HEALTH
KwaZulu-Natal

ANNUAL PERFORMANCE PLAN

MTEF PERIOD 2008/09 - 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

HEALTH
KwaZulu-Natal

Ms N.P. Nkonyeni

Endorsement by the

Member of the Executive Council (MEC) for Health

There is a time for reflection and a time for action. Our Annual Performance Plan allowed time for deliberation, during which the Department strove to find innovative and sustainable interventions to the challenges facing healthcare in the Province.

During 2008/09 the Department will commit itself to implementing identified strategies and interventions, moving seamless from reflection to action – from planning to implementation. This will contribute towards achieving a better life for all our people. Our goals, objectives and priorities are making a substantial contribution towards realisation of the apex priorities of Government.

As Health MEC in KwaZulu-Natal I have pledged this Department to give effect to its rallying cry "fighting disease, fighting poverty, giving hope". Last year the Department committed itself to "listening to the voices of the people" and "listening to the voices of healthcare workers". This year, we give effect to all that we have learned via focusing on rendering health services on the Primary Health Care approach. We believe this approach will make a significant difference to healthcare in our Province because our health system will be operationalised as part of the overall social and economic development of the community.

While we have made improvements to our Primary Health Care service, the Department must further strengthen management and staffing at these facilities. This will help to reduce the unacceptably long queues experienced at PHC Clinics. Our challenge is to demonstrate real improvement in service delivery by creating a health care service that eradicates inefficiencies and duplication.

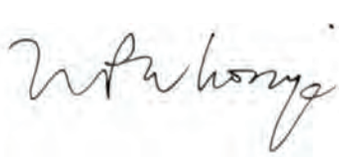
The burden of disease continues to place pressure on our health system. While we exceeded our targets in providing anti-retroviral treatment – the challenge of effectively communicating prevention remains.

Similarly, Tuberculosis remains a major challenge. This is a treatable and curable disease. It is important that the Department effectively communicates this message particularly in the context of the emergence of MDR TB and XDR TB. Some of the challenges mitigating against effective TB control are late presentation of patients to facilities, late detection of patients by healthcare workers, poor adherence to treatment, and poverty.

Trauma and violence are eroding the Department's limited resources and placing unnecessary pressure on our health facilities and staff. Apart from providing quality health services to all our patients, as a Department we have a role to play in educating our communities about the impact of violence on our ability to provide better health care to the people in KwaZulu-Natal.

Special emphasis will be placed by the Department on improving clinical governance in all public health facilities through the implementation of a new framework on clinical governance.

We will also intensify our promotion of health lifestyles to all people of the Province. It is the responsibility of the Department to create conditions where our citizens are able to make healthier choices. We need to promote health and healthy living and in doing so contribute to a vibrant and healthy Province.



MS N P NKONYENI
MEMBER OF THE EXECUTIVE COUNCIL: DEPARTMENT OF HEALTH – KWAZULU-NATAL PROVINCE

DATE: 30 March 2008.

HEALTH
KwaZulu-Natal

DR Y. MBELE

Foreword by the
Acting Head of Department

The Department of Health in KwaZulu-Natal is tasked with the provision of a comprehensive package of health services to the people of KwaZulu-Natal. The primary purpose for the existence of the Department of Health is to develop and implement a sustainable, coordinated, integrated, comprehensive and accessible health system. As part of enhancing access to health service, the Department is strengthening its Primary Health Care Facilities.

The aim is that all Districts offer the full package of primary health care services and that Mobile Clinics increase access to healthcare in remote and rural areas. The focus of the Primary Health Care approach is to move beyond management of the sick to a more comprehensive health promotion approach where healthy lifestyles and prevention of diseases forms the foundation of interventions.

Community Health Carers and Home Based Carers are used by the Department to "bridge the gap" between health services and the community by promoting healthy lifestyles and improving health seeking behaviours. This mechanism continues to strengthen partnerships and involve Non-Governmental Organisations and ensures that the Home Care Giver programme succeeds in delivering services to our communities.

In the current year the District Health Service will see approximately 22 million Primary Health Care patients. In addition, the average utilisation rate for District hospitals is 68%. This is the level of care where most people access the service and where the pressure of numbers and the demand for services is the greatest.

In line with the initiative to strengthen Primary Health Care, funding has been allocated to strengthen both the management and the service delivery at Primary Health Care Clinics and Community Health Centre levels. Management and support structures have been aligned with the supervisory cluster structures which are cognisant of catchment populations for facilities and the burden of disease.

I have the greatest confidence that our management and staff will deal proactively with the challenges that face the Department in achieving their mandate to provide accessible, quality healthcare.

DR Y. MBELE
ACTING HEAD: DEPARTMENT OF HEALTH

DATE: 30 March 2008.

HEALTH
KwaZulu-Natal

PART A

1. STRATEGIC OVERVIEW

2. SITUATIONAL ANALYSIS

3. BROAD POLICIES, STRATEGIC GOALS AND PRIORITIES

MTEF PERIOD 2008/09 - 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

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The KwaZulu-Natal Department of Health is guided by its Vision, Mission and Core Values.

HEALTH
KwaZulu-Natal

VISION OF THE DEPARTMENT

Achieve optimal health status for all persons in the Province of KwaZulu-Natal.

MISSION OF THE DEPARTMENT

Develop and deliver sustainable, coordinated, integrated and comprehensive health systems at all levels of care through the Primary Health Care Approach based on the District Health System.

CORE VALUES OF THE DEPARTMENT

Trust built on truth, integrity and reconciliation.
Open communication, transparency and consultation.
Commitment to performance.
Courage to learn, change and innovate.

HEALTH
KwaZulu-Natal

LEGAL MANDATE OF DEPARTMENT

The Constitution of the Republic of South Africa, 1996 (Act 109 of 1996).
National Health Act of 2003 (Act 61 of 2003).
Public Finance Management (Act 1 of 1999 and Treasury Regulations).
International Health Regulations Act (Act 28 of 1974).
Promotion of Administrative Justice Act (Act 3 of 2000).
Promotion of Access to information Act (Act 2 of 2000).
Basic Conditions of Employment Act (Act 75 of 1997).
Skills Development Act (Act 97 of 1998)
Preferential Procurement Policy Framework Act (Act 5 of 2000).
Employment Equity Act (Act 55 of 1998).
State Information Technology Act (Act 88 of 1998).
The Competition Act (Act 89 of 1998).
The Copyright Act (Act 98 of 1998).
The merchandise Marks Act (Act 17 of 1941).
Trade Marks Act (Act 194 of 1993).
Designs Act (Act 195 of 1993).
Promotion of Equality and the Prevention of Unfair Discrimination Act (Act 4 of 2000).
State Liability Act (act 20 of 1957).
Broad Based Black Economic Empowerment Act (Act 53 of 2003).
Unemployment Insurance Contributions Act (Act 4 of 2002).
Protected Disclosures Act (Act 26 of 2000).
Control of Access to public Premises and Vehicles Act (Act 53 of 1985).
Conventional Penalties Act (Act 15 of 1962).
Intergovernmental Fiscal Relations Act (Act 97 of 1997).
Public Service Commission Act (Act 46 of 1997).
Public Service Act (Act 103 of 1994), Public Service Regulations and Public Service.
Bargaining Council Resolutions.
Division of Revenue Act (Act 97 of 1998).
Medical Schemes Act (Act 131 of 1998).
Medicines and Related Substances Act (Act 101 of 1965).
Mental Health Care Act of 2002 (Act 17 of 2002).
Choice on Termination of Pregnancy Act (Act 92 of 1996).
Sterilization Act (Act 44 of 1998).
SA Medical Research Council Act (Act 58 of 1991).
Tobacco Products Control Amendment Act (Act 12 of 1999).
National Health Laboratory Services Act (Act 37 of 2000).
Health Professions Act (Act 56 of 1974).
Pharmacy Act (Act 53 of 1974).
Nursing Act (Act 33 of 2005).
Allied Health Professions Act (Act 63 of 1982).
Dental Technicians Act (Act 19 of 1979.
Hazardous Substances Act (Act 15 of 1973).
Foodstuffs, Cosmetics and Disinfectants Act (Act 54 of 1972).
Occupational Diseases in Mines and Works Act (Act 78 of 1973).
Council for Medical Schemes Levy Act (Act 58 of 2000).
Occupational Health and Safety Act (Act 85 of 1993).
Child Care Act (Act 74 of 1983).
The Patents Act (Act 57 of 1978).

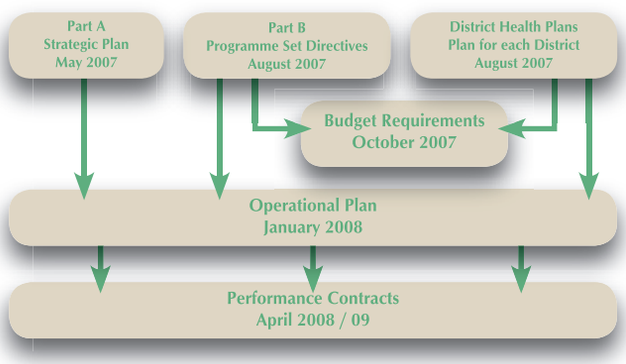
1. STRATEGIC OVERVIEW

1.1 Departmental Strategic Planning Process

The Strategic Plan for the Department was developed for the period 2005/06 – 2009/10. The Strategic Plan includes the Departmental priorities, as well as the different activities included in the Programme of Action for the current five year electoral cycle. The Health Services Transformation Plan (STP) forms the basis for finalising the Strategic Plan for the next five years (2010/11 – 2016/17). The planning process commenced in the Medium Term Expenditure Framework (MTEF) 2006/07 and will be finalised and approved in MTEF 2008/2009.

Figure 1 diagrammatically represents the planning framework that the Department has followed for MTEF 2008/09.

FIGURE 1: Planning Framework



To realise the Departmental vision and mission, the Strategic Plan for MTEF for 2008/09 has been guided by key strategic imperatives:

A high level strategic planning workshop took place on 17-19 May 2007. The workshop was attended by the Member of the Executive Council for Health (MEC), the Head of the Department of Health (HOD), Senior Managers, District Managers, Representatives from the Health Portfolio Committee, and Representatives from the University of KwaZulu-Natal.

The workshop critically reviewed and analysed the achievements, constraints and the challenges facing health care service delivery in the Province. Based on the findings, the Department identified the strategic goals and objectives which are included in the Annual Performance Plan (APP) for MTEF 2008/09.

1.2 Governance Framework

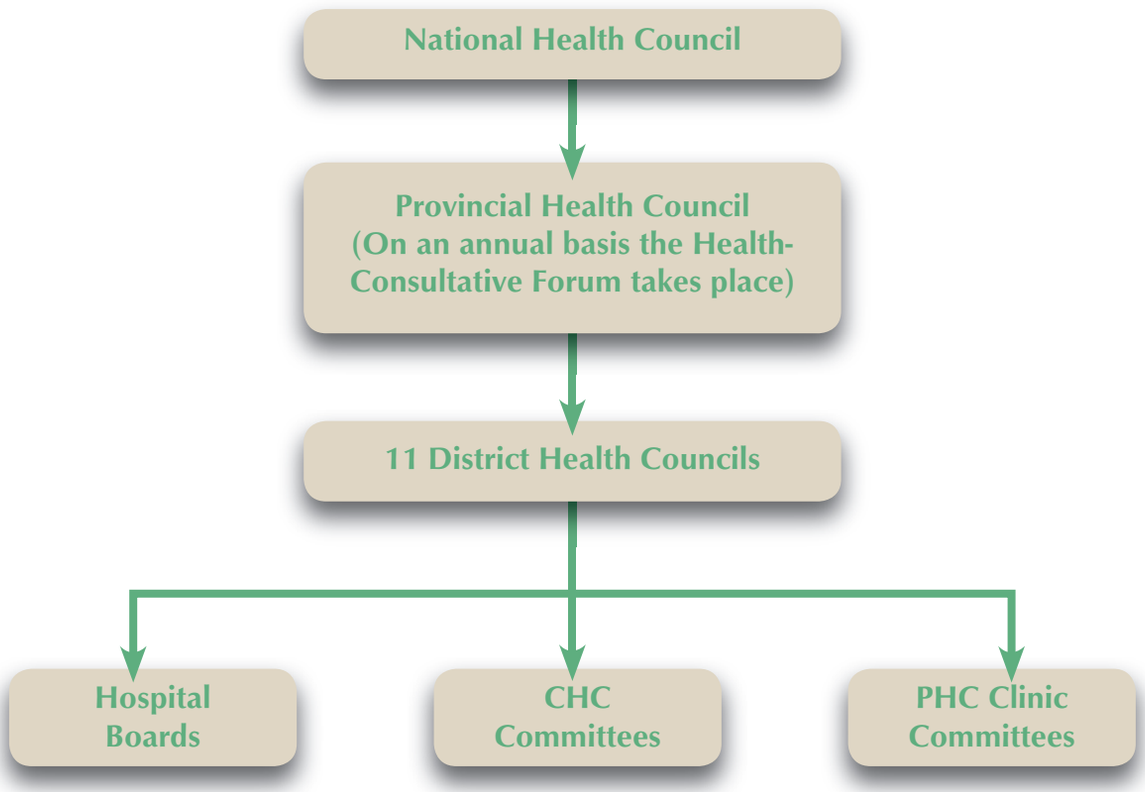
The governance framework of the Department is represented diagrammatically in Figure 2.

The Provincial Health Council was established in December 2005. The Council is chaired by the MEC for Health, one Representative each from the Metropolitan- and the District Municipalities, the HOD, and three Representatives involved in the management of Local Government. Meetings are held on a quarterly basis.

District Health Councils are not operational as yet. Each Hospital, Community Health Centre (CHC), and Primary Health Care (PHC) Clinic in the Province has a Board or Committee that represents the interests of the communities and oversees sound governance. There are four Mental Health Review Boards (Durban, Empangeni, Newcastle, and Pietermartizburg).

1. The Africa Health Strategy (April 2007).
2. The National Cabinet Lekgotla (March 2007) and the apex priorities.
3. The Provincial Executive Committee Lekgotla (May 2007).
4. Departmental review to measure performance and achievement against health targets (May 2007).
5. Outcomes of the 2nd Provincial Health Consultative Forum (17 July 2007).
6. Outcomes of the National Health Consultative Forum (19 – 20 July 2007).
7. Burden of Disease in the Province.

FIGURE 2: Governance Framework



1.3 Service Delivery Challenges

Over the past three years the Department has made significant strides to address the health challenges. Although substantial progress has been made in all areas, the Department will continue to focus on the following challenges:

- Improve the quality of Maternal,-Child- and Women's Health services by reducing the preventable causes of death at community level, PHC Facilities and Hospitals.

- Fast track the implementation and monitoring of the Provincial Tuberculosis (TB) Crisis Management Plan - linked to nutrition enhancement and increased community awareness and participation. Special emphasis will be placed on Multi-Drug Resistant (MDR) TB and Extreme Drug Resistant (XDR) TB.

- Intensify the implementation of:
  - The Comprehensive Human Immuno-virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), Sexually Transmitted Infections (STI) Strategic Plan for South Africa 2007 – 2011: and
  - Other Strategic Health Programmes.

- Improve evidence-based planning through monitoring and evaluation, research and knowledge management.

- Focus on improving the quality of care at all levels (with specific emphasis on Clinical Governance).

- Implement the Department of Health Operational Plan for the 2010 Fifa Soccer World Cup.

- Promote healthy lifestyles.

- Continue to support the delivery of sustainable health services in the Integrated Sustainable Rural Development Areas i.e. Ugu District, Zululand District, Umkhanyakude District, Umzimkhulu District, and Umzinyathi District.

- Strengthen the delivery of PHC services through the District Health System (DHS) as integral part of the STP.

- Improve alignment between planning and budgeting in the Department.

The Department adopted a 12 Point Plan. The 12 Point Plan is listed as follows:

1. Improved management of TB.
2. Accelerated implementation of the Comprehensive Plan on management of HIV and AIDS.
3. Enhanced management of mother and childhood illnesses.
4. Implemented comprehensive health care package for identified "Massification Project Areas".
5. Accelerated infrastructure development.
6. Expanded health worker pool to respond to the burden of disease.
7. Improved Health- and Management Systems.
8. Enhanced Management and Leadership capability.
9. Development and Implementation of a STP.
10. Improved Clinical Governance, and implementation of Batho Pele and Patients Rights Charter.
11. Implementation of developmentally orientated Supply Chain Management (SCM) processes.
12. Enhanced alignment of Budget with Strategic Plan.

2. SITUATION ANALYSIS

2.1 Geographic and Spatial considerations

The KwaZulu-Natal Department of Health serves ten Municipal Districts and one Metropolitan District (eThekwini). The health service boundaries are aligned to municipal boundaries as determined by the Municipal Demarcation Board.

Health Districts have been consolidated into three Service Delivery Areas. The Areas are:

Area	Districts
Area 1: South Eastern	Ugu eThekwini Ilembe
Area 2: Western	Sisonke Amajuba Umgungundlovu Uthukela Umzinyathi
Area 3: North Western	Uthungulu Zululand Umkhanyakude

Map 1 indicates the Health Districts.

MAP 1: KwaZulu-Natal Health Districts per Management Area

The Province of KwaZulu-Natal is situated in the eastern part of South Africa. Map 2 below illustrates the geographical location of the Province in the country.

MAP 2: KwaZulu-Natal Locality Map

The Province shares borders with Swaziland and Mozambique in the North, Mpumalanga in the North-West, Free State and Lesotho in the West and the Eastern Cape in the South. The Northern Districts of Umkhanyakude and Zululand attract patients from

Mozambique and Swaziland and similarly patients from the Eastern Cape utilise health facilities in the Southern Districts of Ugu and Sisonke. Table 1 provides an overview of the main demographic characteristics for the Province. Natural features including rivers, wetlands and mountainous terrain, as well as scattered distribution of homesteads in the rural areas pose unique transport and access challenges for equitable service delivery.

It is estimated that 54% of the total population live in rural areas, the majority of the rural population is women and children, and 10% of the urban population live in underdeveloped informal settlements.[1]

The eThekwini Metropolitan Municipality has the biggest population density with 1,394 people per km², and Sisonke the lowest with 42 people per km². This illustrates the diversity in the Province and the challenge it poses for equity in health service delivery.[2]

TABLE 1: Demographic Characteristic

DEMOGRAPHICS	
Size of Province	92 303km²
Share of South Africa (new boundaries)	7.57%
Share of national population (new boundaries)	20.9%
Population density per km²	107.52
Population mid-year estimate (2006)	9 924 000
Population (2006)Bureau of Market Research (UNISA) estimate	9 813 467
Proportion African	83.15%
Proportion Coloured	1.35%
Proportion Indian	8.85%
Proportion White	6.63%
Population growth per annum (2001–2006)	0.47%
Average annual population growth (1997–2010)	*7.23%*

The total fertility rate is estimated at 2.1 children per woman[3] although it is possibly a slight under-estimate especially in rural areas where evidence shows a higher fertility rate - correlated with education levels.

Rural areas have a greater percentage of children in the age range 0-15 years, and promotion and integrated development programmes should therefore target this age group to promote healthy lifestyles and habits.

The significant differences between the urban and rural areas of the Province also imply that policies and implementation strategies suitable for urban communities may be less applicable to their rural counterparts. Policies and strategies should be 'tailor made' based on demographic and social determinants, target groups/ beneficiaries, and health profiles. "One size fits all" intervention strategies to address the burden of disease in the Province may exclude health beneficiaries most in need of health services.

Table 2 below the social demographic characteristics of the Province compared to National characteristics.

TABLE 2: Social Demographic Characteristics

Characteristics	Province	National
% of population	21%	100%
% Female	53%	52%
% < 5 years	11%	11%
% < 15 years	34%	32%
% > 60	7%	8%
% of population >20 years with no formal education	11%	9.60%
% of population that live on incomes below the poverty line	47%	45%
Unemployment Rate	29.9%	25.6%

The burden carried by rural households is significant as they are more likely to be female headed, have more foster children compared to their urban counterparts, are about two times more likely to go hungry compared to urban households, are less likely to have access to safe water and electricity, and more likely to use wood as the primary source of energy.

It is therefore not surprising that the burden of disease in rural/ deep rural areas is different to that found in urban communities. Planning and resource allocation is sensitive to specific demographic and health profiles to ensure equity and improved quality of care.

Table 3 and 4 give an indication of the projected total and uninsured population for the Province per District.

[1] Stats SA.
[2] Stats SA.
[3] South African Demographic & Health Survey 2003.

TABLE 3: Projected Population for KwaZulu-Natal from 2001 to 2010 (per District)

Health District	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Ugu	704 029	707 913	713 126	718 376	723 666	728 994	734 361	739 768	745 215	750 702
Umgungundlovu	927 849	932 968	939 837	946 757	953 728	960 751	967 824	974 951	982 129	989 360
Uthukela	656 982	660 607	665 471	670 370	675 306	680 279	685 287	690 333	695 416	700 536
Umzinyathi	456 456	458 974	462 354	465 758	469 187	472 642	476 122	479 628	483 159	486 717
Amajuba	468 036	470 618	474 083	477 574	481 090	484 633	488 201	491 795	495 417	499 064
Zululand	804 457	808 895	814 851	820 851	826 895	832 983	839 116	845 295	851 518	857 788
Umkhanyakude	573 340	576 503	580 748	585 024	589 331	593 671	598 042	602 445	606 881	611 349
Uthungulu	885 968	890 856	897 415	904 023	910 679	917 384	924 139	930 943	937 798	944 703
Ilembe	560 393	563 485	567 634	571 813	576 023	580 265	584 537	588 841	593 176	597 544
eThekwini Municipality	3 090 123	3 107 172	3 130 049	3 153 096	3 176 312	3 199 699	3 223 258	3 246 991	3 270 898	3 294 981
Sisonke	456 513	459 032	462 411	465 816	469 246	472 701	476 181	479 688	483 219	486 777
KwaZulu-Natal Total	**9 584 146**	**9 637 023**	**9 707 980**	**9 779 459**	**9 851 464**	**9 924 000**	**9 997 070**	**10 070 677**	**10 144 827**	**10 219 523**

- **Note:** Population figures were extracted from the Statistics South Africa (Stats SA) and projected from 2001 using growth rates obtained from the mid-year estimates for July 2006 which are released by Stats SA annually.
- Highlighted Districts: Presidential Integrated Sustainable Rural Development Areas.

TABLE 4: Projected Uninsured Populations for KwaZulu-Natal from 2001 to 2010 (per District)

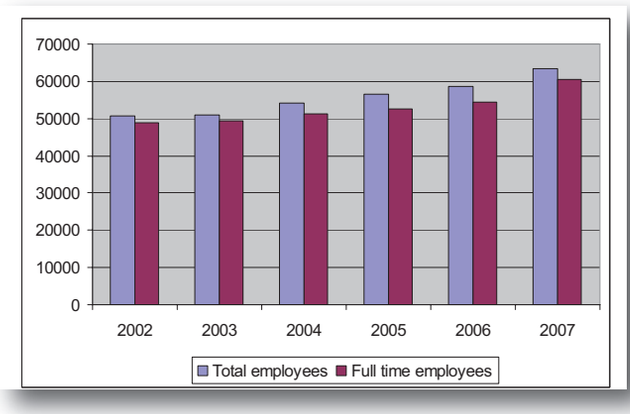
Health District	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Ugu	619 546	622 964	627 550	632 171	636 826	641 515	646 238	650 996	655 789	660 618
Umgungundlovu	816 507	821 012	827 057	833 147	839 281	845 460	851 686	857 956	864 274	870 637
Uthukela	578 144	581 334	585 614	589 926	594 270	598 645	603 053	607 493	611 966	616 472
Umzinyathi	401 681	403 897	406 871	409 867	412 885	415 925	418 987	422 072	425 180	428 311
Amajuba	411 872	414 144	417 193	420 265	423 359	426 477	429 617	432 780	435 967	439 177
Zululand	707 922	711 828	717 069	722 349	727 667	733 025	738 422	743 859	749 336	754 854
Umkhanyakude	504 539	507 323	511 058	514 821	518 612	522 430	526 277	530 152	534 055	537 987
Uthungulu	779 652	783 953	789 725	795 540	801 398	807 298	813 242	819 230	825 262	831 339
Ilembe	493 146	495 867	499 518	503 196	506 901	510 633	514 393	518 180	521 995	525 839
eThekwini Municipality	2 719 308	2 734 311	2 754 444	2 774 724	2 795 154	2 815 735	2 836 467	2 857 352	2 878 390	2 899 584
Sisonke	401 731	403 948	406 922	409 918	412 936	415 977	419 040	422 125	425 233	428 364
KwaZulu-Natal Total	**8 434 048**	**8 480 580**	**8 543 022**	**8 605 924**	**8 669 289**	**8 733 120**	**8 797 421**	**8 862 196**	**8 927 448**	**8 993 180**

- **Note:** Uninsured population is currently calculated at 88% of the population; however this percentage may decrease with the implementation of the Government Employee Medical Scheme.
- Highlighted Districts: Presidential Integrated Sustainable Rural Development Areas.

2.2 Workforce Profile

The Department increased the staff component from 49,139 in March 2002 to 64,302 in September 2007 (Figure 3), but still faces tremendous challenges to successfully recruit and retain skilled and experienced health professionals. The internal and external migration of health professionals is still too high. The optimal skills mix has not yet been achieved.

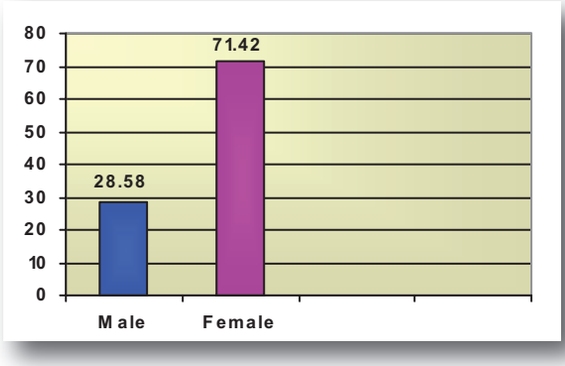
FIGURE 3: Personnel in Provincial Health Facilities: 2002 – 2007



- The high levels of internal migration compromises quality of care with staff not acquiring specialised skills in their field of operation.
- The implementation of the Occupational Specific Dispensation will assist with the retention of health professionals, but the Department needs to focus more on the other contributory factors that influence motivation of staff e.g. staff accommodation and performance management.

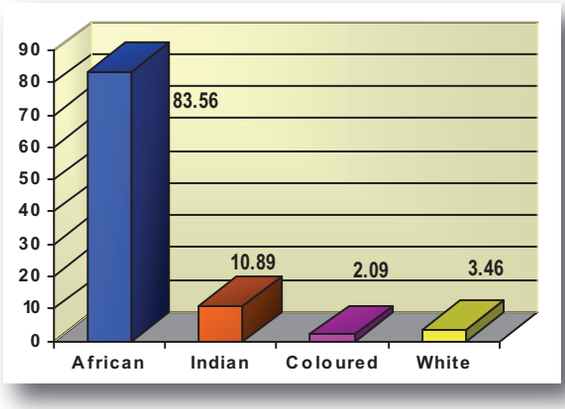
Figure 4 indicates the gender representivity of the Department for all health worker categories of staff. The preponderance of the female gender is as a direct result of the influence of the nursing occupational categories. Nurses form approximately 45% of the Department's staffing complement, and they are predominantly female. Consequently the Department shows a high female gender representivity for health worker categories. The situation is equalised between the genders when non-health specific categories are included in the analysis.

FIGURE 4: Employment Equity: Gender



The Department complies with the requirements as stipulated in the Employment Equity Act, 55 of 1998. Figure 5 provides an indication of the distribution of the staff component in term of race groups.

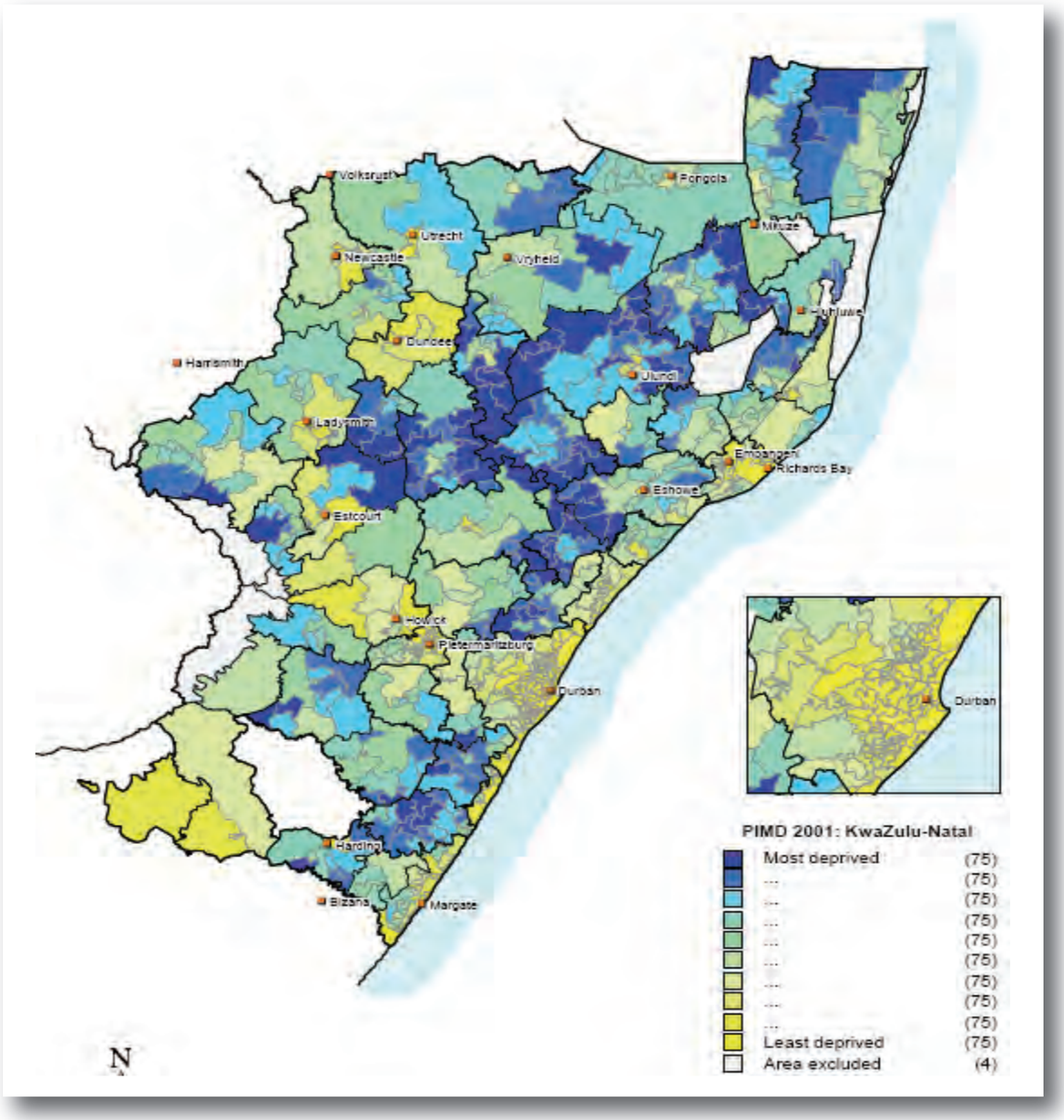
FIGURE 5: Employment Equity: Race



3. POVERTY AND HEALTH PROFILE

Rural areas are faced with very different challenges as compared to urban areas, compounded by poverty and the triple burden of disease. Map 3 provides a spatial image of the index of multiple deprivations in the Province. The domains making up the multiple deprivation index include: Income and Material Deprivation, Employment Deprivation, Health Deprivation, and Living Environment Deprivation.

MAP 3: KwaZulu-Natal Index of Multiple Deprivation at Ward Level[4]



[4] Centre for Analysis of South African Social Policy, University of Oxford, 2006.

3.1 Poverty and Socio Economic Profile

The contribution of environmental factors to morbidity and mortality is well documented. People living in unhygienic environments as indicated by poor drainage systems, inadequate/ non-existent sanitation, and lack of access to piped water suffer higher levels of morbidity and mortality.[5] It is estimated that 40% of world deaths can be attributed to various environmental factors.[6] Access to water correlates strongly with the survival of children under-5, while malnutrition, a major cause of child morbidity and mortality, can also be related to environmental degradation.

Table 5 below provides an indication of the poverty and socio-economic situation of the Province.

TABLE 5: Poverty and Socio Economic Profile

LIVING CONDITIONS	
Average annual nominal growth in social development expenditure (2005/06-2008/09)	*10%*
Households living in formal dwellings	*61.7%*
Households living in informal dwellings	*14.8%*
Households living in traditional dwellings	*23.2%*
Households without water in dwelling	*63.4%*
Households without basic sanitation	*7.7%*
Households using bucket system without sanitation facility, change 2005 vs. 2002	*-29.5%*
Households without electricity	*28.0%*
Households using electricity for heating	*58.3%*
Households using electricity for cooking	*61.8%*
Households without access to a cell/telephone	*8.4%*
LIVING CONDITIONS	
Households with refuse removed by local authority	*56.0%*
People living on less than $1/day 2006 (approximately R7)	*1 165 536*
Rate of urbanisation (2006)	*48.7%*

The effects of inadequate water and sanitation were highlighted in the 2003 South African Demographic and Health Survey (SADHS) report. Child mortality more than doubled where the source of drinking water was any other source than piped water, and mortality rate increased from 7.7/1000 (where there was a flush toilet) to 34.9/1000 where there were none.[7] This is very relevant in KwaZulu-Natal taking into consideration the number of households without basic water and sanitation (Table 8 - Page 17).

3.2 Intra- and Inter-Provincial Equity in the Provision of Services

Table 6 indicates the distribution of resources between rural and urban areas.

TABLE 6: Expenditure per PHC Headcount

District	2006/07	*2007/08*
Ugu	R56.00	*R63.00*
Umgungundlovu	R55.00	*R60.00*
Uthukela	R59.00	*R77.00*
Umzinyathi	R73.00	*R74.00*
Amajuba	R56.00	*R57.00*
Zululand	R76.00	*R74.00*
Umkhanyakude	R64.00	*R65.00*
Uthungulu	R56.00	*R57.00*
Ilembe	R64.00	*R80.00*
Sisonke	R81.00	*R85.00*
eThekwini	R63.00	*R74.00*
KwaZulu-Natal	***R64.00***	***R70.00***

[5] Caldwel JC & Caldwel BK 2002. Poverty and mortality in the context of economic growth and urbanization. Asia-Pacific Population Journal 49-66

[6] Amuyynzu-Nyamono, M., Taff, N., 8 Jan 2004. The triad of poverty, environment and child health in Nairobi informal settlements. Journal of health and population in developing countries.

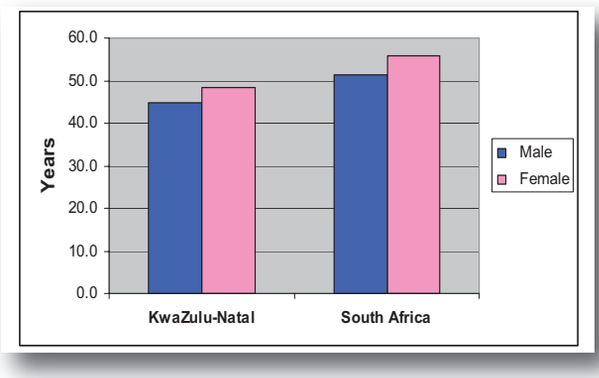
[7] SADHS 2003.

3.3 Health Profile

The Province continues to have a scourge of diseases including infectious diseases (e.g. TB, HIV, AIDS and STI) and chronic diseases (e.g. diabetes, cancers and heart diseases) which has a profound effect on quality of life, productivity and life expectancy. The rising trend in diseases of lifestyle continues against a constant backdrop of trauma, paying tribute to the strategies to promote healthy lifestyles and prevent preventable causes of morbidity and mortality.

Figure 6 below illustrates the life expectancy at birth for the period 2001 – 2006.[8]

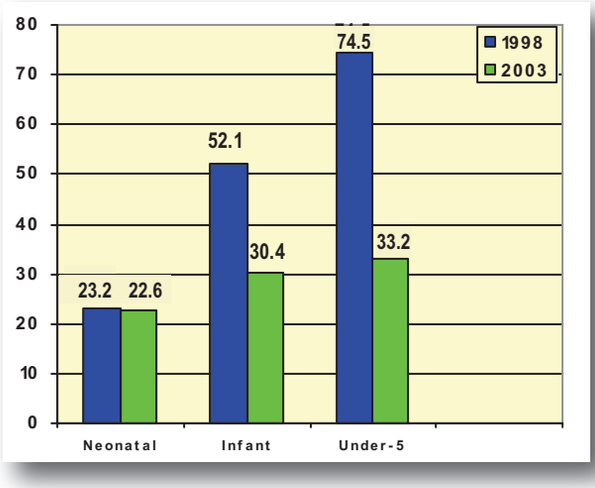
FIGURE 6: Gender Specific Life Expectancy



This has dire implications for orphans and young children cared for by women/ families affected by ill-health. Access and utilisation of health services is compromised where the sick must take care of the sick, resulting in poor health-seeking behaviour and increase in morbidity and mortality.

There is no consensus amongst the scientific community about exact figures for under-5 mortality (including neonatal, infant and child mortalities). The Presidency's Development Indicators Midterm Review quotes 5 'reliable' sources of data, which yield inconsistent and contradictory Under-5 Mortality Rates. Measuring progress towards attainment of the Millennium Development Goals is therefore compromised and concerted efforts are required to find the solution to establishing reliable data to measure progress. Figure 7 illustrates the 'accepted' Department of Health data for KwaZulu-Natal. Figure 8 gives an indication of mortality indicators.

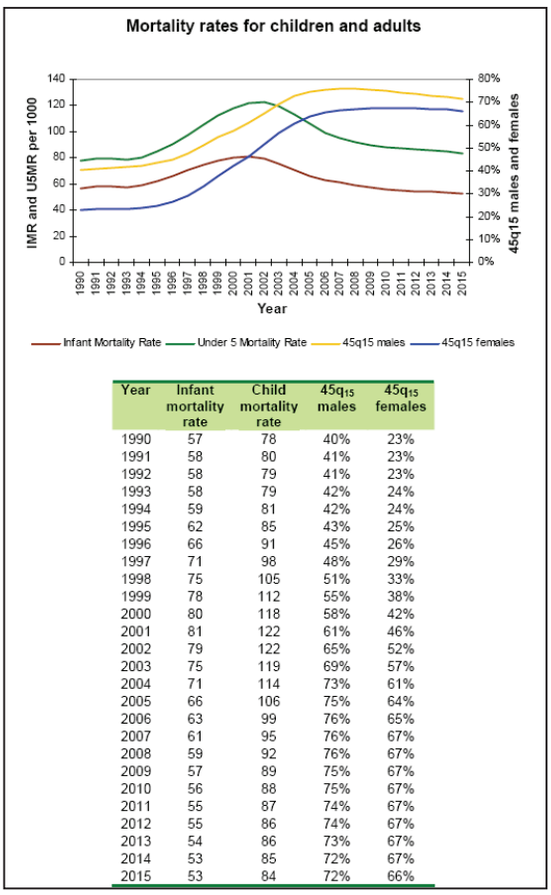
FIGURE 7: Neonatal, Infant & Under-5 Mortality rates[9]



[8] Stats SA Mid-Year Estimates for 2006.

[9] SADHS, 1998 & 2003.

FIGURE 8: Mortality Indicators



Year	Infant mortality rate	Child mortality rate	$45q_{15}$ males	$45q_{15}$ females
1990	57	78	40%	23%
1991	58	80	41%	23%
1992	58	79	41%	23%
1993	58	79	42%	24%
1994	59	81	42%	24%
1995	62	85	43%	25%
1996	66	91	45%	26%
1997	71	98	48%	29%
1998	75	105	51%	33%
1999	78	112	55%	38%
2000	80	118	58%	42%
2001	81	122	61%	46%
2002	79	122	65%	52%
2003	75	119	69%	57%
2004	71	114	73%	61%
2005	66	106	75%	64%
2006	63	99	76%	65%
2007	61	95	76%	67%
2008	59	92	76%	67%
2009	57	89	75%	67%
2010	56	88	75%	67%
2011	55	87	74%	67%
2012	55	86	74%	67%
2013	54	86	73%	67%
2014	53	85	72%	67%
2015	53	84	72%	66%

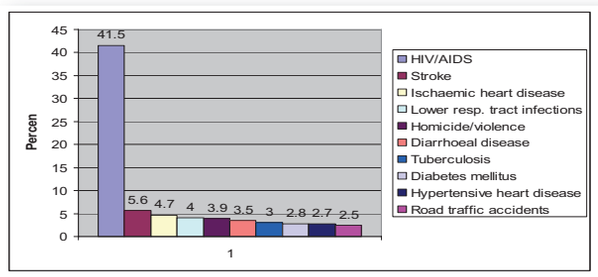
Mortality rates are consistently higher in non-urban areas, while it is well established that bio-demographic factors of both the mother and child influence childhood mortality. The relationship between the age of the mother and child mortality shows the expected U-shape, with women younger than twenty years old having slightly higher infant and under-five mortality rates than women between 20 and 40 years of age. However, children borne to women over the age of forty experience sharply increased mortality rates.

The interval from one birth to the next can also have a dramatic effect on the child's survival chances. Data shows that when this period is less than two years, under-five mortality (101/1000) is double what it is for a previous birth interval of 2-3 years (52/1000) or 4 years or more (47/1000). These findings are also consistent with other research and highlight the importance of birth spacing as a means of reducing child mortality.

Integrated Sexual & Reproductive Health services (including contraceptive services) can dramatically reduce under-5 and maternal mortality. In line with Provincial Strategic Goal 5: *To strengthen Priority Health Programmes through the PHC approach and the District Health system.*

The major causes of death across all age groups in the Province, for both men and women, are summarised in the graph below (Figure 9).[10] KwaZulu-Natal shows a high burden of disease across all categories of communicable and non-communicable diseases, HIV, AIDS and trauma.

FIGURE 9: Top 10 Leading Causes of Death in KwaZulu-Natal, 2000



The profile of risk factors for chronic diseases suggests the urgency of innovative and pro-active client-centred health promotion strategies.

The relationship between poverty and HIV transmission is a complex one as HIV infection can be both determinant and consequence of the epidemic. Increased poverty and income inequality fuel the spread of the epidemic, while the epidemic in turn worsens the economic situation of the household, often leading to increased poverty and inequality.[11]

Poverty increases susceptibility to contracting HIV and AIDS through several channels including: increased migration to urban areas, limited access/ utilisation of health care, poor nutrition and other basic services, limited access to education and information, sexual exploitation and gender inequality. Studies found that food insecurity and malnutrition may accelerate the spread of HIV both by

[10] South African National Burden of Disease Study 2000.
[11] IDRC Working Papers on Globalisation, Growth and Poverty, March 2006. The impact of HIV and AIDS on Poverty, inequality and economic growth. HEARD, University of KwaZulu-Natal, South Africa.

increasing people's exposure to the virus and by increasing the risk of infection following exposure.[12]

It was found that falling calorie and protein consumption and increasing inequality were strongly correlated with HIV prevalence in 44 sub-Saharan African countries. Moreover studies suggest that improved maternal micronutrient status may reduce vertical transmission of HIV; concluding that one of the main factors determining the risk of mother to child transmission of HIV is the health and nutritional status of the mother.

The Department increased access to nutritional supplements to children, pregnant and post partum women and patients on Anti-retroviral Therapy (ART) or TB treatment.

[12] Gillespie, S., Kadiyala, S., 2005. Impacts of Food and Nutrition Insecurity on the Spread of HIV. Food Policy Review 7.

3.4. Key Health Indicators

Table 7 provides a summary of the performance of the Province for the period 2004/05 – 2006/07 in terms of key health indictors. Table 8 provides an indication of various factors that influence optimal health status.

TABLE 7: Key Health Indicators during the Period 2004/05 – 2007/08

Indicator	Provincial 2004/05	Provincial 2005/06	Provincial 2006/07	Provincial 2007/08[13]
Child Health				
Immunisation coverage under 1 year	84%	76.4%	89.7%	90%
Immunisation drop-out rate (DTP 1-3)	12%	13%	6.9%	7.3%
Measles coverage	88.9%	79%	91%	90%
Diarrhoea incidence under-5 years	516.6/1000	470.5/1000	257/1000	-
Nutrition				
Not gaining weight rate under-5 years	1.2%	1.8%	1.7%	1.4%
Severe malnutrition rate under-5 years	-	0.7%	1.5%	-
Vitamin A coverage under-1 year	82.3%	116%	100%	100%
Maternal & Neonatal Health				
Antenatal Coverage (ANC) coverage	117	114	87	-
Delivery rate in facility	86.2%	85.7%	83%	81.1%
Caesarean section rate	22.3%	24.1%	27%	18.4%
Stillbirth rate	30.5%	31.2%	24.8%	-
HIV, AIDS & STI				
Proportion of ANC clients tested for HIV	63.1%	43.8%	44%	45.2%
HIV testing rate (excluding ANC)	-	91%	91%	90.5%
Nevirapine uptake rate among pregnant HIV^+ women	35%	59.8%	63%	68.5%
Nevirapine uptake rate among newborn babies of HIV^+ women	-	39%	93%	96%
ART patients registered	11,449	57,149	85,264	110,307
Incidence of STI treated - new	26%	22%	23%	21.5%
Tuberculosis				
TB cure rate	35.6%	35.1%	42%	44.5%
TB smear conversion rate	38.7%	40.4%	60%	-
TB treatment interruption rate	16.2%	13.6%	13.8%	12.4%

- Immunisation is one of the most effective ways to prevent/ control vaccine preventable diseases i.e. TB, diphteria, tetanus, polio, hepatitis B, etc. Good performance in these indicators can therefore make a significant contribution towards reducing morbidity and mortality.
- Provincial immunisation coverage dropped during the period 2005/06 due to a change in the population denominator. The province exceeded the National target of 90% during both Polio campaign (95%) in October 2006 and Measles and Polio campaign in May 2007 with 93% and 90% respectively.
- The diarrhoea incidence reduced dramatically since 2004/05. In spite of the decrease, diarrhoea (with dehydration), that may also be related to HIV and AIDS, continue to be one of the leading causes of morbidity and mortality in children under-5.
- It is expected that malnutrition is under-reported especially in the more deprived areas.

Research will be undertaken to determine trends and health profiles linked to poverty and access to services.

[13] Refer to data for Quarters 1 and Quarters 2 only.

TABLE: 8 Key Health Indicators during the Period 2006/07

District	Catchment population (Uninsured) 2008	Households with no sanitation	Schools with no sanitation	No access to piped water	PHC Expenditure	PHC Utilization Rate	*Under-5 Utilisation rate*
Amajuba	432 780	71%	*17%*	21.7%	R100	1.4	*2.9*
eThekweni	2 857 352	34%	*35%*	5.1%	R-	2	*3*
Ilembe	518 180	44%	*32%*	48.2%	R78	1.8	*2.9*
Sisonke	422 125	48.2%	*50.8%*	38.5%	R78	1.8	*3.4*
Ugu	650 996	35%	*40%*	51.5%	R78	1.8	*3.4*
Umgungundlovu	857 956	54%	*94%*	15.6%	R78	1.8	*3.2*
Umkhanyakude	530 152	38%	*69%*	57.5%	R60	1.9	*3.6*
Umzinyathi	422 072	54%	*15%*	55.4%	R70	1.6	*3.3*
Uthukela	607 493	43%	*42.4%*	32.8%	R59	1.6	*3.1*
Uthungulu	819 230	38%	*69%*	44.9%	R56	1.8	*3.3*
Zululand	*743 859*	35.6%	*30%*	*49.3%*	*R63*	*1.6*	3.5

- Multiple factors contribute to the attainment of health - many of which are outside the control of the health department e.g. access to water & sanitation that can be used as a single-variable indicator of socio-economic status or deprivation, and a valuable marker for the need/ gaps of basic health services. This indicator (Table 8) confirm the lower-economic status of the four Integrated Sustainable Rural Development Nodes and although access to water & sanitation is not under the direct control of the health department it clearly indicates the importance of integrated development strategies between different sectors in the province.
- Improved health systems alone will not be able to reap sustainable change in the health status of communities and should form part of an integrated developmental strategy where communities are equally involved.

4 RESOURCE TRENDS

TABLE 9: Trends in Key Provincial Service Volumes

Indicator	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)
PHC headcount in PHC facilities	16,313,406	17,369,006	18,411,276	18,888,338	19,250,110	20,548,203
PHC headcount in Hospitals	Not collected prior to October 2004	Not collected prior to October 2004	Not collected prior to October 2004	415,300	498,470	454,908
Hospitals separations	675,992	600,280	672,265	735,315	762,447	116,379

TABLE 10 Trends in Provincial Public Health Expenditure

Expenditure	2004/05 (Actual) (R'000)	2005/06 (Actual) (R'000)	2006/07 (Actual) (R'000)	Average Annual % Change	2007/08 (Estimated Actual) (R'000)	2008/09 (MTEF projection) (R'000)	2009/2010 (MTEF projection) (R'000)	2010/11 (MTEF Projection) (R'000)
CURRENT PRICE								
Total.	R8 950,609	R10 555,752	R11 663,951	14.16%	R14,572,383	R15,042,826	R16,843,770	R19,523,923
Total per person.	R915.25	R1,071.49	R1,175.33	13.32%	R1,457.24	R1,493.16	R1,659.55	R1,909.39
Total per uninsured person.	R1,040.05	R1,217.60	R1,335.60	13.32%	R1,655.96	R1,696.77	R1,885.85	R2,169.76
CONSTANT 2007/08 PRICES								
Total.	R10 382,706	R11 822,442	R12 480,428	9.64%	R14 572,383	R14 140,256	R15 159,393	R12 722,215
Total per person.	R1,061.69	R1,200.07	R1,257.60	8.84%	R1,457.24	R1,403.57	R1,493.60	R1,642.07
Total per uninsured person.	R1,206.46	R1,363.72	R1,429.09	8.84%	R1,655.96.61	R1,594.96	R1,697.84	R1,865.99
% total spent on								
District Health Services.	47.52%	46.66%	46.04%	(1.57)%	46.90%	45.97%	45.93%	45.70%
Provincial Hospital Services.	28.09%	26.49%	32.29%	7.22%	26.76%	28.17%	28.33%	20.51%
Tertiary Hospital Services.	10.22%	10.12%	10.22%	0.01%	9.41%	9.57%	9.50	9.98%
All personnel.	R5 413,761	R5 925,640	R6 628,829	10.65%	R8 282,240	R8 707,238	R9 612,664	R11053,931
Capital.	R298,959	R540,922	R505,542	30.04%	R949,673	R837,737	R1,100,113	R1,441,292
Health as a percentage of total public expenditure.	31.9%	31.7%	31.6%	(0.47)%	31.3%	29.4%	29.00%	30.5%

5. MANDATE, GOALS AND PRIORITIES

5.1 Mandate

The Department is responsible for the implementation of legislative imperatives (refer to legal mandate on page 4), National and Provincial health policies, norms and standards.

The main purpose of the Department of Health is to develop and implement a sustainable, coordinated, integrated and comprehensive health system encompassing promotive, preventative, curative, rehabilitative and supportive/palliative care. This is guided by the principles of accessibility, equity, community participation, appropriate technology, inter-governmental - and inter-sectoral cooperation.

Four main categories of services are provided:

- PHC services.
- Hospital services.
- Emergency Medical Rescue Services (EMRS).
- Forensic medical pathology services.

The organisational configuration of the Department is the vehicle used to ensure effective and efficient health service delivery in pursuance of the objectives set in the Strategic Plan, STP and the APP of the Department.

The Department uses the DHS as the vehicle to render the main functions of the Department through the PHC Approach.

The Department continues to align the roles and responsibilities of the different organisational layers towards the promotion of seamless service delivery. Figure 10 summarises the District Health Service Delivery Platform in each District and Figure 11 summarises the Provincial Health Service Delivery Platform.

FIGURE 10: District Based Health Services

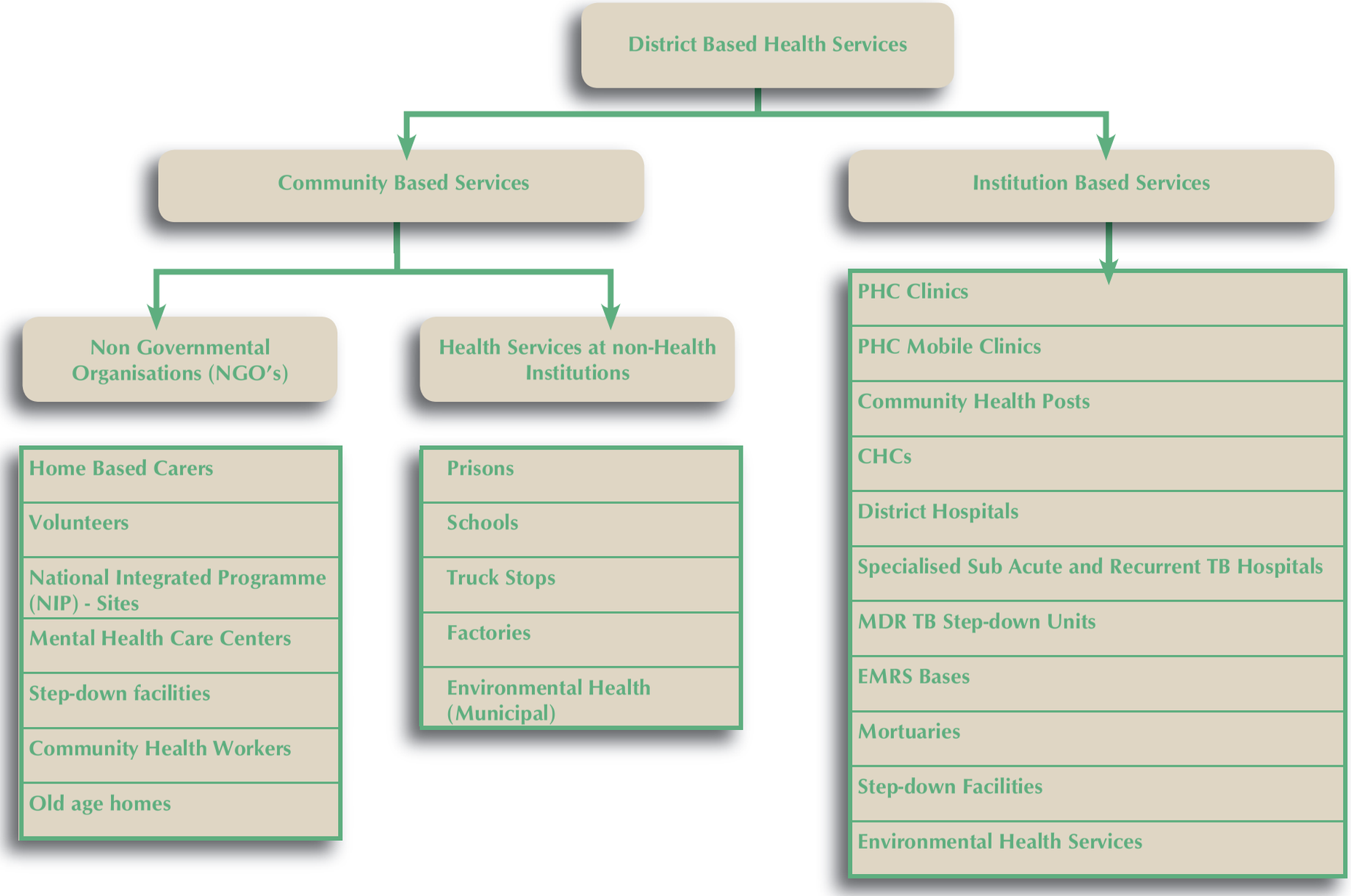
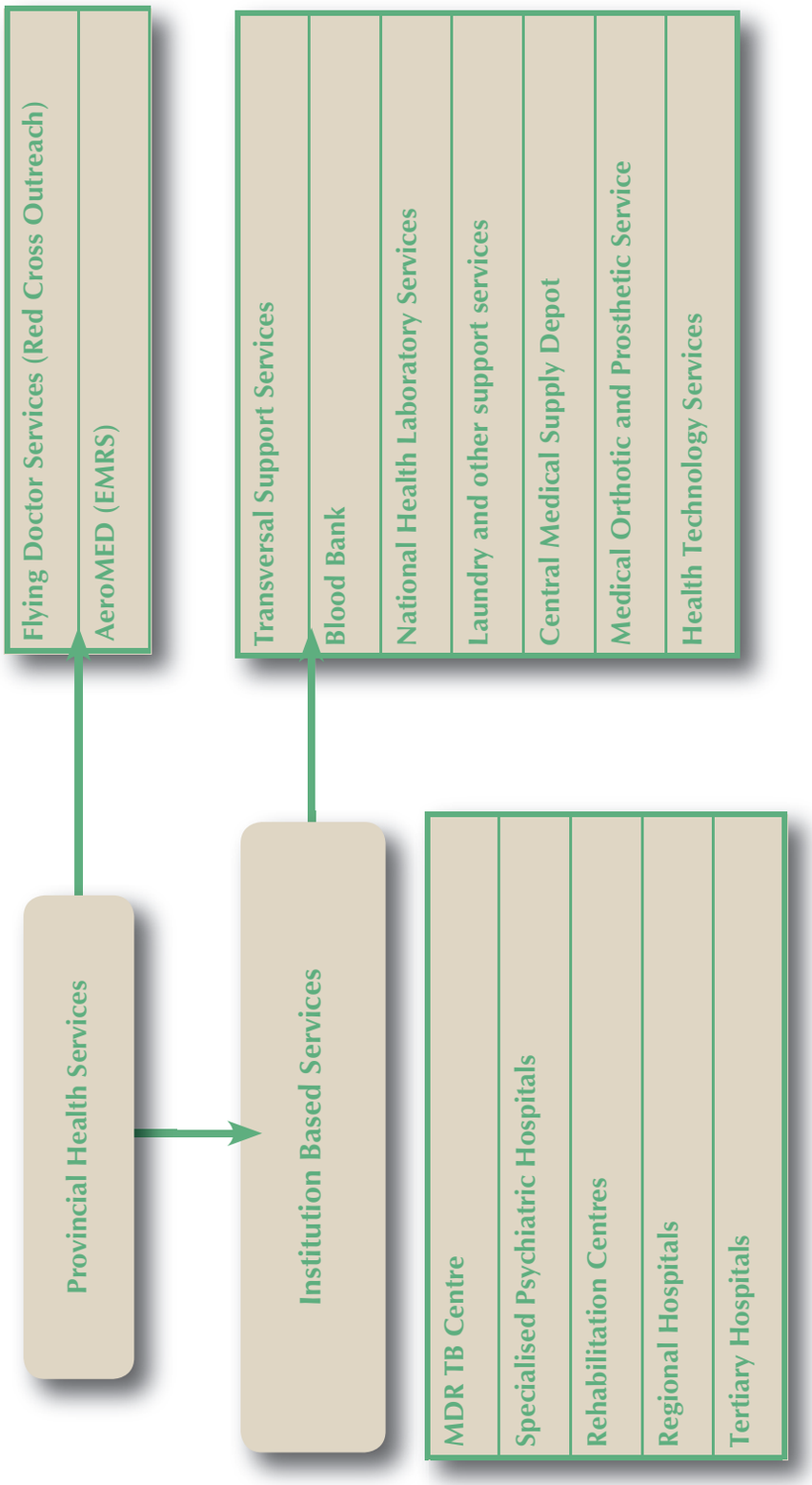


FIGURE 11: Provincial Based Health Services



5.2 Strategic Goals

The Departmental Strategic Goals are derived from the goals, targets and indicators of the Millennium Development Goals, as summarised in Table 11 below.

TABLE 11: Millennium Development Goals

MILLENNIUM DEVELOPMENT GOAL	TARGET	*INDICATORS*
1. Eradicate extreme poverty and hunger.	Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	*Prevalence of underweight children under 5 years of age.*
		Proportion of population below minimum level of dietary energy consumption.
2. Achieve universal primary education.	Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.	*Nett enrolment ratio in primary education.*
		Literacy rate of 15 -24 year olds.
3. Promote gender equality and empowerment of women.	Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015.	*Ratio of girls to boys in primary, secondary and tertiary education.*
		Ratio of literate females to males 15 -24 years old.
4. Reduce child mortality.	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.	*Under-5 mortality rate.*
		Infant mortality rate.
		Proportion of one-year old children immunised against measles.
5. Improve maternal health.	Reduce by three quarters, between 1990 and 2015, the maternal mortality ratios.	*Maternal mortality rate.*
		Proportion of births attended by skilled personnel.
6. Combat HIV and AIDS, malaria and other diseases.	Begun to decrease the spread of HIV and AIDS, malaria and other diseases.	*HIV prevalence among 15-24 year old pregnant women.*
		Condom use rate.
		Decrease in the number of children orphaned by HIV and AIDS.
		Proportion of the population in malaria risk areas using effective malaria prevention and treatment measures.
		Prevalence and mortality rates associated with TB.
		Proportion of TB cases detected and cured under the Directly Observed Treatment Short Course (DOTS).
7. Ensure environmental sustainability.	Halve, by 2015, the proportion of people without sustainable access to safe drinking water.	*Proportion of people with sustainable access to an improved water source.*
	By 2020 achieved a significant improvement in the lives of at least 100 million slum dwellers.	*Proportion of urban population with access to improved sanitation.*
8. Develop a global partnership for development.	Further develop an open, rule-based, predictable, non-discriminatory trading and financial system.	*Official development assistance.*
		Proportion of exports admitted free of duties and quotas.
	In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries.	*Proportion of population with access to affordable essential drugs on an established basis.*

5.3 Provincial Strategic Goals

The third session of the African Union Conference of Ministers of Health adopted the Africa Health Strategy for the period 2007 - 2015. This strategy provides an overarching framework to enable coherence within and between countries, civil society and the international community.

The overall objective of the Africa Health Strategy is to strengthen health systems in order to reduce ill-health and accelerate progress towards attainment of the MDGs. It aims to do this by:

- Facilitation of stronger collaboration between health and other sectors to improve the socio-economic and political environment for improving health.
- Strengthening and revitalising PHC.
- Decentralisation to ensure transparent management of the health system.
- Determination of an optimal health worker skills mix.
- Integrating traditional medicine into the national health system.
- Development of a timely health information system that is suitable to monitor progress, inform decision making and ensure quality in the delivery of health care.

The National Cabinet Lekgotla addressed the key themes of:

- Accelerating the implementation of health service delivery.
- Promoting and strengthening integrated health services planning for implementation.

The Provincial Social Cluster identified the following priorities:

- Integrated wellness programmes.
- Acceleration of the infrastructure backlog in the Province.
- Intensification of Human Capital.
- Developmentally orientated Supply Chain Management.
- Improving food security.

Health indicators for the country provide a mixed picture of performance. The responsibility for improving these indicators does not only rest with the health sector, but is indicative of the need for greater inter-sectoral coordination and cooperation (refer to Table 8). The main thrust for the Provincial Health Department is to accelerate the implementation of health services towards the attainment of the Millennium Development Goals (MDG) and related health indicators.

In moving forward national and international imperatives such as the 2014 vision, the 10 Point Plan and the five annual priorities of the National Department of Health have been incorporated into the planning agenda of the Provincial Department of Health. The National Department of Health identified five priority areas namely:

- Improving service delivery.
- Defining the role of Private Health Care.
- Improving health indicators.
- Improving Human Resources for health.
- Strengthening priority health programmes.

In line with the Priorities identified by the National Department of Health, the KwaZulu-Natal Department of Health adopted the Strategic Goals and Objectives for MTEF 2008/09 summarised in the Figure 12.

The goals are as follow:

- To improve health service delivery through optimal allocation of resources and collaboration with stakeholders and partners.
- To achieve health outcomes through improved health information systems, collection and analysis of health data and rigorous monitoring and evaluation.
- To strengthen Human-and other key Resources for optimal health services delivery.
- To strengthen priority health programmes using the PHC approach through the District Health System.
- To implement and sustain health programme to reduce non-communicable diseases.

STRATEGIC GOAL 1:

To improve health service delivery through optimal allocation and utilisation of resources and collaboration with all stakeholders & partners.

➢**Desired Outcome:**

The overall focus of this goal is to strengthen health systems in order to reduce ill-health and accelerate progress towards the attainment of the MDGs. The Department aims to improve service delivery via the facilitation of stronger collaboration between health and other sectors to improve the socio-economic and political environment for improving health. Partnerships with health sector organisations, other government departments, local community based organisations and non-governmental organisations will therefore be prioritised. The integrated planning process involving all stakeholders and prioritising PHC will therefore also continue. The utilisation of PHC services and supervision needs to be improved. Community based PHC services will also be strengthened.

The ultimate aim of the STP is to reshape the health services delivery system in order to provide accessible and quality health care services to all. The main purpose of the STP is to develop a plan that will enable the Province to deliver on all health priorities through the implementation of the primary health care approach. In this regard the Department is striving to demonstrate closer alignment of the infrastructure plans and budget plans to the STP. It is critical that infrastructure development and the purchase of medical equipment are fast tracked. The Department will continue to promote the community development through business opportunities.

In each District the Department has made significant progress towards Integrated District Management in terms of participation in the development and review of Integrated Development Plans and the development of District Health Plans (DHPs).

More emphasis is required to improve clinical governance issues inter alia quality of care and infection control. This focus also needs to be extended to enhancing implementation of the Patients Rights Charter, Citizens Charter and Batho Pele.

The historical definition of the Private Health Sector has to date failed to include Traditional Health Practitioners and African Traditional Medicine. The integration of traditional medicine into the provincial health systems is of great importance. Over one-third of the population in developing countries lack access to essential medicines. The provision of safe and effective Traditional Medicine (TM) and Complimentary Alternative Medicine (CAM) therapies could become a critical tool to increase access to health care.

Traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being [World Health Organisation (WHO), 2003].

Also imperative is to define the role of the Private Health Sector in developing the not-for-profit sector. Developing the not-for-profit sector would increase accessibility of health care and improve the long-term treatment of patients with poor prognosis. This strategy would also be enhanced by increasing the local manufacture of health products.

➢Strategic Focus Area

The following diagram summarises the different strategic objectives and measurable objectives which will be achieved through Goal 1.

Goal 1
To improve health service delivery through optimal allocation & utilisation of resources and collaboration with all stakeholders & partners.

Strategic Objective 1
To mainstream Primary Health Care Services. (See Annexure 3)

- **Measurable Objective:** To improve clinical care at PHC level.
- **Measurable Objective:** To improve PHC utilisation.
- **Measurable Objective** To improve PHC supervision.
- **Measurable Objective** To strengthen community-based PHC services.
- **Measurable Objective** To implement the roll-out of PHC Clinics & CHCs.
- **Measurable Objective** To design & implement a monitoring tool to validate the effectiveness of Community Based Services.

Strategic Objective 2
To improve clinical governance including quality of care & infection prevention & control. (See Annexures 1,2,7, 8,9)

- **Measurable Objective** To develop & implement a framework to improve clinical governance at all health facilities .
- **Measurable Objective** To guide & assess the implementation of infection prevention & control.
- **Measurable Objective** To ensure that all Central & Tertiary Hospitals provide quality care to all patients.
- **Measurable Objective** To ensure that all Regional Hospitals provide quality care to all patients.
- **Measurable Objective** To ensure that all District Hospitals provide quality care to all patients.

- **Measurable Objective** To guide & assess health services against norms & standards of the Quality Improvement Plan.
- **Measurable Objective** To improve access to EMRS in the Province.

Strategic Objective 3
To strengthen and increase collaboration with stakeholders & service providers involved in the health sector. (See Annexure 1)

- **Measurable Objective** To ensure community awareness on business opportunities.
- **Measurable Objective** To ensure that the Private Health Care Industry adheres to National Health Standards.
- **Measurable Objective** To promote collaboration between Provincial Health & Traditional Medicine/Healers.
- **Measurable Objective** To monitor the rendering of laboratory services by the National Health Laboratory Services (NHLS).

Strategic Objective 4
To ensure integrated planning for the provision of health services. (See Annexure 1)

- **Measurable Objective** To finalise a Strategic Plan for the Department for the period 2010-2016.
- **Measurable Objective** To compile the Annual Performance Plan & District Health Plans based on disease profiles & service delivery challenges .
- **Measurable Objective** To align the budget to approved Departmental Plans.
- **Measurable Objective** To report on service delivery via Quarterly Reports & the Annual Report.
- **Measurable Objective** To undertake & manage key research to inform health service planning & service delivery.

Strategic Objective 5
To accelerate infrastructure development and purchase of medical equipment. (See Annexure 12)

- **Measurable Objective** To facilitate the provisioning of basic enabling services such as electricity etc .
- **Measurable Objective** To appropriately manage & monitor Asset Management.
- **Measurable Objective** To oversee the implementation of capital Maintenance & Equipment.
- **Measurable Objective** To facilitate the commissioning of new infrastructure projects.
- **Measurable Objective** To appropriately manage & monitor infrastructure projects.
- **Measurable Objective** To quantify infrastructure backlogs & fast track implementation.

STRATEGIC GOAL 2:

To achieve health outcomes through improved health information systems, collection and analysis of health data and rigorous monitoring and evaluation of health data.

➢Desired Outcome:

It is imperative that the Department improves health indicators. To achieve this, health information systems, research, the quality of data and the process of monitoring and evaluation need to be improved. The monitoring and evaluation of the performance of the health system depends on the generation and use of sound data on health system inputs, processes, outputs and outcomes.

The Department needs to develop a simple, timely health information system that is suitable to monitor progress, inform decision making and assure quality in the delivery of health care. For such an information system to be effective, protocols and validation need to be put in place to ensure that the data collected is accurate and timely. Such data will then indicate both the performance of the system as well as the relevance of programmes to health problems. Improvement in health indicators is therefore intricately linked to management information systems, and quality assurance is an integral part of implementation at all systems.

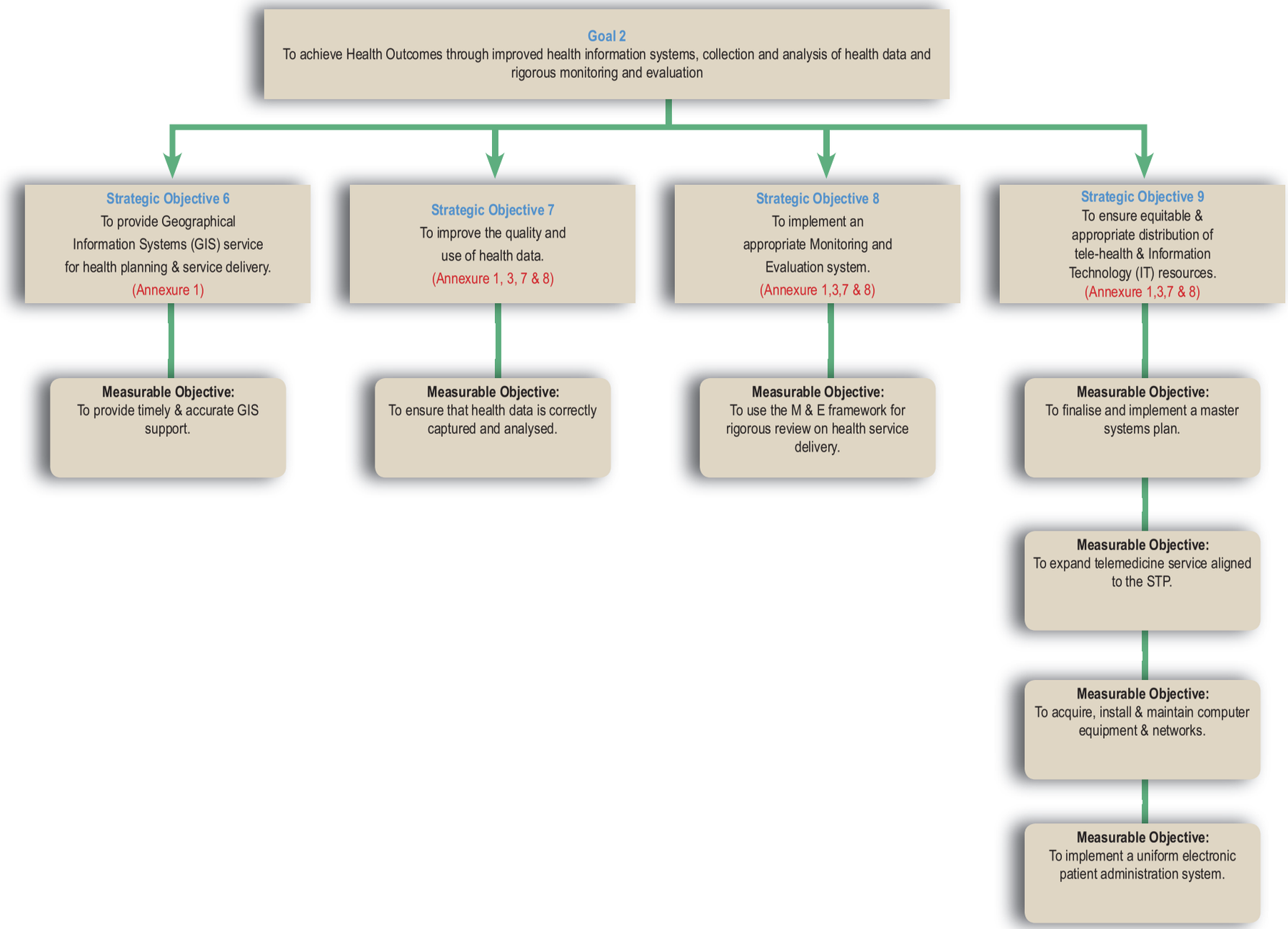
Critical insight to the relevance and value of indicators can also be obtained by empowering local researchers. This is a method of ensuring the development of innovative approaches and interventions which reflect the Provinces multi-cultural diversity.

Other key focus areas will include the:

- Implementation of interventions aimed at improving the quality of health data.
- Development and implementation of a uniform electronic patient administration system.
- Implementation of Telemedicine and the use of Information Technology (IT) for education in healthcare over distance. This will include the expansion of the provision of clinical services to remote rural communities, improved access to the provision of medical research; improved efficiency an dcost effectiveness in the delivery of rural healthcare services and a reduction of patient transfers.

➢Strategic Focus Area

The following diagram summarises the different strategic objectives and measurable objectives which will be achieved through Goal 2.


Goal 2
To achieve Health Outcomes through improved health information systems, collection and analysis of health data and rigorous monitoring and evaluation
Strategic Objective 6
To provide Geographical Information Systems (GIS) service for health planning & service delivery.
(Annexure 1)
Strategic Objective 7
To improve the quality and use of health data.
(Annexure 1, 3, 7 & 8)
Strategic Objective 8
To implement an appropriate Monitoring and Evaluation system.
(Annexure 1,3,7 & 8)
Strategic Objective 9
To ensure equitable & appropriate distribution of tele-health & Information Technology (IT) resources.
(Annexure 1,3,7 & 8)
Measurable Objective:
To provide timely & accurate GIS support.
Measurable Objective:
To ensure that health data is correctly captured and analysed.
Measurable Objective:
To use the M & E framework for rigorous review on health service delivery.
Measurable Objective:
To finalise and implement a master systems plan.
Measurable Objective:
To expand telemedicine service aligned to the STP.
Measurable Objective:
To acquire, install & maintain computer equipment & networks.
Measurable Objective:
To implement a uniform electronic patient administration system.

STRATEGIC GOAL 3:

To strengthen Human- and other key resources for optimal Public Health Services Delivery.

➢**Desired Outcome:**

One of the critical areas that need attention in the Department is the provision, retention and development of the health workforce. The Department will also strengthen human resources management to support the strategic objectives and service delivery imperatives of the Department. Special emphasis will be placed on talent management and the implementation of performance management. The Department has developed organisational structures and post establishments as part of the STP, which make provision for the optimal mix of scarce skills health professionals. These organisational structures are aligned to the package of services to be provided by each facility and allow for the strategic placement of health personnel to ensure optimal utilisation and efficiency. It is imperative that these structures are approved and implemented, especially the PHC structures. Implementation will result in a substantial strengthening of primary health care services across the Province. The Department will also develop and align the Service Delivery Improvement Plan as required by the Public Service Regulations.

The Department needs to determine which categories of nursing staff to train as well as the overall number to train per category. This determination will be guided by current vacancy and attrition rates in nursing occupational categories, as well as the skills mix required to deliver the package of services at each health facility. In this regard the Department plans to strengthen training and deployment of mid-level workers, as well as to contract independent practitioners into the public health system.

During MTEF 2008/09 the Department will focus on the expansion of the Home Based and Community Care Givers pool, to respond to the burden of disease and integration/ cross training of all DOT Supporters. Many communities in rural areas have limited and difficult access to health care. Home-Based Care Givers and Community-Based Lay Counselors render health services at household and community level.

These services include:

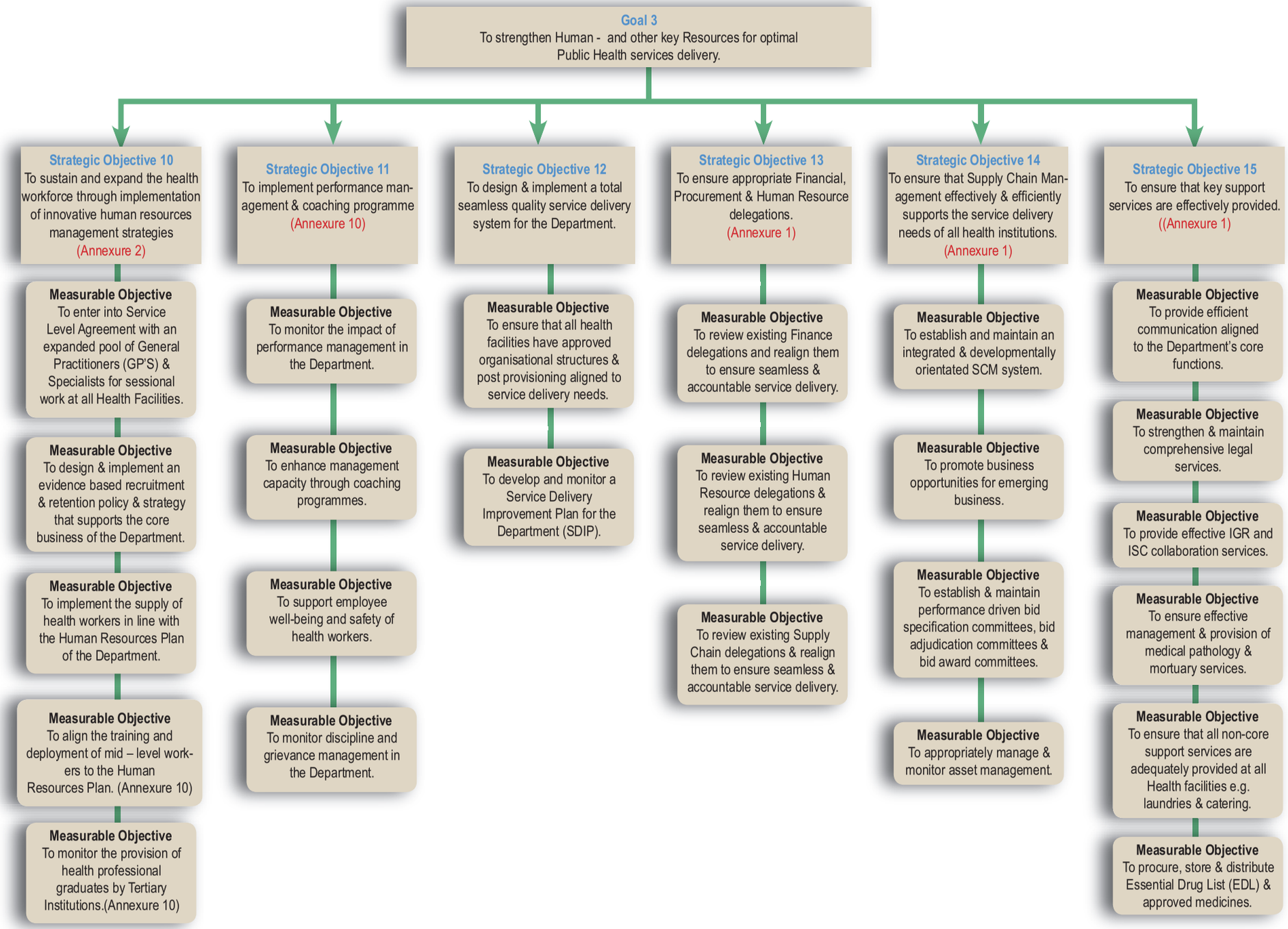
1. Home-Based Care.
2. Counseling.
3. Rehabilitative Services.
4. Treatment for TB, ART, Chronic Diseases and Mental Health.
5. Growth monitoring of orphans and vulnerable children.
6. Support for orphans and vulnerable children.

Areas that need further improvements include the rendering of SCM services. There is a need to ensure that these services are rendered effectively and efficiently to support the service delivery needs of all Health Institutions. Financial, procurement and Human Resource delegations will be reviewed and aligned towards the promotion of seamless and accountable service delivery. The Department will also improve asset management at all levels.

The Department will continue to provide communication services to all stakeholders within and outside the Department. Effective Inter-Governmental and Inter-Sectoral collaboration will be promoted. The Department will continue to improve the rendering of support services such as legal services, distribution of medicine, laundries and catering.

➢**Strategic Focus Area**

The diagram below summarises the different strategic objectives and measurable objectives which will be achieved through Goal 3.


Goal 3
To strengthen Human - and other key Resources for optimal Public Health services delivery.
Strategic Objective 10
To sustain and expand the health workforce through implementation of innovative human resources management strategies (Annexure 2)
Measurable Objective
To enter into Service Level Agreement with an expanded pool of General Practitioners (GP'S) & Specialists for sessional work at all Health Facilities.
Measurable Objective
To design & implement an evidence based recruitment & retention policy & strategy that supports the core business of the Department.
Measurable Objective
To implement the supply of health workers in line with the Human Resources Plan of the Department.
Measurable Objective
To align the training and deployment of mid – level workers to the Human Resources Plan. (Annexure 10)
Measurable Objective
To monitor the provision of health professional graduates by Tertiary Institutions.(Annexure 10)
Strategic Objective 11
To implement performance management & coaching programme (Annexure 10)
Measurable Objective
To monitor the impact of performance management in the Department.
Measurable Objective
To enhance management capacity through coaching programmes.
Measurable Objective
To support employee well-being and safety of health workers.
Measurable Objective
To monitor discipline and grievance management in the Department.
Strategic Objective 12
To design & implement a total seamless quality service delivery system for the Department.
Measurable Objective
To ensure that all health facilities have approved organisational structures & post provisioning aligned to service delivery needs.
Measurable Objective
To develop and monitor a Service Delivery Improvement Plan for the Department (SDIP).
Strategic Objective 13
To ensure appropriate Financial, Procurement & Human Resource delegations. (Annexure 1)
Measurable Objective
To review existing Finance delegations and realign them to ensure seamless & accountable service delivery.
Measurable Objective
To review existing Human Resource delegations & realign them to ensure seamless & accountable service delivery.
Measurable Objective
To review existing Supply Chain delegations & realign them to ensure seamless & accountable service delivery.
Strategic Objective 14
To ensure that Supply Chain Management effectively & efficiently supports the service delivery needs of all health institutions. (Annexure 1)
Measurable Objective
To establish and maintain an integrated & developmentally orientated SCM system.
Measurable Objective
To promote business opportunities for emerging business.
Measurable Objective
To establish & maintain performance driven bid specification committees, bid adjudication committees & bid award committees.
Measurable Objective
To appropriately manage & monitor asset management.
Strategic Objective 15
To ensure that key support services are effectively provided. ((Annexure 1)
Measurable Objective
To provide efficient communication aligned to the Department's core functions.
Measurable Objective
To strengthen & maintain comprehensive legal services.
Measurable Objective
To provide effective IGR and ISC collaboration services.
Measurable Objective
To ensure effective management & provision of medical pathology & mortuary services.
Measurable Objective
To ensure that all non-core support services are adequately provided at all Health facilities e.g. laundries & catering.
Measurable Objective
To procure, store & distribute Essential Drug List (EDL) & approved medicines.

STRATEGIC GOAL 4:

To strengthen Priority Health Programmes using the Primary Health Care Approach through the District Health System.

➢**Desired Outcome:**

The Department will continue to intensify Priority Health Programmes using the Primary Health Care approach through the District Health Systems. The importance of prevention versus management of diseases will receive high priority through the implemetation of healthy lifestyle programmes coupled with various community out-reach programmes to facilitate the participation and buy-in of communities in health programmes.

Consistent with the goals reflected in the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment, the Department recognises that HIV and Aids is the business and responsibility of every programme and every health practitioner. The Department recognises the Operational Plan goals that encompasse the three pillars of the South African Government's response to the HIV epidemic, namely prevention, treatment and care, situated within the context of a comprehensive continuum of comprehensive care where all citizens will have equal access to services.

The Department will focus on three core outputs namely:

1. Integrated, comprehensive and coordinated services through collective programmatic planning within the Department especially between the reciprocally affected programmes of prevention of mother to child transmission (PMTCT), TB and STIs to ensure that all users entering the health system receive appropriate services within and outside the health system.

2. Rendering a comprehensive package of HIV and AIDS services (including nutrition enhancement) by defining the service package per facility, assessing all users against a holistic health assessment tool, and by ensuring that service providers are appropriately trained and supported.

3. Improving the quality of services received by users by providing clear guidelines for the integration of HIV and Aids service, and through assessments of adherence to Service Principle Guidelines, protocols and procedures by applying qualitative and quantitative indicators to facilitate evidence-based planning and delivery.

The Department will continue to implement the Provincial TB Crisis Management Plan with special focus on the 6 priority areas namely:

1. Strengthening Laboratory Services Capacity;
2. Improving Programme Management Capacity to ensure effective technical support and monitoring;
3. Strengthening case finding and improving the capacity for clinical management of TB patients at Facility level;
4. Strengthening community support i.e. DOTS support and community participation;
5. Strengthening management of MDR/ XDR TB; and
6. Strengthening the TB reporting and recording system.

The reduction of morbidity and mortality amongst infants, children under-5 and pregnant women are recognised as key public health goals internationally and also key MDGs to be attained by 2015.

