health

Department:
Health
PROVINCE OF KWAZULU-NATAL

ANNUAL PERFORMANCE PLAN 2012/13

ANNUAL PERFORMANCE PLAN 2012/13

MTEF: 2012/13 – 2014/15

ANNUAL PERFORMANCE PLAN 2012/13 – 2014/15

FOREWORD BY THE MEC FOR HEALTH

We, as a Department, are tenaciously navigating our way towards a health care system of choice where communities will be at the epicentre of care. We are still determined to do things differently, smarter and faster to stay on par with increasing demands for healthcare.

We look forward to our active participation in the first phase of implementation of National Health Insurance. Three of our districts, Umgungundlovu, Umzinyathi and Amajuba have been selected as part of the national pilot project and we look forward to the lessons learned to craft our way forward to high quality and equitable healthcare for all.

The key service delivery priorities in this year's Annual Performance Plan include:

- Strengthening Human Resources for Health.
- Implementing the National Core Standards for Health Establishments including the following core standards:
  - Patient Rights;
  - Patient Safety;
  - Clinical Support Services;
  - Public Health;
  - Leadership and Corporate Governance;
  - Operational Management; and
  - Facilities and Infrastructure.
- Implementing the Maternal, Neonatal, Child and Women's Health and Nutrition Strategy.
- Implementing the integrated HIV & AIDS, STI and TB Strategy.
- Re-engineering of PHC with Operation Sukuma Sakhe as vehicle for community-based action.

I would like to thank all the staff for their dedication and commitment in improving health care in KwaZulu-Natal. Your contributions make change possible and provide hope to our citizens who are dependent on our services.

I endorse the 2012/13 Annual Performance Plan as a framework for the Department's commitments and performance targets within the available budget.

Dr SM Dhlomo
MEC for Health
KwaZulu-Natal Department of Health
Date: 01/04/2012

ANNUAL PERFORMANCE PLAN 2012/13 – 2014/15

MESSAGE BY THE HEAD OF DEPARTMENT

During the coming year the Department will continue to execute its mandate from the Negotiated Service Delivery Agreement with staunch commitment. In this context, we stay committed towards reducing the leading causes of disease, injury, disability and death.

With the eminent rollout of National Health Insurance over the coming 14 years we are challenged by a mammoth task to overhaul and revitalise public health services to be the service of choice. This provides us with the opportunity to aspire to sustainable services of excellence that will re-dress inequities of the past and ensure equitable access to high levels of care, to reduce the burden of disease, and ultimately improve the life expectancy at birth.

The Department is committed to re-dress inequalities in service delivery to ensure that all citizens have access to good quality health care and therefore embarked on robust engagements in search of innovative and sustained solutions to frustrating challenges experienced over the last few years.

The paradigm shift from facility to community-based health services is at best challenging, but a solid foundation has been crafted through the re-engineering of PHC model with Operation Sukuma Sakhe as vehicle for community-based care. PHC re-engineering earns high priority over the coming year with robust monitoring and evaluation to craft the way forward.

My gratitude goes to all the staff for their commitment, dedication and daily efforts to improve the health and wellbeing for all people in the Province. I am looking forward to this next phase of innovation, development and consolidation in the Department and I am committed to work tirelessly with my staff to achieve our goals.

I am pleased to present the Department's Annual Performance Plan for 2012/13 including the MTEF cycle up to 2014/15.

Dr SM Zungu
Head of Department
KwaZulu-Natal Department of Health
Date: 29. 03 . 2012

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OFFICIAL SIGN-OFF OF THE KWAZULU-NATAL ANNUAL PERFORMANCE PLAN 2012/13 – 2014/15

It is hereby certified that the 2012/13 – 2014/15 Annual Performance Plan for the KwaZulu-Natal Department of Health:

- Was developed by the Provincial Department of Health in KwaZulu-Natal.
- Was developed under leadership of the Head of Department and MEC for Health and complies with the National Framework, the Negotiated Service Delivery Agreement, and the 2010 – 2014/15 Strategic Plan of the KwaZulu-Natal Department of Health.
- Accurately reflects the performance targets which the Provincial Department of Health in KwaZulu-Natal will endeavour to achieve given the resources and budget for 2012/13 – 2014/15.

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Mr J Govender

Acting General Manager: Health Service Planning, Monitoring & Evaluation

Date: 29/03/2012

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Mr S. Mkhize

Chief Financial Officer

Date: 29/03/2012

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Dr SM Zungu

Head of Department

Date: 29.03.2012

APPROVED BY:

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Dr SM Dhlomo

MEC for Health

Date: 01/04/2012

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PART A

1. STRATEGIC OVERVIEW

1.1. VISION

To achieve the optimal health status for all persons in KwaZulu-Natal

1.2. MISSION

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

1.3. VALUES

Trust built on truth;

Open communication;

Commitment to performance;

Integrity and reconciliation;

Transparency and consultation; and

Courage to learn, change and innovate

1.4. STRATEGIC GOALS

Table 1: (A1): Strategic Goals

Strategic Goal	Goal Statement	Rationale	Expected Outcomes
1. *Overhaul Provincial Health Services.*	Transform the Provincial health care system through implementation of the STP [including 10 core components] to improve equity, availability, efficiency, quality and effective management to enhance service delivery and improve health outcomes of all citizens in the province.	An efficient and well-functioning health care system with the potential to respond to the burden of disease and health needs in the Province.	▪ Transformation in line with NHS 10 Point Plan, Negotiated Service Delivery Agreement [NSDA] and Service Transformation Plan [STP]. ▪ Improved access, equity, efficiency, effectiveness and utilisation of public health services. ▪ Improved Human Resource Management including reconfiguration of organisational structures, appropriate placement of staff [appropriate skills mix and competencies], appropriate norms and standards to respond to burden of disease and package of services, strengthened performance management and decreased vacancy rates. ▪ Improved Financial & SCM efficiency and accountability to curb over-expenditure, improve return on investment and value for money, budget aligned with service delivery priorities and needs.

Strategic Goal	Goal Statement	Rationale	Expected Outcomes
			▪ Appropriate response to the burden of disease and consequent health demands. ▪ Improved governance including regulatory framework, and policies and delegations to facilitate implementation of the Strategic Plan. ▪ Decentralised delegations, controls and accountability. ▪ Improved information systems, data quality and information management, and improved performance monitoring and reporting. ▪ Strengthened infrastructure to improve service delivery.
2. *Improve the efficiency and quality of health services.*	Achieving the best possible health outcomes within the funding envelope and available resources.	Improved compliance with legislative/ policy requirements and Core Standards for quality service delivery in order to improve clinical/ health outcomes.	▪ Accreditation of health facilities in line with National Core Standards for Quality. ▪ Improved management capacity. ▪ Improved health outcomes and increased life expectancy at birth as a result of improved clinical governance. ▪ Improved performance towards achieving the MDG targets. ▪ Patient satisfaction.
3. *Reduce morbidity and mortality due to communicable diseases and non-communicable conditions and illnesses.*	Implement integrated high impact strategies to improve prevention, detection, management and support of communicable diseases & non-communicable illnesses and conditions at all levels of care.	Reduction of preventable/ modifiable causes of morbidity and mortality at community and facility level contributing to a reduction in morbidity and mortality rates.	▪ Decrease in morbidity and mortality – with specific reference to preventable causes. ▪ HIV & AIDS: Reduce HIV incidence to 1.4% by 2014/15. ▪ TB: Increase the TB cure rate to 85% by 2014/15. ▪ PMTCT: Decrease the baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks to less than 1% by 2014/15. ▪ Maternal mortality rate: Reduce the facility maternal mortality rate to 119/100k by 2014/15. ▪ Malaria: Maintain the malaria incidence per 1000 population at risk at less than 1/1000 population. ▪ Change in trends of non-communicable disease patterns.

- Source: 2010-2014/15 Strategic Plan with reviewed targets included from the 2012/13 APP
- The HIV & AIDS and PMTCT targets have been reviewed since tabling of the Strategic Plan. It is based on the KZN Provincial Strategic Plan for HIV, AIDS, STIs and TB 2012-2016.
- The TB targets has been reviewed based on performance and improved TB outcomes.

PLANNING PROCESS

With guidance and leadership from the MEC for Health and the Head of Department, the Department conducted a Provincial planning workshop in the 3rd quarter of 2011/12 to review the Provincial performance in order to determine the Provincial priorities for the 2012/13 Annual Performance Plan. Delegates included Senior Managers, Head Office Managers and District and Facility Management.

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PART A

In November and December 2011/12, the Strategic Planning Component, supported by a multi-disciplinary team, conducted four [4] decentralised planning workshops with representatives from District and Facility Management. The objective of the decentralised workshops was to align District Health Plans with Provincial priorities. District Health Plans have been presented to Finance in the final Budget Bid for the forthcoming MTEF.

The draft Annual Performance Plan was presented to Senior Management for approval in the 4th quarter of 2011/12 and subsequently circulated for final comments. The final draft APP has been submitted and discussed with the Budget Section to ensure alignment between budget and service delivery.

PROVINCIAL PRIORITIES FOR 2012/13

Provincial priorities for 2012/13 are clearly noted in Part B of the APP as part of the introduction to each Budget Programme.

National Health Insurance, relevant to the health system as a whole, is covered under Programme 1: Administration. Outcomes will however be measured as part of service delivery in analysis of data.

NOTES ON THE PRESENTATION OF CORE BUSINESS FOR 2012/13

The format for the Annual Performance Plan has been determined by the National Department of Health. The format is in line with Treasury requirements.

Core performance indicators [per Budget Programme] have been determined by the National Department of Health in consultation with National Treasury referred to as "*Performance Indicators*" in Part B of the APP. These indicators are monitored quarterly and formal reports "*Provincial Quarterly Performance Report*" submitted to Provincial and National Treasury and the National Department of Health.

Provinces have the responsibility to add performance indicators and targets, in addition to Treasury indicators, in order to actively monitor and report on progress and health outcomes. Provincial indicators and targets are reflected in Part B of the APP under "*Provincial Strategies, Objectives, Indicators and Targets*". Quarterly targets indicated in the same section will provide measures against which to monitor progress on a quarterly basis.

Other core and sub-set indicators are included in the Monitoring & Evaluation Framework to regulate quarterly reporting. Operational Plans, both Provincial and District, incorporate sub-set indicators and targets to ensure comprehensive reporting against priorities.

PART A

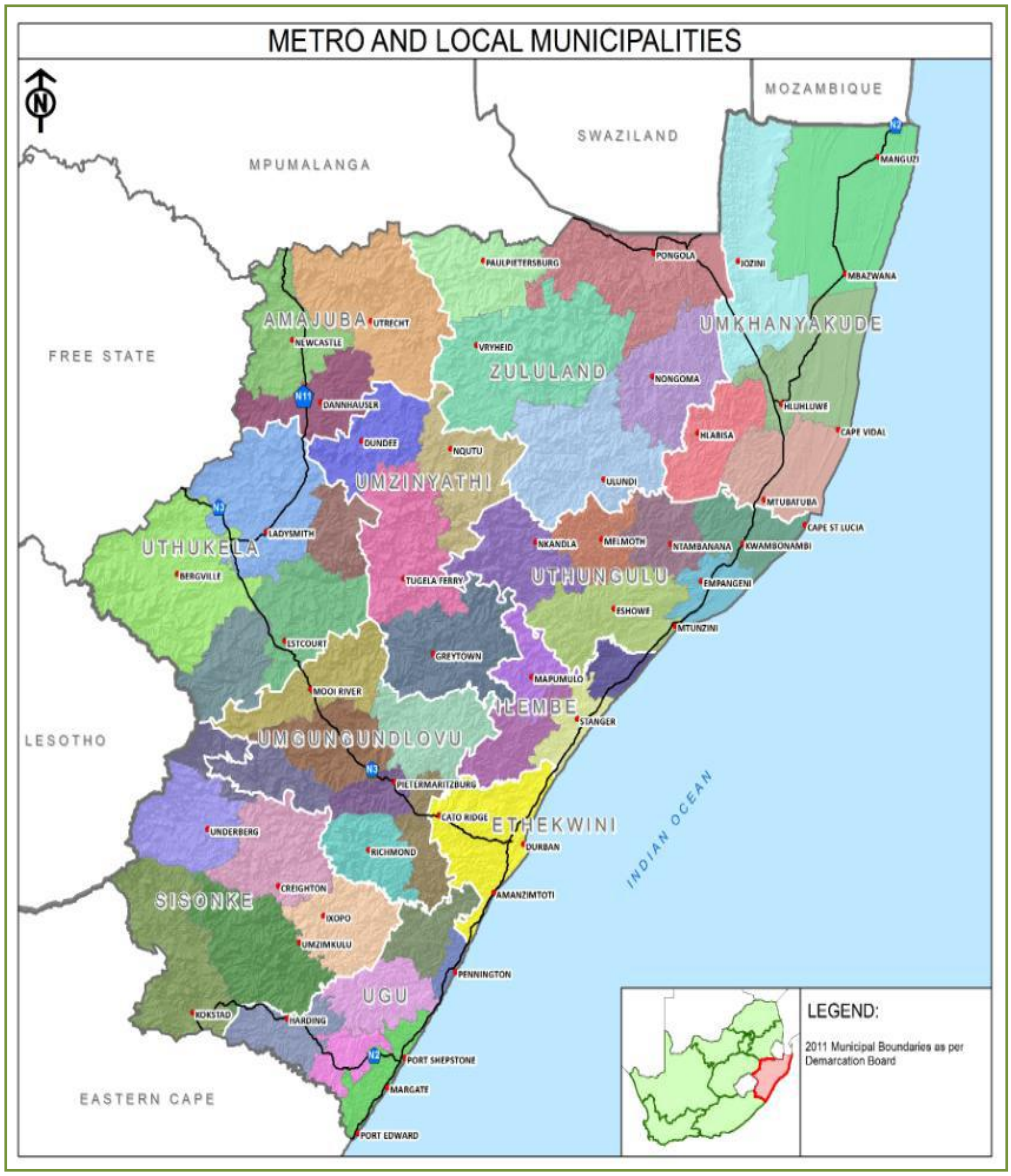
1.5. SITUATION ANALYSIS

1.5.1 POPULATION PROFILE AND DEMOGRAPHIC CHARACTERISTICS

KwaZulu-Natal is the second most populous province in South Africa, with an estimated 10.6 million people of which an estimated 9,504,000 is uninsured. [32]

Geographically, the Province occupies 7.6% or 92,100 sq km of the total land surface in South Africa with a population density of 112.8 people per square kilometre. The Province borders Eastern Cape in the South, Free State and Lesotho in the West and Swaziland and Mozambique in the North as indicated in the map below.

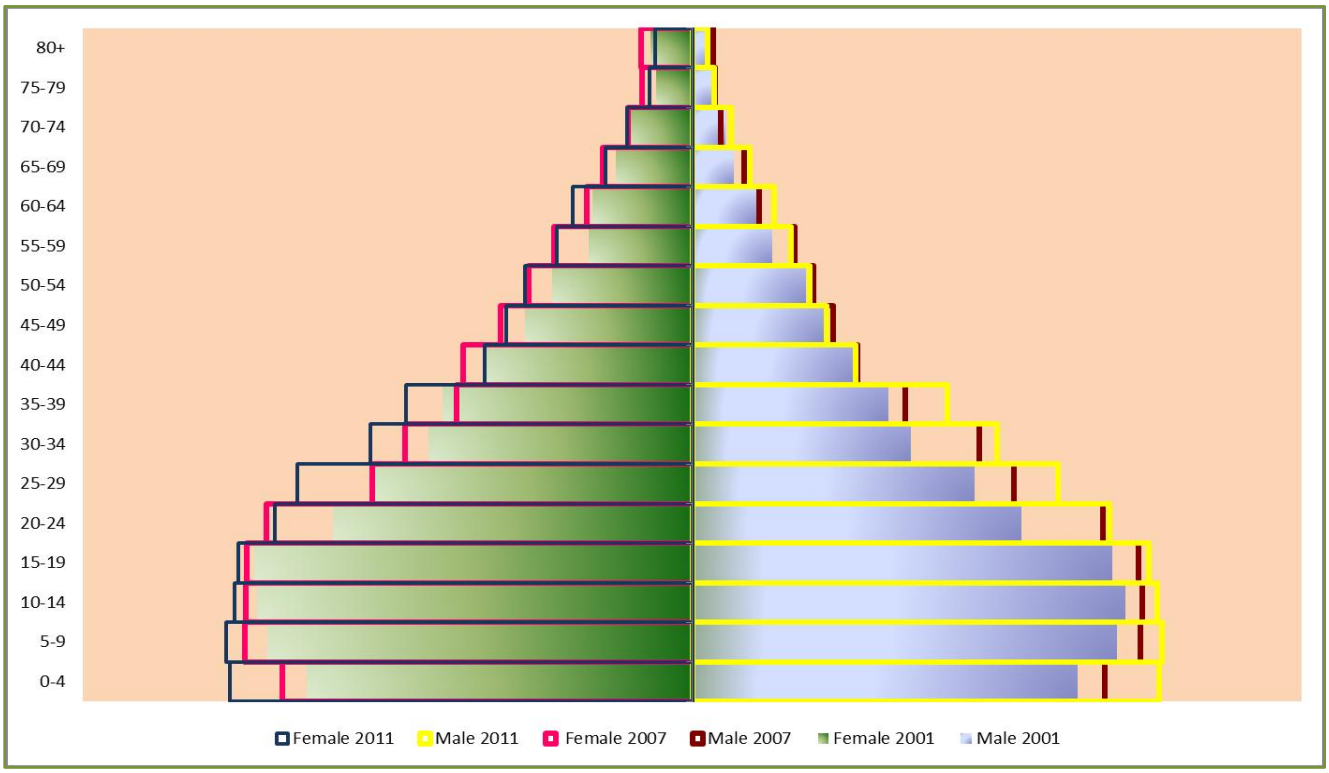
Map 1: Province of KwaZulu-Natal



The Province is divided into 50 Municipalities, one Metropol and 10 Health Districts, with health service boundaries aligned to municipal boundaries. Four Districts and one Municipality have been declared Integrated Sustainable Rural Development Programme [ISRDP] Nodes i.e. Ugu, Umzinyathi, Zululand and Umkhanyakude Districts, and the Umzimkhulu Municipality in Sisonke. The Municipalities of Nkandla in Uthungulu and Msinga in Umzinyathi are specifically targeted as Cabinet priorities.

StatsSA estimate that 54% of the total Provincial population lives in rural areas, and an estimated 10% of the urban population in under-developed informal settlements. [32] Urbanisation, especially relevant to the economic hubs, increased the population in informal settlements which put additional unforeseen pressure on service delivery.

Figure 1: Provincial Population Pyramid 2001; 2007, 2011



Source: StatsSA – Developed by KZN Department of Health GIS

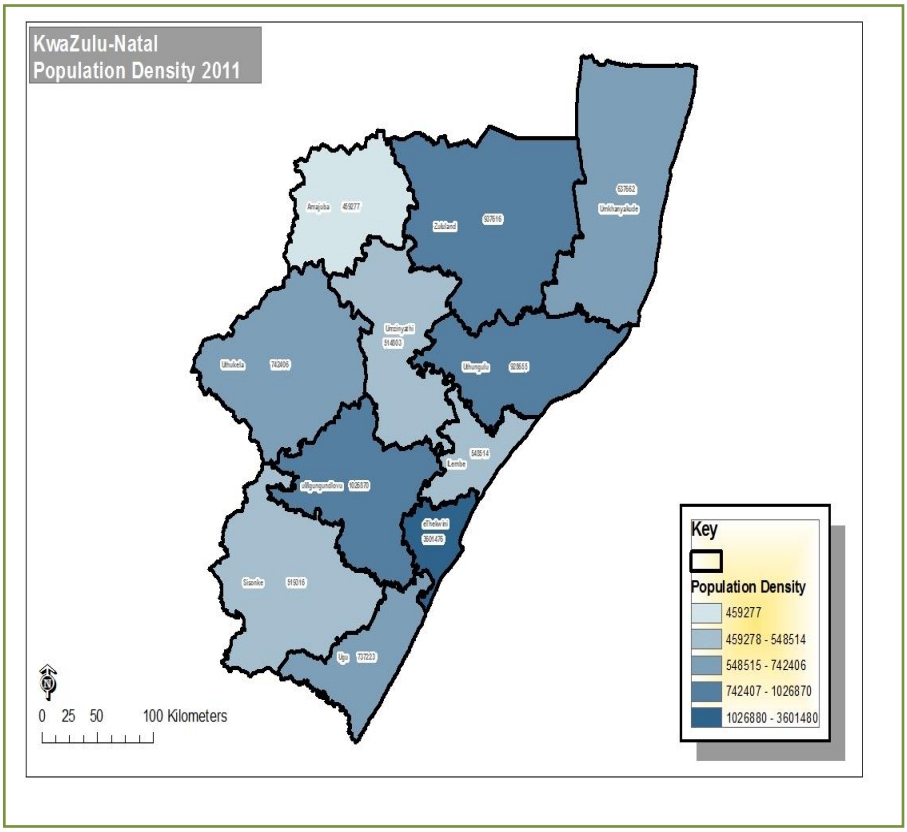
KZN has the highest population under 1 year in the country with nearly a quarter of all infants living in the Province.[6] The population is young with an ageing index of 13[1]. Nearly one third of the population is younger than 15 years; approximately 6.7% is 60 years or older; and 52.3% of the total population is female.

[1] The ageing index is defined as the number of people aged 65 and over per 100 youths under the age of 15 years

From 2000 to 2009, the Provincial share of the national population has increased from 20.9% to 21.4%, although population growth has decreased from 0.47% to 0.28%.

The map below illustrates the population density per municipality with eThekwini by far the most populous area, followed by uMgungundlovu, uThungulu and Zululand. The least populous districts are Umzinyathi, Sisonke, Ilembe and Amajuba.

Map 2: KZN Population per District [StatsSA]



Population density has a definite impact on socio-economic factors including, but not exclusive to, unemployment, finance and housing, service provision, and environmental degradation.

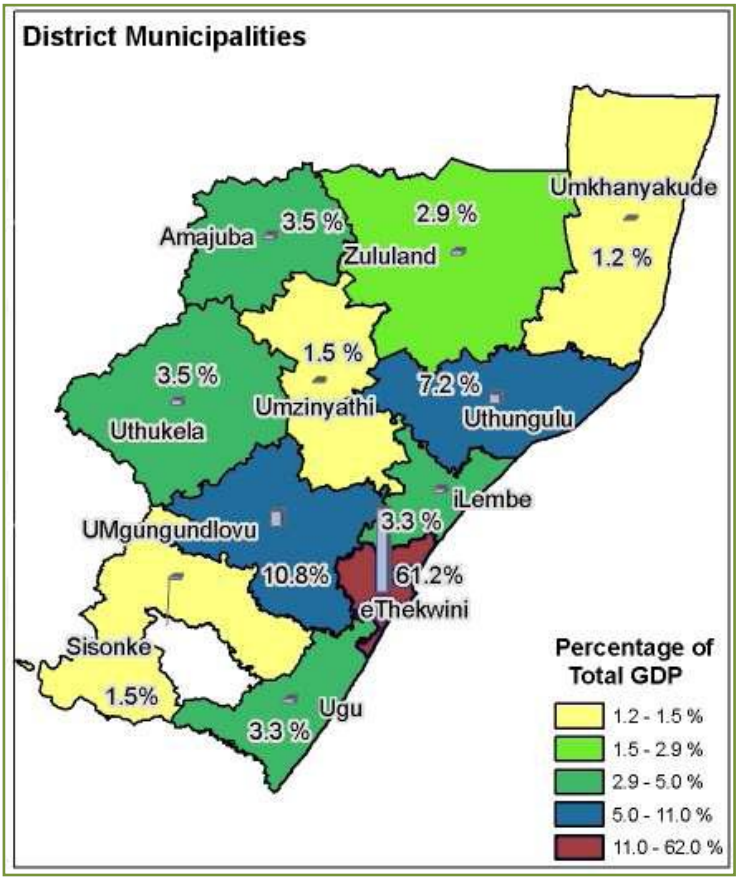
These challenges are not exclusive to high density areas as service backlogs [including inadequate access to education, health care, water, sanitation, and electricity] are experienced in most rural areas [*see Socio-Economic Profile*].

The highest concentration of population is found in eThekwini and Mzundusi, followed by the Newcastle and Umhlatuze complexes. A third level of density concentrations is also evident in the areas of Emnambithi, Hibiscus Coast and KwaDukuza.

There is no direct correlation between utilisation rates and number of facilities to density which question actual reasons why patients are not utilising existing services as often as expected.

1.5.2 SOCIO-ECONOMIC PROFILE

Map 3: District Municipality Contribution to Total GDP



Map 3 shows the distribution of economic activity in KZN with 61% of the Provincial output generated by eThekwini [indicated in red] and 70% of the total economic activity concentrated in Umgungundlovu and eThekwini.

In contrast, Umkhanyakude, Sisonke and Umzinyathi [indicated in yellow] have the lowest levels of economic activity in the Province – all Rural Development Nodes.

Unemployment, poverty and access to basic services have a significant impact on health. Implementation of the integrated Operation Sukuma Sakhe [OSS] strategy, used as vehicle for implementation of PHC re-engineering at ward/household level, aims to address challenges through inter/intra-departmental community development programmes.

Poverty and Deprivation

According to the 2010 District Health Barometer [7] the Province is one of three provinces with the ten most deprived districts in South Africa where 63% to 82% of households live on less than R800 per month.

The unemployment rate shows a decline [by 0.6 of a percentage point] since 2010. Unemployment is highest among the youth [15-34 years] and lowest among 55-64 year olds showing a distinctive increase for those with an education level less than matric. The unemployment rate for women remains higher than the Provincial average although it is lower than the national average. This is significant especially in view of the high burden of disease e.g. HIV and AIDS with increasing numbers of female headed households and orphans.

In 2008, 70.9% of children less than 18 years [2,902,000] lived in households with a monthly per capita income of less than R569, and 42.7% [1,749,000] lived in households without an employed adult.[19] In 2009, 20.8% of the population in KZN was unemployed [official definition] [2], while 2,344,413 children received the Child

[2] The official definition of unemployment includes those who are currently willing and able to work and have actively been looking for work within the previous month

Support Grant. 23.1% of the population had inadequate or severely inadequate access to food. [5]

This has significant implications for service delivery referring to the population groups at risk i.e. youth [high teenage pregnancy, increased risk behaviour i.e. alcohol and substance abuse, early sexual debut, HIV infection, etc.] and women and children under-5 years [high risk pregnancies, HIV infection, high maternal, neonatal, infant and child mortality, etc.]. The OSS poverty eradication programme is intended to address poverty through intensified and renewed strategies that directly focus on individuals and households at community level with the following objectives:

- Poverty eradication through coordinated community-based interventions at household level with the ultimate aim to increase life expectancy.
- Community development with the primary focus being on vulnerable groups e.g. women and youth.
- Rural development and food security.
- Integration and cooperative governance to improve service delivery.

