: U-Amp	Number of upgrading and renovation projects with construction completed	None	Process	Number	Quarterly	No	Effective monitoring of performance and progress.	Health Facility Maintenance Programme.
Upgrading and renovation commissioning completed	The number of upgrading and renovation projects fully commissioned.	Monitor progress with upgrading and renovation projects.	2010: IRM 2010: IPMP 2010: Optimisation Plan 2011/12: U-Amp	Number of upgrading and renovation projects commissioned	None	Process	Number	Quarterly	No	Effective monitoring of performance and progress.	Health Facility Maintenance Programme.

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