In recent years, the HIV and AIDS epidemic has increased the already heavy burden of disease and death among this vulnerable population. The increase in the prevalence of HIV infection amongst women of reproductive age has resulted in an increase in infection rates among infants and children, most of which is associated with Mother-To-Child-Transmission. As a consequence, HIV and AIDS is now a significant cause of under-five mortality.

MC&WH and Nutrition services are built into the District Health System and integrated within a suite of Primary Health Care services. The principles of PHC will be vigorously encouraged to ensure a move away from traditional vertical and autonomous health care programmes towards integrated (health) infrastructure capable of providing both general and specialised health care (from community to tertiary level) effective to the entire target population in relation to their main health needs – a principle supported by the STP.

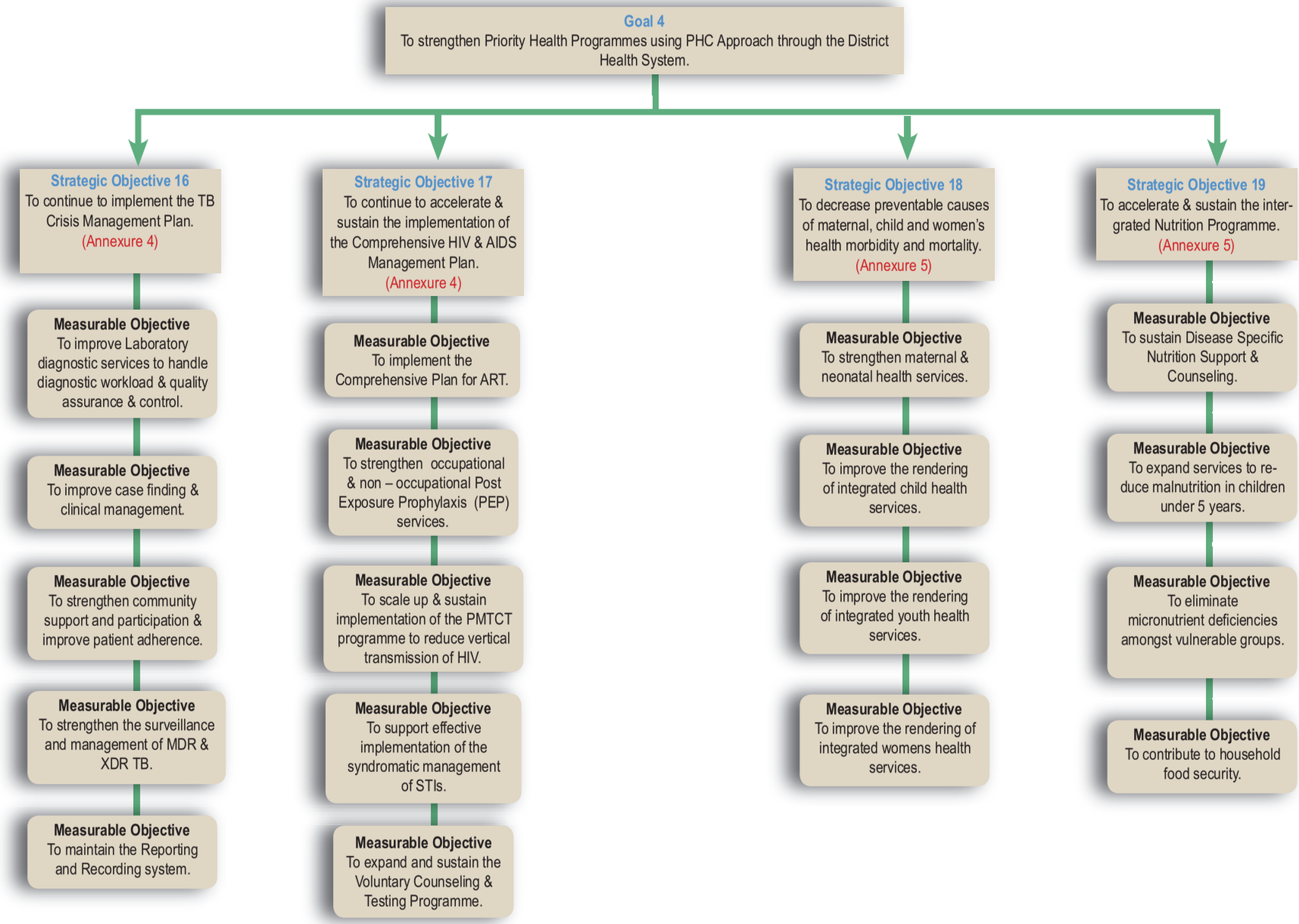
MC&WH will focus on:

1. Improving Neonatal and Maternal health through the implementation of the 10 Saving Mother's Recommendations;
2. Expanding IMCI services (both the clinical management of the sick child and the Clinic to Community Component);
3. Improving the Expanded Programme on Immunisation (EPI) with strong focus on the Reach Every Child/District (RED) strategy in hard to reach areas;
4. Establishing Well Child services to reduce missed opportunities and improve health seeking behaviours;
5. Improving Sexual and Reproductive Health services that form the foundation of MC&WH.

The Nutrition services component will continue to extend services to vulnerable groups through interactive strategies and activities while simultaneously playing an active role in promoting healthy nutritional practices.

➢Strategic Focus Area

The following diagram summarises the differnet strategic objectives and measurable objectives which will be achieved through Goal 4.


Goal 4
To strengthen Priority Health Programmes using PHC Approach through the District Health System.
Strategic Objective 16
To continue to implement the TB Crisis Management Plan.
(Annexure 4)
Measurable Objective
To improve Laboratory diagnostic services to handle diagnostic workload & quality assurance & control.
Measurable Objective
To improve case finding & clinical management.
Measurable Objective
To strengthen community support and participation & improve patient adherence.
Measurable Objective
To strengthen the surveillance and management of MDR & XDR TB.
Measurable Objective
To maintain the Reporting and Recording system.
Strategic Objective 17
To continue to accelerate & sustain the implementation of the Comprehensive HIV & AIDS Management Plan.
(Annexure 4)
Measurable Objective
To implement the Comprehensive Plan for ART.
Measurable Objective
To strengthen occupational & non – occupational Post Exposure Prophylaxis (PEP) services.
Measurable Objective
To scale up & sustain implementation of the PMTCT programme to reduce vertical transmission of HIV.
Measurable Objective
To support effective implementation of the syndromatic management of STIs.
Measurable Objective
To expand and sustain the Voluntary Counseling & Testing Programme.
Strategic Objective 18
To decrease preventable causes of maternal, child and women's health morbidity and mortality.
(Annexure 5)
Measurable Objective
To strengthen maternal & neonatal health services.
Measurable Objective
To improve the rendering of integrated child health services.
Measurable Objective
To improve the rendering of integrated youth health services.
Measurable Objective
To improve the rendering of integrated womens health services.
Strategic Objective 19
To accelerate & sustain the inter-grated Nutrition Programme.
(Annexure 5)
Measurable Objective
To sustain Disease Specific Nutrition Support & Counseling.
Measurable Objective
To expand services to re-duce malnutrition in children under 5 years.
Measurable Objective
To eliminate micronutrient deficiencies amongst vulnerable groups.
Measurable Objective
To contribute to household food security.

STRATEGIC GOAL 5:

To implement and sustain health programmes to reduce non-communicable diseases.

➢**Desired Outcome:**

With regard to mental health, the Department will adopt a new policy framework on the delivery of mental health services. The aim is to ensure that adequate provisioning is made in the comprehensive treatment plans of patients for a Rehabilitation Plan addressing rehabilitation in the Institution, step down arrangements and continuation within the community context after discharge.

Provision is made in the STP for two categories of Mental Health Services, namely hospital based mental health services and community based mental health services. Hospital based mental hospital services consists of Psychiatric Hospitals (Category A), Forensic Hospitals (Category B) and Specialised Long-term Psychiatric Hospitals (Category C). Additionally, the STP makes provision for "entry" level psychiatric services to be provided by District and Regional Hospitals. In each District Hospital four mental health beds are provided. 20 Mental Health beds are provided at each Regional Hospital. Each of the above mentioned facilities will also have a dedicated holding room.

A generic organisational and post establishment structure for the provisioning of the designated packages of service was developed for the different categories of Institutions. This structure was based on a standard catchment population with the input of Clinicians, District Office Management Teams and the Unit: Integrated Health Policy and System Development. The post establishment provisions (only health care workers) are based on the nature of the clinical procedures to be performed, the bed allocation and specific service delivery barriers.

In terms of the STP, the Department does not view community based mental health services as a separate entity that is divorced from specialised psychiatric services, but rather a continuum of care. There must be ongoing interaction between the two levels, with a reciprocal relationship of one supporting the other. Community based care relies on ongoing outreach and support from Specialised Psychiatric Services. Likewise, Specialised Psychiatric Services rely on community based mental health services for step-down care, out-patient follow-up care, de-institutionalisation, screening, early diagnosis and timely/ appropriate referral for specialised care.

As the burden of care migrates from specialised care towards community services, there is a natural progression from highly specialised human resources towards a reliance on community based individuals and organisations. The same applies for mental health services. The community based mental health care approach has a strong emphasis on inter-sectoral collaboration with various inputs from non-governmental organisations, non- profit organisations and faith-based organisations. Their role is invaluable to the process to improve the overall health status of communities.

The strengthening of community based support systems will include close collaboration with non-profit organisations and other PHC service providers. The intention is to establish partnerships with non-profit organisations for the establishment and maintenance of "day-care centres" and "group homes" for those clients who require longer term rehabilitation. The aim is to utilise relevant health care users as far as possible to "operate" the facilities on their own, thereby encouraging independent living. These facilities will therefore be supported on a limited scale by the departmental PHC network.

The Healthy Lifestyle Programme will use a more focused and integrated client-centered health promotion approach in line with the National and Provincial Health Priorities. This approach supports a comprehensive and inter-sectoral solution to service delivery commencing at community and PHC level through the DHS. The five National Health 'Healthy Lifestyle' priorities i.e. nutrition, physical activity ('Vuka SA – Move for your Health campaign'), tobacco control, alcohol and drug abuse, and safe sexual practices are prioritised by all Districts and outcome will be monitored to determine input versus outcome.

Chronic Diseases & Geriatrics will extend the *Vision 2020* (Prevention of Blindness) Programme by extending cataract surgery including refractive services. The Provincial cataract surgery rate increased from 7,892 in MTEF 2004/05 to 8,701 in MTEF 2006/07.[14] Community outreach programmes are providing the vehicle through which sustainable partnerships with the private sector are sustained.

Equality and social integration of people with disabilities are prioritised and achieved through strategies such as community based rehabilitation, employment equity, and capacity development and training.

➢Strategic Focus Area

The following diagram summarises the differnet strategic objectives and measurable objectives which will be achieved through Goal 5.

[14] DHIS.

Goal 5
To implement and sustain health programmes to reduce communicable and non-communicable diseases.

Strategic Objective 20
To ensure the effective implementation of programmes to reduce non-communicable diseases & diseases of lifestyle.
(Annexure 6)

Measurable Objective:
To implement integrated health promotion & healthy lifestyle programmes.

Measurable Objective:
To operationalise the imperatives set by the Mental Health Act, 2002.

Measurable Objective:
To implement & sustain an integrated diability & rehabilitation strategy.

Measurable Objective:
To implement & sustain the comprehensive programme for Chronic Diseases & Geriatrics.

Measurable Objective:
To reorientate Oral Health from a curative to a preventive approach.

Measurable Objective:
To reduce morbidity * mortality due to non-communicable diseases.

HEALTH
KwaZulu-Natal

PART B

1. BUDGETS

2. PROGRAMMES

3. SUB-PROGRAMMES

MTEF PERIOD 2008/09 - 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

HEALTH
KwaZulu-Natal

NOTES

MTEF PERIOD 2008/09 - 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

HEALTH
KwaZulu-Natal

ANNEXURE 1

PROGRAMME 1:

ADMINISTRATION PLANNING

MTEF PERIOD 2008/09 - 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

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PROGRAMME DESCRIPTION

The provision of strategic leadership and -management, including overall administration of the Department.

PROGRAMME STRUCTURE

Sub-programme 1.1 – Office of the Member of the Executive Council (MEC)
Ensuring effective and efficient governance arrangements and systems supporting the MEC.

Sub-programme 1.2 – Management
Policy formulation, planning, monitoring and evaluation in line with legislative- and governance mandate.

1. INTRODUCTION

The Administration Programme comprises of two Sub-Programmes, namely: the Office of the MEC and Management (Office of the Head of Department).

The objective of the Programme is to provide dynamic strategic leadership and management steering towards health services that contribute towards the achievement of optimal health status of all the people in the Province, and administration in line with legislative imperatives and good governance practice.

The role of the Programme includes the following:

- Formulation of evidence-based policies and strategies in line with relevant National and Provincial priorities, legislative mandates, existing evidence and the '*voices of communities'*.
- Ensuring that systems and processes in support of health service delivery is developed.
- Rigorous monitoring and evaluation of service delivery and health outcomes in the Province.

Office of the MEC

The purpose of this Office is to ensure effective and efficient governance arrangements and systems in support of the MEC and the provision of technical assistance to the MEC to manage and account for the performance of the Provincial Health Portfolio. It includes, inter alia, the provision of parliamentary, stakeholder and community liaison services.

Management

The purpose of the Office of the Head of Department (HOD) (inclusive of all head office components) is to:

- Enable the MEC to fulfil her legislative and political mandate.
- Ensure effective and efficient utilisation of resources, including the development of staff.
- Provide strategic leadership and support in the development of health services in the Province.
- Ensure compliance to legislative and good governance imperatives by all layers of the Department.
- Enable health services to perform optimally through strategic direction, evidence-based policies and guidelines and supportive leadership.
- Facilitate processes to unblock health service delivery barriers falling outside the functional mandate of the Department.
- Provide transversal services that cannot be decentralised from an economy-of-scale perspective.

2. SITUATION ANALYSIS

The Department defined the role of the Head Office as a Strategic Enabler, the role of Districts as Operational Enablers and the role of Health Institutions as Implementation Agents.

The Head Office Structure is diagrammatically illustrated in Figure 1. The structure provides for the following three Clusters:

Cluster: Integrated Health Services Delivery

Includes four Units:

- Service delivery Coordination in each of the three Management Areas. (Operations Western Service Area, Operations North Eastern Service Area, Operations South Eastern Service Area).
- Infrastructure Development and Clinical Support.

Cluster: Integrated Health Services Development

Includes three Units:

- Health Service Planning, Monitoring and Evaluation.
- Strategic Health Programmes.
- Health Service Policy and System Development.

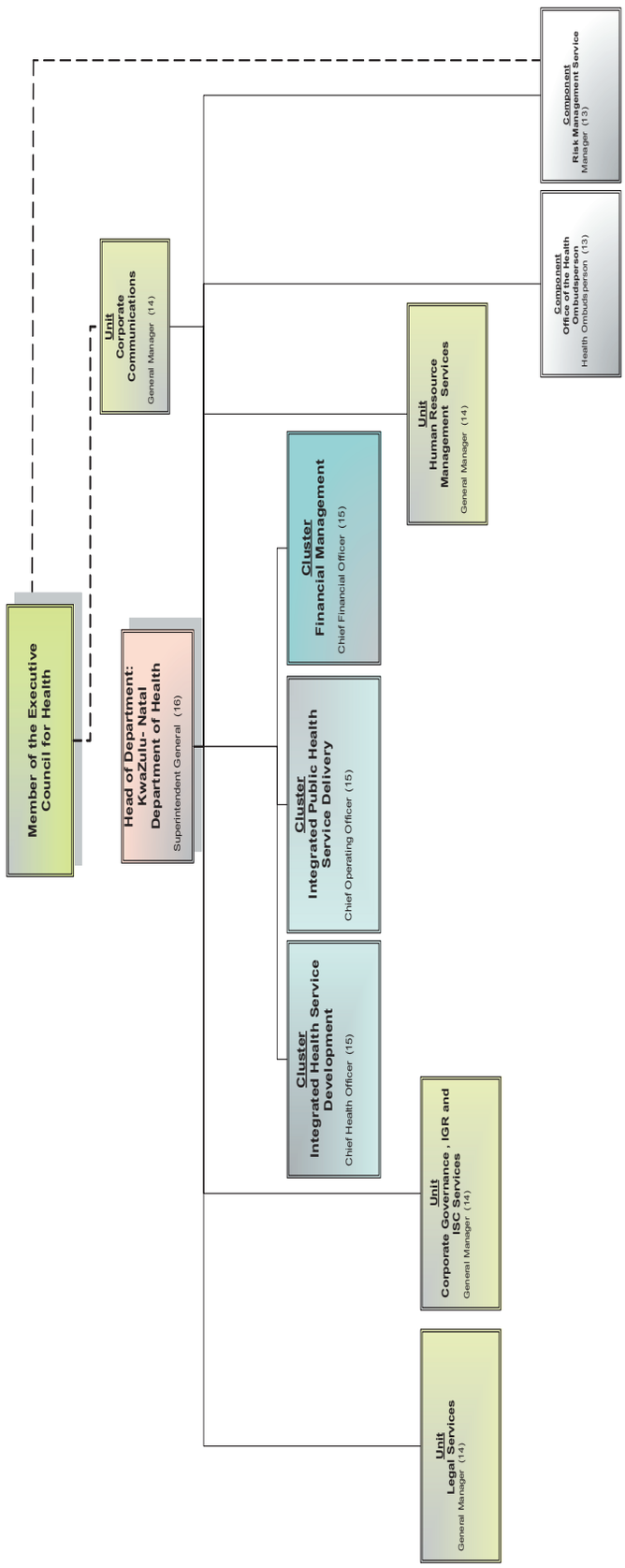
Cluster: Financial Management

Includes two Units:

- Budget and Supply Chain Management Service.
- Accounting Service.

ANNEXURE 1

FIGURE 1: Macro Organisational Chart Configuration



3. POLICIES, STRATEGIC OBJECTIVES AND PRIORITIES

3.1 Policies and Strategic Objectives

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

A high standard of professional ethics.
≈
Efficient, economic and effective use of resources.
≈
Public administration must be development-oriented.
≈
Services must be provided impartially, fairly, equitably and without bias.
≈
People's needs must be responded to and the public must be encouraged to participate in policy-making.
≈
Public administration must be accountable.
≈
Transparency must be fostered by providing the public with timely, accessible and accurate information.
≈
Good human-resource management and career-development practices to maximise human potential must be cultivated.
≈
Public administration must be broadly representative of the South African people.

During MTEF 2006/07 the Department commenced with a review of all health and governance policies including transversal human resources and supply chain management policies. The following policies were developed during MTEF 2007/08:

Health and Governance Policies:

- Hospital Governance Policy.
- Integrated Child Health Policy.
- Integrated Antenatal and Post Natal Care Policy.
- Disaster Management Policy.
- Psycho-Social Rehabilitation Policy.
- Integrated HIV and AIDS Policy.
- Infection Control Policy.

Transverse Human Resources Policies:

- Entitlement Leave Policy.
- Family Responsibility Leave Policy.
- Policy on Remunerative work outside the Public Sector.
- Appointment of Sessional Employees Policy.
- Policy on Counter Offers.

The Department's strategic objectives are based on the 5 Strategic Goals in line with the National Department of Health priorities for MTEF 2007/08 – 2009/10 (referred to as the National Health System Priorities).

ANNEXURE 1

TABLE 1: National Health System Priority 1: Development of Service Transformation Plans

Activity	Indicators	Targets 2006/07	Targets 2007/08	Targets 2008/09	Responsibility
Application of the Integrated Health Planning Framework.	Scenarios developed by the Province.	Completed and first draft STP submitted in May 2006.	Completed and second draft STP submitted in February 2007. Final draft submitted in May 2007.	Consultation with communities. Commence with implementation of STP.	Health Services Planning, Monitoring and Evaluation Unit.
Provincial APP.	APP Part A completed.	100% completed by end of May 2005. Approved by the HOD and MEC.	100% completed by end of May 2006. Approved by the HOD and MEC.	100% completed by end of May 2007. Approved by the HOD and MEC.	Health Services Planning, Monitoring and Evaluation Unit.
	EMRS business Plans completed & aligned with STP.	EMRS business plans completed by June 2007.	EMRS business plan to be aligned to the STP.	EMRS business plan to be aligned to the STP.	EMRS Component.
	Modernisation of Tertiary Services (MTS) hospitals) implementation plan agreed to by the Province by December.	MTS business plan aligned to the needs of the Province and submitted to National Health in November 2006.	MTS Hospital Plan completed and submitted to National Department of Health in February 2007.	MTS Hospital Plans completed and submitted to National Department of Health in November 2008.	Health Policies and Systems Unit.
	Develop full transport systems plan for delivery of patients to hospitals and specialists to lower care levels.	Plan developed by September 2007.	Transport systems Plan aligned to STP.	Transport systems Plan aligned to STP.	Health Policies and Systems Unit.
	Develop full plan for utilisation of telemedicine links to increase Specialist availability.	Plan developed by May 2007 as part of the STP.	Approval of Telemedicine Plan and commencement with Implementation.	Implementation of Telemedicine Plan.	IT & Telemedicine Unit.

Activity	Indicators	Targets 2006/07	Targets 2007/08	Targets 2008/09	Responsibility
	APP Part B.	100% completed by end of August 2005. Approved by the HOD and MEC.	100% completed by end of August 2006. Approved by the HOD and MEC.	100% completed by end of August 2007. Approved by the HOD and MEC.	Health Services Planning, Monitoring and Evaluation Unit.
Implementation Management.	Effective Planning, implementation & monitoring.	Developed strategic planning Unit closely linked to information, Monitoring and Evaluation Units.	Monitoring &E situation analysis completed. M&E Strategy formulated.	M&E framework completed and implemented. M&E System developed and implemented.	Health Services Planning, Monitoring and Evaluation Unit.
	Fully implement delegations at all levels but especially at Hospital level.	Audit and strengthen existing delegations by September 2007.	Review delegations and implement recommendations by April 2008.	Review delegations and implement recommendations by April 2009.	Human Resource Management Services Unit. Finance Cluster.
	Health Information Systems.	Master Systems Plan (MSP) completed by March 2008.	Integrated hospital and patient information system implemented at all Tertiary and Regional Hospitals by March 2009.	Integrated hospital and patient information system implemented at all District Hospitals by March 2010.	IT & Telemedicine Unit.
	All Tertiary- and Central Hospitals 33% of Regional Hospitals to be routinely reporting International Classification of Diseases version 10 (ICD 10) coding.	All Tertiary and Central hospitals and 33% of Regional hospitals to be routinely reporting ICD 10 coding.	70% of Regional Hospitals routinely reporting ICD 10 coding.	80% of Regional Hospitals and 8% District Hospitals routinely reports ICD 10 coding.	Health Policy and Systems Unit.
	Timely data reporting into Quarterly Reporting System used at all levels of the health system by August 2006.	Quarterly reports submitted within the required time frames.	Quarterly reports submitted within the required time frames.	Quarterly reports submitted within the required time frames.	Health Services Planning, Monitoring and Evaluation Unit.

TABLE 2: Programme 1 Provincial Objectives and Performance Indicators for administration

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
CORPORATE COMMUNICATIONS								
Strategic Objective: To ensure that key support services are effectively provided. (Goal 3)								
Measurable Objective: To provide efficient communication aligned to the Department's core functions.								
Number of media briefings.	Not measured	1	4	4	4	4	4	8
Number of campaigns undertaken.	4	4	4	4	4	4	4	12
Provincial Council Indaba coordinated.	Not measured.	Not measured.	Not measured.	1	1	1	1	1
Imbizo per area per National Imbizo Focus Week.	Not measured.	1	5	12	12	12	12	12

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
LEGAL SERVICES								
Measurable Objective: To strengthen and maintain comprehensive legal services.								
Analysis of litigation cases.	Not measured.	Not measured.	Not measured.	60%	70%	80%	90%	100%-
Establishment of a compendium of all legislation.	Not measured.	10%	20%	30%	50%	70%	90%	95%
Ad hoc legal advice rendered.	Not measured.	40%	60%	60%	70%	70%	70%	75%
Contract management system operational.	Not measured.	40%	60%	70%	70%	80%	90%	95%
CORPORATE GOVERNANCE, IGR AND ISC								
Measurable Objective: To provide effective IGR & ISC collaboration services.								
% of planned IGR services provided.	Not measured.	Not measured.	0%	0%	30%	55%	75%	80%
% compliance with Social Cluster actions.	Not measured.	Not measured.	25%	50%	80%	90%	90%	90%
Coordination of donor services.	Not measured.	Not measured.	Not measured.	30%	30%	50%	75%	85%
Co-ordination of youth, gender and special focus groups.	Not measured.	Not measured.	Not measured.	40%	40%	60%	75%	80%
To strengthen collaboration between the University of KwaZulu-Natal & the Department.	-	-	-	30%	30%	50%	75%	95%

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Measurable Objective : To render effective and efficient corporate services to Head Office								
% of posts filled in terms of posts advertised for Head Office.	Not measured.	Not measured.	Not measured.	20%	40%	60%	75%	80%
% SMS compliance to Financial Disclosures.	Not measured.	Not measured.	Not measured.	100%	100%	100%	100%	100%
Coordination of General Administration Services for Head Office.	30%	30%	30%	45%	55%	70%	80%	90%
Measurable Objective: To provide an effective document management system for the Head Office.								
% compliance with legal prescripts governing document – and archive management.	Not measured	Not measured	Not measured	30%	50%	70%	80%	90%
% of Forms designed and systems established.	Not measured	Not measured	Not measured	10%	20%	40%	60%	80%

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
OMBUDSPERSON								
Measurable Objective: To ensure the implementation of mechanisms for the management of complaints.								
% of complaints acknowledge within 3 days after receipt.	70%	75%	80%	80%	80%	90%	100%	100%
% of complaints resolved within 60 days[1].	70%	75%	80%	80%	80%	90%	100%	100%
INSTITUTIONAL SECURITY AND RISK MANAGEMENT SERVICE								
Measurable Objective: To ensure organisational integrity within the Department.								
Conduct high profile investigations in collaboration with Law Enforcement Agencies.	Not measured.	Not measured.	Not measured.	50%	50%	80%	100%	100%
Development of Anti-Fraud and Corruption Plan.	Not measured.	Not measured.	Not measured.	80%	100%	100%	100%	100%
Measurable Objective: To strive towards the establishment of a safe and secure work environment.								
Development of a security manual relevant to the service delivery challenges of the Department.	Not measured.	Not measured.	Not measured.	70%	100%	100%	100%	100%
Vetting of staff (Percentage related to specified staff categories.	Not measured.	Not measured.	Not measured.	20%	40%	60%	80%	100%

[1] Indicator has changed to 25 days and Department will report against this indicator as from MTEF 2008/09.

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Conduct security audit.	Not measured.	Not measured.	Not measured.	20%	40%	60%	80%	100%
Implement asset protection system at all Health Institutions.	Not measured.	Not measured.	Not measured.	20%	40%	60%	80%	100%
Security advice on MEC's events.	Not measured.	Not measured.	Not measured.	100%	100%	100%	100%	100%
Measurable Objective: To ensure the provision of effective and efficient risk management support services.								
Creation of a fully functional Risk management service.	Not measured.	Not measured.	Not measured.	30%	50%	80%	100%	100%
Development of a Departmental Risk Management Policy.	Not measured.	Not measured.	Not measured.	100%	100%	100%	100%	100%
Development of Risk Management strategy for the Department.	Not measured.	Not measured.	Not measured.	100%	100%	100%	100%	100%
Departmental risk profile assessments conducted.	Not measured.	Not measured.	Not measured.	100%	100%	100%	100%	100%
Measurable Objective: To foster a risk management culture in the Department.								
Development and implementation of a Departmental Risk Mitigation Plan.	Not measured.	Not measured.	Not measured.	80%	90%	100%	100%	100%

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Conduct risk awareness programmes.	Not measured.	Not measured.	Not measured.	80%	90%	100%	100%	100%
Ensure that risk management form an integral part of the Key Result Areas of relevant staff.	Not measured.	Not measured.	Not measured.	50%	70%	80%	100%	100%
SUPPLY CHAIN MANAGEMENT (SCM)								
Strategic Objective: To ensure that SCM effectively & efficiently supports the service delivery needs of all health institutions. (Goal 3)								
Measurable Objective: To establish and maintain an integrated & developmentally orientated SCM system.								
SCM delegations approved and implemented.	Not measured.	40%	60%	100%	100%	100%	100%	100%
% of Health Institutions included in training sessions on SCM.	Not measured.	Not measured.	50% of all Health Institutions.	70% of all Health Institutions.	80% of all Health Institutions.	95% of all Health Institutions.	100% of all Health Institutions.	100% of all Health Institutions.
% of Procurement Plans completed to guide acquisition of goods and services by Head Office and Institutions.	Not measured.	Not measured.	40%	60%	75%	80%	100%	100%
Accurate and updated asset register maintained in Institutions.	Not measured.	Not measured.	50%	60%	90%	95%	100%	100%

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Policies, processes and systems for safeguarding of assets and for inventory control developed and implemented.	Not measured.	Not measured.	40%	50%	90%	100%	100%	100%
Contract Management System implemented.	Not measured.	Not measured.	40%	50%	90%	100%	100%	100%
Updated specifications for the acquisition of transversal goods and services developed and compiled in catalogue.	Not measured.	Not measured.	Not measured.	55%	75%	80%	100%	100%
Logistical support systems implemented to reduce “stock outs” and improve service delivery.	Not measured.	Not measured.	Not measured.	70%	80%	95%	100%	100%
Measurable Objective: To promote business opportunities for emerging business.								
Strategic sourcing guidelines for targeted procurement formulated and implemented.	Not measured.	Not measured.	Not measured.	50%	75%	100%	100%	100%
% of business awarded to Small Medium and Micro Enterprises (SMMEs).	Not measured.	Not measured.	+9%	+10%	+10%	40%	40%	40%
% of businesses awarded to co-operatives.	Not measured.	Not measured.	+9%	+10%	+10%	10%	10%	10%
% of business awarded to persons with disabilities.	Not measured.	Not measured.	+0%	+20%	+10%	+10%	+10%	+10%

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
% of business awarded to companies owned by the "youth".	Not measured.	Not measured.	N0%	+30%	+10%	+10%	+10%	+10%
% of business awarded to companies from rural areas.	Not measured.	Not measured.	+9%	+50%	+10%	+10%	+10%	+10%
% of business awarded to companies owned by women.	Not measured.	Not measured.	+9%	+50%	+10%	+10%	+10%	+10%
Objective: To establish & maintain performance driven Bid Specification Committees, Bid Adjudication Committees & Bid Award Committees								
Fully functional Bid Specification Committee at Head Office.	Not measured.	Not measured.	Not measured.	100%	100%	100%	100%	100%
Fully functional Bid Adjudication Committee at Head Office.	Not measured.	Not measured.	Not measured.	100%	100%	100%	100%	100%
Fully functional Bid Award Committee at Head Office.	Not measured.	Not measured.	Not measured.	100%	100%	100%	100%	100%
Required SCM Committees fully functional t all hospitals.	Not measured.	Not measured.	Not measured.	90%	95%	100%	100%	100%
Measurable Objective: To ensure community awareness on business opportunities in the Department								
Number of awareness campaigns conducted.	Not measured.	Not measured.	40	50	70	85	85	85

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
% increase of targeted groups participating in the procurement process of the Department.	Not measured.	Not measured.	25%	30%	45%	60%	65%	70%
Measurable Objective: To establish systems to support the acquisition of goods and services (database).								
Database established to support the acquisition of goods and services.	Not measured.	Not measured.	Not measured.	40%	80%	100%	100%	100%
FINANCIAL MANAGEMENT								
Strategic Objective: To ensure appropriate Financial, Procurement Delegations. (Goal 3)								
Measurable Objective: To review existing Finance delegations & realign them to ensure seamless & accountable service delivery.								
Written delegations in place.	Not measured.	Not measured.	Not measured.	Not measured.	Not measured.	95%	97%	100%
Last review of written delegations.	Not measured.	Not measured.	Not measured.	Not measured.	Not measured.	Target outstanding from Finance Cluster.	Target outstanding from Finance Cluster.	Target outstanding from Finance Cluster.
Effective measures to ensure monitoring & measurement of delegations in the Department.	Not measured.	Not measured.	Not measured.	Not measured.	Not measured	Target not determined by Finance Cluster.	Target not determined by Finance Cluster.	Target not determined by Finance Cluster.

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
% of Departmental expenditure fruitless, unauthorised/lost due to theft.	Not measured.	Not measured.	Not measured.	Not measured.	Not measured	0%	0%	0%
% of Department's budget constituting donor funding.	Not measured.	Not measured.	Not measured.	Not measured.	Not measured	Target not determined by Finance Cluster.	Target not determined by Finance Cluster.	Target not determined by Finance Cluster.
Measurable Objective: To ensure that all finance systems & budgetary processes are aligned to the Strategic & Service Transformation objectives of the Department.								
An equitable & aligned budget.	Not measured.	80%	85%	88%	90%	100%	100%	100%
Improved budget management & control.	Not measured.	Not measured.	Not measured.	80%	95%	100%	100%	100%
Mechanism to guide prioritisation & budgeting processes for institutions.	Not measured.	Not measured.	Not measured.	90%	95%	98%	100%	100%
Measurable Objective: To implement and maintain effective and efficient financial and revenue administration systems.								
An effective, efficient, disciplined and competent financial management at Institutions, including financial management, banking services, reporting and taxation services.	60%	85%	80%	90%	92%	97%	100%	100%

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
TELEHEALTH AND INFORMATION TECHNOLOGY								
Strategic Objective: To ensure equitable & appropriate distribution of tele-health & IT resources. (Goal 2)								
Measurable Objective: To expand the provision of clinical services to remote rural communities by December 2008.								
Number of tele-health sites operational.	37	37	37	37	37	37	37	37
Number of sites providing medical research, education & training to rural health care providers.	3	3	3	3	3	3	3	3
Number of sites providing access to medical research, education training to rural health providers.	3	3	3	3	3	3	3	3
Number of post graduate training programmes provided.	6	6	6	6	6	6	6	6
Measurable Objective: To acquire, install and maintain computer equipment, systems and networks supporting seamless service delivery processes.								
% redundant/obsolete Personal Computers (PCs) replaced.	Not measured.	10%	25%	20%	80%	100%	100%	100%
% of Hospitals, CHCs and Institutions other than PHC Clinics that are VPN compliant.	Not measured.	0%	0%	100%	100%	100%	100%	100%

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
% of PHC Clinics with PCs and Printers.	Not measured.	5%	8%	20%	80%	100%	100%	100%
% of Hospitals with upgraded data lines.	Not measured.	Not measured.	Not measured.	0%	100%	100%	100%	100%
% of Hospitals with functioning Kiosks.	0%	0%	0%	90%	100%	100%	100%p	100%
% of Health Professionals trained on Funda. La online training project.	Not measured.	Not measured.	0%	0%	25%	50%	75%	100%
Measurable Objective: To develop a MSP by December 2008.								
Master Systems Plan approved by December 2008.	0%	0%	0%	0%	0%	100%	100%	100%
All IT & Data Management systems being used in the Department aligned to the MSP.				0%	10%	20%	25%	30%-

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Measurable Objective: To implement a uniform electronic patient administration system.								
All tertiary hospitals implementing a uniform electronic patient administration system.				0%	1	3	3	4
HEALTH SERVICE POLICY & SYSTEMS DEVELOPMENT UNIT								
FORENSIC PATHOLOGY								
Strategic Objective: To ensure that key support services re effectively provided. (Goal 3)								
Measurable Objective: To ensure the effective and efficient management and provision of forensic medical pathology and mortuary services.								
Number of functional Mortuary Facilities in the Province.	Not measured.	Not measured.	25	25	46	46	46	46
% Objectives and Targets set for the Business Plan to access Conditional Grant resources accomplished.	Not measured.	Not measured.	Not measured.	70%	80%	90%	100%	100%
Policies, norms, standards and protocols decentralised provision implemented.	Not measured.	Not measured.	Not measured.	70%	80%	90%	100%	100%
NHLS								
Measurable Objective: To monitor the rendering of laboratory services by the NHLS to the Department.								
Departmental NHLS utilisation protocol developed and implemented.	Not measured.	Not measured.	Not measured.	100%	100%	100%	100%	100%

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Analysis of tariff structure.	Not measured.	Not measured.	Not measured.	50%	80%	90%	100%	100%
Monitoring and Evaluation of Service Level Agreement (SLA) for NHLS.	Not measured.	Not measured.	Not measured.	50%	80%	100%	100%	100%
% of instances of non compliance with Service Level Agreement Imperatives reported/resolved.	Not measured.	Not measured.	Not measured.	50%	80%	90%	100%	100%
OTHER HOSPITALS								
Strategic Objective: To strengthen and increase collaboration with stakeholders involved in the health sector. (Goal 3)								
Measurable Objective: To ensure that the Private Health Care industry adheres to National Health Standards.								
Percentage of Private Hospitals inspected.	Not measured.	Not measured.	Not measured.	100%	100%	100%	100%	100%
Percentage of applications for Re-licensing of Private Hospitals services received and processed.	Not measured.	Not measured.	Not measured.	100%	100%	100%	100%	100%
Percentage of applications for the provisioning of private services processed.	Not measured.	Not measured.	Not measured.	100%	100%	100%	100%	100%
Percentage applications for new licences reviewed at a quarterly basis.	Not measured.	Not measured.	Not measured.	50%	80%	100%	100%	100%

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Fully established & functional Committees at Head Office to review all applications for licenses.	Not measured.	Not measured.	Not measured.	50%	80%	100%	100%	100%
Measurable Objective: To develop health policies and systems ensuring seamless and effective health service delivery.								
Health Policies guidelines and systems developed, including norms and standards for service delivery.	Not measured.	Not measured.	Not measured.	Not measured.	5[2]	5	3	3
Develop a framework to improve clinical governance in the Health Facilities.	Not measured.	Not measured.	Not measured.	Not measured.	80%	100%	100%	100%
HEALTH SERVICE PLANNING, MONITORING AND EVALUATION UNIT								
Strategic Objective: To ensure integrated planning for the provision of health services. (Goal 2)								
Measurable Objective: To finalise a strategic Plan for the Department for the period 2010-2016 based on the STP by December 2008.								
Approved Strategic Plan for next 5 years reflecting Provincial needs & based on the STP.	Not measured.	Not measured.	Not measured.	50%	60%	90%	90%	100%
Measurable Objective: To compile the Annual Performance Plan & District Health Plans (DHP) based on the disease profile & service delivery challenges.								
Approved APP reflecting Provincial needs.	Not measured.	Not measured.	Not measured.	60%	75%	100%	100%	100%

[2] The policies developed can be found on p 43.

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Approved DHP's reflecting the outcome of District Health Expenditure Review (DHER) & District specific needs.	Not measured.	Not measured.	Not measured.	60%	75%	100%	100%	100%
DHER completed for each District to determine efficiency, effectiveness, equity, sustainability & cost.	Not measured.	Not measured.	Not measured.	60%	75%	100%	100%	100%
Service delivery targets determined.	Not measured.	Not measured.	Not measured.	Not measured.	Not measured.	100%	100%	100%
Measurable Objective: To implement the STP as from MTEF 2008/09.								
Finalised STP.	Not measured.	Not measured.	Not measured.	60%	90%	100%	100%	100%
Analysis of key health trends to inform epidemiology profile.	Not measured.	Not measured.	Not measured.	0%	60%	70%	60%	90%
Completed Health Profile Study for PHC 11 Districts for PHC for 2007.	Not measured.	Not measured.	Not measured.	0%	0%	11 Districts	Data captured and analysed.	11 Districts
Measurable Objective: To Compile Quarterly Reports & Annual Report in line with the indicators & targets indicated in the APP & DHP's.								
Approved Annual Report aligned to performance targets.	Not measured.	Not measured.	Not measured.	60%	100%	100%	100%	100%
Approved Quarterly Reports aligned to service delivery performance indicators.	Not measured.	Not measured.	Not measured.	60%	100%	100%	100%	100%

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Measurable Objective: To undertake & manage key research to inform health services planning & service delivery.								
Number of Appropriate research studies to improve health services.	Not measured.	Not measured.	Not measured.	0	0	3	3	3
Fully functional & institutionalised Departmental Research & Ethics Committee.	Not measured.	Not measured.	Not measured.	0 Meeting	1 Meeting	4 Meetings	4 Meetings	4 Meetings
Assessment of research proposals & analyses of research findings.	Not measured.	Not measured.	Not measured.	0%	100%	100%	100%	100%
Research findings updated on the Provincial database.	Not measured.	Not measured.	Not measured.	0%	0%	100%	100%	100%
Strategic Objective: To provide GIS services for health planning & service delivery.								
Measurable Objective: To provide timely & accurate GIS support.								
Updated dissemination of data.	Not measured.	Not measured.	Not measured.	Not measured.	60%	100%	100%	100%
Compliance with National Spatial Information Framework.	Not measured.	Not measured.	Not measured.	Not measured.	0%	100%	100%	100%
Updated STP database.	Not measured	Not measured	Not measured	Not measured	70%	90%	100%	100%

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Strategic Objective: To improve the quality & use of health data.								
Measurable Objective: To ensure that health data is correctly captured & analysed for MTEF 2008/09.								
DHIS Version 1.4 implemented.	Not measured.	Not measured.	Not measured.	Not measured.	0%	100%	100%	100%
Data Management Policy implemented.	Not measured.	Not measured.	Not measured.	Not measured.	0%	100%	100%	100%
Measurable Objective: To use the M & E framework for rigorous review on health service delivery as from May 2008.								
Approved M&E framework.	Not measured.	Not measured.	Not measured.	Not measured.	TOR approved.	100%	100%	100%
Approved early warning system established on monitoring established.	Not measured.	Not measured.	Not measured.	Not measured.	20%	100%	100%	100%
Strategic Objective: To improve clinical governance including quality of care & infection prevention & control. (Goal 1)								
Measurable Objective: To guide & assess the implementation of infection prevention & control.								
Two modules of the Infection Assessment Tool (ICAT) implemented. Modules: hand washing, labour & delivery, isolation & employee health.	-	-	-	-	0%	100% Hospitals implementing	100% Hospitals implementing	100% Hospitals implementing
Approved implementation plan for Infection Prevention & Control (IPC).	-	-	-	-	0%	Approved Plan.	100% Hospitals implementing	100% Hospitals implementing
Early warning on IPC developed.	-	-	-	-	0%	100%	100%	100%

ANNEXURE 1

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Measurable Objective: To guide & assess health services against norms & standards of the Quality Improvement Plan.								
Quality Assurance (QA) policy & Integrated QA Tool.	-	-	-	-	0%	100%	100%	100%
External Client Experience Survey conducted.	-	-	100%	0%	0%	2 CHCs & 26 Hospitals	2 CHCs & 26 Hospitals	2 CHCs & 26 Hospitals
Waiting time survey conducted at hospitals.	-	-	-	58%	13%	58%	65%	80%
Integrated QA implemented at all Tertiary Hospitals.	-	-	-	0%	0%	100%	100%	100%

TABLE 3: Programme 1 Trends in Provincial Public Health Expenditure (R million)

Expenditure (R million)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual))	Average Annual percentage change	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices								
Total	R162,295	R192,917	R224,900	17.72%	R284.755	R305,488	R325,165	R359,916
Total per person.	R16.60	R19.58	R22.66	16.86%	R28.48	R30.32	R32.04	R35.20
Total per uninsured person.	R18.86	R22.25	R25.75	16.86%	R32.36	R34.46	R36.41	R40.00
Total capital.	-	-	-		-	-	-	
Constant (2007/08) prices.								
Total.	R188,262	R216,067	R240,643	13.06%	R284,755	287,159	R292,649	R309,528
Total per person.	R19.25	R21.93	R24.25	12.23%	R28.48	R28.50	R28.83	R30.27
Total per uninsured person.	R21.88	R24.92	R27.56	12.23%	R32.36	R32.39	R32.77	R34.40
Total capital.	-	-	-	-		-	-	-

HEALTH
KwaZulu-Natal

NOTES

MTEF PERIOD 2008/09 - 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

HEALTH
KwaZulu-Natal

ANNEXURE 2

PROGRAMME 1: ADMINISTRATION PLANNING

SUB PROGRAMME: HUMAN RESOURCE MANAGEMENT

MTEF PERIOD 2008/09 - 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

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1. SITUATION ANALYSIS

1.1 Human Resources Plan

The Human Resources Plan (HRP), which has been developed as an integral part of the STP, addresses the present and future human resource requirements of the Department. It provides an indication of the number of Health Workers to be trained to ensure optimal service delivery in accordance with core functions of the Department.

The Human Resource Planning Tool focuses on how human resources will contribute towards the achievement of the health system goals of quality, efficiency, equity, affordability, sustainability, and the overall health goals of improved health status, fair financing, and responsiveness.

The Tool, developed by the Harvard School of Public Health and the WHO was customised for use by the Department. Basic Human Resources Management elements incorporated in the Tool include the level, number and types of Health Workers, their distribution and their performance. Cross cutting issues include migration of Health Workers, the general attractiveness of different health professions, the package of services, structures, multiple job holding, absenteeism and motivation.

The Tool also addresses issues of financing, education (which will be reviewed in MTEF 2008/09) and management, which are key policy levers for change. (Note: The Departmental HRP did not address the Assessment Factors of Financing and Education. The factors of skills mix, Human Resources for Health (HRH) Performance, Quality and Efficiency under the State of HRH have also been excluded. These factors will be assessed in MTEF 2008/09).

The HRP forecasts HR requirements for the next ten years. The Plan will be reviewed annually to ensure that it is informed by service delivery imperatives. The HRP also supports the development and provision of critical human resources required to implement the STP. As part of the implementation of the HRP, staffing norms for PHC Clinics, CHC's and Hospitals (all levels) have been developed. The HRP provides a coherent analysis of supply and demand curves for all health profession categories that will be required to successfully implement the STP.

The Tool analysed the areas listed in Figure 1. The finalisation of the financing and education assessment factors has not been completed by the Department.

FIGURE 1: Human Resource Planning Tool

Assessment factor	Cross cutting issues	State of HRH	System goals agreed in STP	Health Goals
Financing Education Management Stakeholders	Package of services & structures Professional attractiveness Migration Sensitivity analysis Multiple job holding Absenteeism & Ghost workers Motivation	Human Resources for Health (HRH) level - How many: Categories Distribution Skills mix Geographical location Sector Gender HRH Performance (What & how they do it) Quality (clinical service) Efficiency	Quality Efficiency Equity/ Accessibility Sustainability	Health status Fair financing Responsive

The HRP identified the following key issues:

1. The implementation of Rural Allowances to recruit and retain staff is adversely influenced by the lack of staff accommodation and a shortage of essential community infrastructure. Health Professionals[1] are generally reluctant to relocate to areas where their spouses are unlikely to find employment and their children cannot easily access schools.

2. Rural allowance is having unintended consequences namely:
   - Internal migration of nursing staff out of PHC services to Hospitals where facilities and accommodation are available and the rural allowance is still payable. It is anticipated that with the introduction of the Occupational Specific Dispensation (OSD) for Nursing

[1] The term Health Professionals refers to health occupational categories requiring registration. The term Health workers refers to health occupational categories not requiring registration.

personnel effective from July 2007, the situation will improve as recognition is granted for PHC qualified Nursing staff.

3. There is a high level of internal migration in the Department. Health Workers do not occupy posts for sufficient periods to develop a sound knowledge/ skills base and community/ patient relations, which directly influences quality of care. From June 2006 to June 2007 a total of 1,038 officials were promoted whilst on probation, with the highest percentage of promotions for the occupational categories of Medical Officer (272 equivalent to 25%), Professional Nurses (345 equivalent to 31%) and Staff Nurses (74 equivalent to 6%). These statistics show that Health Workers are not staying at an institution long enough to build community relations and develop an adequate knowledge and skills base to improve quality of care.

4. An analysis of the migration of Health Workers in the Department over a 12-month period, June 2006 to June 2007, revealed high percentages of staff migration between facilities to obtain higher-level positions and taking lateral transfers back to their District of origin. Salary levels reflected a lateral transfer rate in excess of 21%.

5. The Department's Recruitment and Retention Policy and Strategy for Health Workers has not been finalised and is impacting negatively on service delivery.

6. The proportional split between Professional Staff and Support Staff in the Department is alarming. It is generally accepted that a 17% to 35% (of total staff) provision of support staff in relation to core staff reflects an acceptable health mix for service delivery. In some Districts in the Province the ratio for support staff is as high as 63%.

7. The entry salary levels for the Health Professions Occupational Categories are not market related, resulting in the majority of entry-level posts being advertised with no appropriate applications being received.

8. There is increased pressure to convert entry-level posts into more senior positions. The arguments expressed here are clearly demonstrated in Table 1. In interpreting the Table it is particularly important to focus on the number of applicants short-listed.

Although many applications may be received for a post only those applicants who meet all the requirements for a position may be short-listed. This position means that the Department does not have a wide pool or broad variety of applicants from which to select. The information again reinforces the argument that professional attractiveness of health professionals within the Public Sector is perceived negatively.

There is some reported evidence that use of provider incentives and enablers can improve performance under specific circumstances. For example, Eichler and colleagues[2] show that indicators of achievement that were used to establish bonus payments improved when a bonus system was introduced in Haiti, and use of financial incentives was reported to positively change health worker behaviour in terms of heightened productivity in Cambodia[3].

TABLE 1: Short-listed Candidates

Job Title	Posts advertised	Applications received	Applicants short-listed
Dietician	75	120	82
Medical Officer	704	1133	721
Nursing Assistant	836	8380	2139
Nursing Manager	29	357	114
Occupational Therapist	50	79	61
Pharmacist	208	381	231
Physiotherapist	101	198	148
Professional Nurse	2621	6171	2813
Psychologist	21	42	26
Radiographer	170	333	256
Social Worker	98	740	364
Specialist	129	124	105
Speech Therapist	19	29	24
Staff Nurse	697	7535	1720
Grand Total	**5758**	**25622**	**8804**

[1] Eichler R, Auxila P, Pollock J. Output based health care: paying for performance in Haiti. Public Policy for the Private Sector, Note No. 236. Washington DC: World Bank 2001.

[3] van Damme W, Meessen B, von Schreeb J, et al. Sotnikum New Deal, the first year: better income for health staff: better service to the population. Cambodia: Medecins Sans Frontieres; Antwerp: Institute of Tropical Medicine; Phnom Penh: National Institute of Public Health; Brussels: AEDES; Cambodia: UNICEF, 2001.

9. There is an increase in the number of Pharmacists, Emergency Care Practitioners, Medical Officers and Professional Nurses performing remunerative work outside the Public Service.

10. In all Districts, approximately 70% of all vacant posts in the Department are filled through the appointment of internal applicants, although applications from outside are being received. The Department is therefore not succeeding in expanding the pool of Health Workers.

11. All Senior Managers in Head Office completed competency assessments in line with the Senior Management Framework as prescribed by the Minister for Public Service and Administration. Development, mentoring, coaching and training of these Managers are based on the outcome thereof.

    The process to ensure that all Institutional Senior Managers undergo competency assessments is in progress. This will assist in developing management capacity for the envisaged increased delegated powers in line with the promotion of autonomy and the enhancement of service delivery. 15 Managers are scheduled to benefit from the KHAEDU project, 20 Managers are currently undergoing a Masters Programme in Public Health, 20 Managers for Advanced Management Development Programme, 4 Managers are currently attending an Integrated Management Development Programme and 20 Managers and Supervisors are scheduled to attend and benefit from the Foundation Management Development Programme.

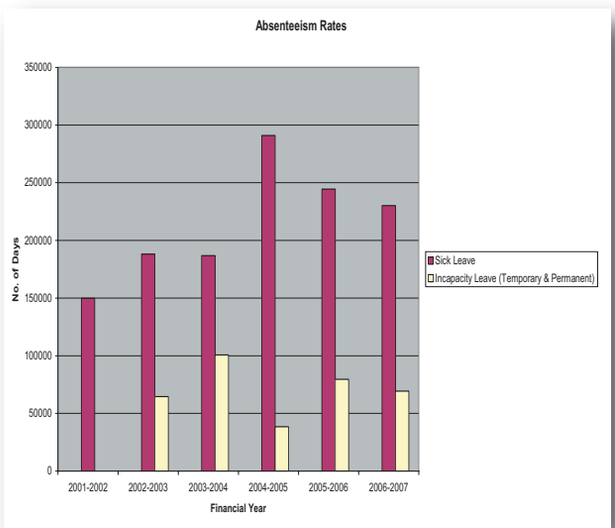
12. The vacancy rate for Professional Nurses is 20.75% in 2007/08 as compared to 17% in 2006/07, and attrition rates 12.80% as compared to 13% in 2006/07.

    Attrition rates for doctors were 10.30% as compared to 13.8% in 2006/07. Recruitment of foreign health professionals continues to address gaps in professional categories.

13. An analysis of leave patterns was undertaken. The analysis revealed that leave categories (sick leave, temporary incapacity leave and permanent incapacity) show consistent and constant increases in comparison with preceding years. It is anticipated that with the introduction of the Health Risk Manager (Thandile Health Risk Management) effective from November 2006, cases of temporary and permanent incapacity leave will be viewed more closely with a view of curbing abuse of these privileges and staff being referred to the necessary service for the necessary rehabilitation and care with a view of improving their health status.

    The same analysis indicates that approximately 68% of employees have utilised sick leave benefits. The majority of this leave is utilised by staff occupying posts between levels 4 and 8. This is disconcerting as these are the operational production level of the Department.

FIGURE 2: Absenteeism Rate



14. In assessing the impact of HIV and AIDS it should be noted that the Department of Health bears a dual burden. The Department has to deal with the impact of HIV and AIDS on its workforce however, is also faced with dealing with the impact of HIV and AIDS on the patient population. HIV and AIDS has changed the disease profile of the population, the level and intensity of care provided by healthcare professionals have increased dramatically, whilst in many cases prognosis has worsened. This condition also impacts on the consultation time of health care professionals as they are seeing patients with multiple complaints e.g. HIV and AIDS, TB, and STI's which requires more time per patient as apposed to seeing a patient with minor ailments.

    Health care professionals face intense physical, emotional and psychological demands which, when

taken in conjunction with increased workloads, may result in stress and burnout.

15. Only 56% of facilities implemented employee satisfaction surveys in 2007/08 and this will receive extensive attention in 2008/09 as part of the retention strategy.

16. The Department did not implement performance management during MTEF 2005/06 and MTEF 2006/07 as required by the Public Service Regulations. The Department only commenced with the implementation of performance management as required by the Public Service Regulations as from MTEF 2007/08. An agreement was reached (approved by the National Minister of Public Service and Administration) that a 1.5% increase was awarded to staff on condition that there was satisfactory performance and that performance management will be implemented as from MTEF 2007/08. Consultants were appointed to train all staff, supervisors and managers on performance management.

1.2 Staffing Norms and Gaps

The development and implementation of the STP by Provincial Health Departments is one of the five National Health System Priorities. These Plans will be implemented within the next 10 years (2006/07 to 2015/2016).

The Department utilised service delivery needs (accessibility, referral patterns, bed occupancy rates, average number of patients per month visiting PHC facilities), disease, health and poverty profiles and population norms in terms of catchment population for different levels of care to determine staffing norms for Health Workers. Generic organisational and post establishment structures for the provisioning of the designated packages of service were developed for the different categories of institutions using a standard catchment population. Input was provided by Clinicians, District Offices, Management Teams and the Unit: Integrated Health Policy and System Development.

The first draft of the STP was released in May 2006 for comment by stakeholders within the Department. The draft was based on the application of the Integrated Health Planning Framework Tool (IHPF) of the National Department of Health, using National norms and standards. The outcome of the scenario planning process identified a possible service delivery model (platform) for the Province and how to re-configure the health services system through integrated planning of resources.

The second and third draft STP were finalised during May 2006 – February 2007. The final STP was presented to all stakeholders during the period June 2007-October 2007.

During MTEF 2007/08 the Department will commence with the implementation of the revised organisational arrangements and post establishment structures at District Offices and Institutional levels. A decentralisation framework will simultaneously be implemented for the maintenance and alignment of post establishment provisions at Public Health Institutions in the Province.

For an analysis of Staffing Norms, please refer to Annexure 3.

2. PRIORITIES AND STRATEGIC OBJECTIVES

2.1 Human Resource Priorities

1. Align the Human Resource Development strategies of the Department with the service delivery imperatives in the STP.
2. Align the business of HRM and HRD to support the core business of the Department.
3. Implement the Employee Performance Management and Development System.
4. Develop and implement an effective Human Resource Recruitment and Retention Strategy.
5. Implement the HRP of the Department in close consultation with Universities, Colleges and other key role players.
6. Fast track the implementation of an effective and efficient employee well-being programme including special focus on health workers.

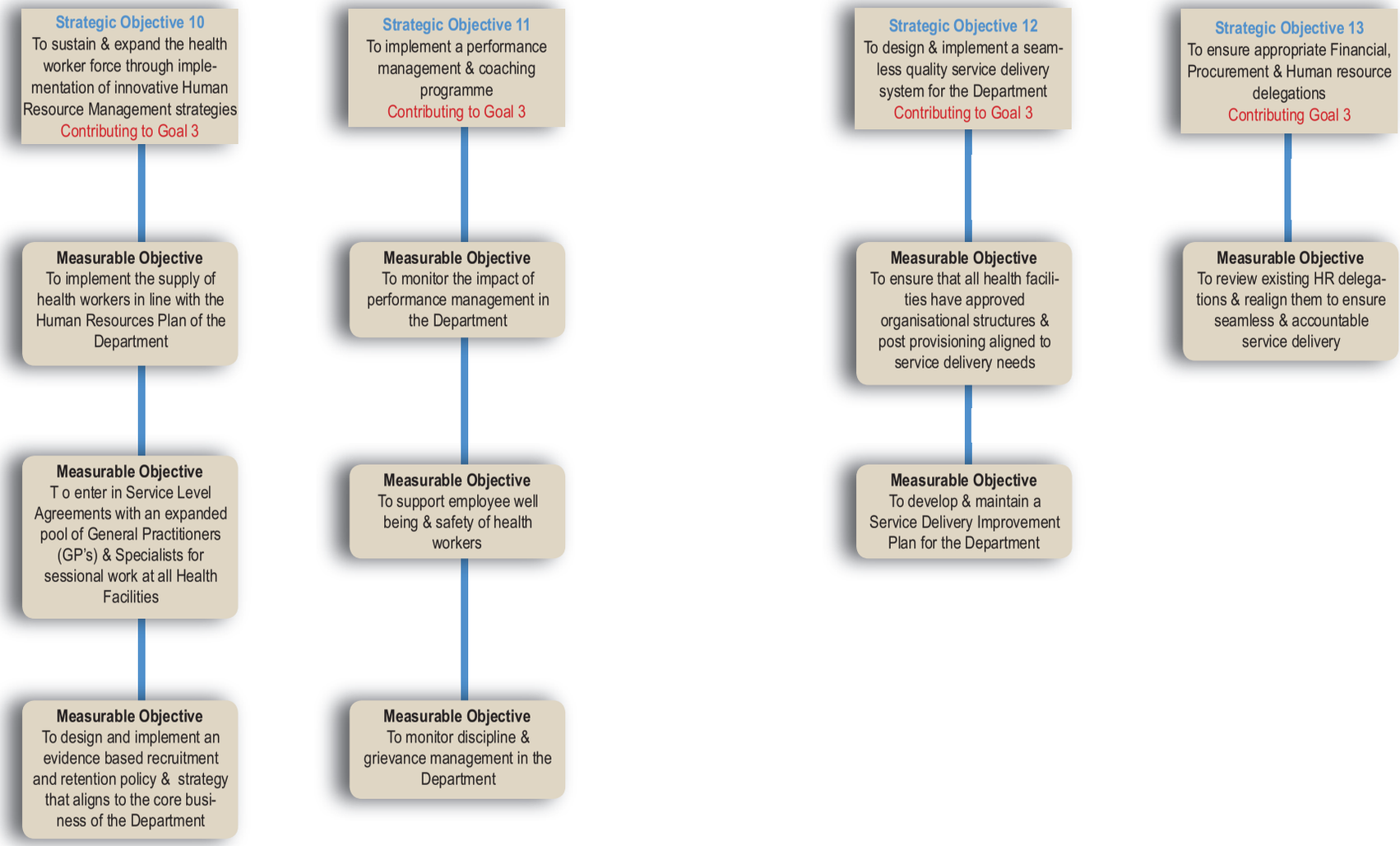
Include the following areas in the Human Resource Plan:

- **EMRS.**
- **Mortuary posts.**

The Department must still align the learning sites to the STP. This will be done in consultation with the University of KwaZulu-Natal, the Nursing College and the College of Emergency Care.

2.2 STRATEGIC - AND MEASUREABLE OBJECTIVES

The strategic and measureable objectives of the Human Resource Management Unit are indicated in the following diagram. Baseline data refers to 2006/2007 actual data unless otherwise indicated. The indicators are indicated in Table 7



3. OCCUPATIONAL HEALTH POLICIES, PRIORITIES:

3.1 Policies

- The Occupational Health & Safety Act, 1993, Compensation for Occupational Injuries and Diseases Act, White Paper on the Transformation of Health Care System in South Africa, National Health Act, 2003, Occupational Diseases in Mines & Works Act, 1993 and other complimentary legislation provide a flexible and supportive framework for the Department to develop and implement flexible Occupational Health and Safety Policies to support seamless service delivery.

- A key area that needs attention is the finalisation of the Occupational Health and Safety Policy for the Department.

- The Department of Health has a dual role in the provisioning of Occupational Health and Safety i.e.
  - To its employees as a legal requirement and moral obligation; and
  - To the public as a service provider.

3.2 Priorities

1. Align infrastructure to the requirements stipulated in the legislation.
2. Capacitate all staff employed in Occupational Health and Safety to ensure that they fulfil their mandate.
3. Ensure that Occupational Health and Safety conditions improve quality of care in all health facilities.
4. Develop the Provincial Occupational Health & Safety Policy for approval.

TABLE 2: (HR 3) Situational Analysis and Projected Performance for Human Resources (excluding Health Sciences and Training) [1]

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	National target 2007/08
Input										
1. Medical Officers per 100,000 people.	No	10.08	11.63	14	16	14.5	22	23	28	*18.7*
2. Medical Officers per 100,000 people in rural districts.	No	6.53	9.77	9	10.5	10.7	11	12	12	*12.2*
3. Professional Nurses per 100,000 people.	No	96.33	96.52	101	103	100.5	115	120	120	*105*
4. Professional Nurses per 100,000 people in rural Districts.	No	75.69	101.16	84	88	95.2	100	110	115	*92.5*
5. Pharmacists per 100,000 people.	No	2.17	2.5	10	15	13	21	23	26	*34*
6. Pharmacists per 100,000 people in rural Districts.	No	0.81	1.65	5	8	2.6	12	15	16	*24*
Process										
7. Vacancy rate for Professional Nurses.	%	22.29%	26.93%	19%	17%	20.75%	16%	15.5%	15%	*15*
8. Attrition rate for Doctors.	%	-	79.77%	90%	13.8%	10.30%	9%	8%	7%	*25*
9. Attrition rate for Professional Nurses.	%	10.91	11%	12%	13%	12.80%	12%	11%	10%	*25*
10. Absenteeism for Professional Nurses.	%	-	-	10%	50%	49.70%	30%	15%	5%	*5*
Quality										
11. Hospitals with employee satisfaction survey.	%	63.29%	61.11%	67%	71%	56%	67%	80%	100%	*50*
Efficiency										
12. Nurse clinical workload (PHC).	No	-	-	-	1:40	1:37	1:36	1:36	1:36	*1:35*
13. Doctor clinical workload (PHC).	No	-	-	-	1:23	1:23	1:24	1:25	1:26	*1:30*
Outcome										
14. Supernumerary staff as percentage of establishment.[4]	%									
Indicators removed from this table: Clinical audit rate and complaints resolved within 25 days.										

[4] The Department has supernumerary staff however the exact number has not been determined.

TABLE 3: Analysis of Constraints and Measures Planned To Overcome Them

Human Resource Priority	Level of Risk	Approach to mitigate risk and achieve outcome
Recruitment/ Staffing.	High level of risk.	Implement an appropriate recruitment policy and strategy..
Workload/ Staff utilisation.	Medium level of risk.	Implement newly determined staffing norms and ratios, in conjunction with appropriate skills mix.
Performance Management.	Medium level of risk.	Full implementation of the EPMDS in the Department. Monitor implementation.
Implementation of STP.	Medium level of risk.	Redress strategic & capacity shortcomings highlighted in the STP. Align infrastructure and HR plans with the STP to ensure full integration of HR Planning with other pivotal planning components in the Department.
Strengthen Provincial Data Systems.	High level of risk.	Interrogate the accuracy of information contained on PERSAL. Monitor the supply of graduating health professionals.

TABLE 4: Public Health Personnel in 2007/08

Categories	Number employed	% of total employed	Number per 1000 people	Number per 1000 uninsured people	Number per 100 000 people	Vacancy rate	% of total personnel budget [5]	Annual cost per staff member
Medical Officers	2,512	7.31%	0.13	0.15	12.80	56.15		R289,405
Medical Specialists	400	1.16%	0.04	0.05	4.00	71.12		R449,798
Dentists	71	0.21%	0.01	0.01	0.71	42.28		R289,405
Dental Specialists	0	0%	0.00	0.00	0.00			
Professional Nurses	10,517	30.61%	1.05	1.20	105.20	41.51		R203,578
Enrolled Nurses	8,364	24.35%	0.84	0.95	83.66	17.17		R115,939
Enrolled Nursing Auxiliaries	6,563	19.10%	0.66	0.75	65.65	18.47		R88,861
Student Nurses	1,803	5.25%	0.18	0.20	18.04	25.62		R88,893
Pharmacists	449	1.31%	0.04	0.05	4.49	73.18		R247,764
Physiotherapists	223	0.65%	0.02	0.03	2.23	55.22		R164,204
Occupational Therapists	91	0.26%	0.01	0.01	0.91	57.48		R164,204
Radiographers	459	1.34%	0.05	0.05	4.59	48.6		R164,204
Emergency Medical Staff	2,803	8.16%	0.28	0.32	28.04	13.94		R138,983
Nutritionists	27	0.08%	0.00	0.00	0.27	18.18		R164,204
Dieticians	72	0.21%	0.01	0.01	0.72	78.12		R164,204
Community Care-Givers	15,700	-	1.57	1.78	157	N/A	N/A	N/A
Total	**33,122**	**100**	**3.31**	**3.76**	**331.32**	**66.41**	**100**	

[5] This information could not be sourced from either BAS or PERSAL because the personnel budget is allocated per programme & responsibility and not by occupational category.

TABLE 5: (NHS Priority 2): Human Resources

Activity	Indicators	Targets 2006/07	Targets 2007/08	Targets 2008/09	Responsibility
Staff distribution.	Appropriate staff establishments as required by level of care and package of services.	Tertiary and Central Hospitals structures developed. All TB structures developed (19 facilities). All Specialised Psychiatric Hospitals structures developed (8 facilities).	20% reduction in vacancy rate.	20% reduction in vacancy rate.	Human Resource Management Services Unit.
	HR plan.	HRP aligned to STP requirements.	Implementation of STP & HRP.	20% of HRP implemented.	Human Resource Management Services Unit.
Private sector partnerships.	Private sector Specialists in public facilities.	Agree SLA with General Practitioners (GPs) and Specialists for sessional work in public sector facilities.	10% reduction in vacancy rate through private sector SLAs. 10% of PHC facilities with sessional GP's.	20% reduction in vacancy rate through private sector SLA's. 20% of PHC facilities with sessional GP's.	Human Resource Management Services Unit.

TABLE 6: (NHS Priority 2) Human Resources

Activity	Indicators	Targets 2006/07	Targets 2007/08	Targets 2008/09	Responsibility
Private sector partnerships.	Private sector Specialists in public facilities.	Agree SLA with GP's and Specialists for sessional work in public sector facilities.	All Regional - and Tertiary Hospitals with private sector Specialists.	All Regional – and Tertiary Hospitals with private sector Specialists.	Human Resource Management Services Unit.
Remuneration levels.	Recruitment and retention.	Agree and implement OSD. Develop and implement an appropriate recruitment and retention strategy.	10% reduction in turnover.	20% reduction in turnover.	Human Resource Management Services Unit.
Increase training of Nurses.	% of trained Nurses.	Identify additional training resources.	Training of additional students aligned to HRP.	Sustain training of additional students.	Human Resource Management Services Unit.
Training of Hospital Chief Executive Officers (CEOs).	% of Hospital CEO's trained.	Competency assessments. Based on outcome of competency assessment develop and implement personal training development plans.	100% competency assessment completed and development programmes developed.	100% CEO's trained.	Human Resource Management Services Unit.

TABLE 7: (HR2): Departmental objectives and performance indicators for Human Resources

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Estimated Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
HUMAN RESOURCES MANAGEMENT AND DEVELOPMENT SERVICE								
Measurable Objective: To enter into Service Level Agreements with an expanded pool of General Practitioners (GP's) and Specialists for sessional work at all Health Facilities.								
Number of Private Sector doctors doing sessional work.	Not measured.	Not measured.	Not measured.	Not measured.	552	607	667	733
Number of Private Specialists doing sessional work.	Not measured.	Not measured.	Not measured.	Not measured.	179	197	217	239
Measurable Objective: To design and implement evidence based Recruitment Policy and Strategy and Retention Policy that aligns to the core business of the Department.								
Percentage of professional staff migrating outside the Department.	Not measured.	Not measured.	Not measured.	6%	5%	4%	3%	3%
Number of professional staff leaving the service of the Department.	Not measured.	Not measured.	Not measured.	Not measured.	1 957	1 859	1766	1731
Average years of employment per professional staff.	Not measured.	Not measured.	Not measured.	Not measured.	8.9	9.79	10	10.5
Average number of day's staff members' act in a position.	Not measured.	Not measured.	Not measured.	Not measured.	256	192	154	123
Approved HR Plan for Department (all health posts).	Not measured.	Not measured.	Not measured.	Draft HR Plan.	Draft HR Plan.	Approved HR Plan aligned to STP.	Approved HR Plan aligned to STP.	Approved HR Plan aligned to STP. Approved Plan.

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Estimated Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Average number of sick leave days taken per staff member (annualised).	Not measured.	Not measured.	Not measured.	Not measured.	8	7.5	7	6
% of staff members utilising sick leave.	Not measured.	Not measured.	Not measured.	Not measured.	54.9%	49%	47%	47%
Total number of staff utilising sick leave.	Not measured.	Not measured.	Not measured.	Not measured	36 265	34 451	32 728	31 092
% of personnel budget spent on overtime.	Not measured.	Not measured.	Not measured.	Not measured.	5%	3%	3%	3%
Approved Recruitment Policy & Strategy and Retention Policy.	Not measured.	Not measured.	Not measured.	100%	50% Reviewed.	Policies approved.	Impact of policy on recruitment evaluated.	Impact of retention policy evaluated.
Measurable Objective: To implement the supply of health workers in line with the Human Resources Plan of the Department.[6]								
Number of Professional Nurses employed versus number required.	Not measured.	Not measured.	Not measured.	Filled posts: 10 578	Filled posts: 12 171	Filled posts: 20 117	As per HR Plan.	As per HR Plan.
Number of Medical Officers employed versus number required.	Not measured.	Not measured.	Not measured.	Filled posts: 2 565	Filled posts: 2 173	Filled posts: 2 500	As per HR Plan.	As per HR Plan.
Number of Dieticians employed versus number required.	Not measured.	Not measured.	Not measured.	75	288	320	As per HR Plan.	As per HR Plan.

[6] Actual vacant posts on PERSAL were used.

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Estimated Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Number of Advanced Midwifes employed versus number required.	Not measured.	Not measured.	Not measured.	Not measured.	1 000	1 100	As per HR Plan.	As per HR Plan.
Number of Psychologists employed versus number required.	Not measured.	Not measured.	Not measured.	62	56	68	As per HR Plan.	As per HR Plan.
Number of Specialists employed versus number required.	Not measured.	Not measured.	Not measured.	590	419	460	As per HR Plan.	As per HR Plan.
Number of Dentists employed versus number required.	Not measured.	Not measured.	Not measured.	63	63	63	As per HR Plan.	As per HR Plan.
Number of Pharmacists employed versus number required.	Not measured.	Not measured.	Not measured.	439	407	437	As per HR Plan.	As per HR Plan.
Number of Occupational Therapists employed versus number required.	Not measured.	Not measured.	Not measured.	104	78	85	As per HR Plan.	As per HR Plan.
Measurable Objective: To monitor the impact of Performance Management in the Department.								
Percentage of level 13 and above assessed according to their performance contracts.	Not measured.	Not measured.	Not measured.	Not measured.	100%	100%	100%	100%
Current management to staff ratio.	Not measured.	Not measured.	Not measured.	Not measured.	0.3%	0.5%	0.5%	0.5%
Percentage of level 13 and above with signed performance agreements.	Not measured.	Not measured.	Not measured.	Not measured.	100%	100%	100%	100%
Number of staff with formal signed job descriptions.	Not measured.	Not measured.	Not measured.	Not measured.	100%	100%	100%	100%

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Estimated Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Measurable Objective: To enhance management capacity through variety management programmes.								
Number of Hospital Managers/CEO's that have been enrolled on accredited Hospital Management training programmes.[7]	Not measured.	Not measured.	Not measured.	10	24	16	16	16
Measurable Objective: To support employee well being and safety of health workers.								
Number of employees counselled for EAP.	Not measured.	Not measured.	Not measured.	916	2 318	100% of referred cases.	100% referred cases.	100% referred cases.
Number of Hospitals providing Occupational Health services.	100%	100%	100%	100%	100%	100%	100%	100%
Measurable Objective: To monitor discipline and grievance management in the Department.								
Number of disciplinary hearings registered.	Not measured.	Not measured.	Not measured.	210	201 (100%)	100% cases registered resolved within timeframes.	100% cases registered resolved within timeframes.	100% cases registered resolved within timeframes.
Number of disciplinary hearings concluded with sanctions.	Not measured.	Not measured.	Not measured.	210	201 (100%)	100% cases registered resolved.	100% cases registered resolved.	100% cases registered resolved.
Number of sanctions implemented.	Not measured.	Not measured.	Not measured.	210	201 (100%)	100% sanctions implemented. timeframes	100% sanctions implemented. timeframes	100% sanctions implemented. timeframes

[7] The Hospital Management Programme is a new Programme over a period of 2 years. Only Hospital Managers with an Honors qualification qualify for enrolment.

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Estimated Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Of grievance hearings, number of grievance cases concluded.	Not measured.	Not measured.	Not measured.	92	110 (84%)	100% cases registered resolved within timeframes.	100% cases registered resolved within timeframes.	100% cases registered resolved within timeframes.
Measurable Objective: To ensure that all health facilities have approved organisational structures and post provisioning aligned to service delivery needs.								
Number of Hospitals with approved organisational structures.	Not measured.	Not measured.	Not measured.	All Tertiary & Central Hospitals. 11 TB Hospitals, 7 TB structures within District Hospitals & 1 TB structure within a regional Hospital 8 Specialised Psychiatric Hospitals.	20	All hospitals.	All hospitals.	All hospitals.
Number of CHCs with approved organisational structures.	Not measured.	Not measured.	Not measured.	0	16	All CHCs.	All CHCs.	All CHCs.
Number of PHC Clinics with approved organisational structures.	Not measured.	Not measured.	Not measured.	-	0	544[8]	All PHC Clinics.	All PHC Clinics.
Number of Districts with approved organisational structures.	Not measured.	Not measured.	Not measured.	Draft structures developed.	11	11	11	11

[8] Includes all Local Government PHC Clinics.

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Estimated Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Approved Head Office structure.	Not measured.	Not measured.	Not measured.	1	0	1	1	1
Measurable Objective: To develop and monitor a Service Delivery Improvement Plan for the Department.								
Service Delivery Improvement Plan compliant with PSR and approved by HOD and MEC.	Not measured.	Not measured.	Not measured.	0%	0%	100%	100%	100%
Measurable Objective: To review existing HR delegations and realign them to ensure seamless and accountable service delivery.								
Written delegations in place.	Not measured.	Not measured.	Not measured.	100%	100%	100%	100%	100%
Last review of written delegations.	Not measured.	Not measured.	Not measured.	1/1/2007	1/1/2008	1/1/2009	1/1/2010	1/1/2011

TABLE 8: Situational Analysis and Projected Performance for Human Resources (excluding Health Sciences and Training)

Indicator	Type	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	National target 2007/08
Input												
1. Medical Officers per 1000 people.	No	13.57	9.93	10.08	11.63	14	16	14.5	22	23	28	18.7
2. Medical Officers per 1000 people in rural Districts.	No	5.87	5.74	6.53	9.77	9	10.5	10.7	11	12	12	12.2
3. Professional Nurses per 1000 people.	No	81.27	93.50	96.33	96.52	101	103	100.5	115	120	120	105
4. Professional nurses per 1000 people in rural districts.	No	96.85	75.22	75.69	101.16	84	88	95.2	100	110	115	92.5
5. Pharmacists per 1000 people.	No	2.80	2.41	2.17	2.5	10	15	13	21	23	26	34
6. Pharmacists per 1000 people in rural Districts.	No	1.17	0.89	0.81	1.65	5	8	2.6	12	15	16	24
Process												
7. Vacancy rate for Professional Nurses.	%	23.36%	25.49%	22.29%	26.93%	19%	17%	20.75%	16%	15.5%	15%	15%

Indicator	Type	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	National target 2007/08
Attrition rate for Doctors.												
9. Attrition rate for Professional Nurses.	%	24..26%	14.35%	10.91%	11%	12%	13%	12.80%	12%	11%	10%	25%
10. Absenteeism for Professional Nurses	%	94.71%	109.89%	105.36%	124.05%	10%	50%	49.7%	30%	15%	5%	5%
Quality												
11. Facilities with employee satisfaction survey.	%	N/A	N/A	N/A	10%	20%	30%	56%	67%	80%	100%	50%
12. Complaints resolved within 25 days.	%						70%	92%	100%	100%	100%	50%
Efficiency												
13. Nurse clinical workload (PHC).	Ratio	N/A	N/A	N/A	1:8000	1:8085	1:40	1:37	1:36	1:36	1:36	1:35
14. Doctor clinical workload (PHC).	Ratio	N/A	N/A	N/A	1:170,000	1:165,000	1:23	1:23	1:24	1:25	1:26	1:30
Outcome												
15. Surplus staff as a percentage of establishment.[9]	%	N/A	N/A	0	None	None						

[9] The Department has supernumerary staff however the exact number has not been determined.

HEALTH
KwaZulu-Natal

ANNEXURE 3

PROGRAMME 2 :

DISTRICT HEALTH SERVICES

MTEF PERIOD 2008/09 - 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

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ANNEXURE 3

PROGRAMME DESCRIPTION

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

PROGRAMME STRUCTURE

Sub-Programme 2.1
District Management

Delivery of comprehensive, integrated, efficient, effective and sustainable health services based on the PHC approach.

Sub-Programme 2.2
Community Health Services

Rendering of compassionate, dedicated, integrated, effective and efficient PHC services, which fall under the scope of practice of a Professional Nurse. The services are rendered at Fixed PHC Clinics, Mobile Clinics and NIP Sites (Drop-In Centres). It includes outreach services and community-based health care services.

Sub-Programme 2.3
Community Health Centres

Rendering a broad range of out-patient and PHC services falling under the scope of practice of a General Practitioner and a Professional Nurse, inclusive of accident/ emergency/ midwifery services but excluding surgery under general anaesthesia.

Sub-Programme 2.4
Community-Based Health Services

Rendering health services at non-health facilities including programmes and services for home-based care, care for survivors of violence, mental health care, chronic care, school and youth health and programmes for women and children. Services include healthy lifestyles, counselling and support, rehabilitative services, growth monitoring for children under-5, treatment support for TB, Anti Retroviral Therapy (ART), and services for chronic diseases and geriatrics.

Sub-Programme 2.5
Other Community Health Services (Annexure 6)

Rendering Environmental and Port Health services including hazardous substances, water and sanitation, and storage, labelling, preparation and selling of food substances. Environmental Health services also monitor services at abattoirs and dairies, monitor air quality and pollution and ports of entry.

Sub-Programme 2.6
HIV and AIDS, STI and TB (Annexure 4)

Rendering PHC services related to the comprehensive management of HIV, AIDS, and TB. This includes sustaining Programmes for Sexually Transmitted Infections (STIs), Prevention of Mother to Child Transmission (PMTCT) of HIV, Non-Occupational and Occupational Post Exposure Prophylaxis, Voluntary Counselling and Testing (VCT), Anti Retroviral (ARV) Programme and TB Programmes.

Sub-Programme 2.7
Nutrition (Annexure 5)

Rendering integrated, sustainable and community driven direct and indirect nutrition services aimed at the most vulnerable groups in communities.

Sub-Programme 2.8
Maternal, Child & Women's Health (Annexure 5)

Rendering comprehensive and integrated promotive, preventive and educational services and programmes targeting women, children, youth and men to reduce preventable causes of morbidity and mortality.

Sub-Programme 2.9
Coroner Services (Annexure 1)

Provision of effective and efficient forensic pathology and forensic medical services to establish the circumstances and causes surrounding unnatural death.

Sub-Programme 2.10
District Hospitals

Rendering of a designated range of diagnostic, curative and in-patient and out-patient hospital services mostly under the scope of practice of a General Practitioner. Designated procedures are performed under general anaesthesia.

Global Fund

The Department currently does have a budgetary item dedicated to the Global Fund. Funds are managed as part of the Donor funding outside the Departmental accounting system.

1. INTRODUCTION

The Department is gradually moving away from a fragmented and hospicentric health system to a more decentralised and cost effective health service model aimed at achieving the PHC goals of the Department. This requires substantial re-configuration of the health services system towards well-defined service delivery areas of manageable size where planning is informed by evidence-based health service needs and delivered in an integrated and coordinated manner in direct answer to the health needs of beneficiaries in the Province.

PHC services act as the interface between National and Provincial policies, directives and available services/ resources on the one hand and families and community programmes on the other.

The direct effect of general primary care is well documented. For example, WHO reported local reductions of between 5% and 32% in mortality among children in Liberia, Niger, and the Democratic Republic of Congo attributed to the provision of general primary care.[1]

To achieve improved PHC, the Department commenced with the development and implementation of the STP. The principles adopted by the Department for the STP[2] are in line with the White Paper on Transformation of Health Services (1997).

The Priorities of the STP in relation to District Health Services are:

1. To develop and provide a comprehensive and integrated package of health services at all levels of care using the PHC approach through the DHS.

2. To ensure that all patients receive compassionate health care at the appropriate level in line with the package of services designated to the different levels of care.

3. To increase the number of patients managed at PHC level by ensuring appropriate distribution of PHC facilities with appropriate systems to support quality service delivery at all levels of care in line with the Patient's Charter and Batho Pele principles.

4. To facilitate integrated, effective and efficient functioning of community-based health care structures and services in line with health care needs of the communities they serve.

5. To ensure that health care providers are optimally empowered through enabling policies, delegations, integrated plans and systems to deliver high quality health care services and effectively measure service delivery progress and performance against National and Provincial strategic objectives and targets.

6. To establish a reliable health information system for effective analysis of disease profiles and trends that can inform evidence-based planning and decision-making.

7. To mobilise all sectors within the Province to optimally support public health care service delivery initiatives, especially at PHC level, and to adequately address health determinants falling outside the functional mandate of the Department.

8. To establish a comprehensive synchronous telemedicine programme as a vehicle by which access to health care services can be improved through supporting health care professionals, especially in rural areas, and maximising the use of scarce skills.

Figure 1 diagrammatically illustrates the District Based Health Services.

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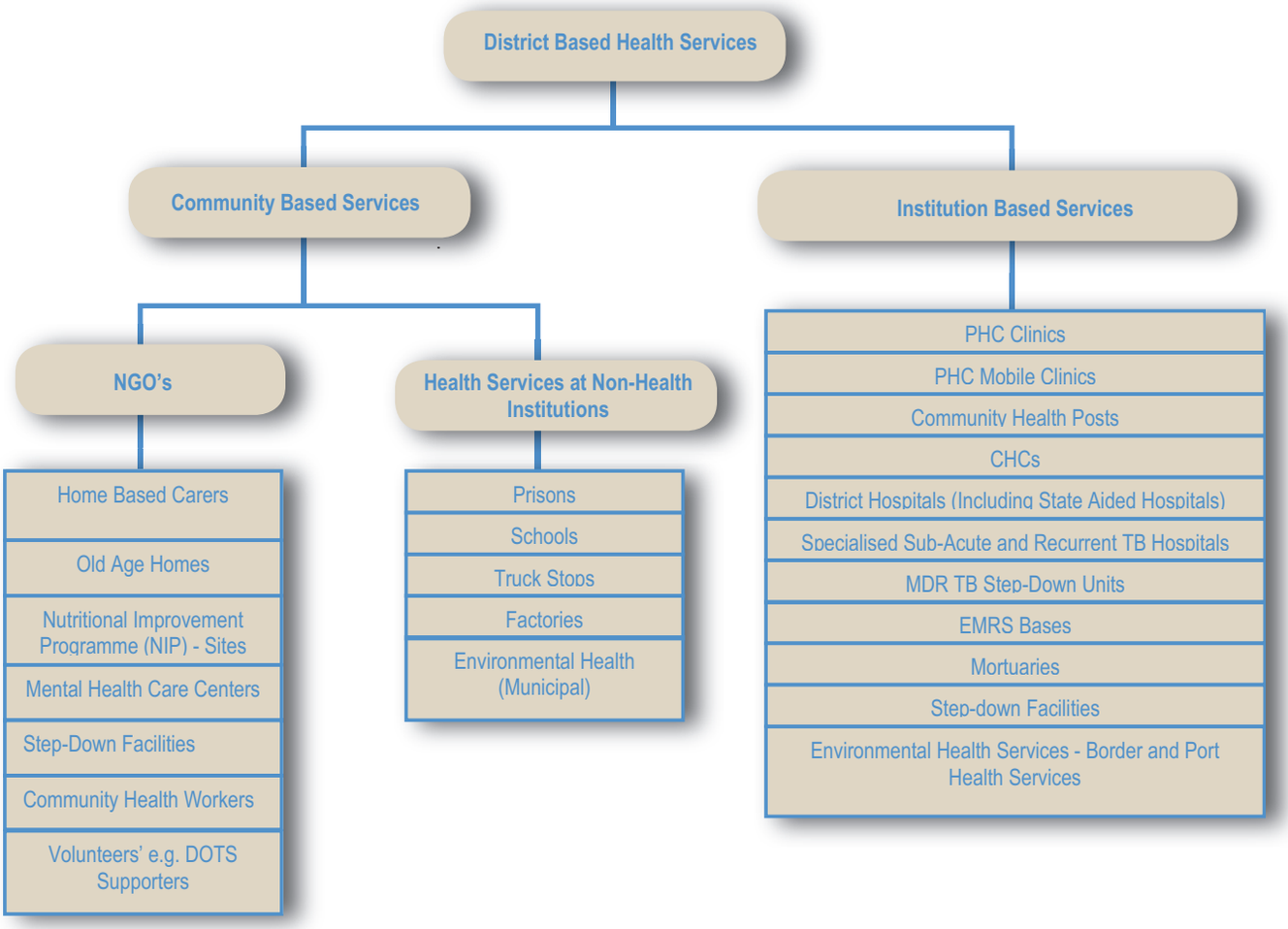
[1] WHO 2002. Reducing Risks, Promoting Healthy Life. Geneva.