Access to Basic Services

While significant progress has been made in addressing service delivery backlogs, the pace of delivery is too slow to achieve universal access to water, sanitation and electricity by 2014. According to a 2011 COGTA Report, 80% of households in the Province have access to water, with the highest backlogs in Ugu, Umkhanyakude, Umzinyathi, and Newcastle in Amajuba District. [3]

The Provincial "*Blue Drop*" score [measuring management and processes to ensure acceptable drinking water quality] deteriorated from 73% in 2009 to 65% in 2010. All Water Service Authorities reported a decline except Umgungundlovu, Newcastle and Sisonke. The worst score was Umkhanyakude at 22.4%. [3]

The Provincial "*Green Drop*" assessment in 2009 was 44% with only three Water Services Authorities scoring more than 50% i.e. eThekwini [80%], uMhlathuze [72%] and Ugu [51%]. This indicates deficiencies in the management and treatment of waste water. [3]

78.7% of households in the Province have access to sanitation with the highest backlogs recorded in Uthungulu, Umkhanyakude and Umgungundlovu. 79% of households in the Province have access to electricity with the highest backlogs in Umkhanyakude, Umzinyathi and Sisonke. [3]

1.5.3 EPIDEMIOLOGICAL PROFILE – BURDEN OF DISEASE

There is growing pressure on the health care system to respond to the increasing burden of disease in the Province including [but not exclusive to]:

- HIV and AIDS;
- TB;
- High maternal and child mortality;
- Increasing non-communicable diseases; and
- Trauma including violence and road traffic accidents.

According to StatsSA 2010 estimates, life expectancy for males increased from 47.3 in 2009 to 48.4 in 2011 and from 51 in 2009 to 52.8 in 2011 for females.

The number of reported malaria cases decreased from 428 cases in 2009/10 to 380 cases in 2010/11. The number of deaths increased from 4 in 2009/10 to 5 in 2010/11.

The use of artemether/lumefantrine as first line therapy and strengthened vector control has contributed to the reduction of malaria cases and improved malaria outcomes in the province. [12]

The Department will monitor the impact of climate change on malaria closely as a projected increase in mean temperature of ±1.4 to 5.8 degrees Celsius under climate change may result in a "faster parasite development and a potentially higher incidence of malaria".

The general observation is that climate change is likely to enhance the number of cases in countries with high levels of currently infected people. Data, presented in Zimbabwe, predict that the number of malaria cases will increase by between 4.84 and 29.66 per 1000 people by 2080-2100. [12, 18]

Access to Health Care

According to the 2011 District Health Barometer [6] approximately 15.7% of the population had access to medical insurance in 2010 with variations between 4.9% in Umkhanyakude and 25.8% in eThekwini. Day and Grey [2] estimated that 9.2 million people in the Province are dependent on public health services which add considerable pressure on scarce resources e.g. human resources and infrastructure.

Kibel et al [19] reported that 2,180,000 children in KZN live more than 30 minutes away from a clinic irrespective of the mode of transport they use.

In 2010, the average catchment population per clinic was 17,832. Eight [8] municipalities had an average catchment population of less than 10,000 and eThekwini on average exceeded 30,000 catchment population per clinic.

Zululand and Umkhanyakude have the 2nd and 3rd lowest catchment populations per clinic mainly due to the geographical distribution of households [sparsely populated], challenging topography, and erratic informal transport to health services.

This challenges equity in provisioning of infrastructure and other resources with regards to economy of scale, and innovative strategies must be explored to address equity in cost effective way.

HIV and AIDS

The UNAIDS estimated the Provincial HIV incidence at 2.2% in 2010 compared with the ASSA estimate of 1.8%.

According to MRC, the mother to child transmission rate decreased from 20.5% in 2005 to 2.8% in 2010.

Table 2 shows the estimated new HIV infections in the Province between 2009 and 2010.

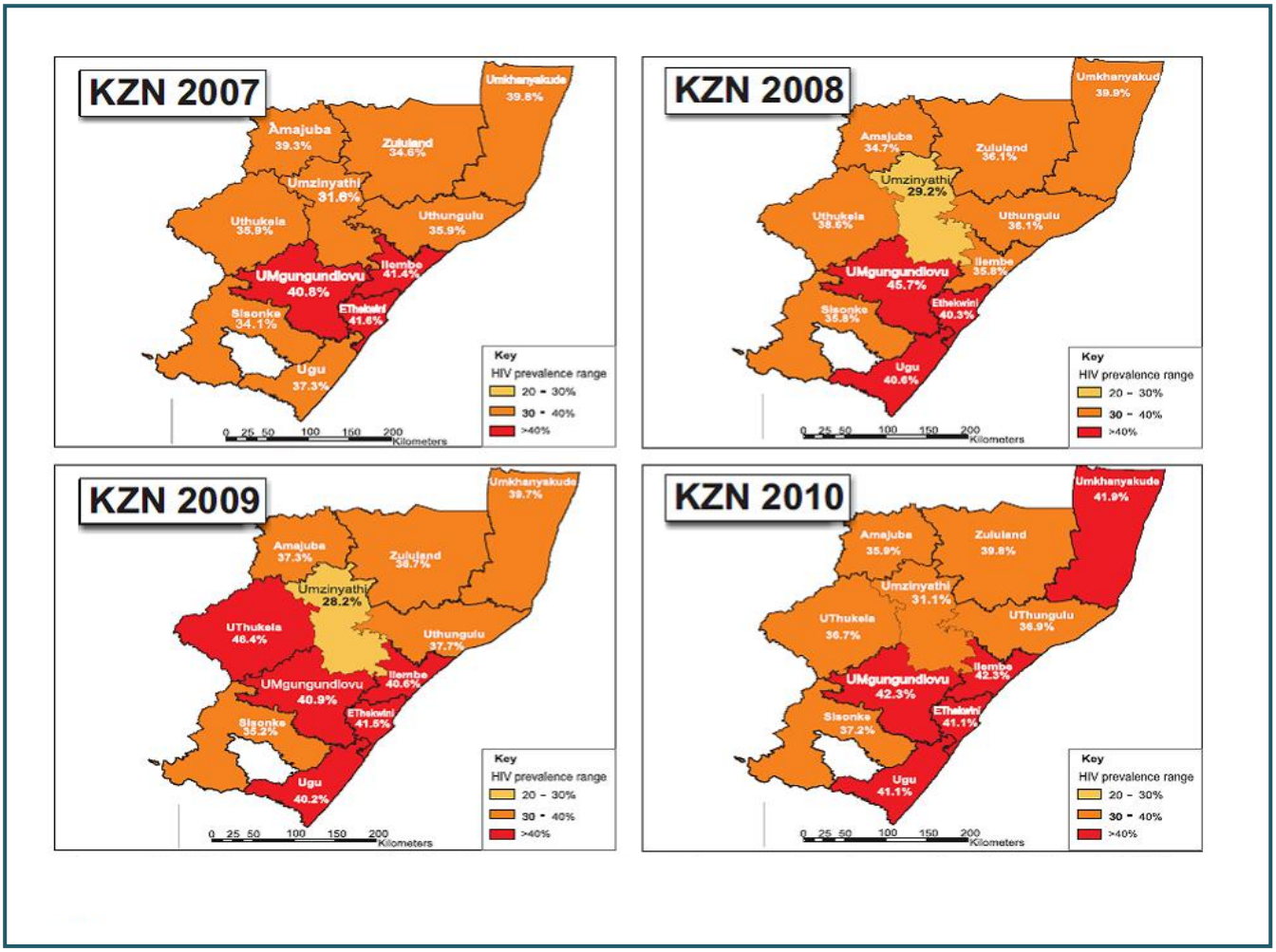
Table 2: Estimated New Infections in KZN 2009 – 2010

Year	Estimated number of new infections [Adults 15-49 years]		Estimated number of new infections [Adults 15-49 years] % per annum		Estimated number of new infections [Children birth to 14 years]	
	UNAIDS	ASSA	UNAIDS	ASSA	UNAIDS	ASSA
2010	95,896	76,000	2.2%	1.8%	14,226	15,000
2009	98,600	78,000	2.3%	1.9%	14,235	17,000

Source: 2010 National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa

In 2010, the HIV prevalence under antenatal women was 39.5% compared with 30.2% nationally with prevalence's over 40% in 5 districts. [9] The HIV prevalence has been consistently higher in KZN than in the rest of the country and continues to be one of the leading causes of mortality in KZN. A recent study in rural KZN showed that HIV [including tuberculosis] was the primary cause in 50% of all deaths [15].

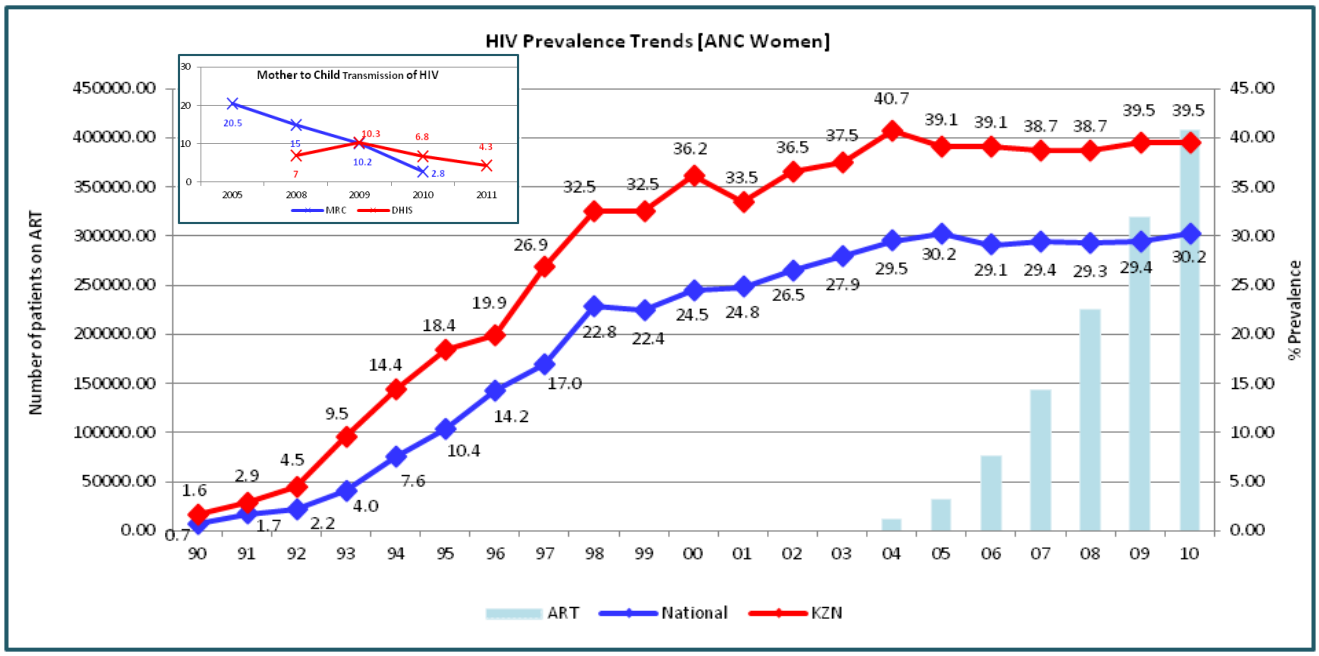
Map 4: HIV Prevalence in Antenatal Women in KwaZulu-Natal 2007 - 2010



Source: 2010 National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa

PART A

Graph 1: HIV Prevalence, Management, Output and Outcome



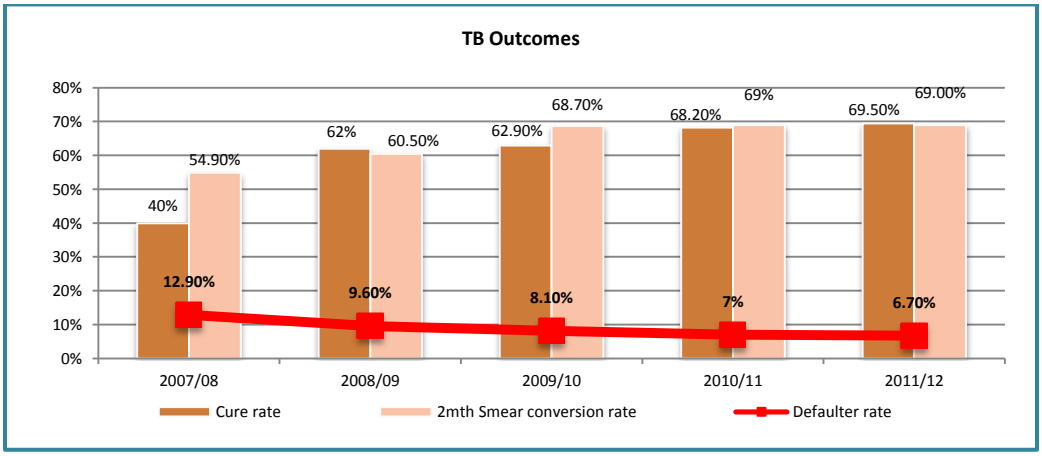
Source: HIV Prevalence Study; MRC; DHIS

Tuberculosis

In 2010, a total number of 106,129 new TB cases were reported at facilities - TB incidence of 1,014/100 000 population. It is likely that there is still a large pool of undetected cases in communities which will inevitably show an increase in incidence as case detection improves.

Of the total number of cases managed at facility level, 8.4% of cases [10,381] were children between 0-4 years; 28% of cases were new smear positive; 27% new smear negative; and 16% extra-pulmonary cases.

Graph 2: Provincial TB Outcomes 2007/08 to 2011/12 [ETR.Net]



HIV positive patients remain at high risk of tuberculosis. Screening for TB among HIV positive patients is often not sensitive enough to detect the disease, as shown in a recent study conducted in Durban among patients starting anti-retroviral treatment. Of those with positive sputum cultures for TB, only 9% had positive smears and only 52% reported having a cough. [2]

Between 2004 and 2010, a total of 11,303 MDR TB cases and 1,499 XDR TB cases were diagnosed in the Province suggesting an increasing demand for services to effectively manage MDR TB.

Maternal and Child Health

According to 2010 StatsSA estimates, the fertility rate in KZN is 3.0 with wide variations between rural and urban districts i.e. 3.6 and 3.4 in Uthukela and Zululand and 2.5 and 2.2 in eThekwini and Umgungundlovu.

Accurate population-based data to determine maternal and child mortality is hindered by the absence of accurate vital registration reporting for births and deaths. The Department therefore uses facility-based information as proxies to monitor trends.

According to DHIS data, a total of 365 maternal deaths were reported in the Province in 2009 decreasing to 318 reported deaths in 2010. The facility maternal mortality rate [proxy] increased from 169/100 000 live births in 2009/10 to 195/100 000 live births in 2010/11.

The delivery rate for women under-18 years increased from 8.9% of the total number of deliveries in 2010/11 to 9.3% in 2011/12 [estimated annual performance]. This is a challenge taking into consideration that according to the Saving Mothers Report 2004-2007 [8] 9.8% of reported maternal deaths in the triennial reporting period was in this age group.

According to Day and Grey [5], pregnant women attend antenatal care services an average 3.7 times during their pregnancy. According to data in the DHIS, the proportion of pregnant women visiting antenatal care before 20 weeks increased from 34.3% in 2009/10 to 39.6% in 2011/12 [estimated annual performance]. Early and regular antenatal care attendance is critical to ensure appropriate and effective management of pregnancy and labour. Postnatal follow-up [within 6 days of delivery] is still poor although it shows an upward trend between 2009/10 and 2011/12 [42% to 56.3% for mothers and 57.7% for babies].

According to Day and Grey [5] the neonatal mortality rate in KZN was 11.1 per 1000 live births in 2009 showing an increase from 5.9 and 6.9 per 1000 live births in 2007 and 2008 respectively. According to the ASSA2008 projection, the under-5 mortality is 64 per 1000 live births and the infant mortality 44 per 1000 live births. This is close to the UNICEF [16] estimate of 43 per 1000 live births and 43.2 per 100 live births estimated by the CIA [17].

According to the Saving Babies Report [29] the underlying causes of child mortality include children infected or exposed to HIV [55%]; malnutrition [66%], and severe malnutrition [35%]. The report further stated that for every 1000 live births, 60 children die by the age of 5; of the under-5 deaths 75% die in the first year [infant death], and 25% children die in the first month [neonatal

death]. It estimates that approximately 50% of infants died at home.

According to Kibel et al [19], 23.6% of children live in households where child hunger was reported. DHIS data indicated that severe malnutrition under-5 year's incidence decreased from 9.5/1000 to 7/1000 between 2009/10 and 2010/11. The number of children admitted with severe malnutrition however increased from 2,557 in 2009/10 to 3,558 in 2010/11, and the number of admitted children who died increased from 383 to 430 during the same period.

According to the National Institute of Communicable Diseases, 17,354 laboratory confirmed measles cases were reported in South Africa between January 2009 and August 2010 [5]. Just under a quarter of these [3 680] occurred in KwaZulu-Natal.

Pneumonia and diarrhoea remains two of the leading causes of morbidity and mortality in children under-5 years. The number of children under-5 years reporting to health facilities with diarrhoea and pneumonia decreased from 232,397 and 209,920 in 2009/10 to 146,350 and 167,910 in 2011/12 [estimated annual performance]. The direct impact of the Pneumococcal Conjugate vaccine [introduced in April 2009] and Rota Virus vaccine [introduced in August 2009] has not been established yet.

The Expanded Programme on Immunisation has been prioritised to reduce vaccine preventable diseases. *See Part B: Programme 2 [Maternal, Child & Women's Health and Nutrition] for performance against targets.*

Non-Communicable Diseases

Diabetes, and specifically type2 diabetes, is increasing worldwide. Diabetes retinopathy is present in 20% of all diabetic cases and account for 5-10% of all blindness. Early diagnosis, control of blood sugar levels and effective treatment play a major role in the prevention and control of diabetes retinopathy.

According to DHIS data, the number of new diabetes mellitus cases that were put on treatment decreased from 32,345 in 2009/10 to 31,673 in 2010/11. Estimates for 2011/12 indicate that it decreased further to 22,540 in 2011/12. The total number of PHC visits for diabetes increased from 229,893 in 2009/10 to 250,585 in 2010/11. This increase shows a statistically significant linear trend [p = 0.016] which suggests the Department is improving management of cases.

The number of new hypertension cases that were put on treatment decreased from 74,671 in 2009/10 to 70,973 in 2010/11. Estimates for 2011/12 indicate that the number of new cases increased to 76,388 in 2011/12. The total number of PHC visits for hypertension increased from 734,163 in 2009/10 to 808,003 in 2010/11. This increase shows a statistically significant linear trend [p = 0.001] which suggests the Department is improving management of hypertension.

Cancer

According to Day and Grey [5] the most frequent cause of cancer deaths in men in KZN in 2007 were malignant neoplasm of the bronchus and lung [16.27%] followed by the oesophagus [10.62%]. This suggests that health promotion programmes to reduce smoking [a risk factor

for both types of cancer], and alcohol abuse [a risk factor for oesophageal cancer] may help to reduce the incidence of these cancers. This supports the re-engineering of PHC, with primary focus on prevention.

The most frequent causes of cancer deaths in women in KZN in 2007 were malignant neoplasm of the cervix [18.21%] and of the breast (15.21%).[5] Screening for cervical cancer has been prioritised in the Province through the Phila Ma campaign – *See Part B: Programme 2 [Maternal Child and Women's Health] for performance information.*

Eye Care

80% of blindness is avoidable and effective prevention, education and treatment, as part of the re-engineering of PHC, is therefore essential. People with visual impairment, currently estimated at half a million South Africans or 10,000/1mil population, risk exclusion from basic health and education services and are more prone to suffering economic deprivation. Four out of five children with vision problems are needlessly visual impaired. [27]

According to a Rapid Assessment of Avoidable Factors [RAAP] conducted in the eThekwini Metropolitan, the prevalence of blindness is 2.8% in the 50+ year age group. There are an estimated 59,544 blind people in KZN of whom 80% are needlessly blind.

Blindness due to treatable cataracts is an estimated 32,749 people of which 1,190 are children. Current data indicate that four out of five school children who need spectacles cannot afford it which will impact on health and education. [27]

Table 3: Prevalence of Blindness in KwaZulu-Natal

District	*Indigent Population*	*Total Number Blind*	*Cataract [55%]*	*Spectacles Required [30%]*	*Total Diabetes [3%] of indigent population*	*Diabetes Retinopathy [20%] of Diabetes*	*Glaucoma [14%]*	*Childhood Blindness [2%]*
Ugu	608,228	4,562	2,562	182,468	18,247	3,649	639	91
Umgungundlovu	846,460	6,348	3,492	253,938	25,394	5,079	889	127
Uthukela	557,834	4,184	2,301	167,350	16,735	3,347	586	84
Umzinyathi	411,872	3,089	1,699	123,562	12,356	2,471	432	62
Amajuba	411,078	3,083	1,696	123,324	12,332	2,466	432	62
Zululand	524,518	3,934	2,164	157,355	15,736	3,147	551	79
Umkhanyakude	681,288	5,110	2,810	204,386	20,439	4,088	715	102
Uthungulu	772,758	5,796	3,188	231,827	23,183	4,637	811	116
Ilembe	503,700	3,778	2,078	151,110	15,111	3,022	529	76
Sisonke	405,555	3,042	1,673	121,667	12,167	2,433	426	61
eThekwini	2,740,974	20,557	11,307	822,292	82,229	16,446	2,878	411
KZN	**8,464,266**	**63,482**	**34,915**	**2,539,280**	**253,928**	**50,786**	**8,887**	**1,270**

Disability and Rehabilitation

According to the 2011 World Disability Report, approximately 24% of the world population comprise of persons with disabilities. According to StatsSA, approximately 5-10% of the KZN population is disabled. The main causes of disability include trauma, motor vehicle accidents, HIV and AIDS, and malnutrition related to poverty.

Trauma

Trauma is the second most common cause of death in South Africa [31] and an important cause of morbidity and mortality in KZN. In a rural area of the Province, a recent study showed an injury mortality rate of 142.2 per 100 000 person years of observation, which is almost twice the global estimate [in 2000] of 83.7 deaths per 100 000 population [31]. Fifty percent of deaths were due to homicide and 26% to road traffic accidents. It is suggested that trauma is a neglected cause of significant morbidity and mortality in KZN, and that improved data collection and strategies for prevention and treatment should be explored.

1.6. PROVINCIAL SERVICE DELIVERY ENVIRONMENT

Inequities in the allocation and/or placement of human resources are still evident in the significant variations between Medical Officer and Professional Nurse PHC workload between districts, sub-districts and clinics. Delays with filling of critical posts, finalisation of post establishments, and effective analysis of service delivery demands were identified as core challenges.

Table 4: PHC Workload [not including District Hospitals] [23]

District	% Clients Seen by Doctor	Doctor Clinical Workload	Professional Nurse Clinical Workload
Ugu	2%	24	40
Umgungundlovu	14%	26	15
Uthukela	1%	19	38
Umzinyathi	0.2%	12	43
Amajuba	2%	11	40
Zululand	2%	16	35
Umkhanyakude	2%	17	52
Uthungulu	3%	25	36
Ilembe	12%	38	23
Sisonke	1%	22	36
eThekwini	13%	30	27
KZN	**6%**	**27**	**32**

Source: DHIS

Re-engineering of PHC

The re-engineering of PHC is one of the priorities in the 10 Point Plan and the fourth pillar of the NSDA. The National Health Council adopted the concept with the stipulation that the model must be ward-based "as implemented in KwaZulu-Natal". The main focus over the next ten years will be to change the main service delivery focus from the management of "illness" to promoting and sustaining "health and wellness" in line with governments' commitment to improve the lives of all South Africans through improved integration, partnerships and consultation – shifting from a passive reactive approach to a pro-active approach. The implementation of integrated developmental community-based services, delivered by an integrated pool of providers as the first point of contact for community-based services, and effectively linked with facility-based services, will assist in streamlining programmes and contribute to economies of scale and improved health outcomes. Facility-based PHC services will focus on issues of access, equity, utilisation, quality, appropriate referral, PHC infrastructure and maintenance, human resources for effective service delivery, appropriate package of services, training and development including mentoring and succession training, and provincialisation of Local Government PHC services.

The Province finalised the Provincial PHC Re-engineering Model and rollout commenced in 2011/12. The main focus will be on the establishment of PHC Outreach [Family Health] Teams, School Health Teams, District Specialist Teams, and the integration of community and facility-based services through equal distribution of resources. *See Part B: Programme 2 [Primary Health Care]*.

Re-engineering of PHC is using Operation Sukuma Sakhe [OSS] as primary vehicle for integrated multi-sectoral service delivery at household level which commenced in 2010. The OSS delivery model has been designed to address the critical areas of community participation, integrated services delivery, behaviour change, economic empowerment and environmental care. "War Rooms" [meeting places for multi-disciplinary teams] are based in wards to enhance effective coordination of services delivery at household level. Provincial leadership provides OSS oversight and support; District and Local Mayors are OSS champions at district and local municipality levels; and Councillors are ward level champions. The Premier, MECs and HODs oversee OSS implementation in specific districts to ensure ongoing leadership and support.

Oral and Dental Health Services

A review of Oral and Dental Health services informed the new Oral and Dental Health Strategy [*Oral Health 10 Point Plan 2011-2015*] to guide the overhauling of Dental and Oral Health Services in KZN over the next 5 years. The Plan prioritises the following:

1. Establish comprehensive preventive and promotive oral health programmes including:
   a) School-based tooth brushing programmes.
   b) Fissure sealants programme.
   c) Screening and education programmes.
2. Establish and implement comprehensive pain and sepsis relief programmes.

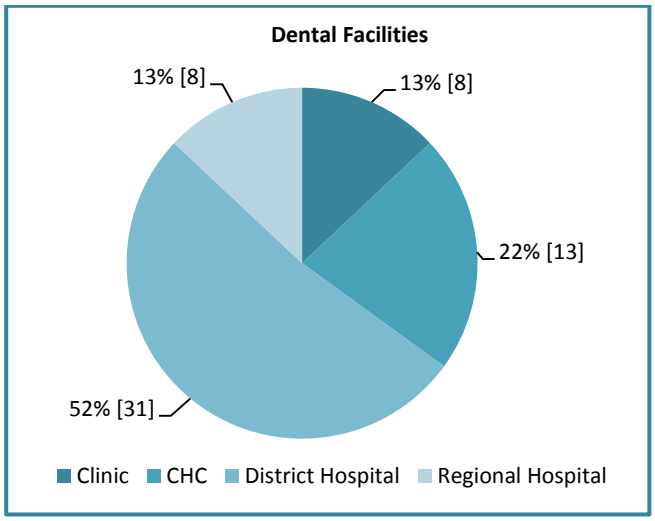
3. Reduce the extraction to restoration ratio.
4. Establish Regional Maxillofacial and Oral Surgery services.
5. Establish a Regional Orthodontic service for school children.
6. Establish a District Denture service for the elderly/ pensioners.
7. Establish Provincial Interventionist Mobile Dental Clinics.
8. Establish a centralised Dental Technology and Laboratory service.
9. Overhaul Infection Prevention and Control measures in all dental facilities.
10. Establish a KZN Dental School and increase Dental Specialist training capacity.

Current human resource constraints challenge sustainability of Oral Health programmes/services and jeopardise seamless service delivery from PHC to Tertiary/Central level of care. The vacancy rate for Oral Hygienists is 37.5% [25/40 posts filled] which impacts significantly on the sustainability of oral health prevention, promotion, screening, and school-based programmes [school tooth brushing programme and screening as part of the broader School Health Services]. *The Department has set aside funding [estimated budget of R13.6 million] for the filling of 15 Oral Hygienists, 10 Dental Therapists, 40 Dental Assistants, 4 Dental Technician and 10 Dentists to scale up oral health services at PHC level.*

A tender for 62 dental sterilisation autoclaves is at a technical evaluation stage, and a tender for R6 million has been awarded for supply of new dental surgery units to 31 institutions as part of the modernisation of dental services.

Current distribution of dental facilities is reflected in Graph 3 and Table 5 below. The 5 year strategy makes provision for the development of appropriate services to address inequities in service delivery at all levels of care.

Graph 3: Distribution of Dental Facilities in KZN



Source: Oral Health Programme

Table 5: Number of Dental Facilities - KZN

District	Number of Facilities
Ugu	6
Umgungundlovu	5
Uthukela	3
Umzinyathi	7
Amajuba	4
Zululand	5
Umkhanyakude	4
Uthungulu	5
Ilembe	6
Sisonke	5
eThekwini	10
Total	**60**

HIV and AIDS

High Transmission Intervention Sites increased from 48 to 53 with a total of 1,549,611 male and 1,549,611 female condoms distributed at these sites in 2011/12.

The condom distribution rate increased from 8 in 2009/10 to 8.1 in 2010/11 still considered very low taking into consideration the high HIV incidence in the Province. *A new Provincial strategy will be implemented in 2012/13 to improve male and female condom distribution.*

The Department took over 4,868 Community Health Workers from the KZN Progressive PHC in 2010/11. The total number of Community Care Givers on Persal increased to 9,225 in 2011/12 [mid-year] as integrated component of the re-engineering of PHC.

The male medical circumcision campaign was launched in 2010 by His Majesty the King. To date, a cumulative total of 73,070 circumcisions have been performed [estimated 2011/12 performance].

The HCT campaign was launched in April 2010 and 100% of fixed facilities in the Province provide the service. In 2010/11, a total of 2,920,433/ 3,059,233 people were tested for HIV [95.4% of target]; 561,057 of tested patients tested positive for HIV [19%]; a total of 2,305,000 patients were screened for TB; and 356,761 of those patients were referred for clinical diagnosis. The campaign will continue to target men, farms, mines, high transmission areas and tertiary institutions in 2012/13.

Implementation of the Integrated Access of Care and Treatment [IACT] strategy to strengthen care and support to people living with HIV [PLHIV] commenced in 2011/12. There are currently 546 active support groups with an average of 20-25 PLHIV per support group. The programme commenced in eThekwini, Ilembe, Uthukela and Umgungundlovu and will be rolled out to the rest of the Province in 2012/13.

The number of patients registered on ART increased from 408,238 in 2010/11 to 497,217 in December 2011 [21.7% increase].

Tuberculosis

The TB information system [ETR.Net] is still beleaguered with technology challenges resulting in critical delays [approximately 3 months] in submission of data. The system is broken down into 31 capturing units with 12 merger units and 752 facilities [TB Registration and Management] are linked with the reporting system [including non-public health facilities].

A total of 81 Microscopy sites are operational managing an average of 85,000 specimens per month. One Culture DST Site is operational with capacity increasing from 5,500 specimens per month to 16,500 specimens per month. SMS printers for laboratory results have been installed in 345 facilities and daily 'lab' transport are available to all facilities.

The Province commenced implementation of the GeneXpert in 4 districts i.e. eThekwini, Uthungulu, Sisonke and Zululand to improve TB diagnosis. The Province plans to roll out the service to another 4 districts in 2012/13 provided that an adequate budget

will be available. Diagnosis of MDR TB and positivity rate improved from 9% to 20%.

The Department started decentralised Community-Based Management of MDR TB in 2007. In 2008, the National Health Council approved the treatment programme as pilot in KZN and approved it in principle. After extensive consultation, the National Department of Health launched the *National Policy Framework on Decentralised and De-institutionalised Management of Drug-Resistant TB for SA* in August 2011. There are currently 16 Mobile Teams in Umzinyathi and Umkhanyakude Districts for community management.

Maternal, Child & Women's Health and Nutrition

The weighing coverage increased from 75.2% in 2010/11 to 85% in 2011/12, and the underweight for age rate decreased from 26.3 per 1000 in 2009/10 to 24.5 per 1000 in 2011/12 [estimated performance] with more children detected through improved screening and weighing. Nutritional supplements were issued to 114,913 patients 15 years and older and 19,004 children under-5 years.

There are 36 accredited Baby-Friendly Hospitals in the Province. Estimated 2011/12 data indicate that only 30% of mothers exclusively breastfeed at 14 weeks which is a concern for PMTCT programme outcomes. *The Department is intensifying the implementation of the Infant, Youth, Child Feeding [IYCF] Policy and Guidelines to improve exclusive breastfeeding.*

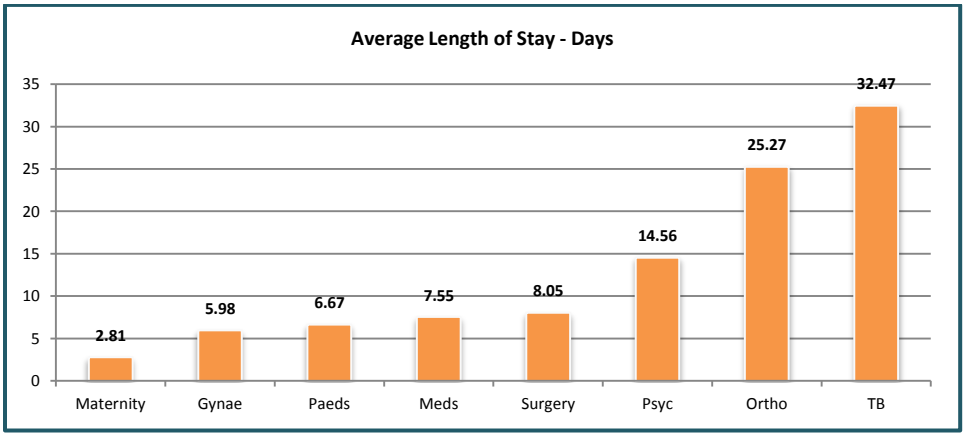
Between 2009/10 and 2011/12 [estimated annual performance] the Rota Virus 2nd dose coverage increased from 58% to 106.9%. During the same period, the number of diarrhoea cases for children under-5 years [ambulatory] decreased from 232,397 to 146,350. The Pneumococcal 3rd dose coverage increased from 75.9% to 97.4% during the same period, and the number of pneumonia cases [ambulatory] decreased from 209,920 to 167,910 during the same period.

District Hospitals

Classification of hospitals, considered one of the fundamental aspects of transformation, is being reviewed as part of the STP process to address issues of equity, affordability, efficiency and effectiveness in line with the Draft Regulations published in the Government Gazette (Regulations Gazette No. 9570 Volume 554, 12 August 2011, No 34521 (R655). [14] There are 8 Small, 25 Medium, and 6 Large District Hospitals in the Province [including 2 State Aided Hospitals in eThekwini]. There are currently 9,113 approved District Hospital beds [0.87 per 1000 population] and 8,301 usable beds [0.79 per 1000 population] compared with the national norm of 0.66 beds per 1000 population.

The average length of stay increased from 4.7 days in 2009/10 to 6.1 days in 2010/11 compared with the national target of 3.5 days. The high burden of disease, late reporting to health facilities, inadequate step-down facilities, high turn-over rate of Medical Officers, and inadequate patient transport is considered the main contributors to extended length of stay.

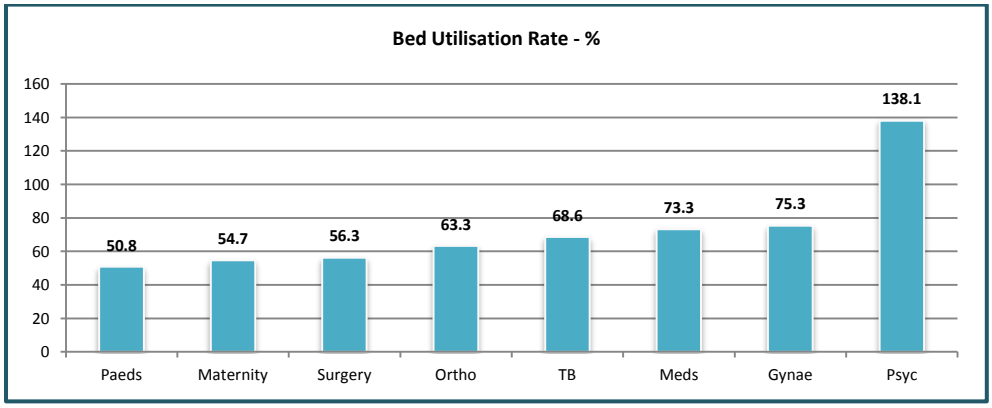
Graph 4: Average length of stay in District Hospitals



Source: DHIS

The bed utilisation rate decreased from 65.4% in 2009/10 to 63.8% in 2010/11 compared with the national target of 75%. Only medical, gynae and psychiatric beds show adequate utilisation rates which raise concerns about the current bed norms. This will be addressed as part of the STP process.

Graph 5: Bed utilisation rate in District Hospitals



Source: DHIS

Emergency headcounts still constitute a significant percentage of the ambulatory visits in District Hospitals which points to inadequate access to PHC services. It is hoped that the re-engineering of PHC services will address this challenge to a certain extent.

The Amajuba ambulatory to in-patient day ratio increased from 4.3 in 2009/10 to 6.3 in 2010/11 which is a prime indicator of inadequate/ poor access to PHC. Niemeyer Memorial Hospital [52 beds] is however the only District Hospital in the district and located in a sparsely populated municipality. Madadeni and Newcastle Regional Hospitals, both based in Newcastle, render the bulk of level 1 services in the district which challenge the validity of the district performance against this indicator. The district reported a decrease in PHC

utilization from 1.4 visits per person per year in 2009/10 to 1.3 in 2010/11.

Significant variations in Doctor, Professional Nurse and Enrolled Nurse workloads are a concern pointing to still existing inequities in resource allocation and placement of staff. The lack of national human resource norms challenge the reconfiguration of establishments which will be addressed through implementation of the National Human Resource for Health Strategy 2012/13 – 2016/17.

Patient day equivalent [PDE] per month per full-time equivalent [FTE] has been used to calculate workloads as it is considered a more accurate measure of human resource needs per category of staff compared to staffing per bed. Utilisation-based human resource needs reflect the bed occupancy rate and the level of ambulatory visits.

The high workload in Umzinyathi [804], Uthungulu [780] and Zululand [766] is a concern. The high number of Community Service personnel working in Umzinyathi and Zululand indicates a challenge pertaining to high turn-over of medical staff. If the 44 Interns in Umgungundlovu are excluded from the calculation below, the FTE per month increases to 405, still the lowest in the Province. [23]

Table 6: District Hospital Workload per District [23]

District	Patient Day Equivalent [PDE] per Full Time Equivalent [FTE] in District Hospitals		
	Medical Officers	Professional Nurses	Enrolled Nurses
Ugu	549	36	128
Umgungundlovu	126	197	157
Uthukela	461	62	93
Umzinyathi	804	69	92
Amajuba	451	67	92
Zululand	766	61	104
Umkhanyakude	503	71	67
Uthungulu	780	70	90
Ilembe	412	66	90
Sisonke	531	81	149
eThekwini	604	88	119
KZN	**528**	**67**	**100**

Source: 2010/11 District Health Expenditure Reviews

Emergency Medical Services

There are currently 185 operational ambulances out of a total of 501, which translates to 1 ambulance per 55,719 population compared with the national norm of 1 ambulance per 10,000 population. This contributes to delayed response times and compromise health outcomes as a result of delayed clinical intervention in emergency cases. The Department procured 274 new vehicles - 115 awaiting conversion pending finalisation of tender and 159 are in the process of being converted. Within an optimal functioning system, ambulances should not exceed 250,000km which is usually reached

within a three-year period. At present, 25% of ambulances fall within this usable lifespan. The table below shows the current gap for emergency service vehicles.

Table 7: Emergency Services Vehicles Gap [EMS Database]

District	Current ESV's	Population/ ESV	ESV's Required	Gap
Ugu	14	41,759	71	57
Umgungundlovu	18	44,947	99	81
Uthukela	15	47,660	71	56
Umzinyathi	15	29,160	50	35
Amajuba	17	21,060	44	27
Zululand	16	56,430	90	74
Umkhanyakude	12	40,936	61	49
Uthungulu	16	44,713	89	73
Ilembe	12	35,213	53	41
Sisonke	13	31,255	50	37
eThekwini	39	80,653	347	308
KZN	**187**	**473,786**	**1,025**	**838**

The table below shows the current qualified EMS staff which will be used as baseline for Human Resources for Health strategy and development to improve equity and service outcomes.

Table 8: Qualified Emergency Medical Services Staff

Description	DC21	DC22	DC23	DC24	DC25	DC26	DC27	DC28	DC29	DC43	METRO	Total
Operations												**2,251**
BLS	88	109	151	113	140	136	170	172	91	145	235	1,550
ILS	50	62	43	33	42	35	16	38	51	29	200	599
ECT	2	2	4	0	0	2	1	2	2	3	1	19
ALS	6	9	3	3	6	3	4	7	8	9	23	81
ECP	1	0	0	0	0	0	0	0	0	0	1	2
Communications												**303**
BLS	19	25	22	16	15	18	18	23	19	15	42	232
ILS	1	6	5	0	1	0	3	3	4	0	47	70
ECT	0	0	0	0	0	0	0	0	0	0	0	0
ALS	0	0	0	0	0	0	0	0	1	0	0	1
Planned Patient Transport [PPT]												**234**
BLS	19	16	18	12	12	23	8	28	15	8	35	194
ILS	6	5	2	0	0	0	0	0	5	2	20	40
ECT	0	0	0	0	0	0	0	0	0	0	0	0
ALS	0	0	0	0	0	0	0	0	0	0	0	0

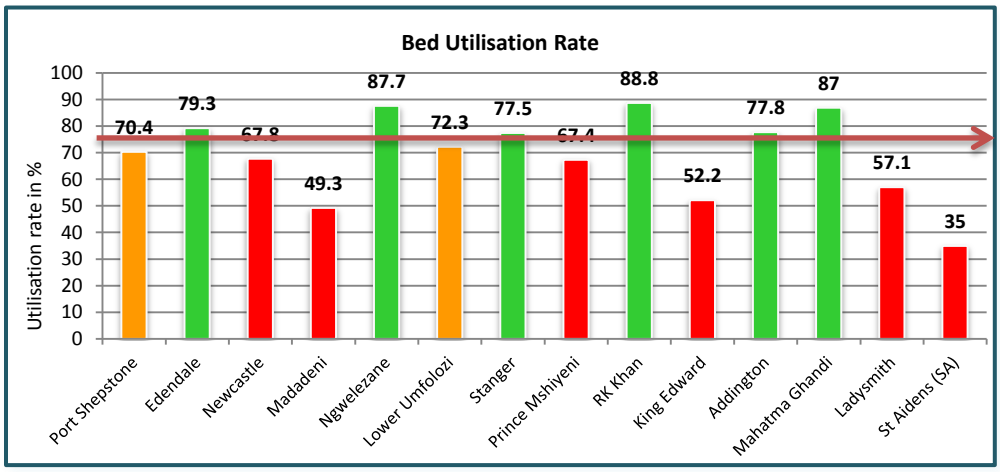
- Source: EMS database
- DC 21: Ugu; DC 22: Umgungundlovu; DC 23: Uthukela; DC 24: Umzinyathi; DC 25: Amajuba; DC 26: Zululand; DC 27: Umkhanyakude; DC 28: Uthungulu; DC 29: Ilembe; DC 43: Sisonke; Metro: eThekwini

Regional Hospitals

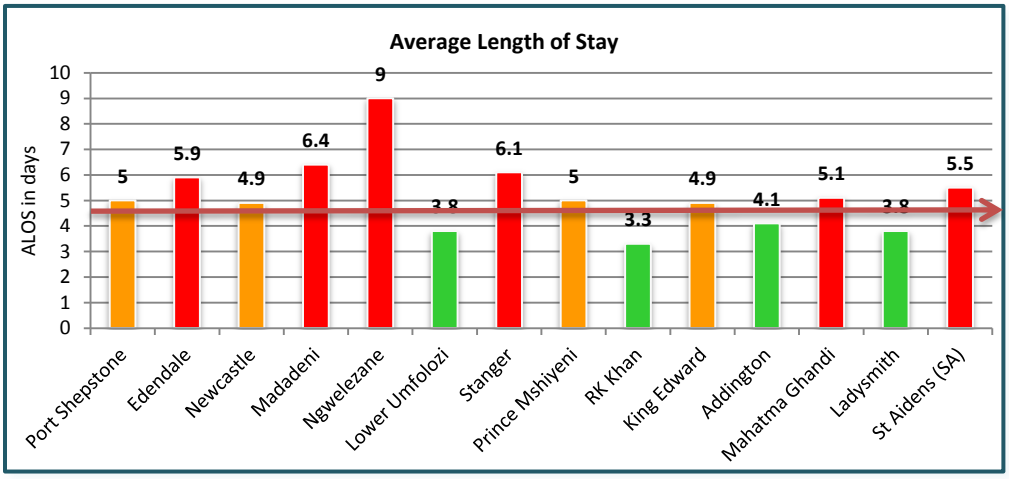
Bed utilisation rate decreased from 72.8% in 2009/10 to 63.6% in 2010/11 compared with the national target of 75%, and the average length of stay increased from 5 days in 2009/10 to 5.4% in 2010/11 compared with the national target of 4.5 days. The significant variation between hospitals is reflected in the graphs below.

Contributing to low efficiencies in some hospitals is the increasing burden of disease, non-compliance with admission and discharge policies, high turn-over of Medical Officers, and inadequate step-down beds for down referral.

Graph 6: Regional Hospital Bed Utilisation Rate – 2010/11 [DHIS]



Graph 7: Regional Hospital Average Length of Stay – 2010/11 [DHIS]



The high ambulatory to IPD ratio [2:6] with variation between 1.8 and 4.8 indicates issues of access and/or utilisation of PHC services [clients bypassing PHC services to enter the public health system at Regional

Hospital level]. New data elements in DHIS [implementation commenced in 2011/12] will make it possible to extrapolate relevant data to determine the extent of the challenge. Re-engineering of PHC, including early detection and treatment of communicable and non-communicable diseases, increase of Step-Down facilities, management of clients at the appropriate level of care, and review of bed allocation is expected to improve efficiency and quality.

Modernisation of Regional Dental Health Services

The shortage of staff jeopardise delivery of specialised oral and dental health services. There are currently 2 full time Maxillofacial Specialists [based at IALCH and Greys Hospital]; 1 sessional Specialist in Newcastle Hospital; 3 sessional Specialists in King Edward Vlll Hospital and IALCH; and 3 sessional Specialists in the Oral and Dental Training Centre [Maxillofacial, Orthodontics and Periodontics]. Engagement with private Specialists for provision of sessional tertiary services at Newcastle, Port Shepstone and Ngwelezane Hospitals is at an advanced stage and contracts are currently being drawn up. This will improve access to areas not currently covered.

Oral and Dental Training Centre

The Oral and Dental Training Centre [ODTC], situated at King George V Hospital in eThekwini, has two main functions namely training of Dental Therapists and Oral Hygienists and Public Health services. The Centre is currently staffed by Clinical Manager [1]; Dentists [5]; Dental Therapists [4]; Oral Hygienists [4]; and Dental Assistants [13].

The Centre is linked to the training programme for Dental Therapy and Oral Hygiene students at UKZN, and provides basic, specialized and limited tertiary services for teaching purposes. A total of 100 first year students enrolled for 2012, while the Centre produces an average of 30 students per year for combined degrees. The average patient headcount is 2,200 per month.

The package of services provided at the Centre includes:

- Primary Health Care: Examination and patient charting, education, and management of pain and sepsis.
- Secondary and tertiary services: Prosthodontics [dentures], Orthodontics [fixed and removable braces for children], Periodontics [treatment of gum related diseases] and Maxillofacial and Oral Surgery [treatment of trauma and pathology related diseases of the oro-facial area].

Operation of the Training Central forms part of the modernisation of Oral and Dental Health services in the Province that will be prioritised during the coming MTEF.

KwaZulu-Natal Children's Hospital

In 2010/11 the Department, in collaboration with MatCH [Maternal, Adolescent and Child Health – Department of Obstetrics and Gynaecology University of Witwatersrand], conceptualised the establishment of the KwaZulu-Natal Children's Centre/ Addington Health and Wellness Precinct.

The Hospital was approved by Cabinet at the end of 2009 and officially launched by the MEC for Health Dr S Dhlomo on the 15th of July 2010.

Development of the Precinct will create a Provincial 'first' Health Precinct, as part of a proposed inner city regeneration project to address adult and child health as well as welfare issues, HIV, poverty and urban renewal in the Durban inner city.

The Precinct will include:

- In and out-patient Children's Centre [old Addington Children's Hospital] for children younger than 14 years. Acute services for local children will remain in Addington Hospital.
- Refurbished and extended KwaZulu-Natal Children's Hospital and Wellness Centre.
- Addington Primary School to the south and the Claire Ellis Brown Pre-Primary to the south-west.
- South African Police Service [SAPS] station and Family Court.
- Existing Doctors Quarters and Administrative Accommodation [3 buildings].
- National Health Laboratory Services [NHLS] headquarters.
- Emergency Medical Services base within the KwaZulu-Natal Children's Hospital Complex.

The project duration is expected to be between 3-5 years and renovations will occur in phases incorporating 'green' eco-friendly design elements.

Phase 1 [June 2011- February 2012]: Re-construction of the "Old Outpatients Building"

- Training Centre, Adolescent Clinic, Child Development Assessment Centre [including psychological support, allied health services] and temporary parking.
- *Progress:* Site survey commenced, architect commissioned, and development of building plans in process.

Phase 2 [April 2012 – June 2013]

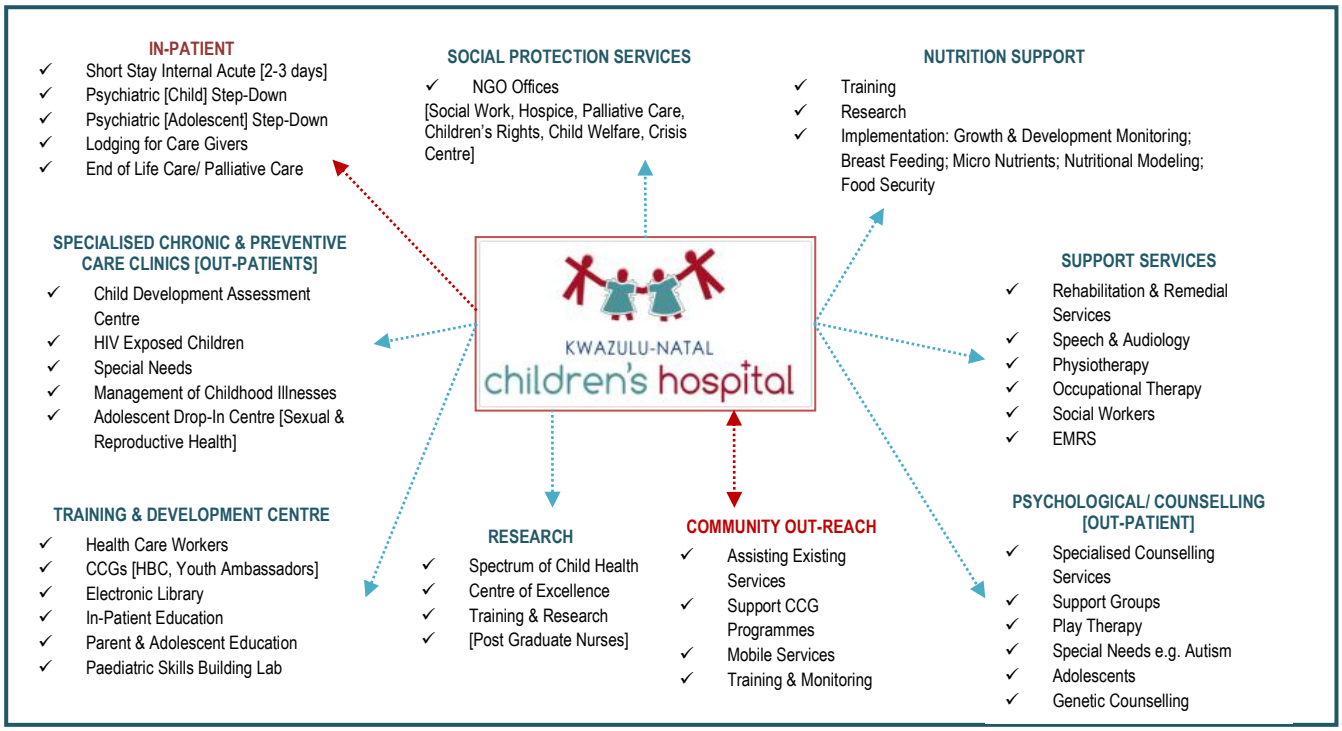
- Renovation of other non-AMAFA protected buildings [Old Administration Block, Central Museum and Old Dining Hall].
- These buildings will house organisations such as Social Protection, Rights affiliated organisations, Home Affairs, and the Crisis Centre.

Phase 3 & 4 [June 2012- December 2014]

- Phase 3: 'Old Children's Hospital' and 'Old Nurses' Home'
- Phase 4: 'Central Nurses Home and 'Prince Wing'
- *Timeframes will be reviewed at 6 monthly intervals*

The recommended service package will echo the NHS 10 Point Plan and the MTSF priorities with a shift towards a health and wellness focus. The package of services is reflected in the figure below.

Figure 2: Proposed Service Package KZN Children's Hospital



Specialised TB Hospitals

There are currently 2,012 approved beds in Specialised TB Hospitals translating to 0.19 beds per 1000 population. There are 6 decentralised MDR TB Units [281 beds] and 9 satellite MDR TB Units [129 beds] translating to 410 beds for MDR TB. Allocation of beds for the management of acute/recurrent TB and MDR/XDR TB will take into consideration inefficiencies in current service delivery, existing resources and infrastructure. Immediate focus will include equitable distribution of resources [including HR and infrastructure] for the expected increase in MDR TB following the rollout of the GeneXpert. The table below reflects the current Specialised TB Hospitals and Decentralised and Satellite Units for MDR TB.

Table 9: Specialised TB Hospitals, MDR TB Decentralised Units and MDR TB Satellite Units

District	Facility	Classification	MDR TB Units
Ugu	Dunstan Farrell	Specialised TB [180 beds]	Satellite MDR TB [23 beds]
	Murchison	District Hospital [300 beds]	Decentralised MDR TB [40 beds]
Umgungundlovu	Richmond Chest	Specialised TB [364 beds]	-
	Doris Goodwin	Specialised TB [113 beds]	Decentralised MDR TB [64 beds]
Umzinyathi	M3 Greytown	Specialised TB [37 beds]	MDR TB Decentralised [37 beds]. Community-Based Management: 10 Mobile Injection Teams – best practice model.

District	Facility	Classification	MDR TB Units
Amajuba	Madadeni	Regional Hospital [1,107 beds]	Satellite MDR TB [23 beds] Proposed Decentralised Unit as part of Revitalisation
Zululand	Thulasizwe	Specialised TB [155]	Decentralised MDR TB [60 beds]
	Mountain View	Specialised TB [92 beds]	-
	Siloah Lutheran	Specialised TB [145 beds]	-
Umkhanyakude	Hlabisa	District Hospital [296 beds]	Satellite MDR TB [45 beds] Convert to a Decentralised Unit. Two Mobile Injection Teams are functional and linked to clinics
	Manguzi	District Hospital [251 beds]	Decentralised MDR TB [40 beds] [50% functionality] - one Mobile Injection Team functional
	Mosvold	District Hospital [213 beds]	Ad Hoc Satellite MDR TB with limited bed space [8 beds]. Two Mobile Injection Teams functional.
	Bethesda	District Hospital [230 beds]	Ad Hoc Satellite MDR TB [8 beds] - one Mobile Injection Team functional.
Uthungulu	Catherine Booth	District Hospital [170]	Decentralised MDR TB [40 beds]
Sisonke	St Margaret's	Specialised TB [80 beds]	Satellite MDR TB [10 beds]
eThekwini	Charles James	Specialised TB [220 beds]	Satellite MDR TB [5 beds]
	Don McKenzie	Specialised TB [220 beds]	Satellite MDR TB [7 beds]
	FOSA	Specialised TB [187 beds]	Satellite MDR/XDR TB [185 beds]
	King George V	Approved beds [396]. Central Specialised MDR TB [192 + 64 beds] – Centre of Excellence and main referral unit for the Province.	