[2] Principles: Equity, efficiency, effectiveness, quality, comprehensive services, access to services, decentralisation and local accountability for health services, community participation, sustainability & developmental approach.

ANNEXURE 3

FIGURE 1: District Based Health Services



Demographic & Socio-economic Profile

The total Provincial population is estimated at 10,259,230 (2007)[3] with an uninsured population of approximately 9,028,122 (calculated at 88% of the total Provincial population).

TABLE 1: Health District Population Figures[4]

Health District	Total Population	Area (Sq Km)	Density (Population /Sq Km)
Amajuba	488,664	6,921	71
eThekwini	3,222,739	2,295	1 404
Ilembe	584,675	3,273	179
Sisonke**	476,922	11,139	43
Ugu*	735,531	5,052	146
Umgungundlovu	968,281	8,945	108
Umkhanyakude*	597,890	13,877	42
Umzinyathi*	500,547	8,601	58
Uthukela	685,424	11,342	60
Uthungulu	924,279	8,225	112
Zululand*	815,031	14,823	55

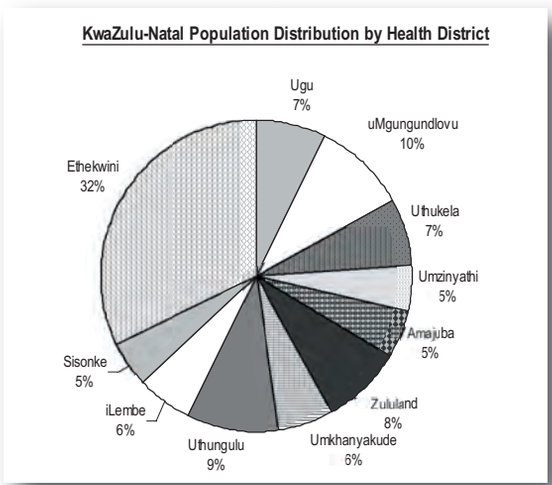
* Presidential Rural Development Nodes.
** Umzimkhulu in Sisonke District.

KwaZulu-Natal comprises approximately 21% of the total population of South Africa and is considered one of the poorest Provinces in the country. It is well documented that Districts of lower socio-economic status e.g. low percentage of households with access to piped water, electricity and sanitation are potentially in greater need for PHC.

In KwaZulu-Natal more than half (54%) of the population live in rural areas; only 79.4% of households have access to piped water (72.5% in 2001) compared to the national average of 88.6%; 71.5% of households use electricity for lighting (60.9% in 2001) which is below the national average of 80%; and 11.7% have no toilet facilities (16% in 2001) as compared to a national average of 8.6%.[5] The unemployment rate in the Province improved from 32.8% in 2005 to 26.6% in 2007.

The Provincial Rural Nodes are all in the lowest socio-economic quintile. Households in these Districts have poor access to piped water i.e. Ugu (51.5%); Umzinyathi (57.5%); Zululand (50%); Umkhanyakude (57.5%); and Sisonke (61.5%) of households have no access to piped water.[6]

FIGURE 2: Population Distribution per Health District[7]



Management Structures

- District organisational structures have been customised to accommodate District specific needs and service delivery imperatives, making provision for decentralised planning, monitoring, evaluation and information management. Corporate Service Centres are established in each of the District Offices to provide Human Resource, Financial and Supply Chain Management services to District Office Components, including EMRS and Forensic Medical Pathology Services.

[3] Stats SA. 2007 Community Survey.
[4] Stats SA.
[5] Community Survey 2007 Basic Results – Stats SA.
[6] Stats SA.
[7] Stats SA

- The spending on District Management in the Rural Nodes is between 1.5% and 2.7% whilst the National average is 5%. This might compromise service delivery in terms of support to strengthen PHC delivery. District Office structures have been redesigned and if fully implemented (as recommended in the STP), spending will increase to 5%.

- Good progress has been made aligning DHPs to the APP, the Quarterly Report and the STP, while a more critical analysis of health service performance formed the basis for District Operational Plans for MTEF 2008/09. DHPs now include a more focussed analysis of trends, disease profiles analysed in relation to epidemiological and poverty profiles, and progress towards National and Provincial goals and targets.

- District Management of all Districts (with exception of eThekwini) and the Provincial Health Services Planning Unit had very constructive workshops where critical analysis of data informed the development of District Health and Operational Plans. Specific planning, monitoring, evaluation and research needs were identified and will be addressed during MTEF 2007/08 – MTEF 2008/09.

- The Province is in the process of taking over the Local Government PHC Clinics from Local Municipalities as required by the National Health Act of 2003. This process will be finalised during MTEF 2007/08 and MTEF 2008/09.

2. SITUATIONAL ANALYSIS

Expenditure per PHC Headcount

- Provincial Expenditure per PHC Headcount increased from R64.00 in MTEF 2006/07 to R70.00 in MTEF 2007/08.

- Ugu and Umkhanyakude Districts, both in the lowest socioeconomic quintile, still spend considerably less than other Rural Nodes, which may affect service delivery including improving access to basic PHC services.

- Table 2 indicates the Expenditure per PHC Headcount per District for the periods MTEF 2006/07 and MTEF 2007/08.

TABLE 2: Expenditure per PHC Headcount

District	2006/07	2007/08
Ugu	R56.00	R63.00
Umgungundlovu	R55.00	R60.00
Uthukela	R59.00	R77.00
Umzinyathi	R73.00	R74.00
Amajuba	R56.00	R57.00
Zululand	R76.00	R74.00
Umkhanyakude	R64.00	R65.00
Uthungulu	R56.00	R57.00
Ilembe	R64.00	R80.00
Sisonke	R81.00	R85.00
eThekwini	R63.00	R74.00
KwaZulu-Natal	**R64.00**	**R70.00**

PHC Utilisation

- The PHC Headcount increased from **20,548,203** in MTEF 2006/07 to **21,079,790** in MTEF 2007/08; while over the same period the Outpatients (OPD) total Headcount for District Hospitals decreased from **2,412,352** in MTEF 2006/07 to **2,168,440** in MTEF 2007/08.

- It is not yet clear if the increased headcounts at PHC and decreased Out-Patient headcounts at District Hospital level are as a result of improved service delivery at PHC level, improved implementation of the Planned Patient Transport (PTP)/ EMRS, and the implementation of District Referral Protocols - resulting in clients entering the health system at the appropriate level. This will be closely monitored.

- The National target of **3.5** visits/ person/ annum appears to be very high, but increased accessibility and improved quality of care at PHC level (including improved community participation) may encourage improved utilisation.

- The Provincial PHC utilisation rate is **2.3** visits/ patient/ year in MTEF 2007/08 as compared to 1.7 in 2006/07 and 1.8 in 2005/06.

- The Under-5 utilisation rate is **4** visits/ child/ year in MTEF 2007/08 as compared to 3.2 in 2006/07. The National norm is **5** visits/ child/ year.

- The rural nodes compare well with other Districts, and all showed an increase in utilisation to an average of 2.2 visits/ person/ year, except Sisonke District that improved from 1.8 to 2.5 visits/ person/ year.

- The utilisation rates might be an indication that the Province is starting to achieve equity in access between the deprived areas in the Province.

Table 3 indicates the utilisation rates for PHC and Under-5 per District for MTEF 2006/07 and MTEF 2007/08.

TABLE 3: Utilisation Rates: PHC and Under-5

District	Utilisation Rate: PHC		Under-5 Utilisation Rate	
	2006/07	2007/08	2006/07	2007/08
Ugu	1.8	2.2	3.4	4
Umgungundlovu	1.8	2.2	3.2	4
Uthukela	1.6	2.2	3.1	4
Umzinyathi	1.6	2.2	3.3	4
Amajuba	1.4	2.2	2.9	4
Zululand	1.6	2.2	3.5	4
Umkhanyakude	1.9	2.2	3.6	4
Uthungulu	1.8	2.2	3.3	4
Ilembe	1.8	2.5	2.9	4
Sisonke	1.8	2.5	3.4	4
eThekwini	1.7	2.2	3.1	4

Supervision

- The Provincial Supervision Rate is still very low although there is a slight increase from 50% in MTEF 2006/07 to 53% in MTEF 2007/08.

- All Districts, except Uthukela District, have supervisors allocated to all PHC services, with 74% of Supervisors having dedicated transport for supervision.

- District Management attribute the low supervision rate to the fact that most supervisors have multiple job responsibilities. In addition to supervisory functions supervisors are also rendering PHC services at facilities that are short staffed. Staff shortages at PHC Clinics are due to the lack of approved structures, attrition, vacancies and absenteeism.

Table 4 indicates the Supervision Rate per District for MTEF 2006/07 and MTEF 2007/08.

TABLE 4: Supervision Rate per District

District	2006/07	2007/08
Ugu	50%	53%
Umgungundlovu	70%	77%
Uthukela	68%	59%
Umzinyathi	100%	100%
Amajuba	100%	100%
Zululand	96%	96%
Umkhanyakude	70%	72%
Uthungulu	92%	100%
Ilembe	77%	55%
Sisonke	58%	56%
eThekwini	70%	75%

- Umzinyathi and Amajuba Districts maintained their 100% supervision rate for 2 years in succession and should be able to see improved quality of care as a result of sustained quality improvement and supportive supervision.

- The Supervisors' Manual is currently under review and the updated version will be introduced in MTEF 2008/09.

Nurse/Doctor Clinical Workload PHC

- Numerous factors can influence the Nurse/ Doctor Clinical Workload including vacancies, attrition, absenteeism, etc. During MTEF 2007/08, the Provincial vacancy rate for Professional Nurses is 20.75%; the attrition rate is 12.80%; and of grave concern is the high absenteeism rate of 49.7%.

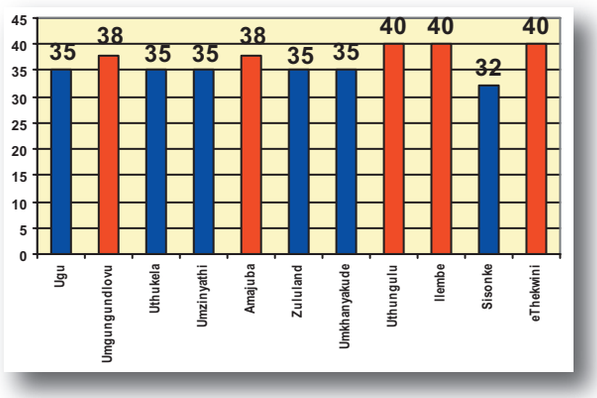
- The high absenteeism rate will be investigated as that may have a direct impact on availability of services and standard of care.

- The Employee Assistance Programme (EAP) is actively pursuing staff wellness programmes in collaboration with Occupational Health and Safety. *(See Annexure 2)*

- Clinical Workload is a measure of efficiency, and very low values indicate that scarce skills/ competencies (i.e. Professional Nurse Time and Qualifications) are not optimally utilised.

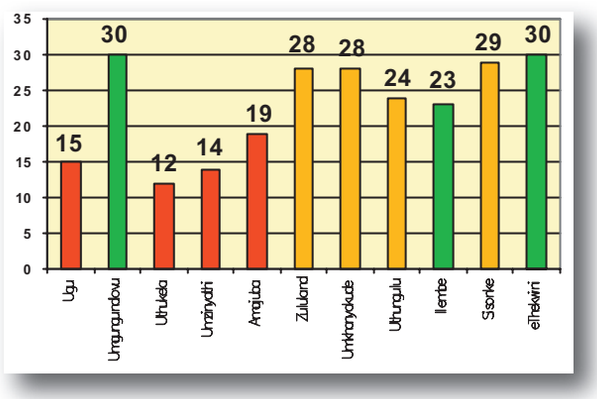
Very high values indicate that nurses are seeing too many patients per day which may compromise quality, lead to burnout and/or absenteeism, or both. Data quality will be verified if values are outside "normal" values.

FIGURE 3: Professional Nurse Clinical Workload – MTEF 2007/08



- All the rural node Districts reported a Nurse Clinical Workload within the National range of 35 patients per day.
- The Provincial Doctor Clinical Workload for PHC is 23 patients per day, as compared to the National target of 30.

FIGURE 4: Doctor Clinical Workload MTEF 2007/08



- The low values reported by Uthukela, Umzinyathi, Ugu and Amajuba will be verified.

3 DISTRICT HEALTH SERVICES

3.1 Community-Based Primary Health Care Services

Health programmes based in communities can reduce costs and barriers that impede people's access to health services, while PHC acts as the interface between these programmes and individual clinical care. Community programmes cannot substitute the health system, but can provide a channel through which families and communities can be reached with information and resources to reduce such risk factors as malnutrition and diseases of lifestyle that accounts for up to 40% of the burden of disease in low income settings.[8]

Community programmes not only promote healthy lifestyles, responsible health behaviours and preventive action, but can effectively mobilise demand for services at the appropriate levels of care and improve utilisation of available services.

Increased input and accountability from underserved populations is imperative because strengthening these structures and introducing mechanisms to ensure that users have a voice in the local health system can influence health priorities and are likely to encourage community buy-in and improved health seeking behaviours.[9]

Community health needs are best met through a shared vision of health service providers and the communities serviced by them. By involving communities to provide designated health care services or participate in planning of relevant health interventions, the scarce resources available to the Department can be redirected to improve the quality of the clinical services and access thereto. This approach therefore enables the Department to substantially improve the available pool of resources to perform advocacy, promotion, prevention, continuum of care, support and data collection activities. The aim is to develop strong and effective community based partnerships working towards improving the health status of all communities.

- PHC Clinic and CHC Committees and Hospital Boards have been established in all health facilities. These committees are strategically well placed to facilitate dialogue between health services and the communities they represent. This channel of community participation is still not fully utilised and innovative strategies will be implemented to involve committees to their full potential.

[8] SA National Burden of Disease Study 2000.
[9] Levine R, and the What Works Working Group, with M Kinder 2004 Millions saved: Proven Success in Global health.

In line with the Departmental strategic objective to decentralise functions to the lowest possible level and to support community-based health activities, dedicated capacity is provided in PHC Clinics to:

- Mobilise communities to participate/ support health service delivery initiatives/ programmes.
- Coordinate activities of community-based structures to prevent duplication.
- Monitor and evaluate the outcomes of community-based initiatives and facilitate corrective action where necessary.
- Monitor and evaluate the performance of community-based structures in terms of norms and standards specified in Service Level Agreements.
- Coordinate activities to ensure that the number of treatment defaulters (especially TB and ART) is decreased.
- Coordinate and direct activities to increase the number of case findings.
- Coordinate activities aimed at facilitating lifestyle changes.
- Coordinate activities to mitigate the health risks associated with personal hygiene, unsafe water, lack of sanitation, unbalanced nutritional intake, etc.
- Coordinate activities to assist members of the community to utilise the public health system appropriately.

The mechanism used by the Department to bridge the "gap" between the health system and communities include programmes by **Community Health Carers** (working at community and family level) and **Home Based Carers** (supporting individual members in the community). In order to develop a platform for Community and Home Based Carers to operate from, the Department is committed to strengthen and develop local NGO's.

To ensure effective implementation of community-based programmes, the Department developed norms as indicated in Table 5.

TABLE 5: Community-Based Norms

Sector	Rural Areas	Urban Areas
Community Based Carers	1:50 households	1:100 households
Home Based Carers	1:20 users	1:20 users

Home Based Carer (HBC)

Home Based Carers can be volunteers who have been trained for a specific purpose. The care provided by them is directed towards the terminally ill, DOTS support for TB patients, care of people with mental or physical disabilities, etc. Home Based Carers are usually contracted to an NGO and may receive a stipend.

Community Based Carer (CBC)

Community Based Carers are "employed" on contract by Non-Governmental Organisations (NGOs) under direct supervision from the NGO. The NGO is also responsible for training of the Carers to National Qualifications Framework (NQF) - Level 4 as determined by National Guidelines.

The aim of the training programmes is to develop a multi-skilled cadre of CBC's with a wide knowledge base of health related issues, who will be able to:

- Mobilise communities to identify local health needs.
- Encourage and educate families/ or individuals to take responsibility for their own health.
- Effectively communicate information about healthy lifestyles and health behaviours.
- Identify acute and chronic illnesses and facilitate appropriate referral into the public health care system at PHC level.
- Play an effective advocacy role as a Change Agent.
- Offer delegated health care support e.g. DOTS, contact tracing during disease outbreaks, follow up of children needing special care, immunisation campaigns, etc.
- Identify environmental hazards and providing assistance during corrective action.
- Render basic first aid services in the community.

ANNEXURE 3

Non-Governmental Organisations (NGO's)

The function of NGOs' is to contract individual Home and Community Based Carers according to the specific needs of a service area with a view to:

- Supervise and manage Home and Community Based Carers to ensure effective and efficient service delivery.
- Administer payroll and conditions of service matters.
- Provide training in accordance with the specified standards.
- Act as the link between the health service, Carers and the community.

The implementation of Community-Based programmes contribute towards achieving the Millennium Development Goals i.e.

Goal 1: Eradicate extreme poverty.
Goal 3: Promote gender equality and empowerment of women.
Goal 4: Reduce child mortality.
Goal 5: Improve maternal health.
Goal 6: Combat HIV and AIDS, Malaria and Other Diseases.

The Department actively pursues this strategy to take '*health to the people*' and plan further expansion of this strategy in MTEF 2008/09.

Current status:

- 1,100 new DOTS supporters have been trained in 2007/08 (November 2007) – with 82% of TB patients having DOTS supporters. Amajuba (99%) and Umkhanyakude (92%) are leading in this priority TB strategy, while other districts are reporting between 61% in Uthungulu and 82% in Umzinyathi Districts.

- 210 Peer Educators are providing Sexuality and Life Skills education in schools and communities as part of integrated School Health and Youth-Friendly Services out-reach programmes.

- The Mothers2Mothers2Be (M2M2B) Programme in support of the Prevention of Mother to Child Transmission (PMTCT Programme) is currently implemented in 8 sites in the Province. Improved disclosure and uptake is reported as an outcome of the programme.[10] The Programme will be rolled out to the rest of the province during MTEF 2007/08 and MTEF 2008/09.

- The RED Strategy to improve immunisation coverage, Vitamin A uptake, nutrition and growth monitoring in hard to reach communities is implemented in 3 Districts and currently rolled out to other Districts.

- The Integrated Management of Childhood Illnesses (IMCI) Community Component is implemented in 5 Districts in an effort to reach communities with 16 basic household messages to reduce child morbidity and mortality. This is currently being rolled out to other Districts.

- 500 Youth Ambassadors, who will actively participate in taking health messages to communities, commenced training in October 2007 and were deployed to all Districts. Another 500 Ambassadors will commence training in February 2008.

- There are currently 15,700 Community Based Carers of which 7,600 receive stipends. They were able to make contact with 164,480 clients in MTEF 2007/08 (Quarters 1&2). Another 3,724 new Carers were trained during MTEF 2007/08 to date.

- A total of 10,210 clients were referred by Carers to health facilities during the first two quarters of 2007/08.

- There are currently 73 registered National Integration Programme (NIP) Sites where cooked meals are provided to approximately 1,300 families.

[10] HST Mothers 2 Mothers 2 Be Programme.

3.2 Community Based Mental Health

In terms of the STP, Community Based Mental Health Services forms an integral part of the District Health System which is comprehensive, integrated and follows a PHC approach.

In line with the Mental Health Care Act (Act 17 of 2002) the Department aims to ensure that all mental health care users receive mental health care appropriate to their clinical condition and needs, in the least restrictive environment and wherever possible, within the communities from which they come.

In terms of the STP, the Department does not view community-based mental health services as a separate entity divorced from specialised psychiatric services, but a continuum of care. There will be ongoing interaction between the two levels, with a reciprocal relationship of one supporting the other, as community-based care relies on ongoing outreach and support from Specialised Psychiatric Services.

Likewise, Specialised Psychiatric Services rely on community-based mental health services for step-down care, out-patient follow-up care, de-institutionalization, screening, early diagnosis and timely and appropriate referral for specialised care.

As the burden of care migrates from specialised care towards community services, there is a natural progression from highly specialised human resources towards a reliance on community-based individuals and organisations.

The community-based mental health care approach has a strong emphasis on inter-sectoral collaboration with various inputs from NGOs, Non-Profit Organisations and Faith-Based Organisations. Their role is invaluable to the process of improving the overall health status of communities.

The Department has adopted the following model for Community Mental Health Service Facilities.[11]

- The Provincial Psychosocial Rehabilitation Policy (submitted in MTEF 2007/08 for approval) will provide the necessary framework to facilitate this process. The Policy provides for the optimal rehabilitation and reintegration of mentally ill individuals back into the community. It involves a network of the entire multi-disciplinary team including Professional Nurses, Occupational Therapists, Social Workers, Pharmacists and Medical Officers. The emphasis is on facilitating each patient's rehabilitation on an individual basis, focusing on their unique circumstances and needs. It provides for the completion of a Psychosocial Rehabilitation Plan for patients admitted into mental health care at any level. The expected outcome is for mentally ill persons to reach their optimal level of independent functioning within the community.

- The clinical aspects of care will be concentrated in PHC Clinics, PHC Mobiles and CHCs.

- Early diagnosis and initial screening will be performed by the above-mentioned Institutions. Minor psychiatric disorders will be treated at this level, provided there are trained Psychiatric Professional Nurses and Psychologists (at CHCs). Regular outreach and support initiatives will be provided by Specialised Psychiatric Hospitals.

- Dispensing of medicine will be done at this level for patients presenting with psychiatric conditions in line with the conditions set by the EDL and the scope of practice of "dispensing staff". This will not only improve access to care but limit the number of defaulters resulting in better clinical outcomes.

- Professional Nurses, Enrolled Nurses and Nursing Assistants will be trained in basic counseling and support for patients and their families.

- A register of all public mental health care users will be kept as part of a Departmental initiative to improve information management practices.

[11] STP.

- A Medical Officer will review all prescriptions six-monthly as part of the "*visiting doctor*" programme. This Medical Officer will be sourced, on a rotation basis, from CHC's, District/ Regional/ and Specialised Psychiatric Hospitals. As more CHC's become available, Medical Officers attached to these Institutions will gradually take over this function.

- Depending on clinical need, level of expertise and availability of infrastructure, patients will be referred to District Hospitals for further assessment. After clinical assessment, patients will, if needed, be admitted for 72 hour observation where a decision will be made regarding treatment and/or referral. This will encourage treatment of less serious cases closer to the place of residence with referral of severe psychiatric illnesses to Specialised Psychiatric Hospitals.

- As more Professional Nurses complete the Advanced Psychiatric Nursing Course, they will be placed in CHC's to further improve the quality of community based care.

- With reference to *Figure 5*, Type B and Type C services (sheltered employment, etc.) will allow for the care of patients within the community of residence, thus minimizing the historical custodial care. There will be less emphasis on clinical care and more on an integrated approach towards reintegration into society, the achievement of semi/ independent living and improved quality of life.

- These facilities are usually managed by NGO's, (Not for Profit Organisations) and Faith-Based Organisations (FBO), in some cases with subsidization from the Department.

- The Department is currently subsidising 17 Day Care Centres, 13 Residential Care Facilities and three Halfway Houses. Service Level Agreements are signed with each facility on an annual basis to ensure that norms and standards are agreed and adhered to, with optimal rehabilitation being the goal. The facilities are provided with the basic norms, standards and requirements for optimum care to facilitate effective monitoring and evaluation.

- Organisations are required to provide the Department with monthly reports, while the Department undertakes quarterly and annual inspections. The outcomes of these inspections determine renewal of the SLAs.

- The type of facility chosen depends on the conditions and needs of patients. The facilities must have regular contact with the clinicians described in Type 'A' Facilities. When patients are discharged from Specialised Psychiatric Hospitals to residential care or halfway houses, there is down referral to Type 'A' services. The Type 'A' services are in regular contact with Residential Care Facilities and Halfway Houses by virtue of the community mental health services provided by CHC's and PHC Clinics.

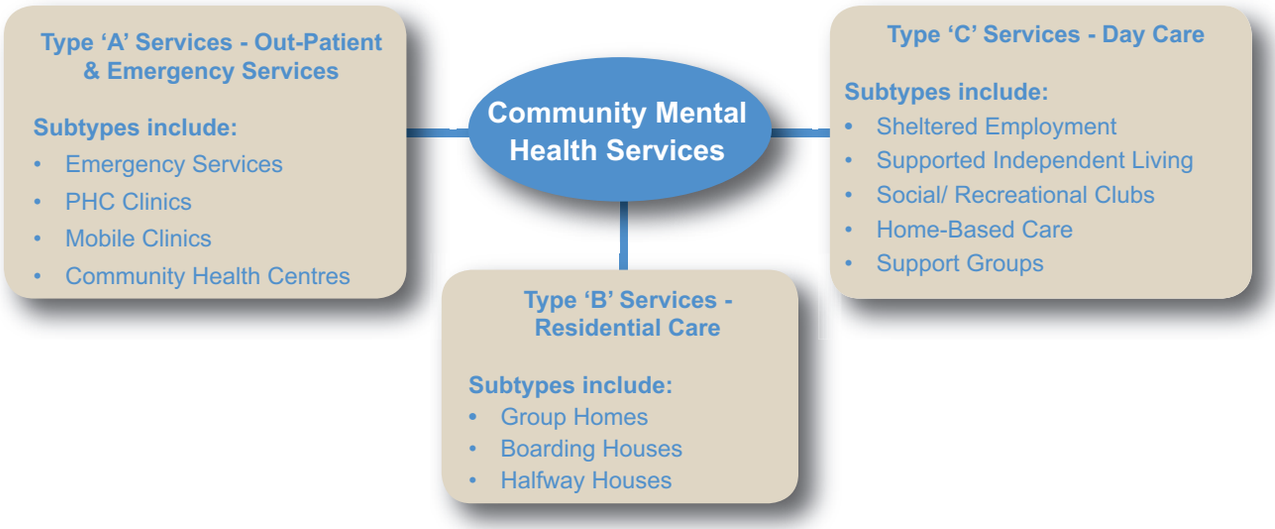
- The joint responsibility of all three types of services is to engage the community to reduce the stigma associated with mental illness, participate actively in prevention and wellness promotion campaigns, educate and create awareness about mental illness.

Each Health District will have as part of their Community Based Mental Health Services:

- A fully implemented Psychosocial Rehabilitation Plan.
- Type 'B' and 'C' Services for the provision of residential and day care, depending on identified and clinically appropriate needs.
- Type 'A' Services for out-patient and emergency services within the communities where users reside.

The Model for Community-Based Mental Health Services is illustrated in Figure 5.

FIGURE 5: Community Mental Health Services



3.3 Primary Health Care Clinics

A key strategy in the STP is to strengthen PHC services in the Province in response to increased patient numbers requiring basic primary care. The existing configuration of PHC facilities currently 'force' a substantial number of public health care users to enter the health system at inappropriate levels, increasing costs to both patients and the health care system. This will gradually improve as more appropriately located facilities are commissioned.

The National Health Act, 2003 and the STP inform the development of the PHC model through the DHS with appropriate reporting requirements.

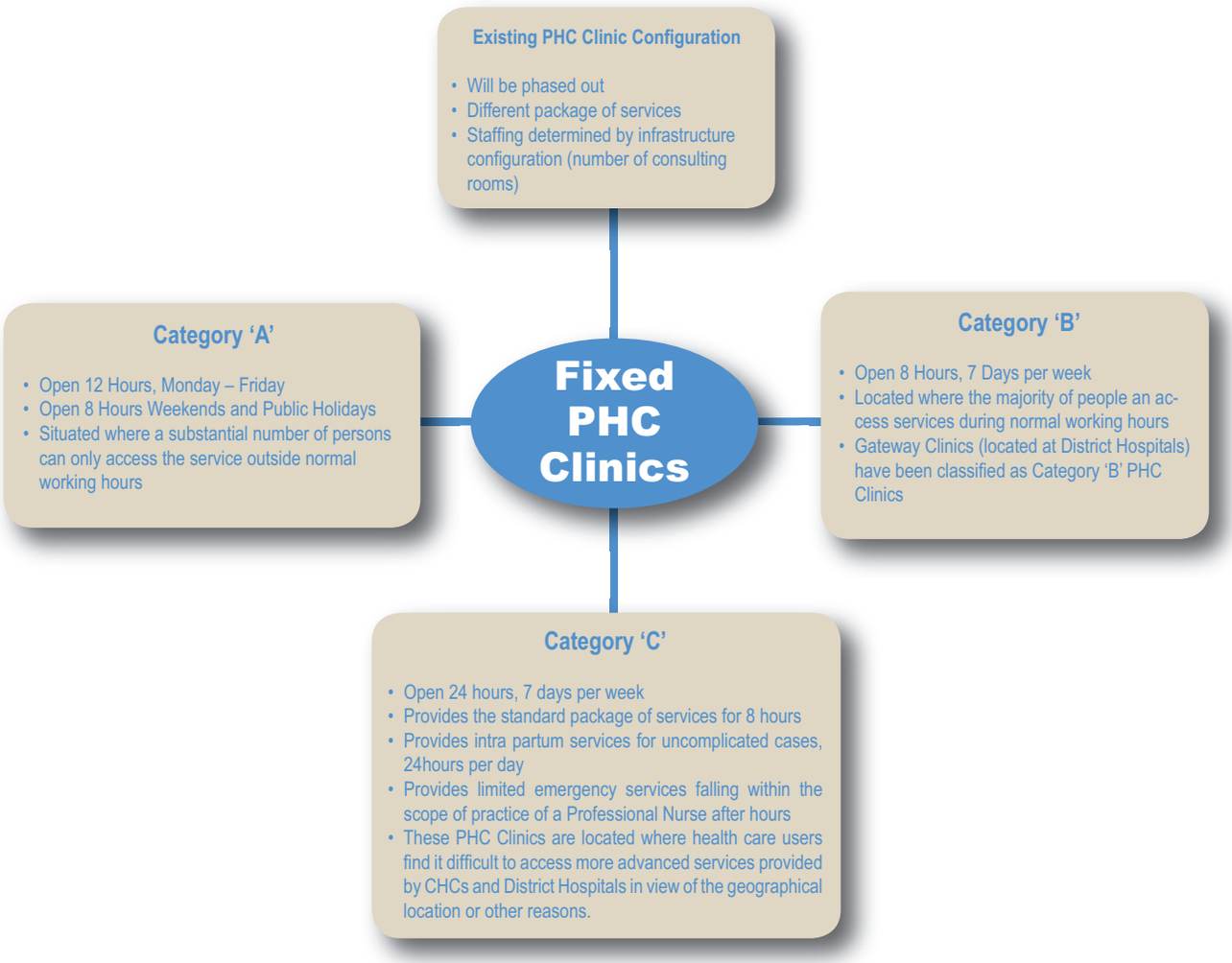
PHC services are rendered in each District by the following facility-based Institutions:

- Fixed Provincial and Local Government PHC Clinics that differ in terms of the hours and days that they are open, and the package of services being provided.
- CHCs.

The STP makes provision for four types of Provincial PHC Clinics (Fixed) as illustrated in Figure 6.

ANNEXURE 3

FIGURE 6: Types of Provincial PHC Clinics



For PHC Services (fixed Clinics and Community Health Centres), the catchment population is the total projected population (not only the uninsured projected population).

- PHC Clinics, on average, will serve a catchment population of between 10,000 – 30,000 patients.
- The National Target for the average walking distance to a PHC Clinic is 5km, while the norm for KwaZulu-Natal is between 10km to 20km. This norm has been agreed upon based on the availability of suitable land, terrain, and inaccessibility in many parts of the Province due to game reserves, forests and mountainous areas. Although the norm is between 10km – 20km, certain arears are desnely populated, hence in these areas the norm will be 5km.
- There are currently 554 fixed PHC Clinics in the Province (MTEF 2007/08) which include Local Municipality Clinics, and 27 Gateway Clinics which are classified as PHC Clinic Type B. The STP makes provision for a total of 562 fixed PHC Clinics and an additional 100 Type B Clinics by MTEF 2016.
- 75 PHC Clinics are planned to assume the functions of CHC's over the period MTEF 2007/08 to MTEF 2015/16.
- A revised number of new PHC Clinics is planned due to the recognition of the existing PHC Clinic Platform that aims at providing better

resourced PHC Clinic Categories and an increase in the number of CHCs, each with its own PHC Clinic Component (Clinic B), which would be able to serve the additional population.

Designated Functional Domain

1. Provide Promotive, preventive, curative, rehabilitative and palliative services falling within the scope of practice of a Professional Nurse.
2. Ensure the integrated, effective and efficient functioning of community-based health care structures operating in the catchment area.
3. Monitor public health indicators within the designated catchment area with a view to identify trends timeously and facilitate appropriate action.
4. Ensure the effective and efficient functioning of the prescribed governance arrangements.
5. Mobilise community participation for the effective delivery of PHC services in the catchment area.
6. Ensure the effective, efficient and economical management and utilisation of allocated resources.

Package of Services

A basic package of services has been developed, supported by infrastructural requirements to ensure effective implementation.

The basic package of services includes:

1. Basic screening:
   - Diagnoses of ailments;
   - Initiation of treatment;
   - Initiation of appropriate referrals.
2. Healthy Lifestyle Promotion Initiatives.
3. Basic Curative Services.
4. Women's Health Services.
5. Maternal Health Services.
6. Rehabilitative Services.
7. Child Health Services.
8. Reproductive Health Services.

Staffing Arrangements

- The development of staffing norms (based on actual workload and utilisation indicators) is negatively affected by the absence of reliable headcount and patient contact information.

- In order to overcome the above challenge, generic organisational and post establishment structures for the provisioning of the PHC package of services were developed for the various categories of PHC Clinics serving a standard catchment population (Type A and B: 10,000 and Type C: 20,000 health care users per clinic). Based on a comprehensive analysis of clinical procedures at PHC level and to ensure the desired clinical health outcomes, the following staffing norms were adopted:

  - The ideal number of visits by a health care user to a PHC Clinic: **3.5 visits per year.**
  - Average time (Adult Acute/Chronic): **15 minutes.**
  - Average time Children & Infants: **25 minutes.**
  - Average time Ante and Postnatal: **40 minutes.**

  Based on the percentage of health care users per main categories, the above was 'averaged' to a standard consulting time of **20 minutes per patient per visit.**

- Based on the staffing formula, and to ensure a balance between the various occupational categories and their optimal utilisation as part of an integrated PHC team, provisions were made for sufficient management and administrative support staff.

- Dedicated support will be provided on the organisational and post establishment structures of CHC's to provide a 'visiting doctor' and pharmaceutical and facilities management support to PHC Clinics.

  Figure 7 indicates the standard Organisational Structure of a PHC Clinic, while Figures 8 and 9 indicates the Organisational Structures of CHCs to ensure appropriate support to PHC.

ANNEXURE 3

FIGURE 7: Organisational Structure for PHC Clinics

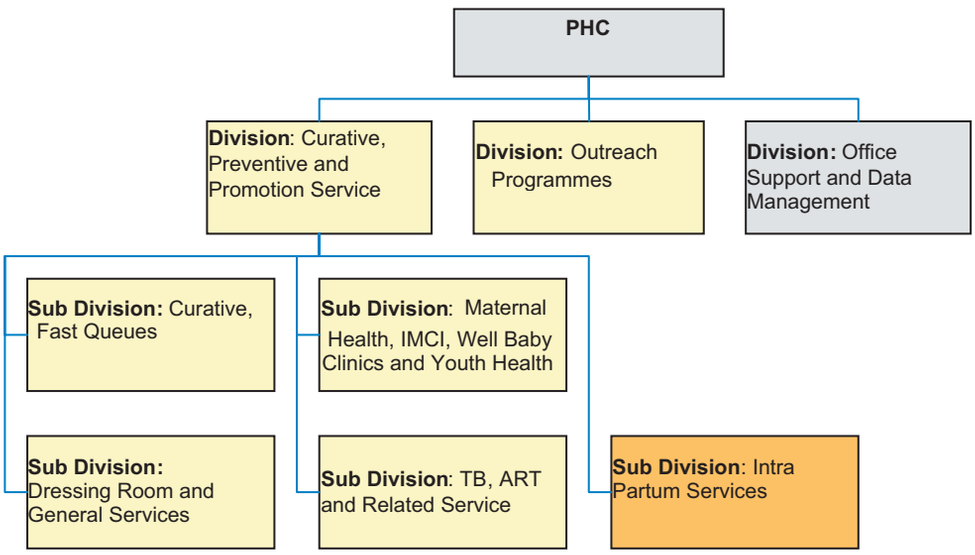


FIGURE 8: CHC's Operational

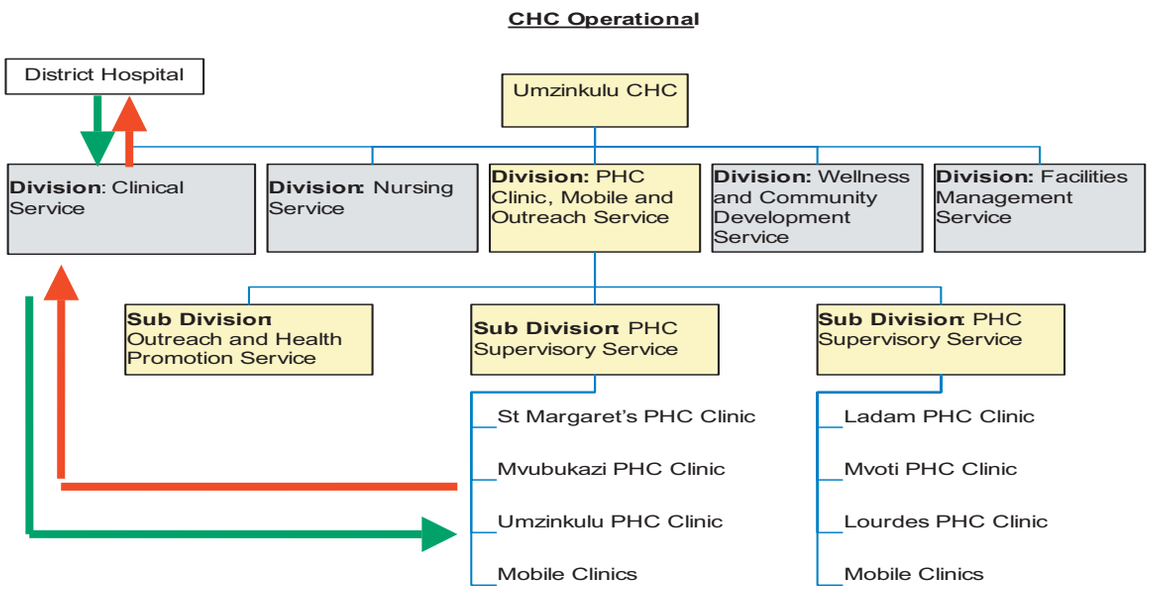
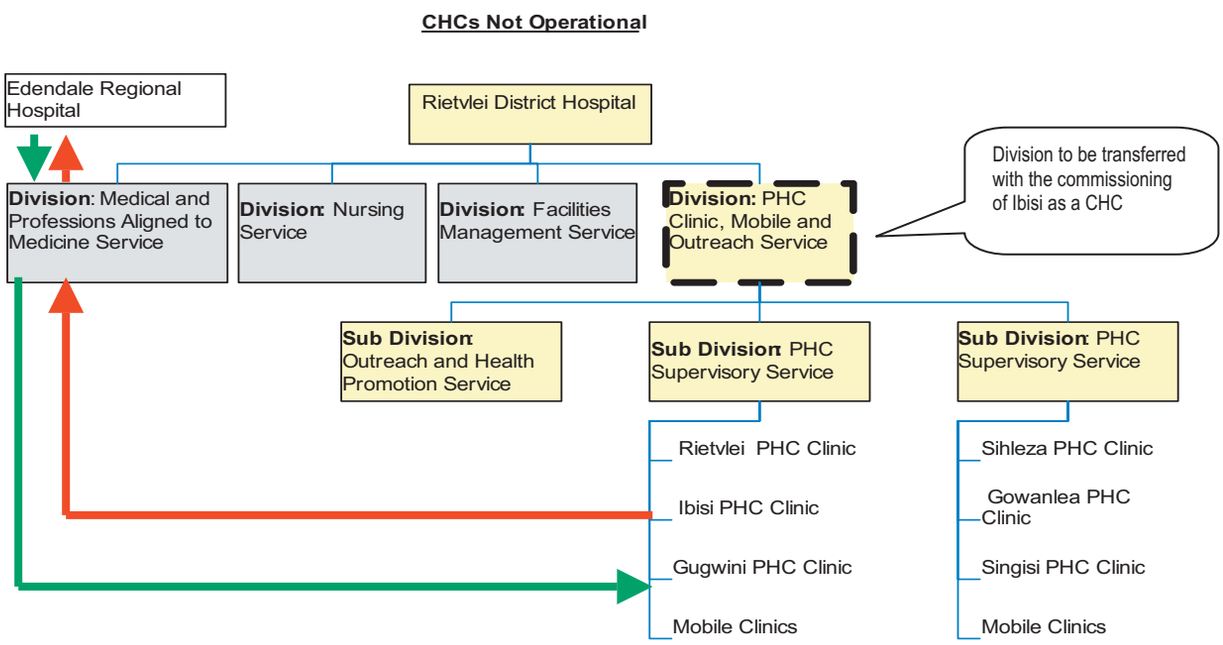


FIGURE 9: CHC's not Operational



ANNEXURE 3

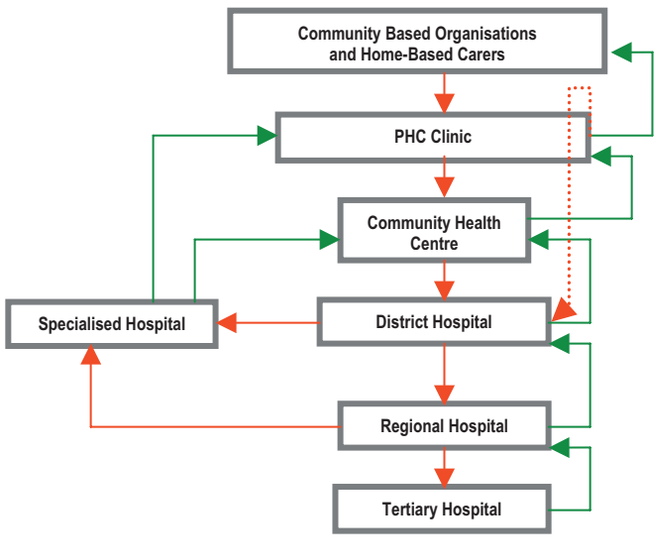
Oversight and Support Arrangements

A CHC or District Hospital (the latter only where CHC's are not operational) designated to receive patients from a PHC Clinic will be responsible for:

1. Providing clinical outreach services ("visiting doctor programme");
2. Clinical advisory services on the alignment of practices and procedures to improve clinical outcomes at all levels of the health service delivery chain (e.g. early detection);
3. Monitoring and evaluating adherence to the prescribed clinical procedures, norms and standards;
4. Providing pharmaceutical support services to ensure that stock is maintained at optimum levels as per the EDL and compliance with the applicable legislation and regulatory framework for dispensing medicine;
5. Providing technical support in the areas of dietetics and rehabilitation procedures;
6. Guiding the implementation, monitoring and evaluation of health programmes at PHC Clinics; and
7. Providing administrative support.

The abovementioned responsibilities have been strengthened through customised job descriptions and performance agreements of health workers.

FIGURE 10: Referral Path



Referral

- Patients will be required to enter the health system at PHC level, and if the need arises be referred to the nearest CHC or in certain cases, the closest District Hospital.
- Each PHC Clinic is linked to a CHC or a District Hospital (the latter only in cases where CHCs are not available) for management/ clinical oversight and support.
- All PHC Clinics will (with support from the Planned Patient Transport/ EMRS Service) refer patients requiring a higher level of health care by a general practitioner directly to the relevant 'mothering' CHC, or in the **absence** of a CHC, the nearest Hospital offering Level 1 services. In instances where the condition of the patient clearly requires more advanced intervention (e.g. obstetric emergencies, etc.) referral will be directly to the nearest District Hospital as per Referral Policy or Protocol.

The desired norm for PHC Clinics and Mobile Services to CHC's is: 6 Fixed PHC Clinics (depending on the need) and the attached Mobile Clinics referring to 1 CHC.

- Currently this norm is not achieved. There are a total of 554 PHC Clinics referring to 16 CHC's. Thus, PHC Clinics will continue to refer directly to District Hospitals providing Level 1 services until such time as more CHC's are fully operational. When the desired norm of 562 PHC Clinics referring to 100 CHC's is achieved by MTEF 2016, a more realistic referral ratio of 5.56 PHC Clinics: 1 CHC will be realised.

TABLE 6: Infrastructure Requirements for PHC Clinics

Facility category	PHC Clinic A	PHC Clinic B	PHC Clinic C
Reception office	Yes	Yes	Yes
Consulting rooms	5	3	5
Procedure room	1	1	1
Well Child Facility	3 Consulting cubicles	3 Consulting cubicles	3 Consulting cubicles
Store room	2	2	2
Office for Head	1	1	1
Office for outreach programme	1	1	1
Administration Office	1	1	1
Waiting area	1	1	1
HAST Office and cubicles for HAST activities (2 for VCT/PMTCT, 1 for TB and 1 for ARV)	4	4	4
Integrated Resource Centre	1	1	1
Maternity beds	N/A	N/A	2
Staff / Training Room	1	1	1
Cough Booth	1	1	1
Sluice Room	1	1	1
Medication Room	1	1	1

3.4 Mobile Services

Mobile Services are provided to ensure that health care users from communities residing in outlying areas, or areas falling outside the "walking norm" or low population density areas (e.g. commercial farming areas) are provided with quality PHC services on a regular basis. The service is provided during normal working hours and at pre-designated sites on a rotating schedule.

Package of Services

- In order to provide quality PHC services, the full package of diagnostic and curative services provided by Categories A and B fixed PHC Clinics is provided by mobile teams. Special focus is given to minor ailments, maternal, child and women's health services, chronic diseases, and health promotion and education. Counselling and support is provided as the need arise.

Service Delivery Platform

- Mobile Services are provided in all Districts as indicated in Table 7.

TABLE 7: Summary of Mobile Units per District[12]

District	Number of PHC Mobile Units 2007/08
Amajuba	10
eThekwini*	15
iLembe	37
Sisonke	16

[12] The mobile numbers will be verified in 2008/09.

ANNEXURE 3

District	Number of PHC Mobile Units 2007/08
Ugu	15
Umgungundlovu	19
Umkhanyakude	20
Umzinyathi	16
Uthukela	18
Uthungulu*	21
Zululand	20
TOTAL	**207**

* Local Municipalities and State Aided Services in eThekwini (16) and Uthungulu (1) Districts supplement mobile services.

- A spatial model will be implemented to determine the required number of Mobile Clinics per District for each MTEF cycle in order to align the number of service points with the commissioning of new fixed PHC Clinics and population migration.

Staffing Arrangements

- Although staffing arrangements for Mobile Clinics are normally determined by the seating configuration of the vehicles utilised for the provisioning of services, each Mobile Clinic consists of two teams with a Professional Nurse as the Team Leader.

  The staffing provision for a Mobile Unit (to also make provision for leave) is as follows:

TABLE 8: Staffing Provision for Mobile Unit

Occupational Category	Number
Professional Nurse	4
Staff Nurse	3
Nursing Assistant	2
Lay Counsellor	1
Total	**10**

3.5 Community Health Centres

Catchment Population Norms

- The Provincial norm is to have one CHC serving an average catchment population of between 60,000 and 120,000.
- There are currently 16 fully functional CHC's providing the standard package of services, serving much bigger populations as compared to the required norm. However, as implementation of the STP progresses, the situation will change with the norm being adhered to by MTEF 2016 when the Department plan to have 100 operational CHC's.

Designated Functional Domain

- Provide promotive, preventive, curative, rehabilitative & palliative health care services falling within the scope of practice of a General Medical Practitioner, including general outpatient services and intra partum services falling within the scope of practice of a Professional Nurse/ Registered Midwife.
- Ensure the integrated, effective and efficient functioning of PHC Clinics and Mobiles operating in the catchment area including compliance with prescribed clinical, referral and quality protocols as well as administrative and facilities management support.
- Monitor public health indicators within the designated catchment area to identify trends timeously and to facilitate appropriate action.
- Ensure the effective and efficient functioning of the prescribed governance arrangements of the Department.
- Provide effective and efficient community outreach services, including the facilitation of community-based rehabilitation services.
- Provide community development support services.
- Ensure the effective, efficient and economical management and utilisation of allocated resources.

Package of Services

- CHCs provide 24-hour PHC services, seven days per week, inclusive of facilitation processes to strengthen community development initiatives.

- Support community development initiatives through the provisioning of a resource centre and the facilitation of programmes aiming to break the cycle of poverty within the local community.

Oversight and Support Arrangements

- CHC's are linked to a designated District Hospital for management and clinical oversight and support, including general service support.

Referral

- All CHCs will (with support from Planned Patient Transport/ EMRS Services) refer patients requiring **higher** levels of health care directly to the designated Hospital providing Level 1 services (the norm being between 5-6 CHCs referring to a District Hospital). Compliance with prescribed clinical and quality protocols is monitored through outreach programmes from the designated District Hospital.

- The Province has a total of 16 CHC's (MTEF 2007/08) referring to 39 District Hospitals (a ratio of 0.46 CHC's to one District Hospital). With implementation of the STP it is expected to change drastically in MTEF 2016 when 100 CHC's will be referring to 40 District Hospitals, changing the ratio to 2.3 CHC's to one District Hospital.

Infrastructure Requirements

- The infrastructural requirements (Table 9) will be supplemented by the standard infrastructure of a fixed PHC Clinic. A Category B PHC Clinic will operate within the structure of each CHC providing services to a catchment population of 10,000 to 20,000 people residing in the immediate vicinity of the CHC.

TABLE 9: Infrastructure Requirements for CHCs

Infrastructure Feature	Number
First Stage/Post Natal Beds	16
Labour Beds	8
Female Beds	10
Pediatric Beds	5
Male Beds	5
Incubators	3
Consulting rooms	7–8 depending on catchment population
Medical and Surgical Procedure Room	1–2 depending on catchment population
Integrated Community Resource Centre	1
Crèche	1
Body Room	1
Pharmacy	1
"On Call" Room	1
Day care facilities for the provisioning of rehabilitation services by community based organisations	
Standard features for the PHC Clinic 'B' in the CHC serving the surrounding catchment population.	

Staffing Arrangements

- The development of staffing norms, based on actual workload and utilisation indicators, is negatively affected by the limited number of CHC currently operational, the existing configuration of their health service platforms (package of services differs) and health service delivery barriers.

- In order to overcome the above problem, a generic organisational and post establishment structure for the provisioning of the identified package of service was developed (in consultation with Clinicians) for a standard catchment population of 60,000 health care users.

- To ensure a balance between the various occupational categories and their optimal utilisation as part of an integrated PHC team, sufficient management and administrative support staff is also provided, whilst dedicated support is provided to ensure that the CHC is able to support the 'referring' PHC Clinics adequately with 'visiting doctor', pharmaceutical and facilities management support.

- Based on a comprehensive analysis of clinical procedures at this level, and in order to ensure the desired clinical outcomes, the following staffing norms were adopted for the Occupational Category Medical Practitioner.

- Assumed that 10% of visits at PHC Clinic level will require referral to a CHC.
- Standard consulting time of 30 minutes were allowed to provide for 'on call', out-reach services and minor medical and surgical emergencies under anaesthesia (excluding surgery under general anaesthesia).

The staffing model for Medical Occupational Categories is illustrated in Table 10.

TABLE 10: Staffing Model for Medical Occupational Category

Medical Occupational Category	Norm
Total number of visits at six referring PHC Clinics per year.	240,000
Number of patients requiring referral for screening by a General Practitioner per year @ 10%.	24,000
Number of patients per week requiring consultation with a General Practitioner.	460
Time (hours) required for the number of visits per week (nx30÷60).	230
Normal working hours per week	40
Number of Medical Officers required (Hours required ÷ 40 hours).	5.7
Total	**6**

The staffing norms for the Nursing Occupational Categories for "in patient" services (provision for leave and shift work included) is summarised in Table 11.

- The 'in-patient' services are based on the number of allocated beds.
- The 'Gateway' PHC Clinic will be serving persons residing in the vicinity of the CHC, based on the staffing norm for a Category 'A' PHC Clinic.

TABLE 11: Staffing Norms for 'In-Patient' Services

Beds	Occupational Category	Occupational Category	8hr shift
16 x1st Stage/ Postnatal 8 x Intra Partum	Professional Nurse/ Midwife	1: Intra partum bed/ shift 2 Additional Professional Nurses	10
	Enrolled Nurse	1: 2 beds	8
	Professional Nurses	1: 2.2 beds	9
	EnrolledNurse	1: 2.2 beds	9
	Nursing Assistant	1: 5 beds	4

Table 12 illustrates the catchment populations per Community Health Centre – based on Stats SA Population Estimates.

Population norm: 1:10 00

TABLE 12: Summary of Total Catchment Population per CHC

Health District	Total CHC Population MTEF 2007/08	No of CHC's Fully Functional 2007/08	Total CHC Population MTEF 2015/16	No of CHC's Fully Functional 2015/16
Amajuba		0	568,769	4
eThekwini	3,260,645	7	3,141,436	18
Ilembe	806,524	2	549,666	5
Sisonke	497,301	1	577,698	5
Ugu		0	834,942	11
Umgungundlovu	2,308,524	4	1,069,388	10
Umkhanyakude		0	661,303	10
Umzinyathi	595,607	1	696,935	7
Uthukela		0	716,657	9
Uthungulu	790,269	1	809,719	8
Zululand	841,884	1	1,230,072	12
TOTAL	**9,100,754**	**17**	**10,856,585**	**100**

Map 1 below provides an indication of the decreased travelling distance for public health care users to access care at CHC's over the MTEF periods 2006 to 2016.

MAP 1: Distance from Community Health Centres 2006 to 2016

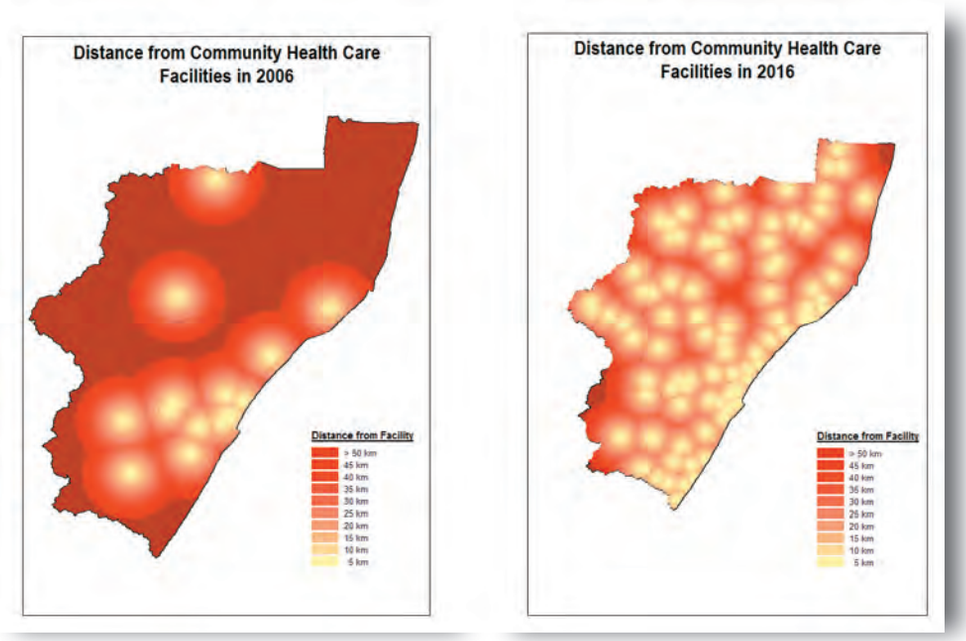
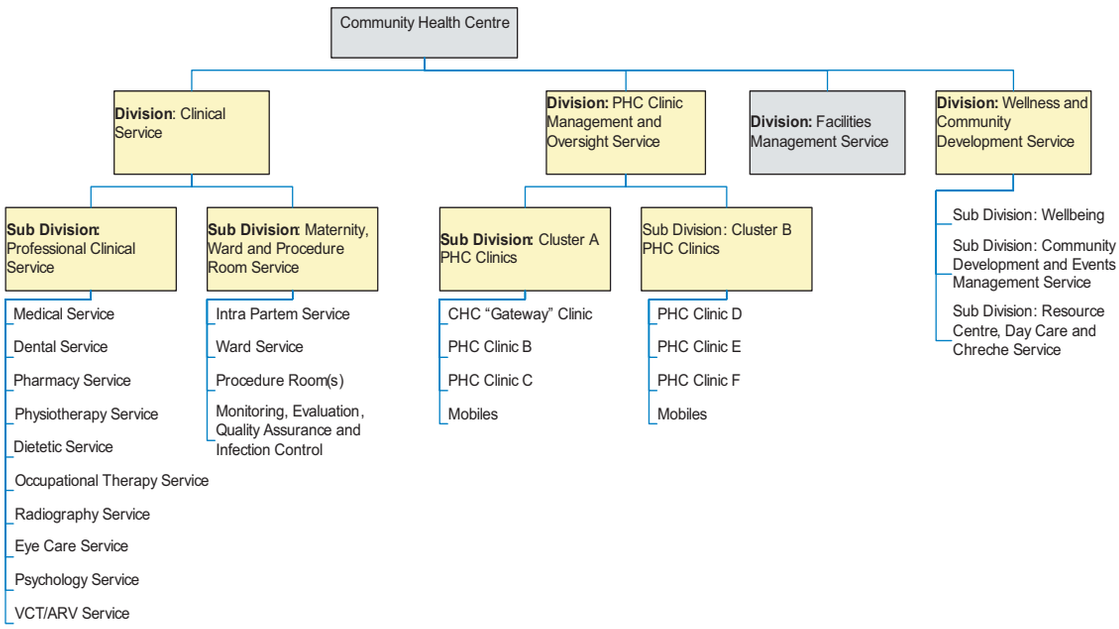


FIGURE 11: Organisational Structure: CHC



3.6 District Hospitals

Based on the imperatives in the STP, District Hospitals will provide a designated range of diagnostic, curative and inpatient services, mostly within the scope of practice of a General Practitioner. A District Hospital will refer 'upwards' to a Regional Hospital (the optimal referral pattern being determined by calculating the shortest distance traveled along roads from facility to facility) and 'downwards' to a CHC for the provisioning of out-patients services.

Provision is made for two categories of District Hospitals:

Category A Hospital

A Health Care Facility providing:

- Diagnostic, curative, surgical (under general anesthesia), accident and emergency in-patient health care services within the scope of practice of a General Practitioner, with a standard bed and theatre provision.
- The preferred number of beds will be between 200 – 400 beds.
- The ideal catchment population would be between 300,000 and 600,000.

Category B Hospital

A Health Care Facility providing:

- Promotive, preventative, curative and palliative out-patient healthcare services.
- Less complicated diagnostic, surgical (under general anesthesia) to sub-acute and step-down services.
- Less complicated accident, emergency and health care services falling within the scope of practice of a General Practitioner as well as intra partum services falling within the scope of a Professional Nurse (Registered Midwife).
- A bed provision of 150 to 200 beds and a functional theatre are key features of this facility. A large proportion of the beds will be step-down beds.

- The ideal catchment population would be between 100,000 and 200,000.
- These Hospitals are located in areas that are poverty stricken and where access to health services is very difficult. Over time it is possible that, as PHC Services are strengthened and the need for step-down beds decreases, Category B Hospitals will be reviewed.

Catchment Population

- District Hospitals will serve a catchment population of approximately 200,000 - 400,000. Due to the topographical composition of the Province, the ability of a substantial number of public health care users to access Hospital Services is problematic. Therefore, some Category A, and all Category B District Hospitals will serve catchment populations less than the standard Provincial norm.

- The distribution of District Hospitals has been particularly challenging since most of them have largely been developed as part of history and inheritance and are not fully aligned to realise the Vision and Mission of the Department. There are historical disparities in the location of existing infrastructure and services together with the settlement patterns in certain areas of the Province which pose major challenges to service delivery.

For District, Specialised, Regional and Tertiary Health Services, the catchment population to be served is the total projected uninsured population.

- All District Hospitals will have TB beds for first time admissions and acute patients.

- "District Hospital beds" (hereinafter referred to as Level 1 beds) will be provided in all Regional Hospitals.

The determination of the required number of Level 1 beds is based on the following norms:

- For the period 2007 – 1011, the National norm of .48 beds per 1,000 uninsured population is used.
- From 2012, the norm2 will increase to .58 per uninsured population to provide for the anticipated increased number of referrals based on improved access to and utilisation of PHC services.

TABLE 13: Provincial Norm for the Allocation of Level One Beds: Clinical Domains

Clinical Domain	Beds
Medical	25% of total District beds and in 2012/13 changes to 40%
Surgical	15% of total District beds
Maternal and Wor Health	40% of total District beds and in 2012/13 changes to 25% due to the number of CHCs and PHC Clinics 'Category C' fully functional - will provide more beds for maternity at PHC levels
Paediatrics	20% of total District beds
Mental Health	4 beds in each District Hospital
In each Regional Hospital, provision has been made for 30% of the total number of beds to be allocated for Level One patients.	

- Step-down beds at District Hospitals are provided depending on the utilisation rate of step-down beds in the last three years.

ANNEXURE 3

TABLE 14: Step-Down Beds

Norm	Base
0.36	Per 1,000 catchment population
20%	Total level 1 beds in District Hospital Period MTEF 2007/08 – MTEF 2009/10
35%	Total level 1 beds in District Hospital Period MTEF 2010/11 – MTEF 2012/13
56%	Total level 1 beds in District Hospital Period MTEF 2014/15– MTEF 2016/17

Oversight and Support Arrangements

- A District Hospital Manager reports to a District Manager and is linked to a designated Regional Hospital for clinical oversight and support.

Referrals

- All District Hospitals will (with support from the PPT/ EMRS Service) refer patients requiring higher levels of health care to a designated Regional Hospital. The norm is to have 4 to 6 District Hospitals referring to a Regional Hospital.
- By 2016, two to three CHC's will refer patients to one District Hospital where the service will be provided 24 hours per day and seven days a week.
- As an *interim* arrangement, and until such time as all planned CHC's in the designated drainage area of a District Hospital are fully operational, PHC Clinics will also refer patients requiring higher levels of care directly to designated District Hospitals.
- It is important to note that even when all CHC's are fully operational, PHC Clinics will still refer some patients directly to District Hospitals.
- These instances must be specified in the detailed Departmental Referral Policy and Protocol Framework.

Staffing Arrangements: 'Category A' District Hospitals

Figure 10 illustrates the Organisational Structure of a Category 'A' District Hospital

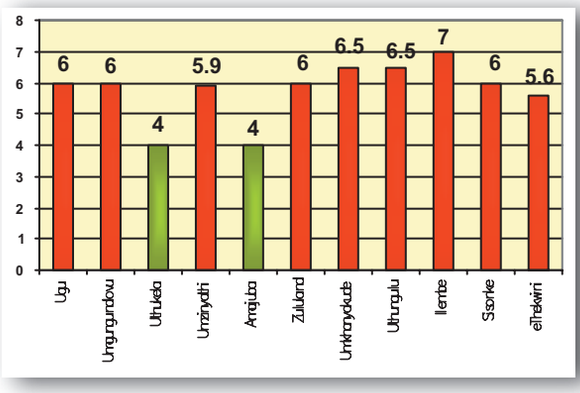
- A generic organisational and post establishment structure for the provisioning of the identified package of service was developed with the input of Clinicians for a standard catchment population of 300,000 public health care users.
- Based on a comprehensive analysis of clinical procedures at this level and the bed allocation as well as to ensure the desired clinical outcomes the staffing norms were developed.

Average Length of Stay (ALOS)

National Target: 4.2 days

- District Hospitals generally admit patients with acute or relatively uncomplicated conditions, with the objective to treat and discharge them as soon as is possible. This indicator (*Average Length of* Stay) is used as a proxy measure for the quality of care as well as efficiency. Figure 12 illustrates the ALOS per District Hospital during 2007/09.

FIGURE 12: Average Length of Stay – 2007/08



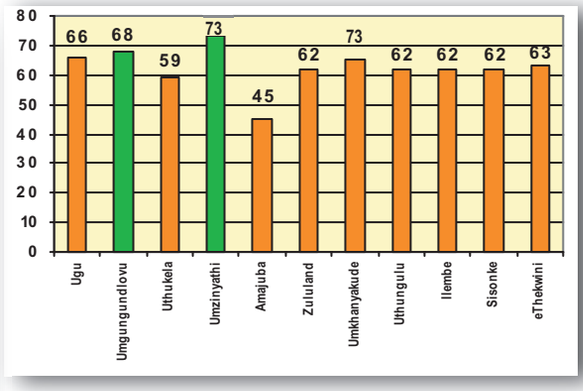
- Uthukela District reduced the ALOS from 5 days in 2006/07, and Amajuba District is within the National range – both Districts demonstrating effective management and utilisation of resources.
- Although other Districts reported high values (as compared to the National target) all improved and decreased the ALOS by at least 1 – 2 days from MTEF 2006/07.
- Contributing factors to extended ALOS may be the shortage of step-down beds for down-referral (chronic, TB, mental health, etc.) or the shortage of doctors to discharge patients timeously.
- Routine data does not allow for analysis of this indicator, and an investigation will be undertaken to determine the reasons for extended stay to inform planning.

Bed Utilisation Rate

National Target: 68%

- The 2007/08 Provincial Bed Utilisation Rate for District Hospitals is 62% (constant from MTEF 2006/07).

FIGURE 13: Bed Utilisation Rate – 2007/08



- Only Umgungundlovu (68%) and Umzinyathi (73%) Districts reached the National target of 68%.
- The reasons for low occupancy rates will be investigated as this has direct bearing on bed allocation in the restructuring of services (including allocation of beds).

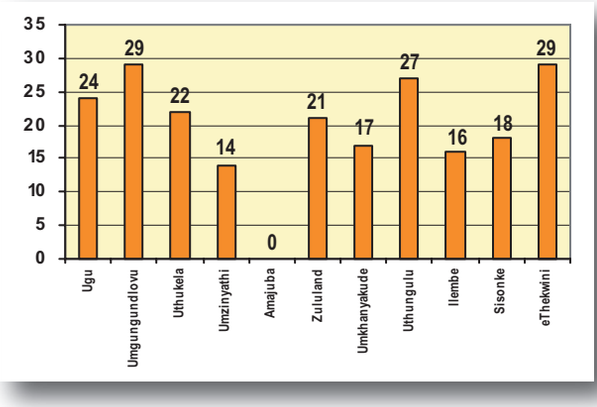
Caesarean Section Rate

National Target: 12.5%

- The Provincial Caesarean Section Rate is 20% for District Hospitals, and although the National target is considered unrealistic this is still a high value for Level 1 services.
- Caesarean section is one of the most basic operations and should be performed in Level 1 Hospitals, except complicated cases that should be referred timeously to the next level of care. Obstetric risk increases with caesarean section and the high values reported by District Hospitals are therefore a concern.
- The reasons for high rates are not clear, and investigations will be undertaken to ensure informed action is taken if so indicated.

Figure 14 illustrates District Caesarean Section Rates for MTEF 2007/08.

FIGURE 14: Caesarean Section Rates – MTEF 2007/08



- Monitoring of implementation of Policies and protocols, use of the partogram and monitoring during labour will be done to ensure quality of care.

- Innovative community strategies are planned to improve antenatal care including utilisation of antenatal care services before 20 weeks gestation.

PRIORITIES FOR PRIMARY HEALTH CARE CLINICS AND COMMUNITY HEALTH CENTRES

1. To increase access to health care services through implementation of the STP.
2. To implement the results-based monitoring and evaluation system at District level.
3. To strengthen PHC services through the implementation of the STP.
4. To improve the quality of health care.
5. To continue to improve clinical governance and management within the District Health Services.

PRIORITIES FOR DISTRICT HOSPITALS IN MTEF 2008/09

1. Continue with the implementation of the revised Organisational structures and post establishments.
2. Increase the number of step-down beds based on the Category A and B District Hospitals in the STP.
3. Develop and provide dedicated capacity for out-reach initiatives to strengthen PHC Clinics and CHC's.
4. To improve the quality of health care.
5. To improve infection prevention and control.

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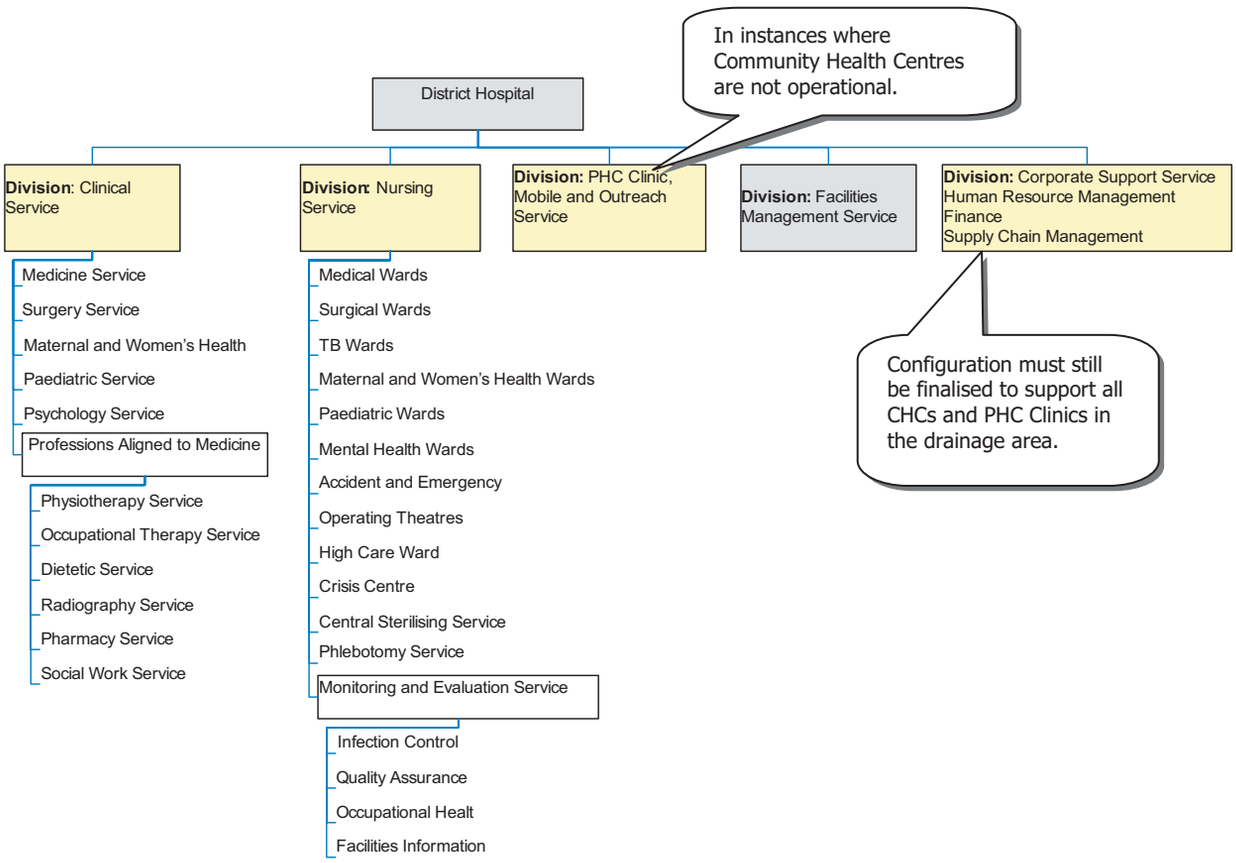
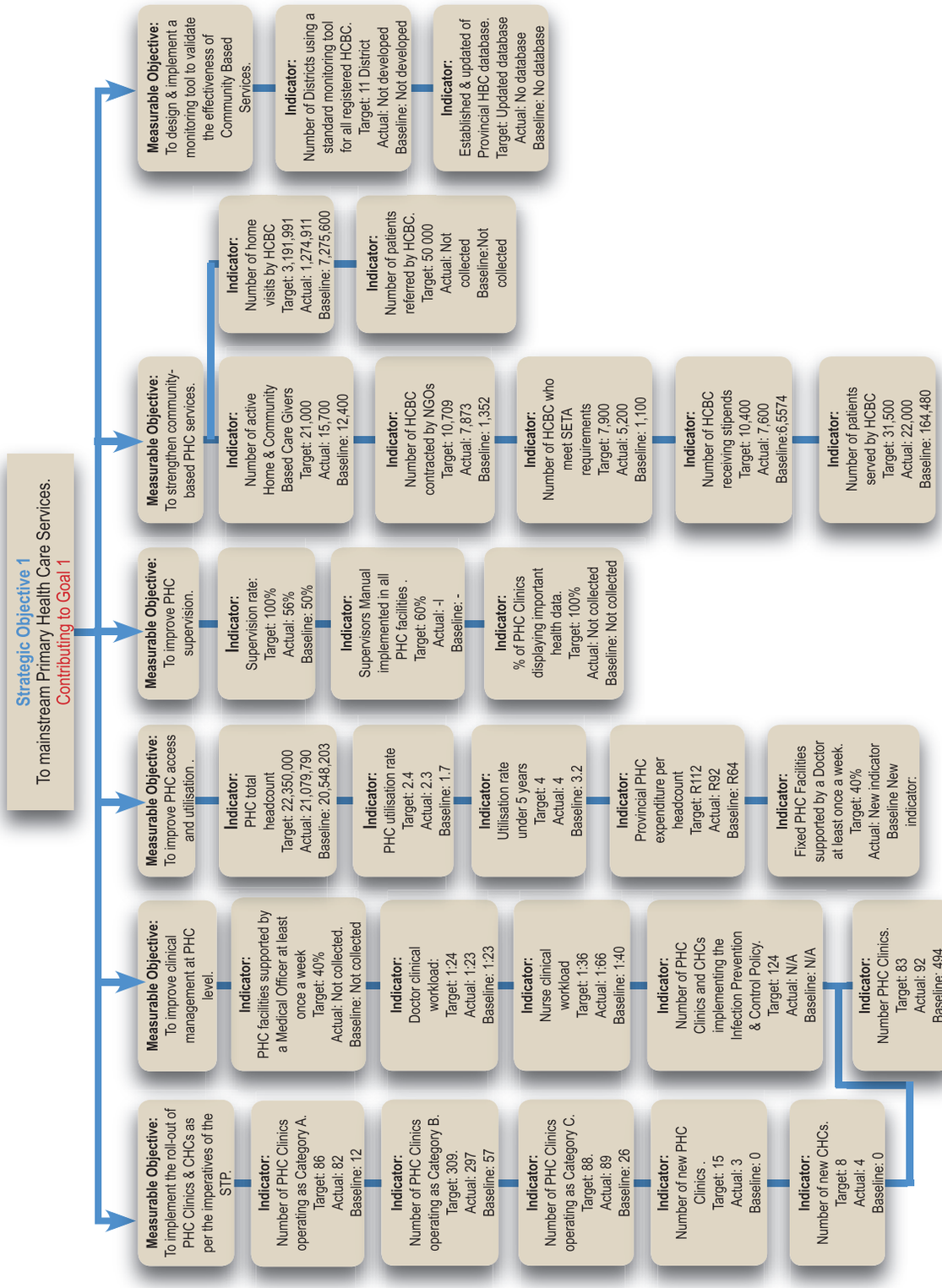
FIGURE 15: Organisational Structure: Category A District Hospital



4. PRIORTIES AND STRATEGIC OBJECTIVES

The strategic objectives, measurable objectives and indicators for PHC are indicated in the following diagram below.



ANNEXURE 3

The strategic objectives, measurable objectives and indicators of quality of care and infection control are indicated in the daigram below:

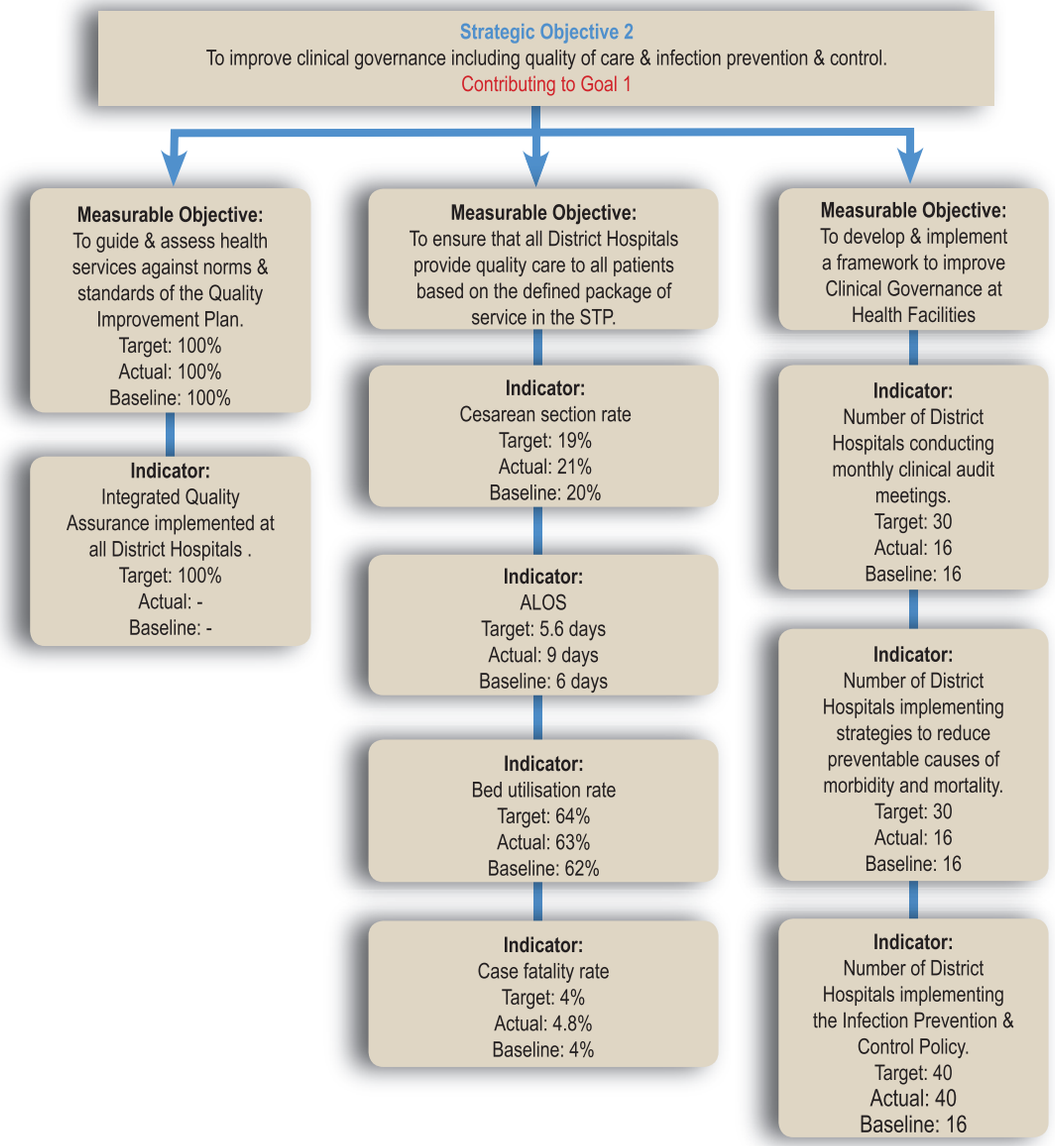


TABLE 15: (DHS 1) District Health Service Facilities by Health District – MTEF 2007/08 – MTEF 2008/09

Health District	Facility Type	MTEF 2006/2007 No.	MTEF 2007/2008[13]	Population	Average Catchment Population MTEF 2007/2008	Per capita utilisation rate MTEF 2006/2007	Per capita utilisation rate MTEF 2007/2008	Per capita utilisation rate MTEF 2008/2009
Amajuba	Fixed clinics:	27	25	475,714	22,092			
	CHC	0	2	623,275				
	Sub-total: Clinics & CHC	**27**	**27**	**1,098,989**	**22,092**	**1.4**	**2.2**	**2.3**
eThekweni	Fixed clinics:	112	112	3,117,459	19,391			
	CHC	6	7	3,125,960				
	Sub-total: Clinics & CHC	**118**	**119**	**6,243,419**	**19,391**	**1.7**	**2.1**	**2.3**
iLembe	Fixed clinics:	31	34	556,342	18,459			
	CHC	2	2	774,634				
	Sub-total: Clinics & CHC	**33**	**36**	**1,330,976**	**18,459**	**1.8**	**2.5**	**2.5**
Sisonke	Fixed clinics:	56	37	458,337	16,396			
	CHC	2	2	521,823				
	Sub-total: Clinics & CHC	**58**	**39**	**980,160**	**16,396**	**1.8**	**2.5**	**3**
Ugu	Fixed clinics:	45	52	714,663	17,866			
	CHC	0	4	730,225				
	Sub-total: Clinics & CHC	**45**	**56**	**1,444,888**	**17,866**	**1.8**	**2.2**	**2.3**
Umgungundlovu	Fixed clinics:	54	45	739,613	19,993			
	CHC	4	4	1,132,189				

[13] The facilities list from which the fixed clinic numbers for 2006 were taken had not been verified prior to the STP process and was reliant on the data provided by the GIS section (which was captured purely for mapping purposes). The numbers therefore have not been verified and may be inaccurate (accounting for a drop in clinic number between 2006 & 2007). In addition, some clinics assume the function of a CHC during the 2007/08 financial period and thus these impacts on the clinic numbers. In addition the 2006 is a list of all clinics. In 2007/08 care has been taken to account for the local government clinics and in some cases these are not included in the STP (this were decisions taken by the Districts) and thus the clinic number may drop. E.g Umgungundlovu Mooi River Truck Stop is listed as a clinic in 2006 but in 2007/08 is a specialised step down treatment facility

ANNEXURE 3

Health District	Facility Type	MTEF 2006/2007 No.	MTEF 2007/2008[13]	Population	Average Catchment Population MTEF 2007/2008	Per capita utilisation rate MTEF 2006/2007	Per capita utilisation rate MTEF 2007/2008	Per capita utilisation rate MTEF 2008/2009
	Sub-total: Clinics & CHC	**58**	**49**	**1,871,802**	**19,993**	**1.8**	**2.2**	**2.3**
Umkhanyakude	Fixed clinics:	55	53	584,302	17,822			
	CHC	0	0	-				
	Sub-total: Clinics & CHC	**55**		**584,302**	**17,822**	**1.9**	**2.2**	**2.3**
Umzinyathi	Fixed clinics:	41	42	488,605	15,805			
	CHC	1	2	632,668				
	Sub-total: Clinics & CHC	**42**		**1,121,273**	**15,805**	**1.6**	**2.2**	**2.3**
Uthukela	Fixed clinics:	39	37	649,851	15,974			
	CHC	0	1	297,030				
	Sub-total: Clinics & CHC	**39**		**946,881**	**15,974**	**1.6**	**2.2**	**2.3**
Uthungulu	Fixed clinics:	56	59	897,560	17,344			
	CHC	1	1	1,267,761				
	Sub-total: Clinics & CHC	**57**		**2,267,761**	**17,344**	**1.8**	**2.2**	**2.3**
Zululand	Fixed clinics:	60	63	767,686	18,041			
	CHC	1	1	505,606				
	Sub-total: Clinics & CHC	**61**		**1,273,292**	**18,041**	**1.6**	**2.2**	**2.3**
Total	**Fixed clinics:**	**576**	**559**	**9,450,132**				
	CHC	**17**	**26**	**9,611,171**				
	Sub-total: Clinics & CHC	**595**	**585**	**19,061,303**		**1,7**	**2.3**	**2.4**

Notes

Average Population: Catchment population were calculated using closest Theissen Polygons and referrals to closest facilities. Populations of catchments have been averaged which may lead to an incorrect representation of the situation especially in those districts and which have a mixture of urban and rural areas. Cross border flows have been accounted for by including a 5km buffer around the KwaZulu-Natal Provincial border.

TABLE 16: (DHS 2) Personnel in District Health Services by Health District for MTEF 2006/07

Health District	Personnel Category	Posts Filled	Posts Approved MTEF 2006/07	Vacancy Rate (%)	Number in post per 1000 uninsured people
Ugu	**PHC facilities**				
Uninsured Population: 641 514	Medical Officers	**0**	1	100	0.000
	Professional Nurses	**134**	223	40	0.209
	Pharmacists	**0**	0	0	0.000
	Community Health Workers[14]	**-**	-	-	-
	District Hospitals				
	Medical Officers	**48**	94	49	0.075
	Professional Nurses	**279**	508	45	0.435
	Pharmacists	**16**	78	79	0.025
uMgungundlovu	**PHC facilities**				
Uninsured Population: 845 460	Medical Officers	**8**	19	58	0.009
	Professional Nurses	**226**	441	49	0.267
	Pharmacists	**3**	12	75	0.004
	Community Health Workers	**-**	-	-	-
	District Hospitals				
	Medical Officers	**45**	120	63	0.053
	Professional Nurses	**305**	486	37	0.361
	Pharmacists	**16**	65	75	0.019
Uthukela	**PHC facilities**				
Uninsured Population: 589 645	Medical Officers	**1**	6	83	0.002
	Professional Nurses	**128**	207	38	0.217
	Pharmacists	**0**	3	100	0.000
	Community Health Workers	**-**	-	-	-

[14] Currently no database for Community Health Workers.