The bed utilisation rate in Specialised TB Hospitals decreased from 70.1% in 2009/10 to 58.1% in 2010/11 which raise serious concerns with regards to efficiency.

In 2010 there were 1,481 MDR and 206 XDR TB patients registered into the treatment programme. The rollout of the GeneXpert is expected to increase MDR TB numbers at an expected average positivity rate of 5.8% of clients screened. Current projections, based on data from the 7 sites that initiated the GeneXpert in 2011/12, the Province would need 1,150 active beds for the management of MDR TB [making provision for 2 month admission]. Current estimates indicate that the Province would need 262 Mobile Injection Teams for the management of MDR TB patients in the community – indicating a current shortfall of 179 teams.

Integration of these teams into PHC [re-engineering process] will be paramount to ensure maximum benefit to communities.

Specialised Psychiatric Hospitals

There are currently 6 Specialised Psychiatric Hospitals in the Province with 3,244 approved beds translating to 0.31 beds per 1000 population.

Historical allocation of resources, including placement of facilities resulted in significant inequities that impacts on service delivery. There is a significant shortfall of acute beds in eThekwini; Area 1 [Ugu, Ilembe and eThekwini] has a shortfall of acute care beds and has no forensic beds; Area 3 is severely under-resourced in terms of both acute and chronic beds; Umgungundlovu District

has the highest number of the specialised beds [both acute and chronic]; and access to regional and tertiary psychiatric services are compromised in most districts.

Table 10: Specialised Psychiatric Hospitals per District

District	Current Specialised Psychiatric Hospitals	Proposed Specialised Hospitals/ Units
Amajuba	No Specialised Hospital	Specialised Psychiatric and Forensic Unit at Madadeni Regional Hospital [Included in Business Case - Revitalisation Project]
Umgungundlovu	Fort Napier Specialised Forensic Hospital [450 beds]	Forensic and Long-Term
	Town Hill Specialised Psychiatric Hospital [425 beds]	Review service delivery platform to include Tertiary Psychiatric services Tertiary services for Area 2
	Umgeni Waterfall Specialised Psychiatric Hospital [624 beds]	Review service delivery platform as it currently functions as Sanatorium. Proposed Specialised Long –Term Psychiatric Hospital
Zululand	St Francis Specialised Psychiatric Hospital [105 beds]	Long-term Psychiatric Hospital
Uthungulu	No Specialised Hospital	Specialised Psychiatric Unit including Tertiary Psychiatric services, Forensic Unit, and long-term beds at Ngwelezane Hospital [Tertiary services for Area 3]
Sisonke	Umzimkhulu Specialised Psychiatric and Forensic Hospital [440 beds]	New Forensic Unit with 60 beds: Adult = 40 male and 7 female; 5 male and 3 female beds for adolescents requiring forensic psychiatric observations; 3 seclusion rooms (2 male and 1 female) and 2 isolation rooms for communicable diseases
eThekwini	Ekuhlengeni Sanatorium classified as Specialised Psychiatric Hospital [1,200 beds]	Review service delivery platform [currently functions as Sanatorium] to Specialised Long-Term Psychiatric Hospital and Forensic Psychiatric Unit with 550 acute, 378 chronic, and 40 forensic beds
	King George V Hospital [Specialised Wing] – operating with 60 instead of proposed 130 beds	Specialised Psychiatric Hospital including Tertiary Psychiatric Services with 182 acute beds – functions as part of the King George V Complex Tertiary services for Area 1

Psychiatric Tertiary Services

The current budget does not make provision for the development of level 3 Psychiatric Sub-Specialty services which represents gross inequity in access to services. Adolescent Units would be best placed at Psychiatric Hospitals; Child Units within IALCH and Greys Hospital; and Eating Disorder Units in selected Regional Hospitals to provide for medical co-management of these complicated and often very sick persons. Will provide outreach support and training to Regional and District Hospitals as well as PHC clinics and CHC's within catchment areas.

Child & Adolescent Psychiatry

There are currently 2 Child & Adolescent Psychiatrists in the Province based in Pietermaritzburg and Durban with a ratio of 1 Sub-Specialist per 5mil population. There are 10 in-patient beds for Child and Adolescent Psychiatry converting to a ratio of 1 bed per 1mil population.

Psycho-Geriatrics

There are currently 10 beds for Psycho-Geriatrics at Town Hill Hospital and 10 beds planned at King George V Hospital which would translate to 1 bed per million population. There is one part-time Psychiatrist working in Psycho-Geriatrics at Town Hill Hospital.

Neuro-Psychiatric Services

Propose allocation of 48 beds translating to 5 beds per million population in the 3 service areas. Service will provide in-patient, out-patient and out-reach support services.

First-Episode Psychosis

The incidence of First-Episode Psychosis [FEP] is 30-50 per 100,000 [Burns & Esterhuizen 2007] translating to approximately 300-500 cases per year per 1mil population. It is estimated that each patient would require approximately 14 days admission within the specialised FEP service translating to 4,200 patient days per 300 patients.

In-Patient Psycho-Therapy Services

The Province proposed a norm of 6 beds per million population translating to 60 beds.

Forensic Psychiatry

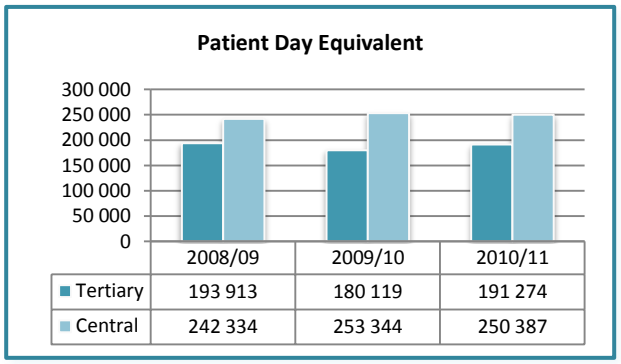
There is currently 1 centralized Forensic Psychiatry service managed by 3 Psychiatrists at Fort Napier Hospital catering for all 30-day psychiatric observations referred from courts throughout the Province. There is a prolonged waiting period of approximately 10 months for male referrals from courts. This means that mentally ill awaiting trial prisoners remain untreated in prisons for nearly a year before seeing a Psychiatrist which is a direct violation of their right to treatment.

The Province plan to make provision for a high-security centralised Forensic Hospital [Fort Napier Hospital] for high-risk observation patients and State Patients. Regionalised provision for medium-low security environment for low-risk and recovered State Patients where rehabilitation in preparation for conditional discharge is the main focus. Services rendered by General Psychiatrists and other mental health workers will provide observation services for local courts for low-risk and 'minor offences' cases thereby obviating the need for referral to Fort Napier Hospital. The Province proposed a norm of 25 beds per million population [264 beds] for Forensic services.

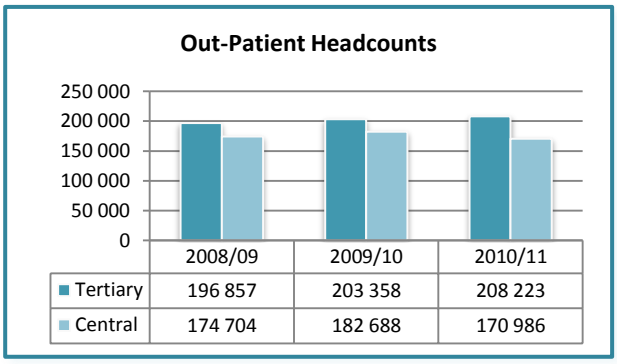
Tertiary and Central Hospitals

Current information systems cannot automatically differentiate between levels of care in hospitals resulting in a range of manual processes to separate clinical, financial and human resource data for reporting and planning purposes. Key performance outputs therefore still reflect the combined outputs for level 2 and 3 services. The following 2 graphs reflect patient activity in Tertiary and Central Hospitals for the period 2008/09 to 2010/11.

Graph 8: Patient Day Equivalent [DHIS]



Graph 9: Out-Patient Headcounts



Source: DHIS

The current bed ratio per 1000 population for Tertiary/Central Hospitals is 0.12 compared with the national norm of 0.22 per 1000 population. Bed numbers will increase from the current 1,340 to 2,699 and the bed ratio to 0.26 per 1000 population once the 2 proposed hospitals [King Edward Vlll as Central and Ngwelezane as Tertiary] are commissioned as recommended in Government Notice No R. 655 of 12 August 2011. [14]

The bed utilisation rate for Tertiary and Central Hospitals increased from 65.4% and 66.2% in 2009/10 to 73.4% and 66.7% in 2010/11 compared with the national target of 75%.

The average length of stay for Tertiary Hospitals increased from 10.4 days in 2009/10 to 12 days in 2010/11, and for Central Hospitals decreased from 9.1 days in 2009/10 to 8.6 days in 2010/11 compared with the national target of 4.5 day. Reasons for the extended period of hospitalisation include the increasing burden of disease [patients with higher acuity required longer hospital stay especially patients admitted to psychiatry and TB], ineffective referral and patient transport, and non-compliance with the admission and discharge policies.

Oral and Dental Health Tertiary Services

The expansion of Oral and Dental Health tertiary services commenced in 2011/12 including:

- Opening of the Maxillofacial and Dental Laboratory and the Maxillofacial and Oral Surgery Unit at IALCH.
- Implementation of a regionally-based denture service for pensioners [Ngwelezane and Greys Hospitals] commenced in December 2011.
- The Department is finalizing contracts for private specialists to provide sessional tertiary services at Greys and Ngwelezane Hospitals.
- Plans commenced for the implementation of a Provincial Registrars Programme in Maxillofacial and Orthodontics [dental deformities] service for children. The programme will be implemented in collaboration with Medunsa and Wits Universities until a new Dental School, linked with the Medical School at UKZN, is established.
- Implementation of comprehensive CPD/Refresher courses commenced in Grey's Hospital (Maxillofacial and Oral Surgery Department) in August 2011.

Additional in-house programmes are planned in Ngwelezane, IALCH and King Edward VIII Hospitals in 2012/13.

Pharmaceutical Services

The Provincial Pharmaceutical Supply Depot [PPSD] has several infrastructural challenges including maintenance of a constant optimal temperature and inadequate storage and packing facilities for distribution and receiving of stock, which limits maintaining adequate stock levels for critical pharmaceuticals including vaccines, TB, and ARV medicines and increases the risk of medicine stock-out. The PPSD warehouse does not comply with the Pharmacy Regulations and failed to acquire a license from the Medicine Control Council to operate as a Pharmaceutical Wholesaler and to pre-pack and/or manufacture medicines [pre-packing not compliant with MCC requirements]. The Pharmacy Council gave the Department an exemption until alternative arrangements have been finalised.

Building of a new PPSD has been approved and consultants have been appointed to plan and design the new Depot. A site has been identified at Clairwood Hospital football field. In the interim, two wards at Clairwood Hospital have been allocated to PPSD to alleviate space shortages although wards are unsuitable for summer storage.

In 2010/11, PPSD was able to supply directly to 83% of clinics, thus capacity must be increased to accommodate the remaining 17% demanders. Due to the current infrastructural constraints the building has reached capacity and no further clinics can be added to the direct distribution system.

Many hospitals, CHCs and PHC clinics are challenged by poor, non-compliant, and inadequate infrastructure for the storage of pharmaceutical supplies and carrying out pharmaceutical operations. The Department has been upgrading infrastructure in various districts although the backlog emanating from previous dispensation is significant. The newly built facilities [e.g. Turton CHC in Ugu District] meets the prescribed specifications and are a good example of excellent work born out of good collaboration between all stakeholders. Newly built facilities, designed before the current prescribed specifications, will need alterations to ensure compliance.

The management, security, and controls are inadequate leading to an increased risk of leakage of pharmaceutical supplies. Some pharmacies are managed by inexperienced junior personnel, often Community Service Pharmacists due to the shortage of Pharmacists and difficulty to recruit and retain staff at rural facilities. Training programmes [targeting Pharmacy Managers] on effective medicine supply management [Standard Operating Procedures and Policies] and general management of pharmacies is planned for 2012/13. The Pharmacy Stores Support Officers provide technical support and training to facilities with regard to pharmaceutical stock control.

The Department piloted the Central Chronic Medication Dispensing Unit [CCMDU] project in 120 service points in eThekwini in 2010/11 with the aim to improve access,

reduce waiting times, and improve controls and patient satisfaction.

The programme is currently implemented in eThekwini and Umgungundlovu. The infrastructure plan for the CCMDU has been approved and will share premises with the Provincial Pharmaceutical Supply Depot. The Request for Proposals will be sent to the market in order to get feedback in terms of models of operation.

The vacancy rate for Pharmacists increased from 36.2% [512 filled posts] in 2010/11 to 46% [473 filled posts] in December 2011. The number of filled posts [in 2011] includes Pharmacy Interns and Community Service Pharmacists. 94% of pharmacies have Pharmacists [ratio of 3 Pharmacist Assistants to 1 Pharmacist]. The average number of patients per day at pharmacies is 2,377 with a pharmacy workload [dispensing personnel] of 32,282 in CHCs, 18,981 in District Hospitals and 6,252 in Regional Hospitals.

Table 11: Trends in key Provincial service volumes

Indicator	2008/09 Actual	2009/10 Actual	2010/11 Actual	Estimated Performance 2011/12
1. PHC headcount - total	23,838,854	25,921,993	25,804,487	28,679,924
2. OPD headcount - new case not referred	Not in DHIS	Not in DHIS	Not in DHIS	941,805
3. Separations District Hospitals	361,244	360,524	318,263	336,844
4. Separations Regional Hospitals	355,778	321 315	460,663	388,419
5. Separations Tertiary Hospital	11,919	10,755	12,456	13,914
6. Separations Central Hospital	20,886	20,204	29,733	24,370

- Source: DHIS
- Indicator 2 [OPD headcount – new case not referred] was included in the National Indicator Data Set [NIDS] in 2011. The "OPD new cases referred" was 991,737 for the same period i.e. March 2011 – January 2012.

Table 12: Progress towards the Millennium Development Goals

Indicator	Data Source	Performance - 2011/12	Target - 2014/15
GOAL 1: Eradicate Extreme Poverty And Hunger TARGET: Halve, between 1990 and 2015, the proportion of people who suffer from hunger			
Incidence of severe malnutrition in children [under 5 years of age]	DHIS	6.7/1000	6/1000
Prevalence of underweight children [under 5 years] *Use Underweight for age rate children under-5 years' incidence – annualised.*	DHIS	24.5/1000	6/1000
GOAL 4: Reduce Child Mortality TARGET: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate			
Under-five mortality rate	ASSA2008 - AIDS Committee of Actuarial Society of South Africa	64/1000 live births	37/1000 live births

Indicator	Data Source	Performance - 2011/12	Target - 2014/15
Facility under five mortality rate [proxy]	*DHIS*	*7.3%* *Numerator: 1,217* *Denominator: 16,736*	*7%*
Infant mortality rate	ASSA2008 - AIDS Committee of Actuarial Society of South Africa	44/1000 live births	18/1 000 live births [NSDA]
Facility under one mortality rate [proxy]	*DHIS*	*5.2%* *Numerator: 1,442* *Denominator: 27,930*	*8.4%*
Proportion of one-year-old children immunised against measles	DHIS	94.5% Numerator: 204,499 Denominator: 216,241	90%
GOAL 5: Improve Maternal Health TARGET: Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate			
Maternal mortality ratio	National Confidential Enquiries into Maternal Deaths 2004-2007	170/100 000 live births	135 or less/100 000 live births
Use facility maternal mortality rate [proxy]	*DHIS*	*184.7/100 000 live births* *Numerator: 182* *Denominator: 98,522*	*119/ 100 000 live births*
GOAL 6: Combat HIV and AIDS, malaria and other diseases TARGET: Have halted by 2015, and begin to reverse the spread of HIV and AIDS			
HIV prevalence among 15- to 24-year-old pregnant women	National HIV & Syphilis Prevalence Survey of SA 2009		22.8%
Contraceptive prevalence rate	SADHS, 2003	76,8%	100%
Use couple year protection rate [proxy]	*DHIS*	*26%*	*44.6%*
Malaria incidence rate	CDC Database	1.47% Numerator: 8 Denominator: 542	<1%
TB cure rate	ETR.Net	69.5%	85%

Source: DHIS

1.6.1 NATIONAL HEALTH SYSTEM PRIORITIES FOR 2009-2014

Table 13: National Health Systems priorities for 2009-2014 - 10 Point Plan

Priority	Key Activities
Provision of strategic leadership and creation of social compact for better health outcomes	Ensure unified action across the health sector in pursuit of common goals
	Mobilise leadership structures of society and communities
	Communicate to promote policy and buy-in to support government programmes
	Review of policies to achieve goals
	Impact assessment and programme evaluation
	Development of a social compact

Priority	Key Activities
	Grassroot mobilisation campaign
Implementation of National Health Insurance (NHI)	Finalisation of NHI policies and implementation plan
	Immediate implementation of steps to prepare the introduction of the NHI e.g. budgeting, initiation of the drafting of legislation
Improving the quality of health services	Focus on the 18 health districts
	Refine and scale up the detailed plan on the improvement of quality of services and directing its immediate implementation
	Consolidate and expand the implementation of the health facilities improvement plans
	Establish a national Quality management and Accreditation Body
Overhauling the health care system and improving its management	Identify existing constitutional and legal provision to unify the public health service
	Draft proposals for legal and constitutional reform
	Development of a decentralised operational model, including new governance arrangements
	Training managers in leadership, management and governance
	Decentralisation of management
	Development of an accountability framework for the public and private sectors
Improved human resources planning, development and management	Refinement of the HR plan for health
	Re-opening of nursing schools and colleges
	Recruitment and retention of professionals, including urgent collaboration with countries that have access of these professionals
	Specify staff shortages and training targets for the next 5 years
	Make an assessment of and review the role of Health Professional Training and Development Grant (HPTDG) and the National Tertiary Services Grant (NTSG)
	Manage coherent integration and standardisation of Community health Workers
Revitalisation of infrastructure	Urgent implementation of refurbishment and preventative maintenance of all health facilities
	Submit a progress report on revitalisation
	Assess progress on revitalisation
	Review the funding of the revitalisation programme and submit proposals to get the participation of the private sector to speed up this programme
Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases	Implementation of PMTCT, paediatric treatment guidelines
	Implementation of adult treatment guidelines
	Urgently strengthen programmes against TB, MDR-TB and XDR-TB
Mass mobilisation for better health for the population	Intensify health promotion programmes
	Strengthen programmes focussing on Maternal, Child and Women's Health
	Place more focus on the programmes to attain the Millennium Development Goals
	Place more focus on non-communicable diseases and patients' rights, quality and provide accountability
Review of the drug policy	Complete and submit proposals and a strategy with the involvement of various stakeholders
	Draft plans for the establishment of a State-owned drug manufacturing entity
Strengthening research and development	Commission research to accurately quantify infant mortality
	Commission research into the impact of social determinants of health and nutrition
	Support research studies to promote indigenous knowledge systems and the use of appropriate traditional medicines

ANNUAL PERFORMANCE PLAN 2012/13 – 2014/15

PART A

The Department continues to focus on strategies that will fast track delivery on the 4 Key Outputs identified in the Negotiated Service Delivery Agreement [which is consistent with the MDGs and 10 Point Plan] namely:

1. Increasing life expectancy.
    a. Decrease non-communicable diseases.
    b. Intentional and unintentional injuries.
2. Decreasing Maternal and Child Mortality.
3. Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis.
4. Strengthening Health Systems effectiveness.
    a. Revitalisation of PHC.
    b. Health Care Financing and Management.
    c. Human Resources for Health.
    d. Quality for Health and Accreditation of Health Establishments.
    e. Health Infrastructure.
    f. Information, Communication and Technology and Health Information System.
    g. Preparation for implementation of National Health Insurance.

1.6.2 HEALTH SECTOR NEGOTIATED SERVICE DELIVERY AGREEMENT (NSDA)

Table 14: Provincial contribution towards achievement of the NSDA Outputs

Provincial Priorities 2012/13	Core Strategies and Activities	Targets 2012/13
OUTPUT 1: INCREASING LIFE EXPECTANCY - *All strategies and health outcomes will contribute to Output 1.* *Increase life expectancy to 58 years for males and 60 years for females*		
Decrease and manage non-communicable diseases.	▪ Re-engineering of PHC [Operation Sukuma Sakhe as primary vehicle for community-based programmes]. ▪ Improve prevention, detection, screening, referral, treatment, follow-up and support at household level [all programmes].	Increase the Diabetes Mellitus cases put on treatment – new from 22,540 to 26,823 Increase the Hypertension cases put on treatment – new from 76,388 to 79,444
Improve the cataract surgery rate.	▪ Develop Vision Centres with high volume cataract and refraction services.	Improve the cataract surgery rate from 566/1mil [6,016 operations] to 1,222/1mil [12,982 operations]
Maintain zero percent cholera status.	▪ Maintain surveillance and early warning systems.	Maintain cholera fatality rate at 0%
Accelerate implementation of integrated school-based services.	▪ *See re-engineering of PHC*. ▪ Scale up implementation of Youth-Friendly services.	Increase the number of accredited Health Promoting Schools from 212 to 228 Improve School Health Services coverage from 50.3% to 60%
Halt malaria transmission and prevent re-introduction of malaria in non-endemic areas.	▪ Maintain preventive strategies for malaria elimination. ▪ Ongoing assessment of antimalarial drug efficiency. ▪ Insecticide spraying of malarious areas.	Maintain the malaria incidence per 1000 population at risk at <1/1000 Maintain the malaria case fatality rate at <1% Increase the indoor residual spraying coverage from 90% to 95%
Reduce and manage intentional and unintentional injuries.	▪ Revitalisation of Emergency Medical Services (EMS) including: – Human Resources for Health - finalise organogram in line with the new service delivery model. – Improve quality of care and ensure effective treatment/ intervention of pre–hospital emergencies. – Improve Planned Patient Transport. – Revitalisation of basic infrastructure [large ambulance stations in Ugu, Umgungundlovu, Umzinyathi, Wentworth, Umzimkhulu, Pomeroy, and Jozini]	Increase rostered ambulances per 10 000 population from 185 [0.17/10 000] to 360 [0.45/10 000] Improve response times of <40 minutes in rural areas from 37% [2010/11] to 50% Improve response times of <15 minutes in urban areas from 29% [2010/11] to 30% Increase the percent of calls responded to within 60 minutes from 53% [2010/11] to 60% Increase the percent of locally based staff with training in BLS (BAA) from 71.5% to 79% Increase the percent of locally based staff with training in

Provincial Priorities 2012/13	Core Strategies and Activities	Targets 2012/13
		ILS (AEA) from 25% to 27%
		Maintain the percent of locally based staff with training in ALS (Paramedics) at 3%
OUTPUT 2: DECREASING MATERNAL AND CHILD MORTALITY		
Reduce child morbidity and mortality.		Decrease the facility infant mortality rate from 9.1% [2010/11] to 8.9%
		Decrease facility child mortality rate from 7.6% [2010/11] to 7.4%
	▪ Scale up interventions for early detection and management of under-nutrition. ▪ Scale up implementation of the WHO 10-Steps for Management of Children with Severe Malnutrition. ▪ Implement the IYCF Policy to improve exclusive breastfeeding. ▪ Strengthen implementation of the Integrated Management of Childhood Illnesses. ▪ GOBI FFF – *re-engineering of PHC*	Reduce the underweight for age under 5 years incidence from 23.7/1000 to 23/1000
		Reduce severe malnutrition under 5-years incidence from 6.7/1000 to 6.5/1000
		Maintain the not gaining weight rate under 5 years at 1%
		Increase the Vitamin A coverage 12-59 months from 32.6% [2010/11] to 40%
	▪ Reduce vaccine preventable diseases by strengthening the Expanded Programme on Immunisation	Immunisation coverage under-1 year 90%
		Measles coverage under-1 year 90%
		Pneumococcal 3rd dose coverage 90%
		Rota Virus 2nd dose coverage 90%
		Reduce the number of diarrhoea cases in children under-5 years from 146,350 to 131,715[3]
		Reduce the number of pneumonia cases in children under-5 years from 167,910 to 151,119
Reduce maternal and neonatal morbidity and mortality.	▪ Increase access to functional Basic Emergency Obstetric Care Units and high care beds in nurseries. ▪ Kangaroo Mother Care in all hospitals. ▪ Waiting mothers' lodges in all hospitals. ▪ Improve access to Choice on Termination of Pregnancy services.	Facility maternal mortality rate 200/100 000[4]
		Decrease the facility delivery rate for women under 18 years from 9.3% to 8.5%

[3] Co-morbidities of diarrhoea and pneumonia [including social determinants of health] will also determine the outcome of interventions and should therefore be considered in the analysis of these indicators.
[4] Maternal deaths for 2011/12 are incomplete [outstanding] hence target above the baseline. The target takes into consideration current trends as well as improved reporting that should increase reported deaths.

Provincial Priorities 2012/13	Core Strategies and Activities	Targets 2012/13
	▪ Implementation of the Antenatal and Postnatal Care Policy including early booking for ANC [BANC].	Increase the percent of mothers and newborn babies who receive postpartum care within 6 days after delivery from 56.3% [mothers] and 57.7% [babies] to 70% for both
		Increase ANC visits before 20 weeks from 39.6% to 50%
Reduce the incidence of cervical cancer.	▪ Scale up implementation of the Phila Ma Campaign.	Increase cervical cancer screening coverage from 73% to 75%[5]
Reduce unplanned, unwanted and high-risk pregnancies.	▪ Implement the Contraceptive Strategy.	Increase the couple year protection rate from 26% to 28.9%
Reduce the mother to child transmission of HIV by intensifying the PMTCT Programme.	▪ NIMART to improve HAART initiation for eligible women. ▪ Promotion of exclusive breastfeeding.	Decrease baby tested PCR positive six weeks after birth as proportion of babies tested at six weeks from 4% to 2% [DHIS data]
		Increase percent of eligible pregnant women placed on HAART from 78.8% to 90%
		Test 100% pregnant women for HIV
		Increase ANC Nevirapine uptake rate from 60.9% to 100%
		Increase baby Nevirapine uptake rate from 97.9% to 100%
OUTPUT 3: COMBATING HIV AND AIDS AND DECREASING THE BURDEN OF DISEASE FROM TUBERCULOSIS		
Decrease HIV incidence and manage HIV prevalence.	▪ Implement the Multi-Sectoral Provincial Strategic Plan [KZNPSP] for HIV and AIDS, STIs and TB 2012-2016. ▪ Strengthen monitoring & evaluation [3-TIER reporting]. ▪ Increase access to ART including decentralised access at PHC level.	Reduce the HIV incidence from 1.8% to 1.7% [ASSA2008]
		Reduce the STI treated new episode incidence from 2.7% to 2.4%
		Increase the percent qualifying HIV-positive patients on ART from 83% to 85% [ART Registers]
		Increase the total number of patients [children and adults] on ART [cumulative] from 526,666 to 785,431
	▪ Strengthen HIV/TB integration.	Increase the percent of HIV/TB co-infected patients placed on ART from 75% to 90%
	▪ Intensify the Male Medical Circumcision Campaign.	Increase the number of neonatal males circumcised from 93 to 150[6]
		Increase the number of adult males circumcised from 73,070 to 174,826

[5] It is suspected that the current collection of data at facility level include incomplete, repeat and diagnostic smears for calculation of this indicator. The current coverage is suspected to be lower than the reported data, which will be investigated by the Epidemiology and Health Research and Knowledge Management Component in 2012/13.
[6] The Department is working with UKZN Ethics Department in addressing ethical issues pertaining to neonatal circumcision [very slow uptake].

Provincial Priorities 2012/13	Core Strategies and Activities	Targets 2012/13
	▪ Expand HCT ▪ Implement the new Condom Distribution Strategy.	Increase the HCT testing rate from 90% to 93%
		Increase the condom distribution rate from 9 to 14 condoms per male
Improve TB outcomes	▪ Implementation of the KZNPSP 2012-2016	Improve the new smear positive PTB cure rate from 69.5% to 73.3%
		Reduce the new smear positive PTB defaulter rate from 6.7% to 6%
		Improve the PTB two month smear conversion rate from 69% to 74%
		Increase the percent of HIV positive patients initiated on IPT from 52% to 60%
		Increase the % of TB/HIV co-infected patients initiated on CPT from 69% to 90%
	▪ Expand community-based management of MDR TB including establishment of "Injection Teams". ▪ Establish decentralised and satellite MDR TB Units. ▪ Rollout of GeneXpert in 4 additional districts.	
Modernisation of Specialised TB Hospitals to improve efficiency and quality	▪ Revitalisation of Specialised TB Hospital services. ▪ Implementation of the National Core Standards.	Maintain an average length of stay of 30 days
		Increase the bed utilisation rate from 54.1% to 70%
		Increased expenditure per PDE from R1 594 to R1 700
		Two hospitals compliant with national core standards[7]
OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVENESS		
Finalise the 10-year plan for revitalisation of health services in line with the national requirements for NHI	▪ Finalise and implement the 2010-2020 Provincial Service Transformation Plan	Published STP
Improve governance and inclusive participation.	▪ Establish Provincial and District Health Councils as per National Health Act, 2003 and convene bi-annual/ annual meetings. ▪ Appoint Clinic Committees and Hospital Boards.	Bi-annual meetings with the Provincial Health Council
		6 District Health Councils established and 6 annual meetings convened
		100% of Hospitals with functional Hospital Boards
		100% of clinics and CHCs with functional Clinic Committees
4.1 Revitalisation of PHC		

[7] Dependent on National processes although all hospitals will be assessed routinely to ensure improved efficiency and quality

Provincial Priorities 2012/13	Core Strategies and Activities	Targets 2012/13
Re-engineering of PHC	▪ Establish PHC Outreach [Family Health] Teams, School Health Teams and District Specialist Teams [three pillars] ▪ Finalise PHC structures and fast track filling of posts ▪ Fast track infrastructure [see Infrastructure] ▪ Improve community participation and governance including: ▪ Operation Sukuma Sakhe ▪ District Health Councils ▪ Clinic Committees and Hospital Boards ▪ Provincialisation of LG services ▪ Integration of Community Care Givers	Increase PHC expenditure per uninsured person from R324 to R335
		Increase the PHC headcount from 28,697,924 to 30,113,920
		Increase the under 5 headcount from 5,088,392 to 5,266,486
		Increase the PHC and under 5 utilisation rates from 2.7 and 4.5 to 2.8 and 4.7
		Improve the supervision rate from 72.1% to 74%
		Increase expenditure per PHC headcount from R101 to R115
		Increase CHCs with resident doctor rate from 94.7% to 100%
		Increase PHC Outreach [Family Health] Teams from 12 to 65
		Increase School Health Teams from 86 to 103
		Establish 3 District Specialist Teams[8]
Revitalisation of Oral and Dental Health services	▪ Implementation of the Oral Health 10 Point Plan 2011 - 2015	Reduce the dental extractions to restoration rate from 20.1 to 19.1
4.2 Health Care Financing and Management		
Improved financial management and accountability.	▪ Implement the Finance and Supply Chain Management Turn-Around Strategy. ▪ Establish Provincial and District Budget Committees to improve financial management and accountability ▪ Align budget with service delivery including alignment of District Health Expenditure Reviews [DHERs] and District Health Plans [DHPs]	Unqualified audit opinion
		11 DHER Reports
		11 DHPs [used for district budget bids]
4.3 Human Resources for Health		
Implement the Provincial Human Resource Plan aligned with the strategic priorities of the Human Resources for Health South Africa Strategy.	▪ Finalise organisational review and expedite filling of critical posts.	Organisational review finalised. *See vacancy rates.*
	▪ Leadership and Governance: Management Training	Increase the number of Managers accessing the

[8] The appointment of District Specialist Teams is managed by the National Department of Health.

Provincial Priorities 2012/13	Core Strategies and Activities	Targets 2012/13
	Strategy including succession training and mentoring programmes	Management Skills Programme from 300 to 550
		20 SMS Managers trained on the compulsory Public Service Induction Programme
	▪ Intelligence and Planning for HRH: Establish a Centre for Health Workforce Intelligence [improve Human Resource Management, systems and processes in line with departmental business processes].	Approved Provincial HR Plan and 11 approved District HR Plans Implementation Reports.
	▪ Professional Human Resource Management: Improve management of human resources in a manner that attracts, retains and motivates the health workforce to both public and private sectors in an appropriate balance [promote access to health professionals in rural and remote areas].	Decrease PN vacancy rate from 31% to 18%.
		Decrease Medical Officer vacancy rate from 48% to 31%.
		Decrease Specialist vacancy rate from 55% to 54%.
		Decrease Pharmacist vacancy rate from 33% to 30%.
		Increase the number of Medical Officers per 100,000 pop from 24 to 26.
		Increase the number of Medical Officers per 100,000 pop in rural districts from 10 to 15.
		Increase the number of Professional Nurses per 100,000 pop from 130 to 139.
		Increase the number of Professional Nurses per 100,000 pop in rural districts from 96 to 100.
		Increase the number of Pharmacists per 100,000 pop from 5 to 5.5.
		Increase the number of Pharmacists per 100,000 pop in rural areas from 2 to 2.7.
	▪ Academic training and service platform interfaces: Strengthen Academic Health Complexes and Nursing Colleges to strategically manage both health care and academic resources and provide integrated platform for service, clinical, research and education functions.	Number of nurse student intakes from 2,707 to 2,404
		Number of Professional Nurses graduating from 972 to 820
		Number of Advanced Midwifes graduating from 127 to 106
		Number of students with bursaries from province from 832 to 800
		Number of basic nurse students graduating from 1,597 to 1,400
		Increase the number of Registrars in training (cumulative) from 632 to 650

Provincial Priorities 2012/13	Core Strategies and Activities	Targets 2012/13
		Retain 70% of Registrars after qualifying
	▪ Upscale and revitalise education, training and research [skills mix and competencies, education and training including training of mid-level workers] in order to strengthen dedicated capacity for critical functions.	
	▪ Quality professional care: Develop a workforce that delivers an evidence-based quality service with competence, care and compassion.	100% of Head Office Managers [level 13 and above] sign Performance Agreements
		100% of District Managers sign Performance Agreements
		100% of Hospital CEOs sign Performance Agreements
4.4 Quality of Health and Accreditation of Health Establishments		
Improve the quality and efficiency of PHC and Hospital services	▪ Rationalisation of Regional Hospital services: Finalise service delivery platform. ▪ Monitor implementation of the National Tertiary Services Grant. ▪ Implement the National Core Standards towards accreditation/licensing of health facilities[9] to improve quality and efficiency ▪ Improve Clinical Governance including Supervision. ▪ National NHI project in Umzinyathi, Amajuba and Umgungundlovu.	100% of facilities implement the Core Standards
		% of facilities compliant with core standards: 2% clinics; 31% CHC's; 5 District Hospitals; 4 Regional Hospitals; 2 Psychiatric; 1 Chronic; and 100% Tertiary and Central Hospitals[10]
		Increase the PHC supervision rate from 72.1% to 74%
		100% of hospitals conduct monthly mortality and morbidity reviews
		Decrease the caesarean section rate in District [26.3% to 26%]; Regional [38.3% to 38%]; Tertiary [68.9% to 68.6%]; and Central [68.9% to 69.8%].
		Decrease the average length of stay in District [5.8 to 5 days]; Regional [5.4 to 5.2 days]; Tertiary [10 to9.8 days]; and Central [10 - 9 days].
		Increase the bed occupancy rate in District [64% to 67%]; Regional [68.5% to 70%]; Psychiatric [71.6% to 73%]; Chronic [63.4% to 67.5%]; Tertiary [70% to 75%]; and Central [69.8% to 75%].
		Expenditure per patient day equivalent in District [R1 574 to R1 700]; Regional [R1 534 to R1 600]; Psychiatric [R918 to R1 100]; Chronic [R1 047 to R1 100]; Tertiary [R3 448 to R3 500]; and Central [R8 775 to R9 000].

[9] Cumulative numbers determined by Project Plan – Quality Improvement Plans forms part of the strategy and are not mentioned separately in the strategic & Annual Performance Plan (included in Operational Plans)
[10] Accreditation/licensing dependent on the national appointment of the National Body of Standard Compliance

Provincial Priorities 2012/13	Core Strategies and Activities	Targets 2012/13
	▪ Improve patient satisfaction with public health services.	Increase the percent facilities that conducted Patient Satisfaction Surveys to 100%
		80% OF complaints of public health users resolved within 25 days.
Improve Pharmaceutical service management and service delivery.	▪ Improve availability of medicines by reducing tracer medicine stock-out rate in bulk stores [PPSD and Institutions].	Decrease stock-out rate in PPSD from 7% to <3% and Institutions from 5% to <3%
	▪ Improve compliance with legislative requirements.	Increase the % of Pharmacies that obtained A or B grading on inspection from 58.6% to 70%
		PPSD 100% compliant with Good Wholesaling Practice Regulations
4.5 Health Infrastructure		
Fast track infrastructure projects in line with the "National Shock Treatment Plan"	▪ Fast track infrastructure projects including maintenance, upgrades, seclusion rooms, 10-bedded psychiatric wards, waiting mother's lodges, new clinics and CHCs, and improved access to people with disabilities. ▪ Implementation of the aligned IPIP. ▪ Hospital Revitalisation Programme: Improvement of facilities; new infrastructure [construction of main building for Pixley KaSeme, King George V for commissioning of 200 beds, Madadeni Psychiatric Unit, Dr John Dube, and new Tertiary Hospital for current King Edward Vlll Hospital.	Output aligned with IPIP and Revitalisation Business Cases.
4.6 Information, Communication & Technology and Health Information Systems		
Improve health information technology and systems and data and knowledge management.	▪ Advance use of E-Health [electronic communication and IT] and M-Health [mobile devices]. ▪ Data and Knowledge Management.	Annual unqualified audit opinion for performance information.
		Increase the Telemedicine sites from 34 to 37
		Finalisation and implementation of the Health Research and Data Management Policies
	▪ Epidemiology and Research projects in support of service delivery.	Burden of Disease study
		Evaluation of implementation of the new model for re-engineering of PHC

1.7. PROVINCIAL ORGANISATIONAL ENVIRONMENT

The Department commenced with an organisational review in 2011/12 with completion expected in 2012/13. This process is informed by core business and business processes in the Department to ensure appropriate human resources for health.

One of the most challenging tasks has always been to predict/determine future workforce in response to predicted health demand and outcome. Poverty, socio-economic and demographic determinants, and changing disease patterns [including co-morbidities] all impact on demand for staffing - exacerbated by the time required to train staff.

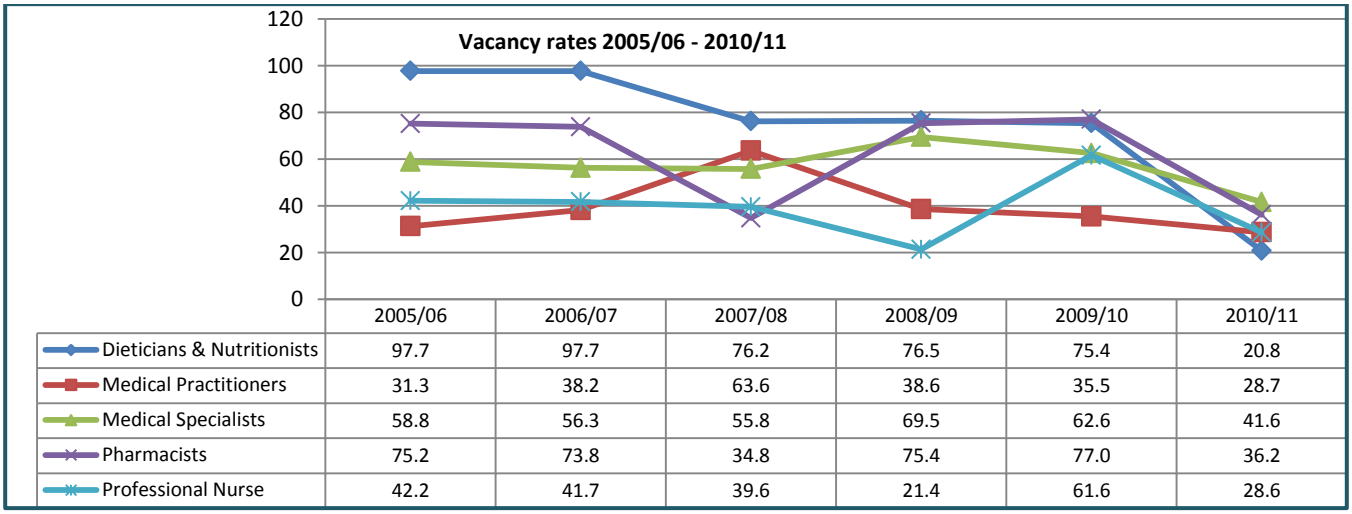
The Human Resource for Health (HRH) National Strategy aims to close the most common human resource gaps, improve working conditions and retention, increase productivity, revitalise aspects of education, training and research, and address skill gaps and use of appropriate policy tools to optimise performance.

In 2010/11 there were 70,432 employees in the Department compared with 61,552 in 2009/10. Inequities in allocation and placement of human resources [especially critical skills] are still evident and require innovative and pro-active strategies to re-dress inequities in preparation of implementation of NHI over the next 14 years.

Vacancy Rates

Vacancy rates are generally used as standard predictor of human resource gaps, needs and subsequent prioritisation for filling of posts. Data inconsistencies however clearly indicate the need to investigate alternative predictors e.g. growth in actual staffing numbers, burden of disease, etc. to ultimately inform strategic direction towards addressing the gaps in human resources for health. The graph below shows vacancy trends between 2005/06 and 2010/11.

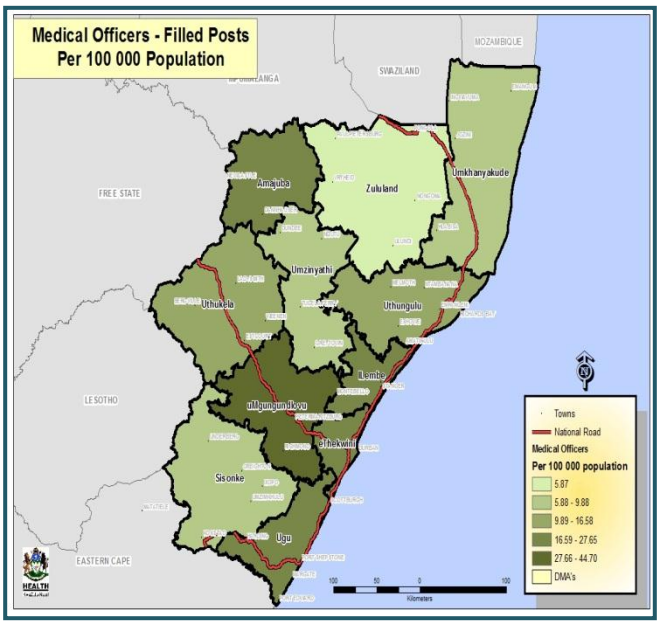
Graph 10: Vacancy Rates between 2005/06 and 2010/11



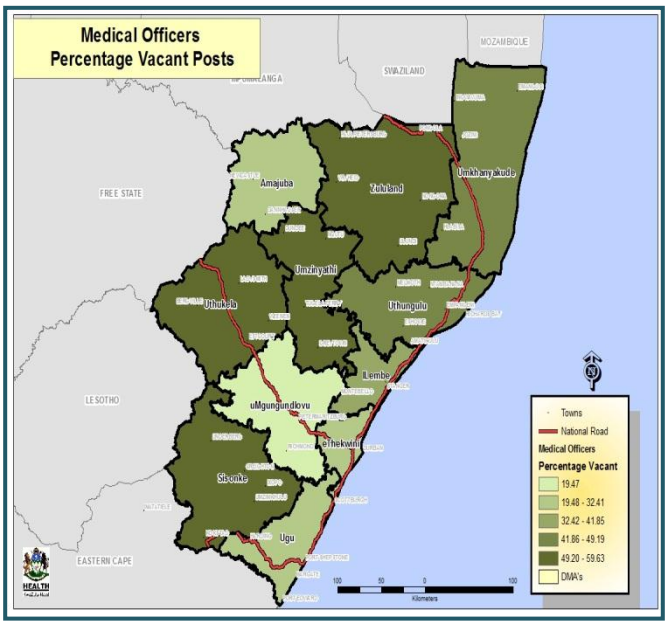
	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Dieticians & Nutritionists	97.7	97.7	76.2	76.5	75.4	20.8
Medical Practitioners	31.3	38.2	63.6	38.6	35.5	28.7
Medical Specialists	58.8	56.3	55.8	69.5	62.6	41.6
Pharmacists	75.2	73.8	34.8	75.4	77.0	36.2
Professional Nurse	42.2	41.7	39.6	21.4	61.6	28.6

As part of the Human Resource turnaround strategy, vacant unfunded posts have been removed from Persal as it artificially inflated vacancy rates. In 2009/10 this process was extended to removing posts, vacant for more than 6 months, from Persal which could account for the significant drop in the vacancy rate for Pharmacists and well as the stabilisation of the vacancy rate for Medical Specialists over the 2008/09 – 2010/11 periods. This supports the use of alternative methodologies for Human Resource Planning. The next 2 maps illustrate the Medical Officer filled posts and vacancy rates in 2010/11 – see legends for interpretation of maps.

Map 5: Medical Officers Filled Posts



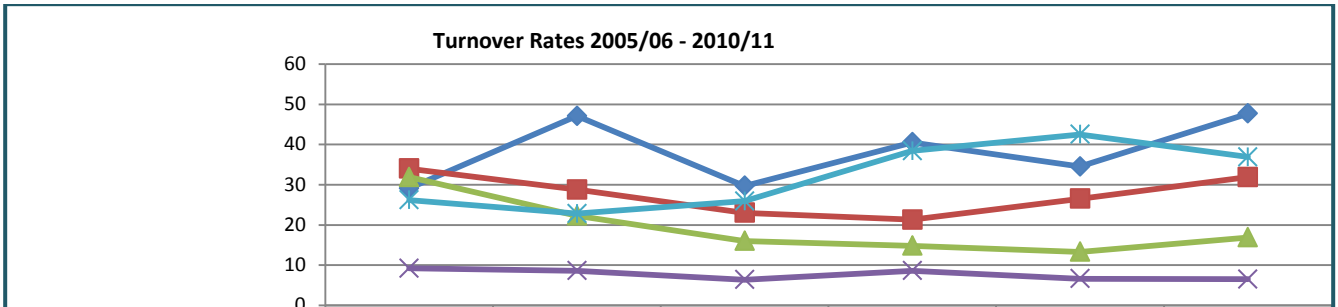
Map 6: Medical Officer Percentage Vacant Posts



Turnover Rates

Turnover rates are defined as the ratio of workers that had to be replaced in a given time period to the average number of workers. Specialists have shown a steady decrease in turnover, in sharp contrast to Pharmacists that show a steady increase in turnover [concomitantly reflected in a high vacancy rate]. The turnover rate for Medical Officers shows a disturbing increase from 2008/09 - despite the implementation of OSD in 2008/09. The next graph illustrates trends in turnover rates which have significant implications for continuity and quality of clinical services.

Graph 11: Turnover Rates 2005/06 – 2010/11



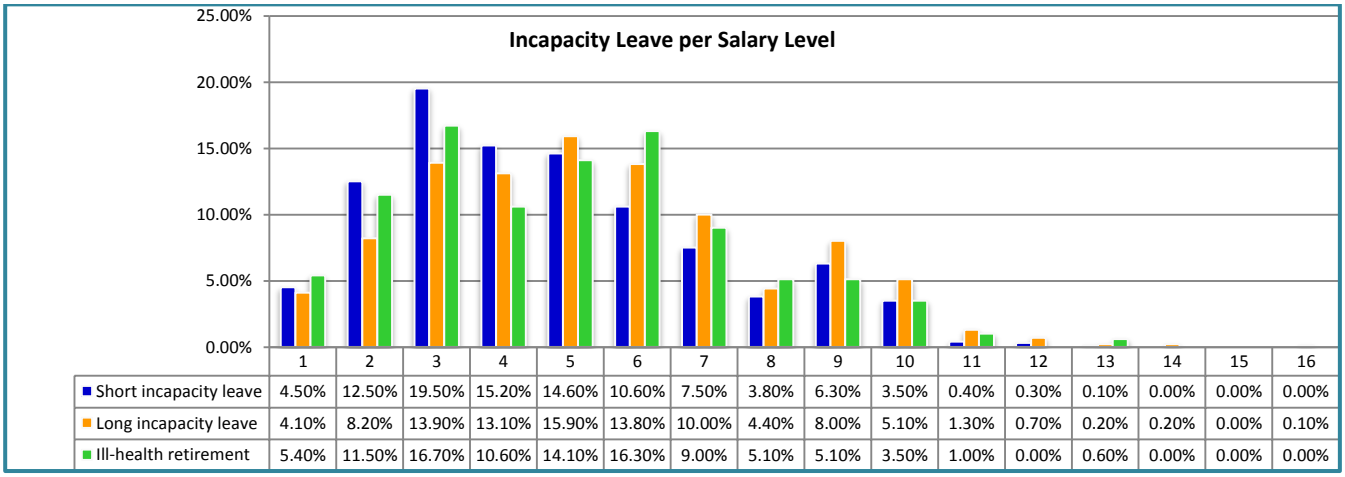
	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Dieticians & Nutritionists	29.1	47.1	29.7	40.5	34.5	47.7
Medical Officers	34	28.8	23.0	21.3	26.5	31.9
Specialists	31.9	22.3	16.0	14.8	13.3	16.9
Professional Nurse	9.2	8.6	6.4	8.6	6.6	6.5
Pharmacists	26.2	22.8	25.9	38.4	42.5	36.9

Incapacity Leave and Ill-health Retirement

The impact of ill-health on the workforce [directly and indirectly] is well documented and expected taking into consideration the quadruple burden of disease in the Province. This has serious implications for service delivery including allocation of staff, distribution of responsibilities, increasing number of staff in acting positions, and critical posts not being filled for extended periods.

Although salary levels 3 to 6 are most affected in terms of incapacity leave [*see the graph below*], the general impact on staff morale and service delivery is far reaching and significant. The critical role of on- and off-site support services is more critical than ever [Employee Assistance Programme] and should be revisited to ensure adequate intervention and support services for all employees.

Graph 12: Incapacity Leave per Salary Level

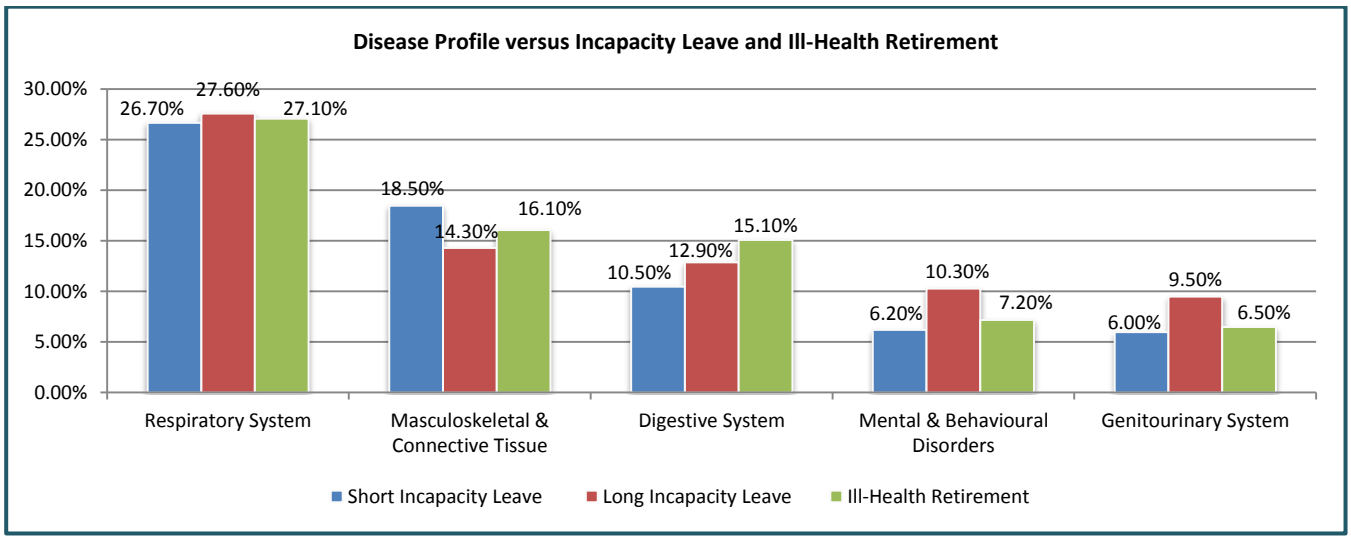


	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Short incapacity leave	4.50%	12.50%	19.50%	15.20%	14.60%	10.60%	7.50%	3.80%	6.30%	3.50%	0.40%	0.30%	0.10%	0.00%	0.00%	0.00%
Long incapacity leave	4.10%	8.20%	13.90%	13.10%	15.90%	13.80%	10.00%	4.40%	8.00%	5.10%	1.30%	0.70%	0.20%	0.20%	0.00%	0.10%
Ill-health retirement	5.40%	11.50%	16.70%	10.60%	14.10%	16.30%	9.00%	5.10%	5.10%	3.50%	1.00%	0.00%	0.60%	0.00%	0.00%	0.00%

- Shows applications received per salary level for short and long periods of temporary incapacity leave, as well as ill health retirement from 1 November 2006 to 30 June 2011.

The disease profile, applicable to applications for incapacity leave and ill-health retirements between November 2006 and June 2011, is depicted in the graph below.

Graph 13: Disease profile versus short and long incapacity leave and ill-health retirement



Although the impact of HIV and AIDS on the workforce is debated extensively it is also acknowledged that it is dependent on voluntary disclosure. Stigma still plays a major role in disclosure of HIV status which inevitably impact on Departmental support and workplace policies.

The graph below shows the impact of HIV and AIDS on the workforce based on completed applications between November 2006 and June 2011. Programmes in the workplace must be scaled up to accommodate the increasing need for support.