Health District	Personnel Category	Posts Filled	Posts Approved MTEF 2006/07	Vacancy Rate (%)	Number in post per 1000 uninsured people
	District Hospitals				
	Medical Officers	**23**	63	63	0.039
	Professional Nurses	**167**	287	42	0.283
	Pharmacists	**8**	48	83	0.014
Umzinyathi **Uninsured Population: 415 924**	**PHC facilities**				
	Medical Officers	**1**	2	50	0.002
	Professional Nurses	**80**	198	60	0.192
	Pharmacists	**1**	2	50	0.002
	Community Health Workers	**-**	-	-	-
	District Hospitals				
	Medical Officers	**46**	123	63	0.111
	Professional Nurses	**454**	845	46	1.092
	Pharmacists	**10**	93	89	0.024
Amajuba **Uninsured Population: 426 477**	**PHC facilities**				
	Medical Officers	**0**	1	100	0.000
	Professional Nurses	**46**	85	46	0.108
	Pharmacists	**0**	0	0	0.000
	Community Health Workers	**-**	-	-	-
	District Hospitals				
	Medical Officers	**23**	52	56	0.054
	Professional Nurses	**188**	271	31	0.441
	Pharmacists	**8**	30	73	0.019
Zululand **Uninsured Population: 733 024**	**PHC facilities**				
	Medical Officers	**3**	6	50	0.004
	Professional Nurses	**170**	281	40	0.232
	Pharmacists	**1**	2	50	0.001
	Community Health Workers	**-**	-	-	-

Health District	Personnel Category	Posts Filled	Posts Approved MTEF 2006/07	Vacancy Rate (%)	Number in post per 1000 uninsured people
	District Hospitals				
	Medical Officers	**49**	151	68	0.067
	Professional Nurses	**582**	1,009	42	0.794
	Pharmacists	**9**	114	92	0.012
Umkhanyakude **Uninsured Population: 522 430**	**PHC facilities**				
	Medical Officers	**1**	3	67	0.002
	Professional Nurses	**101**	177	43	0.193
	Pharmacists	**1**	5	80	0.002
	Community Health Workers	**-**	-	-	-
	District Hospitals				
	Medical Officers	**63**	153	59	0.121
	Professional Nurses	**393**	722	46	0.752
	Pharmacists	**15**	130	88	0.029
Uthungulu **Uninsured Population: 522 430**	**PHC facilities**				
	Medical Officers	**1**	9	89	0.002
	Professional Nurses	**147**	238	38	0.281
	Pharmacists	**1**	3	67	0.002
	Community Health Workers	**-**	-	-	-
	District Hospitals				
	Medical Officers	**73**	214	66	0.140
	Professional Nurses	**542**	968	44	1.037
	Pharmacists	**15**	158	91	0.029
iLembe **Uninsured Population: 510 633**	**PHC facilities**				
	Medical Officers	**3**	12	75	0.006
	Professional Nurses	**118**	294	60	0.231
	Pharmacists	**4**	10	60	0.008
	Community Health Workers	**-**	-	-	-

ANNEXURE 3

Health District	Personnel Category	Posts Filled	Posts Approved MTEF 2006/07	Vacancy Rate (%)	Number in post per 1000 uninsured people
	District Hospitals				
	Medical Officers	**18**	47	62	0.035
	Professional Nurses	**111**	173	36	0.217
	Pharmacists	**5**	46	89	0.010
Sisonke **Uninsured Population: 415 977**	**PHC facilities**				
	Medical Officers	**1**	6	83	0.002
	Professional Nurses	**81**	182	55	0.195
	Pharmacists	**1**	5	80	0.002
	Community Health Workers	**-**	-	-	-
	District Hospitals				
	Medical Officers	**34**	84	60	0.082
	Professional Nurses	**236**	346	32	0.567
	Pharmacists	**8**	73	89	0.019
eThekwini **Uninsured Population: 2 815 735**	**PHC facilities**				
	Medical Officers	**39**	87	55	0.014
	Professional Nurses	**487**	849	43	0.173
	Pharmacists	**34**	55	38	0.012
	Community Health Workers	**-**	-	-	-
	District Hospitals				
	Medical Officers	**78**	238	67	0.028
	Professional Nurses	**767**	1,528	50	0.272
	Pharmacists	**58**	195	70	0.021
KwaZulu-Natal Province **Uninsured Population: 8 733 120**	**PHC facilities**				
	Medical Officers	**58**	152	62	0.007
	Professional Nurses	**1,718**	3175	46	0.197
	Pharmacists	**46**	97	53	0.005
	Community Health Workers	**-**	-	-	-
	District Hospitals				

Health District	Personnel Category	Posts Filled	Posts Approved MTEF 2006/07	Vacancy Rate (%)	Number in post per 1000 uninsured people
	Medical Officers	**500**	1,339	63	0.057
	Professional Nurses	**4,024**	7,143	44	0.461
	Pharmacists	**168**	1,030	84	0.019

TABLE 17: (DHS 6) Situation Analysis and Performance Indicators for District Health Services

Indicator	Type	Province wide value 2004/05	Province wide value 2005/06	Province wide value 2006/07	Province wide value 2007/08	Province wide value 2008/09	Province wide value 2009/10	Province wide value 2010/11
Input								
1. Provincial PHC expenditure per uninsured person.	R	R 210.48	R251.41	R297.28	R382.20	R419.07	R459.81	R482.80
2. Sub-Districts offering full package of PHC services.	%	85%	87%	100%	100%	100%	100%	100%
Output								
3. PHC total headcount.[15]	Number	18,873,246	19,210,359	20,548,203	21,079,790	22,350,000	23,467,500	24,640,875
4. Utilisation Rate – PHC.	Number	1.8	2.0	1.7	2.3	2.4	2.5	2.6
5. Utilisation Rate - PHC Under-5 years.	Number	3.5	4.0	3.2	4	4	4	4
Quality								
6. Supervision rate.	%	83%	93%	50%	56%	100%	100%	100%
7. Fixed PHC facilities supported by a doctor at least once a week.[16]	%	Data not collected	Data not collected	Data not collected	Data not collected	40%	50%	60%
Efficiency								
8. Provincial PHC expenditure per headcount at provincial PHC facilities.	R	R 94	R 92	R64	R 70	R74	R78	

[15] Targets calculated using a 5% increase. Trends will be monitored.
[16] New indicator that will be collected from 2008/09.

TABLE 18: (DHS 7) Performance Indicators for District Hospitals Sub-Programme

Indicator	Type	Province wide value 2006/07	Province wide value 2007/08	Province wide value 2008/09	Province wide value 2009/10
Output					
1. Caesarean section rate for District Hospitals.	%	20%	19%	19%	19%
2. Separations - Total.	No	349,624	329,406	371,300	417,000
3. Patient Day Equivalents.	No	5,542,137	4,903,785	5,600,000	5,650,000
4. OPD Total Headcounts.[17]		2,412,352	2,168,440	2,545,000	2,626,000
Quality					
5. District Hospitals with patient satisfaction survey using DOH template.	%	95%	0%[18]	100%	100%
6. District hospitals with Mortality and Morbidity meetings every month.	%	(16 Hospitals) 40%	(16 Hospitals) 40%	(30 Hospitals) 75%	(40 Hospitals) 100%
7. District hospitals with monthly clinical audit meetings every month[19].	%	(16 Hospitals) 40%	(16 Hospitals) 40%	(30 Hospitals) 75%	(40 Hospitals) 100%
8. Complaints resolved within 25 days[20]		-	-	40%	60%
Efficiency					
9. Average length of stay in District Hospitals.	Days	6 Days	9 Days	5.6 Days	5 Days
10. Bed utilisation rate (based on usable beds) in District Hospitals.	%	62.1%	63.1%	64%	70%
11. Expenditure per patient day equivalent in District Hospitals.	R	R949	R1367	R1436	R1508
Outcome					
12. Case fatality rate in district hospitals for surgery separations.	%	4%	4.8%	4%	4%

[17] Targets calculated using a 5% increase. Trends will be motivated.

[18] A Head Office initiative to ensure standardization. Not conducted due to SCM delaying award of Tender.

[19] 100% of District Hospitals conduct quarterly meetings.

[20] New indicator added for 2008/09.

ANNEXURE 3

TABLE 19: Analysis of Constraints and Measures to overcome them

Health System Priorities	Constraints	Planned Remedial Measures
STP.	Inadequate funding for implementing new PHC model.	To continue to re-prioritise funding to increase the Budget allocation of Programme 2.
Strengthen Physical Infrastructure.	Availability of land.	To work closely with other sectors and Local Government in the identification and use of suitable land.
Strengthen Human Resources.	Insufficient Health Professionals to ensure that extension of service hours in PHC facilities is possible.	To assist the Human Resources Management Unit with the development of an innovative strategy to recruit additional health professionals to PHC facilities.

TABLE 20: (NHS 3) Quality of Care

Improved quality of care in the restructured service platform is essential to the delivery of the required outcomes and the Provincial Department of Health's Vision and Mission.

Activity	Indicators	Targets 2006/07	Targets 2007/08	Targets 2008/09	Responsibility
Hospital improvement plans.	Clinical audits.	Clinical audits routinely monitored in all Tertiary Hospitals, and 25% of Regional Hospitals.	Clinical audits routinely monitored at all Regional Hospitals, 40% of District Hospitals (16).	Clinical audits routinely monitored in 75% of District Hospitals (30).	M & E Component.
	Complaints mechanisms.	Complaints mechanisms routinely managed in all Tertiary Hospitals, 25% Regional Hospitals.	Complaints mechanisms routinely managed in all Regional Hospitals, 35% of Districts (Level 1 Hospitals and PHC facilities).	Complaints mechanisms routinely managed in all Districts (Level 1 Hospitals and PHC facilities).	M & E Component.
	Infection control.	Policy not finalised.	Approved Infection Prevention and Control Policy.	Infection prevention and control management effected in all Hospitals & all CHCs & 100 Clinics.	M & E Component.
Hospital improvement plans.	Tele-medicine.	Hub and spoke systems developed in accordance with STP.	Hub and spoke systems developed in accordance with STP.	Hub and spoke systems developed in accordance with STP.	IT and Tele-health.
Supervision.	Supervision rate for PHC.		50% supervision rate overall, 67% in rural facilities.	100% supervision rate.	PHC Component.

TABLE 21: (DHS 5) Provincial Objectives and Performance Indicators for District Health Services

Performance Indicator	2006/07 (Actual)	2007/08 (Target)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Measurable Objective: To implement the roll-out of PHC Clinics and CHCs as per the imperatives of the STP.					
Number of PHC Clinics operating as Category A Clinics.	12	82	86	113	126
Number of PHC Clinics operating as Category B Clinics.	57	297	309	302	317
Number of PHC Clinics operating as Category C Clinics.	26	89	88	91	94
Number of new PHC Clinics.	0	3	15	25	19
Number of new CHCs.	0	4	8	4	3
Number of PHC Clinics.	494	92	83	70	43
Measurable Objective: To improve PHC access and utilisation.					
Provincial PHC expenditure per headcount.	R64	R70	R74	R78	R82
PHC headcount.[21]	20,548,203	21,079,790	22,350,000	23,467,500	24,640,875
PHC utilisation rate.	1.7	2.3	2.4	2.5	2.6
PHC utilisation rate – under-5 years.	3.2	4	4	4	4
Measurable Objective: To improve PHC supervision.					
Supervision rate.	50%	56%	100%	100%	100%
Supervisors manual implemented at all PHC Facilities.	National Manual not finalised.	National Manual not finalised.	100%	100%	100%
% of PHC Clinics displaying important health data.	Not collected.	Not collected.	100%	100%	100%
Measurable Objective: To improve clinical management at PHC level.					
PHC facilities supported by a Medical Officer at least once a week.	Not collected.	Not collected.	40%	50%	60%
Doctor clinical workload.	1:23	1:23	1:24	1:23	1:23
Nurse clinical workload.	1:40	1:66	1:36	1:35	1:35
Number of PHC Clinics and CHCs implementing the Infection Prevention & Control Policy.	Not collected.	Not collected.	(124) PHC Clinics: 110 CHCs: 14		

[21] Target calculated using a 5% increase. Trends will be monitored.

Performance Indicator	2006/07 (Actual)	2007/08 (Target)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Measurable Objective: To strengthen Community-Based PHC services.					
Number of active Home and Community-Based Care Givers.	12,400	15,700	21,000		
Number of HCBC contracted by NGOs.	1,100-HBC 252-NIP	5,400-CHW 2,200-HBC 273-NIP	6,000-CHW 4,400-HBC 309-NIP		
Number of HCBC who meet SETA requirements.	1,100	3,000-CHW 2,200-HBC	4,000-CHW 400-RPL 3,500-HBC		
Number of HCBC receiving stipends.	2,500-CHW 4,074-HBC	5,400-CHW 2,200-HBC	6,000-CHW 4,400-HBC		
Number of patients served by HCBC.	164,480	22,000	31,500		
Number of home visits by HCBC.	7,275,600	1,274,911	3,191,991		
Number of patients referred by HCBC.	Not Collected.	Not collected	50,000		
Measurable Objective: To design and implement a monitoring tool to validate the effectiveness of Community-Based Services.					
Number of Districts implementing the standard monitoring tool for registered HCBC.	Not Developed.	Not Developed	11 Districts.	11 Districts.	11 Districts.
Established and updated Provincial HBC database.	No database.	No database.	Updated database.	Updated database.	Updated database.
Measurable Objective: To ensure that all District Hospitals provide quality care to all patients based on the defined package of services as per STP.					
Caesarean section rate.	20%	21%	20%	20%	19%
Average Length of Stay.	6 Days	9 Days	5.6 Days	5 Days	5 Days
Bed utilisation rate.	62%	63%	64%	66%	70%
Case fatality rate.	4%	4.8%	4%	4%	3.5%
Number of District Hospitals implementing the Infection Prevention and Control Policy.	-	Policy approved.	40 (100%)	40 (100%)	40 (100%)
Measurable Objective: To develop and implement a framework to improve clinical governance at Health Facilities.					
Number of District Hospitals conducting monthly clinical audit meetings.	16	16 (40%)	30 (75%)	40 (100%)	40 (100%)
Integrated Quality Assurance implemented in all District Hospitals.	-	-	40 (100%)	40 (100%)	40 (100%)
Number of District Hospitals implementing strategies to reduce preventable causes of morbidity and mortality.	-	16 (40%)	30 (75%)	40 (100%)	40 (100%)

TABLE 22: (DHS 8) Transfers to Municipalities and Non-Government Organisations (R '000)

Municipalities	Purpose of Transfer	Base year 2006/07 (actual)	Year 1 2007/08 MTEF Projection	Year 2 2008/09 MTEF Projection	Year 3 2009/10 MTEF projection	Year 4 20010/11 MTEF Projection
Abaqulusi	1,2	365	585	47	51	55
Amajuba District Municipality	**4**	**225**	**-**	**-**	**-**	
Dannhauser	1,2	519	584	24	25	27
EDumbe	1	557	400	-	-	-
Emnambithi/Ladysmith	1,2	3,920	4,645	80	86	92
eNdondakusuka/Madadeni	1,2	854	966	25	26	28
Endumeni	1,2	1,571	2,916	80	86	92
EThekwini	1,2,3,4	**33,632**	**38,246**	**41,137**	**44,223**	**46,859**
Hibiscus Coast	1,2	2,720	3,091	142	154	165
Ilembe District Municipality	4	**343**	**-**	**-**	**-**	
Kokstad	1,2	581	62	66	71	76
KwaDukuza	1,2	3,006	3,935	104	113	121
Matatiele	1,2	1,513				
Mpofana	1	773	819	-	-	-
Msunduzi	**1,2,3,4**	**8,128**	**8,208**	**131**	**141**	**151**
Mthonjaneni	1	784	831	-	-	
Newcastle	1,2	1,056	1,141	90	97	104
Okhahlamba	1	691	1,166	-	-	
Richmond	2		66	71	76	81
Ubuhlebezwe	2		25	27	29	31
Ugu District Municipality	**4**	**266**	**-**	**-**	**-**	
Ulundi	2		56	60	64	68
Umdoni	1,2	1,180	1,232	71	76	81

Municipalities	Purpose of Transfer	Base year 2006/07 (actual)	Year 1 2007/08 MTEF Projection	Year 2 2008/09 MTEF Projection	Year 3 2009/10 MTEF projection	Year 4 20010/11 MTEF Projection
uMgungundlovu District Municipality	**4**	**813**	**-**	**-**	**-**	
UMhlathuze	1,2	3,927	4,279	206	222	238
Umkhanyakude District Municipality	**4**	**235**	**-**	**-**	**-**	-
Umlalazi	1,2	1,538	2,097	73	78	83
UMngeni	1,2	1,061	1,201	80	86	92
UMshwathi	1,2	371	393	-	-	
Umtshezi	1,2	776	1,663	54	58	62
UMuziwabantu	1,2	614	644	31	33	35
Umvoti	1,2	780	1,444	54	58	62
Umzinyathi District Municipality	**4**	**253**	**-**	**-**	**-**	
UPhongolo	2	-	30	32	35	37
Uthukela District Municipality	**4**	**201**	**-**	**-**	**-**	
Uthungulu District Municipality	**4**	**579**	**-**	**-**	**-**	
EMadelangeni	2		22	24	25	27
Zululand District Municipality	**4**	**333**	**-**	**-**	**-**	
Sisonke District Municipality	**4**	**14**	**-**	**-**	**-**	
Unallocated		**1,918**	**608**	**318**	**854**	**2,038**
Total municipalities		**76,148**	**81,355**	**43,027**	**46,767**	**50,705**

Keys : 1 = PCH Clinics, 2 = Environmental Health Clinics, 3 = HIV and Aids Clinics, 4 = Regional Services Council Levies (Abolished).

TABLE 23: (DHS 8) Service Level Agreements signed with Non-Government Organisations (R'000)

Non Government Organisations	Purpose of transfers	Base year 2006/07 (actual)	Year 1 2007/08 (MTEF projection)	Year 2 2008/09 (MTEF projection)	Year 3 2009/10 (MTEF projection)	Year 4 2010/11 (MTEF projection)
Austerville Halfway House	4	314	333	356	383	406
Azalea House	4	34	363	388	417	442
Bekulwandle Bekimpelo	1	4,245	4,487	5,771	6,117	6,484
Benedictine Clinic	1	260	275	294	316	335
Cheschire Home Educare	4	218	231	247	266	282
Claremont Day Care Centre	4	261	277	296	318	337
Day Care Club 91/92	4	127	230	246	264	280
Durban School for the Deaf	7	138	146	156	168	178
Ekuhanyeni Clinic	1	130	173	185	199	211
Elandskop Clinic	1	312	330	457	484	513
Enkumane Clinic	1	187	198	212	228	242
Happy Hour Various	4	1,297	1,376	1,472	1,582	1,677
Hlanganani Ngothando	4	113	92	98	105	111
Ikwezi Cripple Care/DNS	4	1,070	1,133	1,212	1,303	1,381
Jewel House	4	158	167	179	192	204
Joan Tennant House	4	143	152	162	174	184
John Peattie House	4	673	713	763	820	869
Jona Vaughn Centre	4	1,624	1,721	1,842	1,980	2,099
Lynn House	4	271	287	307	330	350
Madeline Manor	4	599	882	944	1,015	1,076
Masada Workshop	4	192	204	218	234	248
Masibambeni Day Care Centre	4	105	111	119	128	136
Matikwe Oblate Clinic	1	338	393	505	535	567
Mccords Hosp	1,3,6	45,471	61,902	64,378	68,241	72,335
Mhlumayo Clinic	1	400	424	453	487	516
Montebello Chronic Sick Home	8	3,378	3,496	3,739	4,019	4,260
Mountain View Hosp	1,3	5,592	7,226	6,675	7,075	7,500
Noyi Bazi Oblate Clinic	1	326	361	386	415	440
Provincial Aids Action Unit	2		-	-	-	0

Non Government Organisations	Purpose of transfers	Base year 2006/07 (actual)	Year 1 2007/08 (MTEF projection)	Year 2 2008/09 (MTEF projection)	Year 3 2009/10 (MTEF projection)	Year 4 2010/11 (MTEF projection)
District Srv Delivery (All Districts for HIV/AIDS)	2	1,696	39,228	40,797	43,245	45,840
Pongola Hospital/Pongola Jozini	5	1,722	2,118	2,265	2,435	2,581
Phrenaid A L P	4	71	75	81	87	92
Rainbow Haven	4	277	294	314	338	358
Scadifa Centre	4	653	692	741	797	845
Sibisisiwe home	4	436	212	227	244	259
Siloah Hospital	1,2,5	8,503	10,408	10,950	11,662	12,362
Sparkes Estate	4	911	966	1,033	1,110	1,177
St Lukes Home	4	376	399	426	458	485
St Mary's Hosp Marianhill	1,3,5	59,069	68,421	71,158	75,072	79,576
Sunfield Home	4	99	105	112	120	127
Ithembalethu	1	-	4,923	5,169	5,479	5,808
Umlazi Halfway House	4	171	181	194	209	222
Philanjalo Hospice (Step down Centre)	2	787	1,115	1,520	1,612	1,708
Earmarked for further negotiations		-	479	602	721	981
Total		**142,747**	**215,376**	**227,649**	**241,384**	**256,084**

NOTE: Refer to the codes listed below which indicate the main purpose of the individual institutions in respect of transfers: The above figures are subject to change as final negotiations with the institutions are still in progress. PHC Clinics (1); HIV and AIDS (2), TB (3), Psychiatric (4), District Hospitals (5), Other Hospitals (6), Private Enterprises providing a service to the Department (7), Other (8).

TABLE 24: (DHS 9) Trends in Provincial Public Health Expenditure for District Health Services (R million)

Expenditure (R'000)	2004/05 (Actual)	2005/06 (Actual)	200607 (Actual)	Average Annual Percentage Change	2007/08 (Estimated Actual)	2008/09 (MTEF Projection)	2009/10 (MTEF Projection)	2010/11 (MTEF Projection)
Current prices.								
Total	R4 253,689	R4 924,947	R5 370,301	12.36%	R6 834,483	R6 915,052	R7 736,926	R8 922,508
Total per person	R434.96	R499.92	R541.14	11.54%	R683.45	R686.39	R762.29	R872.60
Total per uninsured person[22]	R494.27	R568.09	R614.93	11.54%	R776.65	R779.99	R866.24	R991.59
Total capital								
Constant (2007/08) prices.								
Total	R4 934,279	R5,515,941	R5,746,222	7.91%	R6,834,483	R6,500,149	R6,963,233	R7,673,357
Total per person	R504.56	R559.91	R579.02	7.13%	R683.45	R645.21	R686.06	R750.43
Total per uninsured person[23]	R573.36	R636.26	R657.98	7.13%	R776.65	R733.19	R779.61	R852.77

[22] Due to different levels of care being provided by the same Districts & Hospitals the expenditure per uninsured person is not accurate.

[23] Due to different levels of care being provided by the same Districts & Hospitals the expenditure per uninsured person is not accurate.

HEALTH
KwaZulu-Natal

ANNEXURE 4

PROGRAMME 2 : DISTRICT HEALTH SERVICES

Sub Programme: HIV, AIDS, STI and TB Control

MTEF PERIOD 2008/09 - 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

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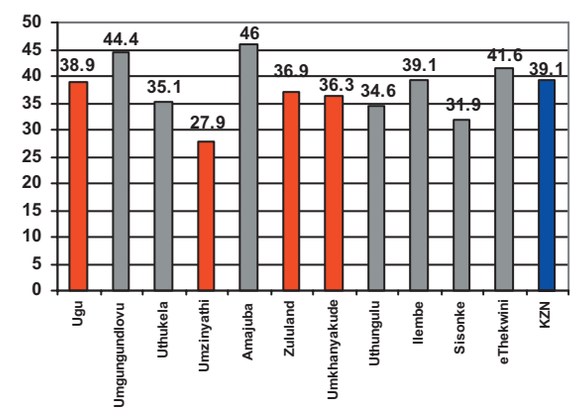
1. SITUATIONAL ANALYSIS

1.1 Introduction

According to the 2006 National Antenatal HIV and Syphillis Prevalence Survey, HIV prevalence in the Province remains at 39.1% in comparison to the overall national prevalence of 29.1% in 2006. The survey noted a significant decline in prevalence amongst participant's under-20 years (15.9% in 2005 to 13.7% in 2006). Of concern however is the increase in HIV prevalence from 36.4% to 37% amongst women between 30 – 35 years, and 28% - 29.3% in the 35 – 39 year age group. This is especially significant because it affects women in their reproductive years and has implications for the already unacceptably high maternal, infant and child morbidity and mortality rates in the Province.

FIGURE 1: HIV prevalence amongst antenatal clinic attendees by District



Red: Presidential Nodal Districts

Syphilis poses a significant risk to pregnancy and can result in spontaneous abortion, stillbirth and perinatal death. The Department improved routine screening and treatment of syphilis in 100% of ANC clinics, while the Syndromic Management of Sexually Transmitted Infections (STIs) is available in 100% of public health facilities. The Syphilis prevalence shows a slight decline from 1.2% in 2005 to 1.0% in 2006 as compared to 1.8% nationally.

STI is a well documented risk factor for acquiring HIV. Gonorrhoea prevalence ranges between 4% and 7% with 47% of clients on ART presenting with new episodes of STIs in 2006/07. This highlights the importance of integrated and comprehensive services at all levels of care as confirmed by the Mwanza study, which documented a notable reduction of STIs through the use of the Syndromic Management of STIs.[1]

There is a rapid change in the mortality profile with a profound impact from HIV-related diseases. The HIV epidemic poses a significant threat to the achievement of the MDGs in the Province.

- HIV is fuelling the TB epidemic with approximately 34% of adults with newly diagnosed TB infected with HIV in 2004.[2]
- Indirect causes of maternal deaths are significant higher with HIV and TB co-infection. Women of reproductive age are the most vulnerable group.
- In the Province, maternal deaths due to non-pregnancy related infections (associated mainly with HIV and AIDS) increased from 38% in 1999 - 2001 to 46.8% in 2002 -2004.[3]
- Modelled estimates suggest an upward trend in neonatal/infant/child mortality rates. This is ascribed largely to the HIV epidemic that currently accounts for ±40% of all under-5 child deaths.[4]
- HIV contributes to an increased prevalence and severity of under-nutrition and micronutrient deficiency in children, while children on ARV (particularly those on protease inhibitors) are at higher risk of acquiring diabetes, dyslipidaemia and artherrosclerosis.
- Studies found a link between HIV infection and low birth weight rate, irreversible stunting, underweight and wasting.

The Provincial Burden of Disease Analysis shows that HIV and AIDS are the leading cause of death (41.5%) in the Province. Dorrington et al. estimated that 28.7% of all HIV infections in South Africa are in KwaZulu-Natal within the age group of 20 – 64 years. The Province has a workforce HIV prevalence of 5.4% (currently 3 times higher than the Western Cape). It is further estimated that 145,078 people were sick with AIDS (new infections in 2006) in the Province. The Province also had the highest number of HIV^+ births in South Africa (11,683) and the highest percentage of babies infected through vertical transmission (7,944) in 2006/07.[5]

[1] DHIS Data Sheet on STI – 2006.
[2] Dye C. Global Epidemiology of Tuberculosis. Lancet 2006;367:938-40.
[3] Third Report on Confidential Enquiries into Maternal Deaths in SA 2002-2004.
[4] Saving Children 2005: A survey of child healthcare in South Africa.
[5] Dorrington RE, Johnson LF, Bradshaw D, Daniel T. The Demographic Impact of HIV & AIDS in SA and National & Provincial Indicators for 2006. (Cape Town: Centre for Actuarial Research, SA MRC and Actuarial Society of South Africa.

ANNEXURE 4

The interconnectedness of HIV and TB is demonstrated with an estimated 50% – 80% of TB patients being HIV positive - and in the presence of HIV these patients have substantially higher case fatality rates regardless of effective TB chemotherapy.[6] Data shows that the increased HIV prevalence relates to an increase in women being diagnosed with TB and a decrease in the average age of TB cases. The prevalence of drug resistant strains (20% of all sputum TB cultures showed MDR TB in 2006)[7] further challenges health systems, resources and services. This has significant implications for service delivery especially related to preventive strategies targeting women and children.

MDGs Progress

Goal 6: Combat HIV and AIDS, Malaria & other *Diseases.*

Target 7: Have halted by 2015, and begin to reverse *the spread of HIV and AIDS.*

- Comprehensive HIV and AIDS services are implemented within the framework of the National Comprehensive Plan for HIV and AIDS and the Inter-sectoral Strategic Plan for HIV & AIDS 2007 – 2011.
- HIV prevalence amongst pregnant women in the Province stabilised at 39.1% in 2006.[8] Syphilis prevalence decreased from 1.2% to 1.0% in 2006 – possibly attributed to more effective screening and treatment programmes.
- There are 74 accredited comprehensive ARV sites in the Province, and 300 PHC Clinics providing one or more elements of the comprehensive HIV and AIDS service package and down referral are in progress in 69 PHC Clinics.
- A cumulative total of 128,354 patients were on antiretroviral treatment in September 2007. Of this number 11,540 are children and 79,517 are female. A total of 679 patients deregistered or were transferred and 638 deaths were recorded for the same period.
- VCT and PMTCT services are available at 96% of facilities, although utilisation is still inadequate. Insufficient infrastructure jeopardises 100% roll-out of these services.
- 65% of pregnant women were tested for HIV, with nevirapine uptake for HIV+ women ranging between 46% and 68% and uptake for targeted babies ranging between 48% and 93%.
- Non-Occupational Post Exposure Prophylaxis (PEP) is provided in 50 Hospitals and 7 CHC's with ±40% of sexual assault cases receiving PEP. Occupational PEP for health workers exposed to HIV in the workplace is provided in 100% of Health Facilities.
- Nutritional packages were provided to 81,230 adults and 14,561 children on ARV and TB treatment (January – September 2007).
- The Syndromic Management of STIs is available in 100% facilities, with 308,443 clients treated in public health facilities between January and September 2007, and an additional 5,000 clients treated at 'truck stops' during 2006/07. The partner treatment rate was 30%, between 17% and 51% in districts, and the condom distribution rate 7 condoms per male per year.
- *Research is required to establish the current HIV prevalence and incidence in the Province.*

MDGs Progress

Goal 6: Combat HIV and AIDS, Malaria & other Diseases.

Target 8: Have halved by 2015, begin to reverse the spread of TB

- *Prevalence and mortality rates associated with TB.*
- *Proportion of TB cases detected and cured under DOTS.*

- Total number of MDR TB: 1,929 and XDR TB: 182 – October 2007 (*Table 1- Page 8).*
- 82% TB patients have DOTS supporters.
- 45% Facilities implement the new '*Patient Tracking System'* to ensure more effective follow up of patients on treatment.
- Smear conversion rate: 60%
- Cure rate: 42%
- Success rate: 61%
- Defaulter rate: 13%

2. SERVICE DELIVERY APPRAISAL

The HIV epidemic continues to grow and pose significant challenges to health care systems in the Province. In spite of significant inroads made with extensive education, increased public awareness through community out-reach, expansion and improved

[6] HIV & AIDS and STI Strategic Plan for SA 2007-1011.
[7] Inkosi Albert Luthuli Central Hospital data.
[8] National HIV & Syphilis Prevalence Survey 2006.

access and utilisation of services, the Department needs to constantly revisit strategies and action to improve community participation and cohesion to halt infections and improve care for people living with HIV and AIDS.

Existing programmes are implemented within the framework of the following:

1. **Millennium Development Goals:** *Goal 6: 'Combat HIV and AIDS, Malaria & other diseases".*

2. **HIV & AIDS and STI Strategic Plan for South Africa 2007 – 2011:** *1) Prevention. 2) Treatment, care & support. 3) Research, monitoring & surveillance. 4) Human rights and access to justice.*

3. **KwaZulu-Natal TB Crisis Management Plan:** *1) Structure, Management & supervision. 2) Laboratory services. 3) Case finding, clinical management & case retention. 4) Advocacy & social mobilisation. 5) Reporting & recording. 6) MDR/ XDR management.*

4. **National Health System Priorities:** *Strengthening Priority Health Programmes e.g. National TB Crisis Management Plan and Acceleration of HIV prevention.*

5. **Provincial Service Delivery Imperatives:** *1) Fast track implementation of the TB Crisis Management Plan linked with nutrition enhancement and increased community awareness, and 2) Intensify implementation of the Comprehensive HIV and AIDS Plan and other Strategic Health Programmes.*

2.1 HIV, AIDS and STI

2.1.1 PREVENTION

The Department continues to improve and expand robust prevention programmes that have the potential to decrease the incidence and impact of HIV, AIDS and STIs and contribute towards the enhancement of the quality of life of people affected and infected in KwaZulu-Natal.[9] Within the framework of the HIV, AIDS and STI Strategic Plan, progress has been made with the following:

[9] HIV and AIDS Strategy for the Province of KwaZulu-Natal 2006 – 2010.

Vulnerable groups including Youth

Programmes are directed at common determinants of behaviours rather than separate manifested behaviours, understanding that interventions focussing on specific behaviour only (sexual activity, HIV & AIDS) are less effective because they do not address the antecedents or determinants of the behaviour.

- A total of 5,474 (57%) schools were visited during 2006/07 reaching in excess of 230,000 primary and secondary school learners with information on HIV, AIDS, STI, TB, sexuality education, life skills, nutrition, and hygiene. Learners at risk were referred through the PHC system for management and follow-up. Educators and parents participated in all programmes.

- The Mpilonhle Mobile Health & Education Project commenced in 12 schools in the Umkhanyakude District in 2006/07. The focus of the 3-year project is on HIV & AIDS education, VCT, CD4 counts at school (through parents/caregivers), mental health, and violence and abuse.

- There are currently 39 accredited Youth-Friendly PHC services supported by 43 loveLife groundBREAKERS to facilitate increased access to information, improved health-seeking behaviour and effective community out-reach and participation.

- A total of 210 Peer Educators (between 20 – 28 years) were trained in Sexuality and Life Skills during 2006/07. The programme uses the 'buddy' approach for youth infected and affected by HIV and AIDS.

Voluntary Counselling and Testing (VCT)

- VCT services were extended to 96% of public health facilities and 63 non-medical sites. PHC Clinic upgrading commenced in 26 PHC services to address inadequate space for VCT.

- In 2006/07 a total of 349,558 clients (excluding ANC) were pre-test counselled of which 319,689 clients (91%) were tested for HIV.

ANNEXURE 4

The Provincial '*HIV testing coverage*' is only ***6%*** which is a great concern. This confirms that availability of services does not guarantee utilisation and the Department will reconsider integrated and innovative strategies to improve VCT.

- To improve counselling and testing the Province commenced with a '*Provider Initiated Testing and Counselling*' pilot in the Ugu District in 2007/08 with the intention to roll it out to other Districts once results are available.
- Partnerships are being formed to expand services to other vulnerable groups i.e. farm workers.

Integrated Sexual & Reproductive Health (SRH)

- Integrated SRH services (including STI, HIV and AIDS, screening and dual protection) are implemented in all Districts and Facilities. A total of 829 service providers completed the integrated training package in 2006/07.
- Integration of SRH services (including contraceptive services) still poses a challenge to the Department. The Reproductive Health and HIV Research Unit (RHRU) commenced with a 2-year study to investigate effective integration models.

Prevention of Mother to Child Transmission (PMTCT) of HIV

- PMTCT is offered at 96% PHC facilities and four non-medical sites. Inadequate infrastructure prevents the roll-out to the remaining PHC Clinics. It has been included in infrastructure planning for MTEF 2007/08 and 2008/09.
- During 2006/07, a total of 197,487 (69%) pregnant women were tested for HIV[10] with a Nevirapine uptake rate ranging between 46% and 68% in Districts.[11] The low uptake in some Districts is a concern since 31% of pregnant women attending ANC are not tested for HIV.
- The Nevirapine dose to baby uptake rate was 36% in 2006/07[12] while data in the District Health Plans (DHP) reflected a range between 48% and 93%.
- The HIV transmission rate to babies ranges between 15% - 19%.[13] The poor follow-up of babies within the PMTCT programme remains a challenge.
- The Good Start Study, conducted in sites (including Umlazi Durban), reported that 42% of breastfeeding women practise exclusive breastfeeding and 58% practise mixed feeding.[14]
- The Mothers-to-Mothers-to-Be programme, using women on the PMTCT programme as mentors for prospective PMTCT clients, is currently implemented in 8 sites in the Province and will be rolled out to other sites in 2007/08 – 2008/09.

Post Exposure Prophylaxis (PEP)

- In 2006/07, Non-Occupational PEP for sexual assault was provided in 89% of Hospitals and 7 CHCs. Other Hospitals all provide PEP '*starter packs'* before referral. A total of 8,681 new cases of sexual assault were reported at public health facilities and 3,822 survivors received prophylaxis.[15] Approximately 40% of cases are under the age of 12 years.
- There are 34 Crisis Centres attached to Health Facilities – providing comprehensive sexual assault care (including PEP for sexual assault).
- Two Thuthuzela Centres at Prince Mshyeni & Mahatma Ghandi Hospitals provide comprehensive intervention programmes to improve the process of reporting, management & prosecution in a dignified manner. Centres are implemented as partnership between the National Prosecuting Authority (NPA), Departments of Health and Social Development, South African Police Services and Justice and Constitutional Development. Four additional centres are planned for 2007/08.

[10] Provincial Division of Revenue Act (DORA) Report 2006/07.
[11] District Health Plans MTEF 2008/09.
[12] Provincial DORA Report 2006/07.
[13] Report: National HIV and Syphilis Prevalence Survey South Africa 2006.
[14] HIV and Infant Feeding: Policy Brief June 2007. MRC.
[15] Provincial DORA Report 2006/07.

- 35 Students are expected to complete the two-year Diploma in Forensic Health in 2007, and 210 service providers rendering PEP services attended in-service training on Non-Occupational Post Exposure Prophylaxis in 2006/07.

- Occupational Post Exposure Prophylaxis services for health workers exposed to HIV in the workplace are implemented in 100% of the Health Facilities, and 92 providers attended an update on Occupational PEP in 2006/07.

Sexually Transmitted Infections (STIs)

- 100% Public Health Facilities distribute condoms free of charge and offer Syndromic Management of STIs.

- The Province has a condom distribution rate of 7 condoms per male per year, with over 30 million male condoms and over 200,000 female condoms distributed in 2006/07.[16]

- A total number of 308,443 clients were treated for STIs between April and August 2007 with a treatment rate of 23% in 2006/07.[17] The STI partner treatment rate ranged between 17% and 51% in Districts and more vigorous follow-up should be done to trace and treat partners.[18]

Community Mobilisation

- Implementation and roll-out of community participation programmes to improve community education and participation, utilisation of available services, and reduction of preventable causes of illness and death at community level are implemented through:
  - RED strategy in three Districts in 2006/07 and IMCI Community Component implemented in five Districts in 2006/07.
  - Community events and health days.

- 500 Youth Ambassadors commenced training in October 2007, with a further 500 scheduled to commence training in February 2008. Although this process is facilitated from the Strategic Health Programmes, the Ambassadors will focus on a wide range of priority issues including HIV and AIDS, STI, TB, sexuality education, and other PHC issues. Community Health Facilitators will provide mentoring and monitoring under the District Management Teams.

PHC Clinic Committees are strategically well placed as entry points to the community and have the potential to facilitate dialogue between the Department and community in addressing health needs. This avenue must still be explored fully.

High Transmission Areas (HTA)

- Four truck-stops currently function as Wellness Centres in the Province with four additional sites - one in the Timber Industry factories, one in a central taxi rank in Ladysmith (Uthukela District), and two Tertiary Institutions.

- A total number of 5,000 clients received STI treatment at HTA sites during 2006/07.

Lay Counsellors

- A total of 1,787 Lay Counsellors were trained and they provide on-going pre/ post-test and counselling for STI, TB, ARV (Adherence and Treatment Literacy Counselling).

2.1.2 TREATMENT, CARE & SUPPORT

Anti-Retroviral Therapy (ART)

- Comprehensive ART services are provided in 74 accredited sites (October 2007). All Hospitals are accredited and more than 300 PHC Clinics provide one or more of the comprehensive HIV and AIDS service package including adherence counselling, CD4 count testing, and treatment literacy sessions. Down referral is currently provided from 69 PHC Clinics.

[16] Premier's Mid-Term Report, August 2007: Health Service Planning, Monitoring & Evaluation.
[17] Premier's Mid-Term Report, August 2007: Health Service Planning, Monitoring & Evaluation.
[18] District Health Plans MTEF 2008/09.

- There are currently 128,354 patients on treatment (11,540 paediatric) which is in line with the provincial target of 120,000 patients for 2007/08.[19]
- The ART defaulting rate ranged between 1% and 9.3% in 2006/07[20] and is addressed by more intensive focus on community involvement & support.
- The Department is scaling up immunisation services in all ARV sites to reduce lost opportunities, and to ensure that all HIV infected children complete their immunisation schedule to reduce vaccine preventable morbidity and mortality due to higher susceptibility of HIV children.
- IMCI Clinical case management (including management of the HIV positive child) is implemented in 72% of PHC Facilities.[21] This golden standard of care will be rolled out to all PHC and Hospital services.
- Active screening for HIV and TB is conducted in 100% of ANC, maternity and post natal care clinics with priority referrals of HIV positive clients.

Home-Based Care (HBC)

- During 2006/07 there were 4,246 HBC teams with 14,360 active Home-Based Carers – 4,074 receiving stipends. A total of 164,480 patients were reached through this programme.
- 3,724 New carers were trained during 2006/07.
- The Department established 73 National Integration Programmes (NIP) sites where 24 soup kitchens provide cooked meals to approximately 1,300 families.

Nutrition

- Nutritional support packs are provided to patients on ART and TB treatment. A total of 81,230 adults and 14,561 children benefited from this programme from April – September 2007.[22]

2.1.3 RESEARCH, MONITORING & SURVEILLANCE

Monitoring, Evaluation & Research

- The HAST Programme appointed a Principal Technical Advisor: Monitoring and Evaluation in September 2007 to improve active monitoring, evidence-based service delivery and policy development.
- A Non-Occupational PEP Situational Analysis was conducted in 2006 and results disseminated to service providers in 100% facilities. Results were used to inform strategic and operational plans for MTEF 2007/08.
- A number of relevant research studies are being conducted in the Province by various Universities and Scientists to support provision of quality and evidence-based health care. The Health Research and Knowledge Management Sub-Component in the Health Services Planning, Monitoring & Evaluation Unit manages these research activities in conjunction with external researchers. A database of research is kept by this sub-component and is available to service providers.

2.1.4 HUMAN RIGHTS & ACCESS TO JUSTICE

All Policies relevant to the implementation of comprehensive and integrated HIV, AIDS and TB Programmes are monitored for compliance.

2.2 Tuberculosis (TB)

The Province is dealing with a huge burden of TB and an increasing number of MDR/ XDR TB cases. The TB Crisis Management Plan is implemented and actively monitored with special emphasis on implementation in eThekwini-, Umgungundlovu-, Uthungulu-, and Umzinyathi Districts.

[19] October 2007.
[20] District Health Plans MTEF 2008/09
[21] Integrated Management of Childhood Illnesses (IMCI) Quarterly Report 2006/07.
[22] Premier's Mid-Term Report, August 2007: Health Service Planning, Monitoring & Evaluation.

- **KwaZulu-Natal TB Crisis Management Plan Targets**

- Bacterial coverage: 85% (baseline 78%)
- Smear conversion rate: 60% (baseline 54%)
- Cure rate: 40% (baseline 35%)
- Success rate: 60% (baseline 55%)
- Defaulter rate: 10% (baseline 16%)
- Results not evaluated: 8% (baseline 12%)
- Improve case finding by: 10% (baseline 683 cases)
- Increase MDR TB beds to: 621 (baseline 396 beds)

The TB Control Programme has prioritised 6 areas to improve implementation, service delivery, and management of TB through implementation of the Provincial TB Crisis Management Plan.

2.2.1 Improve Programme Management Capacity

- TB is organisationally located within the Strategic Health Programmes Unit.
- The following Provincial staff were appointed in 2007: Principal Advocacy/ Mobilisation Advisor, and TB Surveillance Officer. In addition, 10 District TB Supervisors were appointed in the TB Crisis Management Plan Districts i.e. eThekwini (6), Umgungundlovu (2), and Uthungulu (2) with an additional 18 posts to be filled in the remaining districts during MTEF 2007/08.

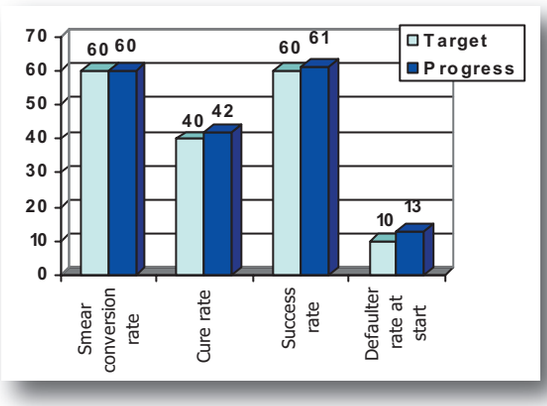
2.2.2. Strengthen Laboratory Services Capacity

- To improve capacity to handle the diagnostic workload and quality assurance/ control the following staff were appointed: 47 Microscopists, four Laboratory Assistants, 1 TB Clerk (Surveillance), 1 Medical Technologist, and 2 Data Capturers.

2.2.3. Strengthen case finding and improve the capacity for clinical management of TB patients at Facility level

- The TB suspect register is implemented in 322 out of 616 facilities (52%) to improve case finding.
- 118 Nurses have been appointed at facility level with another 290 posts required to ensure effective implementation of the TB programme.
- Training was outsourced to train 814 Health Care Workers (HCW) in the TB Crisis Management Plan Districts – training commenced in January 2007.
- 1,352 HCW were trained in the National Tuberculosis Control Programme Guidelines.
- 281 Facilities out of 616 (45%) currently implement the newly designed patient tracking system to monitor return dates/ visits of TB patients. An electronic tracking system is being piloted in three sites in the Amajuba District for possible roll-out to other services following results of the pilot.

FIGURE 2: TB Indicators – October 2007



2.2.4. Strengthen community support

- This component is responsible for DOTS, contact and defaulter tracing, as well as community education and mobilisation.
- A total of 1,100 treatment supporters (DOTS) have been trained, 33 TB community officers (tracing teams) appointed (*needing an additional 148 posts*), and 40 dedicated TB vehicles procured and delivered to districts with another 111 in the process of being ordered.
- 82% of TB patients have DOTS supporters, which will be increased extensively during 2007/08.
- One TB Indaba, five TB blitz campaigns, 55 District TB awareness events with extensive media coverage on radio and newspapers, and 15 TB

awareness/ imbizo events were conducted during 2006/07. Newspaper, radio, and taxi awareness advertising campaign conducted in eThekwini, and currently running in Msinga (100 Taxis).

- The Provincial Advocacy and Mobilisation Plan are based on the Knowledge, Attitudes & Perceptions (KAP) Survey findings that were presented in July 2007 and will focus on:
  - Training of all staff in counseling.
  - One on One community out-reach.
  - Family targeting.
  - Story telling.
  - Area specific language.
  - Target businesses and schools.
  - Radio.
  - Door-to-door blitz campaigns.

2.2.5. Strengthen management of MDR/XDR TB

- 119 HCW have been trained in the MDR TB guidelines during 2006/07.
- Two new MDR TB Satellite Centres have been opened, increasing the bed capacity from 240 to 396 (target 621 beds).
- A Park Home for MDR TB patients (capacity for 40 patients) was delivered to Murchison Hospital.
- Completed the retrospective laboratory surveillance on all specimens (backdated to January 2005) in October 2006.

TABLE 1: MDR/ XDR TB (October 2007)

District	MDR	XDR
Ugu	169	8
Umgungundlovu	153	16
Uthukela	43	5
Umzinyathi	308	117
Amajuba	18	2
Zululand	74	1
Umkhanyakude	214	1
Uthungulu	196	5
Ilembe	109	4
Sisonke	35	2
eThekwini	610	21
KZN	1,929	182

Priority Districts highlighted

2.2.6. Strengthen the TB reporting and recording system

- An additional 14 District Data Capturers and 2 District Surveillance Officers have been appointed to improve the capacity to manage workload and improve monitoring.

TABLE 2: (HIV 3) Performance Indicators for HIV & AIDS, STI & TB Control

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Target	2008/09 Target	2009/10 Target	2010/11 Target	National Target 2008/09
Input							
1. Fixed PHC facilities offering PMTCT (%).	96%	96%	96%	98%	98%	99%	100%
2. Fixed PHC facilities offering Voluntary Counselling and Testing (VCT) (%).	97%	97%	98%	100%	100%	100%	100%
3. Hospitals offering PEP for occupational HIV exposure (%).	100%	100%	100%	100%	100%	100%	100%
4. Hospitals offering PEP for sexual abuse (%).	57%	87%	89%	90%	95%	98%	100%
5. ART service points registered (Number).	55	72	74	79	86	92	-
6. ART patients – Total registered (Number).	57,149	75,136	110,227	195,312	255,000	315,000	-
Process							
7. TB cases with a DOTS Supporter (%).	80%	77%	82%	90%	95%	96%	100%
8. Male condom distribution rate from Public sector health facilities.	7	7	8	9	10	11	11
9. Fixed facilities with any ARV drug stock out (%).	0	0	0	0	0	0	0%
10. Fixed facilities referring patients to ARV treatment points sites for assessment (%).	100%	100%	100%	100%	100%	100%	-
Output							

ANNEXURE 4

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Target	2008/09 Target	2009/10 Target	2010/11 Target	National Target 2008/09
11. STI partner treatment rate (%).	22%	28%	30%	30%	30%	30%	40%
12. Nevirapine dose to baby coverage rate (%).	39%	102%[23]	93%	98%	98%	98%	70%
13. Nevirapine uptake – antenatal clients (%).	25%	63%	70%	76%	80%	90%	-
14. Clients HIV pre-test counselled rate in fixed PHC facilities (%).	100%	100%	100%	100%	100%	100%	100%
15. HIV testing rate (excluding antenatal) (%).	91%	91%	93%	95%	96%	97%	-
16. TB treatment interruption rate (%).	13.6%	13.8%	11%	9%	8%	6%	4%
Quality							
17. CD4 test at ARV treatment service points with turnaround time >6 days (%).	0%	0%	0%	0%	0%	0%	0%
18. TB sputa specimens with turnaround time <48 hours (%).	15%	55%	60%	85%	90%	95%	
Efficiency							
19. Dedicated HIV and AIDS budget spent (%).	R 528 093 million 97%	R 778 390 million	100%	100%	100%	100%	100%
Outcome							
20. New smear positive PTB cases cured at first attempt (%).	35.1%	43.9%	46%	50%	55%	60%	85%
21. New MDR TB cases reported - % annual change (%).	No data available	683	1080 (58%)				-30%
22. New XDR TB cases reported – annual % change (%).[24]		74	148 (100%)				-

[23] Incorrect data due to system changes.
[24] Data not available.

TABLE 3: (NHS Priority 4) Priority Health Programmes

Activity	Indicators	Targets 2006/07	Targets 2007/08	Targets 2008/09	Responsibility
Implementation of the National Strategic Plan for HIV and AIDS.	Increase the proportion of Health Facilities providing comprehensive HIV care including ART.	-	10%	25%	HIV and AIDS Unit.
Implementation of the TB Crisis Management Plan.	Increase in smear conversion rate in selected Districts.	10% above baseline.	10% above baseline.	10% above baseline.	TB Programme.
	Increase in cure rate in selected Districts.	10% above baseline.	10% above baseline.	10% above baseline.	

TABLE 4: (HIV 1) Situation Analysis Indicators for HIV & AIDS, STI & TB Control per Health District

Indicator	Ugu 2006/07	Umgungundlovu 2006/07	Uthukela 2006/07	Umzin-yathi 2006/07	Amajuba 2006/07	Zululand 2006/07	Umkhanyakude 2006/07	Uthungulu 2006/07	iLembe 2006/07	Sisonke 2006/07	eThekwini 2006/07	National target 2006/07
Input												
1. Fixed PHC facilities offering PMTCT.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2. Fixed PHC facilities offering VCT.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
3. Hospitals offering PEP for occupational HIV exposure.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
4. Hospitals offering PEP for sexual abuse.	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	89%	100%
5. ART service points registered.	4	8	3	4	4	6	5	10	5	5	17	-
6. ART patients – total registered.	7,301	11,298	5,912	5,797	3,928	4,222	8,668	7,194	6,260	4,880	19,904	-
Process												
7. TB cases with a DOTS Supporter[25].	64%	45%	60%	78%	99%	75.6%	90%	83.1%	60%	60%	N/A	-
8. Male condom distribution rate from Public sector health facilities.	6	5	8	7	8	6	9	4	5	9	8	-
9. Fixed facilities with any ARV drug stock out.	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	-
10. Fixed facilities referring patients to ARV treatment points sites for assessment.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-
Output												
11. STI partner treatment rate.	26%	18%	20%	28%	45%	21%	22%	30%	35%	15%	17%	-

[25] Data from District Health Plans MTEF 2008/09.

Indicator	Ugu 2006/07	Umgungundlovu 2006/07	Uthukela 2006/07	Umzin-yathi 2006/07	Amajuba 2006/07	Zululand 2006/07	Umkhanyakude 2006/07	Uthungulu 2006/07	iLembe 2006/07	Sisonke 2006/07	eThekwini 2006/07	National target 2006/07
12. Nevirapine dose to baby coverage rate.	95%	76%	96%	89%	98%	75%	67%	84%	88%	88%	94%	-
13. Nevirapine uptake – antenatal clients.	63%	59%	69%	45%	35%	69%	89%	70%	54%	56%	71%	-
14. Clients HIV pre-test counselled rate in fixed PHC facilities. [26]												-
15. HIV testing rate (excluding antenatal).	89%	97%	94%	93%	94%	91%	93%	95%	94%	85%	91%	-
16. TB treatment interruption rate.	8.9%	13.4%	18.2%	3.5%	5.5%	6.8%	6.1%	9.7%	8.2%	4.8%	22.8%	5%
Quality												
17. CD4 test at ARV treatment service points with turnaround time >6 days.	0	0	0	0	0	0	0	0	0	0	0	-
18. TB sputa specimens with turnaround time > 48 hours.	0%	No data.	No data.	14%	7%	50%	70%	50%	83%	66%	31%	-
Efficiency												
19. Dedicated HIV / AIDS budget spent.	53,694	47,910	44,317	40,088	24,254	64,955	59,093	59,213	53,772	28,016	169,415	-
Outcome												
20. New smear positive PTB cases cured at first attempt. .	33.1%	29.5%	44.5%	65.7%	65.6%	66%	41.8%	42.5%	59.6%	49.2%	37.4%	-
21. New MDR TB cases reported - annual % change. [27]												-

[26] Data not available.
[27] Data not available.

ANNEXURE 4

3. POLICIES, STRATEGIC OBJECTIVES AND PRIORITIES

3.1 HIV and AIDS Policies

The Department adopted a comprehensive approach to the management of HIV, AIDS, STI and TB within the framework of National and Provincial strategic goals and objectives, legal imperatives, the HIV, AIDS, and STI Strategic Plan for SA 2007 – 2011, the HIV and AIDS Strategy for the Province of KwaZulu-Natal 2006-2010, and the Provincial TB Crisis Management Plan.

The following Policies and/ or Guidelines were reviewed and developed during 2006/07 – 2007/08:

1. Integrated HIV and AIDS Policy and Implementation Guidelines – making provision for an integrated and comprehensive approach to HIV and AIDS.
2. PMTCT Site Manual.

The Department is implementing the Updated Protocol for the Syndromic Management of STI, the National TB Guidelines and Standardised MDR TB Guidelines. The aim is to achieve a smear conversion and cure rate of 85% in new smear positive pulmonary TB patients and a defaulter rate of <5%.

In addition, HIV, AIDS, STI and TB will be monitored within the context of the following Policies:

1. The Integrated Child Health Policy – screening and management of children with HIV or AIDS.
2. The integrated Antenatal and Post-Natal Care Policy & Implementation Guidelines – screening and management of pregnant women with HIV, AIDS or TB.
3. Implementation of the 'Saving Mothers Recommendations' – screening and management of pregnant women with HIV, AIDS, STI and TB.

3.2 HIV and AIDS and STI Priorities

Anti-Retroviral Therapy

1. Strengthen the ART Programme by expanding accredited ART sites to ensure that all qualifying HIV positive persons receive ART.
2. Strengthen the monitoring and evaluation of the ART Programme including active monitoring of viral loads to determine adherence and effectiveness of ART (success = ≤400).
3. Increase the uptake of HAST services by children.
4. Strengthen the implementation of integrated strategies and services targeting vulnerable children to increase the uptake of HAST services.
5. Test and implement an electronic monitoring and evaluation data system to improve monitoring of:
   - Adherence to treatment;
   - Viral loads; and
   - Pharmaco-vigilance.
6. To expand accredited ART sites to PHC level including TB Facilities.

Home Based Care

1. Standardise the HBC/CBC Programmes and develop a Provincial database to determine and monitor coverage.

High Transmission Areas

1. Expand HTA sites to strengthen prevention & treatment services for STI and HIV and AIDS.

Post Exposure Prophylaxis

1. Establish an effective monitoring and evaluation system to improve the monitoring of adherence to treatment, follow-up and sero-conversion.
2. Implement the Non-Occupational Post Exposure Prophylaxis Situational Analysis Recommendations and monitor progress.

PMTCT

1. Scale up implementation of the integrated PMTCT Programme to reduce vertical transmission of HIV.
2. Improve PCR testing (at 6 weeks) of babies born to HIV positive mothers to improve Nevirapine uptake.

Step-down Care

1. Implementation of STP in collaboration with District Services.

STI

1. Improve the implementation of Syndromatic Management of STI's.

3.3 TB Priorities

1. Optimise and sustain the quality of DOTS through continued commitment, increased accountability, and the allocation of adequate resources and implementation of community awareness and mobilisation programmes.
2. Align standard diagnostic protocols to include screening for TB in all instances, irrespective of the reasons for clients entering the Public Health System.
3. Improve access to quality assured TB sputum microscopy for case detention.
4. Implement standardised treatment protocols.
5. Ensure an effective and regular drug supply system (Facilitate the procurement of appropriate fixed dose combination TB medication).
6. Implementation of the Electronic TB Register.
7. Collaborate with external providers to improve the efficiency of the TB Programme.
8. Implementation of the STP in relation to TB services.

TB MDR Priorities

1. Implement the National TB Crisis Plan (NTCP) rationale and stepwise approach, which includes:
   - Identification of the causal factors for the emergence of drug resistant TB.
   - Strengthening of surveillance of drug-resistant TB.
   - Measures to prevent the development and spread of drug-resistant TB.
   - Assessment and strengthening of the quality of MDR TB-treatment.
   - Systematic implementation of infection control measures in MDR TB-treatment centres.
   - Development of clearly defined clinical protocols enabling Institutions to identify possible MDR TB cases and to manage confirmed cases appropriately.
2. Improved laboratory capacity for MDR TB diagnosis.

ANNEXURE 4

Implementation of the STP

TB Bed Norms

The STP makes provision for the increased burden placed on the existing health system/ resources to ensure effective management of TB patients. Projections are based on data collected through the electronic TB register as well as data in the DHIS.

Bed numbers/ norms are estimated based on the following rationale:

- Current number of TB cases = 92 000.
- The average length of stay = between 7 – 14 days.
- Approximately 50% of patients are diagnosed at PHC level and 50% at hospital level. Approximately 50% of patients diagnosed at hospital level are admitted and would require care for an average of 10 days.
- At least 15% of TB cases will require re-treatment. That is 13,800 patients with an average length of stay of 75 days.
- MDR and XDR TB = 683 (existing cases), with an average length of stay of 360 days.

The norms for the number of required beds to address the immediate crisis are reflected in Table 5.

TABLE 5: Norms for Required TB Beds (April 2007)

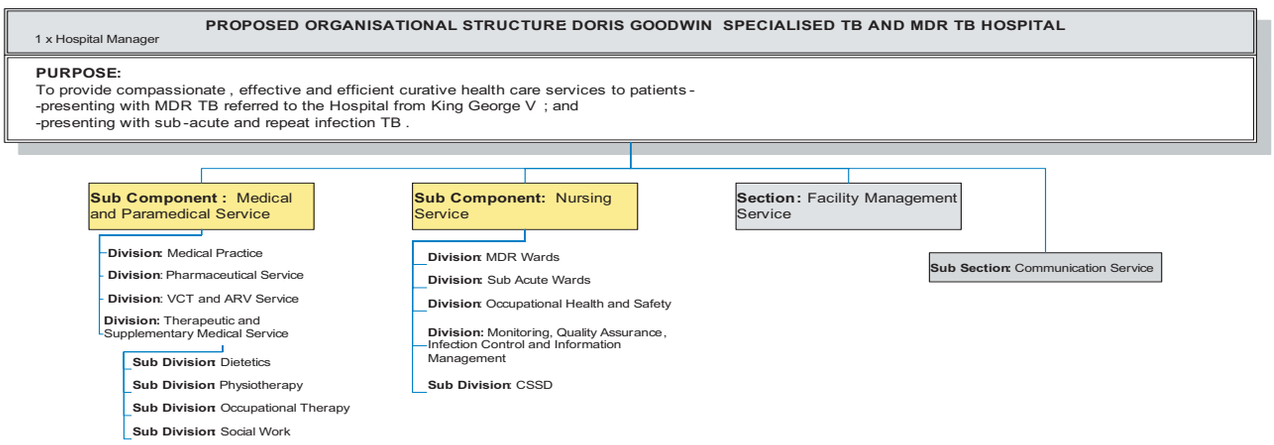
Year	TB 1 Acute	TB Re-Treatment	*TB MDR & XDR*
2007	.21% per 1000 population	.23% per 1000 population	.14% per 1000 population
2008	.21% per 1000 population	.23% per 1000 population	.14% per 1000 population
2009	.20% per 1000 population	.22% per 1000 population	.12% per 1000 population
2010	.19% per 1000 population	.19% per 1000 population	.12% per 1000 population
2011	.18% per 1000 population	.18% per 1000 population	.10% per 1000 population
2012	.17% per 1000 population	.17% per 1000 population	.10% per 1000 population
2013	.16% per 1000 population	.16% per 1000 population	.8% per 1000 population
2014	.15% per 1000 population	.15% per 1000 population	.8% per 1000 population
2015	.14% per 1000 population	.14% per 1000 population	.6% per 1000 population
2016	.13% per 1000 population	.13% per 1000 population	.6% per 100 population

Organisational Configuration

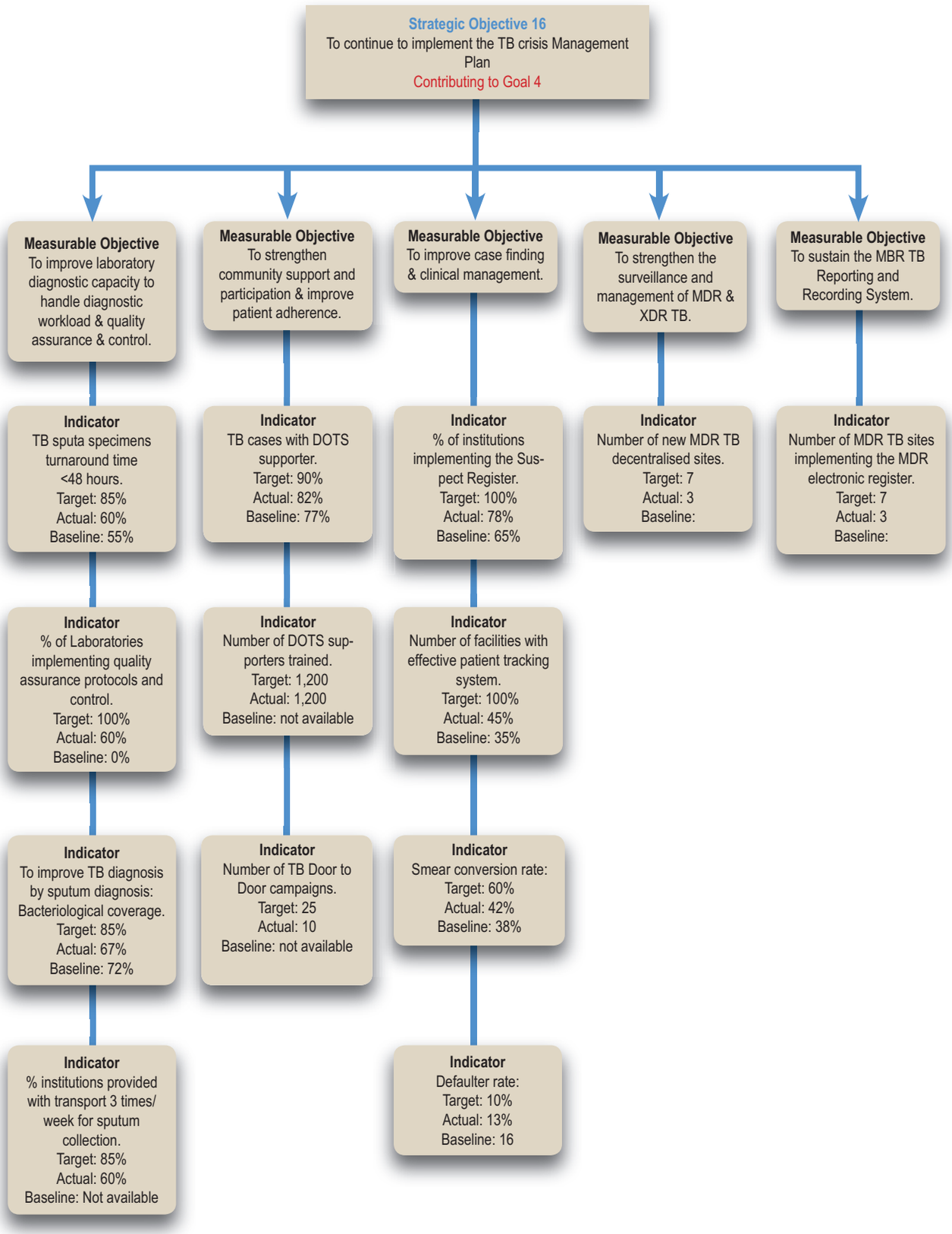
The organisational structures and post provisioning of all TB Hospitals have been reviewed during 2007/08. New structures and post provisioning have been implemented to provide for the service delivery needs. There are still challenges with the retention of health workers appointed at these Institutions.

The following proposed organisational structure is an example of the organisational arrangements to provide Specialised TB Services in the Province.

FIGURE 3: Proposed Organisational Structure: Doris Goodwin Specialised TB and MDR TB Hospital



ANNEXURE 4


Strategic Objective 16
To continue to implement the TB crisis Management Plan
Contributing to Goal 4
Measurable Objective
To improve laboratory diagnostic capacity to handle diagnostic workload & quality assurance & control.
Indicator
TB sputa specimens turnaround time <48 hours.
Target: 85%
Actual: 60%
Baseline: 55%
Indicator
% of Laboratories implementing quality assurance protocols and control.
Target: 100%
Actual: 60%
Baseline: 0%
Indicator
To improve TB diagnosis by sputum diagnosis: Bacteriological coverage.
Target: 85%
Actual: 67%
Baseline: 72%
Indicator
% institutions provided with transport 3 times/ week for sputum collection.
Target: 85%
Actual: 60%
Baseline: Not available
Measurable Objective
To strengthen community support and participation & improve patient adherence.
Indicator
TB cases with DOTS supporter.
Target: 90%
Actual: 82%
Baseline: 77%
Indicator
Number of DOTS supporters trained.
Target: 1,200
Actual: 1,200
Baseline: not available
Indicator
Number of TB Door to Door campaigns.
Target: 25
Actual: 10
Baseline: not available
Measurable Objective
To improve case finding & clinical management.
Indicator
% of institutions implementing the Suspect Register.
Target: 100%
Actual: 78%
Baseline: 65%
Indicator
Number of facilities with effective patient tracking system.
Target: 100%
Actual: 45%
Baseline: 35%
Indicator
Smear conversion rate:
Target: 60%
Actual: 42%
Baseline: 38%
Indicator
Defaulter rate:
Target: 10%
Actual: 13%
Baseline: 16
Measurable Objective
To strengthen the surveillance and management of MDR & XDR TB.
Indicator
Number of new MDR TB decentralised sites.
Target: 7
Actual: 3
Baseline:
Measurable Objective
To sustain the MBR TB Reporting and Recording System.
Indicator
Number of MDR TB sites implementing the MDR electronic register.
Target: 7
Actual: 3
Baseline:

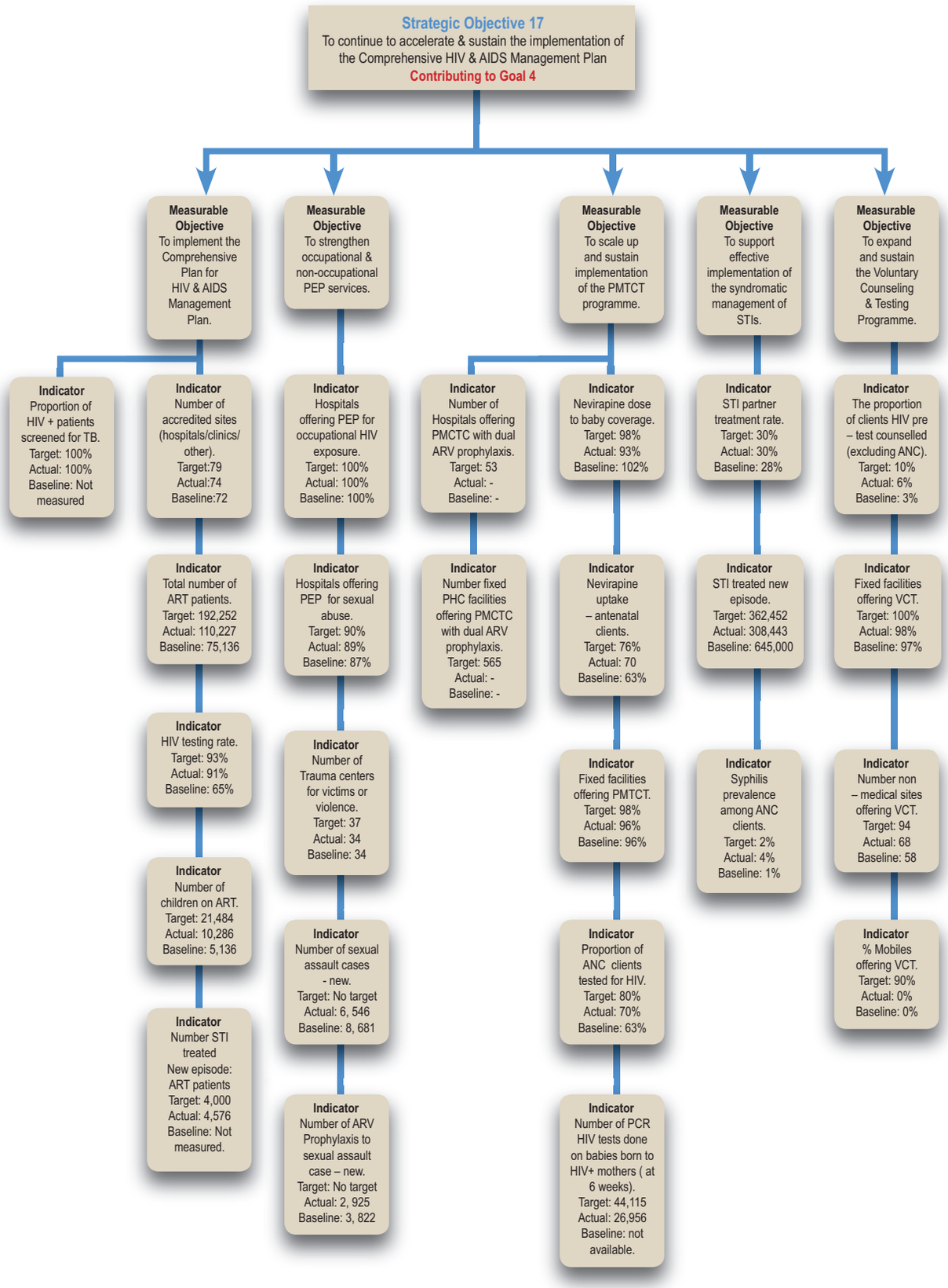

Strategic Objective 17
To continue to accelerate & sustain the implementation of the Comprehensive HIV & AIDS Management Plan
Contributing to Goal 4
Measurable Objective
To implement the Comprehensive Plan for HIV & AIDS Management Plan.
Indicator
Proportion of HIV + patients screened for TB.
Target: 100%
Actual: 100%
Baseline: Not measured
Indicator
Number of accredited sites (hospitals/clinics/ other).
Target:79
Actual:74
Baseline:72
Indicator
Total number of ART patients.
Target: 192,252
Actual: 110,227
Baseline: 75,136
Indicator
HIV testing rate.
Target: 93%
Actual: 91%
Baseline: 65%
Indicator
Number of children on ART.
Target: 21,484
Actual: 10,286
Baseline: 5,136
Indicator
Number STI treated New episode: ART patients
Target: 4,000
Actual: 4,576
Baseline: Not measured.
Measurable Objective
To strengthen occupational & non-occupational PEP services.
Indicator
Hospitals offering PEP for occupational HIV exposure.
Target: 100%
Actual: 100%
Baseline: 100%
Indicator
Hospitals offering PEP for sexual abuse.
Target: 90%
Actual: 89%
Baseline: 87%
Indicator
Number of Trauma centers for victims or violence.
Target: 37
Actual: 34
Baseline: 34
Indicator
Number of sexual assault cases - new.
Target: No target
Actual: 6, 546
Baseline: 8, 681
Indicator
Number of ARV Prophylaxis to sexual assault case – new.
Target: No target
Actual: 2, 925
Baseline: 3, 822
Measurable Objective
To scale up and sustain implementation of the PMTCT programme.
Indicator
Number of Hospitals offering PMCTC with dual ARV prophylaxis.
Target: 53
Actual: -
Baseline: -
Indicator
Number fixed PHC facilities offering PMCTC with dual ARV prophylaxis.
Target: 565
Actual: -
Baseline: -
Indicator
Nevirapine dose to baby coverage.
Target: 98%
Actual: 93%
Baseline: 102%
Indicator
Nevirapine uptake – antenatal clients.
Target: 76%
Actual: 70
Baseline: 63%
Indicator
Fixed facilities offering PMTCT.
Target: 98%
Actual: 96%
Baseline: 96%
Indicator
Proportion of ANC clients tested for HIV.
Target: 80%
Actual: 70%
Baseline: 63%
Indicator
Number of PCR HIV tests done on babies born to HIV+ mothers (at 6 weeks).
Target: 44,115
Actual: 26,956
Baseline: not available.
Measurable Objective
To support effective implementation of the syndromatic management of STIs.
Indicator
STI partner treatment rate.
Target: 30%
Actual: 30%
Baseline: 28%
Indicator
STI treated new episode.
Target: 362,452
Actual: 308,443
Baseline: 645,000
Indicator
Syphilis prevalence among ANC clients.
Target: 2%
Actual: 4%
Baseline: 1%
Measurable Objective
To expand and sustain the Voluntary Counseling & Testing Programme.
Indicator
The proportion of clients HIV pre – test counselled (excluding ANC).
Target: 10%
Actual: 6%
Baseline: 3%
Indicator
Fixed facilities offering VCT.
Target: 100%
Actual: 98%
Baseline: 97%
Indicator
Number non – medical sites offering VCT.
Target: 94
Actual: 68
Baseline: 58
Indicator
% Mobiles offering VCT.
Target: 90%
Actual: 0%
Baseline: 0%

TABLE 6: Analysis of Constraints and Measures Planned To Overcome Them

HIV, AIDS and STI

System Priorities	Constraints	Planned Remedial Interventions
Increasing ART coverage to 50% of eligible patients by March 2008.	▪ High demand on services due to the HIV and AIDS rates and staff shortages.	▪ Create posts at higher levels & train lower categories of staff to fulfil functions currently the responsibility of professional staff.
	▪ Inadequate space for counselling and CCMT services.	▪ Provision of park homes and partnerships with NGOs for optimal utilisation of resources.
	▪ Inadequate monitoring & evaluation – inadequate data.	▪ Appointment of M&E Manager. ▪ Implement an electronic M&E/ data system.
	▪ VCT and PMTCT uptake remains poor.	▪ Community out-reach programmes.
	▪ VCT not offered to all clients accessing the health system.	▪ Strategy to improve integrated service delivery.
Increase uptake of HAST services by children.	▪ Inadequate follow-up of babies in PMTCT Programme.	▪ Integration of reproductive health services at health facilities (ANC, STI, VCT, TB, and FP). ▪ Increase laboratory capacity to increase PCR testing.
	▪ Provision of CCMT services to children remains poor.	▪ Improve identification of vulnerable children at entry point e.g. immunisation services.
	▪ Psychosocial constraints faced by special groups e.g. child headed households.	▪ Inter-sectoral programmes with Social Welfare and Home Affairs.

Reduce STI incidence from current 7/1000 cases (population 15 years and above) to 5/1000 by March 2008.	▪ Inadequate distribution of male and female condom.	▪ Increase the male/ female condom distribution rate. ▪ Increase High Transmission Areas.
	▪ Inadequate integration of services.	▪ Improved integration and monitoring of services.
Ensure effective combined management of TB and HIV.	▪ Vertical referral & reporting systems for TB and HIV.	▪ Integrate referral and reporting systems and data management. ▪ TB facilities accredited as ART sites to ensure effective reporting and monitoring.
	▪ Lack of integrated data collection tools.	

TB Programme

System Priority	Constraints	Planned Remedial Interventions
Improve case management of PTB.	▪ Inadequate trained staff. ▪ Retention of health workers.	▪ Appointment of facility staff. ▪ Training programmes to address training gap. ▪ Retention strategy to be developed by HRM Unit.
Improve case retention.	▪ Inadequate TB Community Officers.	▪ Appoint TB Community Officers.
Improve management of MDR TB.	▪ Inadequate MDR TB beds.	▪ Decentralise MDR TB management to District Satellite Centres. ▪ Infrastructural changes.

TABLE 7: (HIV 2) Provincial Objectives and Performance Indicators for HIV & AIDS, STI & TB Control

Indicator	2006/07 (Actual)	2007/08 (Actual)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
TB PROGRAMME					
Measurable Objective: To improve case finding and improve clinical management.					
% Institutions implementing the Suspect Register.	65%	78%	100%	100%	100%
Number of Facilities with effective patient Tracking system.	35%	45%	100%	100%	100%
Smear conversion rate.	38%	42%	60%	70%	75%
Defaulter Rate.	16%	13%	10%	8%	6%
Measurable Objective: To improve laboratory diagnostic capacity to handle diagnostic workload and quality assurance and control.					
TB sputa specimens turnaround time <48 hours.	55%	60%	85%	90%	95%
% Laboratories implementing quality assurance protocols and controls.	0%	60%	100%	100%	100%
To improve TB sputum diagnosis: Bacteriological coverage.	72%	67%	85%	90%	95%
% Institutions provided with transport three times per week for sputum collection.[28]	-	60%	85%	90%	100%
Measurable Objective: To strengthen community support and participation and improve patient adherence.					
TB cases with a DOTS supporter.	77%	82%	90%	95%	98%
Number of DOTS Supporters trained.	Not available	1,200	1,200	1,500	1700
Number of TB Door to Door campaigns.	-	10	25	33	33
Measurable Objective: To sustain the MDR TB reporting and recording system.					
Number of MDR TB Sites implementing the MDR Electronic Register.	-	3	7	7	7
Measurable Objective: To strengthen the surveillance and management of MDR and XDR TB.					
Number of MDR TB decentralised sites.	-	3	7	7	7

[28] New indicator – no baseline in 2006/07.

TABLE 8: Provincial Objectives and Performance Indicators for HIV, AIDS and STI

Indicator	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Target)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)						
Measurable Objective: To scale up and sustain implementation of the PMTCT Programme.						
Navirapine dose to baby coverage.	102%[29]	93%	98%	98%	98%	98%
Nevirapine uptake – antenatal clients.	63%	70%	76%	80%	90%	95%
Fixed Facilities offering PMTCT.	96%	96%	98%	98%	99%	99%
Portion of ANC clients tested for HIV	63%	70%	80%	90%	90%	95%
Number of PCR tests done on babies born to HIV positive mothers (at 6 weeks).	Not available.	26,956	44,115	50,000	55,000	56,000
Number of Hospitals offering PMTCT with dual ARV prophylaxis.[30]	-	-	53	53	53	53
Number of fixed PHC facilities offering PMTCT with dual ARV prophylaxis.	-	-	565	570	570	570
POST EXPOSURE PROPHYLAXIS (PEP)						
Measurable Objective: To strengthen Occupational and Non-Occupational PEP services.						
Hospitals offering PEP for Occupational HIV exposure.	100%	100%	100%	100%	100%	100%
Hospitals offering PEP for sexual abuse.	87%	87%	89%	90%	95%	98%
Number of Trauma Centres for victims of violence.	30	34	34	37	39	40

[29] Data is questionable.
[30] New indicator starting 2008/09.

Indicator	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Target)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Number of sexual assault cases – new.[31]	-	8,681	6,546	No target	No target	No target
Number of ARV Prophylaxis to sexual assault case – new.[32]	-	3,822	2,925	No target	No target	No target
ANTI-RETROVIRAL THERAPY						
Measurable Objective: To implement the Comprehensive Plan for HIV and AIDS.						
Number of accredited sites (Hospitals / Clinics/ Other).	69	72	74	79 Hospital: 62 PHC: 17	86	92
Total number of ART Patients.	-	75,136	110,227	195,312	255,000	315,000
HIV testing rate.	-	65%	91%	93%	93%	95%
Number of children on ART.	-	-	10,286	21,484	28,050	34,650
Number of STI treated new episode: ART patients.	-	-	4,576	4,000	3,500	3,000-
Proportion of HIV+ patients screened for TB.	-	-	100%	100%	100%	100%
SEXUALLY TRANSMITTED INFECTIONS						
Measurable Objective: To support the effective implementation of the Syndromic Management of STIs.						
STI partner treatment rate.	-	28%	30%	30%	30%	30%
STI treated – new episode.	-	645,000	362,452	368,000	268,000	218,000
Syphilis prevalence among antenatal clients tested	-	1%	4%	2%	2%	2%
VOLUNTARY COUNSELLING AND TESTING						
Measurable Objective: To expand and sustain the Voluntary Counselling and Testing Programme.						
Proportion clients HIV pre-test counselled (excluding ANC).	2%	3%	6%	10%	12%	15%
Fixed facilities offering VCT.	97%	97%	98%	100%	100%	100%
Number non-medical sites offering VCT.	-	58	68	94	117	130
% Mobile clinics offering VCT	-	-	-	90%	100%	100%

[31] Record the number of cases per quarter. Trends will be monitored.
[32] Record the number. Trends will be monitored.

TABLE 9: (HIV 4) Trends in Provincial Public Health Expenditure for HIV and AIDS Conditional Grant (R million)

Expenditure (R million)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	Average annual percentage change	2007/08 (MTEF projection	2008/09 (MTEF projection)	2009/10 (MTEF projection)	20010/11 (MTEF projection)
Current prices.								
Total·	R186,348	R251,468	R344,304	22.71%	R466,922	R629,694	R828,174	R927,793
Total per person.	R19.06	R25.53	R34.69	22.11%	R46.69	R62.50	R81.60	R90.74
Total per uninsured person.	R21.65	R29.01	R39.43	22.11%	R53.06	R71.03	R92.72	R103.11
Constant (2007/08) prices.								
Total·	R216,164	R281,644	R368,405	19.45%	R466,922	R591,912	R745,357	R797902
Total per person.	R22.10	R30.63	R37.12	18.87%	R46.69	R58.75	R73.44	R78.03
Total per uninsured person.	R25.12	R32.49	R42.8	18.87%	R53.006	R66.77	R83.45	R88.67

HEALTH
KwaZulu-Natal

NOTES

MTEF PERIOD 2008/09 - 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

HEALTH
KwaZulu-Natal

ANNEXURE 5

PROGRAMME 2 : DISTRICT HEALTH SERVICES

SUB PROGRAMME: NUTRITION AND MATERNAL, CHILD AND WOMEN'S HEALTH

MTEF PERIOD 2008/09

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

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1. SITUATIONAL ANALYSIS

1.1 Introduction

Maternal and Child Health is a global priority.

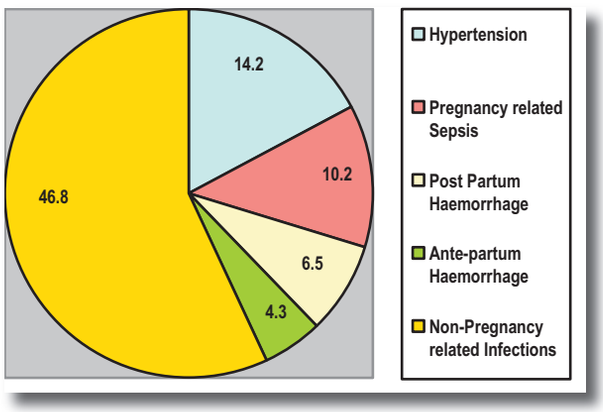
The first significant Programme of Action was signed by 179 countries (including South Africa) at the 1994 International Conference on Population and Development (ICPD). This realisation of human and women's rights forms the foundation of subsequent programmes. In 2000, the MDGs adopted by the United Nations again prioritised the health of women and children on the global health agenda, with clear targets for the reduction of under-five and maternal mortality by the year 2015.[1]

The HIV prevalence (antenatal women) in the Province remains constant at 39.1% with a significant decline in prevalence amongst women under-20 years (15.9% in 2005 to 13.7% in 2006). Of great concern is the increase in HIV prevalence from 36.4% to 37% amongst women between 30 – 35 years, and 28% – 29.3% in the 35 – 39 year age group.[2] This has profound implications for women in their reproductive age as well as pregnant women and babies. The additional burden of disease on women negatively affects health-seeking behaviour of both women and children with poor utilisation of services and consequent negative health outcomes.