Graph 14: Health HIV Status of applications finalised

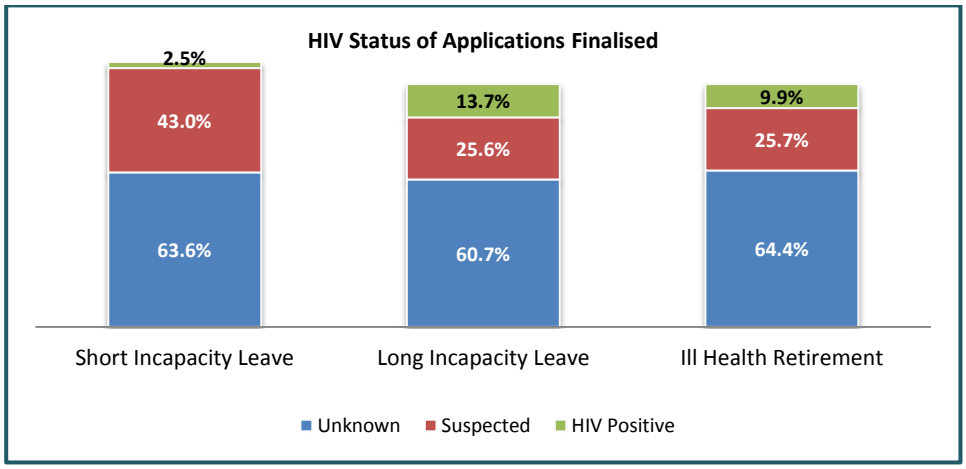


Table 15: Public Health Personnel in 2010/11

Categories	Number Employed	% of Total Employed	Number per 100,000 people	Number per 100,000 Uninsured People	Vacancy Rate
Medical Officers	2,760	3.9%	24.4	27.7	32.6
Medical Specialists	497	0.7%	6.6	7.5	46.7%
Dentists	103	0.1%	0.98	1.1	19.5%
Professional Nurses	12,227	17.5%	130.1	147.9	28.0%
Staff Nurses	8,770	12.5%	93.8	106.6	22.2%
Nursing Assistant	6,051	8.7%	58	66	27.5%
Student Nurses	1,918	2.7%	19.1	21.7	14.4
Pharmacists	530	0.8%	4.8	5.5	32.9%
Physiotherapists	220	0.3%	2.2	2.5	14.7%
Occupational Therapists	108	0.2%	1.2	1.4	14.3%
Radiographers	499	0.7%	4.6	5.2	10.7%
Emergency Medical Staff	2,739	3.9%	0.03	0.04	3.9%
Dieticians & Nutritionists	137	0.2%	1.1	1.3	16.5%
Community Care-Givers	5,104	7.3%	48.7	55.4	-

- Source: Persal
- Note: Budget is not allocated per occupational category. Estimated expenditure figures have therefore been used.

1.8. LEGISLATIVE MANDATES AND NEW POLICY INITIATIVES

There are no new legislative mandates since the last Annual Performance Plan.

PART A

1.9. OVERVIEW OF THE 2010/11 BUDGET AND MTEF ESTIMATES

1.9.1 EXPENDITURE ESTIMATES

Table 16: Expenditure Estimates

Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Administration (1)	284 066	1 048 878	356 025	344 171	378 202	377 526	397 670	418 060	440 577
District Health Services (2)	8 132 272	9 188 678	9 830 109	11 739 824	10 900 160	10 843 458	11 953 719	12 881 283	14 045 437
Emergency Medical Services (3)	672 360	782 332	842 050	926 747	1 035 427	1 036 997	1 045 888	1 077 843	1 140 298
Provincial Hospital Services (4)	4 378 814	5 071 290	5 654 225	6 366 182	7 096 305	7 053 454	7 568 389	8 128 189	8 627 686
Central Hospital Services (5)	1 821 221	2 059 135	2 103 423	2 473 982	2 458 428	2 398 840	2 659 359	2 793 324	2 953 759
Health Sciences and Training (6)	676 601	793 186	851 143	933 442	944 587	896 799	998 051	1 079 590	1 149 358
Health Care Support Services (7)	34 209	27 528	10 764	13 971	13 971	13 971	15 170	16 004	18 000
Health Facilities Management (8)	1 103 558	1 378 249	1 087 247	1 686 536	1 842 016	1 842 016	1 917 104	2 114 316	2 169 792
Sub-total	**17 103 101**	**20 349 276**	**20 734 986**	**24 484 855**	**24 669 096**	**24 463 061**	**26 555 350**	**28 508 609**	**30 544 907**
Direct charges against the National Revenue Fund	-	-	-	-	-	-	-	-	-
Total	**17 103 101**	**20 349 276**	**20 734 986**	**24 484 855**	**24 669 096**	**24 463 061**	**26 555 350**	**28 508 609**	**30 544 907**
Unauthorised expenditure (1st charge)	-	**(758 000)**	-	-	-	-	-	-	-
Change to 2011/12 budget estimate	**17 103 101**	**19 591 276**	**20 734 986**	**24 484 855**	**24 669 096**	**24 463 061**	**26 555 350**	**28 508 609**	**30 544 907**

Source: BAS

Table 17: Summary of Provincial Expenditure Estimates by Economic Classification

Economic Classification	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Current payments	**15 466 848**	**17 547 283**	**18 985 291**	**21 844 207**	**21 847 905**	**21 844 703**	**24 121 856**	**25 934 771**	**28 031 284**
Compensation of employees	10 077 044	11 367 849	12 935 381	14 837 633	15 074 380	15 092 047	16 516 085	17 731 710	19 261 214
Goods and services	**5 389 804**	**6 179 434**	**6 049 910**	**7 006 574**	**6 773 525**	**6 752 636**	**7 605 771**	**8 203 061**	**8 770 070**
Communication	103 323	94 599	82 128	91 543	87 757	84 332	88 553	93 438	96 834
Computer Services	117 157	117 344	80 192	104 866	104 683	128 677	156 492	185 034	191 265
Consultants, Contractors and Special Services	745 782	905 262	656 965	810 683	781 494	824 414	985 330	1 045 679	1 141 450
Inventory	2 774 547	3 420 796	3 469 119	4 043 398	3 701 133	3 656 469	4 092 743	4 394 002	4 753 348
Operating Leases	88 748	70 686	96 543	104 697	90648	44 328	43 438	45 945	47 698
Rental and Hiring	41 764	59 048	55 796	57 797	66 481	65 698	70 010	73 931	76 445
Travel and Subsistence	66 148	37 430	38 063	43 789	50 935	59 686	74 579	83 373	86 767
Other including Assets<5000, agency and outsourced services, training and development, property payments, operating expenditure and venues and facilities	1 452 335	1 474 269	1 571 104	1 749 801	1 890 394	1 889 032	2 094 626	2 281 659	2 376 263
Interest and rent on land	-	-	-	-	-	20	-	-	-
Maintenance , repair and running costs	Included under Contractors and Inventory to avoid double counting								
Transfers and subsidies to	**447 706**	**498 279**	**562 293**	**522 821**	**529 433**	**536 851**	**562 780**	**610 724**	**625 394**
Provinces and municipalities	51 538	84 010	126 756	94 173	97 735	98 950	88 819	87 584	91 946
Departmental agencies and accounts	39 957	34 312	18 401	22 137	22 559	22 559	24 530	25 817	28 730
Universities and technikons	40	-	-	-	-	-	-	-	-
Non-profit institutions	243 734	278 846	289 009	266 787	283 265	271 404	296 679	310 403	304 718
Households	112 437	101 111	128 127	139 724	125 874	143 938	152 752	186 920	200 001
Payments for capital assets	**1 188 449**	**1 545 699**	**1 181 773**	**2 117 827**	**2 291 664**	**2 081 411**	**1 870 714**	**1 963 114**	**1 888 228**
Buildings and other fixed structures	635,593	1 005 258	778 749	1 357 938	1 062 128	1 052 128	1 085 471	1 317 862	1 393 458

Economic Classification	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Machinery and equipment	552 856	540 441	402 226	759 889	1 229 536	1 029 272	785 243	645 252	494 770
Software and other intangible assets	-	-	-	-	-	-	-	-	-
Land and sub-soil assets	-	-	798	-	-	**11**	-	-	-
Payment for financial assets	98	758 015	5 629		94	96			
Total economic classification	**17 103 101**	**20 349 276**	**20 734 986**	**24 484 855**	**24 669 096**	**24 463 061**	**26 555 350**	**28 508 609**	**30 544 907**
Unauthorised expenditure (1st charge) not available for spending	-	**(758 000)**	-	-	-	-	-	-	-
Total	**17 103 101**	**19 591 276**	**20 734 986**	**24 484 855**	**24 669 096**	**24 463 061**	**26 555 350**	**28 508 609**	**30 544 907**

Source: BAS

1.10. RELATING EXPENDITURE TRENDS TO SPECIFIC GOALS

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

Expenditure	Audited/ Actual			Estimate	Medium Term Projections		
	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
Current prices							
Total	R17 103 101	R19 591 276	R20 734 986	R24 689 096	R26 556 061	R 28 508 638	R30 544 907
Total per person	R1 652.87	R1 874.92	R1 967.14	R2 324.29	R2 480.97	R 2 644.18	R2 833.04
Total per uninsured person	R1 878.26	R2142.76	R2 248.16	R2 656.33	R2 835.39	R 3 021.91	R3 237.76
Constant (2008/09) prices							
Total	R17 103 101	R18 611 712	R18 661 487	R21 232 623	R22 838 212	R 24 517 429	R26 268 620
Total per person	R1 652.87	R1 781.17	R1 770.42	R1 998.89	R2 133.63	R 2 273.99	R2 436.41
Total per uninsured person	R1 878.26	R2 035.62	R2 023.34	R2 284.45	R2 438.44	R 2 598.85	R1 330,582
% of Total spent on:-							
DHS	47.55%	46.90%	47.41%	44.19%	45.08%	45.25%	46.04%

Expenditure	Audited/ Actual			Estimate	Medium Term Projections		
	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
PHS	25.60%	25.89%	27.27%	28.77%	28.50%	28.52%	28.26%
CHS	10.65%	10.51%	10.14%	9.97%	10.01%	9.8%	9.67%
All personnel	R10 077 044	R11 367 849	R12 935 381	R15 074 380	R16 512 980	R 17 731 710	R19 261 214
Capital	R765 222	R1 113 340	R826 789	R1 412 968	R1 465 476	R1 631 403	R1 655 090
Health as % of total public expenditure	29.7%	29.4%	31.2%	31.0%	31.0%	31.0%	31.0%

Source: BAS

Table 19: CPIX multipliers for adjusting current prices to constant 2007/08 prices

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

Source: National Department of Health

OUTLOOK FOR THE 2012/13 FINANCIAL YEAR

Transformation of Health Services

Transformation of health services is paramount in order to appropriately respond to the increasing demands for health services and preparation for NHI. The World Health Organisation Health Systems Framework remains an important anchor and reference point for transformation.

Fiscal and Economic Management of the Department

Infrastructure Management will be strengthened, with attention to improved working relationship with IAs, Department of Public Works and the Independent Development Trust [IDT].

Subscription to National Treasury contracts and implementation of periodic contracts over the last two years brought price stability, and the Department will continue to pursue the strategic sourcing agenda in 2012/13.

The Department continues to strive towards an unqualified audit opinion, and strategies are in place to improve financial management and accountability.

Continued focus on National and Provincial Priorities

Financial allocation will make provision for implementation of core priorities as indicated in the 2012/13 Annual Performance Plan and District Health Plans.

Increasing economic participation and creating jobs

Job creation will continue with small KZN companies and rural women being given an increasing share in market opportunities in the Department. The Department's tender documentation and contract conditions will be reviewed to include safeguards for job creation and payment of sector determined salaries.

2012/13 Budget

The Department is projecting to under-spend by R206.035 million in 2011/12 mainly due to the slow delivery of vehicles and medical equipment, as well as

improved contract prices for various medical *Goods and Services* mainly in Programme 2: District Health Services.

Total receipts are expected to increase from R24.587 billion in the 2011/12 *Adjusted Appropriation*, to R30.545 billion in 2014/15.

Additional funding has been provided in the 2012/13 MTEF for introduction of the NHI pilot programme through the NHI Conditional Grant, the refurbishment of Nurses Training Colleges (Nursing Colleges and Schools Grant), funding for capacity building to ensure support for infrastructure in the management of health facilities, as well as the carry-through costs of the 2011 wage agreement.

PART B
BUDGET PROGRAMMES

ANNUAL PERFORMANCE PLAN 2012/13 – 2014/15

PART B

PROGRAMME 1: ADMINISTRATION

1. PROGRAMME PURPOSE AND STRUCTURE

Provide strategic and supportive leadership and management and overall administration of the Provincial Department of Health.

Sub-Programme 1.1: Office of the Member of the Executive Council [MEC]

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

Sub-Programme 1.2: Office of the Head of Department [including all Head Office Components]

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

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

Performance of all services or programmes, not specifically prioritised in the APP is included in Operational Plans and will be monitored quarterly. Overall performance outcomes will be incorporated in the 2012/13 Annual Report.

Strategic Planning

Great strides have been made with the integration of provincial and district planning processes.

- Draft District Service Transformation Plans [STPs] informed the Provincial STP.
- Services have been spatially mapped by the GIS Component as part of the 10 year long-term planning horizon and in line with the National Health Council directive for re-engineering of PHC.
- District Health Expenditure Reviews [DHERs] informed District Health Plans [DHPs] which have been aligned with the Annual Performance Plan.
- DHPs were presented during district budget bids for 2012/13 and will serve as foundation for the MTEF plans.
- Quarterly performance reviews will accentuate linkage between expenditure and service delivery.

Information Technology (IT)

Implementation of the new Information, Technology and Communication Strategy commenced in 2011/12 and includes e-Health [electronic communication and IT]; m-Health [mobile devices]; Telemedicine; and other.

Most of the network backbone is old and will be replaced in 2012/13 in order to provide a reliable platform within which systems can be implemented.

Upgraded health information systems have been implemented at Addington Hospital and will be rolled out to an additional five hospitals in 2012/13 as part of the Hospital Revitalisation Project. The programme will be sourcing for e-Health Patient Management Systems and Patient Administration and Billing Systems within the planning period.

All facilities will be on network infrastructure at the end of 2012/13, and usage of e-Health technologies will be enhanced to improve service delivery.

Currently, 37 facilities have telemedicine infrastructure which will complement the traditional consultation process in health care delivery. Mobile telemedicine vehicles will complement the service.

Epidemiology and Health Research & Knowledge Management

The Epidemiology and Health Research & Knowledge Management Policy has been finalised and is awaiting final approval.

The Provincial Burden of Disease study commenced in 2011/12 and will continue in 2012/13. This will provide critical evidence-based information pertaining to the burden of disease and service delivery needs and demands.

This Component will play a critical role in the evaluation of the re-engineering of PHC and will provide the critical evidence to inform the ultimate development of a sustainable and robust PHC Model for KZN. The Component also plays a critical role in capacity development at district level to improve knowledge management.

Data Management

A reliable and action-oriented health information system is critical to ensure reliable performance information to inform evidence-based decision-making and planning in response to health needs and demands.

Data quality [not exclusive to DHIS] is still a challenge and the various vertical information systems [ETR.Net, CDC, and EMS] confound interventions to standardise the Departmental information system.

The Data Management Policy has been finalised after extensive consultation and submitted for final approval. The Provincial Information Data Set has been reviewed in the 4th quarter of 2011/12 to make provision for additional indicators to monitor performance.

Provincial and District Information Committees are being established to improve data integrity and management.

Monitoring & Evaluation

The Monitoring & Evaluation Framework is used as standard framework for integrated monitoring and reporting which has been aligned with service delivery priorities in the Annual Performance Plan.

PROGRAMME 1: ADMINISTRATION

Human Resource Management Services

The Human Resource Plan has been aligned with the Strategic Priorities of Human Resources for Health [HRH] South Africa Strategy including:

1. *Leadership and governance*: Provide proactive leadership and enabling framework to achieve the objectives of the National HRH Strategy.

2. *Intelligence and planning for HRH*: Establish a Centre for Health Workforce Intelligence which will provide health workforce information and ensure oversight on workforce planning.

3. *Workforce for new service strategies*: Meet workforce requirements of new and emerging service strategies to ensure health services that promote health and provide value for money.

4. *Upscale and revitalise education, training and research*: Ensure revitalisation of the production of a health workforce with the skills mix and competencies, education and training to meet service demands.

5. *Academic training and service platform interfaces*: Strengthen Academic Health Complexes and Nursing Colleges to strategically manage both health care and academic resources and provide an integrated platform for services, clinical, research and education functions.

6. *Professional Human Resource Management*: Effectively manage human resources in a manner that attracts, retains and motivates the health workforce to both public and private sectors in an appropriate balance.

7. *Quality professional care*: Develop a health workforce that delivers an evidence-based service with competence, care and compassion.

8. *Access in rural and remote areas*: Promote access to health professionals in rural and remote areas.

Finance

The Finance Turn-Around Strategy is still being implemented with robust monitoring of cost saving strategies.

Expenditure is actively monitored and significant progress has been made linking budget with service delivery.

National Health Insurance Pilot Project [Phase 1]

Pilot Districts: Umzinyathi, Umgungundlovu and Amajuba.

Objectives

1. To focus on the most vulnerable sections of society.
2. To reduce maternal and child mortality through district-based health interventions.
3. To strengthen the performance of the public health system in readiness for full roll-out of NHI.
4. To strengthen the functioning of the District Health System.
5. To assess the contribution of the health service package, PHC Teams and strengthened referral system will improve access to quality health care.

6. To assess feasibility, acceptability, effectiveness and affordability of innovative ways of engaging the private sector resources of public health.
7. To access utilisation patterns, cost and affordability of implementing of PHC service package.

Non-Negotiable for Success

1. Infection Control Services
2. Medicines and Medical Supplies including Dry Dispensary
3. Cleaning material and services
4. Essential equipment and maintenance of equipment
5. Laboratory services
6. Blood supply and services
7. Vaccines
8. Food services and relevant supplies
9. Child health services (including neonatal and perinatal)
10. Maternal and reproductive health services
11. Registrars
12. Pilot districts full complement of PHC Teams
13. School Health (Quintile 1 and 2 schools)
14. District Specialist Teams
15. Infrastructure maintenance
16. HIV and AIDS
17. TB
18. Security services

Way Forward

1. Establish the NHI Unit: April 2012
2. Undertake a comprehensive analysis of population and service delivery in districts: April 2012
3. Communication of results to all districts: 13 April 2012
4. Benchmarking – National and International: 20 April 2012
5. Finalise the Communication Plan: 30 April
6. Strategic Planning with 3 Pilot Districts: May 2012
7. Project Implementation Plans with costing completed: 31 May 2012
8. Development of package to strengthen District Management: May 2012

2. CHALLENGES

- SITA costs [data lines] are exorbitant and limit the development of necessary services.
- Integration of services [planning and service delivery] is a challenge resulting in duplication and waste of scarce resources.
- Lack of data on the impact of the burden of disease on health services which jeopardise effective planning.
- Disjuncture between service needs/demands and human resources for health. Inequity in allocation and distribution of human resources.
- Poor data integrity [all information systems], and analysis and review impact on proactive interventions.

PROGRAMME 1: ADMINISTRATION

3. 2012/13 PRIORITIES: PROGRAMME 1

1. *Service Transformation Plan*	▪ Finalise the Service Transformation Plan. ▪ Finalise spatial mapping of health service transformation.
2. *Financial Turn-Around Strategy*	▪ Strengthen integrated expenditure reviews and improve financial management and accountability. ▪ Align budget and expenditure with service delivery.
3. *Implement the Provincial Human Resource Plan aligned with strategic priorities of the Human Resources for Health SA Strategy*	▪ Finalise the organisational review and expedite filling of critical posts. ▪ Leadership and governance: Implement the management training strategy including succession training and mentoring programmes. ▪ Establish a Centre for Health Workforce Intelligence. ▪ Review and implement a recruitment and retention strategy. ▪ Strengthen Academic Health Complexes and Nursing Colleges. ▪ Implement appropriate training programmes [skills mix and competencies, mid-level workers].
4. *Health Information Turn-Around Strategy*	▪ Implement the ITC Strategy including E-Health, M-Health and Telemedicine. ▪ Implement the Data Management turn-around strategy to improve data integrity and information management. ▪ Conduct and facilitate relevant research for health including the Burden of Disease study and evaluation of PHC re-engineering.
5. *National Health Insurance – Phase 1*	▪ Implementation of the National Pilot Project in Umgungundlovu, Umzinyathi and Amajuba Districts as per Implementation Plan.

PROGRAMME 1: ADMINISTRATION

4. SITUATIONAL ANALYSIS AND PROJECTED PERFORMANCE FOR HUMAN RESOURCES – 2012/13

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

Indicators	Data Source	Type	Audited/ Actual Performance			Estimate[11]	Medium Term Targets		
			2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
1. Number of Medical Officers per 100,000 people	Persal	No	28	26	24.4	24 *Target: 25.7*	26	27	27
2. Number of Medical Officers per 100,000 people in rural districts	Persal	No	12	-	9.8	10 *Target: 12*	15	17	28
3. Number of Professional Nurses per 100,000 people	Persal	No	111	111	130.1	130 *Target: 116.1*	139	140	142
4. Number of Professional Nurses per 100,000 people in rural districts	Persal	No	50	-	95.6	96 *Target: 98.2*	100	112	114
5. Number of Pharmacists per 100,000 people	Persal	No	5	4	4.8	5 *Target: 3.9*	5.5	5.5	5.6
6. Number of Pharmacists per 100,000 people in rural districts	Persal	No	2	-	2.1	2 *Target: 2.4*	2.7	2.9	3
7. Vacancy rate for Professional Nurses	Persal	%	21.3%	25.7%	28.6%	31% N: 5,782 D: 18,436 *Target: 19%*	18%	15%	13%
8. Vacancy rate for Medical Officers	Persal	%	33.6%	41.6%	28.7%	48% N: 2,481 D: 5,209 *Target: 32%*	31%	30%	29%
9. Vacancy rate for Medical Specialists	Persal	%	61.6%	65.9%	41.6%	55% N: 651 D: 1,181 *Target: 60%*	54%	53%	52%
10. Vacancy rate for Pharmacists	Persal	%	75.3%	76.4%	36.2%	33% N: 283 D: 846 *Target: 75%**	30%	29%	28%

- Local Government Personnel have not been included in the table above

[11] Estimate based on December 2010 Persal figures

- Rural Districts include Ugu, Umzinyathi, Zululand and Umkhanyakude [Rural Development Nodes]. It should however be noted that all other districts have rural municipalities.
- Vacancy rate changes as excess unfunded vacant posts are abolished and new posts are created. Takeover of local government clinics will require new posts and post establishments will be created to accommodate that. Where relevant, nursing staff may be absorbed from existing posts.
- It is recommended that more attention be given to the incremental increase in the number of staff [and where appropriate task shifting] to determine growth in personnel versus increased patient activity, access to package of services and workload. Forecasting methodologies should be adjusted accordingly.
- After Persal cleanup, the vacancy rate for Pharmacists was reduced as can be seen in 2010/11 and 2011/12 data.

5. PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR ADMINISTRATION – 2012/13

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 21: (ADMIN2): Provincial Strategic Objectives and Annual Targets for Administration

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
1.1) To finalise and implement Provincial Health Plans aligned with the NHS and MTSF priorities for 2010-2014.	1.1.1) Tabled Annual Performance Plan [APP]	Annual tabling of APP as per Regulations	APP sign-off documents	2009/10 APP tabled	2010/11 APP tabled	2011/12 APP tabled	Draft 2012/13 APP submitted	2012/13 APP tabled	2013/14 APP tabled	2014/15 APP tabled
	1.1.2) Number of approved District Health Plans	11 DHP's approved	DHP's sign-off documents	2009/10 DHPs [11] approved	2010/11 DHPs [11] approved	2011/12 DHPs [11] approved	11 Draft 2012/13 DHPs submitted	11	11	11
1.2) To finalise and implement the approved 2010-2020 KZN STP.	1.2.1) Published STP	Approved STP implemented	STP	Phase 1 approved	Draft 2 signed off by HOD and MEC	Draft 3: Deadline extended by DG	Draft 4 – not approved	STP approved	-	-
1.3) To implement the decentralised Operational Model in 11 districts	1.3.1) Number of Hospital Managers who have signed Performance Agreements [PAs].	71/71	Signed PA's	Reporting not required	Reporting not required	64/ 71	39/71 *Target: 71*	71	71	71
	1.3.2) Number of District Managers who have signed PAs.	11/11	Signed PA's	Reporting not required	Reporting not required	11	6/11 *Target: 11*	11	11	11

ANNUAL PERFORMANCE PLAN 2012/13 – 2014/15
PROGRAMME 1: ADMINISTRATION

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
	1.3.3) Percentage of Head Office Managers (Level 13 and above) who have signed PAs.	100%	Signed PA's	Reporting not required	Reporting not required	21.8% N: 7 D: 32	25.6% N: 10 D: 39 *Target: 100%*	100% of level 13 & above	100% of level 13 & above	100% of level 13 & above
1.4) To implement the Financial Turn-Around Strategy to improve financial management and accountability in compliance with the PFMA.	1.4.1) Annual unqualified audit opinion for financial statements.	Unqualified audit opinion	Auditor-General's Report	Reporting not required	Qualified audit opinion for 2009/10	Qualified audit opinion for 2010/11	Audit not yet conducted for 2011/12	Unqualified audit opinion	Unqualified audit opinion	Unqualified audit opinion
	1.4.2) Number of approved District Health Expenditure Reviews (DHER).	11/ 11	Signed off DHER Reports	Reporting not required	11	10[12]	11 *Target: 11*	11	11	11
1.5) To implement an integrated Health Information Turn-Around Strategy to improve data quality and ensure annual unqualified audit opinion on performance information from the AGSA from 2010/11 – 2014/15.	1.5.1) Annual unqualified audit opinion on performance information.	Unqualified audit opinion	Auditor-General's Report	Reporting not required	Reporting not required	Reporting not required [13]	Audit not yet conducted for 2011/12	Unqualified audit opinion	Unqualified audit opinion	Unqualified audit opinion
	1.5.2) Annual Report tabled.	Tabled as per Regulations	Legislative schedule	Annual Report tabled	Annual Report tabled	Annual Report tabled	2011/12 Annual Report not yet due	Annual Report tabled	Annual Report tabled	Annual Report tabled
	1.5.3) Number of progress reports on implementation of the 10-Point Plan.[14]	Four progress reports	4 Reports	Reporting not required	Reporting not required	4 Reports	3 Reports [quarterly submission]	4 Reports	4 Reports	4 Reports
	1.5.4) Number of functional Telemedicine sites	Approved IT Strategic Plan	IT Records	Reporting not required	Reporting not required	Reporting not required	34	37	39	43
1.6) To expand the Registrar training programme to increase the pool of Specialists by retaining 75% of qualified Registrars	1.6.1) Number of Registrars in training.	720	Persal	Reporting not required	272 [2 intakes]	567 [40 complete training]	632 *Target: 620*	650	700	720
	2.6.2) Number of Medical Registrars graduating	80	Persal	34*	87	40	Not yet available *Target: 65*	70	80	90

[12] eThekwini DHER Report was finalised – not signed off by the District Manager
[13] Performance Information not formally audited in 2010/11 – no formal opinion expressed by AGSA
[14] The indicator has been changed from 4 quarterly reports to include the mid-term (6/12) and annual reports

ANNUAL PERFORMANCE PLAN 2012/13 – 2014/15

PROGRAMME 1: ADMINISTRATION

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
by 2014/15.	1.6.3) Number of Registrars retained after qualifying.	75% of total graduates by 2014/15	Persal	Reporting not required	69/87 (79.3%)	134/200 [67%]	Results not yet available *Target: 310/620*	70% of total graduates	75% of total graduates	75% of total graduates
1.7) Improve governance structures and social compact for health.	1.7.1) Provincial Consultative Health Forum convened annually.	Established and convened annually	Minutes of meetings	Reporting not required	Reporting not required	Established and convened	Convened in September 2011	Convened annually	Convened annually	Convened annually
	1.7.2) Number of Provincial Health Council meetings	Established and convened annually	Minutes of meetings	Reporting not required	Reporting not required	Nil	Established 12 August 2011	Bi-annual meetings	Bi-annual meetings	Bi-annual meetings
	1.7.3) Number of District Health Councils established	11	Departmental Records	Reporting not required	Reporting not required	Nil	Nil *Target: 3*	6	[3] 9	[2] 11
	1.7.4) Number of District Health Councils Meetings convened annually.	11	Minutes of meetings	Reporting not required	Reporting not required	Nil	Nil *Target: 3*	6	9	11

6. QUARTERLY AND ANNUAL TARGETS – 2012/13

Table 22: (ADMIN3): Quarterly and Annual Targets for 2012/13

Performance Indicators	Targets 2012/13	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly Indicators					
1. Number of progress reports on implementation of the 10-Point Plan	4	1	1	1	1
2. Vacancy rate for Professional Nurses	18%	28%	24%	21%	18%
3. Vacancy rate for Medical Officers	31%	45%	40%	35%	31%
4. Vacancy rate for Medical Specialists	54%	55%	55%	54%	54%
5. Vacancy rate for Pharmacists	30%	33%	32%	31%	30%
Bi-Annual Indicators					
6. Number of Provincial Health Council meetings[15]	2 Meetings	-	1 Meeting	-	1 Meeting
Annual Indicators					
7. Number of Medical Officers per 100,000 people	26				26
8. Number of Medical Officers per 100,000 people in rural districts	15				15
9. Number of Professional Nurses per 100,000 people	139				139
10. Number of Professional Nurses per 100,000 people in rural districts	100				100
11. Number of Pharmacists per 100,000 people	5.5				5.5
12. Number of Pharmacists per 100,000 people in rural districts	2.7				2.7
13. Tabled Annual Performance Plan	2012/13 APP Tabled	Approved APP tabled			
14. Number of approved District Health Plans	11	11			
15. Published STP	Published				Published
16. Number of District Managers who have signed Performance Agreements	11	11			
17. Number of Hospital Managers/ CEO's who have signed Performance Agreements	71	71			
18. Percentage of Head Office Managers (Level 13 and above) who have signed Performance Agreements	100%	100%			
19. Number of Registrars in training	650				650
20. Number of Medical Registrars graduating	70				70
21. Number of Registrars retained after qualifying	70% of graduates				70% of graduates
22. Annual unqualified audit opinion for financial statements	Unqualified audit opinion		Unqualified audit opinion		
23. Number of District Health Expenditure Reviews (DHER) completed	11	11			
24. Annual unqualified audit opinion on performance information	Unqualified audit opinion		Unqualified audit opinion		
25. Number of functional Telemedicine sites	37				37

[15] The Provincial Health Council has been established in 2011 – bi-annual meetings will be monitored to ensure ongoing consultation

ANNUAL PERFORMANCE PLAN 2012/13 – 2014/15

PROGRAMME 1: ADMINISTRATION

Performance Indicators	Targets 2012/13	Quarterly Targets			
		Q1	Q2	Q3	Q4
26. Tabled Annual Report	2011/12 Annual Report tabled		Annual Report tabled		
27. Number of Provincial Consultative Health Forum meetings convened annually	1				1
28. Number of District Health Councils established	6				6
29. Number of District Health Councils meetings convened annually	6				6

- Quarterly, by-annual and annual APP targets specified as per national framework requirement.
- All indicators, with targets, included in the Monitoring & Evaluation Framework to ensure quarterly reporting on all APP targets. Reports submitted to the Monitoring & Evaluation Component for dissemination.
- Additional secondary indicators, not included in the APP, are included in Operational Plans to ensure in-depth analysis and reporting on core priorities.
- Vacancy rates: Restructuring and review of post establishments affects vacancy rates. Targets are based on current Persal data and will be reviewed and monitored pending final outcome of organisational and post establishment review.

PROGRAMME 1: ADMINISTRATION

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

Table 23: (ADMIN4 (a): Expenditure estimates: Administration

Sub-Programme R' thousand	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
MEC's Office	13 782	12 441	14 452	16 491	17 508	16 842	20 318	20 159	21 284
Management	270 284	1 036 437	341 573	327 680	360 694	360 684	377 352	397 901	419 293
Sub-Total	**284 066**	**1 048 878**	**356 025**	**344 171**	**378 202**	**377 526**	**397 670**	**418 060**	**440 577**
Unauthorised expenditure (1st charge) not available for spending	-	**(758 000)**	-	-	-	-	-	-	-
Total	**284 066**	**290 878**	**356 025**	**344 171**	**378 202**	**377 526**	**397 670**	**418 060**	**440 577**

Source: BAS

Table 24: (ADMIN4 (b): Summary of Provincial Expenditure Estimates by Economic Classification

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Current payments	**279 411**	**285 925**	**347 872**	**336 961**	**349 739**	**343 209**	**379 513**	**411 997**	**436 173**
Compensation of Employees	163 648	168 705	183 201	202 290	210 886	207 433	238 456	256 459	275 324
Goods and services	**115 763**	**117 220**	**164 671**	**134 671**	**138 853**	**135 756**	**141 057**	**155 538**	**160 849**
Communication	6 546	6 095	5 118	7 460	5 158	5 646	4 687	4 845	5 018
Computer Services	17 812	24 532	17 317	22 821	18 229	23 457	27 371	32 267	33 372
Consultants, Contractors and special services	8 110	10 588	13 789	11 172	14 928	16 908	18 210	19 231	19 884
Inventory	5 899	5 795	5 581	7 218	7267	8 815	8 713	9 409	9 736
Operating leases	14 722	10 670	14 934	13 619	11 703	5 846	5 807	6 137	6 345
Travel and subsistence	15 378	9 521	13 038	14 311	16 393	16 194	16 115	17 023	17 598
Interest and rent on land	-	-	-	-	-	20	-	-	-
Maintenance , repair and running costs	Included under Contractors and inventory to prevent double counting								
Financial transactions in assets and liabilities	-	758 000	380	-	41	41	-	-	-

PROGRAMME 1: ADMINISTRATION

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	47 296	50 019	94 894	58 070	65 175	58 890	60 154	66 626	68 896
Transfers and subsidies to	**2 165**	**2 311**	**1 750**	**2 510**	**1 538**	**2 880**	**3 157**	**3 463**	**3 800**
Provinces and municipalities	4	38	33	-	38	38	57	53	49
Universities and technikons	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	2 161	2273	1 717	2 510	1500	2 842	3 100	3 410	3 751
Payments for capital assets	**2 490**	**2 642**	**6 023**	**4 700**	**26 884**	**31 396**	**15 000**	**2 600**	**604**
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Machinery and equipment	2 490	2642	6 023	4 700	26 884	31 396	**15 000**	**2 600**	**604**
Software and other intangible assets	-	-	-	-	-	-	-	-	-
Payment for financial assets	**-**	**758 000**	**380**	**-**	**41**	**41**	**-**	**-**	**-**
Total economic classification	**284 066**	**1 048 878**	**356 025**	**344 171**	**378 202**	**377 526**	**397 670**	**418 060**	**440 577**
Unauthorised expenditure (1st charge) not available for spending	**-**	**(758 000)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total	**284 066**	**290 878**	**356 025**	**344 171**	**378 202**	**377 526**	**397 670**	**418 060**	**440 577**

Source: BAS

8. PERFORMANCE AND EXPENDITURE TRENDS

It is the Department's policy to keep the allocation of Programme 1 to a maximum of 2% of the total budget, which has been achieved over the past four years and will be maintained over the 2012/13 MTEF.

The 2012/13 MTEF allocations includes the carry-through costs of previous wage agreements and OSD for medical personnel, as well as additional funding provided in the form of the National Health Insurance [NHI] Grant to accommodate phased in implementation of NHI.

The significant increase in *Compensation of Employees* over the 2012/13 MTEF is to improve management capacity at Head Office.

In the 2012/13 MTEF, an allocation has been provided for replacement of essential equipment at a reduced rate, in line with available funding.

9. RISK MANAGEMENT

Potential Risks	Mitigating Factors
1. Limited budget versus service delivery demands and unplanned/ unfunded mandates [High].	▪ Alignment of budget with service delivery demands – improved alignment between DHPs and budget allocation [performance measures]. ▪ Improved expenditure reviews at service delivery level.
2. Inadequate management competencies and accountability [High].	▪ Management development programmes.
3. High attrition/ vacancy rates, absenteeism, and high number of staff on extended incapacity leave. Delays in filling of critical posts due to bottlenecks in system [High].	▪ Align HR Plans with identified priorities [provincial and district].
4. Poor data integrity and information management [High].	▪ Implement Information Management Turn-Around Strategy. ▪ Implement IT Strategy.

PROGRAMME 2: DISTRICT HEALTH SERVICES

1. PROGRAMME PURPOSE AND STRUCTURE

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].

Sub-Programme 2.1: District Management

To provide service planning, administration [including financial administration], managing personnel, coordination and monitoring of district health services, including those rendered by district councils and non-government organisations [NGOs].

Sub-Programme 2.2: Community Health Clinics

To render a nurse driven PHC service at clinic level including visiting points, mobiles and Local Government clinics.

Sub-Programme 2.3: Community Health Centres

To render PHC services including maternal child and women's health, geriatrics, occupational therapy, physiotherapy, psychiatry, speech therapy, communicable diseases, oral and dental health, mental health, rehabilitation and disability and chronic health.

Sub-Programme 2.4: Community-Based Services

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

Sub-Programme 2.5: Other Community Services

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

Sub-Programme 2.6: HIV and AIDS

To render PHC services related to the comprehensive management of HIV and AIDS and other special projects.

Sub-Programme 2.7: Nutrition

To render nutrition services.

Sub-Programme 2.8: Forensic Pathology Services

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

Sub-Programme 2.9: District Hospitals

To render hospital services at General Practitioner level.

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

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

2. PRIMARY HEALTH CARE

Between 2010/11 and 2011/12, PHC facilities [clinics and CHC's] increased from 592 to 612 and mobile clinics from 147 to 168.

In 2010/11, the average PHC clinical workload for Professional Nurses was 32 [ranging between 15 and 52], and the PHC clinical workload for Doctors was 27 [ranging between 11 and 38]. This clearly indicates inequities in allocation and placement of human resources versus service demands.

A) Re-engineering of PHC

Re-engineering of PHC [fourth pillar of the NSDA] takes centre stage as integrated ward-based strategy to improve equity and access to PHC. The KZN Model has strong links with the Provincial Operation Sukuma Sakhe strategy ["Let us stand up and build"] that has as philosophical basis a whole Government approach to community participation and development. *A task team was established in 2011/12 to finalise the Provincial PHC re-engineering model. Implementation will be evaluated by the Epidemiology and Health Research & Knowledge Management Component to inform evidence-based practice.*

B) PHC Outreach [Family Health] Teams

Twelve [12] teams were established and linked with clinics in 2011/12 as part of a pilot project in Umgungundlovu, Zululand and eThekwini. Financial provision has been made for expansion of PHC teams i.e. R66 905mil in 2012/13 and R98 454mil in 2013/14. The Department aims to establish a further 65 teams in 2012/13 with the ultimate aim to have 100% coverage of all 828 wards.

Existing Community Care Givers [CCGs], currently 9,225 on Persal, will be integrated into teams to eliminate duplication of services, improve integration and ensure optimal utilisation of resources. Each team will serve ±1,000 to 1,500 households [±6,000 people compared with the national norm of 7,660] to make provision for the unique topography and geographic distribution of households and facilities in the Province. The current norms will be reviewed annually.

C) School Health Services

There are currently 86 School Health Teams in the Province, with school health service coverage of 47.4%. The Province aims to establish 130 teams in 2012/13 that will be linked with clinics with oversight from the Operations Manager. Teams will serve schools in clinic catchment areas and will be targeting quintile 1 and 2 schools during initial phases of implementation.

D) District Specialist Teams

Recruitment, appointment and selection of teams have been taken over by a national task team. The expanded Cuban training programme [434 students in 2012/13] initiated by the MEC for Health in 2011/12 to strengthen PHC re-engineering, will be incorporated into the system to strengthen output especially in light of scarcity of specialists. Family Physicians [currently based at District Hospitals] will play a critical role in supporting mentoring programmes at PHC level.

E) Integration of Programmes as part of re-engineering of PHC

Programmes are still implemented in silos at both strategic and operational level and prevention and promotion programmes are fragmented with inadequate monitoring systems to determine consequent output and outcome. The PHC re-engineering model aims to strengthen integrated screening, detection, referral, follow-up and support at community level through integrated community-based programmes and reviewed service arrangements at district/ sub-district levels.

Integrated prevention and promotion strategies have been prioritised for 2012/13 to balance the scale between investment for non-communicable conditions and strategic health programmes. Integration of community-based data/information into DHIS commenced as a pilot project in 2011/12, and will be assessed for rollout in 2012/13.

The *Oral and Dental Health Strategy* [Oral Health 10 Point Plan 2011-2015] commenced in 2011/12. Currently, 52 of 60 dental facilities are based at PHC level. The shortage of Oral Hygienists [25/40 Oral Hygienists posts filled] negatively affects oral health prevention, promotion, screening, and school-based programmes linked with School Health Services. Budget has been secured for the filling of posts for 15 Oral Hygienists, 10 Dental Therapists, 40 Dental Assistants, 4 Dental Technician and 10 Dentists to scale up oral health services at PHC level in 2012/13.

PHC CHALLENGES

- Poor integration of services at all levels.
- Lack of change management programmes to navigate smooth transition from current facility-based to community-based PHC.
- Inadequate infrastructure i.e. space constraints impacting on pharmaceutical storage, access for people with disabilities, and implementation of full PHC package of services.
- Inadequate specialised rehabilitation centres in especially rural areas.
- Poor supportive supervision, clinical governance, and mentoring programmes.
- Human resource challenges including demand superseding supply, inequity in placement of staff, inadequate skills and competencies, shortage of critical skills e.g. Ophthalmologists, Therapists, etc.
- Inadequate, old and/or absolute machinery and equipment and delays in repair and procurement.
- Considerable gaps in training and development including effective mentoring programmes and succession training; development of Operations Managers as first level managers [extended role in new PHC Model].
- Inequities in human resource allocation and distribution as can be seen in variations in clinical workload.
- Inadequate response to mental health challenges mainly due to resource constraints. *The Provincial Mental Health Summit [March 2012] started the process of revitalisation of mental health services.*

PROGRAMME 2: DISTRICT HEALTH SERVICES

2012/13 PRIORITIES: PHC

1. *Re-engineering of PHC*	▪ Finalise, implement and evaluate the Provincial PHC Model. ▪ Establish and integrate PHC Outreach [Family Health] Teams, School Health Teams and District Specialist Teams – spatially mapped and linked to clinics and allocated wards. ▪ Review of PHC post establishments and expediting the filling of critical posts – align strategy with the Human Resources Plan. ▪ Fast track infrastructure including upgrading and expansion of existing clinics/CHCs and building of new facilities. Improved access for people with disabilities [as per Infrastructure Plan]. ▪ Strengthen community participation and governance including Operation Sukuma Sakhe and the establishment of District Health Councils and Clinic Committees. ▪ Integration of all health programmes with reviewed service arrangements. ▪ Provincialisation of Local Government services.
2. *Improved Quality and Clinical Governance*	▪ Implement and actively monitor the 6 priorities of the National Core Standards in all clinics/CHCs. ▪ Development and monitoring of Service Delivery Improvement Plans. ▪ Improve clinical governance including supportive supervision.

Table 25: (DHS1): District Health Service Facilities by Health Districts in 2010/11

Health District	Facility Types	Number		Total Population	Catchment Pop/ Approved Beds	PHC Headcount	District Hospital PDE	PHC Utilisation Rate
		Provincial	LG					
Ugu	**Non-fixed [mobiles]**	**10**	**0**		-	-	-	
2 Village Posts	PHC Clinics	46	10		-	-	-	
	CHCs	1 [Phase 1]	0	724,188	-	-	-	2.6
	Total Fixed Clinics	***57** [Provincial 47 and LG 10]*			12,705	1,948,253	-	
	District Hospitals	**3**			861 or 1.2/1000	-	310,120	
Umgungundlovu	**Non-fixed [mobiles]**	**16**	**1**		-	-	-	
1 Specialised Health Centre	PHC Clinics	41	23		-	-	-	
	CHCs	3[16]	0	1,008,713	-	-	-	2.5
	Total Fixed Clinics	***67** [Provincial 44 and LG 23]*			15,005	2,706,226	-	
	District Hospitals	2			523 or 0.54/1000	-	249,523	
Uthukela	**Non-fixed [mobiles]**	**14**	**0**		-	-	-	
	PHC Clinics	28	8		-	-	-	
	CHCs	0	0	729,279	-	-	-	1.9
	Total Fixed Clinics	***36** [Provincial 28 and LG 8]*			20,257	1,347,493	-	
	District Hospitals	2			467 or 0.64/1000	-	128,195	
Umzinyathi	**Non-fixed [mobiles]**	**11**	**0**		-	-	-	
	PHC Clinics	40	6		-	-	-	
	CHCs	0	0	505,700	-	-	-	2.5
	Total Fixed Clinics	***46** [Provincial 40 and LG 6]*			10,993	1,291,304	-	
	District Hospitals	4			1,247 or 2.47/1000	-	367,195	
Amajuba	**Non-fixed [mobiles]**	**7**	**0**		-	-	-	
	PHC Clinics	23	2		-	-	-	
	CHCs	0	0	451,156	-	-	-	2.1
	Total Fixed Clinics	***25** [Provincial 23 and LG 2]*			18,046	1,067,514	-	
	District Hospitals	1			52 or 0.12/1000	-	27,400	

[16] Embo CHC now functioning as a PHC clinic – CHC's therefore reduced to 16 in 2010/11

Health District	Facility Types	Number		Total Population	Catchment Pop/ Approved Beds	PHC Headcount	District Hospital PDE	PHC Utilisation Rate
		Provincial	LG					
Zululand	**Non-fixed [mobiles]**	**16**	**0**		-	-	-	
1 Village Post	PHC Clinics	62	1		-	-	-	
	CHCs	1	0	921,037	-	-	-	2.1
	Total Fixed Clinics	***64** [Provincial 63 and LG 1]*			14,391	1,810,031	-	
	District Hospitals	5			1,516 or 1.65/1000	-	384,379	
Umkhanyakude	**Non-fixed [mobiles]**	**14**	**0**		-	-	-	
	PHC Clinics	54	0		-	-	-	
	CHCs	0	0	626,387	-	-	-	3
	Total Fixed Clinics	***54** Provincial*			11,599	1,991,474	-	
	District Hospitals	5			1,174 or 1.87/1000	-	378,989	
Uthungulu	**Non-fixed [mobiles]**	**13**	**0**		-	-	-	
4 Village Posts	PHC Clinics	53	5		-	-	-	
	CHCs	1	0	912,235	-	-	-	2.4
	Total Fixed Clinics	***59** [Provincial 54 and LG 5]*			15,461	2,381,819	-	
	District Hospitals	6			1,443 or 1.58/1000	-	398,209	
Ilembe	**Non-fixed [mobiles]**	**10**	**0**		-	-	-	
7 Village Posts	PHC Clinics	24	8		-	-	-	
	CHCs	2	0	538,815	-	-	-	2.8
	Total Fixed Clinics	***34** [Provincial 26 and LG 8]*			15,847	1,745,844	-	
	District Hospitals	3			458 or 0.85/1000	-	148,642	
Sisonke	**Non-fixed [mobiles]**	**12**	**0**		-	-	-	
3 Village Posts	PHC Clinics	36	0		-	-	-	2.1
	CHCs	1	0	510,134	-	-	-	
	Total Fixed Clinics	***37** Provincial*			13,787	1,080,533	-	
	District Hospitals	4			827 or 1.62/1000	-	244,762	
eThekwini	**Non-fixed [mobiles]**	**11**	**12**		-	-	-	2.6
37 Village Posts [LG 35, P 2]	PHC Clinics	46	59		-	-	-	
3 Specialised Health Centres	CHCs	7	1	3,630,002	-	-	-	
	Total Fixed Clinics	***113** [Provincial 53 and LG 60]*			32,123	9,124,132	-	

PROGRAMME 2: DISTRICT HEALTH SERVICES

Health District	Facility Types	Number		Total Population	Catchment Pop/ Approved Beds	PHC Headcount	District Hospital PDE	PHC Utilisation Rate
		Provincial	LG					
	District Hospitals	4[17]			545 or 0.15/1000	-	365,101	
Province 54 Village Posts 4 Specialised Health Centres	**Non-fixed [mobiles]**	**134**	**13**	**10,467,466**	-	**-**	**-**	**2.5**
	PHC Clinics	453	122		-	-	-	
	CHCs	16	1		-	-	-	
	Total Fixed Clinics	***592 [Provincial 469 and LG 123]***			**17,681**	**26,494,623**	-	
	District Hospitals	**39[18]**			**8,933 or 0.85/1000**	-	**3,002,516**	

- Source: 2010/11 DHER Reports; Stats SA population projections; DHIS

[17] Two State Aided Hospitals included
[18] Two State Aided Hospitals in eThekwini included

PROGRAMME 2: DISTRICT HEALTH SERVICES

SITUATION ANALYSIS INDICATORS FOR DISTRICT HEALTH SERVICES – 2010/11 [TREASURY REPORTING]

Table 26: (DHS2): Situation Analysis Indicators for District Health Services – 2010/11

Indicator	Data Source	Provincial 2010/11	Ugu 2010/11	Umgungundlovu 2010/11	Uthukela 2010/11	Umzinyathi 2010/11	Amajuba 2010/11	Zululand 2010/11	Umkhanyakude 2010/11	Uthungulu 2010/11	Ilembe 2010/11	Sisonke 2010/11	eThekwini 2010/11
Provincial PHC expenditure per uninsured person	BAS/ Stats SA	R 222	R 296	R 352	R 252	R 322	R 270	R 485	R 299	R 264	R 301	R 322	R 218
*PHC total headcount	DHIS	26,494,623	1,948,253	2,706,226	1,347,493	1,291,304	1,067,514	1,810,031	1,991,474	2,381,819	1,745,844	1,080,533	9,124,132
*PHC total headcount under 5 years	DHIS	5,065,881	343,177	444,414	283,665	325,182	224,543	368,873	401,677	568,942	312,615	224,348	1,568,445
* Utilisation rate – PHC	DHIS	2.5	2.6	2.6	1.9	2.5	2.1	2.1	3.0	2.5	2.8	2.1	2.7
* Utilisation rate under 5 years - PHC	DHIS	4.5	4.1	3.9	3.6	4.9	4.2	3.5	4.5	5.2	4.6	3.4	5.2
Fixed PHC facilities monthly supervisory visit rate	DHIS	63.3%	63.2%	38.6%	28.9%	71.3%	68.8%	50.1%	85.4%	71.1%	52.1%	83.8%	71.6%
Expenditure per PHC headcount	BAS/ DHIS	R 101	R 103	R 103	R 114	R 103	R 115	R 139	R 84	R 94	R 104	R 130	R 91
CHC's/CDC's with resident doctor rate	DHIS	94% [15/16]	N/A	100%	N/A	N/A	N/A	100%	N/A	100%	100%	0% 0/1	100%
Number of PHC facilities assessed for compliance against the 6 priorities of the core standards	Quality Control database DQPR	Reporting not required	Reporting not required	Reporting not required	Reporting not required	Reporting not required	Reporting not required	Reporting not required	Reporting not required	Reporting not required	Reporting not required	Reporting not required	Reporting not required

- [*] Denotes data that has been corrected and verified on DHIS since tabling of the 2010/11 Annual Report.
- The low supervision rate for Umgungundlovu [38.6%] and Uthukela [28.9%] was investigated and determined to be due to data quality issues. This has been corrected for 2011/12 reporting.
- CHC resident doctor rate: Sisonke District advertised the post at Pholela CHC without success – the post has been re-advertised in 2011/12.
- Reporting for indicator 9 is only required from 2011/12 onwards as per National requirement.

PERFORMANCE INDICATORS FOR DISTRICT HEALTH SERVICES [TREASURY REPORTING]

Abbreviations for raw data in all the tables: **N** = Numerator; **D** = Denominator

Table 27: (DHS4): Performance Indicators for District Health Services

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
Provincial PHC expenditure per uninsured person	BAS/ StatsSA	R	R 232.29	R 260.26	R 222	R 324 N: R2 882 668 164 D: 8,895,443 *Target: R 303*	R 335	R 348	R 359	-
PHC total headcount[19]	DHIS	No	23,838,854	*25,921,993	26,494,623	28,679,924 *Target: 25,901,744*	30,113,920	31,619,616	33,200,597	-
PHC total headcount under 5 years	DHIS	No	4,705,692	*5,184,242	5,065,881	5,088,392 *Target: 5,670,572*	5,266,486	5,450,813	5,641,591	-
Utilisation rate - PHC	DHIS	No	2.5	*2.6	2.5	2.7 N: 28,679,924 D: 10,622,204 *Target: 2.8*	2.8	2.9	3	3.5
Utilisation rate under 5 years - PHC	DHIS	No	4.4	*4.6	4.5	4.5 N: 5,088,392 D: 1,118,590 *Target: 4.7*	4.7	4.8	4.9	5.5
Fixed PHC facilities monthly supervisory visit rate	DHIS	%	65%	*68%	63.3%	72.1% N: 427 D: 592 *Target: 80%*	74%	76%	80%	100%
Expenditure per PHC headcount	BAS/ DHIS	R	R 89	R 95	R 101	R 101 N: R2 882 668 164 D: 28,679,924 *Target: R 110*	R 115	R 120	R 127	R 180
CHC's/CDC's with a resident doctor rate [Annual]	DHIS	%	Reporting not required	100%	94% N: 15 D: 16	94.7% N: 18 D:19 *Target: 100%*	100%	100%	100%	100%
Percentage of PHC facilities	DQPR	%	Reporting not	Reporting not	Reporting not	73.9%	100%	100%	100%	100%

[19] Indicator number 2 and 3 kept in the APP although not included in Treasury indicators [treasury submission include raw data which include the headcounts]

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
assessed for compliance against the 6 priorities of the core standards [Annual]			required	required	required	N: 438 D: 592 *Target: 100%*				

- [*] Denotes data that has been corrected and verified on DHIS since tabling of the 2010/11 Annual Report.
- Targets for headcounts in 2011/12 were based on incorrect data [hence under-estimation] – data has since been corrected.
- The "estimated performance" is based on confirmed 2011/12 mid-year and projected quarter 3 and 4 data.
- Target for supervision rate is based on the 3 year trend [2008/09 – 2010/11] and availability of resources to improve performance. District variance of 28.9% and 85.4% is a concern which will be addressed through organisational arrangements as part of the re-engineering of PHC. Erroneous calculation of the indicator has been addressed since the 2010/11 reporting period.
- Indicator 9 has been added by the National Department of Health/Treasury for 2012/13. The 100% target for assessment against the core standards is based on the principle that all facilities must be assessed regularly to inform the development and monitoring of Quality Improvement Plans and monitoring of compliance to the 6 priorities of the Core Standards. This does not refer to national assessment/ licensing.
- CHCs: Three new CHCs [eThekwini, Ugu and Uthukela] opened in the 4th quarter of 2011/12.