The maternal mortality rate in the Province has increased over the last five years from 144/100,000 to 150/100,000 live births. The Saving Mothers Report suggested that due to under-reporting of maternal deaths, a more realistic estimate would be 175 to 200/100,000 live births.[3] Non-pregnancy related infections, mainly HIV and AIDS, is now the leading cause of maternal deaths in the Province accounting for 46.8% of the total number of maternal deaths during the period 2002 – 2004, as compared to 38% during 1999 – 2001.[4]

[1] United Nations Millennium Declaration – 2000.
[2] 2006 National Antenatal HIV & Syphilis Prevalence Survey.
[3] KwaZulu-Natal Department of Health Annual Report 2006/07.
[4] Third Report on Confidential Enquiries into Maternal Death in SA 2002-2004. Pretoria 2006.

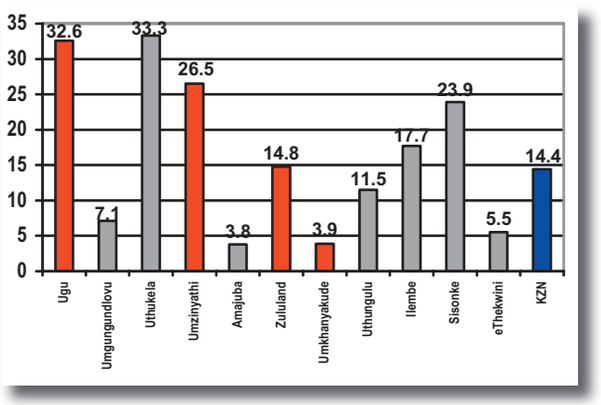
FIGURE 1: Causes of Maternal Deaths in the Province



The infant mortality rate was estimated at 60 per 1000 live births and under-5 mortality rate at 95 per 1000 live births in 2006, showing a decrease from 79 per 1000 live births (infant mortality) and 122 per 1000 (child mortality) in 2002.[5] Modelled estimates suggest an upward trend in mortality across all age groups mainly due to HIV and AIDS. Saving Children 2004 reported that three out of every five children who died under the age of 5 years were associated with HIV infection, and Saving Children 2005 that proportion has risen to four out of five – with an alarming 54% of children not tested for HIV.[6]

The lack of reliable data (including community data) makes it difficult to estimate child and maternal mortality rates. The Perinatal Problem Identification Programme (PPIP) and the Child Health Problem Identification Programme (CHiP) however provide valuable information on avoidable factors that must be addressed to decrease morbidity and mortality. The facility-based mortality rates (based on 2006/07 DHIS data) are reflected below.

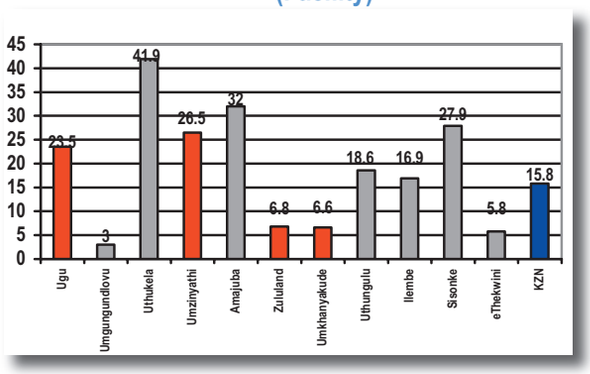
FIGURE 2: Infant Mortality Rate 2006/07 (Facility)



[5] MRC Burden of Disease 2000.
[6] Saving Children 2005. A survey of child healthcare in South Africa.

ANNEXURE 5

FIGURE 3: Under-5 Mortality Rate 2006/07 (Facility)



The incidence of diarrhoea in children under-5 years ranges between 11.4% and 21.5%. Although this is one of the HIV indicator related conditions, it can also be linked to poverty including access to water and sanitation. District data (DHPs) indicate the percentage of households without access to safe and potable water range between 35% and 71% – Presidential nodes ranged between 35% and 54%.

The World Health Organisation (WHO) states: "The two public health interventions that have had the greatest impact on the world's health are clean water and vaccines."

The full immunisation coverage under-1 year decreased from 97.3% in 2005/06 to 89.7% in 2006/07 (National target of 90%). This is attributed to changing the under-1 year denominator using new population figures (Stats SA). Coverage in the Sisonke District further decreased due to an increase in the under-1 year population with the integration of uMzimkhulu in the Sisonke District. Immunisation services are available in 100% of Public Health Facilities.

Health status is intimately linked to nutritional status, and optimal health status requires the appropriate intake of adequate macro and micro nutrients. Inadequate or excessive nutritional intake can result in malnutrition, and in addition, failure to ingest adequate micronutrients, iron, folic acid or vitamin B12 can result in specific micro nutrient deficiencies such as Anaemia. [7]

Over-nutrition and Obesity (BMI>30) co-exist with inadequate food intake in communities in the Province, while the National Food Consumption Survey (1999) indicated that 34.4% of females and 10.4% of males are obese. This is a documented risk factor for diseases of lifestyle including Type 2 Diabetes Mellitus, Hypertension and Coronary Artery Disease. Protein-energy malnutrition is a preventable cause of morbidity and mortality and is being addressed through regular growth monitoring and identification of high risk children requiring nutritional support.

MDGs Progress

Goal 1: *Eradicate extreme poverty and hunger.*
Target 2: *Halve, between 1990 and 2015, the proportion of people who suffer from hunger.*

- Severe malnutrition for children under-5 remains constant at 0.6% (2005/06 – 2006/07), 5% of children visiting health services are not gaining weight, 1.2% are underweight for age, and 0.5% are severely underweight.
- The Department provides Vitamin A supplementation to children under-5 (seen at health facilities):
  - 88% of children 6 – 11 months (national target 90%);
  - 40% of children 12 – 60 months (national target 40%); and
  - 5,479 curative doses to severely malnourished children under 5 years (2007/08).
  - 18,561 Doses of Vitamin A were issued to post partum women within eight weeks post delivery.
  - 81,230 Adults and 14,561 children received nutritional support packs while on ART and TB treatment (2007/08).
  - The Department established food gardens at 250 PHC Clinics (2006/07) to contribute towards household food security.
  - Counselling and support in feeding choices for mothers participating in the PMTCT programme
  - 61% of mothers chose to breastfeed and 35% to bottle feed (2006/07).

[7] Maternal, peri-natal and nutritional conditions in Department of Health, KwaZulu-Natal. Epidemiology Bulletin 2003.

Goal 4: *Reduce child mortality.*
Target 5: *Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.*

- Provincial immunisation coverage: 89.7% in 2006/07 (aimed at protecting children against vaccine preventable diseases). Implementation of the Reach Every Child/District strategy in five Districts.
- Expanded Programme on Immunisation surveillance systems are in place:
  - 37/66 Acute Flaccid Paralysis (AFP) cases fully investigated – no polio case.
  - Fully investigated 47 Adverse Events Following Immunisation (AEFI) cases – 2 deaths reported (still under investigation).
  - Measles surveillance with 963 cases fully investigated & reported – 1 confirmed measles.
  - One neonatal tetanus case reported from Uthungulu District.
- The IMCI is implemented in 72% of facilities, and five Districts implement the Community Component to improve child health.
- Implementation of the Perinatal Problem Identification Programme (PPIP) (29 facilities) and Child Health Problem Identification Programme (CHiP) (nine Facilities) as part of quality improvement programmes to reduce preventable causes of death.
- School Health Services are implemented in 100% districts with 57% school coverage in 2006/07 and 125,000 Grade R-1 learners screened for health conditions with appropriate referral through PHC.
- PMTCT is provided at 96% of facilities with Nevirapine uptake rate for targeted babies ranging between 48% and 93%.

Goal 5: *Improve maternal health.*
Target 6: *Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate.*

- Sustained the Confidential Enquiry into Maternal Deaths with 360 maternal deaths reported for 2006/07 to date.
- 100% Districts implement the 10 Saving Mothers Recommendations as per National directive.
- Delivery rate in facility: 74% in 2006/07.
- Delivery rate to women under-18 years: 8% in 2006/07.
- ANC coverage rate: 97.3% in 2006/07.
- HIV, AIDS and TB services are included in the Antenatal and Postnatal Care Policy.
- Women-Year Protection rate: 22% in 2006/07.

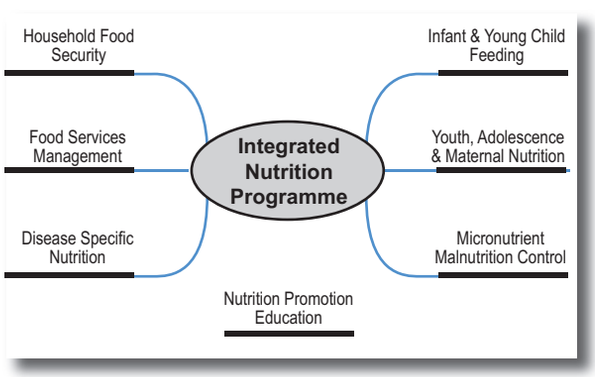
Research is necessary to establish morbidity and mortality data.

2. SERVICE DELIVERY APPRAISAL

2.1 Integrated Nutrition Programme

The components of Nutrition Services are indicated in Figure 4.

FIGURE 4: Integrated Nutrition Services



Infant & Young Child Feeding

- The Infant and Young Child Feeding programme is responsible for the provision of comprehensive nutrition intervention for children under 5 years. This encompasses strategies to improve growth monitoring and promotion, protection promotion and support of breastfeeding, as well as prevention of mother to child transmission of HIV.
- The number of Baby-Friendly Hospitals increased to 55 in 2006/07.

Micronutrient Malnutrition Control

- The activities of this component aim to prevent reduce and/or control dietary deficiencies of vitamins and minerals. This is achieved through direct supplementation of vulnerable populations or groups with micronutrient supplements or dietary diversification. It also involves fortification of commonly consumed foods with micro nutrients focusing on the three main vitamin or mineral nutritional deficiencies of public health significance namely vitamin A deficiency, iron deficiency anaemia and iodine deficiency disorders.
- During 2006/07 the Nutrition Programme issued the following doses of Vitamin A to children:

  - 12,234 doses to 0 – 5 month babies;
  - 99,910 doses to 6 – 11 month infants;
  - 178,980 doses to 12 – 59 month children; and
  - 5,479 doses to severely malnourished children under 5 years (curative doses).

Disease Specific Nutrition Support and Counselling

- Nutrition and dietetics practices are addressed by this component. It aims to prevent and rehabilitate nutrition related diseases, debilitating conditions and illnesses through counselling, support and treatment.
- During 2006/07, 81,230 adults and 14,561 children received nutritional support packs while on ART and TB treatment.

Household Food Security

- Household food security involves nutrition related activities aimed at contributing to adequate access to food for households. Such food must be of the right quality to satisfy dietary needs and to ensure a healthy active life of all household members at all times throughout the year.

Youth, Adolescent Nutrition and Maternal Nutrition

- This component focuses on the nutrition activities for the maintenance of healthy lifestyles and the prevention and management of malnutrition in youth i.e. prevention of obesity and eating disorders.

Food Service Management

- Food Services Management provides guidance in respect of suitable food service systems. This involves the activities of planning, development, control and implementation of food services systems. These systems aim to provide balanced nutrition to groups in the community and in public health institutions.

Maternal Nutrition

- Maternal Nutrition is concerned with nutrition practices that will ensure optimal development and nutritional status for mothers and babies. It involves nutritional supplementation, and prevention of debilitating illnesses such as Foetal Alcohol Syndrome and Mother-to-Child-Transmission of HIV.
- In 2007/08 (to October 2007) 18,561 doses of Vitamin A were issued to women within 8 weeks post delivery.

Nutrition Promotion, Education and Advocacy

- Nutrition Promotion, Education and Advocacy involve communication activities to improve the nutritional status of the population, to prevent nutrition related diseases and to improve the quality of life of the population.
- Information and education materials include:
  - Breastfeeding messages and promotional material.
  - Nutrition messages, garden tools and seeds.
  - Youth booklets.
  - Vitamin A material and messages.
  - Child health messages and material.
  - Healthy eating booklet.
  - Diabetes and heart disease information booklets.

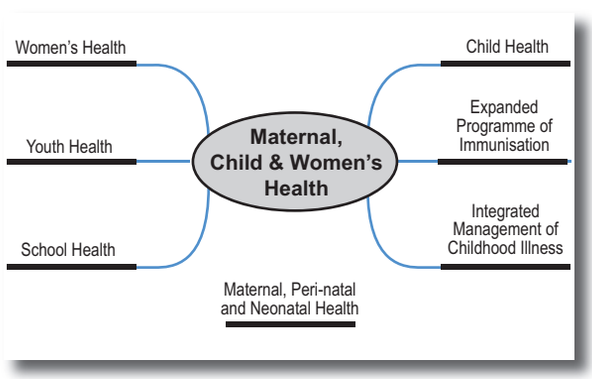
2.2 Maternal, Child & Women's Health

The aim of the MC&WH services is to implement high quality integrated and comprehensive services at all levels of care to reduce the morbidity and mortality of pregnant and non-pregnant women, neonates, infants, children, and youth.

The focus is therefore on the promotion of health behaviours with the potential to prevent/ reduce morbidity and mortality in the target groups; the reduction of preventable causes of death by improving access to quality health care; the utilisation, integration, and improved quality of care; the effective management of clients at the appropriate levels of care; and improving data management for more effective decision-making and planning.

The Maternal, Child and Women Health Services are indicated in Figure 5.

FIGURE 5: Maternal, Child & Women's Health



Maternal, Peri-Natal and Neonatal Health

The number of reported maternal deaths *(Confidential Enquiry into Maternal Deaths)* increased from 189 in 1998, to 275 in 2005 and 360 in 2006. This excludes community deaths.

- Avoidable factors contributed significantly to maternal deaths, with patient related factors (delay in seeking help, failure to book and unsafe abortion) in 58.8% of cases, administrative factors (transport between institutions, lack of trained staff) in 49.9% of cases, and Health Worker avoidable factors (initial assessment, substandard care and monitoring of patients) in 68.3%, 71.2% and 50.8% at Primary Level, Secondary Level and Tertiary Level respectively. [8]
- A Provincial monitoring tool was instituted in 2006/07 to track implementation of the 10 Saving Mothers Recommendations and the outcome thereof. To date the following progress has been made:

  - 100% of Districts developed protocols for the management of the major conditions causing maternal deaths.
  - 2,930 Health Workers were trained on these management protocols.
  - 100% of Districts conduct weekly/ monthly Maternal and Peri–Natal mortality review meetings and established quality improvement programmes.
  - HIV positive mothers (and babies) are fast–tracked to ARV services.
  - 100% Districts established referral routes and criteria although challenges still need to be addressed.
  - Average waiting time for EMRS is reduced to between 15min – 2hours, with a few rural facilities reporting waiting times of more than 4 hours.
  - 100% Facilities have emergency blood available.

(Continued →)

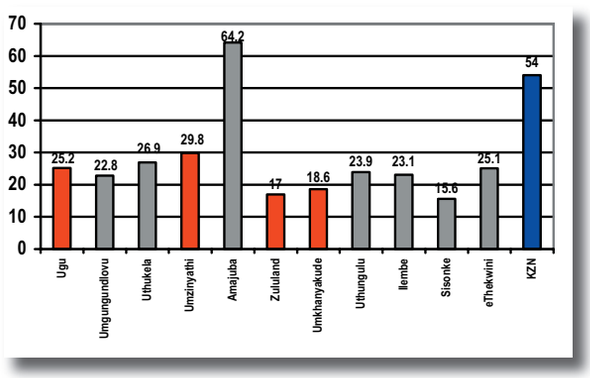
[8] Third Report on Confidential Enquiries into Maternal Deaths in South Africa 2002-2004.

ANNEXURE 5

- Eight Districts provide 1st trimester Termination of Pregnancy services through the Public Health System, while two Districts entered into a SLA with a private service provider.
- 100% Districts started implementation of the intra–partum audit and quality control programme for maternal and neonatal health.

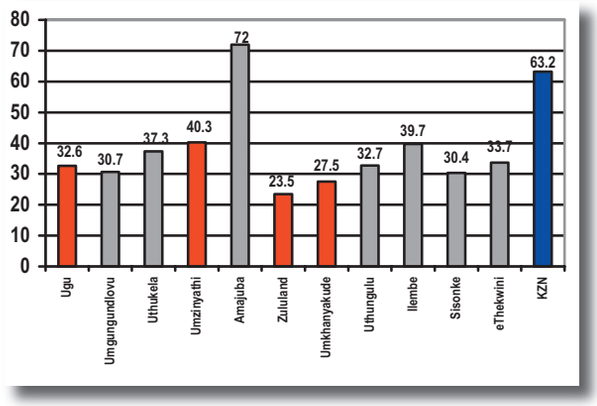
- The Basic Ante-Natal Care package (BANC)[9], an audit and quality improvement/assurance programme, was introduced in two Districts (eThekwini and Umzinyathi) during 2006/07 and is being rolled out to other Districts in the Province during MTEF 2007/08 and MTEF 2008/09.
- The Saving Babies Report estimated the Peri-natal mortality at 37.5/1000 for infants' ≥500g, and 27.9/1000 for infants' ≥1000g.[10] It is globally accepted that a reduction in the neonatal mortality rate (NMR) will result in a reduction in the peri-natal mortality rate (PNMR) that includes early neonatal deaths and stillbirths. The stillbirth rate in the Province is high and there is a concerted effort to improve ANC services.

FIGURE 6: Still Birth Rate (Facility)



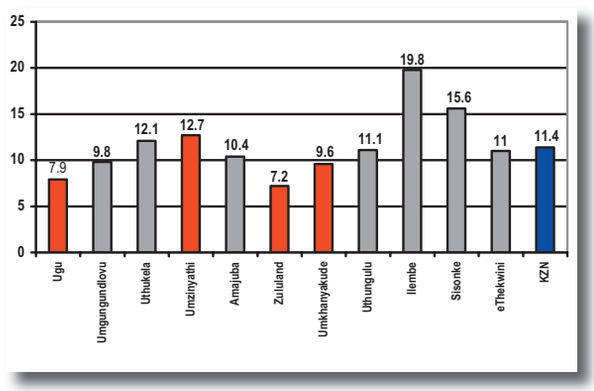
- Achieving MDG-4 and MDG-5 necessitates improvement in coverage and quality of care received by pregnant women and infants as well as an improved health system.[11] The STP addresses systems and staffing issues relevant to improvement of care.

FIGURE 7: Peri-natal Mortality Rate (Facility)



- The PPIP is currently implemented in 29 registered sites – using data in quality improvement programmes through maternal & perinatal mortality meetings.
- The PMTCT programme is now fully integrated in MC&WH services, while progress has been made to fully integrate the service with VCT, STI, ART, and TB services.
- During 2006/07 two Neonatal Experiential Learning Sites were developed at Lower Umfolozi War Memorial and Greys Hospitals to improve neonatal resuscitation and reduce neonatal morbidity and mortality.

FIGURE 8: Neonatal Mortality Rate (Facility)



- Kangaroo Mother Care is implemented in 34 institutions to improve care for the low-birth weight babies.

[9] BANK: An audit and quality improvement/ assurance programme to improve ante-natal care.
[10] Saving Babies V: Perinatal Care Survey of South Africa (2003–2005).
[11] Fifth Perinatal Care Survey of South Africa. 2007.

Child Health

The SADHS (South Africa Demographic and Health Survey 2003) indicates that infant and child mortality is higher in rural areas; higher for babies born to mothers with no formal education; in families with 4 or more children; and in families where the birth interval between children is less than 2 years. All these risk factors are relevant in the Province.

Great variation exists between data for Infant and Child Mortality Rates (both nationally and provincially) due to the lack of reliable community-based information, vital registration data, and routine facility-based data.

- In 2006/07 the Province embarked on a project to implement the Rapid Epidemiological Assessment tools (Preceding Birth Technique) to provide health information with regards to child and infant mortality rates. This technique is more rapid and simple and is at a lower cost than standard methods of data collection. This tool also has the potential to yield reliable results for use primarily at the district and sub-district level. Data quality was however poor and it was difficult to obtain information from women delivering outside the health services. Alternative methods will be explored during 2008/09.

The 2005 Saving Children Report indicated that the majority of child deaths in the Province occur within the first 48 hours (36%) or within the first 7 days of admission. In 38% of modifiable factors (preventable causes) the primary problem was related to the home which highlights the importance of community interventions to change health-seeking behaviours.

- In response to the need for community participation and education the RED strategy was implemented in eThekwini-, Zululand-, and Ilembe Districts during 2006/07. The initiative will be integrated with the Integrated Management of Childhood Illnesses (IMCI) Community Component (functional in five Districts) to improve community education and participation and to improve health seeking behaviours of parents. Focus will be on improvement of immunisation coverage, growth monitoring, Vitamin A coverage, and the 16 Household Messages.
- Nine institutions are currently implementing the ChIP as an audit and reporting tool, using data on in-patient child deaths to appraise services and identify modifiable factors that can be addressed to reduce morbidity and mortality. Data is collated and submitted for the National Saving Children's Report. According to data from the 2005 report the leading causes of death for children less than 5 years are Pneumonia (21.5%), Septicaemia (16.9%) and Diarrhoea (15.3%). Forty-six percent of children that died were not tested for HIV.[12]
- Implementation of Well Baby/Child Services to improve health promotion and education, immunisation, growth monitoring, and Vitamin A coverage commenced in 2007/08.

Expanded Programme on Immunisation

- The Provincial immunisation coverage under-1 year was 89.7% in 2006/07, with five Districts achieving less than the National target of 90%.
- The Province exceeded the National target of 90% during the Polio & Measles Campaigns in 2006/07, recording 95.4% coverage during the Polio campaign in October 2006, and 93.3% Measles and 90% Polio coverage during the Measles and Polio campaign in May 2007.
- 37 AFP cases were fully investigated during 2006/07 with no confirmed polio cases. This is 56% of the provincial target of 66 cases (1/100000 children under 15 years) for investigation.
- AEFI is thoroughly investigated. Forty seven AEFI cases were reported in 2006/07 and 2 deaths occurred following immunisation – investigations in this regard are not yet complete.
- During 2006/07, 963 suspected measles cases were reported and investigated, with 498 rubella cases and 1 confirmed measles case.
- One Neo-Natal Tetanus case was reported from Uthungulu District in 2006/07.

[12] Saving Children 2005: Survey of Child Healthcare in South Africa.

ANNEXURE 5

Integrated Management of Childhood Illnesses (IMCI)

To address the high childhood morbidity and mortality (largely due to preventable illnesses i.e. acute respiratory infection, diarrhoeal diseases and malnutrition) the IMCI strategy was developed by the WHO and UNICEFF in 1995 and adopted by South Africa in 1998.

- In 2006/07 the Province conducted a Provincial IMCI Review and disseminated the results to all Districts. Districts developed evidence-based strategies to improve clinical management of the sick child, improve health systems, and expand and sustain the community component of IMCI. Output and outcome is monitored quarterly.
- For the same period, 30 IMCI clinical management courses have been conducted, 59% of Professional Nurses at PHC level have been trained in IMCI Clinical Case Management, and 72% of PHC facilities implement IMCI Clinical Case Management.
- Five districts implement the Community Component of IMCI where Household Messages are taught in the community as part of promotive and preventive health.

School Health

The Province has the highest number of learners in the country with approximately 2.6 million learners.[13]

- All Districts offer School Health Services (SHS) as prescribed in the Provincial School Health Services Policy & Implementation Guidelines, as compared to the National target of 60%.
- Total school coverage for 2006/07 was 57% (Provincial target 40%), while learners in 35% of primary schools were screened for health barriers to learning. A total number of 125 000 learners were screened (with appropriate referral) for: hearing, vision, oral health, speech, anthropometric assessment, mental health, abuse, and received physical examination for minor ailments. Health promotion & education targeting learners, educators, and parents were undertaken in all schools.
- Two School Health weeks were conducted in October 2006 and March 2007 to improve integration, coordination and networking. The Department of Education (DOE) participated in both weeks and a total of 654 schools were reached. Education on TB, HIV and AIDS, Child Abuse, and Drug Abuse were prioritised – while district specific problems were addressed.
- High ova counts of mixed species of intestinal helminths in children prompted the implementation of a promotive and preventive Parasite Control Programme targeting educators and learners in 2006/07. The programme reached 810 primary schools, 7,290 educators and 36,976 learners. Following the programme 550 schools started programmes on parasite control which were integrated in the school curriculum and 180 schools started food gardens.

Youth Health

- Studies show earlier sexual maturation and sexual debut,[14] supported by a study conducted by the HSRC that demonstrated that 15 – 24 year olds are engaging in sexual intercourse much earlier. This implies that messages to promote primary sexual abstinence and delay of sexual debut should commence at a younger age. The National Youth Risk Behaviour Survey found that the Province had the highest prevalence of youth who had one or more sexual partners and most of the sexually active group did not use any form of modern contraception.[15]
- Another study conducted in Jozini (Umkhanyakhude District) ascertained that of those teenagers that engaged in sexual activity, 75.2% of males and 61.5% of females indicated that they had not used any form of contraception. The high level of sexual activity and low contraceptive use put the youth at risk of unwanted pregnancy, as well as STI and HIV infections. Unplanned teenage pregnancies constitute an important health and social challenge and innovative strategies are therefore necessary to reach young people.
- The teenage pregnancy rate is estimated at 440/1000 and the under-18 facility birth rate was 8% (compared to 13% nationally) in 2006/07.

[13] SAHR 2006.

[14] High school students' attitudes, practices and knowledge of contraception in Jozini, KwaZulu-Natal 2005. Oni TE, Prinsloo EAM, Nortje JD, Joubert JD.

[15] South African Youth Risk Behaviour Survey 2002.

- To improve access to services, improve the health-seeking behaviour of youth, improve access to information, and change risk behaviours with a potentially negative health impact, the Province continues to implement Youth-Friendly Services (YFS). The service package focuses on quality improvement (national standards and criteria in line with PHC norms and standards) and community out-reach programmes.
- In 2006/07, 117 PHC services implemented the YFS standards towards accreditation, with 39 PHC services accredited as YFS (7 gold and 32 silver awards). 43 groundBREAKERS, supported by loveLife are attached to PHC services to support youth out-reach activities.

Women's Health

According to the SAHDS 2003 report, 77% of women in South Africa use some modern method of contraception, with the injectables the most popular method of contraception by women.

- Contraceptive services are available in 100% PHC services, although an alarming decrease in contraceptive uptake is noticed since 2003. The high HIV infection rate, teenage pregnancy/ birth rate, unwanted pregnancies, demand for termination of pregnancy, maternal morbidity and mortality as a result of high-risk pregnancy, etc. all indicate the importance of this service.
- Emergency contraception (EC) reduces the threat of pregnancy after unprotected intercourse or when a planned contraceptive method fails. Although free contraceptives, including emergency contraceptives are widely available at public health facilities in the province unwanted pregnancies and demand for termination of pregnancies are increasing.
- In 2006/07 the Emergency Contraception Toll Free Hotline showed an increase in calls from youth (10 – 24 years) and older women (40 – 45). A total number of 989 calls were recorded. Effective counselling also creates the opportunity to increase condom usage (thereby decreasing the incidence of STI and HIV). Emergency contraception is now actively promoted in all health services as integrated strategy to reduce morbidity and mortality.
- The National goal is to integrate previous vertical sexual and reproductive health service into PHC. This integrated sexual and reproductive health care package includes contraceptive services, early diagnosis of pregnancy and delivery of normal pregnancy, antenatal & postnatal care, growth monitoring, child immunisation, nutrition education, termination of pregnancy services, screening for breast and cervical cancer, the prevention and syndromic management of STIs, and HIV education, counselling and testing. This integrated package of services is widely regarded as essential for meeting the needs of both men and women.[16]
- A Contraceptive Champion Project commenced in 2007/08 to facilitate integrated services – with support from the National Department of Health and Family Health International. Contraceptive Desk Aids have been developed and are utilised in 100% districts to assist all categories of staff to provide comprehensive contraceptive services according to the WHO Medical Eligibility Criteria.
- In 2006/07 a total of 829 Professional Nurses completed training for integrated Sexual & Reproductive Health. High attrition rates result in huge training gaps jeopardising quality of services.

Cervical Cancer Screening

The National & Provincial Cervical Cancer Screening Policies provided that all women attending public health facilities should have:

- Three free Pap smears in their lifetime, with a ten year interval between each smear (unless otherwise indicated for health reasons).
- Pap smears commencing at age 30 or older.

Cervical cancer is the most common cancer in women in South Africa with an approximate 1 in 40 women estimated to develop cancer of the cervix in their lifetime.[17] It remains the leading cause of death in disadvantaged populations[18] and is most widespread in areas where there is either no or very limited screening activity.[19]

[16] Integration of sexual & reproductive health services in KwaZulu-Natal. Health Policy Plan 2005. Maharaj P, Cleland J.
[17] An assessment of the implementation of the Provincial Cervical Cancer Screening Programme in Ilembe 2007. Sibiya MN, Grainger.
[18] Hoffman M. Limited Pap screening associated with reduced risk of cervical cancer in South Africa. 2003.
[19] SAHR 2006.

Effective screening programmes can reduce the incidence of cervical cancer by 70 – 90%, and provide low-cost accessible means of determining who in the target population is likely to have cervical cancer as the first step in the diagnostic and treatment process.[20] Screening is a valuable public health concept to reduce the burden of disease in the female population.

- The cervical cancer screening coverage in the Province almost doubled from 1.9% in 2005/06 to 5.5% (Provincial target of 5% in 2006/07).
- To improve the low adequacy rate of Pap smears (47% as opposed to a 90% target) 514 Professional Nurses were trained in integrated Sexual & Reproductive Health Care (including Pap smears).
- Treatment of pre-cancerous lesions is still a challenge with colposcopy services being available in 6 districts only. The remaining five districts (Umzinyathi, Amajuba, Zululand, Ilembe, and Sisonke) commenced with procurement of Colposcopes and Lletz machines during 2006/07.
- The Province introduced a Women-Women awareness strategy in 2006/07 to increase awareness, promote prevention, and increase utilisation of screening services. Since introduction of the strategy in August 2006, the number of Pap smears increased by 6 000 as compared to the same period the previous year, with the Province achieved a screening coverage of 5.5%.

[20] Gaym A, Mashego M, Kharsany AB. High prevalence of abnormal Pap smears among young women co-infected with HIV in rural South Africa – implications for policies in high HIV prevalence populations.

Termination of Pregnancy (TOP)

The Choice on Termination of Pregnancy Amendment Act, 2004 (Act No 38 of 2004) is yet to be passed by Parliament after public hearings held in September 2007. The Province actively participated in preparation for the hearings by facilitating provincial and district information sessions in preparation for submissions to the National Council of Provinces:

- The demand for termination of pregnancy (TOP) increased steadily over the last 10 years while contraceptive acceptors decreased by 42% from 2003 to 2006.
- Unsafe/ septic abortion is still one of the primary obstetric causes of maternal deaths in the province but showed a decrease from 5.8% in 1999 – 2001 to 3.2% in 2002 – 2004.[21]
- Access to TOP services increased from 19 public and 6 private on-line facilities to 22 public and 9 private on-line facilities in 2006/07, with five public health facilities providing second trimester terminations. Two districts (Ugu and eThekwini) entered into Service Level Agreements with a private Service Provider to improve access to TOP.
- 39 TOP Practitioners completed the recognised training during 2006/07, and are involved in service delivery in institutions providing TOP services. Two TOP Learning Sites were developed at Addington Hospital and Lower Umfolozi War Memorial Hospital.

[20] Third Report on Confidential Enquiries into Maternal Deaths in South Africa 2002 – 2004.

TABLE 1: (MC&WH 3) Situational Analysis Indicators for Nutrition and Maternal, Child and Women's Health

Indicator	2006/07 (Actual)	2007/08 (Projected)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)	National Target
Incidence/Input						
Number of Hospitals offering CTOP Services.	19	22	30	35	40	100%
Number of CHCs offering CTOP services.	0	0	2	3	6	8
Process						
1. Fixed PHC Facilities with DTP Hib vaccine stock out.	0%	0%	0%	0%	0%	0%
Output						
2. Full) Immunisation coverage under 1 year.	74.8%	89.7%	90%	90%	90%	90%
3. Vitamin A coverage under 1 year.	25%	50%	75%	80%	85%	80%
4. Measles coverage under 1 year.	79%	90%	90%	90%	90%	90%
5. Cervical cancer screening coverage.	2%	4.5%	5%	7%	9%	7%
6. Deliveries in facilities.	188 080	198 380	–	–	–	–
Quality						
7. Facilities certified as baby friendly.	70%	75%	75%	79%	82%	40%
8. Fixed PHC Facilities implementing IMCI.	80%	79%	82%	85%	90%	85%
Outcome						
9. Institutional delivery rate for women under 18 years.	8%	8%	8%	7%	7%	13%

TABLE 2: (MCWH 1) Situational Analysis Indicators for Nutrition and Maternal, Child and Women's Health per Health District

Indicator	Target of Province	Ugu 2006/07	Umgungundlovu 2006/07	Uthukela 2006/07	Umzinyathi 2006/07	Amajuba 2006/07	Zululand 2006/07	Umkhanyakude 2006/07	Uthungulu 2006/07	iLembe 2006/07	Sisonke 2006/07	eThekwini 2006/07	National Target 2006/07
Incidence													
1. Hospitals offering TOP services.	45% or 24	1	3	2	1	2	1	2	3	2	2	3	100%
2. CHC's offering TOP services.	5%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	50%
Process													
3. Fixed PHC facilities with DTP-Hib vaccine stock out (number of days).	Number out of stock	0	0	0	0	0	0	0	0	0	0	0	1 day
Output													
4. (Full) Immunisation coverage under 1 year.	90%	91.8%	101.8%	100.6%	91.9%	71.9%	82.3%	89.1%	100%	71.4%	110.7%	87.6%	90%
5. Vitamin A coverage under 1 year.	89%	85%	95%	95%	85%	95%	80%	80%	80%	85%	85%	85%	80%
6. Measles coverage under 1 year.	90%	94%	102.8%	100.5%	93.4%	79.4%	82.5%	90.3%	94.6%	76%	115.2%	88.8%	90%
7. Cervical cancer screening coverage.	5% of women over the age of 30 years [22]	0.6%-	2.2%-	0.5%-	0.6%-	52%-	0.34%-	5.3%-	0.02%-	5%-	0.2%-	Not available.	15%

Indicator	Target of Province	Ugu 2006/07	Umgungundlovu 2006/07	Uthukela 2006/07	Umzinyathi 2006/07	Amajuba 2006/07	Zululand 2006/07	Umkhanyakude 2006/07	Uthungulu 2006/07	iLembe 2006/07	Sisonke 2006/07	eThekwini 2006/07	National Target 2006/07
8. Deliveries in facilities.	75%	100%	75%	100%	100%	100%	90%	100%	80%	90%	90%	70%	
Quality													
9. Facilities certified as baby friendly.	75%	100%	75%	100%	100%	100%	90%	100%	80%	90%	90%	70%	40%
10. Fixed PHC facilities certified as youth friendly.	60 [23]	3	0	0	0	6	0	0	6	8	3 Outlets.	172 Outlets.	20%
11. Fixed PHC facilities implementing IMCI.	80%	100%	78%	96%	66%	99%	78%	78%	75%	63%	74%	62%	100%
Outcome													
12. Institutional delivery rate for women under 18 years.	9.5%	9%	9%	8%	7%	6%	11%	10%	6%	11%	13%	9%	13%

[22] Not in DHIS and no linkage between PHC services and Cytology data base, currently using the District Health Plans. Will be addressed in MTEF 2007/08.
[23] Implementing clinics are not ready for Provincial assessment and accreditation. Previous support from loveLife. Coordinators terminated by loveLife due to lack of funding.

3. POLICIES, STRATEGIC OBJECTIVES AND PRIORITIES

3.1 Nutrition

Policies

Service delivery for the Nutrition Programme is guided by policy imperatives included in various programmes and services. The main focus is the improvement of the lives and health of the poverty-stricken, malnourished, and the vulnerable groups in society. This is inclusive of children suffering from malnutrition and people living with HIV, AIDS and TB.

Nutrition is prominent in the new Ante-Natal and Postnatal Care Policy, Child Health Policy, Integrated HIV and AIDS Policy, and the TB Crisis Management Plan. Integrated monitoring is done to ensure effective implementation and compliance.

Priorities

1. Strengthen the management of severe malnutrition in all Districts.
2. Improve and sustain the coverage of Vitamin A supplementation programmes.
3. Strengthen the implementation of the Baby-Friendly Hospital Initiative in all Districts.
4. Contribute to poverty reduction by providing nutritional support to vulnerable groups.
5. Ensure the inclusion of nutrition indicators in the DHIS to ensure effective monitoring.

3.2 Maternal, Child & Women's Health

Policies

The Department developed an integrated Ante-Natal and Post Natal Care Policy & Implementation Guidelines through extensive networking and consultation during 2006/07 – 2007/08. The policy aims to:

- Ensure an environment in which holistic and integrated services are provided.
- Reduce maternal deaths directly or indirectly caused by inadequate care.
- Reduce perinatal and late neonatal deaths through targeted screening and early referral.
- Increase access including prevention of delays and reduced waiting times, appropriate referrals, hours of service, mobile clinics, and improved EMRS.
- Initiate five targeted visits at PHC level.
- Promote partnerships between providers and the community and improved community involvement in mother and child care programmes.

An integrated Child Health Policy and Guidelines was developed between 2006/07 – 2007/08. The policy aims to:

- Reduce the preventable causes of infant and child morbidity and mortality.
- Ensure an environment in which children can receive integrated promotive, preventive, curative, and rehabilitative health care in a child-friendly environment.
- Facilitate community participation that will embrace continuum of care from household to tertiary level.

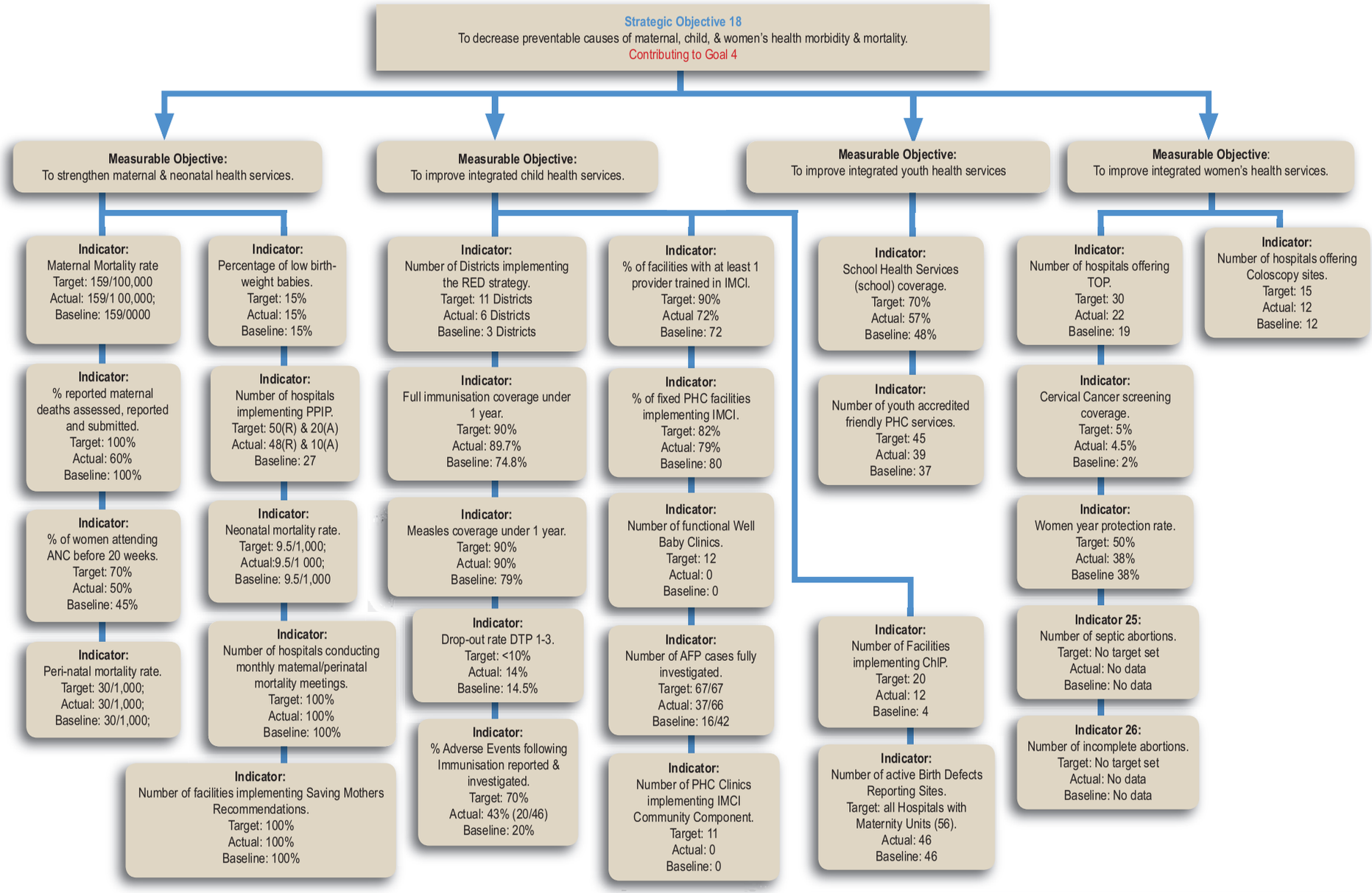
Programme implementation if further guided by legislation e.g. Child Care Act and Amendment Act, Choice on Termination of Pregnancy Act and Amendment Act, etc. and National Policies and Guidelines relevant to service delivery.

Priorities

1. Develop and facilitate the implementation of integrated strategies to reduce perinatal, neonatal, child, youth, maternal, and women morbidity and mortality.
2. Develop and facilitate the implementation of a policy framework to increase VCT uptake of pregnant women to improve the clinical outcomes.
3. Increase the number of sites providing CTOP services as well as programmes to sensitise staff.
4. Develop and facilitate the implementation of strategies to improve the cervical cancer screening programme.
5. Develop appropriate child health services including community out-reach programmes to reduce preventable causes of morbidity and mortality.
6. Improve implementation and evaluation of the Saving Mothers Recommendations and assess impact on preventable causes of death.

PRIORITIES AND STRATEGIC OBJECTIVES

The strategic objectives, measurable objectives and indicators are indicated in the diagrams below.



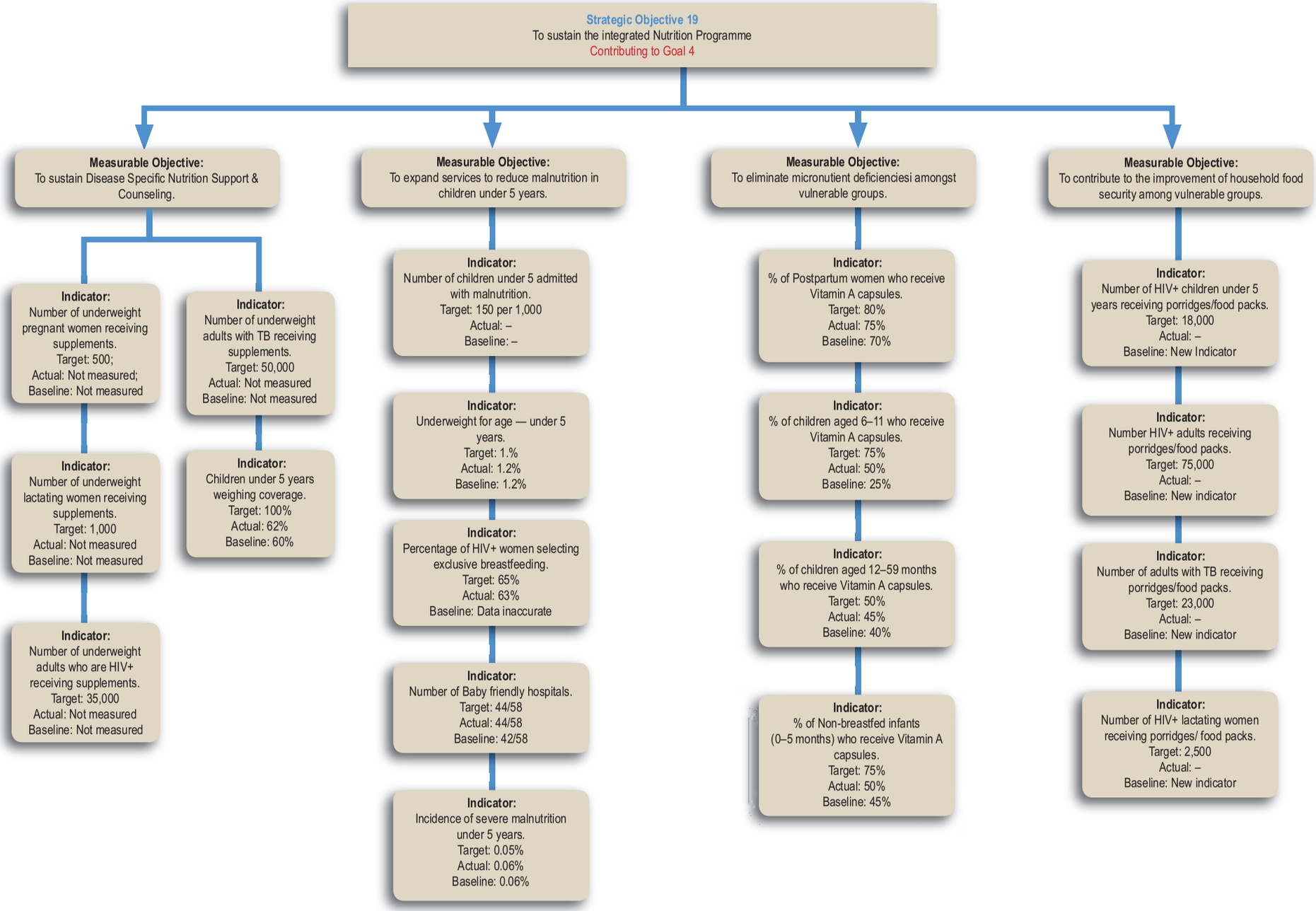

Strategic Objective 19
To sustain the integrated Nutrition Programme
Contributing to Goal 4
Measurable Objective:
To sustain Disease Specific Nutrition Support & Counseling.
Indicator:
Number of underweight pregnant women receiving supplements.
Target: 500;
Actual: Not measured;
Baseline: Not measured
Indicator:
Number of underweight lactating women receiving supplements.
Target: 1,000
Actual: Not measured
Baseline: Not measured
Indicator:
Number of underweight adults who are HIV+ receiving supplements.
Target: 35,000
Actual: Not measured
Baseline: Not measured
Indicator:
Number of underweight adults with TB receiving supplements.
Target: 50,000
Actual: Not measured
Baseline: Not measured
Indicator:
Children under 5 years weighing coverage.
Target: 100%
Actual: 62%
Baseline: 60%
Measurable Objective:
To expand services to reduce malnutrition in children under 5 years.
Indicator:
Number of children under 5 admitted with malnutrition.
Target: 150 per 1,000
Actual: –
Baseline: –
Indicator:
Underweight for age — under 5 years.
Target: 1.%
Actual: 1.2%
Baseline: 1.2%
Indicator:
Percentage of HIV+ women selecting exclusive breastfeeding.
Target: 65%
Actual: 63%
Baseline: Data inaccurate
Indicator:
Number of Baby friendly hospitals.
Target: 44/58
Actual: 44/58
Baseline: 42/58
Indicator:
Incidence of severe malnutrition under 5 years.
Target: 0.05%
Actual: 0.06%
Baseline: 0.06%
Measurable Objective:
To eliminate micronutient deficienciesi amongst vulnerable groups.
Indicator:
% of Postpartum women who receive Vitamin A capsules.
Target: 80%
Actual: 75%
Baseline: 70%
Indicator:
% of children aged 6–11 who receive Vitamin A capsules.
Target: 75%
Actual: 50%
Baseline: 25%
Indicator:
% of children aged 12–59 months who receive Vitamin A capsules.
Target: 50%
Actual: 45%
Baseline: 40%
Indicator:
% of Non-breastfed infants (0–5 months) who receive Vitamin A capsules.
Target: 75%
Actual: 50%
Baseline: 45%
Measurable Objective:
To contribute to the improvement of household food security among vulnerable groups.
Indicator:
Number of HIV+ children under 5 years receiving porridges/food packs.
Target: 18,000
Actual: –
Baseline: New Indicator
Indicator:
Number HIV+ adults receiving porridges/food packs.
Target: 75,000
Actual: –
Baseline: New indicator
Indicator:
Number of adults with TB receiving porridges/food packs.
Target: 23,000
Actual: –
Baseline: New indicator
Indicator:
Number of HIV+ lactating women receiving porridges/ food packs.
Target: 2,500
Actual: –
Baseline: New indicator

TABLE 3: Analysis of Constraints and Measures Planned To Overcome Them

Nutrition

System Priorities	Constraints	Planned Remedial Interventions
Human Resources.	▪ Shortage of nutrition staff.	▪ Staff retention strategy for dieticians. ▪ Employment of Nutrition Advisors at PHC levels.
Human Resources.	▪ Inadequate staff to collect and collate data. ▪ Inadequate data system.	▪ Inclusion of nutrition indicators in DHIS. ▪ Improve data quality through training and development.
Human Resources.	▪ Ineffective and inefficient SCM procedures.	▪ Decrease turnaround times.

Maternal, Child and Women's Health

System Priorities	Constraints	Planned Remedial Interventions
Improve quality of care.	▪ Poor/no access to relevant data. ▪ Indicators not included in DHIS/ HIS. ▪ Poor data management. ▪ Poor monitoring & evaluation including utilisation of data for decision-making at district level.	▪ Joint strategy with Health Systems Unit and Health Services Planning, M&E Unit to improve M&E. ▪ Clear role definitions and accountability for data management at all levels.
Improve quality of care.	▪ Poor integration of services including integrated analysis of relevant indicators.	▪ Integration pilots planned for integrating reproductive health services into mainstream HIV and AIDS services.
Improve quality of care.	▪ Late reporting of maternal deaths – non-reporting of community deaths.	▪ Included in community out-reach strategies.

TABLE 4: (MC&WH 2) Provincial Objectives and Performance Indicators for Nutrition

Indicator	2006/07 (Actual)	2007/08 (Estimated)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Strategic Objective: To sustain the Integrated Nutrition Programme.					
Measurable Objective: To expand services to reduce malnutrition in children under 5 years.					
Number of Baby friendly Hospitals[24].	42/58	44/58	44/58	46	48
Number of children under 5 admitted with malnutrition.	Not previously measured.	Not previously measured.	150 per 1,000 [25]	150 per 1,000	145 per 1,000
Underweight for age under 5 years.	1.2%	1.2%	1%	1	1
% of HIV + women selecting exclusive breastfeeding.	Data inaccurate.	63%	65%	67%[26]	70%
% of HIV + women selecting exclusive formula feeding.	Data inaccurate.	Data inaccurate.	35%	35%	35%
Incidence of severe malnutrition under 5 years.	0.06%	0.06%	0.05 %	0.05%	0.05%
Measurable Objective: To eliminate micronutrient deficiencies amongst vulnerable groups.					
% of Children aged 6–11 months receiving Vitamin A capsules.	25%	50%	75%	80%	85%
% of Children aged 12–59 months receiving Vitamin A capsules (Annualised).	40%	45%	50%	55%	60%
% of Non-breastfed infants (0-5 months) receiving Vitamin A capsules.	45%	50%	75%	80%	85%
% of Postpartum women who receive a Vitamin A capsule.	70%	75%	80%	85%	90%
Measurable Objective: To contribute to the improvement of household food security among vulnerable groups.[27]					
Number of HIV positive children under 5 years receiving porridges/ food packs.	New indicator.	–	18,000		
Number of HIV positive adults receiving porridges/ food packs.	New indicator.	–	75,000		
Number of adults with TB receiving porridges/ food packs.	New indicator.	–	23,000		
Number of HIV positive lactating women receiving porridges/ food packs.	New indicator.	–	2,500		

[24] Only considering Hospitals with Maternity Beds. Annual indicator the will only change in 2009/10

[25] Target based on estimate.

[26] Accurate data pending implementation of Monitoring & Evaluation System.

[27] Monitored against HIV+ clients/catchment area.

Indicator	2006/07 (Actual)	2007/08 (Estimated)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Measurable Objective: To sustain disease specific nutrition support and counselling.					
Number of underweight pregnant women receiving supplements.	Not measured.	Not measured.	500	1,500	2,500
Number of underweight lactating women receiving supplements	Not measured.	Not measured.	1,000	2,000	3,000
Number of underweight adults who are HIV + receiving supplements.	Not measured.	Not measured.	35,000	50,000	75,000
Number of underweight adults with TB receiving supplements.	Not measured.	Not measured.	50,000	60,000	70,000
Children under 5 years weighing coverage.	60%	62%	100%	100%	100%

TABLE 5: Provincial Objectives and Performance Indicators for Maternal, Child and Women's Health

Indicator	2006/07 (Actual)	2007/08 (Projected)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Strategic Objective: To decrease preventable causes of Maternal, Child & Women's morbidity and mortality.					
Measurable Objective: To strengthen Maternal and Neonatal health services					
Maternal Mortality rate.	159/100,000	159/100 000	159/100 000	159/100 000	159/100 000
Percentage of reported maternal deaths assessed, reported and submitted.	100%	60%	100%	100%	100%
Percentage of women attending ANC before 20 weeks.	45%	50%	70%	75%	80%
Peri-natal mortality rate.	30/1000	30/1000	30/1000	30/1000	30/1000
Number of Facilities implementing the Saving Mothers Recommendations.	100%	100%	100%	100%	100%
Number of Hospitals conducting monthly Maternal/ Peri-Natal mortality meetings.	100%	100%	100%	100%	100%
Percentage of low birth-weight babies.	15%	15%	15%	15%	15%
Number of Hospitals implementing PPIP.	27	48 Registered 10 Active	50 Registered 20 Active	53 Registered 30 Active	55 Registered 40 Active
Neonatal mortality rate.	9.5/1000	9.5/1000	9.5/1000	9.5/1000	9.5/1000
Measurable Objective: To improve integrated Child Health services.					
Number of Districts implementing the RED strategy.	3 Districts	6 Districts	11Districts	11Districts	11Districts
Full immunisation coverage under 1 year.	74.8%	89.7%	90%	90%	90%
Measles coverage under 1 year.	79%	90%	90%	90%	90%
Drop-out rate DTP1 – DTP2	14.5%	14%	<10%	<10%	<10%
Percentage of Adverse Events Following Immunisation reported and fully investigated.	20%	43% (20/46)	70%	80%	90%
Number Acute Flaccid Paralysis (AFP) cases fully investigated.	16/ 42	37/ 66	67/ 67	All cases	All cases
Number of Facilities implementing the Child Health Problem Identification Programme (ChIP).	4	12	20	30	40

Indicator	2006/07 (Actual)	2007/08 (Projected)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Number of functional Well Baby Clinics.	0	0	12	22	33
Percentage of fixed PHC Facilities implementing IMCI.	80%	79%	82%	85%	90%
Percentage of Facilities with at least 1 provider trained in IMCI.	72%	72%	90%	92%	95%
Number of PHC Clinics implementing the IMCI Community Component.	0	0	11	22	33
Number of active Birth Defects Reporting Sites.	46	46	All Hospitals with Maternity Units.	All Hospitals with Maternity Units.	All Hospitals with Maternity Units.
Measurable Objective: To improve integrated Youth Health services.					
School Health Services (school) coverage.	48%	57%	70%	80%	90%
Number of accredited Youth-Friendly PHC services.	37	39	45	50	55
Measurable Objective: To improve integrated Women's Health services.					
Number of Hospitals offering CTOP.	19	22	30	35	40
Cervical Cancer Screening coverage.	2%	4.5%	5%	7%	9%
Number of Hospitals offering Colposcopy services.	12	12	15	15	15
Women-Year Protection rate.	38%	38%	50%	60%	65%
Number of septic abortions.[28]	No data.	No data.	No target set.	No target set.	No target set.
Number of incomplete abortions.[29]	No data.	No data.	No target set.	No target set.	No target set.

[28] Baseline targets are not available to inform targets. Numbers will be monitored for future target setting and reporting.
[29] Baseline targets are not available to inform targets. Numbers will be monitored for future target setting and reporting.

HEALTH
KwaZulu-Natal

NOTES

MTEF PERIOD 2008/09 – 2010/11

(STRATEGIC PLAN PERIOD 2005/06 – 2009/10)

HEALTH
KwaZulu-Natal

ANNEXURE 6

PROGRAMME 2 : DISTRICT HEALTH SERVICES

SUB PROGRAMME: COMMUNICABLE AND NON-COMMUNICABLE DISEASES

MTEF PERIOD 2008/09 - 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

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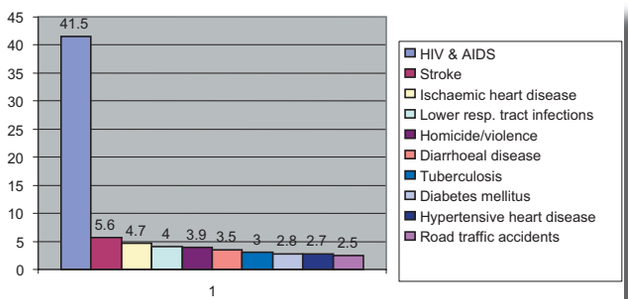
1 SITUATION ANALYSIS

1.1 Introduction

The burden of non-communicable diseases in the Province has increased and is becoming the dominant source of morbidity and mortality.

FIGURE 1: Leading Causes of Death in KwaZulu-Natal 2000



Cardiovascular disease (CVD) is one of the leading causes of morbidity and mortality, with a huge burden of CVD coming from ischemic heart disease, congestive heart failure and stroke. These conditions share many risk factors including obesity, hypertension, physical inactivity, poor nutrition, etc. and are therefore susceptible to the same health interventions.

According to the SAHR 2006, the Provincial prevalence of Ischaemic Heart Disease is 180/100,000 for males and 75/100,000 for females, and Diabetes (currently the 6th leading cause of morbidity in South Africa, and 8th provincially) has an estimated Provincial prevalence of 50/100,000 for males and 85/100,000 for females.[1]

There is a steady increase in chronic degenerative diseases with hypertension and epilepsy in the top ten common causes of morbidity at PHC level, with a Provincial hypertension incidence of 60/100,000 for males and 85/100,000 for females.[2]

Substance abuse impairs judgement and increases risk behaviours associated with negative health outcomes, while evidence demonstrates that the presence of substance abuse is a confounder in the diagnosis of neuro-psychiatric disorders.

There is an increase in substance abuse in the Province, with data indicating cannabis and cocaine to be the most commonly used illicit drugs among youth <20 years.[3] 20% -28% of patients admitted for substance abuse are <20 years,[4] while alcohol remains the dominant substance of abuse with a self-reported rate of 52.9% for males and 25.5% for females. A further 7.4% of patients reported cocaine abuse, and 45% of patients attending specialist treatment centres are abusing cannabis.

Collaborative engagement with the Department of Social Welfare and NGO's in the field of substance abuse improved, while the Drug Abuse Prevention Programme (DAP) of the Department of Social Welfare and Population Development seems reasonably effective as it conforms to 42.8% of the substance abuse prevention principles.[5]

The emphasis placed on the prevention of substance abuse has merit however prevention programmes still focus on problems. A combination of improved legislative controls, policing, community awareness and buy-in, and robust community targeted developmental strategies are necessary to improve community cohesion to address substance abuse and curb the long-term health effects of abuse. Evidence suggests that communities respond better to development programmes than 'problem-prevention' initiatives.[6]

1.2 Healthy Lifestyles

The approach advocated and used by the department has moved beyond the traditional medical curative approach to a more focused and integrated client-centred health promotion approach in line with the National and Provincial Health Priorities. This approach suggests a comprehensive and inter-sectoral solution to service delivery commencing at community and PHC level through the District Health System (DHS).

The common risk factors shared by non-communicable diseases support global evidence suggesting that

[1] Ijumba P & Padarath A. 2006 SAHR.
[2] Ijumba P & Padarath A. 2006 SAHR.
[3] http://www.ajol.info/viewarticle.php.
[4] Sacendu Report: 15 May 2007.
[5] http://upetd.up.ac.za/thesis/submitted-University of Pretoria-Brand, CJ (2006).
[6] WHO Technical Report Series – 886. Programme for Adolescent Health & Development.

morbidity and mortality can be dramatically reduced if service delivery interventions are targeted at risk factors and determinants (primary prevention through a more focussed and integrated client-centred health promotion approach) rather than the traditional vertical curative approach. Health interventions are therefore aimed at deliberate attempts to promote healthy lifestyles, prevent illness and improve health by reducing risk, and/or the duration or severity of the health problem.

Evidence however suggests that preventative health programmes are lacking due to an increasing curative workload in health services, the high burden of disease and increased staff attrition (ranging from 22% - 48%) and shortages (particularly for the occupational categories of dieticians, nutritionists, occupational therapists, physical therapists, psychologists and counsellors[7]).

Healthy Lifestyle Programmes facilitate integrated client-centred health promotion and development programmes (taking health to the people) within the framework of health policies and National and Provincial Strategic Goals and Objectives for MTEF 2008/09.

- District autonomy is actively promoted by the development of District capacity – with functional multi-sectoral/disciplinary Health Promotion Forums established in all Districts. Forums are responsible to establish and monitor health promotion activities and outcomes.
- Documented evidence suggests that early child/adolescent health programming can help to prevent lifelong cycles of self-destructive behaviour, and mitigate the damage caused by harmful environments. It is therefore important to develop desired behaviour at early ages before undesirable behaviours become habits. Schools are the entry point of a larger community group involved in promotion of healthy lifestyles and can be the catalyst in starting such groups if none exist. In an effort to forge links between health, parents/caregivers and communities, the Department facilitates implementation of the Health Promoting Schools (HPS) Programme (*National Health priority).* A total of 153 schools (across all Districts) are included in this programme in collaboration with the Department of Education.
- The Health Promoting Clinic (HPC) Programme has been rolled out to all Districts with 20 PHC Clinics currently implementing the HPC standards and criteria.
- The Health Promoting Hospitals (HPH) Programme is gaining momentum with 14 accredited Hospitals in eight Districts.
- The five National Health 'Healthy Lifestyle' priorities i.e. nutrition, physical activity ('Vuka SA – Move for your Health campaign'), tobacco control, alcohol and drug abuse, and safe sexual practices are prioritised by all Districts in school programmes, Senior Citizens Fitness Programmes, Bringing Tobacco Legislation to KwaZulu-Natal, and public awareness days.

Approaches are based on the principle that development, opportunity and participation underlie the prevention of health problems. Programmes have the potential to contribute to attainment of the Millenium Development Goals for Health.

1.3 Communicable Disease Control (CDC)

The Province is host to the country's main industrial ports, has porous borders and is an international tourist destination, which requires highly responsive *Epidemic Preparedness Plans* and adequate resources. Routine surveillance of notifiable diseases is a key facet of services to prevent and manage outbreaks of disease.

- The Province is faced with constant challenges of communicable diseases such as TB, Cholera, Rabies, etc. Communicable Disease Surveillance and Information Systems are operational – consisting of a database for notifiable medical conditions and cholera. A laboratory surveillance system runs parallel with routine surveillance for rabies and viral haemorrhagic fever.
- Provincial and District *Emergency Response Plans and Teams* are in place, which includes a "*24-Hour Flash Reporting System*" to ensure a prompt response to suspected outbreaks. Investigation of reported outbreaks is maintained at 100% with response times of less than 24-hours.
- The Province developed an *Influenza Pandemic Preparedness Plan* in collaboration with key role players.

[7] KwaZulu-Natal, Department of Health, Annual Report 2007/08.

1.4 Chronic Diseases and Geriatric Development

Services focus on promotive and preventive approaches (including healthy living programmes), screening and early detection of disease, corrective treatment with the potential to decrease morbidity and mortality associated with chronic diseases, and rehabilitation to contribute towards improving the quality of life and ensure higher levels of productivity. Priority areas are in line with National and Provincial Strategic Objectives, and include:

- Screening programmes for early detection of cancer (e.g. breast and cervical cancer), diabetes mellitus and hypertension. Programmes emphasize compliance to treatment, improved health-seeking behaviour, and improved lifestyles.
- Established an efficient, patient-friendly service for accessing repeat/ chronic medication at PHC and facility levels. This initiative reduced the waiting times for collection of chronic medication and relieves pressure on under-resourced hospital pharmacies. PHC clinics are well advanced in the implementation of '*fast queues*' for patients collecting chronic medication.
- The *Vision 2020* (Prevention of Blindness) Programme previously focused on cataract surgery but has since expanded services to include refractive services. The Provincial cataract surgery rate increased from 7,892 in MTEF 2004/05 to 8,701 in MTEF 2006/07.[8] Community outreach programmes are providing the vehicle through which sustainable partnerships with the private sector are sustained.
- '*Sight Saver*' Hospitals (offering both Optometry and Cataract Surgery) are well established in all Districts with services being rendered in: Port Shepstone, Edendale, Greys, Northdale, Ladysmith, Dundee, Madadeni, Nkonjeni, Mosvold, Ngwelezana, Stanger, Christ the King, Rietvlei, St Aidens, IALCH, Mahatma Ghandi, and Addington Hospitals.
- One of the National Health Priorities is to make 'Low Vision' services available in one district per Province by March 2008.[9] Stanger Hospital is currently piloting a '*Low Vision Service*' that caters for the partially sighted and the blind. The highly specialised human resource package required for this service however delays roll-out to other Hospitals.
- The high prevalence of strokes in the Province (the second leading cause of death in the Province at 5.6%) necessitates the development of dedicated *Stroke Units* that will offer comprehensive recovery and rehabilitation services to limit the effects of the stroke on the quality of the patient's life. The Province identified five sites for Stroke Units and planning commenced in MTEF 2006/07 for construction. However, due to reduction in capital expenditure for the MTEF this project has been postponed.

1.5 Oral Health

Oral Health services are almost entirely curative and directed towards combating dental caries. Other conditions (oral cancer, noma, HIV infection and trauma) have been omitted in public and private oral health care and prevention services while these conditions have the greatest morbidity and mortality.

> Early detection of disease is crucial to reduce morbidity and morality. A thorough oral examination can detect signs of nutritional deficiencies as well as a number of general diseases including microbial infections, immune disorders, injuries and oral cancer

- The delivery of Oral Health Services is available in 95% of municipalities, with a high percentage of extraction services and little emphasis on conservation or any other reconstructive services.
- The Province prioritised the revitalisation of dental surgeries and the standardisation of equipment levels at all delivery points following a comprehensive oral health audit. The challenge remains to motivate Districts to allocate funding for Oral Health services. There are still major delays in the acquisition of required equipment and a lack of specialised skills to procure dental goods.
- The Province established Clinical Audit and Review Committees to monitor infection control and compliance with the National Oral Health Strategy norms and standards. Oral Hygienists monitor compliance to standards.
- The Oral Health screening programme for Grade R and Grade 1 learners is implemented in

[8] DHIS.
[9] http://www.doh.gov.za/docs/misc/booklet/index.html.

collaboration with School Health Services with ±33,000 learners screened (with appropriate referrals) during MTEF 2006/07.

- An integrated Oral Health Training Module for School Health Nurses was developed and piloted during MTEF 2006/07, and 72 School Health Nurses completed the training during the same period. District Oral Hygienists will facilitate future district training using the standard training module.

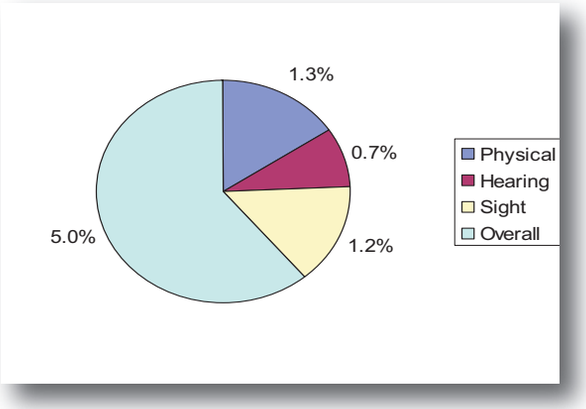
1.6 Mental Health and Substance Abuse

The New Mental Health Care Act, 002 (Act No. 17 of 2002) has resulted in a shift from traditional custodial care associated with mental health to a more patient and community orientated service. It makes provision for users to access mental health services closer to where they live.

- The STP makes provision for service delivery in line with legislative imperatives to address the needs of mental health patients with regards to the provisioning of compassionate, effective and efficient services as close as possible to the area of residence. Provision is made for *Hospital and Community Based Mental Health services* that will begin to address the inadequate bed numbers that currently fall well below the international norm.
- The addition of Umzimkhulu Hospital (Forensic Unit) to the Provincial mental health services has resulted in the streamlining of referral patterns from Sisonke and Ugu Districts, as well as providing additional forensic psychiatric services to the Province.
- The Department currently subsidises 17 Day Care Centres, 13 Residential Care Facilities and three Halfway Houses. Service Level Agreements are signed with each Facility on an annual basis.
- The Child and Adolescent Mental Health Service Infrastructure have been developed. The appointment of Specialist Child Psychiatrists is necessary to facilitate these units becoming fully operational.
- Collaboration with the Department of Psychiatry at Nelson R Mandela School of Medicine (University of KwaZulu-Natal) has resulted in the publication of a manual for common mental health disorders which is being distributed to mental health care practitioners in all Districts. The roll-out strategy for this book includes provision of training workshops for practitioners in each District.
- To facilitate integration and improve quality of care, the Department facilitated extensive mental health training and support initiatives. Human resources however remain a challenge especially skilled Mental Health Care Practitioners. This refers particularly to staff with a mental health qualification. The situation is illustrated by the by a 44% attrition rate experienced in the occupational category of psychologists and counsellors.
- The Mental Health Review Boards have had orientation workshops to sensitise them to their roles and responsibilities with regards to the new Mental Health Care Act. This will serve to enhance their contributions in the implementation of the new Act.
- The de-institutionalisation of patients in chronic care facilities is a priority. The Department is engaging with the NGO sector to expedite this process. Partnerships with the Departments of Housing and Social Welfare will play an important role in this process.
- A task team developed standard mental health indicators and a clinical audit tool to monitor and evaluate implementation of the programme within the legislative framework.
- To strengthen effective and integrated implementation of the Act, the Department embarked on the following:
  - Developed a training manual for the South African Police Service (SAPS) to ensure effective management of patients/offenders affected by mental disorders.
  - Developed a protocol for transfer of services.
  - Strengthened service delivery through provisioning and commissioning of 72-hour Assessment Units at designated Hospitals in the three management areas.
  - Halfway Houses and residential care have been identified for the development of a comprehensive strategy with community and NGOs in MTEF 2007/08.

1.7 Disability and rehabilitation

FIGURE 2: Percentage of the population affected by disability in 2001 (Source: Stats SA)



Equality and social integration of people with disabilities are prioritised and achieved through strategies such as community based rehabilitation, employment equity, and capacity development and training. The programme actively monitors the provision of free healthcare to persons with disabilities, and provides support to various activities of professional forums for Occupational Therapy, Physiotherapy, Audiology and Speech Therapy in line with the National Disability Policy and the Integrated National Disability Strategy within a Human Rights Framework.

- The Department issued 2,500 wheelchairs, 994 hearing aids, 10,408 orthotic and prosthetic devices, and 34 sets of wheelchair spares to the 17 Repair Workshops run by persons with disabilities.
- Developmental training (mobility, orientation to disability and independence) target both health personnel and persons with disabilities, while Community Health Workers (CHW) were trained on stroke and spinal care.
- MTEF 2006/07 was characterised by the programmes' success in improving access to services for persons with disabilities (PWD'S) at hospitals, clinics and within the community. This was largely due to the coverage by community service therapists and a service level agreement for community based rehabilitation.
- One or more therapy services are available in 96% of Hospitals and 50% of PHC Clinics.
- Free repair of wheelchairs continues at 21 repair sites through a service level agreement. The Disabled Employees Forum was launched and comprises of persons with disabilities employed in the department. The Forum conducted various capacity development workshops around reasonable accommodation and health and wellness.
- The Province has one step-down rehabilitation facility – Clairwood-(175 beds) located within the eThekwini Metropolitan Municipality. The main purpose of this institution is to provide 24 hour/ seven days per week short term step-down and chronic health care services to in-patients initially treated at District and Regional Hospitals and whose conditions have stabilised to such an extent that, under normal circumstances, they would have been discharged from hospital. Due to poor support at family/ community level, their stay within a supportive environment has to be extended to adequately sustain treatment gains and prevent costly relapses.
- Specialised Rehabilitation Units have also been established at Regional (R.K. Khan) and Tertiary (Grey's and IALCH) Hospitals to provide, on an out-patient basis, specialised rehabilitative care services to patients affected by strokes and patients with spinal injuries.
- Apart from the above mentioned Units, two other Specialised Rehabilitation Centres (Phoenix and Pietermaritzburg) provide specialised rehabilitation services to stroke patients. The services currently provided by the two Rehabilitation Centres are on an out-patient basis, as no infrastructure is available for medium to long term accommodation of patients. This lack of accommodation limits access from patients who do not reside near these centres.
- To address this challenge, the STP recommends that rehabilitation services provided at Community Health Centres (CHC) should be strengthened with additional support by dedicated Medical Prosthetic and Orthetic Units attached to each District Hospital.
- Clairwood (with 520 beds) is the only Step-Down Convalescent Home of this kind in the Province. The hospital receives patients on referral and is providing long term residential care to patients presenting with degenerative diseases whose condition is such that it is impossible to successfully arrange their re-integration into community and family structures.

1.8 Environmental Health

The Environmental Health Programme performs an advisory role regarding environmental matters falling within the functional domain of Local Municipalities. Such issues include water quality, food control, and waste management, health surveillance of premises, environmental pollution control, mortuary services and chemical safety.

- The required capacity to provide effective environmental health control has been addressed through organisational and post establishment arrangements for Environmental Health within the District and Head Office structures. It is anticipated that this will strengthen capacity for the control of hazardous substances, provide management and technical support, and strengthen inter-sectoral collaboration for the regulation of the management of hazardous materials in the Province.
- Port Health services at existing and future ports of entry receive the necessary attention to ensure prevention and control of the spread of disease. Readiness Plans for the 2010 FIFA Soccer World Cup are on track.
- The Provincial Environmental Health Forum and its District equivalents ensure full discussion and mutual assistance between service providers to strengthen inter-sectoral linkages.
- Training workshops on Participatory and Sanitation Transformation (PHAST) are ongoing in response to need in Sanitation Delivery Programme.

Numerous challenges were encountered in the transfer of services to District and Metropolitan Municipalities. However, a Transfer Agreement and Service Level Agreement have been developed and are being implemented.

MDGs Progress

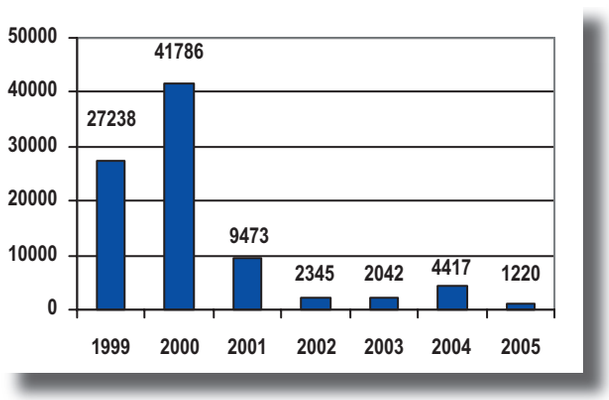
Goal 6: *Begin to decrease the spread of HIV and AIDS, malaria and other diseases*

Target 8: *Have halted by 2015, and begun to reverse the incidence of malaria and other major diseases*

• The Province continues to perform exceptionally well in reducing the malaria incidence with a reported reduction of >90% from 2000 to 2004[10]. The significant reduction of reported malaria cases and deaths has been sustained through effective implementation of the malaria control intervention programmes in Uthungulu and Umkhanyakude Districts.

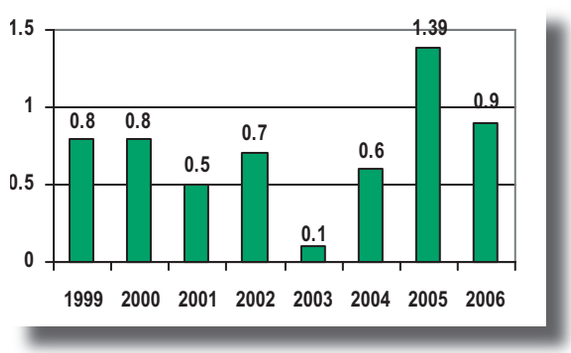
• Provincial malaria incidence in 2006/07: 1/1,000.

FIGURE 3: Malaria Cases in KwaZulu-Natal 1999 - 2005



The Provincial malaria case fatality rate was 0.9/1,000 in MTEF 2006/07 (compared to 1.39/1,000 in MTEF 2005/06) and is within the national range of 0.4/1000 anticipated for MTEF 2008/09.

FIGURE 4: Malaria Case Fatality Rates in KwaZulu-Natal 1999 - 2006



• To ensure an integrated malaria prevention programme, a task team was appointed to review key service delivery imperatives. Outputs from this task team are expected to guide the development of an integrated policy framework for the Malaria Control Programme.

[10] http://www.malaria.org.za/malaria-Risk/Update 2005html.

TABLE 1: Situation Analysis Indicators for Communicable and Non-communicable Disease Control per Health District

Indicator	Ugu 2006/07	Umgungundlovu 2006/07	Uthukela 2006/07	Umzinyathi 2006/07	Amajuba 2006/07	Zululand 2006/07	Umkhanyakude 2006/07	Uthungulu 2006/07	iLembe 2006/07	Sisonke 2006/07	eThekwini 2006/07	Natioanl Target 2006/07
Input												
Trauma centres for victims of violence (Number).	4	3	3	3	3	2	2	5	2	5	3	N/A
Health Districts with health care waste management plan implemented. (Number).	1	1	1	1	1	1	1	1	1	1	1	N/A
Hospitals providing occupational health programmes. (%)	5	10	3	4	3	7	5	8	3	7	15	80%
Schools implementing Health Promoting Schools (HPS) Programme[11] (%)	14	1	5	2	11	2	0	4	0	6	0	-
Integrated epidemic preparedness and response plans implemented. (Y/N)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Quality												
Outbreak response time (days).	<2	<2	<2	<2	<2	<2	<2	<2	<2	<2	<2	2
Outcome												
Malaria fatality rate. (%)	0	0	0	0	0	0	0.9	4.7	0	0	0	0.40%
Cholera fatality rate. (%)	0	0	0	0	0	0	0	0	0	0	0	1%
Cataract surgery rate.[12] (No)												950

[11] Districts misinterpreted indicator as launched schools.
[12] Not available per District

2 POLICIES, STRATEGIC OBJECTIVES AND PRIORITIES

2.1 Healthy Lifestyles

Policies

Healthy Lifestyle programmes are informed by all health policies and guidelines, making provision for integrated health promotion and education interventions targeting health determinants identified through health programmes and services.

Healthy Lifestyle Priorities

1. Enhanced capacity at District level to facilitate integrated and comprehensive health promotion/ education interventions at all levels of care.

2. Focussed capacity-building and monitoring of:
   - Hand washing – infection control.
   - Health promotion & education interventions targeting the care of the pregnant woman, nutrition, and HIV and TB prevention.

2.2 Communicable Disease Control

Policies

- The National Policy Guidelines on Epidemic Preparedness and Response are being implemented and monitored in the Province.
- An Influenza Pandemic Preparedness Plan has been developed in collaboration with key role players. It has been disseminated to all role players in the department.
- Guidelines for the management of Rabies and Viral Haemorrhagic Fevers have been developed and made available to all providers.
- Fact sheets and frequently asked questions for priority diseases have also been developed.

Priorities

1. Improve the communicable disease surveillance and information system.

2. Improve and expand the facility for communicable diseases reporting on the 24-hour Disaster Management Flash Reporting System.

3. Improve capacity at District level to facilitate and monitor the implementation of Provincial Plans for:
   - Influenza Epidemic and the
   - 2010 FIFA Soccer World Cup.

4. Develop and facilitate the implementation of the Provincial Influenza Epidemic Plan and planning for the 2010 FIFA Soccer World Cup.

5. Expand research on Communicable Diseases and develop capacity in research for communicable diseases control.

2.3 Chronic Diseases and Geriatric Development

Policies

A specialist advisory group was established to develop a policy framework and guidelines for Chronic Diseases and Geriatric Development – work has commenced in MTEF 2007/08.

Chronic Diseases and Geriatric Development

Priorities

1. Increase the Provincial cataract surgery rate in collaboration with private partners.
2. Expand the provision of Low Vision services at all Sight Saver Centres.
3. Improve implementation of fast queues at PHC level.
4. Strengthen Family Medicine practice at District Offices to support and provide clinical governance for effective and efficient management of chronic diseases at all levels of care.
5. Promote the implementation of decentralised strategies to facilitate chronic medicine compliance and control through integrated Health Promotion.

2.4 Oral Health

Policies

The Provincial Oral Health Strategy has been developed, approved and disseminated to ensure implementation. This strategy will address the re-focus of oral health services to a more comprehensive and integrated services.

Oral Health Priorities

1. Implementation of strategies to promote drinking water fluoridation.
2. Facilitate and monitor the implementation of mechanisms to reduce the extraction to restoration ratio.

2.5 Mental Health and Substance Abuse

Policies

- The Provincial Mental Health Rehabilitation Policy Framework was developed for dissemination and implementation. The policy addresses rehabilitation in Hospitals, as well as the establishment of community based structures for the support and rehabilitation of mental health users after discharge from institutions.
- A Policy on Mental Health Information Systems was developed during consultations with an integrated Mental Health Task Team. The policy will address information challenges identified during an audit conducted in MTEF 2006/07 to ensure effective monitoring and evaluation of the restructured mental health services.

Mental Health & Substance Abuse Priorities

1. Facilitate and monitor implementation of the Mental Health Care Act of 2002.
2. Facilitate and monitor implementation of decentralised Mental Health Services based on imperatives set in the STP.
3. Develop and implement policies and guidelines on substance abuse, violence prevention, psychosocial rehabilitation and suicide.
4. Develop and monitor implementation of integrated strategies for prevention of violence against women and children.

2.6 Disability and Rehabilitation

Policies

The Programme is guided by National and Provincial Policy imperatives in facilitating the delivery of disability and rehabilitation services as well as the development of persons with disabilities within a human rights framework. As part of the alignment of the role of Head Office Components, the development of an integrated policy framework for the delivery of services to disabled persons at a Provincial Level is being initiated.

Disability and Rehabilitation Priorities

1. Provide Provincial policy guidelines to support Institutions.
2. Facilitate processes to strengthen the provisioning of rehabilitation and other services to disabled persons at PHC level.
3. Develop and facilitate innovative solutions to address the backlog in the provisioning of assistive devices to qualifying patients.
4. To facilitate capacity building in health care workers and persons with disabilities around rehabilitation and disability issues.
5. Facilitate the implementation of the Strategy to Prevent Disability in the Province.

Environmental Health

Priorities

1. Develop and facilitate the implementation of a policy framework enabling the monitoring and evaluation of environmental health service delivery by Local Municipalities.
2. Establish mechanisms for the development of hazardous substance control programmes.
3. Provide technical support to Districts to strengthen vector control.
4. Develop and maintain an Environmental Health Management Information System.
5. Develop a Readiness Plan for the provisioning of Port Health services during the 2010 FIFA Soccer World Cup.
6. Develop and facilitate the adoption of a policy framework to regulate the provisioning of service by private entities such as Funeral Undertakers.

2.7 Environmental Health

Policies

The Department is implementing the National Government Policy to transfer assigned functions to District Municipalities. A Provincial policy framework dealing with the competencies assigned to the Provincial level of government must still be developed.

2010 Preparedness

1. Strengthen port health services including airport & marine health and land ports.
2. Accreditation of formal/informal food vendors & inspection of food outlets.
3. Regular testing of water.

PRIORITIES AND STRATEGIC OBJECTIVES

The following strategic objective, measurable objectives and indicators for the Infrastructure and Clinical Support Services Unit are indicated in the diagram below.

TABLE 2: Analysis of Constraints and Measures Planned To Overcome Them
Healthy Lifestyles

System Priority	Constraints	Planned Remedial Interventions
Improve Quality of Care.	▪ Health promoting programme has poor accountability and responsibility as the onus rests on a number of different units for implementation, leading to poor integration of functions.	▪ The Programme requires an appointment of a coordinator to assume responsibility for the integration and performance of the Programme.
	▪ The implementation of the Health Literacy Programmes is negatively affected by “silo arrangements” and lack of distribution arrangements for IEC material.	▪ District Health Promotion Resource Centres will be established to strengthen distribution and availability of IEC materials and resources to the public.

Constraints		
Strengthen Human Resources.	▪ Lack of adequate capacity at District level to conduct epidemiological investigations, outbreaks and scientific reporting.	▪ Intensify training programmes at district level. ▪ Utilise telemedicine to fast track staff development.
	▪ Lack of capacity at provincial level to provide strategic guidance, policy, systems and monitoring functions.	▪ Implement the approved new structure for Head Office through the recruitment and appointment of adequately skilled staff.
Improve Quality of Care.	▪ Poor reporting of notifiable conditions.	▪ Clarification of the roles and responsibilities of Health Workers and Managers in data collection, data analysis and reporting.

Chronic Diseases and Geriatric Care

System Priority	Constraints	Planned Remedial Interventions
Strengthen Human Resources.	▪ Shortage of Surgeons to perform cataract operations.	▪ Establish partnerships with other health care providers and humanitarian organisations to address the backlog whilst internal capacity is developed through the training of surgeons.
	▪ Insufficient human resources to provide Geriatric services.	▪ Create dedicated capacity at tertiary level to assist with the development of Geriatric Treatment Protocols. ▪ Develop skills at Hospital and PHC levels through 'out-reach programmes.'
Strengthen Physical Infrastructure.	▪ Shortage of medical technology to perform cataract surgery.	▪ Provide technical support to institutions for allocation of relevant resources to address the backlog of surgery.
Improve Quality of Care.	▪ Limited availability of influenza vaccine for vulnerable people.	▪ Develop and circulate a policy regarding the provision of vaccines to vulnerable people, and monitor and evaluate progress.

Oral Health

System Priority	Constraints	Planned Remedial Interventions
Strengthen Physical Infrastructure.	Upgrade and revitalise Oral Health Facilities in all districts. ▪ Lack of dedicated ring-fenced budget for dental clinics at Institutional level.	▪ Assist districts to motivate for budget and provide technical assistance to upgrade facilities.
Quality of Care.	Improve access to Oral Health Care package. ▪ Services are delivered by Regional Hospitals where a fee is levied.	▪ Relocate Oral Health service to gateway clinics and CHC's.
Quality of Care.	Promote drinking water fluoridation. ▪ Delay in publication of Regulations. ▪ Anti-fluoridation lobby.	▪ Promote benefits of drinking water fluoridation.
Quality of Care.	Decrease the number of teeth extracted and increase the number of teeth filled (i.e. restoration). ▪ Lack of equipment and consumables. ▪ Lack of human resources.	▪ Promote the benefits of the retention of natural dentition. ▪ Increase the number of Oral Health personnel employed.

Mental Health and Substance Abuse

System Priority	Constraints	Planned Remedial Interventions
Strengthen Human Resources.	▪ Staff attrition resulting in decrease of skilled staff for training and facilitation.	▪ Retention strategies to retain suitably qualified staff (in conjunction with human resources). ▪ Ongoing training & development.
Strengthen Physical Resources.	▪ Budgetary constraints for infrastructure development.	▪ Motivation for improved budget allocation.
Strengthen Physical Resources	▪ Lack of halfway houses and residential care facilities.	▪ Collaboration with Departments of Housing, Social Welfare, and NGO's.
Improve Quality of Care.	▪ Fragmented approach by all stakeholders resulting in divided efforts with minimal impact.	▪ Improve collaboration with all stakeholders viz SANCA, SACENDU, KwaZulu-Natal Substance Abuse Forum, SAPS, and Department of Social Welfare.

Disability and Rehabilitation

System Priority	Constraints	Planned Remedial Interventions
Strengthen Human Resources.	▪ Poor recruitment and retention of human resources.	▪ STP (including Human Resource Plan) to make provision for recruitment, selection, and retention through financial and non-financial incentives including adequate space, equipment and transport.
Strengthen Physical Infrastructure.	▪ Limited physical space and equipment for treatment at various therapy sites and lack of transport for outreach services.	
Strengthen Physical Infrastructure.	▪ The majority of hospitals in the Province are not fully accessible for persons with disabilities and poor priority is given in ensuring even the minimum criteria are met.	▪ Work with the National Department of Health to conduct yearly audits on accessibility and encourage Managers and Rehabilitation Co-ordinators to engage with facilities in planning, infrastructure development and hospital revitalisation programmes to facilitate physical access and apply minimum norms and standards for access as per guidelines.
Improve Quality of Care.	▪ Poor priority by Managers resulting in limited resource allocation for assistive devices.	▪ Database to monitor status on needs and provision of assistive devices, consumables and accessories. Monitor waiting period for issue of assistive devices.
Strengthen Human Resources.	▪ Limited capacity and training for lower levels of health care workers and persons with disabilities in disability and rehabilitation issues.	▪ Database to reflect capacity building and training of health and other personnel e.g. sign language and community based rehabilitation.
Improve Quality of Care.	▪ Awareness creation and prevention of disability activities are limited as health information need to be in the correct medium.	▪ Prioritize Braille information on HIV and AIDS for blind persons. Prioritize sign language training.
Strengthen Human Resources.	▪ No information is being collected on the DHIS on access to disability.	▪ Minimum data on persons referred to and accessing disability and rehabilitation service including persons eligible for Free Health Care.
Strengthen Human Resources.	▪ Poor compliance with the Employment Equity Act requirements and persons with disabilities employed in the Department are not adequately and reasonably accommodated.	▪ Monitor compliance with Employment Equity Act. Through the Disabled Employees Forum – lobby and advocate with institutions to ensure reasonable accommodation measures are met.

Environmental Health

System Priority	Constraints	Planned Remedial Interventions
Improve Quality of Care.	▪ Lack regulatory framework for the rendering and control of services, service providers, and the public.	▪ Finalisation and promulgation of Regulations.
	▪ Inadequate funding for Environmental Health Services allocated to District Municipalities.	▪ Consultation meetings with stakeholders to assist reprioritising/ new input processes.

TABLE 3: Provincial Objectives and Performance Indicators for Communicable and Non-Communicable Diseases

Indicator	2006/07 (Actual)	2007/08 (Estimate)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
COMMUNICABLE DISEASES					
Strategic Objective: To ensure the effective implementation of programmes to reduce Non-Communicable & Communicable Diseases and diseases of lifestyle.					
Measurable Objective: To reduce morbidity and mortality due to Communicable Diseases.					
Outbreak response t ime.	<1 day	<1 day	<1 day	<1 day	<1 day
Malaria fatality rate.	1%	0.5%	0.5%	0.5%	0.5%
Cholera fatality rate.	<1%	<1%	<1%	<1%	<1%
Percentage of Districts implementing surveillance system.	100%	100%	100%	100%	100%
Number of Facilities implementing the Diarrhoea Programme.	70%	70%	80%	85%	90%
Number of Districts implementing the Disaster Management Flash Reporting System	11	11	11	11	11
CHRONIC DISEASES AND GERIATRIC CARE					
Strategic Objective: To ensure the effective implementation of programmes to reduce Non-Communicable & Communicable Diseases and diseases of lifestyle.					
Measurable Objective: To implement the comprehensive programme for Chronic Diseases & Geriatrics					
Cataract surgery rate.	6,188	11,112	13,000	14,100	15,000
Percentage of Facilities providing flu vaccine for older persons.	75%	80%	100%	100%	100%
Number of Districts with Low Vision services.	1	1	2	3	4
Percentage of PHC Clinics with fast queues for chronic medicine collection.	50%	54%	100%	100%	100%

Indicator	2006/07 (Actual)	2007/08 (Estimate)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
DISABILITY AND REHABILITATION					
Strategic Objective: To ensure the effective implementation of programmes to reduce Non-Communicable & Communicable Diseases and diseases of lifestyle.					
Measurable Objective: To implement and sustain an integrated disability and rehabilitation strategy.					
Number of diagnostic Audiology Clinics		15	24	28	30
Percentage of facilities with appropriate access for persons with disabilities.		60%	80%	90%	100%
Percentage of PHC facilities with health promotion materials in Braille and audiotape.		40%	60%	70%	80%
Service Level Agreements with external support organisations approval and operational		5	10	15	20
Number of Health Workers trained to use sign language to communicate with the deaf.		100	300	350	400
Percentage of Therapists trained, identify and administer the “Free Health Service System”.		40%	75%	85%	90%
HEALTHY LIFESTYLES					
Strategic Objective: To ensure the effective implementation of programmes to reduce Non-Communicable & Communicable Diseases and diseases of lifestyle.					
Measurable Objective: To implement integrated health promotion and healthy lifestyle programmes.					
Number of schools accredited as Health Promotion Schools (HPS)	150	165	200	230	250
Number of accredited Health Promoting Clinics.	0	In pilot phase	1/ Districts (11)	22	33
Number of Health Promoting Homes implemented and supported	0	In pilot phase	10	20	30

Indicator	2006/07 (Actual)	2007/08 (Estimate)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
ORAL HEALTH					
Strategic Objective: To ensure the effective implementation of programmes to reduce Non-Communicable & Communicable Diseases and diseases of lifestyle.					
Measurable Objective: To re-orientate Oral Health services from a curative to a preventive approach.					
Number of Municipalities with Oral Health Services.	85%	90%	95%	98%	98%
Restoration to extraction ratio.	31:1	30:1	25:1	24:1	23:1
Numbers of schools with a 'brushing" programme.	100%	100%	100%	100%	100%
Percentages of Facilities with the standard package of Dental equipment.	50%	50%	75%	80%	85%
MENTAL HEALTH					
Strategic Objective: To ensure the effective implementation of programmes to reduce Non-Communicable & Communicable Diseases and diseases of lifestyle.					
Measurable Objective: To operationalise the imperatives set by the Mental Health Act, 2002.					
Percentage of Hospitals providing designated package of service.	80%	85%	100%	100%	100%
Percentage of District Hospitals providing a 72-hour assessment service.	80%	85%	100%	100%	100%
Percentage of PHC Nurses trained in Mental Health Protocols.	60%	80%	100%	100%	100%
Number of institutions providing detoxifying services.	85%	90%	100%	100%	100%
Percentage of Districts with community initiatives for the prevention of substance abuse.	25%	30%	100% (11 Districts)	100%	100%
Percentage of planned Child and Adolescent services operational.	0%	50%	100%	100%	100%

TABLE 4: Performance Indicators for Communicable and Non-Communicable Diseases

INDICATOR	TYPE	2006/07 (Actual)	2007/08 (Estimate)	2008/09 (Target)	2009/10 (Target)	20010/11 (Target)	National Target 2007/08
Input							
Number of Trauma Centres for victims of violence.	No	34	36	37	38	39	1 per District (11)
Output							
Health Districts with health care waste management plan implemented.	No	11	11	11	11	11	All Districts(11)
Hospitals providing Occupational Health Programmes.	%	100%	100%	100%	100%	100%	100%
Schools implementing Health Promoting Schools (HPS) Programme.	No	150	165	200	230	250	-
Integrated Epidemic Preparedness and Response Plans.	Y/N	Yes	Yes	Yes	Yes	Yes	Yes
Quality							
Outbreak response time.	Days	1 day	1 day	1 day	1 day	1 day	1 day
Outcome							
Malaria fatality rate.	No	1%	0,5%	0,5%	0.3%	0.2%	0.25%
Cholera fatality rate.	No	<1%	<1%	<1%	<1%	<1%	0.5
Cataract surgery rate.	No	6,188	11,112	13,000	14,100	15,000	1,000

HEALTH
KwaZulu-Natal

ANNEXURE 7

PROGRAMME 3 : EMERGENCY MEDICAL RESCUE SERVICES

MTEF PERIOD 2008/09 – 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

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PROGRAMME DESCRIPTION

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

PROGRAMME STRUCTURE

Sub-Programme 3.1
Emergency Patient Transport (EPT)

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

Sub-Programme 3.2
Planned Patient Transport (PPT)

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

Sub-Programme 3.3
Disaster Management

Pre-and in-hospital mass casualty incident management. Conducts surveillance and facilitates 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.

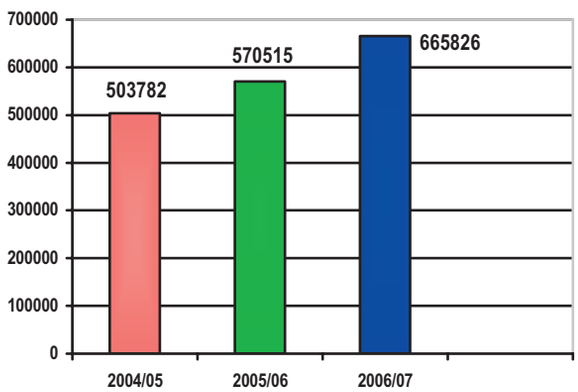
1. SITUATIONAL ANALYSIS

1.1 Emergency Medical Rescue Services

In MTEF 2006/07 the District Control Centres captured 665,826 calls through the toll-free number, and of this total, 506,028 patients were treated and evacuated to Hospitals.

The workload steadily increased over the years, (as evidenced in Figure 1) influencing the demand curve for funding which is currently indirectly proportional to national norms for the appointment of staff and purchase of ambulances, including Support Units.

FIGURE 1: Calls Captured: 2004/05 – 2006/07[1]



There are currently 241 rostered ambulances which translate to 25% of the target in the 2005 – 2009/10 Provincial Strategic Plan. The gap between demand and available resources is clearly demonstrated in response times to calls. An average of 38% urban 'code red' calls are attended to within 15 minutes and an average of 47% rural 'code red' calls within 40 minutes. An average of 58.5% of calls are attended to within 60 minutes of receiving the call.

Response times in the Presidential Rural Nodes are in line with the response times in other Districts, with the exception of Umzimkhulu where extended waiting times of approximately 249min are still reported.

The Department purchased 150 ambulances and 37 support units to complement their fleet which includes both replacement and expansion. This addition to the fleet contributes to the improvement of response times and the reduction in downtime for service and repairs.

EMRS entered into a three year contract with Air Medical Services (Aero Medical Services), with EMRS operating two helicopters and one fixed wing (one helicopter and fixed wing are based at Durban International and the other helicopter is based at Richards Bay). This service has made a positive impact in long distance transfers especially with pregnant women, new-born babies and children, and again with primary response to critically injured patients where there are no advanced life support personnel. EMRS is planning to expand to three helicopters towards 2010.

[1] Call Centre – KwaZulu-Natal Department of Health.

EMRS Learnership/ Scholarship Programme

The KwaZulu-Natal College of Emergency Care is accredited to provide the Advanced Certificate: Emergency Care and Technology. This registered course is the accepted Mid Level Worker (MLW) course for the pre-hospital emergency care profession.

The aim is to increase the learners to 200 learners per annum in MTEF 2009/10. The first 50 learner's commenced training in MTEF 2006/07. As from MTEF 2008/09, school leavers pursuing a career in emergency services will be able to enrol for this course.

The new recruit training programme (job creation/ poverty alleviation programme) is successful with 200 previously unemployed individuals now qualified and employed by the KwaZulu-Natal Department of Health.

During MTEF 2006/07 the Unit recruited 575 Emergency Care Practitioners and trained 50 students as part of a development project, with the primary target group being women from disadvantaged communities. The project commenced in May 2006 and proceeded relatively well with Phase 3 being implemented in MTEF 2007/08. Ongoing training in the form of Continuous Medical Education is carried out to ensure best practices are adhered to. The EMRS College (Indumiso College of Education) will be active in January 2008 therefore increasing training capacity.

Case Profile of EMRS – 2006/07

- 61% Medical Cases
- 8% Motor Vehicle Collisions
- 14% Assault Cases
- 12% Other e.g. domestic accidents, industrial
- accidents, etc.

1.2 Planned Patient Transport (PPT)

Sound progress has been made with implementation of the PPT Programme. All Districts are implementing Hospital to Hospital PPT with an average of 65,991 patients transported per month. The transport of patients from PHC Clinics to CHCs and from PHC Clinics to Hospitals is gradually implemented due to the constraints in funding for staff and vehicles. PPT is currently provided at 20% of PHC Clinics.

The establishment of halfway-houses is subject to the creation and filling of PPT posts in line with Districts' expansion plans. The priority/ target for MTEF 2007/08 is to have 393 ambulances and 1,920 Emergency Care Practitioners. The Department created 600 new posts towards readiness for the 2010 FIFA Soccer World Cup.

1.3 Disaster Management

In terms of Section 28 of the Disaster Management Act (Act No 57 of 2002), Provincial Departments must establish and implement a framework for disaster management. This implies that the Department of Health must have the capacity to contribute to the prevention, mitigation, management and rehabilitation of public health consequences of disasters and establish linkages with other disaster management agencies. Section 25 (g) of the National Health Act (No. 61 of 2003) further requires the Department of Health to co-ordinate health and medical services during provincial disasters and confers this responsibility to Provincial Departments.

There are acting Disaster Coordinators at Provincial and District levels to assist the Provincial Disaster Manager. In the Districts, disaster management functions are performed by District Disaster Coordinators as a secondary function. This arrangement has been functional since 2005 and is not effective due to the primary responsibilities performed by these coordinators in their respective EMRS districts. It is in this regard that the structure for disaster management is currently under review to ensure effective allocation of resources and to support the 2010 FIFA Soccer World Cup preparations for the Department of Health.

TABLE 1: (EMS 3) Situation Analysis Indicators for EMRS and Patient Transport

Indicator	Type	Province 2002/03 Actual	Province 2003/04 Actual	Province 2004/05 Actual	Province 2005/06 Actual	Province 2006/07 Actual	Province 2007/08 Estimate	Province 2008/09 Target	National Target 2003/04
Input									
1. Total rostered ambulances.	No					207	241	399[2]	–
2. Rostered Ambulances per 1 000 people.[2]	No					0,02	0,02	0.04	0.8
3. Hospitals with patient transporters.	%	–	100%	79%	100%	100%	100%	100%	70%
Process									
4. Kilometres travelled per ambulance (per annum).	Km	143,980	144,204	143,404	145,320	–	99,569	298,626	–
5. Total kilometres travelled by all ambulances.	Km	–	–	–	–	–	23,032,335	71,968,866	–
6. Locally based staff with training in BLS (BAA).	%	41.3%	44.3%	53.7%	69%	75%	75%	80%	59%
7. Locally based staff with training in ILS (AEA).	%	52.2%	51%	50.7%	26%	20%	25%	30%	29%
8. Locally based staff with training in ALS (Paramedics).	%	4.4%	5.7%	5.6%	5%	5%	5%	7%	15%
Quality									
9. P1 (red calls) with a response of < 15 minutes in urban areas.	%	39.5%	40.75%	40.50%	40.75%	50%	38%	60%	50%
10. (P1 Red Calls) with a response of < 40 minutes in rural areas.	%	37.7%	38.15%	38.75%	39.25%	50%	37%	60%	50%

[2] The Department is planning to purchase an additional 230 ambulances, but at least 30% of these ambulances will replace the existing number of rostered ambulances. The definition for determining the number of rostered ambulances per 1000 people needs to be clarified.

[3] The ratio has been calculated using uninsured population. The low target for rostered ambulances per 1000 population supports the need for more ambulances to be purchased by the Province.

Indicator	Type	Province 2002/03 Actual	Province 2003/04 Actual	Province 2004/05 Actual	Province 2005/06 Actual	Province 2006/07 Actual	Province 2007/08 Estimate	Province 2008/09 Target	National Target 2003/04
11. All calls with a response time within 60 minutes.	%	–	–	–	–	27.4%	58.5%	–	–
12. Percentage of operational rostered ambulances.	%	–	–	–	–	0%	0%	–	1.8%
Efficiency									
13. Ambulance journeys used for hospital transfers.	%	5.8%	3.14%	3.53%	3.20%	0%	0%		30%
14. Green code patients transported by ambulance.	%	34%	33.75%	33%	20.25%	20%	15%	15%	–
15. Cost per patient transported by ambulance (Not actual cost but tariff changed in terms of the model).	R	R 350	R 461	R 507	R 558	–	–	–	–
16Ambulances with less than 200 000 km on the odometer.	No	–	326	380	526	595	796	896	–
Output									
17. Patients transported (by PTS) per 1,000 separations.	No	–	49	55	60	65	– [4]	–	50

[4] Not yet planned

TABLE 2: (EMS 1) Situation Analysis Indicators for EMRS and Patient Transport per Health District

Indicator	Type	Ugu 2006/07	Umgungundlovu 2006/07	Uthukela 2006/07	Umzinyathi 2006/07	Amajuba 2006/07	Zululand 2006/07	Umkhanyakude 2006/07	Uthungulu 2006/07	iLembe 2006/07	Sisonke 2006/07	eThekwini 2006/07
Input												
1. Total rostered ambulances.	No	18	22	17	14	15	24	15	21	14	15	32
2. Rostered Ambulances per 1 000[5] people .	No	0.02	0.02	0.03	0.03	0.03	0.03	0.02	0.02	0.02	0.03	0.01
3. Hospitals with patient transporters (refer to Hospital coverage).	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Process												
4. Kilometres travelled per ambulance (per annum).	Kms	234, 242	208,618	161,179	230,140	141,535	244, 686	282,107	198,747	175,480	208,373	232,887
5. Total kilometres travelled by all ambulances.	Kms	234,242	208,618	161,179	230,140	141,535	244,686	282,107	198,747	175,480	208,373	232,887
6. Locally based staff with training in BLS (BAA).	%	37.7%	49%	39%	58%	65.3%	76.8%	83.6%	71.8%	33.3%	57%	36%
7. Locally based staff with training in ILS (AEA).	%	55.2%	41%	55%	36.4%	30.6%	23.2%	15.3%	25%	60%	38.3%	58%
8. Locally based staff with training in ALS (Paramedics).	%	7%	10%	5.3%	5.6%	4.1%	0%	1.02%	3.2%	7%	5%	6.2%
Quality												
9. (P1 Red Calls) with a response of < 15 minutes in urban areas	%	10.4%	28.6%	8.21%	12.31%	20.10%	8.31%	0	7.2%	12.0%	0	50.3%
10. (P1 Red Calls) with a response of < 40 minutes in rural areas.	%	16.5%	11.1%	11.6%	9.2%	6.2%	8.1%	4.8%	6.6%	16.8%	14.7%	7.2%
11. All calls with a response time within 60 minutes.	%	39.0%	25.5%	39.5%	49.0%	41.5%	39.5%	38.7%	39.0%	35.5%	39.0%	24.5%

[5] The ratio has been calculated using uninsured population.

Indicator	Type	Ugu 2006/07	Umgungundlovu 2006/07	Uthukela 2006/07	Umzinyathi 2006/07	Amajuba 2006/07	Zululand 2006/07	Umkhanyakude 2006/07	Uthungulu 2006/07	iLembe 2006/07	Sisonke 2006/07	eThekwini 2006/07
12. Percentage of operational rostered ambulances with single person crews.	%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Efficiency												
13. Ambulance journeys used for hospital transfers.	%	3%	2%	2%	2%	2%	1%	6%	4%	4%	9%	8%
14. Green code patients transported by ambulance.	%	11,847	19,373	9,920	7,254	4,292	8,098	4,101	9,821	11,492	7,251	44,289
15. Cost per patient transported by ambulance.	R	–	–	–	–	–	–	–	–	–	–	–
16. Ambulances with less than 200 000 km on the odometer.	%	42%	66%	33%	43%	34%	41%	44%	40%	42%	40%	100%
Output												
17. Patients transported (by PTS) per 1 000 separations.	No	1.3	0.05	0	2.3	1.1	1.2	3.07	1.07	0	3.08	1.2

2. POLICIES, STRATEGIC OBJECTIVES AND PRIORITIES

2.1 EMRS

Policies

Existing policies guide the improvement of EMRS services, PPT and aero-medical services, and improve the quality of care.

EMRS Priorities

1. Implementation of the Operational Plan for the 2010 FIFA Soccer World Cup.
2. Procurement of additional ambulances to comply with the norm of 1:10,000.
3. Provisioning for vehicle replacement in the annual procurement plans.
4. Expanding Planned Patient Transport to comply with District referral protocols.
5. Enhance service delivery and efficiency of the "Call Centre".
6. Expanding to a 3-rotor wing aircraft, one being a twin engine.

MTEF	Recruitment	Vehicles
2007/08	Emergency Care Practitioners: **1,920**	Ambulances: **393**
2008/09	Emergency Care Practitioners: **3,200**	Ambulances: **515**

2.2 DISASTER MANAGEMENT

Policy

In terms of Section 28 of the Disaster Management Act (57 of 2002), provincial organs of state must establish and implement a framework for disaster management. This implies that the Department of Health must possess the capacity to contribute to the prevention, mitigation, management and rehabilitation of the public health consequences of disasters and establish linkages with other disaster management agencies.

Section 25 (g) of the National Health Act (No. 61 of 2003) further requires the Department of Health to co-ordinate health and medical services during provincial disasters and confers this responsibility to provincial departments.

The Policy for Disaster Management was approved in November 2005. The policy set the tone for the implementation of disaster management programs in the department.

The integrated Policy on the Comprehensive Management of Public Health Disasters was submitted for approval in April 2007.

Disaster Management Priorities

1. Establish Provincial and District capacity to deal with health related disaster management issues.
2. Improve disaster risk management.
3. Integrate guidelines for disaster management into service delivery plans.
4. Sustain and monitor early warning systems and emergency preparedness.

ANNEXURE 7

STRATEGIC OBJECTIVES AND PRIORITIES

The strategic objectives, measurable objectives and indicators for EMRS are contained in the following diagram.

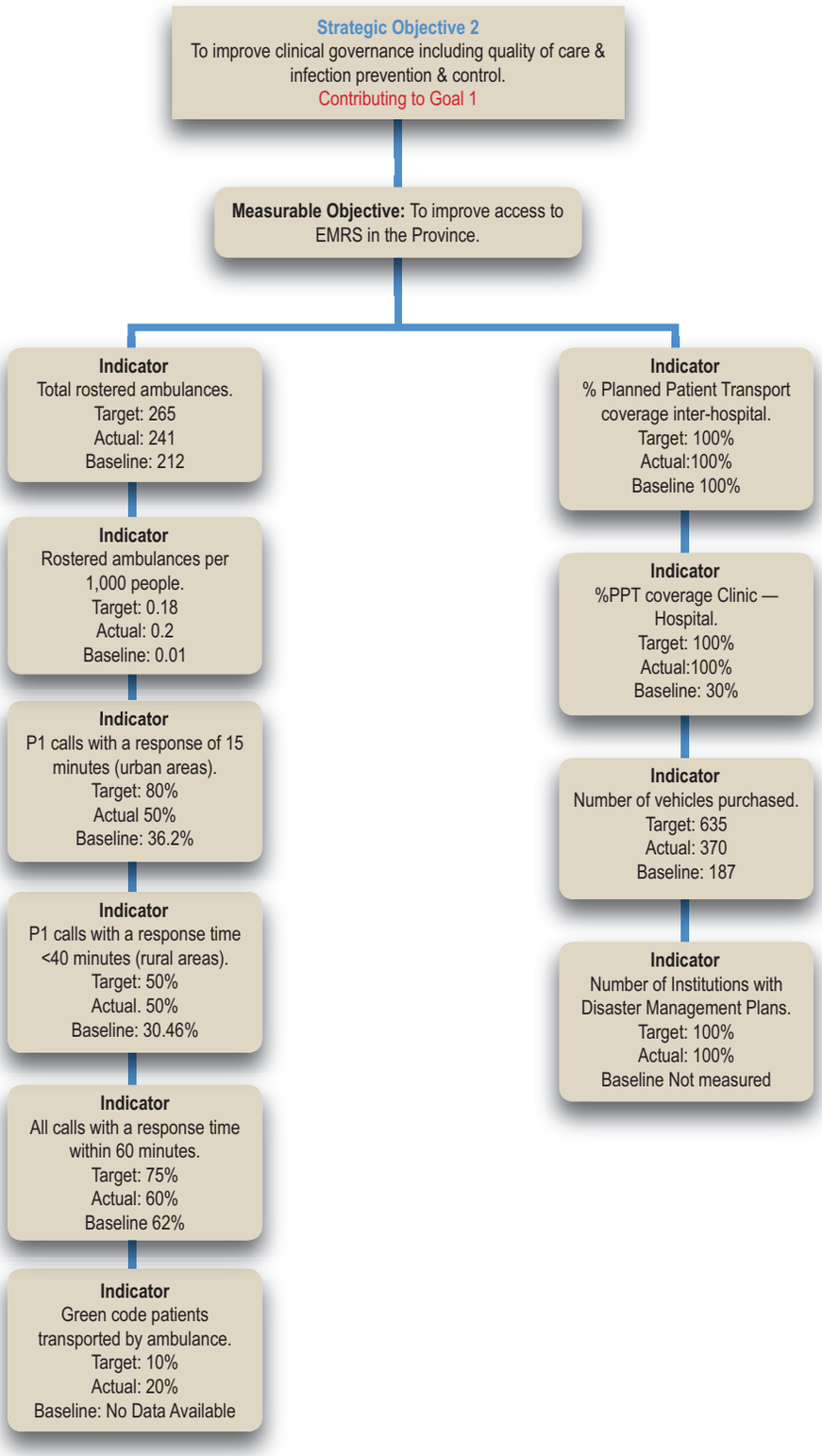


TABLE 3: (NHS 3) Quality of Care

Improved quality of care in the restructured service platform is essential to the delivery of the required outcomes and the Provincial Department of Health Vision and Mission.

Activity	Indicators	2006/07 (Target)	2007/08 (Target)	2008/09 (Target)	Responsibility
Improving access to services.	Transport systems.	10% Increase in Planned Patient Transport fleet deployed.	25% Increase in Planned Patient Transport fleet deployed.	50% Increase in Planned Patient Transport fleet deployed	EMRS District Managers
		10% Increase in EMRS road ambulance fleet deployed.	25% Increase in EMS road ambulance fleet deployed.	50% Increase in EMRS road ambulance fleet deployed	EMRS District Managers
		Flying Doctor services started or SLA effected.	Operational.	Operational.	EMRS Component at Head Office.
		Air EMS service expanded and SLA effected.	SLA signed and effected Provincially.	SLA signed and effected Provincially.	EMRS Component at Head Office.
		Private Sector agreements in place for patient referrals.	No agreements are in place. The Department will review this and agreements will be entered into with RTI and the major role-players in the private sector. Specific targets will be set in 2008/09.	No agreements are in place. The Department will review this and agreements will be entered into with RTI and the major role-players in the private sector. Specific targets will be set in 2008/09.	EMRS Component at Head Office.

TABLE 4: (EMS 2) Provincial Objectives and Performance Indicators for EMRS and Patient Transport

Indicators	2006/07 (Target)	2007/08 (Estimate)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Strategic Objective: To improve Clinical Governance including quality of care and Infection Prevention and Control.					
Measurable Objective: To improve access to Emergency Medical Rescue Services (EMRS) in the Province.					
Total rostered ambulances.	212	241	265	399	515
Rostered ambulances per 1,000 people.[6]	0.02	0.02	0.02	0.04	0.05
P1 calls with a response of 15 minutes (urban areas).	36.2%	50%	80%	85%	90%
P1 calls with a response time <40 minutes (rural areas).	30.46%	50%	50%	55%	60%
All calls with a response time within 60 minutes.	62%	60%	75%	80%	85%
Green code patients transported by ambulance.	–	20%	10%	9%	8%
Percentage Planned Patient Transport coverage inter-Hospital.	100%	100%	100%	100%	100%
Percentage Planned Patient Transport coverage Clinic-Hospital	30%	100%	100%	100%	100%
Number of vehicles purchased.	150 ESV 37 Support Vehicles	288 ESV 60 Support Vehicles 22 PPT	515 ESV 79 Support Vehicles 41 PPT	–	–
Number of Institutions with Disaster Management Plans.	Not Measured	100%	100%	100%	100%

[6] The ratio has been calculated using the uninsured population.

TABLE 5: EMRS Training Courses

TRAINING COURSES									
COURSE NAME	NUMBER OF COURSES			INPUT			EXPECTED OUTPUT		
	2007/8	2008/9	2009/10	2007/8	2008/ 9	2009/10	2007/8	2008/9	2009/10
1. BLS (based on 93% pass rate).	3	3	3	150	150	150	140	140	140
2. BLS (based on 70% pass rate).	4	5	5	96	120	120	67	84	84
3. BLS (based on 70% pass rate).	1	1	1	24	24	24	16	16	16
4. Mid-level qualification (2 year duration) (This is a new course therefore expected output is reflected in MTEF 2008/09).	1	1	1	50	100	150	Nil	45	90
5. EMD (based on 93% pass rate).	20	20	20	240	240	240	223	223	223
6. BLS refresher.	200	220	240	80% of all BLS to attend a Course	80% of all BLS to attend a Course	80% of all BLS to attend a Course	95% ”pass rate”	95% “pass rate”	95% “pass rate”
7. ILS refresher.	100	120	140	80% of all ILS to attend a Course	80% of all ILS to attend a Course	80% of all ILS to attend a Course	95% ”pass rate”	95% ”pass rate”	95% ”pass rate”
8. ALS refresher.	5	10	10	80% of all ALS to attend a Course	80% of all ALS to attend a Course	80% of all ALS to attend a Course	100% ”pass rate”	100% ”pass rate”	100% ”pass rate”
9. Basic Medical Rescue (based on 90% pass rate).	10	10	10	120	120	120	108	108	108
10. Aviation Health Care provider (based on 70% pass rate).	2	2	2	30	30	30	21	21	21
11. Advanced Driver Training.	20	50	50	80	200	200	72	190	190
12. Defensive Driver Training.	300	300	300	3000	3000	3000	All operational staff to maintain emergency driving proficiency.		

TABLE 6: Analysis of Constraints and Measures Planned to Overcome Them

EMRS

Priority	Constraints	Planned Remedial Actions
Emergency Transport and Planned Patient Transport.	Staff shortage.	Upgrading ALS salary level as part of the retention strategy.
	Vehicles cover long distances which contribute to the down time of the ESVs.	Increased budget allocation for fleet replacement and expansion.
	Poor road infrastructure.	Improved integration and consultation with Department of Transport and Roads.
	Customisation of PPT vehicles (buses).	Awaiting suppliers to provide appropriate vehicles specification to convert buses. PPT busses still to be procured with the rest of the fleet.
	Non – emergency patients transported by ambulance.	Approval of PPT structure.
	The acquisition of customised buildings and staff accommodation.	Department of Works in the process of locating premises.
	Shortage of ALS operational and College of Emergency Care.	First recruitments commenced training (50 students). District motivation for creation of ECP posts for the 2007/08 – 2008/09 financial year.

DISASTER MANAGEMENT

Priority	Constraints	Planned Remedial Actions
Integrated institutional capacity.	Creation of disaster management structures at all levels.	Address delay in approval of policy, and budget allocation for procurement of services and equipment for disaster management.
Strengthening the capacity of Disaster Management Committees.	Inadequate dedicated human resources to monitor and evaluate the District Disaster Management Committees. Lack of understanding re roles and responsibilities of disaster management stakeholders at all levels.	Develop terms of reference for Disaster Management Committees. Develop protocols and procedures for all role players in disaster management. Monitor implementation of Disaster Management Policies, goals and priorities.

TABLE 7: (EMS 4) Trends in Provincial Health Expenditure for EMRS and PPT (R million)

Expenditure (R'000)	2004/05 Actual	2005/06 Actual	2006/07 Actual	Average annual percentage change	2007/08 Projection	2008/09 Projection	2009/10 Projection	2010/11 Projection
Current prices.								
Total.	R305,627	R420,604	R474,023	24.54%	R569,891	R632,501	R760,404	R862,205
Total per person.	R31.25	R42.69	R47.77	23.63%	R56.99	R62.78	R74.92	R84.32
Total per uninsured person.	R35.51	R48.52	R54.28	23.63%	R64.76	R71.34	R85.14	R95.82
Total capital	–	–	–	–	–	–	–	
Constant (2007/08) prices.								
Total.	R354,527	R471,076	R507,205	19.61%	R569,891	R594,551	R684,364	R741,496
Total per person.	R36.25	R47.82	R51.11	18.74%	R56.99	R59.02	R67.43	R72.52
Total per uninsured person.	R41.20	R54.34	R58.08	18.74%	R64.76	R67.06	R76.62	R82.40
Total capital.	–	–	–	–	–	–	–	

HEALTH
KwaZulu-Natal

NOTES

MTEF PERIOD 2008/09 – 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

HEALTH
KwaZulu-Natal

ANNEXURE 8

PROGRAMME 7 : PROVINCIAL HOSPITALS (REGIONAL AND SPECIALISED)

MTEF PERIOD 2008/09 – 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

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PROGRAMME DESCRIPTION

Deliver accessible, appropriate, effective, and efficient general specialist hospital services.

PROGRAMME STRUCTURE

Sub-Programme 4.1
To render Regional Hospital services at specialist level.

Sub-Programme 4.2
To render Hospital services for TB, including Multi-Drug Resistant TB.

Sub-Programme 4.3
To render Hospital services for Mental Health.

Sub-Programme 4.4
To render comprehensive Dental Health services and provide training for Oral Health personnel.

Sub-Programme 4.5
To render Step-Down and Rehabilitation services to the chronically ill.

1. INTRODUCTION

Health interventions form a web of services that can only function optimally if all services are fully coordinated and integrated. Referral Hospitals cannot function optimally without other levels fulfilling their role, neither can District Hospitals, Primary Health Care, and Community Health Services function effectively without the ability to refer complex cases to specialised hospitals. Health screening provides no benefit to the beneficiaries of public health care without consequent treatment. Referrals are of no benefit without access to the required care; and referral facilities will be overwhelmed if essential promotive and preventive care is neglected. Services must therefore be a trade-off between specialisation and integration, between health care at one level versus that at another.

To realise the full benefit of linkage between the different levels of health care, referral hospitals need to provide various forms of support including training & development, managerial & administrative support, research (on disease burden), criteria for referral, post-discharge care, long-term management of chronic conditions, and feedback to the referral source. In essence they become the vehicles for disseminating technologies, evidence-based practice and training.

In terms of the STP, Regional Hospitals will function as Regional General Hospitals providing specialised in-patient and out-patient care upon referral. Services will be provided to a catchment population of approximately 1.2 million people, however, in some cases, due to population density or substantial investments already made, the average population may be slightly lower. Projected catchment populations per Regional Hospital will be finalised during 2007/08.

For Regional Hospitals the catchment population to be served is calculated on the **total projected uninsured population**.

Services are provided 24 hours per day 7 days a week.

In terms of the imperatives set by the STP, the rendering of regional services will be structured to ensure dedicated and adequately capacitated Regional General Hospitals by 2014.

2. POLICIES

Service delivery is guided by the implementation of legislative imperatives, National and Provincial health policies and norms and standards.

Implementation and compliance to evidence-based Policies and Guidelines should be monitored and strengthened through supportive supervision with follow-up training and development to ensure compliance and improved quality of care.

The development of a Provincial Hospital Governance Policy is reaching finalisation and will provide the framework to support and monitor the functioning of governance structures.

3. SITUATIONAL ANALYSIS

3.1 REGIONAL HOSPITALS

According to the STP, Regional Hospitals will provide in-patient health care services to public health care users presenting with complex health and trauma conditions and requiring the intervention of General Medical Practitioners as well as Specialists.

At each Regional Hospital provision has been made for the planning of Isolation Facilities.

TABLE 1: Regional Hospitals per Area

Area 1	Area 2	Area 3
Mahatma Ghandi	Newcastle	New Hospital
Prince Mshiyeni	Madadeni	
RK Khan	Edendale	
Stanger	Ladysmith	
Port Shepstone		

1. Addington and St Aidans Hospitals will provide Regional services until 2011 when King Edward VIII Tertiary Hospital is expected to be rebuilt and operational. The aim is to develop St Aidans Hospital to be a dedicated Mother and Child Facility.
2. Ngwelezana Tertiary Hospital will continue with current Regional services until the new Area 3 Hospital is operational.

In terms of Regional and Tertiary services, priority will be given to Management Area 3.

3.1.1 Package of Services: Regional Hospitals

Regional Hospitals provide in-patient and out-patient health care services to public health care users presenting with complex health and trauma conditions which require the intervention of Specialists in the following specialties:

- Medicine;
- Surgery;
- Paediatrics;
- Orthopedics;
- Obstetrics and Gynaecology; and
- Psychiatry.

  This package will be supported by:
  - Accident and Emergency;
  - Radiology;
  - Opthalmology (only in specific circumstances); and
  - Anesthetics, ICU and High Care.

According to the STP Regional Hospitals will also:

- Provide clinical oversight and support to dedicated District Hospitals linked to a designated Regional Hospital.
- Provide a platform for the training of under-graduate students and Registrars.
- Provide care for patients with highly complex health and trauma conditions requiring intervention at sub-specialty level.
- Provide specialised treatment procedures, technologically advanced equipment and medical support services (diagnostic imaging, therapy and nursing care) in line with the complex health conditions of patients.

3.1.2 Staffing Arrangements [1]

The development of staffing norms, based on actual workload and utilisation indicators is negatively affected by the existing configuration of health service platforms (health care users still enter the Public Health System at inappropriate levels) and health service delivery barriers including but not exclusive to shortage of staff and to a lesser extent equipment.

[1] STP

In order to overcome the above problem, a generic organisational and post establishment structure for the provisioning of the identified package of service was developed with the input of Clinicians for a standard catchment population of 1,200,000 health care users. Based on a comprehensive analysis of clinical procedures at this level and the bed allocation as well as to ensure the desired clinical outcomes the staffing norms have been developed.

Filling of posts is compromised due to inadequate staff accommodation, and the lack of a supportive recruitment and retention policy and strategy.

3.1.3 Referral Pathways

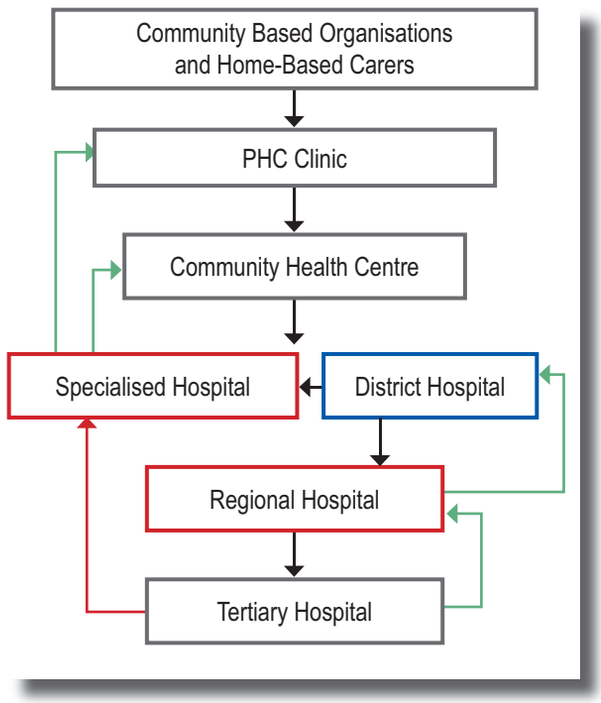
Equitable access and seamless service delivery are determined by adequate and functional PHC services, understanding and buy-in to the PHC approach, patients' perception of quality health care and consequent health seeking behaviours, and appropriate referral services.

In an effort to decongest Regional Hospitals and enforce appropriate utilisation and referral, the Department developed referral pathways and protocols that are being enforced with EMRS and PPT in all Districts.

All District Hospitals (with support from PPT and EMRS) refer patients requiring more advanced health care to specific designated Regional Hospitals. The norm (according to the STP) is to have four to six District Hospitals referring to one Regional Hospital.

The improved functioning of PPT improved the timely repatriation of patients, and is functional in all Districts between District, Regional, Tertiary and Central Hospitals. PHC Clinic to PHC Clinic and CHC must still be implemented during MTEF 2007/08 – 2008/09.

FIGURE 1: Referral Pathways



The shortage of ambulances and transfer of patients to the appropriate level of care (between community and health facilities) still remains a challenge. Protocols will be enforced with EMRS to ensure better triaging of cases, while community education will be prioritised to ensure compliance with the Departmental Referral Policy.

3.1.4 Utilisation of Services

Appropriate systems, resources and restructured health services will improve availability at primary level; improve PHC utilisation *(PHC Utilisation Rate)*; and decongest Hospital services *(OPD Headcount, Patient Day Equivalent, and Separations)*. Utilisation trends will be followed closely to establish effective implementation and to direct planning.

ANNEXURE 8

TABLE 2: Service Utilisation: 2006/07 – 2007/08[2]

Data Element	2006/07	2007/08
Separations	372,597	342,480
Patient Day Equivalent	2,783,246	2,407,259
OPD Headcount	3,074,707	2,345,542
PHC Headcount	20,548,203	21,079,790

Current routine data in the DHIS does not allow for adequate interpretation of utilisation per level of care. However, utilisation per level of care will be carefully monitored within the wider context of integrated health services as prescribed in the STP.

3.1.5 Bed Allocation and Occupancy Rates

STP

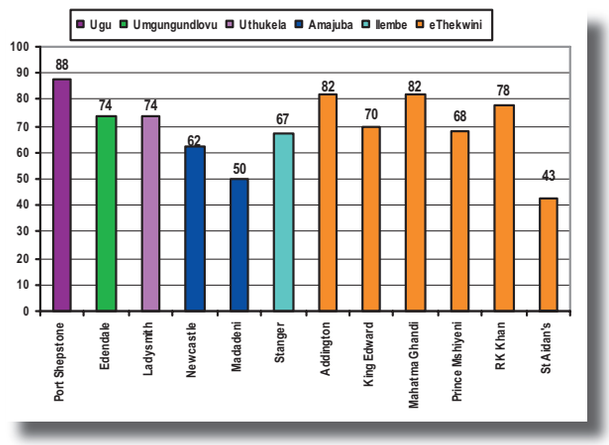
District beds will be provided in each Regional Hospital, with Level Two beds designated for the referral of patients from District Hospitals. Beds will be centralised in Regional Hospitals. Formula for Level Two beds to Regional Hospitals: **.23 beds per 1 000 population**.

3.1.6 Bed Occupancy Rate

Bed occupancy rate is generally a good measure of efficiency and expresses effective utilisation of available capacity and resources.

The indicative value for *'Bed Utilisation Rate'* in Regional Hospitals set by the National Department of Health is **75%**. During 2006/07 the Province achieved an average of 72% and 71% during 2007/08. Individual performance of Hospitals is reflected in Figure 1.

FIGURE 2: Bed Occupancy Rates: 2006/07



Currently only Port Shepstone, Mahatma Ghandi, Addington and RK Khan Hospitals exceed the National target of 75%.

The reasons for low occupancy rates will be investigated as it has a direct impact on provisions made in the STP and allocation of resources to affect the relevant package of services.

3.1.7 Average Length of Stay (ALOS)

The indicative value for 'Average Length of Stay' in Regional Hospitals set by the National Department of Health is **4.1 days**. During 2006/07 the Provincial average was 5.4 days decreasing slightly to 5.2 days in 2007/08. Individual Hospital performance is indicated in Figure 3.

[2] Utilisation data for 2007/08 is projected data using Quarters 1 and 2 actual data.

FIGURE 3: Average Length of Stay per Regional Hospital: 2006/07

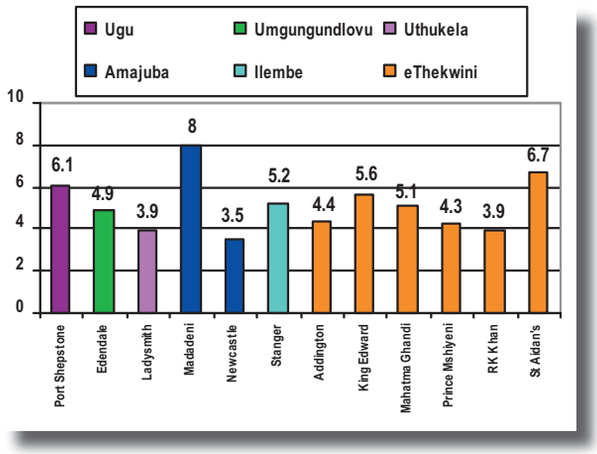
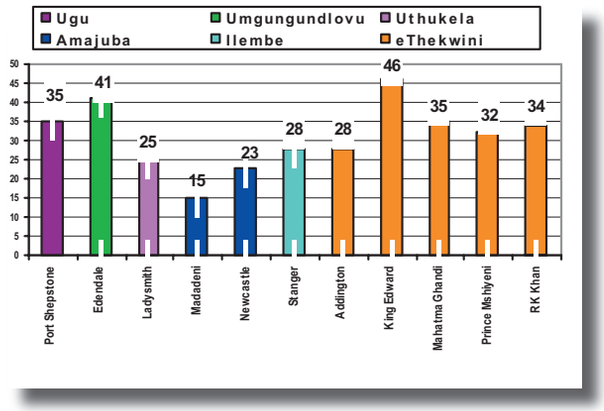


FIGURE 4: Caesarean Section Rate per Regional Hospital: 2006/07



Currently only Ladysmith, Newcastle, and RK Khan Hospitals reached the National target of 4.1 days. The reasons for the high values in the other Hospitals are unclear as data is not currently separated for reporting purposes. It is however important to investigate this to determine appropriate referral (according to referral pathways), impact of burden of disease (which will inform further development of the STP), need and utilisation of step-down or specialised beds, appropriate discharge of patients (which might be linked to doctor clinical workload) and impact of Regional services vs. Regional/ District or Regional/ Tertiary services on ALOS.

The reasons for the extended ALOS will be investigated.

3.1.8 Caesarean Section Rate

Although the National target of 18% for *'Caesarean Section Rate'* in Regional Hospitals is generally viewed as unrealistic by Clinicians, the Province constantly reports the highest caesarean section rates in the country.[3] During 2006/07 the reported caesarean section rate was 34% as compared to 31% in 2007/08. Individual Hospital performance is indicated in Figure 4.

Possible contributing factors to high caesarean section rate:[4]

- Poor intrapartum monitoring resulting in late referral when complications are irreversible.
- Poor implementation of antenatal and intrapartum care protocols and guidelines.
- Poor implementation and/or interpretation of the partogram (less than 60% of deliveries were found to have adequately completed labour figures).
- Lack of transport (either facility or client), or delay in referral resulting in late reporting of complicated labour when the only option is caesarean section.
- Lack of clinical skills to manage complicated labour leading to substandard management decisions.
- Poor utilisation of antenatal care facilities.

Recognising the increased risk to the client and increased cost associated with caesarean section, the reason for the high rates will be investigated.

3.1.9 Hospital Governance

Governance Structures are in place with the exception of some Specialised Hospitals i.e. the TB Hospitals that were taken over from SANTA. Processes are however in place to ensure that all these Hospitals establish appropriate structures during MTEF 2007/08. All Districts embarked on training programmes for appointed Board Members.

[3] South African Health Review 2006.

[4] D Nyasulu. Review of Intrapartum Care in KwaZulu-Natal, 2005.

3.1.10 Quality Improvement

Port Shepstone Hospital received full accreditation status from the Council for Health Services of Southern Africa Standards (COHSASA) in 2007/08, while progress certificates were awarded to Edendale, Madadeni, Ladysmith, and RK Khan Hospitals.

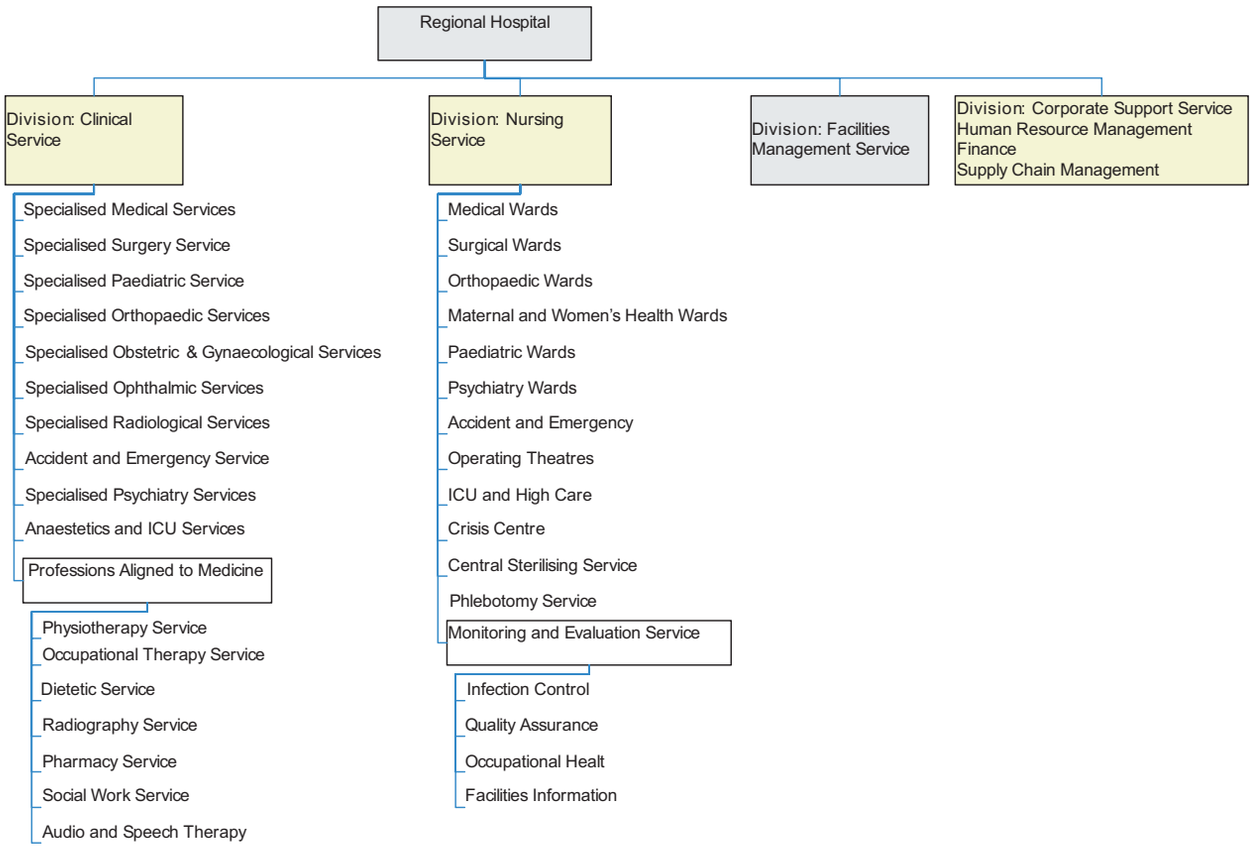
Integrated health promotion strategies (one of the pillars of the PHC approach) are being extended to Hospitals through the Health Promoting Hospital initiative. Edendale, Ladysmith and Newcastle Hospitals will be assessed for accreditation during MTEF 2007/08.

The Department has intensified staff awareness towards the implementation of Prevention and Control Practices to promote the achievement of quality patient care.

Appointment systems have been successfully initiated at RK Khan, Prince Mshiyeni and Stanger Hospitals to reduce congestion, waiting times and improve general patient satisfaction.

All Regional Hospitals implement weekly/ monthly mortality review meetings to inform quality improvement strategies to reduce morbidity and mortality.

FIGURE 5: Organisational Structure – Regional Hospital



3.2 SPECIALISED TUBERCULOSIS HOSPITALS

The HIV and AIDS pandemic has increased the burden of Tuberculosis in the Province, while the low cure rate (currently much lower than the National value) resulted in the development of acquired drug resistant stains i.e. MDR TB and XDR TB. In order to address this challenge the Department has developed an additional service platform through the STP to supplement current services provided by District Hospitals *(Figure 3)*.

Specialised TB Hospitals will make provision for sub-acute and chronic care beds for patients being discharged from District Hospitals after an average length of stay of 3 days. The STP makes provision for each District to have at least one Specialised TB Hospital with the exception of Ilembe and Uthukela Districts.

FIGURE 6: Structure of TB Facilities as per STP

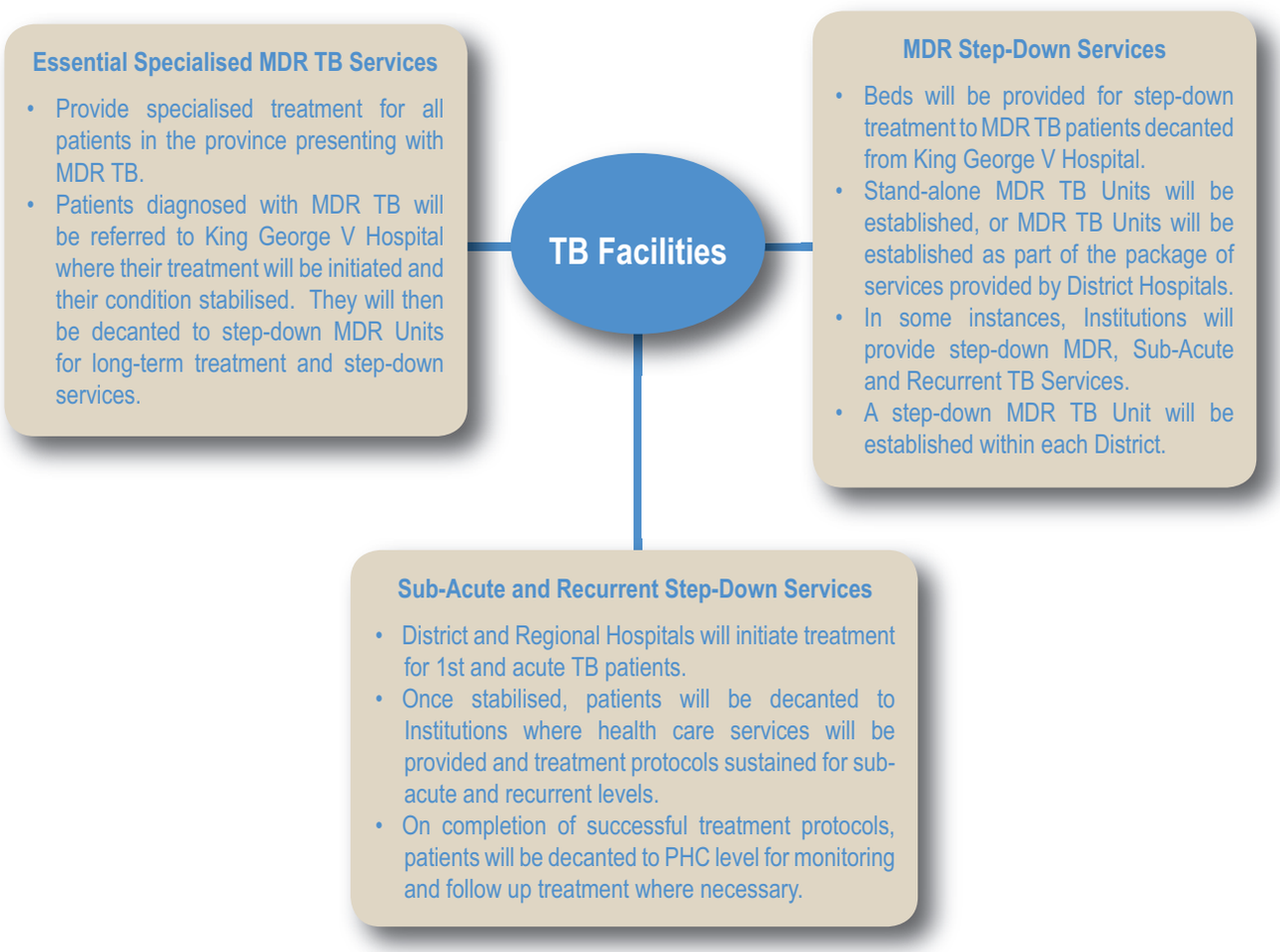


TABLE 3: Proposed Specialised TB and MDR TB Hospitals and existing beds[5]

Hospital	Proposed Type	Sub-Acute	Recurrent	MDR TB	Step-Down
Madadeni (2007)	Specialised TB & MDR TB	34	42	20M & 10F	0
Charles James (2007)	Specialised TB	32	148	0	40
Don McKenzie (2007)	Specialised TB	32	148	0	40
FOSA (2007)	Specialised MDR TB	0	o	234	0
King George V (2007)	Central Specialised MDR TB	0	0	320	0
Osindisweni (2013)	Specialised TB	54	0	0	0
Dunstan Ferrel (2007)	Specialised TB	50	150	0	40
Murchison (2008)	Specialised MDR TB	16M & 20F	0	40	18M & 20F
Doris Goodwin (2007)	Specialised TB & MDR TB	20	47	30	50
Richmond (2007)	Specialised TB	50	60	0	451
Hlabisa (2007)	Specialised MDR TB	20	21	0	0
Manguzi (2007)	Specialised MDR TB	25	24	40	0
Mosvold (2007)	Specialised MDR TB	0	0	40	0
Greytown (2008)	Specialised TB & MDR TB	20	38	60	0
Catherine Booth (2007)	Specialised MDR TB	0	0	40	0
Mountain View (2008)	Specialised TB	70	12	0	0
Siloah Lutherine Mission (2008)	Specialised TB	90	0	0	0
Thulasizwe (2007)	Specialised TB & MDR TB	20	32	70	26
St Margaret's (2008)	Specialised TB & MDR TB	30	50	10	0

[5] STP

Current TB bed status:[6]

- King George V Hospital: 160 operational beds with a total of 320 planned for 2007/08.
- FOSA: 160 operational beds.
- Greytown Hospital (M3): 27 beds operational with 51 to open in 2007/08.
- Murchison Hospital: 40-bedded park home unit erected for use.
- Mosvold and Manguzi Hospitals: 15 patients being managed with two 40 GRC ModUnit plans completed and quotes received.
- Thulasizwe Hospital: 17 patients being managed with one 40-bedded GRC ModUnit expected in MTEF 2007/08.
- Doris Goodwin: 6 patients being managed, alterations to existing wards commenced for an additional 30 beds.
- Catherine Booth Hospital: 14 beds operational with a 40-bedded GRC ModUnit in the planning phase.

3.2.1 Referral Patterns for TB Patients

King George V Hospital is the central referral site for all MDR TB cases in the Province. Patients diagnosed with MDR TB are, as a first step, referred to King George V Hospital for the initiation of treatment protocols. Once stabilised, patients are decanted to a district based facility designated for MDR TB follow-up. It will be necessary to increase the number of central referral sites and this will be reviewed.

District Hospitals refer patients requiring longer term treatment and care to Specialised TB Hospitals with Step-Down beds.

It is proposed that Uthukela patients, as an interim arrangement, be referred to Doris Goodwin and Richmond Hospitals until such time as Emmaus Hospital can be reconfigured as a Specialised TB and District Hospital Category B (in 2012 depending on the commissioning of the new Bergville Hospital).

Likewise, it is proposed that patients' residing in Ilembe District requiring MDR TB step-down and long-term treatment be referred to facilities in eThekwini.

3.2.2 Post Establishments and Staffing Arrangements

The post provisions for the provisioning of Specialised TB services are based on the nature of the clinical procedures to be performed, the bed allocation and specific service delivery barriers.

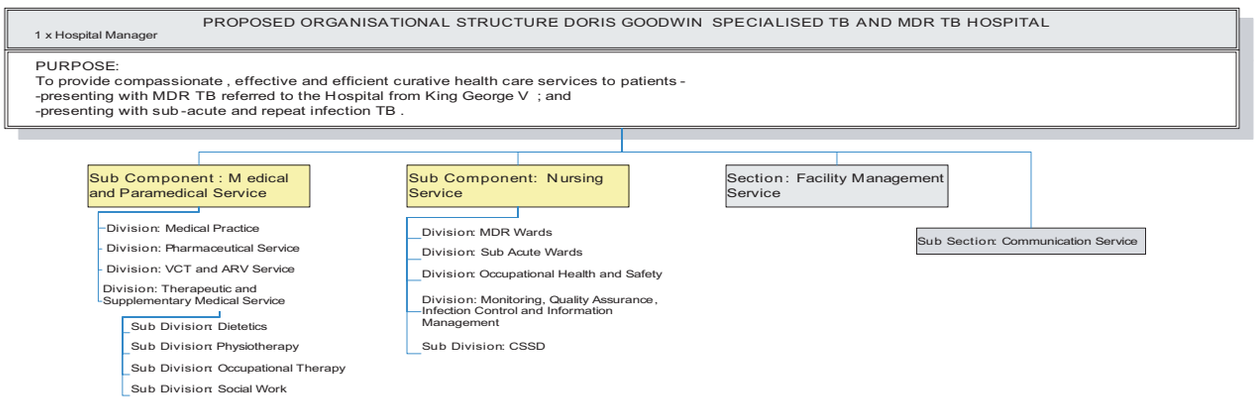
The development of staffing norms, based on actual workload and utilisation indicators, is negatively affected by the configuration of the former SANTA Hospitals that were only transferred to the Department during 2006/07 coupled with other health service delivery barriers, including shortage of appropriately trained and placed staff and inadequate infrastructure for delivery of effective TB services.

3.2.3 Organisational Structure for TB

The approved organisational structure for TB Hospitals is illustrated in Figure 7.

[6] MANCO Presentation October 2007.

FIGURE 7: Organisational Structure TB



3.3 SPECIALISED PSYCHIATRIC HOSPITALS

The provisioning of Mental Health Services has suffered from poor planning, racial inequities, fragmentation and inadequate budgets. People with severe psychiatric conditions were frequently treated for long periods in large centralised institutions and conditions were inhumane for many patients. The adoption of a new legislative framework in terms of the Mental Health Act (Act 17 of 2002), giving substance to a range of Constitutional imperatives, requires the urgent transformation of Mental Health services.

Specialised TB Hospitals will make provision for sub-acute and chronic care beds for patients being discharged from District Hospitals after an average length of stay of 3 days. The STP makes provision for each District to have at least one Specialised TB Hospital with the exception of Ilembe and Uthukela Districts.

FIGURE 8: Hospital Based Mental Health Services

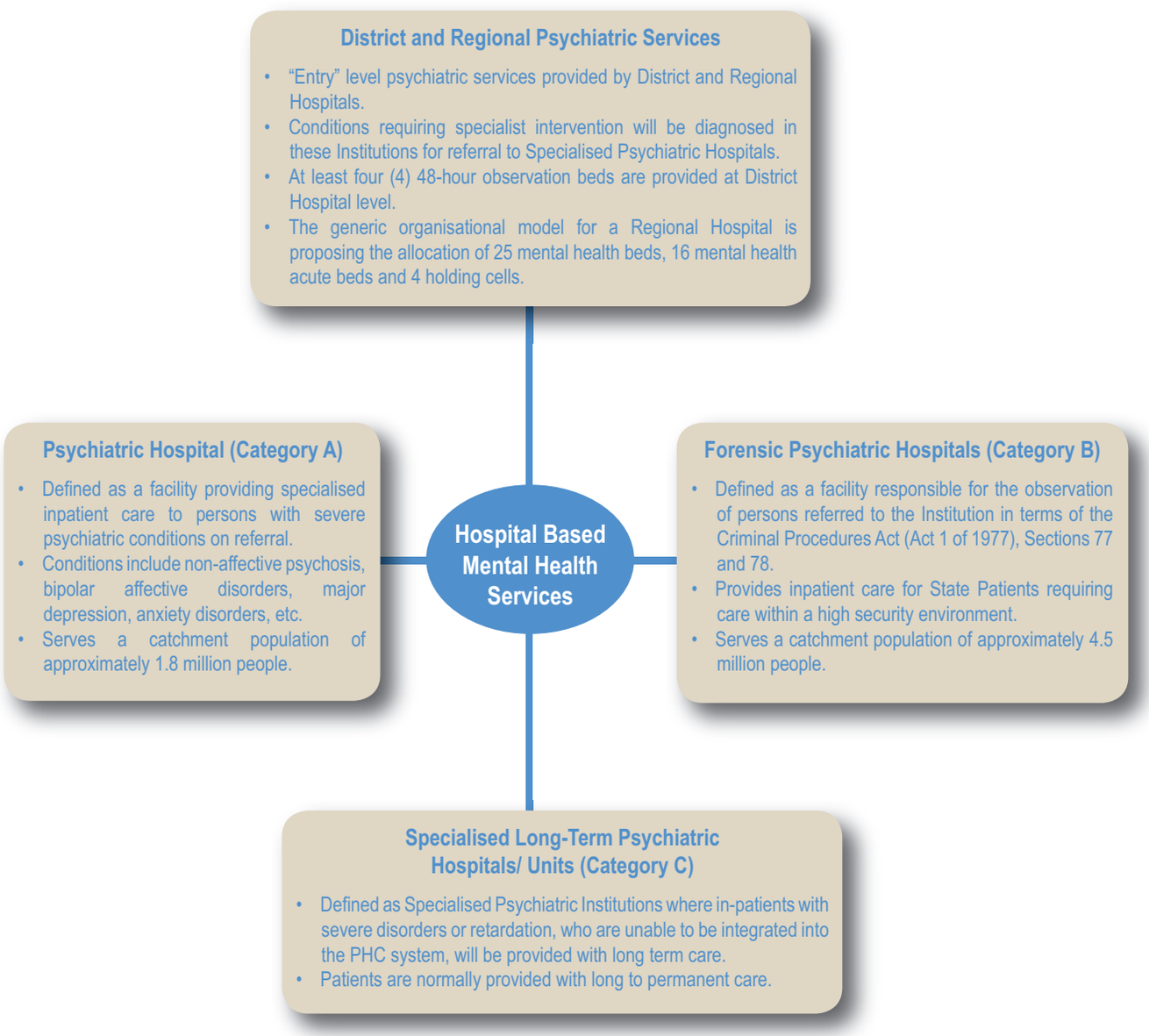


Table 5 below summarise the proposed Specialised Psychiatric Hospitals[7]

TABLE 4: Specialised Psychiatric Hospitals

Health District	Name	Current Classification	Proposed Classification
Amajuba	Madadeni	Regional Hospital.	Regional Hospital with Specialised Psychiatric Unit.
eThekwini	Ekuhlengeni Sanatorium	Specialised Psychiatric Hospital.	Specialised Long –Term Psychiatric Hospital.
eThekwini	King George V	District Hospital & Specialised MDR TB.	District Hospital & Specialised MDR TB Unit & Specialised Psychiatric Unit.
Sisonke	Umzimkulu	Specialised Psychiatric Hospital.	Specialised Psychiatric & Forensic Psychiatric Hospital.
Umgungundlovu	Fort Napier	Specialised Psychiatric Hospital.	Specialised Forensic Psychiatric Hospital.
Umgungundlovu	Midlands Centre – Umgeni	Specialised Psychiatric Centre.	Specialised Long –Term Psychiatric Centre.
Umgungundlovu	Town Hill	Specialised Psychiatric Hospital.	Specialised Psychiatric Hospital.
Zululand	St. Francis	Specialised Psychiatric Hospital.	Specialised Long-term Psychiatric Hospital.

3.3.1 Hospital Beds

The STP makes provision for Mental Health beds in each District and Regional Hospital (excluding Specialised Psychiatric Hospitals). Each District Hospital provide: 4 Mental Health beds. Each Regional Hospital will provide: 25 Mental Health beds, 16 Mental Health Acute beds and 4 Isolation Rooms. Table 6 below summarise the allocation of Mental Health beds in Specialised Psychiatric Hospitals.

TABLE 5: Beds at Specialised Psychiatric Hospitals[8]

Health District	Name	Specialised Psychiatric Beds Facility	Mental Health Beds at District Hospital	Mental Health Beds at Regional Hospitals			Total Mental Health Beds per District*
				Mental Health	Mental health Acute	Isolation Rooms	
Amajuba	Madadeni	513	–	25	16	4	558
eThekwini	Ekuhlengeni Sanatorium	984	44	100	64	16	1382
eThekwini	King George V	130					
Sisonke	Umzimkulu	250	16	–	–	–	266
Umgungundlovu	Fort Napier	370	12	25	16	4	1476
Umgungundlovu	Midlands Centre-Umgeni	624					
Umgungundlovu	Town Hill	425					
Zululand	St. Francis	19	24	–	–	–	43

This table doesn't include the beds at District and Regional Hospitals as mentioned above in Districts that do not have a specialised Psychiatric Hospital (e.g. Ilembe)

[7] STP

[8] STP

3.3.2 Staffing Arrangements

The development of staffing norms, based on actual workload and utilisation indicators for Specialised Psychiatric Institutions is negatively affected by the existing configuration of mental health service platforms i.e. limited structures are operational to facilitate the delivery of services at PHC/ Community level and patients are therefore provided with care at an inappropriate level. Health service delivery barriers including inappropriate infrastructure, shortage of appropriately trained and skilled staff and to a lesser extent equipment still hamper delivery.

In order to overcome these challenges, a generic organisational and post establishment structure for the provisioning of the designated packages of service was developed for the different categories of Institutions through extensive consultation with Clinicians, District Management Teams and the Unit: Integrated Health Policy and System Development. Based on a comprehensive analysis of clinical procedures performed at the various levels of care the following staffing norms were adopted as summarised in Table 6.

TABLE 6: Occupational Categories

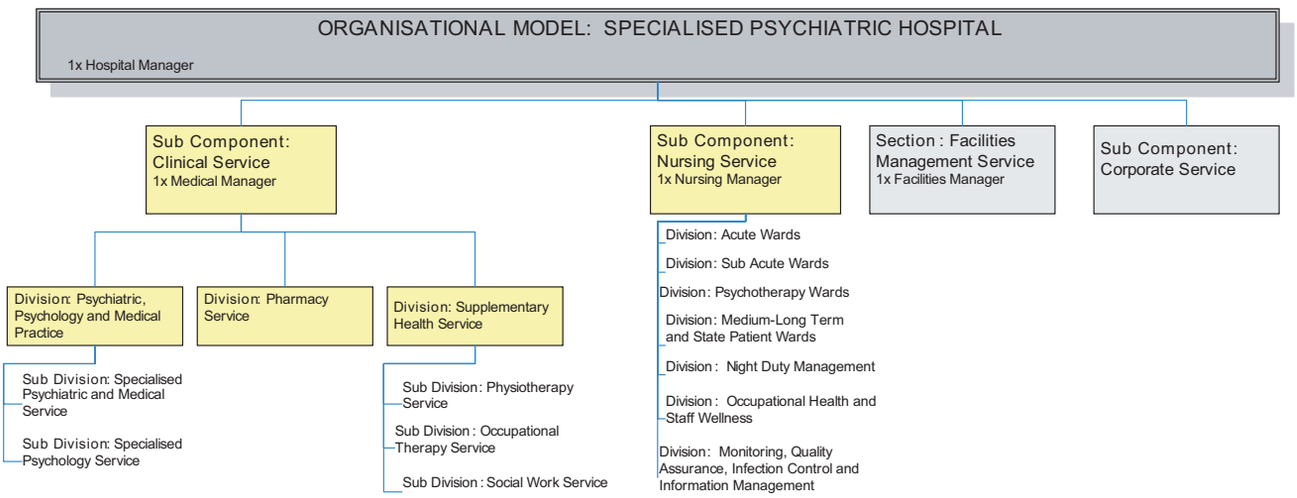
Institution	Standard Catchment Population	Occupational Category				
		Specialist	Medical Officer	Professional Nurse	Staff Nurse	Nursing Assistant
Specialised Psychiatric Hospital (Category A)	1,8m	1: 95,000	1: 120,000	1: 10,000	1: 11,3002	1: 48,000
Specialised Forensic Psychiatric Hospital (Category B)	4,5m	1: 350,000	1: 750,000	1: 21,000	1: 57,600	1: 54,000
Specialised Long-Term Psychiatric Hospital (Category C)	Number of actual Beds per Institution	N/A	1: 460 beds	1: 20 beds	1: 15 beds	1: 5 beds

Note: The above staffing norms provide for adequate 24 hour, seven days per week staff coverage.

3.3.3 Organisational Models for Hospital-based Mental Health Services

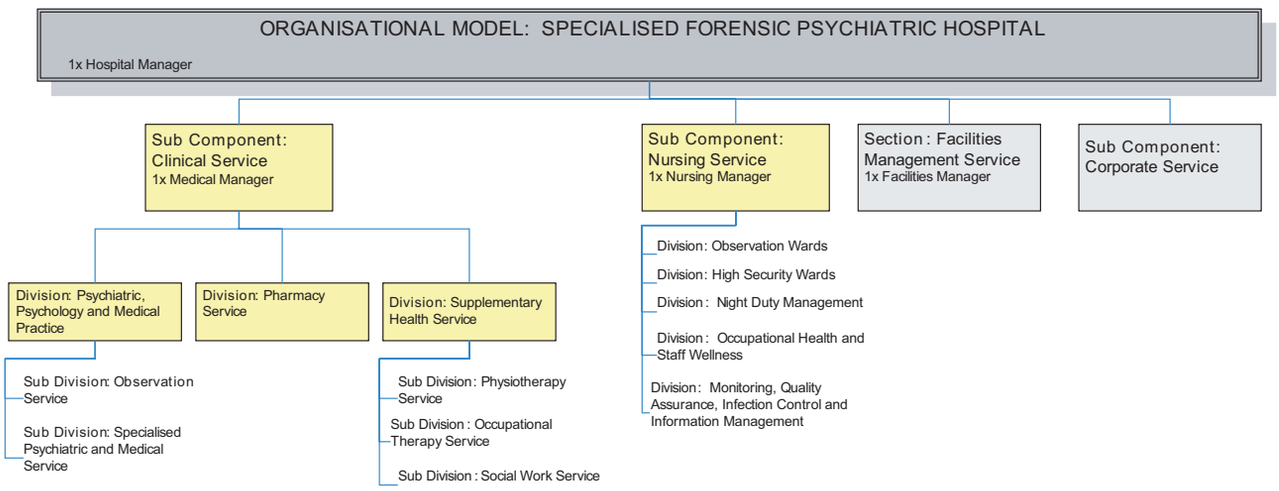
To ensure a balance between the various occupational categories and their optimal utilisation as part of an integrated health care team approach, the said staffing norms were utilised to develop customised organisational and post establishment structures for the Institutions designated to provide specialised in-patient services to patients presenting with psychiatric disorders. The detailed Organisational Models for the three Categories of Specialised Psychiatric Hospitals are summarised in Figures 9, 10 and 11.

FIGURE 9: Organisational Model Specialised Psychiatric Hospital



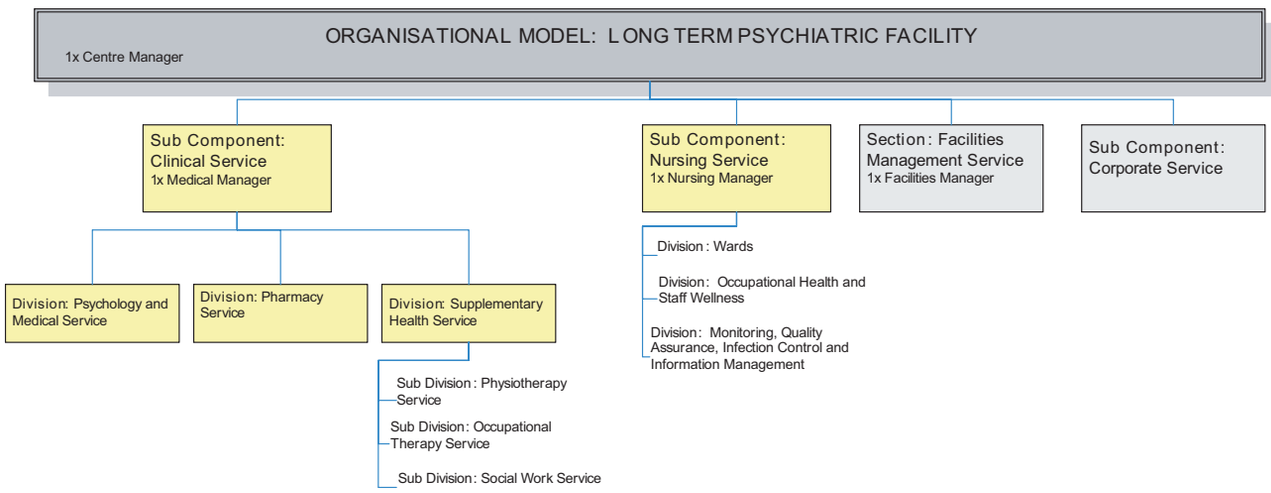
3.4 Specialised Forensic Psychiatric Hospital (Category B)

FIGURE 10: Organisational Model Specialised Forensic Psychiatric Hospital



3.5 SPECIALISED LONG-TERM PSYCHIATRIC HOSPITAL (CATEGORY C)

FIGURE 11: Organisational Model Long-Term Psychiatric Hospital



3.5.1 Step-down Convalescent

Clairwood Hospital in Ethekwini Metropolitan Municipality (520 beds) is currently the only Institution of this kind in the Province. The Hospital receives patients on referral from all Hospitals in the Province and is providing long-term residential care to patients presenting with degenerative diseases whose condition is such that it is impossible to successfully arrange their re-integration into community and family structures.

Although the acuity of patients is of a severe nature, palliative treatment procedures within the scope of practice of a Professional Nurse (under supervision of a General Practitioner) are provided. In instances where more specialised treatment is required, patients are referred to Institutions providing the appropriate level of care.

The service is provided 24 hours per day, seven days a week.

An appropriate organisational structure and staffing norms must still be developed.

3.5.2 Step-down Rehabilitation

Hillcrest Hospital is a 175-bed Step-Down Rehabilitation Facility located within the eThekwini Metropolitan Municipality. The main purpose of the Institution is to provide a 24-hour seven days per week short term "step-down" and chronic health care services to in-patients initially treated at District and Regional Hospitals whose conditions have stabilised to such an extent that, under normal circumstances, they would have been discharged from Hospital. Due to a lack of support at family/ community level, their stay within a supportive environment has to be extended to adequately sustain treatment gains and prevent costly relapses.

Due to the low level of acuity of patients, treatment procedures within the scope of practice of a Staff Nurse or Nursing Assistant (under indirect supervision of a Professional Nurse and General Practitioner) are provided.

The aim of Step-Down Rehabilitation is to:

- Provide minimum supervision on the intake of prescribed medication;
- Ensure a healthy nutritional intake in support of desired clinical and health outcomes;
- Promote healthy lifestyle behaviours;
- Monitor progress towards recovery at lower cost and ensuring timely identification of complications with referral for appropriate management; and
- Provide access to health services for patients over the age of 50 years on repeat chronic medication.

3.5.3 Staffing Norms for Step-down Services

Day shift (8-hour shifts)

Professional Nurse:	1: 30 beds
Enrolled Nurses:	1: 15 beds
Nursing Assistant:	1: 15 beds
General Orderly:	1: 30 beds

Night Shift:

Professional Nurse:	1: 30 beds
Nursing Assistant:	1: 20 beds

3.5.4 Stroke and Spinal Rehabilitation Units

Specialised Rehabilitation Units have been established at Regional (R.K. Khan Hospital) and Tertiary (Grey's and IALC Hospitals) levels to provide, on an out-patient basis, specialised rehabilitative care services to patients affected by strokes and spinal injuries.

Apart from the above mentioned Units, two other Specialised Rehabilitation Centres (Phoenix and Pietermaritzburg) were established in the Province prior to 1994 to provide specialised rehabilitation services.

The current services are on an out-patient basis as no infrastructure is available for medium to long term accommodation of patients. As such, access is problematic to patients from the rest of the Province.

It is for this reason that the STP is proposing that rehabilitation services provided at Community Health Centres should be strengthened substantially, with additional support by dedicated Medical Prosthetic and Orthetic Units attached to each District Hospital.

It is proposed that the Phoenix Rehabilitation Centre is retained as a stand-alone Specialised Rehabilitation Centre for patients residing in the Ethekwini Metropolitan Municipality, Ugu and Ilembe Districts (likewise Planned Patient Transport services will have to be strengthened to improve accessibility). Dedicated Speech and Audio Therapy capacity will be developed as part of the strengthening of Tertiary Services (Ngwelezana Hospital) for the North Eastern Service Area.

Services provided at the Phoenix Rehabilitation Centre are within the scope of practice of Physio, Occupational, Speech and Audio Therapists with outreach support by Psychologists attached to other Health Institutions. An appropriate organisational structure and staffing norms must still be developed on actual case load and other prevalence indicators.

3.5.5 Dental Health Services

The Centre, based on the premises of King George V Hospital, is the only Institution within KwaZulu-Natal that provides a full package of Specialised Dental Services.

It serves as a training site for Dental Therapists, Oral Hygienists, and Dental Therapy Assistants, redressing the human resource shortages amongst these categories of personnel. It further provides continuing professional development for all categories of oral health personnel as per requirements of the Health Professionals Council of South Africa.

The centre updates relevant research to improve the type and quality of oral health care provided to the population.

The following services are provided by the Oral and Dental Health Service

- Prosthodontics – Dentures
- Orthodontics – Straightening of teeth – Fixed and removable appliances
- Maxillo – Facial and Oral Surgery
- Periodontics
- Pediatric Dentistry
- Endodontics
- Oral Medicine
- Management of HIV and AIDS patients – Oral manifestations
- PHC interventions
- Dental Health Education and Promotion
- Satellite Dental Clinic Services

3.5.6 Sub Acute Step-down, Chronic and Rehabilitation Services

- The primary aim of this sub-programme is the provisioning of Hospital facilities and long-term care for in-patients with severe disorders who are unable to be integrated into the PHC system.
- There are currently no norms for this category. The STP has however identified the required number and location of such Institutions, and the norms will be developed during MTEF 2007/08.

4. POLICIES, PRIORITIES AND OBJECTIVES

The strategic objectives, measurable objectives and indicators for Regional Hospitals are indicated in the following diagram.

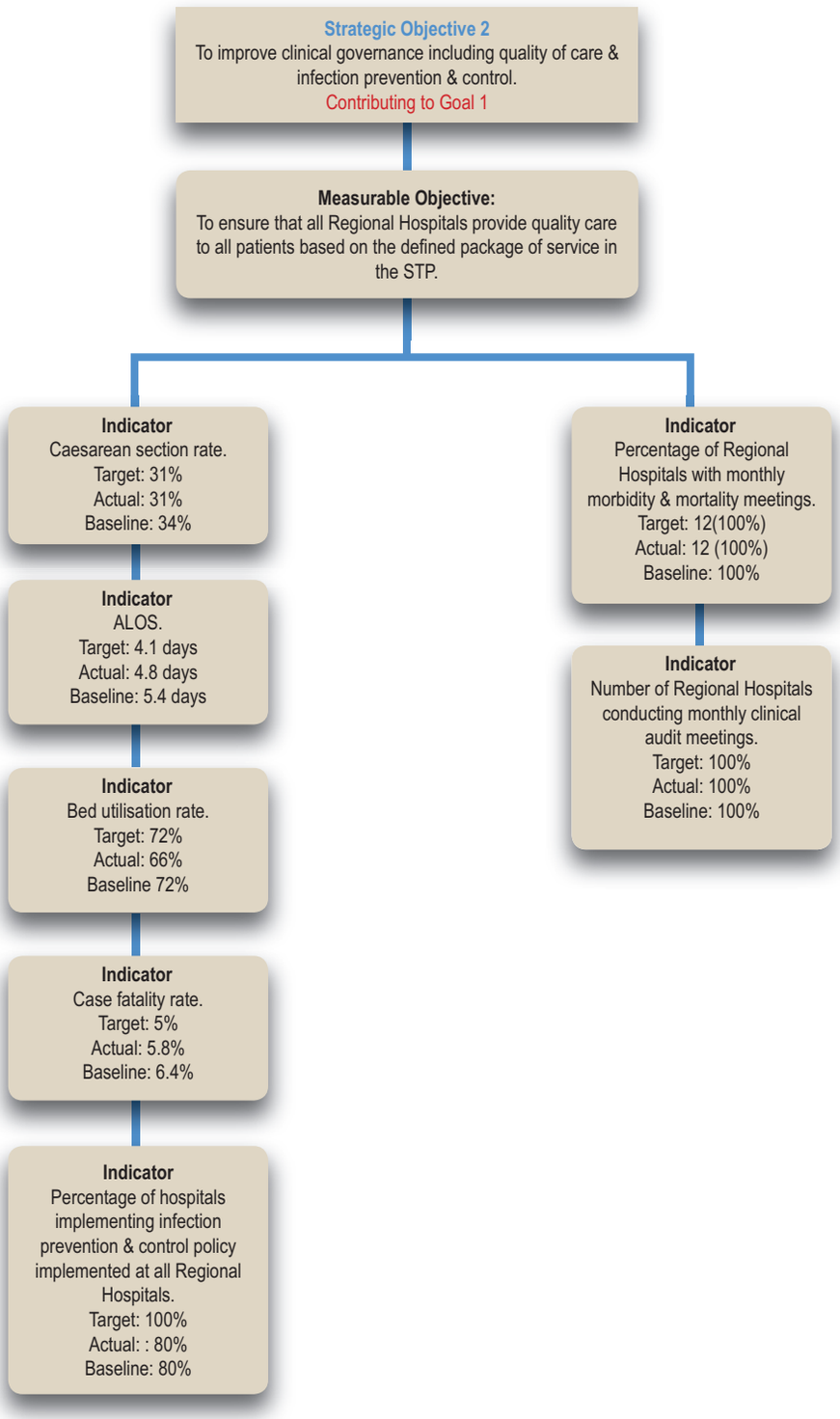


TABLE 7: (PHS 1) Public Hospitals by Hospital Type

Hospital type	Number of hospitals	Number of beds	Beds per 1000 uninsured people		
			Provincial average	Highest District (include name)	Lowest District (include name)
District Hospitals. [9]	40	8,981	1/1,000	1.8/1,000 (Umkhanyakude)	0.4/1,000 (eThekwini)
Regional Hospitals. [10]	12	7,294	0.8/1,000	2.5/1,000 (Amajuba)	0.4/1,000 (Ugu)
Tertiary and Central Hospitals. [11]	3	1,928 [12]	0.2/1,000	0.2/1,000 (eThekwini)	0.2/1,000 (eThekwini)
Sub-total – Acute Hospitals.					
Tuberculosis. [13]	11	2,269	0.25/1000 [14]	0.87/1000 (UMgungundlovu)	0.04/1000 (Uthukela)
Specialised Psychiatric. [15]	6	3,315	0.37/1000 [16]	1.7/1000 (UMgungundlovu)	0.05/1000 (Zululand)
Other Specialist. [17]	3	695	0.07/1000	0.07/1000 (eThekwini)	
Total Public.					
Private Sector (including step down). [18]	40	3,381	0.002/1000		

[9] Includes step down beds.
[10] King Edward is included under the Regional Hospitals. Once rebuilt, the classification of King Edward will change to a Tertiary Hospital.
[11] It is difficult to determine the exact number of regional beds in Tertiary hospitals.
[12] The 80 Spinal Beds at King George V Hospital has not been included under the Tertiary beds. The beds will be included once the commissioning of King George V Hospital is completed.
[13] It only includes beds for Specialised TB, TB MDR and TB XDR. It excludes beds for TB in District Hospitals and step down beds for TB. It includes Specialised TB, TB MDR and TB XDR beds in the following District Hospitals: Manguzi, Mosveld, Murchison, Hlabisa, Madadeni, Catherine Booth, King George V.
[14] Includes all hospitals that provide Specialised TB, TB MDR, TB XDR and step down beds are included.
[15] The number of beds includes Specialised Psychiatric beds in the following Hospitals: King George V and Madadeni. It excludes the planned 44 psychiatric beds at Ngwelezana. The Department plans to have 3, 681 beds for Mental Health (Mental health, Acute and Isolation). The implementation of this plan will depend on the funding envelope.
[16] Ratio's to not include Districts that do not have Specialised Psychiatric beds.
[17] Excludes the beds at Phoenix.
[18] Ratio calculated in terms of 12% of total population (insured).

TABLE 8: (PHS 2) Public Hospitals by Level of Care

Hospital type	Number of hospitals providing level of care	Number of beds	Beds per 1000 uninsured people		
			Provincial average	Highest District (include name)	Lowest District (include name)
District Hospitals.	40	8,981	1/1,000	1.8/1,000 (Umkhanyakude)	0.4/1,000 (eThekwini)
Regional Hospitals.	12	7,294	0.8/1,000	2.5/1,000 (Amajuba)	0.4/1,000 (Ugu)
Tertiary and Central Hospitals.	3	1,928	0.2/1,000	0.2/1,000 (eThekwini)	0.2/1,000 (eThekwini)

TABLE 9: (PHS 3) Situation Analysis Indicators for Regional Hospitals per Health Distric

Indicator	Type	eThekwini	Ugu	uMgungundlovu	Amajuba	Uthungulu	iLembe	Uthukela
Output								
Caesarean section rate for Regional Hospitals.	%	39.2%	35.2%	42.9%	18.1%	31.2%	28.3%	24.6%
Separations – Total.	No	171,183	16,201	48,721	36,589	38,248	22,987	29,731
Patient Day Equivalents.	No	1,678,533	162,759	322,930	279,654	288,805		178,703
OPD Total Headcounts.	No	2,073,393	190,105	244,848	117,318	168,376		168,867
Quality								
Regional Hospitals with patient satisfaction survey using DOH template[19].	%	No	No	No	No	No	No	No
Regional hospitals with mortality and morbidity meetings every month. [20]	%	100%	100%	100%	100%	100%	100%	100%
Regional Hospitals with clinical audit meetings every month. [21]	%	100%	100%	100%	100%	100%	100%	100%
Complaints resolved within 25 days. [22]	%							
Efficiency								
Average length of stay in Regional Hospitals.[23]	Days	5	6	5	7	6	5	4
Bed utilisation rate (based on usable beds) in Regional Hospitals.	%	72..2%	87.8%	74.0%	51.5%	80.0%	65.0%	74.2%
Expenditure per patient day equivalent in Regional Hospitals.	R							
Outcome								
Case fatality rate in regional hospitals for surgery separations.	%	4.7%	8.9%	7.1%	2.9%	5.4%	3.8%	5.2%

[19] This is a Head office initiative. Due to delays by SCM to award the tender, the survey was not conducted.
[20] These are meetings to discuss all deaths at facilities (avoidable and unavoidable).
[21] These are meetings to discuss clinical audits for specific disciplines in relation to morbidity & mortality, disease surveillance, nursing/patient audits and disease specific conditions.
[22] The Department used the ratio of 60 days. As from MTEF 2007/08 the Department will apply the ratio of 60 days.
[23] It is not possible to determine expenditure per patient per day per District due to the fact that different levels of services (both District and Regional services) are rendered in the Regional Hospitals. A system has not been implemented to collect the data in each of these Hospitals per level of care.

TABLE 10: (NHS 3) Quality of Care

Improved quality of care in the restructured service platform is essential to the delivery of the required outcomes and the Provincial Department of Health Vision and Mission.

Activity	Indicators	Targets 2006/07	Targets 2007/08	Targets 2008/09	Responsibility
Hospital improvement plans.	Clinical audits.	Clinical audits routinely monitored in all Regional Hospitals.	Clinical audits routinely monitored at all Regional Hospitals.	Clinical audits routinely monitored in all Regional Hospitals.	M & E Component.
	Complaints mechanisms.	Complaints mechanisms routinely managed in all Regional Hospitals.	Complaints mechanisms routinely managed in all Regional Hospitals.	Complaints mechanisms routinely managed in all Regional Hospitals.	M & E Component.
	Infection Control audits.	Infection control management effected in Regional Hospitals.	Infection control management effected in all Regional Hospitals.	Infection control management Regional Hospitals.	M & E Component.
	Telemedicine.	Hub and spoke systems developed in accordance with STP in all Regional Hospitals.	Hub and spoke systems developed in accordance with STP, in all Regional Hospitals.	Hub and spoke systems developed in accordance with STP, in all Regional Hospitals.	Tele-health Component.

TABLE 11: (PHS 4) Provincial Objectives and Performance Indicators for Regional Hospitals

Indicator	2006/07 (actual)	2007/08 (target)	2008/09 (target)	2009/10 (target)	2010/11 (target)
Strategic Objective: To improve Clinical Governance including quality of care and Infection Prevention and Control.					
Measurable Objective: To ensure that all Regional Hospitals provide quality health care to all patients based on the defined package of service as prescribed in the STP.					
Caesarean Section rate.	34%	31%	31%	29%	28%
Average Length of Stay.	5.4 days	4.8 days	4.1 days	4	4
Bed Utilisation rate.	72%	66%	72%	75%	76%
Case fatality rate.	6.4%	5.8%	5%	4%	3%
Measurable Objective: To develop and implement a framework to improve clinical governance at all Health Facilities.					
Percentage of Regional Hospitals with morbidity & mortality meetings every month.		100%	100%	100%	100%
Measurable Objective: To guide and assess the implementation of Infection Prevention and Control.					
Percentage of Regional Hospitals conducting monthly clinical audit meetings.	-	100%	100%	100%	100%
Percentage of Regional Hospitals implementing the Infection Prevention & Control Policy.	80%	80%	100%	100%	100%
Measurable Objective: To guide and assess health services against norms and standards of the Quality Improvement Plan.					
Integrated Quality Assurance Tool implemented at all Regional Hospitals.	-	100%	100%	100%	100%

TABLE 12: (PHS 5) Performance Indicators for Regional Hospitals

Indicator	Type	2006/07 (Actual)	2007/08 (Estimate)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)	National target 007/08
Output							
Caesarean section rate for Regional Hospitals.	%	34%	31%	31%	29%	28%	18%
Separations – Total.	Number	372,597	342,480 [24]	382,000	395,500	409,000	–
Patient Day equivalents.	Number	2,783,246	2,407,259	3,059,425	3,131,000	3,205,000	–
OPD Total headcounts.	Number	3,074,707	2,345,542	3,385,000	3,609,000	3,833,000	–
Quality							
Regional hospitals with patient satisfaction survey using DoH template. [25]	%	–	0	100%	100%	100%	100%
Regional hospitals with morbidity and mortality meetings every month. [26]	%	–	100%	100%	100%	100%	100%
Regional hospitals with clinical audit meetings every month. [27]	%	–	100%	100%	100%	100%	100%
Complaints resolved within 25 days. [28]	%	–	–	100%	100%	100%	100%
Efficiency							
Average length of stay in Regional Hospitals.	Days	5.4	4.8	4.1	5	5	4.1
Bed utilisation rate (based on usable beds) in Regional Hospitals.	%	72%	66%	72%	75%	76%	75%
Expenditure per patient day equivalent in regional hospitals.	R	R 748	R 1,024	R 1,128	R 1,184	R 1,243	–
Outcome							
Case fatality rate in Regional Hospitals for surgery separations.	%	6.4%	5.8%	5%	4%	3%	2%

[24] Data is lower than previous year due to Ngwelezana being included under Tertiary Hospitals.
[25] This is a Head office initiative. Due to delays by SCM to award the tender, the survey was not conducted.
[26] These are meetings to discuss all deaths at facilities (avoidable and unavoidable).
[27] These are meetings to discuss clinical audits for specific disciplines in relation to morbidity & mortality, disease surveillance, nursing/patient audits and disease specific conditions.
[28] The ratio used was 60 days. The Department will use the ratio of 25 days from MTEF 2008/09.

TABLE 13: (PHS 6) Trends in Provincial Public Health Expenditure for Provincial Hospitals (R million)

Expenditure (R'000)	2004/05 (actual)	2005/06 (Actual)	2006/07 (Actual)	Average annual percentage change	2007/08 (MTEF projection)	2008/09 (MTEF projection	2009/10 (MTEF projection)	2010/11 (MTEF projection)
GENERAL (REGIONAL) HOSPITALS								
Current prices								
Total.	R1,946,654	R2,212,986	R2,405,363	11.16	R2,768,561	R2,714,000	R2,975,525	R3,252,156
Total per person.	R199.06	R224.64	R242.38	10.35	R276.86	R269.39	R293.17	318.05
Total per uninsured person.	R226.20	R255.27	R275.43	10.10.10.35	R314.61	R306.13	R333.14	R361.42
Total capital.								
Constant (2007/08) prices								
Total.	R2,258,119	R2,478,544	R2,573,738	6.76	R2,768,561	R2,551,160	R2,677,973	R2,796,854
Total per person.	R230.90	R269.56	R259.34	5.98	R276.86	R253.23	R263.85	R273.52
Total per uninsured person.	R262.39	R285.90	R294.71	5.98	R314.61	R287.76	R299.83	R310.82
Total capital								
PSYCHIATRIC HOSPITALS								
Current prices								
Total.	R266,760	R295,734	R334,552	11.99	R395,495	R455,451	R494,540	R529,880
Total per person.	R27.28	R30.02	R33.71	11.17	R39.55	R45.21	R48.73	R51.82
Total per uninsured person.	R31.00	R34.11	R38.31	11.17	R44.94	R51.37	R55.37	R58.89
Constant (2007/08) prices								
Total.	R309,442	R331,222	R357,971	7.56	R395,495	R428,124	R445,086	R455,697
Total per person.	R31.64	R33.62	R36.07	6.77	R39.55	R42.50	R43.85	R44.57
Total per uninsured person.	R35.96	R38.21	R40.99	6.77	R44.94	R48.29	R49.83	R50.64

Expenditure (R'000)	2004/05 (actual)	2005/06 (Actual)	2006/07 (Actual)	Average annual percentage change	2007/08 (MTEF projection)	2008/09 (MTEF projection	2009/10 (MTEF projection)	2010/11 (MTEF projection)
TUBERCULOSIS HOSPITALS								
Current prices								
Total.	R242, 287	R230,.332	R314,451	13.92	R501,511	R616,813	644,744	R858,271
Total per person.	R24.78	R23.38	R31.69	13.09	R50.15	R61.23	R63.52	R83.94
Total per uninsured person.	R28.15	R26.57	R36.01	13.09	R56.99	R69.57	R72.19	R95.38
Constant (2007/08) prices								
Total.	R281,053	R257,972	R336,463	9.41	–	R579,804	R580,270	R738,113
Total per person.	R28.74	R28.06	R33.90	8.61	R50.15	R57.55	R57.17	R72.19
Total per uninsured person.	R32.66	R29.76	R38.53	8.61	R56.99	R65.40	R64.97	R82.03
CHRONIC HOSPITALS								
Current prices								
Total.	R50,401	R49,052	R76,140	22.91	R90,168	R94,715	R103,170	R110,813
Total per person.	R5.15	R4.98	R7.67	22.01	R9.02	R9.40	R10.16	R10.84
Total per uninsured person.	R5.86	R5.66	R8.72	22.01	R10.25	R10.68	R11.55	R12.32
Constant (2007/08) prices								
Total.	R58,465	R54,938	R81,470	18.05	R90,168	R89,032	R92,853	R95,299
Total per person.	R5.98	R5.97	R8.21	17.18	R9.02	R8.84	R9.15	R9.32
Total per uninsured person.	R6.79	R6.34	R9.33	17.18	R10.25	R10.04	R10.40	R10.59
DENTAL HOSPITALS								
Current prices								
Total.	R7,833	R7,977	R8,439	3.80	R10,551	R18,513	R19,890	R21,084
Total per person.	R0.80	R0.81	R0.85	3.04	R1.06	R1.84	R1.96	R2.06
Total per uninsured person.	R0.91	R0.92	R0.97	3.04	R1.20	R2.09	R2.23	R2.34
Constant (2007/08) prices								
Total.	R9,086	R8,934	R9,030	(0.31)	R10,551	R17,402	R17,901	R18,132
Total per person.	R0.93	R0.97	R0.91	(1.04)	R1.06	R1.73	R1.76	R1.77
Total per uninsured person.	R1.06	R1.03	R1.03	(1.04)	R1.20	R1.96	R2.00	R2.02

HEALTH
KwaZulu-Natal

NOTES

MTEF PERIOD 2008/09 – 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

HEALTH
KwaZulu-Natal

ANNEXURE 9

PROGRAMME 5: TERTIARY AND CENTRAL HOSPITAL SERVICES

MTEF PERIOD 2008/09 – 2010/11

(STRATEGIC PLAN PERIOD 2005/06 – 2009/10)

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1. INTRODUCTION

According to the imperatives set in the STP a Tertiary Hospital is a Health Facility that provides specialist and sub-specialist health care as defined for Level Three Services. In the Public Sector, these Hospitals are defined as **Tertiary One Hospitals → Provincial Tertiary Hospitals**.

Some Tertiary One Hospitals will also provide a defined range/ package of other specialised services (Group 2 Specialties in Table 2). These are classified as **Tertiary Two Hospitals → National Referral Hospitals**.

In a very small number of Hospitals, currently two, there will be an additional package of sub-specialties (Group 3 Specialties in Table 2). These will be referred to as **Tertiary Hospitals → Central Referral Hospitals**.

A Specialised Level Three Hospital will only have one speciality represented (e.g. cardiology or spinal injuries) and a General Level Three Hospital will have sub-speciality representation in at least 50% of the range of the Group 1 Specialties as listed in Table 2.

The STP makes provision for two Tertiary Hospitals in eThekwini (one being a Central Hospital) and one Tertiary Hospital each in the other two Management Areas of the Department.

1. SITUATION ANALYSIS

Tertiary Hospital Services will be provided at four Hospitals, while Tertiary Spinal Services are also provided at King George V Hospital (80 beds).

Layered service delivery poses unique management and monitoring challenges as the current reporting system (DHIS) does not allow for a break down of service delivery indicators. Interpretation of specific service delivery indicators is therefore a time consuming and often frustrating exercise.

Greys Hospital provides 80% Tertiary and 20% Regional Services; Ngwelezana Hospital 40% Tertiary, 40% Regional and 20% District services; and King Edward VIII Hospital provides 25% Tertiary and 75% Regional services. Current reporting of health service delivery indicators does not differentiate between services rendered for different levels of care in these Hospitals, making it difficult to analyse trends in service delivery. Reporting should be reconsidered to ensure a more appropriate analysis of service delivery indicators to determine performance against National and Provincial targets/ norms and imperatives set in the STP.

Table 1 indicates the Hospitals designated to provide Tertiary services and their catchment population.

TABLE 1: Tertiary Hospitals and their Catchment Populations – 2008/09

Hospital	Catchment Population	Required Beds
IALC*	3,039,997	668
Greys	2,708,548	591
Ngwelezana**	2,412,426	525
King Edward VIII***	623,737	213

* Inkosi Albert Luthuli Central Hospital.

** Ngwelezana Hospital will continue to render both Tertiary and Regional services until the new Area 3 Tertiary Hospital is built and functional (expected date for completion: 2016). The package of services for the new Area 3 Hospital must still be determined based on the outcome of the Burden of Disease Study.

*** King Edward VIII Hospital will be rebuilt once adequate funding is secured. Expected completion: 2012. Until King Edward has been rebuilt, the reporting on King Edward will continue under Regional General Hospitals.

2.1 Organisational Structures

The organisational structure for Greys Hospital has been approved in 2007/08. The structure for IALCH is awaiting approval.

TABLE 2: Specialties in Tertiary Hospitals

Group1 Specialties	Group 2 Specialties	Group 3 Specialties
Anaesthetics	Cardiology	Haematology
Burns	Cardiothoracic Surgery	Liver Transplant
Clinical Pharmacology	Clinical Immunology	Clinical Pharmacology
Critical Care & ICU	Craniofacial Surgery	Dermatology
Dermatology	Endocrinology	Maxillofacial Surgery
Diagnostic Radiology	Geriatrics	
Ear Nose & Throat	Haematology	
Gastroenterology	Human Genetics	
Infectious Diseases	Medical & Radiation Oncology	
Mental Health	Neurology	
Neonatology	Neuro Surgery	
Nephrology	Nuclear Medicine	
Obstetrics & Gynaecology	Paediatric Sub-Specialties	
Ophthalmology	Renal Transplant	
Paediatric Medicine	Rheumatology	
Paediatric Surgery	Spinal Injuries	
Paediatric ICU		
Plastic & Reconstructive Surgery		
Rehabilitation Centre		
Respiratory Medicine		
Trauma		
Urology		
Vascular Surgery		

2.2 Bed Allocation

The STP used the norm of ***0.22 Beds per 1,000 uninsured population*** to calculate the beds required for Tertiary Hospitals.

The Level 3 beds in each Tertiary Hospital will be managed separately to enable management to determine the human resource needs of individual Hospitals as well as being able to determine the Conditional Grant funding from National Treasury.

The Spinal Facility at King George V Hospital (80 beds) will, from a management perspective, be linked to Inkosi Albert Luthuli Central Hospital.

2.3 Staffing Arrangements

The staffing norms for this level of care are still outstanding given the differences in the Tertiary Hospital package of services, the current infrastructure configuration of Tertiary Hospitals, diverse service delivery demands, and lack of case management information.

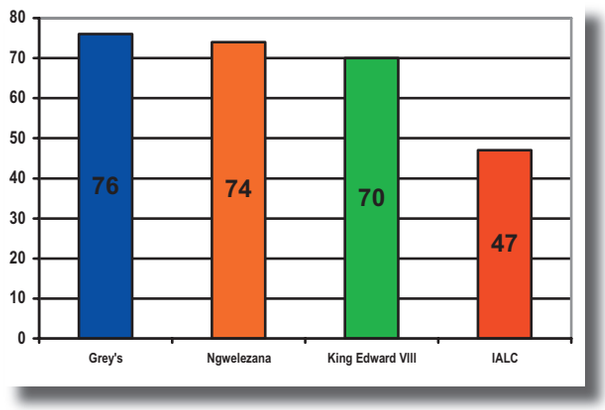
However, to overcome these challenges, the Department is currently finalising proposals to customise organisational and post establishment structures for the provisioning of the identified package of service per Institution (IALCH and Grey's). This is done through extensive consultation involving Clinicians, a comprehensive analysis of clinical procedures at this level of health care and the existing bed allocation.

2.4 Utilisation of Tertiary Hospital Services

Effective utilisation of Tertiary Hospital services is dependent on effective implementation of and adherence to referral policies and criteria and optimal functioning of Regional, District and PHC services.

Figure 1 indicates bed utilisation rates of Tertiary Hospital Services.

FIGURE 1: Bed Utilisation Rate



- Only Greys Hospital exceeds the National target of 75% set for Tertiary Hospitals, while the low utilisation rate in IALC Hospital is a concern that the Department will investigate to ensure that resources are utilised appropriately.

- Inappropriate utilisation and referrals to Tertiary Services are still a challenge. Re-enforcement of the existing referral pathways, policies, and criteria is therefore paramount to ensure seamless service delivery and appropriate utilisation of resources.
- Service delivery indicators of Institutions rendering services for different levels of care (Tertiary, Regional and District) should be analysed routinely to determine performance and resource allocation.

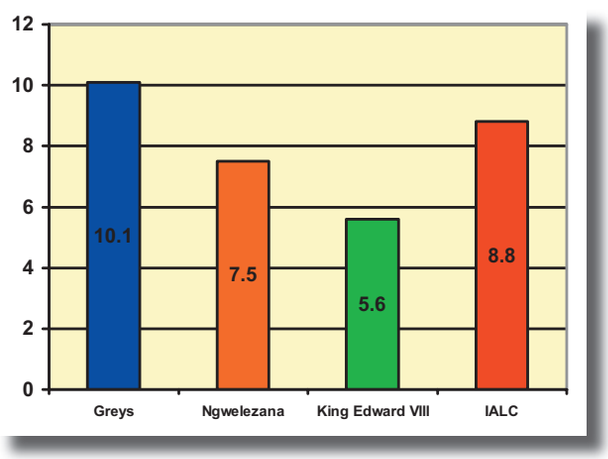
2.5 Average Length of Stay

The National Department of Health set a target of 5.3 days for Tertiary Hospitals, as compared to 4.1 days for Regional Hospitals and 4.2 days for District Hospitals.

The STP makes provision for additional bed capacity in the form of Specialised Hospitals and Step-Down Facilities to counteract the increasing need for extended health care. Extended time spent in hospitals (other than Specialised Hospitals) should therefore be closely monitored to ensure effective decanting of patients to the appropriate level of care.

Figure 2 indicates the Average Length of Stay in Tertiary Hospitals.

FIGURE 2: Average Length of Stay



- All Tertiary Hospitals exceed the National target of 5.3 days average stay. Routine data in the DHIS does not allow accurate interpretation of this indicator, and investigation will be actioned to determine the reason for extended stay.

2.6 General

- Data management will be strengthened by the implementation of Meditech Hospital Information Systems and ICD-10 coding systems. Training commenced in MTEF 2006/07.
- Strategies will be put in place to improve quality improvement programmes linked with client and staff satisfaction surveys and supportive supervision.
- All Hospitals providing tertiary services conduct morbidity and mortality meetings that are used to improve clinical management of clients. The monitoring of outcome indicators is therefore crucial to assess output following meetings.
- The quality assurance capacity and compliance in Hospitals needs to be improved and sustained. Both Inkosi Albert Luthuli Central and Greys Hospitals have participated in the COHSASA programme and has been fully accredited. Regular monitoring is necessary to ensure that both Hospitals continue to comply with the criteria.
- Recruitment and retention of appropriately skilled staff (Nurses, Doctors, Specialists and Supplementary Personnel) in the different specialities remain a challenge. The STP provides a platform for the development and implementation of a sustainable Recruitment and Retention Policy a strategy facilitated by the Human Resource Management Unit.
- Medical and Radiation Oncology, including Nuclear Medicine, requires urgent and immediate attention. It is estimated that nationally, approximately 40% of patients requiring oncology services receive care, with the major part of these resources situated within the private sector. This has led to sub-optimal service delivery (especially in diagnostic radiology), and poor access to these services especially for the un-insured population. These services are currently being provided in Durban, mainly at Addington Hospital (in the process of being decommissioned) and Inkosi Albert Luthuli Central Hospital. Commissioning of Oncology Services at Greys Hospital will commence in 2007/08 – 2008/09 to accommodate the increase in patient load from the Midlands area and Western half of the Province.

- MTS which comprises the strengthening and maintenance of existing radiation and medical oncology services (mainly capital cost in the 2007/08 year), development of regional hospital services for basic chemotherapy and palliative care, and rationalisation of oncology centres and development of patient hotels including the development of national and central referral service units will be actioned in line with the funding envelope secured from Treasury from MTEF 2009/10 onwards.

ANNEXURE 9

FIGURE 3: Organisational Structure for Tertiary Hospital

Example: Inkosi Albert Luthuli Hospital

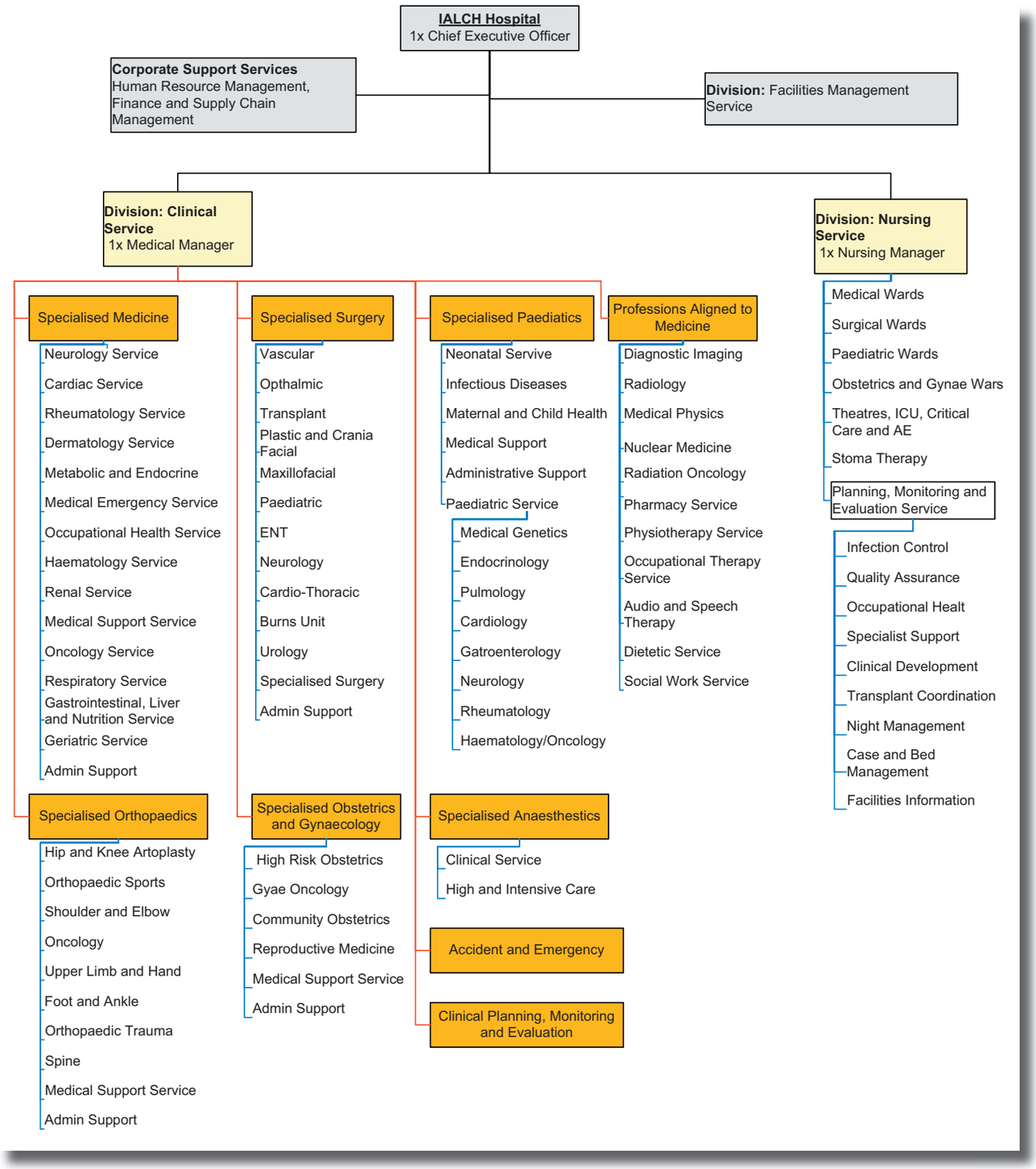


TABLE 3: (CHS 1) Number of Beds in Tertiary Hospitals

Name	Medical Beds	Surgical Beds	Maternity Beds	Paediatric Beds	Orthopaedic Beds	Gynaecological Beds	High Care /ICU Beds	Specialised Psychiatric
IALC	208	302	64	217	0	0	74	0
Grey's	99	140	80	94	54	22	5	0
Ngwelezana	186	123	232	170	56	0	8	44 are planned for MTEF 2008/09.

3. PRIORITIES AND STRATEGIC OBJECTIVES

The strategic objectives, measurable objectives and indicators for Tertiary and Central Hospitals are indicated in the diagram below.

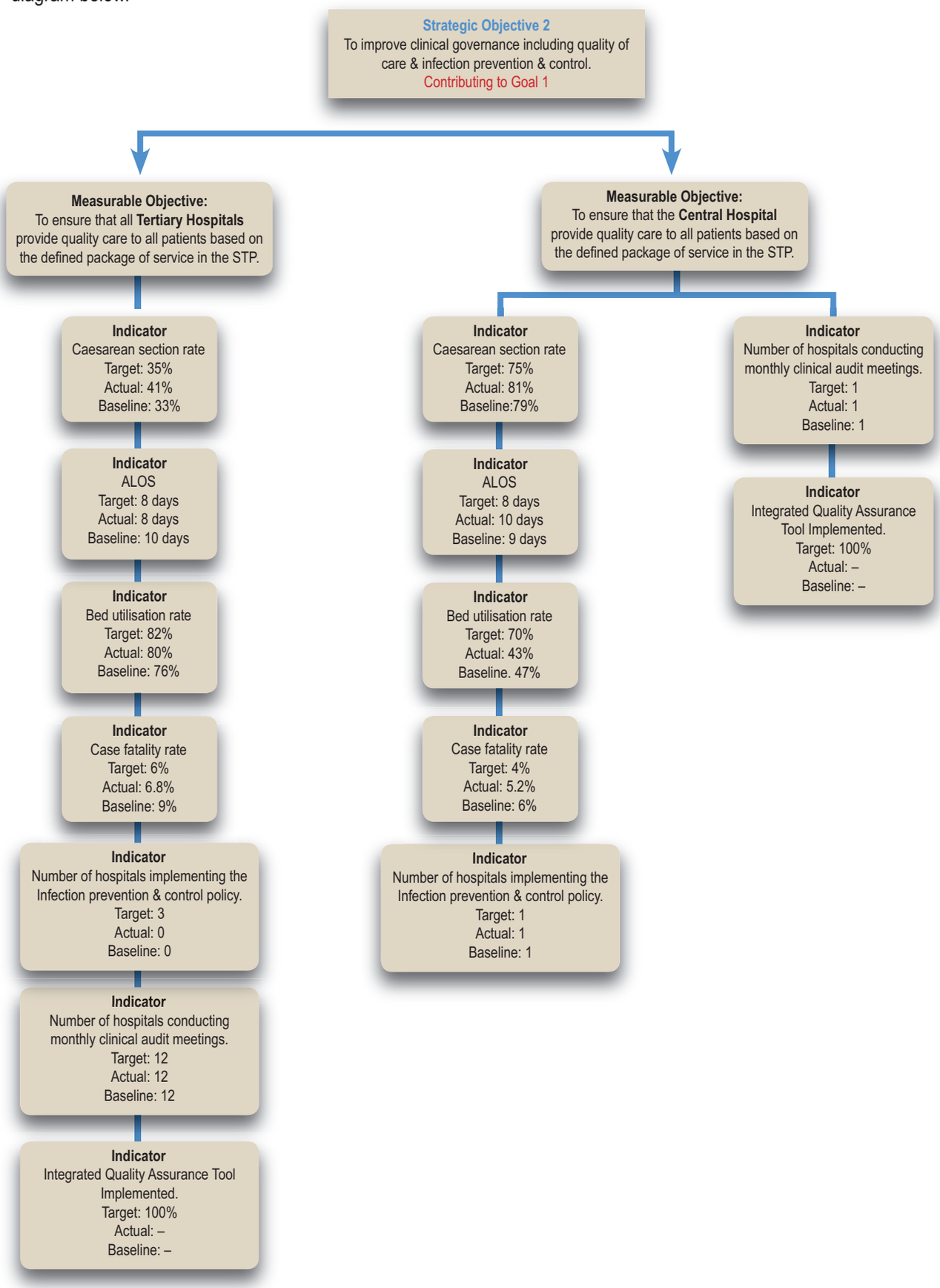


TABLE 4: (CHS 2) Performance Indicators for Ngwelezane/ Lower Umfolozi

Indicator	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Estimate)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)	National target 2007/08
Output								
1. Caesarean section rate.	32%	38%	35%	35%	35%	35%	35%	35%
2. Separations – Total.	32,901	36,397	38,248	40,160	42,186	44,276	46,490	
3. Patient Day Equivalents.	240,698	241,619	288,805	303,245	318,407	334,327	351,043	
4. OPD total headcounts.	148,402	134,115	168,376	176,794	185,633	194,9155	204,661	
Quality								
5. Patient satisfaction survey completed. Using DOH template.	Yes	Yes	No	No	Yes	Yes	Yes	
6. Morbidity and mortality meetings at least once a month.	100%	100%	100%	100%	100%	100%	Yes	
7. Clinical audit meetings (at least once a month).	100%	100%	100%	100%	100%	100%	Yes	
8. Complaints resolved within 25 days.[1]	–	–	–	–	100%	100%	100%	–
Efficiency								
9. Average length of stay.	7.18 days	7.3 days	5.6 days	6.5 days	6 days	6 days	5.5 days	5.3
10. Bed utilisation rate (based on usable beds).	63.1%	66.5%	80.0%	68.5%	70%	75%	75%	75%
11. Expenditure per patient day equivalent.	–	–	R 1,135	R 2,735	R 2,871	R 3,015	R 3,166	R 1,877
Outcome								
12. Case fatality rate for surgery separations.	6.3	6.1%	5.4%	5.5%	5.2%	5%	4.5%	3.0%

[1] New Indicator added for 2008/09. The Department has reported against this Indicator as being 60 days until MTEF 2007/08. As from MTEF 2008/09 the Department will report against this indicator as being 25 days.

TABLE 5: (CHS 2) Performance Indicators for Grey's Hospital

Indicator	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Target)	2008/09 (Target)	2009/10 (Target)	2009/10 (Target)	National target 2007/08
Output								
1. Caesarean section rate.	61.5%	73%	67%	60%	55%	50%	45%	25%
2. Separations – Total.	15,156	15,486	12,305	12,048	12,650	13,282	13,947	–
3. Patient Day Equivalents.	118,170	139,844	189,402	192,880	202,524	212,650	223,282	–
4. OPD total headcounts.	199,287	178,493	181,595	197,442	207,314	217,679	228,563	–
Quality								
5. Patient satisfaction survey completed.[2]	–	0	0	0	100%	100%	100%	
6. Morbidity and mortality meetings at least once a month.	100%	100%	100%	100%	100%	100%	100%	Monthly
7. Clinical audit meetings (at least once a month).		100%	100%	100%	100%	100%	Monthly	Monthly
8. Complaints resolved within 25 days.[3]	–	–	–	–	100%	100%	100%	
Efficiency								
9. Average length of stay.	7.7 days	6.53 days	10 days	5.5 days	5.5 days	5.5 days	5.5 days	5.3 days
10. Bed utilisation rate.	70.4%	77%	76.4%	80%	85%	85%	85%	75%
11. Expenditure per patient day equivalent.	No data	R 1,273	R 1,336	R 1,402	R 1,472	R 1,546	R 1,623	R1,877
Outcome								
12. Case fatality rate for surgery separations.	5.9%	No data	7%	7%	6%	5.5%	5%	3.0%

[2] SCM delays in award of tender resulted in survey not completed in 2006/07 and 2007/08

[3] New Indicator added for 2008/09. The Department has reported against this indicator as being 60 days until MTEF 2007/08. As from MTEF 2008/09 the Department will report against this indicator as being 25 days.

TABLE 6: (CHS 2) Performance Indicators for Inkosi Albert Luthuli Hospital

Indicator	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Target)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)	National target 2007/08
Output								
1. Caesarean section rate.	5%	74%	79%	75%	75%	75%	75%	25%
2. Separations – Total.	17,414	14,733	1,717,115	13,208	17,500	18,000	18,500	
3. Patient Day Equivalents.	237,197	191,673	157,954	139,697	160,000	165,000	170,000	
4. OPD total headcounts.	148,202	145,768	154,072	161,012	158,000	161,000	164,000	
Quality								
5. Patient satisfaction survey completed.[4]	Yes	Yes	No	No	Yes	Yes	Yes	–
6. Morbidity and mortality meetings at least once a month.	100%	100%	100%	100%	100%	100%	100%	Monthly
7. Clinical audit (M and M) meetings.	100%	100%	100%	100%	100%	100%	Monthly	Monthly
8. Complaints resolved within 25 days.[5]					100%	100%	100%	
Efficiency								
9. Average length of stay.	3 days	10 days	9 days	10 days	8 days	8 days	8 days	5.3 days
10. Bed utilisation rate.	66%	61%	47%	43%	48%	55%	65%	75%
11. Expenditure per patient day equivalent.	R 2,494	R 3,855	R 2,230	R 3,130	R 3,286	R 3,450	R 3,623	R1,877
Outcome								
12. Case fatality rate for surgery separations.	No data	6%	6%	5.2%	4%	4%	4%	3.0%

[4] SCM delays in award of tender resulted in survey not completed in 2006/07 and 2007/08.
[5] New Indicator added for 2008/09. The Department has reported against this Indicator as being 60 days until MTEF 2007/08. As from MTEF 2008/09 the Department will report against this Indicator as being 25 days.

TABLE 7: Performance Indicators for all Central/Tertiary Hospitals

Indicator	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Target)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)	National target 2007/08
INKOSI ALBERT LUTHULI CENTRAL HOSPITAL								
Input								
1. Expenditure on hospital staff as % of hospital expenditure.	27.73%	27.93%	28.09%	31.33%	32.52%	33.54%	37.59%	70%
2. Expenditure on drugs for hospital use as % of hospital expenditure.	3.58%	3.86%	4.19 %	4..22%	4.24%	4.87%	5.32	13%
GREY'S HOSPITAL								
1. Expenditure on hospital staff as % of hospital expenditure.	54.20%	64.96%	60.72%	58.08%	58.22%	58.37%	58.97%	70%
2. Expenditure on drugs for hospital use as % of hospital expenditure.	16.16%	9.21%	8.32%	9.06%	9.09%	9.19%	9.74	13%
NGWLEZANE HOSPITAL								
1. Expenditure on hospital staff as % of hospital expenditure.	–	–	55.82%	52.72%	52.72%	57.82%	57.89%	70%
2. Expenditure on drugs for hospital use as % of hospital expenditure.	–	–	3.75%	7.82%	8.16%	9.21%	13%	13%
LOWER UMFOLOZI								
1. Expenditure on hospital staff as % of hospital expenditure.	–	–	55.14%	55.16%	55.23%	57.88%	60.00%	70%
2. Expenditure on drugs for hospital use as % of hospital expenditure.	–	–	7.19%	7.90%	7.90%	7.90%	7.67%	13%

1. Inkosi Albert Luthuli Hospital is the only Tertiary Hospital with funding being dedicated to central/tertiary services.
2. Grey's Hospital is in the process of developing its tertiary services and has funds allocated to programmes other than central hospital services.
3. Ngwelezane/Lower Umfolozi Hospital is in the process of developing its tertiary hospital services and funds have been allocated from 2006/07.

TABLE 8: (NHS) Performance Indicators

Activity	Indicators	Targets 2006/07	Targets 2007/08	Targets 2008/09	Responsibility
Hospital improvement plans.	Clinical Audits.	Clinical audits routinely monitored in all Tertiary and Central Hospitals.	Clinical audits routinely monitored in all Tertiary and Central Hospitals.	Clinical audits routinely monitored in all Tertiary and Central Hospitals.	Monitoring and Evaluation Component.
	Complaints Mechanisms.	Complaints mechanisms routinely managed in all Tertiary and Central Hospitals.	Complaints mechanisms routinely managed in all Tertiary and Central Hospitals.	Complaints mechanisms routinely managed in all Tertiary and Central Hospitals.	Monitoring and Evaluation Component.
	Infection Control.	Infection Control management effected in all Tertiary and Central Hospitals.	Infection Control management effected in all Tertiary and Central Hospitals.	Infection Control management effected in all Tertiary and Central Hospitals.	Monitoring and Evaluation Component.
Hospital Improvement Plans.	Telemedicine.	Hub and spoke system developed in accordance with the STP.	Hub and spoke system developed in accordance with the STP.	Hub and spoke system developed in accordance with the STP.	Tele-health Component.

TABLE 9: (CHS 3) Provincial Objectives and Performance Indicators for Tertiary and Central Hospitals

Indicator	2006/07 (Actual)	2007/08 (Estimate)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Strategic Objective: To improve Clinical Governance including quality of care and Infection Prevention and Control.					
Measurable Objective: To ensure that all Central and Tertiary Hospitals provide quality care to all patients based on the defined package of services in the STP.					
Caesarean Section rate.	Tertiary: 33% Central: 79%	Tertiary: 41% Central: 81%	Tertiary: 35% Central: 75%	Tertiary: 34% Central: 74%	Tertiary: 33% Central: 73%
Average Length of Stay	Tertiary: 10 Days Central: 9 Days	Tertiary: 8 Days Central: 10 Days	Tertiary: 8 Days Central: 8 Days	Tertiary: 8 Days Central: 8 Days	Tertiary: 8 Days Central: 8 Days
Bed Utilisation rate.[6]	Tertiary: 76% Central: 47%	Tertiary: 80% Central: 43%	Tertiary: 82% Central: 70%[6]	Tertiary: 83% Central: 75%	Tertiary: 85% Central: 75%
Case fatality rate.	Tertiary: 9% Central: 6%	Tertiary: 6.8% Central: 5.2%	Tertiary: 6% Central: 4%	Tertiary: 5% Central: 3.5%	Tertiary: 4% Central: 3%
Measurable Objective: To guide and assess the implementation of Infection Prevention and Control.					
Number of Tertiary/ Central Hospitals implementing the Infection Prevention and Control Policy.	Tertiary: 1 Central: 1	Tertiary: 2 Central: 1	Tertiary: 2 Central: 1	Tertiary: 2 Central: 1	Tertiary: 2 Central: 1
Number of Tertiary/ Central Hospitals conducting monthly clinical audit meetings.	Tertiary: 1 Central: 1	Tertiary: 2 Central: 1	Tertiary: 2 Central: 1	Tertiary: 2 Central: 1	Tertiary: 2 Central: 1
Measurable Objective: To develop and implement a framework to improve clinical governance at all health facilities.					
Number of Tertiary/ Central Hospitals implementing strategies to reduce preventable causes of morbidity and mortality (emanating from morbidity and mortality meetings).	Tertiary: 1 Central: 1	Tertiary: 2 Central: 1	Tertiary: 2 Central: 1	Tertiary: 2 Central: 1	Tertiary: 2 Central: 1

[6] The bed occupancy rate for IALH is very low. However the caesarean section rate is very high. The hospital will urgently review the situation and implement measures to improve the occupancy rate/validate if the data is correct during MTEF 2008/09 in order to meet the required target.

TABLE 10: (CHS 5) Trends in Provincial Public Health Expenditure for Tertiary Hospitals (R million)

Expenditure (R million)[7]	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	Average annual percentage change	2007/08 (Projection)	2008/09 (Projection)	2009/10 (Projection)	2010/11 (Projection)
Current Prices.								
Total.	R914,324	R1,068, 606	R1,191,810	14.17%	R1,371,313	R1,440,152	R1,600,115	R1,948,949
Total per person.	R93.49	R108.47	R120.09	13.34%	R137.13	R142.95	R157.65	R190.60
Total per uninsured person.	R106.24	R123.26	R136.47	13.34%	R155.83	R162.44	R179.15	R216.59
Constant (2007/08) prices								
Total.	R1 060,616	R1 196,839	R1 275,237	9.65%	R1 371,313	R1 353,743	R1 440,104	R1 676,096
Total per person.	R108.45	R121.49	R128.50	8.85%	R137.13	R134.37	R141.89	R163.92
Total per uninsured person.	R123.24	R138.06	R146.02	8.85%	R155.83	R152.70	R161.24	R186.27
Total capital.								

[7] Due to the different levels of care the expenditure per person cannot be validated.

HEALTH
KwaZulu-Natal

NOTES

MTEF PERIOD 2008/09 – 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

HEALTH
KwaZulu-Natal

ANNEXURE 10

PROGRAMME 6 :

HEALTH SCIENCES AND TRAINING

MTEF PERIOD 2008/09 - 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

CONTENTS

List of Tables

PROGRAMME DESCRIPTION

Provide training and development opportunities for existing and potential employees of the Department.

PROGRAMME STRUCTURE

Sub-Programmes

Nurse Training College
Provide training for nurses at both undergraduate and postgraduate level.

EMRS Training College
Provide training for Emergency Care Practitioners.

Bursaries
Provide bursaries for students studying Health Sciences at undergraduate levels.

PHC Training
Provide PHC related training for Professional Nurses working in the PHC setting.

Training (Other)
Provide skills development programmes for all occupational categories.

1. SITUATIONAL ANALYSIS

The capacity of Human Resource Development Components attached to Institutions has been strengthened with decentralised delegations to Institutions in 2006/07. During 2007/08 the People Development Component at Head Office has appointed incumbents that will be responsible for the sub-components of Bursary Administration, Policy Development and Planning and Monitoring and Evaluation. These sub-components will provide support to the institutions in respect of People Development issues and to monitor and evaluate the impact and value of training in the Department.

The KwaZulu-Natal College of Nursing provides nursing education in the fields of Enrolled Nursing (EN), Enrolled Nursing Assistant (ENA) courses, the 4-year Registered Nurse Programme, Bridging Courses and Post Basic courses. In 2007/08 a total number of 4,954 students were registered, with an anticipated 1,300 to assume duty annually in the Department. Doubling of nurse intakes has increased the supply of nurses by approximately 700 nurses per annum.

During 2007/08, the following number of nurses were trained and awarded their qualifications at a graduation ceremony held in September 2007: Enrolled Nursing Assistants: 29; Enrolled Nurses: 543; Bridging Nurses: 333; Registered Nurses: 392; Post Basic Nurses: 201; Primary Health Care Nurses: 38; Midwifery: 212 and Psychiatric Nursing: 21.

Primary Health Care is at the heart of the plans to transform the health services in South Africa. In order for this to happen, training in PHC takes place at local colleges and tertiary institutions in the Province. In order to monitor outstanding services performed by nursing personnel, this component co-ordinates the annual Cecelia Makiwane awards for the Province who enters the National competition. For MTEF 2007/08 the KwaZulu-Natal winner was Sister S Pillay of Northdale Hospital.

Recruitment and placement of student nurses is effective, and the relevant District Selection Policy is in place. All graduating Professional Nurses are successfully placed in vacant Professional Nurse posts to honour contractual obligations. The demand for Professional Nurses however exceeds supply and the 4-year Diploma programme is too long to meet the current demand. The 2-year Bridging Programme has the potential to yield twice as many Professional Nurses in 4 years time to fill this gap.

Future intake must focus on improving the Registered Nurse category (in line with norms determined in the STP) either through increasing intake into the four year programme or via the Bridging Course (a process of career pathing an Enrolled Nurse to a Registered Nurse via a 2-year bridging course). Ilembe and Sisonke Districts have no nurse training institutions which may impact negatively on retention strategies.

The People Development Component has faced the following challenges during the reporting period:-

- Limited number of the accredited providers;
- Delay in filling of practitioner posts at Institutional level; and
- Fragmented evaluation systems that failed to determine the impact of training and development.

The component successfully implemented the following programmes:

1.1 Adult Basic Education and Training (ABET)

There are 2,134 registered learners on different ABET levels for the 2007 academic year. One of the challenges with ABET is that VEGA was contracted to undertake fundamentals training only, thus learners are unable to complete ABET Level 4.

In order to have learners progressing to matric, core and elective learning areas will be introduced in the 2008 Academic year.

1.2 Learnerships

The Department is currently administering the EMRS Learnership and Youth Ambassador programmes. In preparation for the 2010 Fifa World Cup, 50 in-service learners have commenced training in a newly established registered programme. In 2009 the intake will be increased to 200 learners. School leavers who want to pursue a career in emergency services will also be able to access the programme.

The Youth Ambassador learnership is in the process of being implemented. The aim of the project is to strenghten the Departments' manpower resources in the community and to provide employment. 496 Youth Ambassadors will be enrolled in the programme during 2007 and another 496 will be enrolled in 2008.

Learnerships are a relatively new form of intervention in the provision of human resource requirements. Other current learnerships include: – Basic Pharmacy Assistant, Post Basic Pharmacy Assistant, Enrolled Nursing Assistant, and Assistant Radiographer.

1.3 Internships

The Department is currently implementing the internship programme and 276 interns in various occupational fields have been recruited. All interns have been assigned to a mentor and bi-monthly reports on interns serve as the monitoring tool. The People Development Monitoring and Evaluation division will be monitoring this programme to evaluate the impact thereof.

About 90% of interns for the 2006/07 financial year intake have secured permanent employment within the Department through the attainment of skills and experience relevant and complimentary to their educational qualifications.

1.4 Bursaries

Bursaries to the value of R28,315,618. were awarded in Health Sciences fields during the 2006/07 financial year. Currently the Department has 736 bursarial students studying in Health Sciences fields, of which 381 are studying MBCHB, 73 in nursing and 282 in other health related categories. It is anticipated that approximately 218 students will assume duty in the Department annually as a result of this process.

Bursaries were awarded to 736 students in Tertiary Institutions and 71 for EMRS (Intermediate Life Support) students in 2006/07. 567 Bursaries were awarded to existing students for the 2006/07 academic year and 169 bursaries were awarded to new students in January 2007. A projected 350 new (first time) bursaries would have been allocated to applicants in the 4th quarter of the 2007 academic year. The target therefore is 868 active bursaries for 2007/08.

It must be noted that 109 of the approved 278 new bursary applicants were not accepted at the Tertiary Institutions where they applied to study because of poor Matric results, change in field of study and equity placements. It must further be noted that of the 291 existing KwaZulu-Natal students, 65 failed their 2006 academic year and were not promoted to the next level of study in 2007. These students are currently repeating the failed academic year at their own cost.

Twenty students have been nominated to participate in the Cuban medical programme. They will be leaving for Cuba in the second week of October 2007.

During 2007, 129 bursary holders were placed in various KwaZulu-Natal Health Institutions of which 63 were Doctors, 27 Nurses, 13 Radiographers, 5 Physiotherapists, 1 Occupational Therapist, 1 Optician, 1 Speech and Language Therapist, 1 Audiologist, 1 Speech Therapist, 4 Dentists, and 12 Pharmacists.

TABLE 1: Specification of Measurable Objectives and Performance Indicators of the Health Sciences and Training Programme

Sub-Programme	Objectives (Outputs)	Indicator	Performance				
			2004/05 Actual	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Strategic Plan Target
Health Sciences and Training Programme.	To provide cost effective Training of Nurses.	No of ENAs trained	141	76	66	29	60
		No of ENs trained	752	600	689	543	670
Nurse training colleges.	To provide cost effective Training of Nurses.	No of Bridging students trained	308	334	349	333	600
		No of RNs trained	262	318	344	392	650
PHC Training.	To provide cost effective Training of Nurses.	No of post basic graduates	323	457	499	434	510
		PHC nurses trained	230	230	256	38	260
Bursaries.	Ensure appropriate development of HR via bursaries.	Students in tertiary institutions	709	730	359	868	890
EMRS training college.	To increase ILS training.	No of ILS trained	46	47	71	96	120
	Provide Emergency Care Technician (ECT) training. NB. The ALS training has been cancelled for 2007/08.	No of ECT trained. NB. Data prior to 2007/08 is for ALS training.	18	16	8	50	100
Human Resource Management Service.	Development of HRP.	Finalised HRP.	100% (MANCO approval pending)	Implementation of plan.	HR norms developed	100%	100%
	Finalisation of post established.	N/A	100%	Restructuring.	Restructuring.	100%	100%
	Implement Employee Performance Management and Development (EPMDS).	N/A	N/A	100%	M&E	100%	100%
	Consolidation of recruitment & retention strategy.	Implementation of policy.	N/A	100% implementation.	Policy being revised.	100%	100%

Sub-Programme	Objectives (Outputs)	Indicator	Performance				
			2004/05 Actual	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Strategic Plan Target
	Realignment of HR portfolio.	HR posts decentralised.	N/A	80%	100%	100%	100%
	Decentralise HR delegations.	Decentralised delegations effected by institutions.	N/A	80%	100%	100%	100%
	Management capacity building.	Training received.	80%	100%	100%	100%	100%
	Effective management of misconduct cases.	Backlogs cleared.	Not measured.	80%	80%	100%	100%
	Compliance with National Minimum Information Requirements (NMIR) on PERSAL.	Updating information.	Not measured.	70%	70%	75%	75%
	PERSAL training needs established.	Database updated.	Not measured.	11 Districts.	100%	100%	100%

TABLE 2: Health, Professionals Training and Development Grant

Indicator	Type	2003/04 Actual	2004/05 Actual	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Strategic Plan Target
Input							
Intake of medical students.	No	402	361	365	367	385	396
Intake of nurse students.	No	2,403	2,450	2,455	2,475	2,485	2,495
Students with bursaries from the Province.	No	692	567	612	645	868	890
Process							
Attrition rates in first year of medical school.	%	0%	0%	0.7%	0%	0%	0%
Attrition rates in first year of nursing school.	%	0.4%	0.4%	0.4%	0.4%	0.4%	0%
Output							
Basic medical students graduating.	No	79	79	80	85	89	93
Basic nurse students graduating.	No	1,147	1,150	1,152	1,160	1,170	1,180
Medical registrars graduating.	No	0	0	0	[1]	0	0
Advanced nurse students graduating.	No	384	409	450	510	540	570
Efficiency							
Average training cost per nursing graduate.	R	62,000	67,000	72,000	80,000	85,000	90,000
Development component of Health Professionals Training and Development Grant (HPT & D) grant spent.	%	Information not available.	Information not available.	Information not available.	Information not available.	Information not available	Information not available.

[1] No data available

2. POLICIES, PRIORITIES AND STRATEGIC GOALS

2.1 Policies

≈ The Public Service Act, the Public Service Regulations and National Policies provide a flexible and supportive framework for the Department to develop and implement flexible Human Resources Management and Development Policies to support seamless service delivery.

≈ The Department has during the 2007/08 financial year developed policies to support health service delivery. These policies provide for: -

- Counteroffers for employees in the Department which seeks to address the retention of staff that are offered employment in the private sector or other Departments;
- The re-employment of retired Public Servants so as to complement the workforce in occupations where the demand of such skills outweighs the supply e.g. Professional Nurses and Doctors; and
- Current staff to undertake studies in the fields of Financial Management, Human Resource Management, Public Management, Public Relations and Management Assistant at the Further Education and Training (FET) College. On completion of the 18 month training programme at the FET College, staff can apply for the relevant qualification to be converted to a National Diploma provided they have 18 months of relevant work experience in the respective field of study. This initiative promotes staff remaining in the Department as part of a retention strategy and the Department having suitably qualified personnel to career path for more senior positions.

2.2 Priorities

1. Effective recruitment and placement of graduating nurses.
2. Increase the number of Nurses trained by the Province.
3. Recruitment and placement of graduating bursary holders.
4. Strengthen the training of postgraduate PHC nurses.
5. Develop the skills and capabilities of Middle Management through Talent Management and Mentoring.

2.3 Strengthening Human Resources

1. Place graduating nurses and bursary holders in under served institutions to fulfil their contractual obligations in order to address the imbalances of resources between rural and urban facilities.
2. Provide for career pathing of staff through a system of talent management, mentoring and coaching so that a pool of skilled and capable people is available in the Department.
3. Minimise the negative impact of prolonged administrative processes and 'red tape' on service delivery.
4. Promote the training of PHC nurses through distance learning in association with accredited service providers.
5. Strengthen accountability arrangements, 'leaving limited scope to blame others for non-delivery'.
6. Improve the data quality on PERSAL, including the utilisation of reliable data and information generated by PERSAL for monitoring, evaluation and reporting.

TABLE 3: Analysis of Constraints and Measures Planned to Overcome Them

Human Resource Priority	Level of Risk	Approach to mitigate risk and achieve outcome
Recruitment/ Staffing.	High level of risk.	Development and implementation of revised recruitment and retention policy and strategy.
Workload/ Staff utilisation.	Medium level of risk.	Implement newly determined staffing norms and ratios, in conjunction with appropriate skills mix.
Performance Management.	Medium level of risk.	Full implementation of the EPMDS in the Department.
Implementation of STP.	Medium level of risk.	Redress strategic & capacity shortcomings highlighted in the STP. Align HRP with the STP to ensure full integration of HR Planning with other pivotal planning components in the Department.
Strengthen Provincial Data Systems.	High level of risk.	Interrogate the accuracy of information contained on PERSAL. Disease profile data readily available per catchment area. Monitor the supply of graduating health professionals.

TABLE 4: (HR 2) Provincial Objectives and Performance Indicators for Human Resources

Indicator	2006/07 (Actual)	2007/08 (Estimate)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Strategic Objective: To design and implement a total seamless quality service delivery system for the Department.					
Measurable Objective: To enhance management capacity through a variety of management Programmes.					
Number of Managers, Level 13 and above, being trained in Khaedu programme.	10	15	20	20	20
Number of middle Managers, Level 7 to 12, who attended Management Programmes.	150	110	795		
Number of Hospital Managers / CEOs that have been enrolled on an accredited Hospitals Management training programme.	10	24	16	16	16
Measurable Objective: To align the training and deployment of health workers to the Human Resources Plan.					
Number of Dental Technicians trained.	Nil	Nil	Nil		
Number of Advanced Midwives trained.	70	70	100	100	100
Number of Physiotherapists trained.	7	7	Targets to be informed by HRP.	Targets to be informed by HRP.	Targets to be informed by HRP.
Number of Occupational Therapists trained.	3	3	Targets to be informed by HRP.	Targets to be informed by HRP.	Targets to be informed by HRP.
Number of Dentists trained.	2	2	Targets to be informed by HRP.	Targets to be informed by HRP.	Targets to be informed by HRP.
Number of Pharmacists trained.	24	24	Targets to be informed by HRP.	Targets to be informed by HRP.	Targets to be informed by HRP.

TABLE 5: Situation Analysis and Projected Performance for Health Sciences and Training

Indicator	Type	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	National Target for 2007/08
Input									
1. Intake of medical students (provided with provincial bursaries).	Number	338	402	371	365	367	381	396	–
2. Intake of nurse students (student nurses and bursary holders).	Number	2,185	2,403	2,450	2,455	2,475	2,485	2,495	–
3. Students with bursaries from the province (excluding nursing and medicine).	Number	574	604	567	571	645	282	590	–
Process									
4. Attrition rates of bursary holders in first year of medical school.	%	0%	0%	0%	0,7%	0%	0%	0%	10%
5. Attrition rates of bursary holders and student nurses in first year of nursing school.	%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	10%
Output									
6. Basic medical students graduating.	Number	80	79	79	80	85	89	93	–
7. Basic nurse students graduating.	Number	963	1,147	1,150	1,152	1,160	1,170	1,180	–
8. Medical registrars graduating.	Number	0	0	0	0	0	0	0	–
9. Advanced nurse students graduating.	Number	373	384	409	450	510	540	570	–
Efficiency									
10. Average training cost per basic nursing graduate.	R	58,000	62,000	67,000	72,000	80,000	85,000	90,000	–
11. Development component of Health Professionals Training and Development grant spent.	%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100%

TABLE 6: Trends in Provincial Public Health Expenditure for HPT and D Conditional Grant (R million)

Expenditure (R million)	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	Average annual percentage change	2007/08 (Actual)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF Projection)
Current prices.								
Total	R183,669	R180,087	R204,659	5.56%	R201,992	R212,092	R222,425	R235,771
Total per person.	R18.78	R18.28	R20.62	4.79%	R20.20	R21.05	R21.91	R23.06
Total per uninsured person.	R21.34	R20.77	R2.43	4.79%	R22.95	R23.92	R24.90	R26.20
Constant (2007/08) prices.								
Total.	R213,056	R201,697	R218,985	1.38%	R201,992	R199,366	R200,183	R202,763
Total per person.	R21.79	R20.47	R22.07	0.64%	R20.20	R19.79	R19.72	R19.83
Total per uninsured person.	R24.76	R23.27	R25.08	0.64%	R22.95	R22.49	R22.41	R22.53

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ANNEXURE 11

PROGRAMME 7 :

HEALTH CARE SUPPORT SERVICES

MTEF PERIOD 2008/09 - 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

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PROGRAMME DESCRIPTION

To render support services required by the Department.

PROGRAMME STRUCTURE

Sub-Programme 7.1
Medicine Trading Account

1. SITUATIONAL ANAYSIS

The Provincial Medical Supply Centre (PMSC) is responsible for the bulk procurement, storage and distribution of medicines to public health facilities, and the pre-packing of patient-ready medication packs.

- The introduction of deliveries directly from PMSC to PHC Clinics and ARV sites improved availability of medicines at facility level and resulted in a marked decrease in medicine 'stock-outs' from 10% in 2002/03 to 5% in 2006/07.
- The implementation of this arrangement further enhanced service delivery through:
  - The delivery, at least once every two weeks, of pharmaceutical items to all PHC Clinics serviced by the Central Pharmaceutical Supply Store (CPSS).
  - Enhanced stock control at all levels.
  - Screening of requests and requisitions against the historical provisioning profile of facilities with an immediate response to address discrepancies.
  - Reduction of waiting times because 'high volume' items are 'pre-packed' and 'pre-labelled' at the CPSS according to the standard dispensing dosage.
  - Strengthening of the planning and procurement processes.
- Outsourcing of the delivery function to a private courier company allows PMSC to concentrate on its core function, and most importantly, the risk of transit-losses has been transferred to the courier company.
- PMSC is currently supplying medicines to a total of 1,905 clients at 800 supply points. This is inclusive of Municipal clinics and a number of accredited NGOs.
- PMSC also ensures the uninterrupted supply of ARVs to a total of 110,395 patients at 74 ART sites.[1] This has been accomplished by astute procurement procedures and innovative re-organising of the store area to cope with the added volumes of stock.
- PMSC has reached full capacity at the current premises and is unable to cope with the increasing volumes of orders, which means that additional supply points can no longer be accommodated. To accommodate increasing demand, PHC orders are now collected directly from the depot or from feeder hospitals.
- PMSC is not fully compliant with the provisions of the Pharmacy Act as well as those of the Medicines and Related Substances Act.
  - The current entrance facility at PMSC for deliveries of goods is inadequate and trucks are sometimes kept waiting or have to deliver stocks the following day.
  - Due to inadequate space, stock is being stored incorrectly and therefore it becomes difficult to relocate when necessary. Emergency Exit passages are blocked with stock due to a shortage of storage space.
  - Staff shortages cannot be dealt with at the moment because of a lack of accommodation for existing staff.

[1] October 2007

2. POLICIES, PRIORITIES AND STRATEGIC OBJECTIVES

Policies

PMSC is guided by the following:

- The Pharmacy Act (Act No 53 of 1974) as amended.
- The Medicines and Related Substances Control Act (Act No 101 of 1965) as amended.
- Good Pharmacy Practice Rules of SA Pharmacy Council.
- Good Manufacturing Practice, Good Wholesaling Practice, and Good Distribution Practice of the Medical Control Council (MCC).

New Policies

1. Provincial Policy for Supply of Contraceptives to the Private Sector – to improve access to comprehensive contraceptive services.

Priorities

Ensure compliance with the registration requirements of the South African Pharmacy Council and the Medicines Control Council for a Pharmaceutical Warehousing Facility.

Improve operational efficiency through the implementation of an electronic warehouse management system to progressively replace manual systems.

Develop mechanisms, within the limitations set by the Standard Stock Account, to develop a "buffer stock" capacity for critical pharmaceutical items.

Streamline requisition processes and practices ("orders" from Institutions / PHC Clinics are currently faxed to PMSC - creating a high margin of error).

Relocation of PMSC to new premises to create extra capacity and improve storage conditions.

Improve the coordination between Pharmaceutical Policy and Systems Development and PMSC.

3. ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Health System Priority	Constraints	Planned Remedial Interventions
Improving Quality of Care.	• PMSC is currently non-compliant with the provisions of the Pharmacy Act as well as those of the Medicines and Related Substances Act. • Lack of ambient temperature control cannot ensure optimum storage conditions as stipulated by the manufacturer.	• Relocation to new premises in extent of 37 804 m2 to house the Provincial Medical Supply Centre, currently accommodated at Clairwood Hospital and the Centralised Chronic Dispensing Unit currently accommodated at Esplamed Pharmacy – will meet the need for the next 10 years.
Strengthen infrastructure.	• PMSC has reached capacity at the present premises and is unable to cope with the increasing volumes of orders. It also means that additional supply points can no longer be accommodated.	• Request direct deliveries from Suppliers to Institutions thereby reducing stock holding. This will solve space and logistical problems in the long term, but increase cost of supply. • Establish more distributed PMSC depots in more Districts.
Improving Quality of Care.	• The current electronic warehousing system is outdated and requires a high degree of manual data capturing.	• A new Oracle-based stores management system will be introduced in early 2008. This will include an automated scanning system to register receipts and issues of medicines as well as the management of stock that will ensure improved management reports. The system will also enable facilities to place orders electronically.

TABLE 1: Provincial Objective and Performance Indicators for Support Services – PMSC

Indicator	2006/07 (Actual)	2007/08 (Estimate)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Strategic Objective: To ensure that key support services are effectively provided.					
Measurable Objective: To procure, store and distribute EDL and approved medicines.					
Un-interrupted supply of ARV medication for patients initiated on HAART.	100%	100%	100%	100%	100%
Stock-out rate of EDL medicines.	3%	2%	<2%	<2%	<2%
Compliance with legislation of Institutional Pharmacies.	–	50%	75%	100%	100%
"Buffer" stock maintained for critical pharmacy items.	–	–	100%	100%	100%

TABLE 2: Trends in Provincial Public Health Expenditure for Support Services (R million)

Expenditure (R million)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	Average annual percentage change	2007/08 (Projection)	2008/09 (Projection)	2009/10 (Projection)	2010/11 (Projection)
Current prices.								
Total.	R10,600	R7,600	R29.560	66.99	R12,649	R34,130	R25,162	R21,072
Total per person.	R1.08	R0.77	R2.98	65.77	R1.26	R3.39	R2.48	R2.06
Total per uninsured person.	R1.23	R0.88	R3.38	65.77	R1.44	R3.85	R2.82	R2.34
Constant (2007/08) prices.								
Total.	R12,296	R8,512	R31,629	60.38	R12,649	R32,082	R22,646	R18,122
Total per person.	R1.26	R0.86	R3.19	59.21	R1.26	R3.18	R3.18	R1.77
Total per uninsured person.	R1.43	R0.98	R3.62	59.21	R1.44	R3.62	R2.54	R2.01

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NOTES

MTEF PERIOD 2008/09 - 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

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ANNEXURE 12

PROGRAMME 6 :

HEALTH SCIENCES AND TRAINING

MTEF PERIOD 2008/09 - 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

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PROGRAMME DESCRIPTION

To provide new health facilities, upgrading and maintenance of existing health facilities, including the management of the Hospital Revitalisation Programme and concomitant Conditional Grant.

PROGRAMME STRUCTURE

Sub-Programme 8.1
Community Health Services – PHC Clinics and Community Health Centres (CHC).

Sub Programme 8.2
District Hospitals.

Sub Programme 8.3
Emergency Medical Rescue Services.

Sub Programme 8.4
Provincial Hospital Services.

Sub Programme 8.5
Tertiary and Central Hospital Services.

Sub Programme 8.6
Other Facilities.

1. INTRODUCTION

The Component Infrastructure Development and Health Technology Service are established within the Infrastructure Development and Clinical Support Service Unit. This component facilitates the provisioning of all physical facilities to the Department in terms of buildings, plant and life support equipment.

The purpose of the Component is to:

- Develop and maintain the policy framework and norms and standards for the development and maintenance of public health buildings and plant.
- Facilitate and coordinate processes for the acquisition of land and the design and construction of new buildings inclusive of the coordination of activities to equip newly constructed buildings for commissioning in accordance with the STP of the Department.
- Oversee the implementation of major capital maintenance projects in accordance with the Departmental Multi-Year Upgrading Plan.
- Ensure that the medical equipment used in the Province is maintained in an optimum condition.
- Provide technical advice and guidance with regard to the acquisition, utilisation, care and disposal of medical equipment.
- Centrally manage processes for the acquisition of technically advanced medical equipment.
- Implement the Hospital Revitalisation Programme.

The main outputs of the Programme are:

- Maintenance and monitoring of the Facilities Audit System indicating the status of existing infrastructure (Buildings and Plant).
- Facilitation of processes to prioritise infrastructure and plant maintenance needs identified through the Facilities Audit System and the alignment thereof with the Multi-Year Maintenance Plan.
- Implementation of Projects planned in terms of the Multi-Year Maintenance Plan.
- Development of a Multi-Year Infrastructure Development Plan that complies with the imperatives of the STP, as wel as the implementation of related projects. This includes the implementation of the Infrastructure Development Improvement Programme which is a 3 year programme to improve the delivery of social infrastructure at provincial level. The Programme is funded by National Treasury in partnership with the Development Bank of Southern Africa, Department of Public Works and the Construction Industry Development Board.
- Ensuring that costly and highly technical advanced medical equipment is optimally maintained, replaced and procured on behalf of Institutions.
- The Revitalisation of Infrastructure, Equipping, and commissioning of Hospitals identified under the Hospital Revitalisation Grant, and to facilitate, co-ordinate and manage all projects being implemented as part of the Hospital Revitalisation Grant.

2. SITUATION ANALYSIS

- During MTEF 2007/08, projects to the value of R 419,797 million were completed as summarised in Table 2.

- During 2006/07 – 2007/08 14 new PHC Clinics, five PHC Replacement Clinics and eight PMTCT/ HAART Clinics were built and 34 PHC Clinics upgraded. Three New Community Health Centres (CHCs) are under construction: KwaMashu Replacement (eThekwini), St Chads at Ezakheni (Uthukela) and Turton (Ugu). The implementing agent for these three CHCs is Ithala. The date for opening of these CHCs is the middle of MTEF 2009/10. Umzimkhulu CHCs is in the tender phase.

  During MTEF 2007/08 and 2008/09 the Programme will focus on the new PHC Clinics to the value of R109 million and upgrades of existing PHC Clinics to the value of R131 million. 47 Capital and 51 Upgrade Projects are under construction.

There are 36 Hospital projects where construction is on site.

The progress being made and planned in terms of Hospitals being funded as part of the Hospital Revitalisation Grant is as follows:

- Substantial progress has been made during MTEF 2007/08 with the upgrading of King George V Hospital to provide District-, Specialised Psychiatric-, Spinal- and Specialised TB, TB MDR and TB XDR services. The TB Wards, which have been developed in a star shape design, have been completed. It is planned that occupation will be 100% by the end of June 2008. The 130 beds for Psychiatric services will be handed over at the end of March 2008. The commissioning of the District health beds (453 beds) and the Spinal Unit (80 beds) is behind schedule (8 months delay). It is planned that construction of the Level 1 District Hospital will be completed in December 2008, with 2009 required to complete the equipping, commissioning, and staffing of the facility, which is planned to be open for admissions early in December 2009. The TB Surgical Wards and Mortuary are now commencing, and will be completed by September 2009.

- Phase II of the Rietvlei Hospital was completed in MTEF 2007/08. Phase II comprised the construction of male and female medical wards, doctors' accommodation and a new mortuary. The design and planning of Phase III has commenced in MTEF 2007/08. It includes the Pharmacy, the Laundry, Administration Block, Workshops, Kitchen, ARV Clinic, upgrade of staff accommodation and a Laboratory for utilisation by NHLS. The Department plans to have the contractors on site in November 2008. The planned completion date is November 2009.

- The following contracts have been completed at Lower Umfolozi Memorial Hospital in MTEF 2007/08: 11 kva intake, Nursery and Mothers Lodge, Replacement of cold water feeds, medical air compressors, six air handling units and perimeter fencing. During MTEF 2008/09 attention will be given to the further upgrading of water supply and further air handlers, replacement of kitchen equipment and conversion to electricity, and conversion of the autoclave from steam to electricity. The Trauma and casualty wards at Ngwelezana Hospital have been completed in MTEF 2007/08. The completion of the new Pharmacy will be the end of July 2008. During MTEF 2008/09, the Department will commence with the development of the new Mental Health Unit. The helipad contract will also commence in MTEF 2008/09.

- The Independent Development Trust is the implementation agent for the development of Dr Pixley Seme Hospital as a District Hospital (eThekwini). The design phase has commenced and a peer review will take place in conjunction with the National Department of Health at the beginning of MTEF 2008/09. The Department is waiting for the initial investigation studies for Dr John Dube Hospital as a District Hospital (eThekwini) from the Provincial Department of Public Works.

- The planning for the master plan for the construction of Madadeni Regional Hospital has commenced in MTEF 2007/08. It is planned to commence with the detailed design of the first institution – being the Regional & District Hospitals, in September 2008. The Master Planning exercise will identify the priorities and determine sequencing. As the capital value of revitalising this complex is

substantial, ongoing development will be subject to availability of funding. The total of beds is 1493 (Regional beds – 192; District beds – 149, Specialised Psychiatric beds – 513, Mental health beds – 45 beds, 4 isolation wards, Specialised TB and TB MDR beds – 508, Step down beds – 128).

- Extensive renovations are being implemented in the Hlabisa Hospital as part of a Presidential Lead Project. The first phase of the project was completed MTEF 2007/08. During MTEF 2008/09 the design of Phase II will commence. The design of Phase II will be implemented in two stages, namely first the Pharmacy and Outpatients section and thereafter the completion of the district beds (312 district beds and 105 TB beds – acute and recurrent).

- Two mortuary upgrades are underway and three others are in the tender phase. A further nine new facilities and 6 upgrades are in planning.

- After an extensive campaign to provide grid electricity to PHC Clinics the last 58 PHC Clinics were electrified (with the exception of the 8 Umzimkhulu Clinics). The Department contributed 641 km of electrical distribution line to improve infrastructure.

- Telephone communication in PHC Clinics improved substantially with 114 PHC Clinics provided with telephonic communication systems. The remaining 21 PHC Clinics (eight in Umzimkhulu) will be targeted during 2007/08.

TABLE 1: Work Projects per Region

Regions	Hospitals	Clinics	Mortuaries	Total
Midlands	26	50	5	81
Southern	38	65	3	106
eThekwini	50	40	1	91
North Coast	98	70	6	174
Total	212	225	15	452

- There is an estimated R6.42 billion backlog of maintenance and rehabilitation of Hospital infrastructure, which excludes the take over of the FOSA and SANTA Centres, Forensic Mortuary services as well as the take over of Municipal Clinics. A building inflation of ±20% is escalating the cost of construction on all projects. This is further exacerbated by the shortage of builders due to current demand. For example, in some cases the prices tendered are 40% higher than the estimates. This backlog will be addressed through maximising and utilising available resources through a combination of in-house general maintenance work and the outsourcing of other work.

- An amount of R30 million is required to repair the roof at King Edward VIII Hospital, and a further R4 million to upgrade the lifts at Addington Hospital to comply with fire regulations. The business case for a total re-commissioning of King Edward VIII has been submitted to the National Department of Health. This plan includes 212 Tertiary beds and 638 Regional beds (a total of 850 beds). If approved and funding is secured the Department will commence with implementation of the project in MTEF 2008/09.

- A business case for Edendale Hospital has been approved by the National Department of Health in December 2007. This plan includes 248 Regional beds, 217 District Beds, 161 step down beds, 45 mental health beds, and 4 Isolation Wards. (A total of 674 beds).

- The Department will commence in MTEF 2008/09 with the development of a business case for a new Tertiary Hospital to serve Area 3 (that is Zululand-, Umkhanyakude- and Uthungulu Districts).

- Most pharmacies must be upgraded to meet the requirements of the Pharmacy Act, and mental health facilities still do not comply with the minimum infrastructure criteria determined in the Mental Health Act (Act 12 of 2002).

- There is still a need for:
  - Additional MDR & XDR Wards (in accordance with the imperatives set by the Provincial STP).
  - Appropriate residential accommodation to attract and retain staff.
  - Essential building upgrades to provide infrastructure for Psychiatric and TB facilities according to imperatives set by the Provincial STP.
  - Trauma bed facilities, isolation wards, and EMRS communication centres in preparation for the 2010 FIFA Soccer world Cup.
  - Isolation wards, waste storage sites, milk

kitchens, Neonatal Nurseries and Isolation Cubicles.

The maintenance of health facilities and equipment is the responsibility of the Manager of an Institution, with technical support provided by the in-house technical staff, the Office of the District Engineer and Head Office Components.

- With a few exceptions, each Hospital has a workshop to render day-to-day maintenance with Artisans and Tradesman Aids to undertake minor maintenance work. Larger, more complex maintenance and repair work is referred to the Head Office Component for the development of work specifications, initiating action by the Provincial Department of Works or other service delivery mechanisms.

- The provisioning of Central Laundry Services forms part of this Programme. Apart from the Cato Manor Laundry (situated on IALC premises), the Department is facing a challenging situation at the other sites (Dundee, Sea Cow Lake, Prince Mshiyeni and Fort Napier). The infrastructure, equipment upgrading and maintenance were neglected over a substantial period of time (due to financial constraints and other health priorities). This neglect is now resulting in an increase in "down–time" and in some instances concerns that the Plant is not compliant with the legislative imperatives. This comes at considerable risk for the Department to continue with operations.

- The provisioning of adequate management and supervisory structures for the laundries were also neglected for a substantial period of time and this will receive urgent attention in MTEF 2008/09. The Department will consider different service delivery models for the rending of laundry services during MTEF 2008/09. Other support services for which different service delivery models are required are house keeping and waste management.

The Infrastructure Plan for MTEF 2008/09 has been prepared in order to comply with the legislative requirements of the Infrastructure Delivery Improvement Programme. The purpose of the Infrastructure Plan is as follows:

- To identify and present the infrastructure requirements of the Department for the type of health facilities that will be in line with the imperatives of the STP.
- To ensure that the planning of health facilities is undertaken in accordance with the prioritised needs of the STP.
- To ensure that optimum cost efficiency is achieved insofar as planning for the most appropriate type and location of health facilities.
- To provide an indication of anticipated expenditure per Programme and per Project over the life-cycle of the project for the long term planning period.
- To communicate to external- and internal stakeholders the intentions of the Department as far as its infrastructure delivery programme are concerned.
- To motivate and lobby for funding expectations that does not meet funding availability.
- To ensure that all statutory and regulatory requirements are adhered to.

The Plan is a living document that will be updated annually from April to August in order to ensure that the consequential short term priorities inform the preparation of the Infrastructure Programme Management Plan and the related Infrastructure Programme Implementation Plan.

TABLE 2: Summary of Projects Completed in MTEF 2007/08

Facilities Type	Nature of the Project(s)	Number of Projects	Spent MTEF 2006/07 R (mil)	Total Projects per Facilities Type	Total Spent per Facilities Type R (mil)
Step–down and Rehabilitation Hospitals	New Facility	–	–	–	–
CHCs	New Facility	2	18,421	23	18,798
	Rehabilitation/Renovation	8	376		
	Upgrading	1	0		
PHC Clinics	New Facility	13	22,633	90	49,310
	Replacement	1	6,573		
	Upgrading	23	14,010		
	Maintenance	11	6,092		
	Mobile Clinics	0	0		
District Hospitals	New Facility	53	28,049	117	66,672
	Rehabilitation/ Renovation	4	1,055		
	Upgrading	54	22,269		
	Maintenance	–	–		
	Replacement	6	15,300		
EMRS	New Facility	21	8,442	21	8,442
	Upgrading	–	–		

Facilities Type	Nature of the Project(s)	Number of Projects	Spent MTEF 2006/07 R (mil)	Total Projects per Facilities Type	Total Spent per Facilities Type R (mil)
Regional Hospitals	New Facility	25	33,835	60	22,992
	Rehabilitation/ Renovation	3	1,503		
	Upgrading	27	22,992		
	Replacement	5	1,753		
Other Services	Upgrading	10	970	10	970
	Replacement	0	0		
Psychiatric Hospitals	Upgrading	5	577	6	1,035
	New facilities	1	458		
TB Hospitals	New Facility	3	847	3	847
	Upgrading	–	–		
	Replacement	–	–		
Tertiary Hospitals	Upgrading	5	231	15	5,669
	New Facility	10	5,438		
Mortuary Services	New Facility	9	16,123	11	15,634
	Upgrading	2	4,619		
Training Complexes	Upgrading	1	20	1	20
Total				367	234,444

TABLE 3: Historic and Planned Infrastructure Projects in line with the STP

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 Estimate	2008/09 Projection	2009/10 Projection	2010/11 Projection
New PHC facilities (Clinics and CHC's) and upgrading of PHC facilities in line with the STP.	92 (Including upgrading)	51 (Including upgrading)	209 (Including upgrading)	296 (Including upgrading)	30 (Including upgrading)	30 (Including upgrading)	30 (Including upgrading)	
New District Hospitals.	–	–	–	–	–	1		
Upgrading District Hospitals.	18 Projects	16 Projects	38 Projects	42 Projects	11 Projects	15 Projects	20 Projects	25 Projects
New Regional Hospitals.	–	–	–	–	–	–	–	
Upgrading Regional Hospitals.	16 Projects	3 Projects	15 Projects	30 Projects	9 Projects	13 Projects	11 Projects	15 Projects
Upgrading Tertiary Hospitals.	–	–	–	–	1 Project	–	1 Project	

TABLE 4: (HFM 1) Historic and Planned Capital Expenditure by Type

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (MTEF Projection)	2008/09 (MTEF Projection)	2009/10 (MTEF Projection)	2010/11 (MTEF Projection)
Major capital	195,121	167,890	402,445	551,037	916,566	713,305	877,866	930,538
Minor capital	12,672	59,553	19,972	99,517	115,000	125,000	145,000	148,400
Maintenance				72,694	173,830	182,522	191,648	203,147
Equipment	47,925	71,516	118,505	89,930	73,000	110,000	115,000	127,200
Equip maintenance								
Total capital	255,718	298,959	540,922	813,178	1,278,396	1,130,827	1,329,514	1,409,285

TABLE 5: (HFM 2) Summary of Sources of Funding for Capital Expenditure

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (MTEF Projection)	2008/09 (MTEF Projection)	2009/10 (MTEF Projection)	2010/11 (MTEF Projection)
Infrastructure grant	70,043	127,168	157,561	174,098	259,758	288,193	336,599	356,795
Equitable share	55,815	92,247	237,432	413,552	658,444	640,841	688,676	729,997
Revitalisation grant	129,860	78,544	145,929	225,528	360,194	201,793	304,239	322,493
Donor funding								
Other								
Total capital	255,718	298,959	540,922	813,178	1,278,396	1,130,827	1,329,514	1,409,285

Hospital rehabilitation and reconstruction grant HR&R expenditure prior to 2003/04 should be recorded under revitalisation grant

TABLE 6: (HFM 3) Historic and Planned Major Project Completions by Type

Indicator	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (MTEF Projection)	2008/09 (MTEF Projection)	2009/10 (MTEF Projection)	2010/11 (MTEF Projection)
New Hospitals						1		1
New Clinics / CHC's	3	2	6	6	30	43	3	5
Upgraded Hospitals	34	19	53		21	28	32	38
Upgraded Clinics / CHC's	18	25	58	115	105	8	3	5

TABLE 7: Total Projected Long Term Capital Demand for Infrastructure Development (R million)

Programme	Province wide total Planning Horizon 2007/08 – 2012/13	Province Total Annualised	Annualised										
			Ugu 2007/08	Umgungundlovu 2007/08	Uthukela 2007/08	Umzinyathi 2007/08	Amajuba 2007/08	Zululand 2007/08	Umkhanyakude 2007/08	Uthungulu 2007/08	iLembe 2007/08	Sisonke 2007/08	eThekwini 2007/08
Programme 1													
MECs Office and Administration													
Programme 2													
Clinics and CHC's	2,196,576	366,096	57,993	25,864	26,517	23,198	20,231	42,174	42,423	53,970	15,291	18,809	39,626
Mortuaries	131,406	93,592	8,973	20,969	12,905	12,905	6,452	6,452	7,025	14,767	–	1,719	1,425
District Hospitals	1,880,172	405,125	25,741	9,708	5,738	12,392	8,464	25,924	160,094	30,228	12,921	20,108	93,805
Programme 3													
EMS Infrastructure	46,782	7,797	50	–	1,184	–	–	1,260	1,432	476	1,442	1,466	487
Programme 4													
Regional Hospitals	758,022	126,337	35,526	3,483	6,635	–	3,788	–	–	29,577	12,296	–	35,032
Psychiatric Hospitals	85,314	14,219	–	13,818	–	–	–	–	–	–	–	–	401
TB Hospitals	1,224,516	234,562	7,000	4,500	–	–	–	6,729	4,000	1,976	–	–	210,357
Other Specialised Hospitals	7,332	1,222	–	–	–	–	–	–	–	–	–	–	1,222
Programme 5													
Provincial Tertiary and National Tertiary Hospitals	108,384	18,064	–	18,064	–	–	–	–	–	–	–	–	–
Other Programmes													
Nursing, EMS etc Colleges	68,292	11,382	–	7,681	–	859	–	–	830	–	–	–	2,012
Total all programmes	6,506,796	1,278,396	135,283	104,087	52,979	49,354	38,935	82,529	215,804	130,994	41,950	42,102	384,367

TABLE 8: Situation Analysis Indicators for Infrastructure Development

Indicator	Type	Province wide value 2004/05	Province wide value 2005/06	Province wide value 2006/07	Province wide value 2007/08	Ugu 2007/08	Umgungundlovu 2007/08	Uthukela 2007/08	Umzinyathi 2007/08	Amajuba 2007/08	Zululand 2007/08	Umkhanyakude 2007/08	Uthungulu 2007/08	iLembe 2007/08	Sisonke 2007/08	eThekwini 2007/08	National target 2007/08
Input																	
1. Equitable share capital programme as % of total health expenditure.	%	1%	4.06%	6.97%	4.9%	0.4%	0.3%	0.1%	0.4%	0.3%	0.4%	0.2%	0.5%	0.3%	0.1%	1.7%	5
2. Hospitals funded on revitalisation programme as % of total health expenditure.	%	7.90%	9.50%	1.93%	2.7%						0.68%		0.41%		0.08%	1.54%	5
3. Expenditure on facility maintenance as % of total health expenditure.	%	2%	1.36%	1.39%	1.6%												2.50
4. Expenditure on medical equipment maintenance as % of total health expenditure.	%	No data available	No data available	0.02%	0.07%	No data available	No data available	No data available	No data available	No data available	No data available	No data available	No data available	No data available	No data available	No data available	–
Quality																	
5. Fixed PHC facilities with access to piped water.	%	86%	86%	86%	98%	–	–	–	–	0.2%	0.2%	0.4%	–	1%	–	–	100%
6. Fixed PHC facilities with access to mains electricity.	%	100%	100%	100%	98%	–	–	–	–	–	–	–	–	–	2%	–	100%

Indicator	Type	Province wide value 2004/05	Province wide value 2005/06	Province wide value 2006/07	Province wide value 2007/08	Ugu 2007/08	Umgungundlovu 2007/08	Uthukela 2007/08	Umzinyathi 2007/08	Amajuba 2007/08	Zululand 2007/08	Umkhanyakude 2007/08	Uthungulu 2007/08	iLembe 2007/08	Sisonke 2007/08	eThekwini 2007/08	National target 2007/08
7. Fixed PHC facilities with access to fixed line telephone.	%	98%	98%	98%	96%	–	0.2%	0.4%	0.2%	0.8%	0.2%	0.4%	–	1.8%	–	–	100%
8. Average backlog of service platform in fixed PHC facilities. (R'000,000)	R	211	252	302	361	15%	5%	8%	8%	9%	16%	9%	11%	3%	2%	14%	30
9. Average backlog of service platform in District Hospitals. (R'000,000)	R	611	731	874	1,045	13%	2%	2%	17%	4%	13%	13%	9%	11%	14%	2%	30
10. Average backlog of service platform in Regional Hospitals. (R'000,000)	R	577	690	825	987	7%	5%	1%		3%			10%	4%		70%	30
11. Average backlog of service platform in Specialised Hospitals. (R'000,000)	R	342	409	489	585	10%	75%		3%		2%		10%				30
12. Average backlog of service platform in Tertiary and Central Hospitals. (R'000,000)	R	1,444	1,727	2,066	2,467		100%										30

Indicator	Type	Province wide value 2004/05	Province wide value 2005/06	Province wide value 2006/07	Province wide value 2007/08	Ugu 2007/08	Umgungundlovu 2007/08	Uthukela 2007/08	Umzinyathi 2007/08	Amajuba 2007/08	Zululand 2007/08	Umkhanyakude 2007/08	Uthungulu 2007/08	iLembe 2007/08	Sisonke 2007/08	eThekwini 2007/08	National target 2007/08
13. Average backlog of service platform in Provincially Aided Hospitals.[1]	R																30
Efficiency																	
14. Projects completed on time.	%	No data	No data	No data													
15. Project budget over run.	%	No data	No data	No data													
Outcome																	
16. Level 1 beds per 10 000 uninsured population	No	10	10	10	10	13	6	6	26	1	19	21	16	7	20	3	
17. Level 2 beds per 10 000 uninsured population.	No	8	8	8	8	5	10	7		31				9		13	
18. Population within 5 km of fixed PHC facility					6,279,899	418,629	709,517	252,374	231,294	307,877	257,938	231,708	343,729	420,166	252,318	2,423,704	uyhj

[1] Data not available

3. POLICIES, STRATEGIC OBJECTIVES AND PRIORITIES

3.1 Policies

Extensive policies on a wide range of issues related to Infrastructure Development and Health Technology are available on the Departmental web-site.

Policies are inclusive of the 'Green Building' good practices, which ensure environmentally friendly and energy efficient buildings.

The most recent policies that have been approved include the following:-

- Policy on the Design of Electrical Installations (Revision 1).
- Policy on the Design of Mechanical Installations (Revision 1).
- Policy on the Design of Structural Installations (Revision 1).

3.2 Priorities

Key strategies to reduce the maintenance backlog include:

Institutions are encouraged to undertake maintenance initiatives under R 200,000 by utilising centrally prepared specifications.

Implementation of a more flexible procurement service by using Fixed Term Contracts to eliminate procurement delays.

Institutions are encouraged to fill vacant posts within the Technician/Artisan Occupational Categories.

With the introduction of the VCT and PMTCT Programmes steps have been taken to supply Mobile Homes as interim facilities for these services.

Compliance with statutory obligations (for example mortuaries, pharmacies etc.). A detailed investigation has been undertaken into both the Forensic and Hospital Mortuaries to establish compliance and to identify the extent of upgrade work requirements.

A survey is currently being conducted to identify and list upgrade requirements in order for all Pharmacies to comply with the provisions of The Pharmacy Act, 2003.

Alignment of projects to the imperatives set by the STP for MTEF 2007/08 – 2008/09.

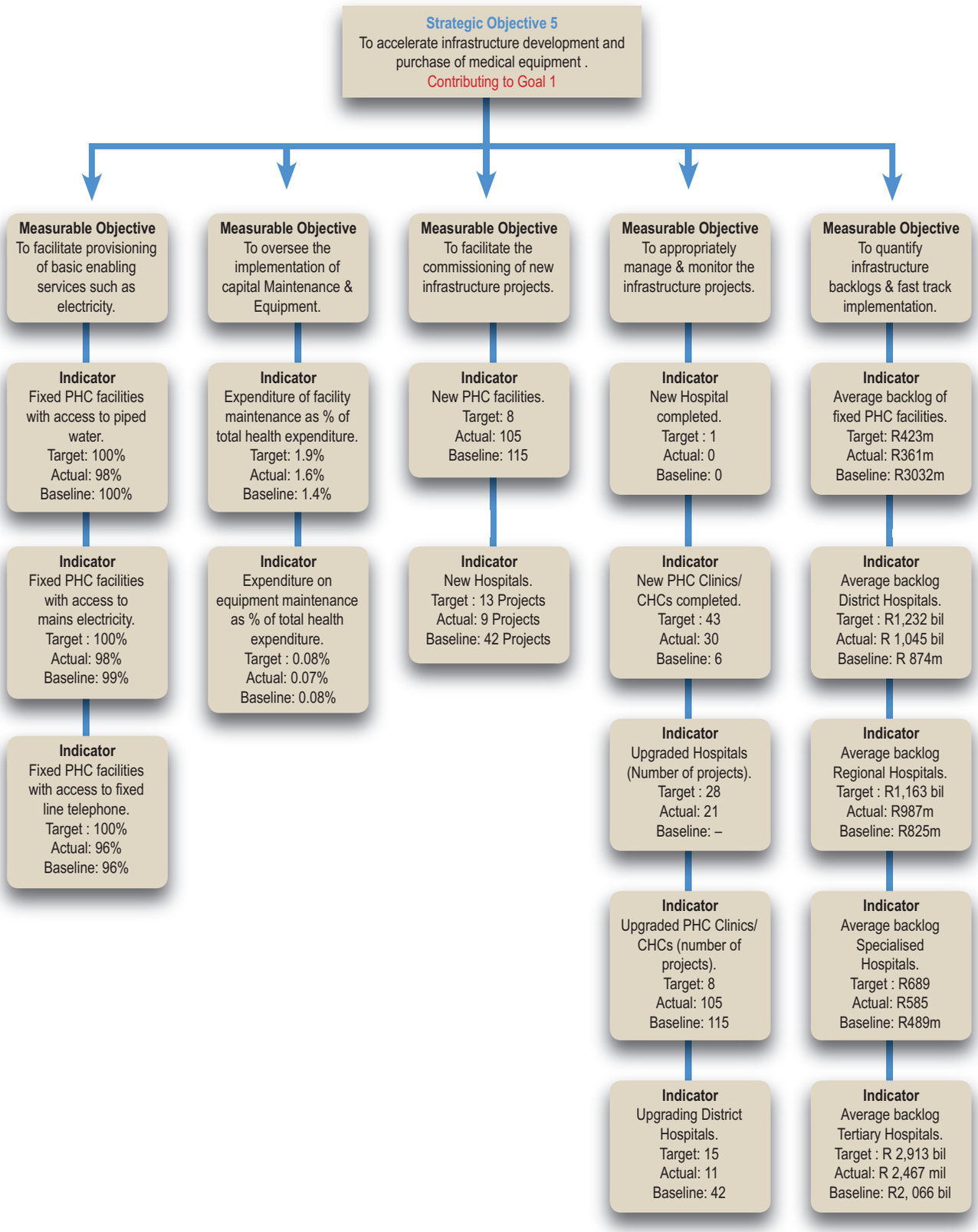
Compliance with the STP categorisation of PHC facilities and minimum structural requirements.

The Department is, as part of its stated objective to assist with the reduction of poverty in the Province, exploring options to "outsource" the washing of "non critical" items to Cooperatives. This approach will reduce the pressure on the laundries and assist with initiatives to properly maintain/upgrade the "ageing" laundry equipment.

Additional funding/ re-prioritising will have to be done to prevent a situation where hospitals will not be able to perform procedures due to the unavailability of clean theatre garments and linen.

PRIORITIES AND STRATEGIC OBJECTIVES

The following strategic objective, measurable objectives and indicators for the Infrastructure and Clinical Support Services Unit are indicated in the diagram below.



4. REVITALISATION PROJECTS

The approved Projects with completed Business Plans for the Conditional Grant are reflected in Table 9 below.

TABLE 9: Revitalisation Projects

Hospitals	Amount
King George V Hospital	R 629 512 728
Empangeni Hospitals Project	R 477,233 607
Dr Pixley Seme Hospital	R 416,188,608
Dr John Dube Hospital	R 491,777,995
Hlabisa Hospital	R 328,068,401
Madadeni Hospital	R 983,215,403
Total	**R 3,325,928,341**

TABLE 10: Analysis of Constraints and Measures Planned to Overcome Them

Health System Priority	Constraints	Planned Remedial Interventions
Strengthen Physical Infrastructure.	Lack of adequate funding for maintenance and rehabilitation.	▪ A gradual increase in budget allocation i.e. from 4% in 2000/01 to 9.5% in 2007/08 of the total budget allocation. Re-prioritisation of Projects to optimally support the Provincial STP.
Strengthen Physical Infrastructure.	Lack of adequate capacity to procure and manage projects.	▪ The "outsourcing" of contracts to alternative implementing agents which will alleviate the inadequate capacity of the KwaZulu-Natal Department of Works. Steps have been taken to establish a Service Level Agreement to "speed up" the infrastructure development processes. ▪ The implementation of "period contracts" which will overcome the impediments faced by time consuming provincial procurement procedures. ▪ Utilisation of Ithala and the Independent Development Trust to assist in the roll out of urgent projects such as Clinics and VCT Centres as well as the re-development of Hlabisa Hospital.
Strengthen Human Resources.	Difficulty in recruiting and retaining staff with engineering and related technical skills.	▪ Assist the Human Resources Management Unit to develop and implement a strategy to recruit and retain engineering and related skills in the Department.

TABLE 11: (NHS 5) Physical Infrastructure

Activity	Indicators	Targets 2006/07	Targets 2007/08	Targets 2008/09	Responsibility
Hospital revitalisation.	Funded hospitals in plan.	36 hospitals started on site, in progress or completed.	42 hospitals started on site, in progress or completed.	42 hospitals started on site, in progress or completed.	Develop MTS hospital business plans and all business cases in line with STP.
	Approved business cases, including MTS hospitals.	At least 2 new business cases completed and approved by May 2006.	At least 1 new business case completed and approved by May 2007.	At least 1 new business case completed and approved by May 2008.	
	Forensic mortuaries re-built /upgraded	20% of forensic mortuaries.	30% of forensic mortuaries.	50% of forensic mortuaries.	Develop and implement transfer plan.
	Maintenance increased.	Worst 10% of non-revitalisation hospitals receiving essential upgrades.	Worst 18% of non- revitalisation hospitals with completed essential upgrades.	Worst 22% of non- revitalisation hospitals with completed essential upgrades.	Develop implementation plan for upgrades.
		Maintenance expenditure increased to 1.4% of budget in all provinces.	Maintenance expenditure increased to 1.6% in all provinces.	Maintenance expenditure increased to 1.9% in all provinces.	Issue guidelines to managers for maintenance requirements and expenditure.
	Essential equipment provision.	Agreement on essential equipment packages (EQL) for all levels of care.	Gap analysis in all facilities against EQL completed by June 2007.	Updated cap analysis.	Implement audits and identify priorities for provision in line with EQL.
			Worst 20% of hospitals with full EQL.	Worst 50% of hospitals with full EQL.	
			Worst 30% of PHC facilities with full EQL.	60% of PHC facilities with full EQL.	

TABLE 12: (NHS 5) Physical Infrastructure

Activity	Indicators	Targets 2006/07	Targets 2007/08	Targets 2008/09	Responsibility
PHC.	Designated staff accommodated.	Audit of required accommodation and business plan by the Department by June 2006.	Accommodation provided in accordance with business plan.	Accommodation provided in accordance with business plan.	Infrastructure and Clinical Support Unit.
	Intersectoral infrastructure provision.	Agreement on gaps in intersectoral infrastructure.	25% of facilities with infrastructure gaps addressed.	50% of facilities with infrastructure gaps addressed.	Infrastructure and Clinical Support Unit.
	Facilities audited.	Audit of size and condition of all PHC facilities completed.	Worst 18% of facilities receiving essential upgrades.	Worst 22% of facilities receiving essential upgrades.	Infrastructure and Clinical Support Unit.
	CHC's development.	STP for CHC restructuring implemented.	STP for CHC restructuring implemented.	STP for CHC restructuring implemented.	Infrastructure and Clinical Support Unit.

TABLE 13: Provincial Objective and Performance Indicators for Infrastructure Development

Indicator	2002/03 (Actual)	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Target)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Measurable Objective: To facilitate the provisioning of basic enabling services									
Fixed PHC facilities with access to piped water.	Not measured.	Not measured.	Not measured.	Not measured.	100%	98%	100%	–	–
Fixed PHC facilities with access to mains electricity.	Not measured.	Not measured.	Not measured.	Not measured.	99%	98%	100%	–	–
Fixed PHC facilities with access to fixed line telephones.	Not measured.	Not measured.	Not measured.	Not measured.	96%	96%	100%	–	–
Measurable Objective: To oversee the implementation of capital Maintenance and Equipment									
Expenditure on facility maintenance as % of total health expenditure.	Not measured.	Not measured.	Not measured.	Not measured.	1.4%	1.6%	1.9%	2.2%	2.5%
Expenditure on equipment maintenance as % of total health expenditure.	Not measured.	Not measured.	Not measured.	Not measured.	0.08%	0.07%	0.08%	0.09%	0.1%
Measurable Objective: To facilitate the provision of new infrastructure projects									
New/upgraded PHC facilities/projects.	Not measured.	Not measured.	Not measured.	Not measured.		30	30	35	40
New/upgraded Hospitals/projects.	Not measured.	Not measured.	Not measured.	Not measured.		1	1	1	0
Measurable Objective: To appropriately manage and monitor infrastructure projects									
New Hospital completed.	Not measured.	Not measured.	Not measured.	Not measured.			1	–	–
New PHC Clinics / CHCs completed.	Not measured.	Not measured.	Not measured.	Not measured.	14	11	43	45	45
Upgraded Hospitals (Number of projects)	Not measured.	Not measured.	Not measured.	Not measured.	76	92	59	65	75
Upgraded PHC Clinics / CHCs (Number of projects)	Not measured.	Not measured.	Not measured.	Not measured.	147	52	47	55	65
Upgraded District Hospitals (Number of projects)	Not measured.	Not measured.	Not measured.	Not measured.	22	28	22	25	30

Indicator	2002/03 (Actual)	2003/04 (Actual)	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Target)	2008/09 (Target)	2009/10 (Target)	2010/11 (Target)
Measurable Objective: To quantify infrastructure backlogs and fast track implementation									
Average backlog of fixed PHC facilities (R'000)	Not measured.	Not measured.	211,000	252,356	303,818	361,9000	423,000	The Infrastructure Development Improvement plan is designed to assess the order of magnitude and facilitate the sourcing of additional funding – plan due for completion 01/03/08. Further progress dependant on sourcing further funding and the capacity of our implementing agents. The rate of deterioration is assessed through PREMIS with a review for 08/09 and beyond currently underway.	
Average backlog District Hospitals (R'000)	Not measured.	Not measured.	611,000	730,756	873,984	1,045,285	1,232,000		
Average backlog Regional Hospitals (R'000)	Not measured.	Not measured.	577,000	690,092	825,350	987,119	1,163,000		
Average backlog Specialised Hospitals (R'000)	Not measured.	Not measured.	342,000	409,032	489,202	585,086	689,000		
Average backlog Tertiary Hospitals (R'000)	Not measured.	Not measured.	1,444,000	1,727,024	2,065,521	2,466,972	2,913,000		
Total average backlog (R'000)			3,185,000	3,809,260	4,555,875	5,445,436	6,420,000		

HEALTH
KwaZulu-Natal

NOTES

HEALTH
KwaZulu-Natal

PART C

OPERATIONAL PLAN

HEALTH
KwaZulu-Natal

MTEF PERIOD 2008/09 – 2010/11

(STRATEGIC PLAN PERIOD 2005/06 - 2009/10)

PROVINCIAL OPERATIONAL PLAN 2008/09

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
PROGRAMME 1: ADMINISTRATION		**SUB-PROGRAMME 1.2: MANAGEMENT**							
CORPORATE COMMUNICATIONS									
STRATEGIC GOAL 3 ↓ **Strategic Objective 15** To ensure that key support services are effectively provided.	To provide efficient communication aligned to the Department's core functions.	Number of media briefings.	4	4	4	1	1	1	1
		Annual Provincial Health Council Indaba coordinated.	1	1	1	–	–	1	–
		Imbizo per Area per National Imbizo Focus Week.	12	12	12 (4/ Area).	3	3	3	3
		Number of campaigns undertaken.	4	4	4	1	1	1	1
LEGAL SERVICES									
STRATEGIC GOAL 3 ↓ **Strategic Objective 15** To ensure that key support services are effectively provided.	To strengthen and maintain comprehensive legal services.	Establishment of a compendium of all legislation, including finalisation of the Provincial Health Care Bill.	30%	50%	70%	50%	60%	65%	70%
		Contract Management system operational.	70%	70%	80%	70%	70%	75%	80%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Analysis of litigation cases.	60%	70%	80%	70%	70%	75%	80%
		Ad hoc legal service rendered.	60%	70%	70%	70%	70%	70%	70%
CORPORATE GOVERNANCE, IGR AND ISC									
STRATEGIC GOAL 1 ↓ **Strategic Objective 4** To ensure integrated planning for the provision of health services.	To provide effective IGR and ISC collaboration services.	% of planned IGR services provided.	0%	30%	55%	35%	40%	45%	55%
		% Compliance with Social Cluster Actions.	50%	80%	90%	80%	83%	86%	90%
		Coordination of donor services.	30%	30%	50%	40%	45%	50%	50%
		Coordination of youth, gender and special focus groups.	40%	40%	60%	40%	45%	55%	60%
		To strengthen collaboration between the University of KZN and the Department.	30%	30%	50%	35%	40%	45%	50%
	To render effective and efficient corporate services to Head Office.	% of posts filled in terms of posts advertised for Head Office.	20%	40%	60%	45%	50%	55%	60%
		% SMS compliance to Financial Disclosures.	100%	100%	100%	100%	100%	100%	100%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Coordination of General Administration Services for Head Office.	45%	55%	70%	60%	65%	70%	70%
	To provide an effective document management system for the Head Office.	% Compliance with legal prescripts governing document – and archive management.	30%	50%	70%	55%	60%	65%	70%
		% of Forms designed and systems established.	10%	20%	40%	25%	30%	35%	40%
OMBUDSPERSON									
STRATEGIC GOAL 3 ↓ **Strategic Objective 15** To ensure that key support services are effectively provided.	To ensure the implementation of mechanisms for the management of complaints.	% of complaints acknowledged within 3 days after receipt.	80%	80%	90%	85%	85%	90%	90%
		% of complaints re-solved within 60 days.	80%	80%	90%	85%	85%	90%	90%
INSTITUTIONAL SECURITY AND RISK MANAGEMENT SERVICES									
STRATEGIC GOAL 3 ↓ **Strategic Objective 15** To ensure that key support services are effectively provided.	To ensure organisational integrity within the Department.	Conduct high profile investigations with Law Enforcement Agencies.	50%	50%	80%	60%	70%	80%	80%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Development of Anti-Fraud and Corruption Plan.	80%	100%	100%	100%	100%	100%	100%
	To strive towards the establishment of a safe and secure work environment.	Development of a security manual relevant to the service delivery challenges of the Department.	70%	100%	100%	100%	100%	100%	100%
		Vetting of staff (% related to specified staff categories).	20%	40%	60%	45%	50%	55%	60%
		Conduct security audit.	20%	40%	60%	45%	50%	55%	60%
		Implement asset protection system at all Health Institutions.	20%	40%	60%	45%	50%	55%	60%
		Security advice on the MEC's events.	100%	100%	100%	100%	100%	100%	100%
	To ensure the provision of effective and efficient Risk Management support services.	Creation of a fully functional Risk Management service.	30%	50%	80%	55%	60%	70%	80%
		Development of a Departmental Risk Management Policy.	100%	100%	100%	100%	100%	100%	100%
		Development of a Risk Management strategy for the Department.	100%	100%	100%	100%	100%	100%	100%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Departmental Risk Profile assessments conducted.	100%	100%	100%	100%	100%	100%	100%
	To foster a risk management culture in the Department.	Development and implementation of a Departmental Risk Mitigation Plan.	80%	90%	100%	90%	95%	95%	100%
		Conduct Risk Awareness programmes.	80%	90%	100%	95%	95%	100%	100%
		Risk Management form an integral part of the Key Result Areas of relevant staff.	50%	70%	80%	75%	75%	80%	80%
SUPPLY CHAIN MANAGEMENT (SCM)									
STRATEGIC GOAL 3 ↓ **Strategic Objective 14** To ensure that SCM effectively and efficiently supports the service delivery needs of all Health Institutions.	To establish and maintain an integrated SCM system in the Department.	SCM delegations approved and implemented.	100%	100%	100%	100%	100%	100%	100%
		% of Health Institutions included in training sessions on SCM.	70% of all Health Institutions	80% of all Health Institutions	95% of all Health Institutions	85%	90%	90%	95% of all Health Institutions

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		% of Procurement Plans completed to guide acquisition of goods and services by Head Office Institutions.	60%	75%	80%	75%	75%	80%	80%
		Accurate and updated asset register maintained in Institutions.	60%	90%	95%	92%	93%	94%	95%
		Policies, processes and systems for safeguarding of assets and for inventory control developed and implemented.	50%	90%	100%	90%	95%	95%	100%
		Contract Management System implemented.	50%	90%	100%	90%	95%	95%	100%
		Updated specifications for the acquisition of transversal goods and services developed and compiled in catalogue.	55%	75%	80%	75%	80%	80%	80%
		Integrated logistical support systems implemented to reduce 'stock–outs' and improve service delivery.	70%	80%	95%	80%	80%	90%	95%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	To promote business opportunities for emerging Business.	Strategic sourcing guidelines for targeted procurement formulated and implemented.	50%	75%	100%	80%	85%	90%	100%
		% of business awarded to Small Medium & Macro Enterprises (SMME's).	+10%	+10%	40%	10%	20%	30%	40%
		% of business awarded to co-operatives.	+9%	+10%	+10%	+10%	+10%	+10%	+10%
		% of business awarded to persons with disabilities.	+20%	+10%	+10%	+10%	+10%	+10%	+10%
		% of business awarded to companies owned by "youth".	+30%	+10%	+10%	+10%	+10%	+10%	+10%
		% of business awarded to companies from rural areas.	+50%	+10%	+10%	+10%	+10%	+10%	+10%
		% of business awarded to companies owned by women.	+50%	+10%	+10%	+10%	+10%	+10%	+10%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
STRATEGIC GOAL 1 ↓ **Strategic Objective 3** To strengthen and increase collaboration with stakeholders and service providers involved in the health sector.	To establish & maintain performance driven Bid Specification Committees, Bid Adjudication and Bid Award Committees.	Fully functional Bid Specification Committee at Head Office.	100%	100%	100%	100%	100%	100%	100%
		Fully functional Bid Adjudication Committee at Head Office.	100%	100%	100%	100%	100%	100%	100%
		Fully functional Bid Award Committee at Head Office.	100%	100%	100%	100%	100%	100%	100%
		Required SCM Committees fully functional at all Hospitals.	90%	95%	100%	100%	100%	100%	100%
	To ensure community awareness on business opportunities in the Department.	Number of awareness campaigns conducted.	50	70	85	–	–	–	85
		% increase of targeted groups participating in the procurement process of the Department.	30%	45%	60%	50%	55%	60%	60%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	To establish systems to support the acquisition of goods and services (database).	Database established to support the acquisition of goods and services.	40%	80%	100%	85%	90%	95%	100%
FINANCIAL MANAGEMENT									
STRATEGIC GOAL 3 ↓ **Strategic Objective 13**: To ensure appropriate Financial, Procurement & Human Resources delegations.	To review existing Finance delegations & realign them to ensure seamless & accountable service delivery.	Written delegations in place.	Not measured	Not measured	95%	–	–	–	95%
		Last review of written delegations.	Not measured	Not measured	Target outstanding from Finance Cluster	–	–	–	Target outstand-ing from Finance Cluster
		Effective measures to ensure monitoring & measurement of delegations in the Department.	Not measured	Not measured	Target not determined by Finance Cluster	–	–	–	Target not determined by Finance Cluster
		% of Departmental expenditure fruitless, unauthorised/ lost to theft.	Not measured	Not measured	0%	0%	0%	0%	0%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		% of Department's budget constituting donor funding.	Not measured	Not measured	Target not determined by Finance Cluster	–	–	–	Target not determined by Finance Cluster
	To ensure that all finance systems & budgetary processes are aligned to the Strategic & Service Transformation objectives of the Department.	An equitable & aligned budget.	88%	90%	100%	95%	100%	100%	100%
		Improved budget management and control.	80%	95%	100%	100%	100%	100%	100%
		Mechanisms to guide prioritisation & budgeting processes for Institutions.	90%	95%	100%	100%	100%	100%	100%
	To implement and maintain effective and efficient financial and revenue administration services.	Effective, efficient, disciplined and competent financial management at Institutions, including financial management, banking, reporting and taxation services.	90%	92%	97%	94%	95%	96%	97%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
TELE-HEALTH & INFORMATION TECHNOLOGY									
STRATEGIC GOAL 2 ↓ **Strategic Objective 9** To ensure equitable and appropriate distribution of Tele-Health and Information Technology (IT) resources.	To implement a Master Systems Plan (MSP) by December 2008.	Master Systems Plan implemented by December 2008.	0%	0%	100%	33%	66%	100%	100%
		All IT and Data Management systems being used in the Department being aligned to the MSP.	0%	0%	10%	0%	5%	0%	10%
	To expand the provision of clinical services to remote rural communities by December 2008.	Number of Tele-Health sites operational.[1]	37	37	37	37	37	37	37
		Number of sites providing medical research, education and training to rural healthcare providers.	3	3	3	3	3	3	3
		Number of sites providing access to medical research, education training to rural health providers.	3	3	3	3	3	3	3

[1] The Province has a substantial videoconferencing network, with 37 video conferencing units operational in Hospitals and at the Medical School. The deployment of infrastructure has been such that every District has at least three videoconference sites. It is not envisaged that this videoconferencing network will be extended, until the existing facilities are being widely used.

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Number of post graduate training programmes provided.[2]	6	6	6	6	6	6	6
	To acquire, install and maintain computer equipment and networks by March 2008.	% Redundant personal computers replaced.	20%	80%	100%	100%	100%	100%	100%
		% Hospitals and CHCs VPN compliant.	100%	100%	100%	100%	100%	100%	100%
		% PHC Clinics with PCs and printers.	20%	80%	100%	100%	100%	100%	100%
		% Hospitals with upgraded data lines.	0%	100%	100%	100%	100%	100%	100%
		% Hospitals with functioning kiosks.	90%	90%	100%	100%	100%	100%	100%
		% of Health Professionals trained on Funda-online training projects.	0%	25%	50%	30%	40%	45%	50%
	To implement a uniform electronic patient administration system.	All Tertiary Hospitals implementing a uniform electronic patient administration system.	0%	1	3	1	2	2	3

[2] Dermatology, burn management, radiology, obstetric, ultra-sonography, specialist psychiatric and psychological support services.

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		All Regional Hospitals implementing a uniform electronic patient administration system.	0%	0%	100%	25%	50%	75%	100%
HEALTH POLICIES AND SYSTEMS UNIT									
STRATEGIC GOAL 3 ↓ **Strategic Objective 15** To ensure that key support services are effectively provided.	To develop Health Policies guidelines and systems ensuring seamless and effective health services.	Health Policies and systems developed, including norms & standards for service delivery.	Not measured	5	5	–	–	–	2
		Develop a framework to improve Clinical Governance in the Health Facilities.	Not measured	80%	100%	85%	90%	95%	100%
FORENSIC PATHOLOGY COMPONENT									
STRATEGIC GOAL 3 ↓ **Strategic Objective 15** To ensure that key support services are effectively provided.	To ensure effective management and provision of Medical Pathology and Mortuary Services.	Number of functional Mortuary Facilities.	25	46	46	46	46	46	46

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		% Objectives and targets set for the Business Plan to access Conditional Grant resources accomplished.	70%	80%	90%	80%	80%	85%	90%
		Policies, norms and standards for decentralised provision implemented.	70%	80%	90%	80%	80%	85%	90%
NATIONAL HEALTH LABORATORY SERVICES (NHLS)									
STRATEGIC GOAL 3 ↓ Strategic Objective 3 To strengthen and increase collaboration with stakeholders & service providers involved in the health sector.	To monitor rendering of National Health Laboratory Services (NHLS) to the Department.	Departmental NHLS utilisation protocol developed and implemented.	100%	100%	100%	100%	100%	100%	100%
		Analysis of tariff structure.	50%	80%	100%	80%	85%	90%	100%
		Monitoring & evaluation of Service Level Agreement (SLA) for NHLS.	50%	80%	90%	–	–	–	90%
		% of instances of non-compliance with SLA imperatives reported/ resolved.	50%	80%	90%	–	–	–	90%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
PRIVATE (OTHER) HOSPITALS									
STRATEGIC GOAL 1 ↓ **Strategic Objective 3** To strengthen and increase collaboration with stakeholders and service providers involved in the health sector.	To ensure that the Private Health Care industry adheres to National Health standards.	% Private Hospitals inspected.	100%	100%	100%	100%	100%	100%	100%
		% of applications for re–licensing of Private Hospitals received and processed.	100%	100%	100%	100%	100%	100%	100%
		% of applications for the provisioning of private services processed.	100%	100%	100%	100%	100%	100%	100%
		% applications for new licenses reviewed at a quarterly basis.	50%	80%	100%	100%	100%	100%	100%
		Fully established and functional Committee at Head Office to review all applications for licenses.	50%	80%	100%	100%	100%	100%	100%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
HEALTH SERVICES PLANNING, MONITORING & EVALUATION									
STRATEGIC GOAL 1 ↓ **Strategic Objective 2** To improve clinical governance including quality of care & Infection Prevention and Control.	To guide and assess the implementation of Infection Prevention and Control.	Two modules of the Infection Control Assessment Tool (ICAT) implemented. Modules: Hand washing, labour & delivery, isolation & employee health.	Tool not available	0%	100% (72) Hospitals implementing	25% (18) Hospitals	50% (36) Hospitals	75% (54) Hospitals	100% (72) Hospitals
		Approved Implementation Plan for Infection Prevention and Control (IPC).	0%	0%	Approved Plan	Approved implementation plan.	–	–	–
		Early warning on IPC fully functional.	0%	0%	100%	0%	25%	50%	100%
	To guide and assess health services against norms and standards of the Quality Improvement Plan.	Quality Assurance (QA) Policy and integrated QA Tool.	0%	0%	100%	Policy developed. Integrated Tool implemented.	– –	– –	– –
		External Client Experience Survey conducted.	0%	0%	2 CHCs and 26 Hospitals (including 5	–	–	–	2 CHCs and 26 Hospitals (including 5 revitalisation Hospitals).
		Waiting time surveys conducted at Hospitals.	58%	13%	58%	–	–	–	58%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
STRATEGIC GOAL 1 ↓ **Strategic Objective 4** To ensure integrated planning for the provision of health services.	To finalise a Strategic Plan for the Department for the period 2010–2016 based on the STP by December 2008.	Approved Strategic Plan for the next 5 years reflecting Provincial needs & based on the STP.	50%	60%	90%	60%	75%	85%	100%
	To compile the Annual Performance Plan (APP) and District Health Plans (DHPs) based on the disease profile & service delivery challenges in the Province by August 2008.	Approved APP reflecting Provincial needs.	60%	75%	100%	80%	85%	95%	100%
		Approved DHPs reflecting the outcome of the District Health Expenditure Reviews (DHER) and District specific needs.	60%	75%	100%	80%	100%	–	–
		DHER completed for each District to determine: efficiency, effectiveness, equity, sustainability and cost.	60%	75%	100%	75%	85%	100%	–
		Service delivery targets determined.	Not measured	Not measured	100%	–	–	100%	–

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	To implement the STP as from MTEF 2008/09.	Finalised STP.	60%	90%	100%	100%	–	–	–
		Analysis of key health trends to inform epidemiology profile.	0%	60%	70%	60%	70%	70%	70%
		Complete Health Profile study for PHC in 11 Districts for 2007.	0%	0%	11 Districts				11 Districts
	To compile Quarterly Reports and Annual Report in line with indicators and targets indicated in the APP and DHPs.	Approved Annual Report in line with performance targets.	60%	100%	100%	100%	100%	–	–
	.	Approved Quarterly Reports aligned to service delivery performance indicators.	60%	100%	100%	100%	100%	100%	100%
	To undertake and manage key research to inform health service planning and service delivery.	Number of appropriate research studies conducted to improve health services.	0	0	3	2	1	–	–

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Fully functional & institutionalised Departmental Research & Ethics Committee.	0 Meeting	1 Meeting.	4 Meetings/ Year.	1 Meeting.	1 Meeting.	1 Meeting.	1 Meeting.
		Assessment of research proposals and analysis of research findings.	0%	100%	100%	100%	100%	100%	100%
		Health research findings updated on the Provincial database.	0%	0%	100%	100%	100%	100%	100%
STRATEGIC GOAL 2 ↓ **Strategic Objective 6** To provide GIS services for health planning and service delivery.	To provide timely and accurate GIS support.	Updated dissemination of data.	Not measured	60%	100%	65%	75%	85%	100%
		Compliance with National Spatial Information Framework.	Not measured	0%	100%	25%	50%	75%	100%
		Updated STP database.	70%	90%	100%	100%	100%	100%	100%
STRATEGIC GOAL 2 ↓ **Strategic Objective 7** To improve the quality and use of health data.	To ensure that health data is correctly captured, reported and analysed for MTEF 2008/09.	DHIS Version 1.4 implemented.	Not measured	0%	100%	30%	60%	90%	100%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Data Management Policy implemented.	Not measured	0%	100%	25%	50%	75%	100%
		Capacity at Districts and Hospitals established for data analysis.	Not measured	40%	100%	60%	70%	80%	100%
STRATEGIC GOAL 2 ↓ **Strategic Objective 8** To implement an appropriate Monitoring & Evaluation System.	To use the M&E Framework for rigorous review of the health service delivery as from May 2008.	Approved M&E Framework.	Not measured	TOR approved	100%	25%	50%	75%	100%
		Approved Early Warning System on monitoring established.	Not measured	20%	100%	25%	50%	75%	100%
HUMAN RESOURCE MANAGEMENT									
STRATEGIC GOAL 2 ↓ **Strategic Objective 10** To sustain and expand the health workers force through implementation of innovative human resources management strategies.	To enter into Service Level Agreements with an expanded pool of General Practitioners (GP's) and Specialists for sessional work at all Health Facilities.	Number of Private Sector Doctors doing sessional work.	Not measured	552	607	–	–	–	607
		Number of Private Specialists doing sessional work.	Not measured	179	197	–	–	–	197

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	To design and implement an evidence-based Recruitment and Retention Policy and Strategy that aligns to the core business of the Department.	% of staff migrating outside the Department.	6%	5%	4%	5%	4.5%	4.5%	4%
		Number of staff leaving the service of the Department.	Not measured	1 957	1 859	–	–	–	1859
		Average years of employment per health professional staff.	Not measured	8.9	9.79	–	–	–	9.79
		Average number of days staff members act in a position.	Not measured	256	192	243	230	218	192
		Approved HR Plan for the Department (all health posts).	Draft HR Plan	Draft HR Plan	Approved HR Plan aligned to the STP.	Approved HR Plan aligned to the STP	–	–	–
		Average number of sick leave days taken per staff member (annual).	Not measured	8	7.5	–	–	–	7.5
		% Staff members utilising sick leave.	Not measured	54.9%	49%	54.35%	53.80	52.73	49%
		Total number of staff utilising sick leave.	Not measured	36 265	34 451	35 902	35 543	35 686	34 451

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		% of personnel budget spent on overtime.[3]	Not measured	5%	3%	–	4%	–	3%
		Approved Recruitment Policy & Strategy and Retention Policy.	100%	50% Reviewed	Policies approved.	50% Both Policies drafted and forwarded for approval	100% Both Policies approved	–	–
	To implement the supply of health workers in line with the Human Resources Plan of the Department.[4]	Number of Professional Nurses employed versus number required.	Filled posts: 10 578	Filled posts: 12 171	Filled posts: 20 117	–	–	–	20 117
		Number of Medical Officers employed versus number required.	Filled posts: 2 565	Filled posts: 2 173	Filled posts: 2 500	–	–	–	2 500
		Number of Dieticians employed versus number required.	75	288	320	–	–	–	320
		Number of Advanced Midwifes employed versus number required.	Not measured	1 000	1 100	–	–	–	1100
		Number of Psychologists employed versus number required.	62	56	68	–	–	–	68
		Number of Specialists employed versus number required.	590	419	460	–	–	–	460

[3] This indicator excludes commuted overtime.
[4] Actual vacant posts on PERSAL was used.

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Number of Dentists employed versus number required.	63	63	63	–	–	–	63
		Number of Pharmacists employed versus number required.	439	407	437	–	–	–	437
		Number of Occupational Therapists employed versus number required.	104	78	85	–	–	–	85
STRATEGIC GOAL 3 ↓ **Strategic Objective 11** To design and implement a total seamless quality service delivery system for the Department.	To monitor the impact of Performance Management in the Department.	% of Level 13 and above assessed according to their performance contracts.	Not measured	100%	100%	85%	90%	95%	100%
		Current Management to Staff ratio.	Not measured	0.3%	0.5%	–	–	–	0.5%
		Percentage of Level 13 and above with signed performance agreements.	Not measured	100%	100%	85%	90%	95%	100%
		Number of staff with formal signed job descriptions.	Not measured	100%	100%	100%	100%	100%	100%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	To enhance management capacity through variety management programmes.	Number of Hospital Managers/ CEOs that have been enrolled on accredited Hospital Management training programmes.	10	24	16				16
		Number of employees counselled by EAP.	916	2 318	100% of referred cases	100% of referred cases	100% of referred cases	100% of referred cases	100% of referred cases
		Number of Hospitals providing Occupational Health services.	100%	100%	100%	100%	100%	100%	100%
	To monitor discipline and grievance management in the Department.	Number of disciplinary hearings registered.	210	201	100% cases registered resolved within timeframes	100% cases registered resolved within time-frames	100% cases registered resolved within time-frames	100% cases registered resolved within time-frames	100% cases registered resolved within time-frames
		Number of disciplinary hearings concluded with sanctions.	210	201	100% cases registered resolved	100% cases registered resolved	100% cases registered resolved	100% cases registered resolved	100% cases registered resolved
		Number of sanctions implemented.	210	201	100% sanctions imple-mented	100% sanc-tions imple-mented	100% sanc-tions imple-mented	100% sanc-tions imple-mented	100% sanc-tions imple-mented

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Number of grievance cases registered.	141	131	100% cases registered resolved within timeframes	100% cases registered resolved within time-frames	100% cases registered resolved within time-frames	100% cases registered resolved within time-frames	100% cases registered resolved within time-frames
		Of grievance hearings number of grievance cases concluded.	92	110	100% cases registered resolved within timeframes	100% cases registered resolved within time-frames	100% cases registered resolved within time-frames	100% cases registered resolved within time-frames	100% cases registered resolved within time-frames
STRATEGIC GOAL 3 ↓ **Strategic Objective 12** To design and implement a total seamless quality service delivery system for the Department.	To ensure that all Health Facilities have approved organisational structures and post provisioning aligned to service delivery needs.	Number of Hospitals with approved organisational structures.	All Tertiary & Central Hospitals. 11 TB Hospitals, 7 TB structures within the District Hospitals & 1TB structure within a Regional Hospital. 8 Specialised Psychiatric Hospitals.	20	All Hospitals.	–	–	–	All Hospitals.

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Number of CHCs with approved organisational structures.	0	16	All CHCs	–	–	–	All CHCs
		Number of PHC Clinics with approved organisational structures.	–	0	544[5]	–	–	–	544
		Number of Districts with approved organisational structures.	Draft structures.	11	11	–	–	–	11
		Approved Head Office structure.	1	Nil	1	–	–	–	1
	To develop and maintain a Service Delivery Improvement Plan for the Department.	Service Delivery Improvement Plan compliant with Public Service Regulations and approved by the HOD and MEC.	0%	0%	100%	–	–	–	100%
STRATEGIC GOAL 3 ↓ **Strategic Objective 13** To ensure appropriate Financial, Procurement and Human Resource delegations.	To review existing HR delegations and align them to ensure seamless and accountable service delivery.	Written delegations in place. HR:	100%	100%	100%	100%	100%	100%	100%
		Last review of written delegations.	1/1/2007	1/1/2008	1/1/2009	–	–	–	01/01/2009

[5] Includes all Local Government PHC Clinics.

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
PROGRAMME 2: DISTRICT HEALTH SERVICES		SUB-PROGRAMMES	2.1: PRIMARY HEALTH CARE CLINICS 2.2: COMMUNITY HEALTH CENTRES						
STRATEGIC GOAL 1 ↓ Strategic Objective 1 To mainstream Primary Health Care (PHC) services.	To implement the roll-out of PHC Clinics and CHCs as per imperatives of the STP.	Number of PHC Clinics operating as Category A.	12	82	86	–	–	–	86
		Number of PHC Clinics operating as Category B.	57	297	309	–	–	–	309
		Number of PHC Clinics operating as Category C.	26	89	88	–	–	–	88
		Number of PHC Clinics.	494	92	83	–	–	–	83
		Number of new PHC Clinics.	0	3	15	–	–	–	15
		Number of new CHC.	0	4	8	–	–	–	8
	To improve PHC access and utilisation.	Provincial PHC expenditure per headcount.	R64	R70	R74	–	–	–	R74
		PHC headcount.	20,548,203	21,079,790	22,350,000	–	–	–	22,350,000
		PHC utilisation rate.	1.7	2.3	2.4	2.3	2.3	2.3	2.4
		PHC utilisation rate – under-5 years	3.2	4	4	4	4	4	4
	To improve PHC supervision.	Supervision rate.	50%	56%	100%	60%	75%	85%	100%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Supervisors Manual implemented in all PHC Facilities.	No revised National Manual.	National Manual not finalised.	60%	15%	25%	40%	60%
		% of PHC Clinics displaying important health data.	Not collected.	Not collected.	100%	100%	100%	100%	100%
	To improve clinical management at PHC level.	PHC Facilities supported by a Medical Officer at least once a week.	Not collected.	Not collected.	40%	–	–	–	40%
		Doctor clinical workload.	1:23	1:23	1:24	1:24	1:24	1:24	1:24
		Nurse clinical workload.	1:40	1:66	1:36	1:60	1:50	1:40	1:36
		Number of PHC Clinics & CHCs implementing the Infection Prevention & Control Policy.	Not collected.	Not collected.	(124) Clinics: 110 CHC: 14	(31) Clinics: 17 CHC:14	(62) Clinics: 48 CHC: 14	(93) Clinics: 79 CHC: 14	(124) Clinics: 110 CHC: 14
PROGRAMME 2: DISTRICT HEALTH SERVICES		**SUB-PROGRAMME 2.3: DISTRICT HOSPITALS**							
STRATEGIC GOAL 1 ↓ **Strategic Objective 2** To improve clinical governance including quality of care & Infection Prevention and Control.	To ensure that all District Hospitals provide quality care to all patients based on the defined package of services in the STP.	Caesarean section rate.	20%	21%	20%	21%	20%	20%	20%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Average Length of Stay.	6 days.	9 days.	5.6 days.	8 days	7.5 days	6.5 days	5.6 days
		Bed utilisation rate.	62%	63%	64%	63%	63%	64%	64%
		Case fatality rate.	4%	4.8%	4%	4.4%	4.2%	4%	4%
	To develop and implement a framework to improve Clinical Governance at all Health Facilities.	Number of District Hospitals implementing the Infection Prevention and Control Policy.	0	0	40	10	20	30	40
		Number of District Hospitals conducting monthly clinical audit meetings.	16	16	30	16	20	25	30
		Number of District Hospitals implementing strategies to reduce preventable causes of morbidity and mortality.	16	16	30	16	20	25	30
	To guide and Assess health services against norms and standards of the Quality Improvement Plan.	Integrated Quality Assurance Implemented at all District Hospitals.	0	0	40	0	10	20	40

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
PROGRAMME 2: DISTRICT HEALTH SERVICES		SUB-PROGRAMMES 2.4: Community-Based SERVICES 2.5: OTHER COMMUNITY SERVICES							
HOME AND COMMUNITY-BASED CARE									
STRATEGIC GOAL 1 ↓ Strategic Objective 1 To mainstream Primary Health Care (PHC) services.	To strengthen Community-Based PHC services.	Number of active Home & Community Based Care Givers (HCBC).	12,400	15,700	21,000	5,250	10,500	15,750	21,000
		Number of HCBC contracted by NGOs.	1,100-HBC 252-NIP	5,400-CHW 2,200-HBC 273-NIP	6,000-CHW 4,400-HBC 309-NIP	1,500-CHW 1,100-HBC 77-NIP	3,000-CHW 2,200-HBC 155-NIP	4,500-CHW 3,300-HBC 232-NIP	6,000-CHW 4,400-HBC 309-NIP
		Number of HCBC who meet SETA requirements.	1,100	3,000-CHW 2,200-HBC	4,000-CHW 400-RPL 3,500-HBC	1,000-CHW 100-RPL 875-HBC	2,000-CHW 200-RPL 1,750-HBC	3,000-CHW 300-RPL 2,625-HBC	4,000-CHW 400-RPL 3,500-HBC
		Number of HCBC receiving stipends.	2,500-CHW 4,074-HBC	5,400-CHW 2,200-HBC	6,000-CHW 4,400-HBC	1,500-CHW 1,100-HBC	3,000-CHW 2,200-HBC	4,500-CHW 3,300-HBC	6,000-CHW 4,400-HBC
		Number of patients served by HCBC.	164,480	22,000	31,500	7,875	15,750	23,625	31,500
		Number of home visits by HCBC.	7,275,600	1,274,911	3,191,991	1,274,911	1,595,996	2,393,993	3,191,991
		Number of patients referred by HCBC.	Not collected.	Not collected.	50 000	–	–	–	50 000

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	To design and implement a monitoring tool to validate the effectiveness of Community-Based Services.	Number of Districts using a standard monitoring tool for registered HCBC.	Not developed.	Not developed.	11 Districts.	–	–	–	11 Districts.
		Established and updated Provincial HBC database.	No database.	No database.	Updated database.	–	Database developed.	–	Functional database.
	To promote collaboration between Provincial Health and Traditional Medicine/ Healers.	To establish a Provincial database for Traditional Healers.	No database.	25%	50%	Nil	Nil	25%	25%
		To develop institutional capacity in the Head Office to deal with Traditional Medicine/ Healers.	No capacity.	Programme commenced.	50%	Nil	Nil	50%	50%
		Number of workshops/ training indabas.	Nil	1	2	Nil	Nil	1	1

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
HEALTHY LIFESTYLES									
STRATEGIC GOAL 5 ↓ Strategic Objective 20 To ensure the effective implementation of programmes to reduce Non-Communicable & Communicable Diseases and diseases of lifestyle.	To implement integrated health promotion and healthy lifestyle programmes.	Number of schools accredited as Health Promotion Schools (HPS).	150	165	200	165	175	190	200
		Number of accredited Health Promoting Clinics.	0	In pilot phase.	1/ District (11).	0	0	0	1/ District.
		Number of Health Promoting Homes implemented and supported.	0	In pilot phase.	10	0	2	2	10
PROGRAMME 2: DISTRICT HEALTH SERVICES		SUB-PROGRAMME 2.6: HIV AND AIDS							
ANTI–RETROVIRAL THERAPY									
STRATEGIC GOAL 4 ↓ Strategic Objective 17 To continue to accelerate and sustain the implementation of the Comprehensive HIV and AIDS Management Plan.	To implement the Comprehensive HIV and AIDS Management Plan.	Number of accredited sites (Hospitals/ Clinics/ Other).	72	74	79 Hospital: 62 PHC: 17	–	–	–	79

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Total number of ATR Patients.	75,136	110,227	195,312	–	–	–	195,252
		HIV testing rate.	65%	91%	93%		92%	93%	93%
		Number of children on ART.	5,136	10,286	21,484		–	–	21,484
		Number of STI treated new episode: ART patients.	Not measured	4,576	4 000		–	–	4 000
		Proportion of HIV+ patients screened for TB.	Not measured	100%	100%	100%	100%	100%	100%
POST EXPOSURE PROPHYLAXIS (PEP)									
STRATEGIC GOAL 4 ↓ **Strategic Objective 17** To continue to Accelerate and sustain the implementation of the Comprehensive HIV and AIDS Management Plan.	To strengthen Occupational & Non-Occupational PEP services.	Hospitals offering PEP for Occupational HIV exposure.	100%	100%	100%	100%	100%	100%	100%
		Hospitals offering PEP for sexual abuse.	87%	89%	89%	87%	87%	87%	89%
		Number of Trauma Centres for victims of violence.	34	34	37	34	35	36	37

[6] Record the number of cases per quarter. Trends will be monitored.
[7] Record the numbers – trends will be monitored.

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Number of sexual assault cases – new.[6]	8,681	6,546	No target.	–	–	–	–
		Number of ARV Prophylaxis to sexual assault cases – new.[7]	3,822	2,925	No target.	–	–	–	–
PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)									
STRATEGIC GOAL 4 ↓ **Strategic Objective 17** To continue to Accelerate and sustain the implementation of the Comprehensive HIV and AIDS Management Plan.	To scale up & sustain implementation of the PMTCT Programme.	Nevirapine dose to baby coverage.	102%[8]	93%	98%	93%	94%	98%	98%
		Nevirapin uptake – antenatal clients.	63%	70%	76%	73%	74%	75%	76%
		Fixed Facilities offering PMTCT.	96%	96%	98%	96%	96%	97%	98%
		Proportion of ANC clients tested for HIV.	63%	70%	80%	75%	75%	75%	80%
		Number of PCR HIV tests done on babies born to HIV+ mothers (at 6 weeks).	Not available.	26,956	44,115	32,000	37,500	41,100	44,115
		Number of Hospitals offering PMTCT with dual ARV prophylaxis.[9]	New service	New service	53				53

[8] Data is questionable.
[9] New indicator starting 2008/09.

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Number of fixed PHC facilities offering PMTCT with dual ARV prophylaxis.	New service	New service	565				565
SEXUALLY TRANSMITTED INFECTION (STI)									
STRATEGIC GOAL 4 ↓ **Strategic Objective 17** To continue to accelerate and sustain the implementation of the Comprehensive HIV and AIDS Management Plan.	To support the effective implementation of the Syndromic Management of STIs.	STI partner treatment rate.	28%	30%	30%	24%	26%	28%	30%
		STI treated – new episode.	645,000	362,452	368,000				368,000
		Syphilis prevalence among antenatal clients tested.	1%	4%	2%		2%	2%	2%
VOLUNTARY COUNSELLING & TESTING									
STRATEGIC GOAL 4 ↓ **Strategic Objective 17** To continue to accelerate and sustain the implementation of the Comprehensive HIV and AIDS Management Plan.	To expand & Sustain the Voluntary Counselling & Testing Programme.	Proportion clients HIV pre–test counselled (excluding ANC).	3%	6%	10%	7%	8%	9%	10%
		Fixed facilities offering VCT.	97%	98%	100%	100%	100%	100%	100%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Number non-medical sites offering VCT.	58	68	94	–	75	–	94
		% Mobile clinics offering VCT	–	–	90%	–	50%	–	90%
PROGRAMME 2: DISTRICT HEALTH SERVICES		**SUB-PROGRAMME 2.7: TUBERCULOSIS (TB)**							
STRATEGIC GOAL 4 ↓ **Strategic Objective 16** To continue to implement the TB Crisis Management Plan.	To strengthen community support and participation and improve patient adherence.	TB cases with a DOTS supporter.	77%	82%	90%	78%	80%	85%	90%
		Number of DOT supporters trained.	Not available.	1 200	1 200	300	300	300	300
		Number of TB Door to Door campaigns.	Not available	10	25	5	5	5	10
	To improve laboratory diagnostic capacity to handle diagnostic workload & quality assurance & control.	TB sputa specimens turnaround time <48 hours.	55%	60%	85%	65%	70%	75%	85%
		% Laboratories implementing quality assurance protocols & controls.	0%	60%	100%	70%	80%	90%	100%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		To improve TB sputum diagnosis: bacteriological coverage.	72%	67%	85%	70%	75%	80%	85%
		% Institutions provided with transport 3 times/ week for sputum collection.[10]	–	60%	85%	65%	70%	75%	85%
	To improve case finding & clinical management.	% Institutions implementing the Suspect Register.	65%	78%	100%	80%	85%	90%	100%
		Number of Facilities with effective patient tracking system.	35%	45%	100%	60%	70%	80%	100%
		Smear conversion rate.	38%	42%	60%	48%	52%	56%	60%
		Defaulter rate.	16%	13%	10%	12.5%	12%	11%	10%
	To strengthen the surveillance and management of MDR & XDR TB.	Number of MDR TB decentralised sites.	New Indicator	3	7	4	5	6	7
	To sustain the MDR TB reporting and recording system.	Number of MDR TB Sites implementing the MDR Electronic Register.	New Indicator	3	7	4	5	6	7

[10] New indicator – no baseline.

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
PROGRAMME 2: DISTRICT HEALTH SERVICES		**SUB-PROGRAMME 2.8: NUTRITION**							
STRATEGIC GOAL 4 ↓ **Strategic Objective 19** To sustain the Integrated Nutrition Programme.	To sustain Disease Specific Nutrition Support & Counselling.	Number of underweight pregnant women receiving supplements.	Not measured.	Not measured.	500	200	300	400	500
		Number of underweight lactating women receiving supplements.	Not measured.	Not measured.	1,000	400	600	800	1,000
		Number of underweight adults who are HIV+ receiving supplements.	Not measured.	Not measured.	35,000	10,000	20,000	30,000	35,000
		Number of underweight adults with TB receiving supplements.	Not measured.	Not measured.	50,000	20,000	30,000	40,000	50,000
		Children under 5 years weighing coverage.	60%	62%	100%	90%	95%	95%	100%
	To expand services to reduce malnutrition in children under-5 years.	Underweight for age –under 5 years.	1.2%	1.2%	1%	1%	1%	1%	1%
		% of HIV+ women selecting exclusive breastfeeding.	Data inaccurate.	63%	65%	50%	55%	60%	65%

[11] Only considering Hospitals with Maternity Beds. Annual indicator that will only change in 2009/10.

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		% of HIV+ women selecting exclusive formula feeding.	Data inaccurate.	Data inaccurate.	35%	50%	45%	40%	35%
		Number of Baby Friendly Hospitals.[11]	42/ 58	44/ 58	44/ 58	–	–	–	44/ 58
		Incidence of severe malnutrition under 5 years.	0.06%	0.06%	0.05%	0.6%	0.5%	0.4%	0.2%
		Number of children under–5 admitted with malnutrition.	Not previously measured.	Not previously measured.	150/1000[12]	200/1000	180/1000	170/1000	150/1000
	To eliminate micronutrient deficiencies amongst vulnerable groups.	% of Children aged 6–11 months receiving Vitamin A capsules.	25%	50%	75%	60%	65%	70%	75%
		% of Children aged 12–59 months who receive a Vitamin A capsule (annualised).	40%	45%	50%	–	–	–	50%
		% of Non-breastfed infants (0–5 months) receiving Vitamin A capsules	45%	50%	75%	60%	65%	70%	75%
		% of Postpartum women who receive a Vitamin A capsule.	70%	75%	100%	80%	90%	95%	100%

[12] Target based on estimate.

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	To contribute to the improvement of household food security among vulnerable groups.	Number of HIV positive children under-5 years receiving porridges/ food packs.	New indicator.	–	18,000	12,000	13,500	15,500	18,000
		Number HIV+ adults receiving porridges/ food packs.	New indicator.	–	75,000	60,000	65,000	70,000	75,000
		Number of adults with TB receiving porridges/ food packs.	New indicator.	–	23,000	20,000	21,000	22,000	23,000
		Number of HIV+ lactating women receiving porridges/ food packs.	New indicator.	–	2,500	800	1,000	1,500	2,500
PROGRAMME 2: DISTRICT HEALTH SERVICES		**SUB-PROGRAMME 2.9: MATERNAL, CHILD & WOMEN'S HEALTH**							
STRATEGIC GOAL 4 ↓ **Strategic Objective 18** To decrease preventable causes of Maternal, Child & Women's morbidity & mortality.	To strengthen Maternal & Neonatal health services.	Maternal Mortality rate.	159/ 100,000[13]	159/ 100,000	159/ 100,000	–	–	–	159/100000
		% reported maternal deaths assessed, reported and submitted.	100%	60%	100%	80%	90%	100%	100%
		% of women attending ANC before 20 weeks.	45%	50%	70%	50%	55%	60%	70%

[13] Saving Mothers Report

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Perinatal mortality rate.	30/1000	30/1000	30/1000	–	–	–	30/1000
		Number of Facilities implementing the Saving Mothers Recommendations.	100%	100%	100%	100%	100%	100%	100%
		Number of Hospitals conducting monthly Maternal/ Perinatal mortality meetings.	100%	100%	100%	100%	100%	100%	100%
		% of low birth–weight babies.	15%	15%	15%	15%	15%	15%	15%
		Number of Hospitals implementing PPIP.	27	48 Registered (R) 10 Active (A)	50 (R) 20 (A)	48 (R) 10 (A)	48 (R) 15 (A)	49 (R) 18 (A)	50 (R) 20 (A)
		Neonatal mortality rate.	9.5/1000	9.5/1000	9.5/1000	–	–	–	9.5/1000
	To improve integrated Child Health services.	Number of Districts implementing the RED strategy.	3 Districts.	6 Districts.	11 Districts.	6 Districts.	8 Districts.	9 Districts.	11 Districts.
		Full Immunisation coverage under 1 year.	74.8%	89.7%	90%	90%	90%	90%	90%
		Measles coverage under 1 year.	79%	90%	90%	90%	90%	90%	90%
		Drop–out rate DTP1 – DTP 3.	14.5%	14%	<10%	14%	13%	12%	10%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		% of Adverse Events Following Immunisation reported and fully investigated.	20%	43% (20/ 46)	70%	47%	50%	65%	70%
		Number Acute Flaccid Paralysis (AFP) cases fully investigated.	16/ 42	37/66	67/ 67	–	–	–	67/ 67
		Number of Facilities implementing the Child Health Problem Identification Programme (ChIP)	4	12	20	14	16	18	20
		Number of functional Well Baby Clinics.	0	0	12	4	8	12	12
		% of fixed PHC Facilities implementing IMCI.	80%	79%	82%	79%	80%	80%	82%
		% of Facilities with at least 1 provider trained in IMCI.	72%	72%	90%	74%	76%	80%	90%
		Number of PHC Clinics implementing the IMCI Community Component.	0	0	11	0	4	8	11
		Number of active Birth Defects Reporting Sites.	46	46	All Hospitals with Maternity Units (56).	48	50	52	56
	To improve integrated Youth Health services.	School Health Services (school) coverage.	48%	57%	70%	60%	65%	65%	70%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Number of accredited Youth–Friendly PHC services.	37	39	45	39	40	40	45
	To improve integrated Women's Health services.	Number of Hospitals offering CTOP.	19	22	30	26	27	28	30
		Cervical Cancer Screening coverage.	2%	4.5%	5%	5%	5.5%	6%	7%
		Number of Hospitals offering Colposcopy services.	12	12	15	–	–	–	15
		Women–Year Protection rate.	38%	38%	50%	40%	40%	45%	50%
		Number of septic abortions.	No data.	No data.	No target set.[14]	–	–	–	–
		Number of incomplete abortions.	No data.	No data.	No target set.[15]	–	–	–	–
PROGRAMME 2: DISTRICT HEALTH SERVICES		**SUB-PROGRAMME 2.10: COMMUNICABLE & NON-COMMUNICABLE DISEASES**							
COMMUNICABLE DISEASE CONTROL									
STRATEGIC GOAL 5 ↓ **Strategic Objective 20** To ensure the effective implementation of programmes to reduce Communicable Diseases and diseases of lifestyle.	To reduce morbidity and mortality due to Communicable Diseases.	Outbreak response time.	<1 day.	< 1 day.	< 1 day	< 1 day	< 1 day	< 1 day	< 1 day

[14] Baseline data not available to set targets. Will be monitored & reconsidered.
[15] Accurate baseline data not available to set targets. Will be monitored & reconsidered.

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Malaria fatality rate.	1%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
		Cholera fatality rate.	< 1%	< 1%	< 1%	< 1%	< 1%	< 1%	< 1%
		% of Districts implementing surveillance system.	100%	100%	100%	100%	100%	100%	100%
		Number of Facilities implementing the Diarrhoea Programme.	70%	70%	80%	65%	70%	75%	80%
		Number of Districts implementing the Disaster Management Flash Reporting System.	11	11	11	11	11	11	11
MENTAL HEALTH									
STRATEGIC GOAL 5 ↓ **Strategic Objective 20** To ensure the effective implementation of programmes to reduce Non-Communicable & Communicable Diseases and diseases of lifestyle.	To operationalise the imperatives set by the Mental Health Act, 2002.	% of Hospitals providing designated package of service.	80%	85%	100%	85%	90%	95%	100%
		% District Hospitals providing a 72–hour assessment service.	80%	85%	100%	85%	90%	95%	100%
		% of PHC Nurses trained in Mental Health protocols.	60%	80%	100%	85%	90%	95%	100%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Number of Institutions providing detoxifying services.	85%	90%	100%	90%	90%	95%	100%
		% of Districts with community initiatives for the prevention of substance abuse.	25%	30%	100% (11 Districts)	3 Districts	6 Districts	9 Districts	11 Districts
		% of planned Child & Adolescent services operational.	0%	50%	100%	25%	25%	25%	25%
DISABILITY & REHABILITATION									
STRATEGIC GOAL 5 ↓ **Strategic Objective 20** To ensure the effective implementation of programmes to reduce Non-Communicable & Communicable Diseases and diseases of lifestyle.	To implement & sustain an integrated disability & rehabilitation strategy.	Number of diagnostic Audiology Clinics.	–	15	24	17	19	21	24
		% of facilities with appropriate access for persons with disabilities.	–	60%	80%	65%	70%	75%	80%
		% of PHC facilities with health promotion materials in braille & audiotape.	–	40%	60%	45%	50%	55%	60%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Service Level Agreements with external support organisations approved & operational.	–	5	10	1	1	1	2
		Number of Health Workers trained to use sign language to communicate with the deaf.	–	100	300	50	50	50	50
		% of Therapists trained to identify and administer the 'Free Health Service System'.	–	40%	75%	45%	50%	65%	75%
CHRONIC DISEASES & GERIATRICS									
STRATEGIC GOAL 5 ↓ **Strategic Objective 20** To ensure the effective implementation of programmes to reduce Non-Communicable & Communicable Diseases and diseases of lifestyle.	To implement the comprehensive programme for Chronic Diseases & Geriatrics.	Cataract surgery rate.	6,188	11,112	13,000	–	–	–	13,000
		% facilities providing flu vaccine to older persons.	75%	80%	100%	100%	100%	100%	100%
		Number of Districts with Low Vision services.	1	1	2	0	1	1	2

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		% Clinics with fast queues for chronic medicine collection.	50%	54%	100%	100%	100%	100%	100%
ORAL HEALTH									
STRATEGIC GOAL 5 ↓ Strategic Objective 20 To ensure the effective implementation of programmes to reduce Non-Communicable & Communicable Diseases and diseases of lifestyle.	To re-orientate Oral Health services from a curative to a preventive approach.	Number of Municipalities with Oral Health Services.	85%	90%	95%	95%	95%	95%	95%
		Restoration to extraction ratio.	31:1	30:1	25:1	25:1	25:1	25:1	25:1
		Number of schools with a 'brushing' programme.	100%	100%	100%	100%	100%	100%	100%
		% of Facilities with the standard package of Dental equipment.	50%	50%	75%	55%	60%	70%	75%
PROGRAMME 3: EMERGENCY MEDICAL SERVICES		SUB-PROGRAMME 3.1: EMERGENCY MEDICAL RESCUE SERVICES							
STRATEGIC GOAL 1 ↓ Strategic Objective 2 To improve clinical governance including quality of care and infection prevention and control.	To improve access to EMRS in the Province.	Total rostered ambulances.	212	241	265	0	0	Additional 12 = 253	Additional 12 = 265

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Rostered ambulances per 1,000 people.	0.02	0.02	0.02	0.02	0.02	0.02	0.02
		P1 calls with a response of 15 minutes (urban areas)	36.2%	50%	80%	50%	60%	70%	80%
		P1 calls with a response time <40 minutes (rural areas)	30.46%	50%	50%	50%	50%	50%	50%
		All calls with a response time within 60 minutes.	62%	60%	75%	60%	65%	70%	75%
		Green code patients transported by ambulance.	–	20%	10%	17.5%	15%	12.5%	10%
PROGRAMME 3: EMERGENCY MEDICAL SERVICES		**SUB-PROGRAMME 3.2: PLANNED PATIENT TRANSPORT**							
STRATEGIC GOAL 1 ↓ **Strategic Objective 2** To improve clinical governance including quality of care and infection prevention and control.	To improve access to EMRS in the Province.	% Planned Patient Transport coverage inter-Hospital.	100%	100%	100%	100%	100%	100%	100%
		% Planned Patient Transport coverage Clinic-Hospital.	30%	100%	100%	100%	100%	100%	100%
		Number of vehicles purchased.	150 ESV 37 Support Vehicles	288 ESV 60 Support Vehicles 22 PPT	515 ESV 79 Support Vehicles 41 PPT	–	–	100 ESV 10 Support Vehicles 10 PPT	127 ESV 9 Support Vehicles 9 PPT

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Number of Institutions with Disaster Management Plans.	Not measured	100%	100%	100%	100%	100%	100%
PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES		**SUB-PROGRAMME 4.1: GENERAL (REGIONAL) HOSPITALS**							
STRATEGIC GOAL 1 ↓ **Strategic Objective 2** To improve clinical governance including quality of care and Infection Prevention and Control.	To develop and implement a framework to improve clinical governance at all Health Facilities.	Number of Regional Hospitals implementing strategies to reduce preventable causes of morbidity and mortality (emanating from morbidity and mortality meetings).	7 (58%) How many regional hospitals do we have? Indicator asks for Number	4 (33%)	12 (100%)	6 (50%)	8 (67%)	10 (83%)	12 (100%)
	To guide and assess the implementation of Infection Prevention and Control.	Number of Regional Hospitals conducting monthly clinical audit meetings.	7 (58%)	4 (33%)	12 (100%)	6 (50%)	8 (67%)	10 (83%)	12 (100%)
		Number of Regional Hospitals implementing the Infection Prevention & Control Policy.	100%	100%	100%	100%	100%	100%	100%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	To guide and assess health services against norms and standards of the Quality Improvement Plan.	Integrated Quality Assurance Tool implemented at all Regional Hospitals.	No Tool	No Tool	Tool developed and implemented in 100% Regional Hospitals.	–	–	–	Tool developed and implemented in 100% Regional Hospitals.
	To ensure that all Regional Hospitals provide quality of care to all patients based on the defined package of services as per STP.	Caesarean section rate.	34%	31%	31%	31%	31%	31%	31%
		Average Length of Stay.	5.4 days.	4.8 days.	4.1 days.	4.6	4.4	4.2	4.1
		Bed utilisation rate.	72%	66%	72%	68%	70%	71%	72%
		Case fatality rate.	6.4%	5.8%	5%	5.6%	5.5%	5.3%	5%
PROGRAMME 5: CENTRAL HOSPITAL SERVICES		**SUB-PROGRAMME 5.1: CENTRAL & TERTIARY HOSPITAL SERVICES**							
STRATEGIC GOAL 1 ↓ **Strategic Objective 2** To improve clinical governance including quality of care and Infection Prevention and Control.	To develop and implement a framework to improve clinical governance at all health facilities.	Number of Tertiary/ Central Hospitals implementing strategies to reduce preventable causes of morbidity and mortality (emanating from morbidity and mortality meetings).	Tertiary: 2 Central:1	Tertiary: 2 Central:1	Tertiary: 3 Central:1	Tertiary: 3 Central: 1	Tertiary: 3 Central: 1	Tertiary: 3 Central: 1	Tertiary: 3 Central: 1

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	To guide and assess the implementation of Infection Prevention and Control.	Number of Tertiary/ Central Hospitals implementing the Infection Prevention and Control Policy.	Tertiary: 0 Central:1	Tertiary: 0 Central:1	Tertiary: 3 Central:1	Tertiary: 3 Central: 1	Tertiary: 3 Central: 1	Tertiary: 3 Central: 1	Tertiary: 3 Central: 1
		Number of Tertiary/ Central Hospitals conducting monthly clinical audit meetings.	Tertiary: 1 Central: 1	Tertiary: 2 Central: 1	Tertiary: 3 Central: 1	Tertiary: 12 Central: 1	Tertiary: 12 Central: 1	Tertiary: 12 Central: 1	Tertiary: 12 Central: 1
	To guide and assess health services against norms and standards of the Quality Improvement Plan.	Integrated Quality Assurance Tool implemented at all Tertiary and Central Hospitals.	–	–	100%	–	–	–	100%
	To ensure that all Central and Tertiary Hospitals provide quality care to all patients based on the defined package of services in the STP.	Caesarean Section rate.	Tertiary: 33% Central: 79%	Tertiary: 41% Central: 81%	Tertiary: 35% Central: 75%	Tertiary: 40% Central: 80%	Tertiary: 38% Central: 78%	Tertiary: 37% Central: 76%	Tertiary: 35% Central: 75%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Average Length of Stay	Tertiary: 10 Days Central: 9 Days	Tertiary: 8 Days Central: 10 Days	Tertiary: 8 Days Central: 8 Days	Tertiary: 8 Central: 8	Tertiary: 8 Central: 8	Tertiary: 8 Central: 8	Tertiary: 8 Central: 8
		Bed Utilisation rate.	Tertiary: 76% Central: 47%	Tertiary: 80% Central: 43%	Tertiary: 82% Central: 70%[16]	Tertiary:80 Central: 45	Tertiary: 81 Central: 55	Tertiary:81 Central: 60	Tertiary: 82 Central: 70
		Case fatality rate.	Tertiary: 9% Central: 6%	Tertiary: 6.8% Central: 5.2%	Tertiary: 6% Central: 4%	Tertiary: 6.6 Central: 5.1	Tertiary: 6.5 Central: 4.8	Tertiary: 6.3 Central: 4.5	Tertiary: 6 Central: 4
PROGRAMME 6: HEALTH SCIENCES & TRAINING		**SUB-PROGRAMME 6.1: TRAINING**							
STRATEGIC GOAL 3 ↓ **Strategic Objective 10** To sustain & expand the health worker force through implementation of innovative human Resource Management strategies.	To align the training and deployment of health workers to the Human Resources Plan.	Number of Advanced Midwifes trained.	70	70	100	–	–	–	100
		Number of Physiotherapists trained.	7	7	7	–	–	–	7
		Number of Occupational Therapists trained.	3	3	3	–	–	–	3

[16] The bed occupancy rate for IALCH is very low. The Hospital will review the situation and implement measures to improve the occupancy rate. Data will be validated.

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Number of Dentists trained.	2	2	2	–	–	–	2
		Number of Pharmacists trained.	24	24	24	–	–	–	24
	To enhance management capacity through a variety of management programmes.	Number of Managers, Level 13 and above, being trained in Khaedu Programme.	10	15	20	–	–	–	20
		Number of Managers, Level 7 – 12, who attended Management Programmes.	150	110	795	–	–	–	795
		Number of Hospital Managers/CEOs that have been enrolled on accredited Hospital Management training programmes.[17]	10	24	16	–	–	–	16
PROGRAMME 7: HEALTH CARE SUPPORT SERVICES		**SUB-PROGRAMME 7.1: LAUNDRIES**							
STRATEGIC GOAL 3 ↓ **Strategic Objective 15** To ensure that key support services are effectively provided.	To ensure effective and efficient provision of key support services.	Assessment of different service delivery models and consulted with organised labour.	Nil	Nil	Assessment complete & discussed with organised labour.	–	–	–	Assessment complete & discussed with organ-ised labour.

[17] The Hospital Management Programme is a new Programme over a period of 2 years. Only Hospital Managers with a Honours qualification qualify for enrolment.

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		Development of a business case for Laundries.	Nil	Nil	Business case for all laundries	–	–	–	Business case for all laundries
		New service delivery model implemented.	Nil	Nil	New model implemented in all laundries	–	–	–	New model implemented in all laundries
PROGRAMME 7: HEALTH CARE SUPPORT SERVICES		SUB-PROGRAMME 7.2: MEDICINES TRADING ACCOUNT							
STRATEGIC GOAL 3 ↓ Strategic Objective 15 To ensure that key support services are effectively provided.	To procure, store And distribute EDL and approved medicines.	Un–interrupted supply of ARV medication for patients initiated on HAART.	100%	100%	100%	100%	100%	100%	100%
		Stock-out rate of EDL medicines.	3%	2%	<2%	<2%	<2%	<2%	<2%
		Compliance with legislation of Institutional Pharmacies.	–	50%	75%	55%	60%	65%	75%
		Maintain 'Buffer' stock for critical pharmacy items.	–	100%	100%	100%	100%	100%	100%

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
PROGRAMME 8: HEALTH FACILITIES MANAGEMENT		**SUB-PROGRAMME 8.1: HEALTH FACILITY MANAGEMENT**							
STRATEGIC GOAL 1 ↓ **Strategic Objective 5** To accelerate infrastructure development and purchase of medical equipment.	To facilitate the provisioning of basic enabling services such as electricity and piped water.	Fixed PHC facilities with access to piped water.	100%	98%	100%	100%	100%	100%	100%
		Fixed PHC facilities with access to mains electricity.	99%	98%	100%	100%	100%	100%	100%
		Fixed PHC facilities with access to fixed line telephone.	96%	96%	100%	–	98%	–	100%
	To oversee the implementation of capital maintenance and equipment.	Expenditure on facility maintenance as % of total health expenditure.	1.4%	1.6%	1.9%	–	–	–	1.9%
		Expenditure on equipment maintenance as % of total health expenditure.	0.08%	0.07%	0.08%	–	–	–	0.08%
	To facilitate the commissioning of new infrastructure projects.	New/ upgraded PHC Facilities/ projects.	–	30	30	–	–	–	30
		New/ upgraded Hospitals/ projects.		1	1	–	–	–	1

Strategic Objective	Measurable Objective	Performance Measure Indicator	Actual 2006/07	2007/08 Estimate	2008/09 Budget (Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	To appropriately manage and monitor the infrastructure projects.	New Hospitals completed.	0	0	1	–	–	–	1
		New PHC Clinics/ CHCs completed.	14	11	43	–	–	–	43
		Upgraded Hospitals (number of projects).	76	92	59	–	–	–	59
		Upgraded PHC Clinics/ CHCs (number of projects).	147	52	47	–	–	–	47
		Upgrading District Hospitals.	22	28	22	–	–	–	22
	To quantify infrastructure backlogs and fast track implementation.	Average backlog of fixed PHC Facilities (R'000).	303	3,619	423	–	–	–	R423 million
		Average backlog of District Hospitals (R'000).	874	1,045	1,232	–	–	–	R1232 million
		Average backlog of Regional Hospitals (R'000).	825	987	1,163	–	–	–	R1163 million
		Average backlog of Specialised Hospitals (R'000).	489	585	689	–	–	–	R689 million
		Average backlog of Tertiary Hospitals (R'000).	2,066	2,467	2,913	–	–	–	R2913 million

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ACRONYMS / ABBREVIATIONS

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ACRONYMS / ABBREVIATIONS

ABET	Adult Basic Education and Training.
AEFI	Adverse Events Following Immunisation.
AFP	Acute Flaccid Paralysis.
AIDS	Acquired Immune Deficiency Syndrome.
ALS	Advanced Life Support.
ALOS	Average Length of Stay.
ANC	Ante-Natal Coverage
APP	Annual Performance Plan.
ART	Anti-retroviral Therapy.
ARV	Anti-retroviral.
ASGI-SA	Accelerated and Shared Growth Initiative of Government.
BANC	Basic Ante Natal Care.
BBBEE	Broad Based Black Economic Empowerment.
BEE	Black Economic Empowerment.
BFHI	Baby Friendly Hospital Initiative.
BLS	Basic Life Support.
BOD	Burden of Disease.
ICAT	Infection Assessment Tool.
CBC	Community Based Carers.
CDC	Communicable Disease Control.
CEO	Chief Executive Officer.
CHC	Community Health Center.
CHIP	Child Health Problem Identification Programme.
CHW	Community Health Worker.
COHSASA	Council for Health Service Accreditation of Southern Africa.
CPD	Continuous Professional Development.
CPSS	Central Pharmaceutical Supply Store.
CVD	Cardiovascular Disease.
DHER	District Health Expenditure Report.
DHIS	District Health Information System.
DHPs	District Health Plans.
DHS	District Health System.
DOTS	Directly Observed Treatment Short Course.
DTP	Diphtheria, Tetanus and Pertusssis.
DUT	Durban University of Technology.
EAP	Employee Assistance Programme.
EC	Emergency Contraception.
ECP	Emergency Care Practitioner.
EDL	Essential Drug List.

EH	Environmental Health.
EMRS	Emergency Medical Rescue Services.
EN to RN	Enrolled Nurse to Registered Nurse.
ENA to EN	Enrolled Nurse Assistant to Enrolled Nurse.
EPI	Expanded Program on Immunisation.
EPMDS	Employee Performance Management & Development System.
EPT	Emergency Patient Transport.
EQL	Essential Equipment Packages.
ESV	Emergency Service Vehicle.
FBO	Faith Based Organisations.
FIO	Facilities Information Officer.
GDP	Gross Domestic Product.
GIS	Geographic Information Systems.
GP's	General Practitioners.
GP's	General Practitioner.
HBC	Home Based Carer.
HIV	Human Immuno-virus.
HOD	Head of Department.
HP	Health Promotion.
HPC	Health Promoting Clinic.
HPHs	Health Promoting Hospitals.
HPH	Health Promoting Hospital.
HPSP	Health Promoting Schools Programme.
HPT&D	Health Professional Training and Development Grant.
HPV	Human Papilloma Virus.
HR	Human Resources.
HRH	Human Resource for Health.
HRP	Human Resource Plan.
HRSC	Human Sciences Research Council of South Africa.
HTAs	High Transmission Areas.
HWSETA	Health and Welfare Sectoral Educational Training Authority.
IALCH	Inkosi Albert Luthuli Central Hospital.
ICD 10	International Classification of Diseases (Version 10).
ICPD	International Conference on Population & Development.
IDDP	International Day of Disabled Persons.
IDP	Inter-Departmental Plan.
IDT	Independent Development Trust.
IEC	Information, Education and Communication.
IGR	Inter-Governmental Relations.
IHPF	Integrated Health Planning Framework.
ILS	Intermediate Life Support.

ACRONYMS / ABBREVIATIONS

IMCI	Integrated Management of Childhood Illnesses.
IMS	Incident Management Systems.
INDS	Integrated National Disability Strategy.
INP	Integrated Nutrition Programme Business Plan.
IPC	Infection Prevention & Control.
ISC	Intersectoral Collaboration
IT	Information Technology.
KMC	Kangaroo Mother Care.
M and E	Monitoring and Evaluation.
M2M2B	Mothers-2-Mother- 2-Be.
MC&WH	Maternal Child & Women's Health.
MCC	Medical Control Council.
MDG	Millennium Development Goals.
MDR	Multiple Drug Resistant.
MDR TB	Multi-drug Resistant Tuberculosis.
MEC	Member of the Executive Council.
MICU	Medical Intensive Care Unit.
MIS	Management Information System.
MLW	Mid Level Worker.
MRC	Medical Research Council.
MSP	Master Systems Plan.
MTEF	Medium Term Expenditure Framework.
MTS	Modernisation of Tertiary Services.
NEPAD	New Economic Partnership for African Development.
NGOs	Non Governmental Organisations.
NHLS	National Health Laboratory Services.
NHS	National Health System.
NICU	Neo Natal Intensive Care Unit.
NIP	National Integrated Programme.
NMIR	National Minimum Information Requirements.
NMR	National Mortality Rate.
NQF	National Qualification Framework.
NTCP	National Tuberculosis Control Programme.
OHSA	Occupational Health and Safety Act.
OIS	Organisational Improvement Services.
OPD	Out-Patient Days.
OSD	Occupation Specific Dispensation.
PBECP	Professional Board for Emergency Care Personnel.
PC's	Personal Computers.
PEP	Post Exposure Prophylaxis.

PHAST	Participatory and Sanitation Transformation.
PHC	Primary Health Care.
PMDS	Performance Management and Development System.
PMO's	Principal Medical Officers.
PMR	Peri-natal Mortality Rate.
PMSC	Provincial Medical Supply Centre.
PMTCT	Prevention of Mother to Child Transmission.
PPIP	Peri-natal Problem Identification Programme.
PPT	Planned Patient Transport.
PWD	Person with Disabilities.
QA	Quality Assurance.
RED	Reach Every District.
RED	Reach Every Child / District.
SADC	Southern African Development Co-operation.
SADHS	South African Demographic & Health Survey.
SAPS	South African Police Service.
SCM	Supply Chain Management.
SETA	Sector Education Training Authority.
SHS	School Health Services.
SLA	Service Level Agreement.
SMMEs	Small Medium and Micro Enterprises.
SMS	Senior Management Service.
SOP	Standard Operating Procedures.
SRA	Sexual Reproductive Health.
STATS SA	Statistics South Africa.
STI	Sexually Transmitted Infections.
STP	Service Transformation Plan.
TB	Tuberculosis.
TED	Targeted Enterprise Development.
TM	Traditional Medicine.
TOP	Termination of Pregnancy.
UKZN	University of Kwa-Zulu Natal.
UNISA	University of South Africa.
VCT	Voluntary Counseling and Testing.
WHO	World Health Organisation.
WOE	Women Owned Enterprises.
XDR	Extreme Drug Resistant.
XDR TB	Extreme Drug Resistant Tuberculosis.

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