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

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 28: (DHS3 (a)): Provincial Strategic Objectives, Performance Indicators and Annual Targets for District Health Services

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Sources	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
1.9) Strengthen governance structures in line with the National Health Act, 2003 and social compact for health.	1.9.1) Percentage of Clinics with functional Clinic Committees	50%[20]	DQPR	81%	82% N: 437 D: 533	56.9% N: 337 D: 592	73.8% N: 437 D: 592 *Target: 20%*[21]	100%	100%	100%
	1.9.2) Percentage of CHCs with functional Clinic Committees	100%	DQPR	81%	81% N: 14 D: 17	43.7% N: 7 D: 16	94.7% N: 18 D: 19 *Target: 62%*	100%	100%	100%
1.10) Revitalisation of PHC services as per STP imperatives and Implementation Plan[22]	1.10.1) Number of accredited Health Promoting Schools	230 cum [2013/14]	DQPR	131 cumulative	39 [170 cum]	18 [188 cum]	24 [212 cum] *Target: 190 cum*	16 [228 cum]	12 [240 cum]	15 [255 cum]
	1.10.2) School Health Services coverage	70% [2013/14]	DQPR	46%	74%	48% N: 2,105 D: 4,411	50.3% N: 2,135 D: 4,244 *Target: 75%*	60%	70%	76%
	1.10.3) Number of operational PHC Outreach Teams	New indicator	DQPR	N/A	N/A	N/A	12 *Baseline: 12*	65	130	130
	1.10.4) Number of operational School Health Teams	New indicator	DQPR	N/A	N/A	N/A	86 *Baseline: 86*	103	113	130

[20] The Strategic Plan targets [for both clinics and CHCs] have been reviewed to make provision for intensified strategies to improve community participation and consultation
[21] The target for 2011/12 has been considering the NHA requirements. The target has been reviewed to include the existing 'interim' committees that is the requirement
[22] All included indicators will serve to demonstrate the impact of revitalisation [and overhaul of health systems/services] on equity, availability, efficiency and quality of services. Improvement of routine PHC services e.g. immunisation coverage, management of chronic conditions, etc. will be monitored to determine the outcome of revitalisation. Timeframes will be determined by the PHC strategy and STP Implementation Plan

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Sources	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
	1.10.5) Number of operational District Specialist Teams	New indicator	DQPR	N/A	N/A	N/A	Nil *Baseline*	3	6	11
	1.10.6) Dental extractions to restorations rate	New indicator	DHIS	14:1	20:1	27:1	20:1 *Baseline*	19:1	15.4	12.3

- The 2011/12 targets for Indicator numbers 1.9.1 and 1.9.2 has been set to reflect appointment of Clinic Committees by the MEC for Health. The new target has been reviewed to incorporate functional interim committees.
- Indicators 1.10.3 to 1.10.5 have been added since tabling of the Strategic Plan and the 2011/12 APP to make provision for implementation of the re-engineering of PHC Model.
- Indicator 1.10.6 has been added to monitor implementation of the Dental and Oral Health Strategy, with supporting indicators included in the Provincial/ Programme Operational Plans.
- The National Indicator Data Set [NIDS] does not currently make provision for monitoring ward-based indicators which will be added in due course once included in NIDS and PIDS [Provincial Data Indicator Set]. Consultation commenced with the Data Management Directorate for the inclusion of additional indicators to monitor re-engineering of PHC. In addition, the Epidemiology and Research Component will evaluate implementation of PHC re-engineering and results will be used to inform rollout.
- The "estimated performance" is based on confirmed mid-year data and projected quarter 3 and 4 data.
- The School Health coverage [Indicator 1.10.2] for 2009/10 has been identified as an outlier – data quality issues were identified and corrected since 2009/10 reporting.

GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

Table 29: (DHS3 (b)): Provincial Strategic Objectives and Annual Targets for District Health Services

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
2.1) To implement the National Core Standards for Quality in 100% of facilities towards accreditation of 50% PHC clinics and 100% CHC's by 2014/15	2.1.1) Percentage of clinics fully compliant with the 6 priorities of the National Core Standards	50%	DQPR	Reporting not required	Reporting not required	Nil	Nil *Target: 5%*	2%	5%	50%
	2.1.2) Percentage of CHCs fully compliant with the 6 priorities of the National Core Standards	100%	DQPR	Reporting not required	Reporting not required	Nil	Nil *Target: 19%*	31%	44%	100%
	2.1.3) Percentage of CHCs conducting annual Patient Satisfaction Survey's [Annual]	100%	DQPR	Reporting not required	70.5% N: 12 D: 17	62.5% N: 10 D: 16	89.4% N: 17 D: 19 *Target: 100%*	100%	100%	100%

- Indicators 2.1.1 and 2.1.2 have been rephrased [previously read "Number of clinics/CHCs accredited"] in order to comply with Performance Indicator 9 [Table 29] - definition stays unchanged.
- National assessment for accreditation/licensing is dependent on national processes for establishment of the National Office of Standard Compliance. Internal processes however provide for regular assessment of performance against the 6 priority areas of the Core Standards with supporting Quality Improvement Plans. Relevant secondary indicators [included as part of monitoring tools] will be monitored as part of Operational and Quality Improvement Plans.
- The "estimated performance" is based on confirmed 2011/12 mid-year and projected quarter 3 and 4 data.
- Average patient waiting times, included in the 2011/12 APP have been moved to the Operational Plan as it is included in tools for monitoring of the Core Standards - avoid duplication.

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

Table 30: (DHS3 (c)): Provincial Strategic Objectives and Annual Targets for District Health Services

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
3.3) To prevent and manage non-communicable diseases with a focus on hypertension and diabetes	3.3.1) Diabetes mellitus case put on treatment - new	New indicator	DHIS	Reporting not required	32,345	31,673	22,540 *Baseline*	26,823	31,919	37,983
	3.3.2) Hypertension case put on treatment - new	New indicator	DHIS	Reporting not required	74,671	70,973	76,388 *Baseline*	79,444	82,621	85,926

- "Hypertension and diabetes mellitus case put on treatment – new" have been added to the APP since tabling of the Strategic Plan and the 2011/12 APP. Additional supporting indicators will be added in the Operational Plan to monitor the impact of improved detection, screening and management. Historic DHIS data have been used to populate table for previous years.
- Targets for diabetes mellitus and hypertension: Used the standard deviation [3 years historic data] and co-efficient of variation [distribution of standard deviation and average performance] to set targets for the MTEF.
- Improved detection and new cases put on treatment will be monitored in relation with number of patients visiting health facilities for hypertension and diabetes mellitus to in turn determine treatment compliance. Additional secondary indicators will be included in the Operational Plan.

QUARTERLY AND ANNUAL TARGETS FOR PHC – 2012/13

Table 31: (DHS5): Quarterly and Annual Targets for District Health Services 2012/13

Performance Indicators	Annual Targets 2012/13	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
Provincial PHC expenditure per uninsured person	R 335	R 325	R 329	R 331	R 335
PHC total headcount	30,113,920	7,528,480	7,528,480	7,528,480	7,528,480
PHC total headcount under 5 years	5,266,486	1,316,621	1,316,621	1,316,621	1,316,623
Utilisation rate - PHC	2.8	2.7	2.7	2.8	2.8
Utilisation rate under 5 years - PHC	4.7	4.5	4.6	4.6	4.7
Fixed PHC facilities monthly supervisory visit rate	74%	73%	73%	74%	74%
Expenditure per PHC headcount	R 115	R 105	R 110	R 112	R 115
Dental extractions to restorations rate	19:1	20:1	20:1	19:1	19:1
Hypertension case put on treatment - new	79,444	19,861	19,861	19,861	19,861
Diabetes mellitus case put on treatment - new	26,823	6,705	6,705	6,705	6,708
Annual Targets					
CHC's/CDC's with a resident doctor rate	100%				100%
Percentage of PHC facilities assessed for compliance against the 6 priorities of the Core Standards	100%				100%
Number of accredited Health Promoting Schools	16 [228 cum]				16 [228 cum]
School Health Services coverage	60%				60%
Percentage of clinics fully compliant with the 6 priorities of the National Core Standards	2%				2%
Percentage of CHCs fully compliant with the 6 priorities of the National Core Standards	31%				31%
Percentage of CHCs conducting annual Patient Satisfaction Survey's	100%				100%
Percentage of PHC clinics with functional Clinic Committees	100%				100%
Percentage of CHCs with functional Clinic Committees	100%				100%
Number of operational PHC Outreach Teams	65				65
Number of operational School Health Teams	103				103
Number of operational District Specialist Teams	3				3

- This table includes all the PHC indicators in APP with quarterly or annual targets. These indicators will be monitored through the Provincial Quarterly Performance Report [Treasury and National Health] and District Quarterly Progress Reports submitted by all components and districts to the Monitoring and Evaluation Component.
- Quarterly targets serve as estimated performance fully acknowledging the various factors that may affect performance.
- Quarterly reviews at district level will focus on both performance information and expenditure to improve linkage.
- District Health Plans have been aligned with APP indicators to ensure seamless monitoring of Provincial/District priorities.
- Additional operational indicators [process, input and output] are included in Operational Plans and will also be monitored quarterly.

3. DISTRICT HOSPITALS

There are currently 39 District Hospitals in the Province [37 Public and 2 State Aided]. Due to historical placement of hospitals, 44% [22/50] sub-districts/municipalities do not have a District Hospital. The 37 Public District Hospitals spent 49.9% of the Programme 2 budget in 2010/11 which is a 10% increase from 2009/10 in real terms. [23]

Workload at District Hospital level, expressed as full time equivalent [FTE] versus patient day equivalent [PDE], shows significant variation between districts which clearly demonstrate inequities in resource allocation/placement of staff versus service demands. In 2010/11, the average workload for Doctors was 528 patients [variance between 412 and 804] and 67 for Professional Nurses [variation between 36 and 88].

Vacancy rates for Medical Officers [33.3%] and Professional Nurses [12.7%] will be addressed in 2012/13 as part of the organisational review and review of the service delivery platform for District Hospitals.

Efficiency indicators compare negatively with national targets. The average length of stay [6.1 days in 2010/11] continues to exceed the national target of 3.5 days. Reasons for extended length of stay include the high quadruple burden of disease, poor health seeking behaviour [patients reporting to clinics/hospitals when already very sick], inadequate step-down facilities to decant patients, high turn-over rate of Medical Officers, and inadequate patient transport.

The bed utilisation rate [63.8% in 2010/11] is still below the national target of 75% although there are significant variations between individual hospitals.

Orthotic and Prosthetic services provided at one main and two satellite centres on a daily basis and monthly at 45 outreach clinics based at hospitals, report extended waiting times. The 16 Medical Orthotists and Prosthetists [MOP's] attend to approximately 25,000 patients annually. MOP's assess, measure and fit orthosis and prostheses and have to manufacture most of the items which contribute to long waiting times.

NHI will be phased in over the next 14 years, and the Department appointed a NHI Team to oversee preparatory work. Umgungundlovu, Umzinyathi and Amajuba have been identified as pilot districts for implementation of the pilot for implementation of National Health Insurance.

Classification of hospitals, considered one of the fundamental aspects of transformation, is being reviewed as part of the revitalisation process to address issues of equity, affordability, efficiency and effectiveness in line with the *Draft Regulations published in the Government Gazette (Regulations Gazette No. 9570 Volume 554, 12 August 2011, No 34521 (R655).* [14]

CHALLENGES – DISTRICT HOSPITALS

- Inadequate human resource capacity. High vacancy rates impact on availability of the full package of services, inequities in workload, poor clinical output/ clinical governance, poor PHC outreach and

support, and sub-optimal response to the high burden of disease.

- Poor efficiencies including low bed utilisation rates and extended length of stay in the majority of hospitals.
- Current service arrangements i.e. "combo" hospitals with inadequate systems to monitor expenditure and service delivery per level of care. This affects budget allocation and monitoring of levels of care.
- Inadequate management capacity and development/mentoring programmes.

2012/13 PRIORITIES: DISTRICT HOSPITALS

1. *Revitalisation of District Hospital services.*	▪ Review the service delivery platform and organisational arrangements to improve response to the burden of disease and service demands. ▪ Review referral patterns [including Planned Patient Transport] including PHC, Regional Hospital services and Emergency Medical Services. ▪ Develop Vision Centres with high volume cataract and refraction services to improve eye care services. ▪ Action the Human Resource for Health Strategy to address gaps and increase management capacity. ▪ Fast-track infrastructure development including maintenance, upgrade [seclusion rooms, 10-bedded psychiatric wards, waiting mothers' lodges, and improved access for people living with disabilities].
2. *Improve quality and efficiency of District Hospitals.*	▪ Implement the National Core Standards and monitor compliance to the 6 priority areas through implementation of Quality Improvement Plans. ▪ National Health Insurance pilot project in Umgungundlovu, Umzinyathi and Amajuba. ▪ Institutionalise the Provincial Clinical Governance Policy and improve clinical support through Telemedicine and appointment of District Specialist Teams.

SITUATION ANALYSIS INDICATORS FOR DISTRICT HOSPITALS – 2010/11 [TREASURY REPORTING]

Table 32: (DHS6): Situation Analysis Indicators for District Hospitals

Indicator	Data Source	Provincial 2010/11	Ugu 2010/11	Umgungundlovu 2010/11	Uthukela 2010/11	Umzinyathi 2010/11	Amajuba 2010/11	Zululand 2010/11	Umkhanyakude 2010/11	Uthungulu 2010/11	Ilembe 2010/11	Sisonke 2010/11	eThekwini 2010/11
1. Caesarean section rate	DHIS	27.5%	35.4%	26.4%	26.4%	23.8%	8.3%	26.5%	21.4%	31.4%	24.6%	25.6%	34.6%
2. Total separations	DHIS	331,419	33,047	25,759	19,103	38,594	2,911	47,478	40,773	35,144	12,029	29,966	46,615
3. Total patient day equivalents	DHIS	3,002,516	310,120	249,523	128,195	367,195	27,400	384,379	378,989	398,209	148,642	244,762	365,101
4. Total OPD headcounts	DHIS	2,664,297	257,643	249,825	70,998	319,190	50,594	223,124	344,299	353,948	142,029	184,027	468,620
5. Average length of stay	DHIS	6.1 days	7.4 days	5.7 days	5.4 days	5.9 days	3.6 days	6.4 days	7.0 days	6.8 days	7.7 days	6.1 days	4.3 days
6. Bed utilisation rate	DHIS	63.8%	72.5%	75.9%	61.9%	53.7%	50.5%	64.2%	59.5%	58.0%	72.9%	64.2%	73.7%
7. Expenditure per patient day equivalent	DHIS/BAS	R 1 668	R 942	R 1 738	R 2 151	R 1 099	R 7 920	R 1 351	R 1 145	R 1 587	R 2 126	R 1 125	R 3 201
8. Percentage of complaints of users of District Hospitals resolved within 25 days	DHIS	DQPR	31%	100%	87%	90%	100%	81%	84%	81%	98%	73%	74%
9. Percentage of District Hospitals with monthly mortality and morbidity meetings	DQPR	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Indicator	Data Source	Provincial 2010/11	Ugu 2010/11	Umgungundlovu 2010/11	Uthukela 2010/11	Umzinyathi 2010/11	Amajuba 2010/11	Zululand 2010/11	Umkhanyakude 2010/11	Uthungulu 2010/11	Ilembe 2010/11	Sisonke 2010/11	eThekwini 2010/11
10. District Hospital Patient Satisfaction Rate [Annual]. *Reporting not required for 2010/11 – Monitoring will commenced in 2012/13*													
11. Number of District Hospitals assessed for compliance against the 6 Priorities of the core standards [Annual]. *Not required in 2010/11 – Monitoring commenced in 2012/13*													

- Indicators 10 and 11 have been added by the National Department of Health for 2012/13 reporting. No historical data available.
- See the next table for comments on indicators.

PERFORMANCE INDICATORS FOR DISTRICT HOSPITALS [TREASURY REPORTING]

Table 33: (DHS8): Performance Indicators for District Hospitals

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Caesarean section rate	DHIS	%	22.7%	*26.5%	27.4% N: 23,461 D: 85,728	26.3% N: 23,108 D: 87,816 *Target: 27%*	26%	25%	24%	15%
2. Separations – total	DHIS	No	361, 244	*350,524	331,419	336,844 *Target: 352,307*	346,991	357,400	368,122	-
3. Patient day equivalents – total	DHIS	No	2,804,928	*3,023,443	3,002,516	3,090,160 *Target: 3,160,237*	3,136,512	3,183,560	3,231,313	-
4. OPD headcount – total	DHIS	No	2,775,255	*3,069,671	2,664,297	2,675,208 *Target: 3,198,675*	2,835,720	3,005,864	3,186,216	-
5. Average length of stay	DHIS	Days	5.6 Days	*4.7 Days	6.1 Days	5.8 Days *Target: 5 Days*	5 Days	5 Days	4.8 Days	3.5 Days
6. Bed utilisation rate	DHIS	%	62.6%	*65.4%	63.8%	64% *Target: 70%*	67%	69%	71%	75%

PROGRAMME 2: DISTRICT HEALTH SERVICES

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
7. Expenditure per patient day equivalent	DHIS/ BAS	R	R 1 441	R 1 639	R 1 668	R 1 574 N: R4 864 768 382 D: 3,090,160 *Target: R1 500*	R 1 700	R 1 750	R 1 778	-
8. Percentage of complaints of users of District Hospital services resolved within 25 days	DHIS	%	79%	79%	78%	65.6% N: 377 D: 575 *Target: 100%*	80%	90%	100%	100%
9. Percentage of District Hospitals with monthly mortality and morbidity meetings	DQPR	%	Reporting not required	Reporting not required	93%	100% *Target: 100%*	100%	100%	100%	100%
10. District Hospital Patient Satisfaction Rate [Annual]	DQPR	%	Reporting not required	Reporting not required	Reporting not required	60% *Target: 100%*	80%	90%	100%	100%
11. Number of District Hospitals assessed for compliance against the 6 Priorities of the Core Standards [Annual]	DQPR	No	Reporting not required	Reporting not required	Reporting not required	37[23] *Target: 37*	37	37	37	-

- [*] Denotes data that has been corrected and verified on DHIS since tabling of the 2010/11 Annual Report.
- The "estimated performance" is based on confirmed 2011/12 mid-year and projected quarter 3 and 4 data.
- The caesarean section rate was 27.5% in 2010/11 [variation between 8.3% in Amajuba and 35.4% in Ugu] compared with the national target of 15%. Amajuba, with one 52 bedded District Hospital, provided limited maternity services with most cases being referred to the 2 Regional Hospitals in the district. Antenatal care has been prioritised to improve maternal health outcomes.
- The ambulatory versus in-patient day ratio varies between 1.1 in Uthukela and 6.3 in Amajuba. The high ratio in Amajuba is an indication of poor access to PHC due to sparsely populated area and only 2 clinics in the municipality with poor road access to services. It is expected that improved access to PHC will reduce congestion at hospital level, which will be monitored as part of re-engineering of PHC.
- The average length of stay [6.1 days] exceeds the national target of 3.5 days with variations between 3.6 and 7.7 days. This is mostly attributed to the high burden of disease. Long-term admissions for TB, Psychiatry, etc. are included in the calculation of this indicator in DHIS which inflate values.
- The bed utilisation rate [63.8%] compares negatively with the national target of 75% with variations between 50.5% and 75.9%. Intensified strategies to improve efficiency i.e. implementation of Core Standards and intensified focus on management capacity is targeted for the reporting period.

[23] Refers to the 37 Provincial Hospitals [excluding the 2 State Aided Hospitals in eThekwini]

PROGRAMME 2: DISTRICT HEALTH SERVICES

PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR DISTRICT HOSPITALS

TRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 34: (DHS7 (a)): Provincial Strategic Objectives and Annual Targets for District Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
1.9) Strengthen governance structures and social compact for health.	1.9.1) Percentage of District Hospitals with functional Hospital Boards	100%	DQPR	89%	100% N: 37 D: 37	100% N: 37 D: 37	100% N: 37 D: 37 *Target: 55%*	100%	100%	100%

- The 2011/12 target referred to Hospital Boards appointed by the MEC for Health as per National Health Act, 2003. The estimated performance refers to functional Interim Hospital Boards, and target for 2012/13 and outer years also refer to interim Boards.

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

Table 35: (DHS7 (b)): Provincial Strategic Objectives and Annual Targets for District Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
2.2) To implement the National Core Standards in 100% of facilities towards accreditation of 100% District Hospitals by 2014/15	2.2.1) Number of District Hospitals compliant with the 6 priorities of the National Core Standards	37/ 37	DQPR	Reporting not required	Reporting not required	Nil	Nil *Target: 9*	5/37 13.5%	7/37 18.9%	37

- National assessment for accreditation/licensing is dependent on national processes for the establishment of the National Office of Standard Compliance. Internal processes however demand regular assessment of performance against 6 priority areas of Core Standards with supporting Quality Improvement Plans. Relevant secondary indicators will be monitored as part of Operational Plans.
- This indicator read as "Number of District Hospitals accredited" in the Strategic Plan and consequent APPs.

QUARTERLY AND ANNUAL TARGETS FOR DISTRICT HOSPITALS – 2012/13

Table 36: (DHS9): Quarterly and Annual Targets for District Hospitals 2012/13

Performance Indicators	Annual Targets 2012/13	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Caesarean section rate	26%	26.3%	26.3%	26.1%	26%
2. Separations – total	346,991	86,747	86,747	86,747	86,750
3. Patient day equivalents – total	3,136,512	784,128	784,128	784,128	784,128
4. OPD headcount – total	2,835,720	708,930	708,930	708,930	708,930
5. Average length of stay	5 Days	5.7 Days	5.5 Days	5.3 Days	5 Days
6. Bed utilisation rate	67%	64%	65%	66%	67%
7. Expenditure per patient day equivalent	R 1 700	R 1 590	R 1 600	R 1 650	R 1 700
8. Percentage of complaints of users of District Hospital services resolved within 25 days	80%	70%	74%	76%	80%
9. Percentage of District Hospitals with monthly mortality and morbidity meetings	100%	100%	100%	100%	100%
Annual Targets					
10. Number of District Hospitals assessed for compliance against the 6 priorities of the Core Standards	37				37
11. District Hospital Patient Satisfaction Rate	80%				80%
12. Percentage of District Hospitals with functional Hospital Boards	100%				100%
13. Number of District Hospitals compliant with the 6 priorities of the National Core Standards	5				5

- APP indicators and targets [annual and quarterly] are translated into the table above. Reporting will be through the Provincial Quarterly Performance Report to Provincial and National Treasury/ National Department of Health and District Quarterly Progress Report submitted to Monitoring and Evaluation Component for distribution.
- Quarterly reviews will focus on both expenditure and performance information to improve alignment and reporting.
- Indicators are aligned with District Health Plans to ensure effective monitoring of Provincial priorities.
- Additional operational indicators [process, input and output] are included in Operational Plans to ensure in-depth analysis and reporting.

4. HIV & AIDS, STI'S AND TB [HAST]

The HIV prevalence [39.5%] among antenatal women stabilised in 2010. Ugu [41.1%], Umgungundlovu [42.3%], Umkhanyakude [41.9%], Ilembe [42.3%], and eThekwini [41.1%] are the only 5 districts in the country with HIV prevalence more than 40%. [9] *See 4-year comparison of HIV prevalence in Part A.*

The mother to child transmission of HIV decreased from 22% in 2005 to 2.8% in 2010 [MRC], and the 'babies tested PCR positive six weeks after birth' decreased from 10.3% in 2009/10 to 4.1% [confirmed mid-year DHIS data].

Since the launch of the MMC campaign in 2010, a total of 105,888 male medical circumcisions have been performed [January 2012], and 55 Traditional Coordinators contracted to mobilise and monitor behaviour after circumcision to maintain negative status of clients post MMC. The Department strengthened its partnership with Indlondlo, an organization in Kokstad responsible for traditional circumcision, to ensure that all boys are tested before and after circumcision. The Province has hosted benchmarking visits by Mozambique, Botswana, Zambia and Zimbabwe, and has sent a trainer to Mozambique, Zimbabwe and Lusaka to support MMC training of healthcare workers.

Since the launch of the HCT campaign in April 2010, a total of 4,360,577 clients were tested for HIV [January 2012]. The campaign will focus on men, farms, mines, high transmission areas, and tertiary institutions in 2012/13. There are currently 7 functional Truck Stops and 1 more will be opening in 2012/13 in Richards Bay [Uthungulu District].

The number of patients registered on ART increased from 408,238 in 2010/11 to 497,217 in December 2011 [21.7% increase]. There are 518 ART facilities including 465 PHC clinics. 282 Nurses have been trained in Nurse Initiated & Managed Antiretroviral Therapy [NIMART] and 120 Nurse Mentors were trained to mentor these nurses. 256 Professional Nurses completed the HIV and AIDS Management certificate course. The percentage of TB/HIV co-infected patients initiated on ART increased from 48% in 2010/11 to 77.5% 2011/12 mid-year.

Implementation of the Integrated Access of Care and Treatment [IACT] strategy commenced in 2011/12 with 546 active support groups. A total of 238 Support Group Facilitators were trained in IACT in eThekwini, Umgungundlovu, Ilembe and Uthukela.

Thirty [30] Master Trainers have been trained in the ART Patient Electronic Information System [3-TIER system] to ensure effective rollout in the Province in 2012/13.

The Province has the highest number of TB infections in the country. Diagnosed TB cases increased from 98,498 in 2005 to 120,168 in 2009 translating to a Provincial incidence of 1,160 per 100 000 population. It is likely that there is still a large pool of undetected cases in which case improved case detection will increase the number of cases and incidence before a reduction can be expected.

The PTB cure rate increased from 40% in 2007/08 to 69.7% in 2011/12 [January 2011] with variation between 81.6% in Umzinyathi and 49.8% in Umkhanyakude.

MDR TB and XDR TB registered cases in the treatment programme increased from 689 and 35 in 2005 to 1,481 and 206 in 2010. The Department received 11 GeneXpert TB diagnostic machines as donation for use in high TB burden districts, and implementation commenced in eThekwini, Uthungulu, Zululand and Sisonke. There are currently 1 Centralised Centre of Excellence [King George V Hospital], 5 functional Decentralised Units and 3 functional Satellite Units. There are currently 16 Mobile Injection Teams in Umzinyathi and Umkhanyakude for community-based management of MDR TB.

The National Department of Health launched the *National Policy Framework on Decentralised and De-institutionalised Management of Drug-Resistant TB for SA* in August 2011. [24] The Policy Framework makes provision for the transfer of drug-resistant TB management to lower levels of the health care system on condition that specific criteria are adhered to. Implementation of community-based management of MDR TB has been prioritised for 2012/13 including service arrangements to accommodate effective management.

The TB information system [ETR.Net] is still beleaguered with systems challenges resulting in critical delays of approximately 3 months. The database is currently available in 31 capturing units with 12 merge units, and 752 facilities [TB Registration and Management] are linked with the reporting system [including non-public health facilities].

A total of 81 Microscopy sites are operational in the Province managing an average of 85,000 specimens per month. One Culture DST site is operational with capacity increasing from 5,500 specimens per month to 16,500 specimens per month.

The Provincial Cabinet endorsed the Multi-Sectoral Provincial Strategic Plan [KZNPSP] for HIV and AIDS, STIs and TB 2012 – 2016 [26] which is aligned with the National Strategic Plan and provides the roadmap for intensified action to address HIV and AIDS, STIs, and TB through a multi-sectoral and integrated approach. The KZNPSP is aligned with the KZN Provincial Growth and Development Strategy and the Mid-Term Strategic Framework 2009 - 2014. The service delivery approach is reinforced by Operation Sukuma Sakhe, PHC re-engineering, and the National Health Insurance Policy. The Plan set ambitious targets in an effort to curb new infections and reduce morbidity and mortality.

KZNPSP Area 1: Prevention of HIV, STI and TB [26]

1. Reduce HIV incidence to less than 1% by 2016.
2. Increase the proportion of males 0-49 years that are circumcised to 80% by 2016.
3. Reduce mother to child transmission to <1% by 2016.
4. Reduce TB incidence to less than 200 per 100 000 population by 2016.
3. Reduce STI incidence to less than 0.5% by 2016.

PROGRAMME 2: DISTRICT HEALTH SERVICES

KZNPSP Area 2: Sustaining Health/ Wellness [26]

1. Increase the number of children receiving ART to 94,687 by 2016.
2. Increase the number of adults receiving ART to 1,013,750 by 2016.
3. Increase the TB cure rate to 85% by 2016.
4. Reduce the TB defaulter rate to 3% by 2016.
5. Reduce the proportion of TB patients with MDR-TB to 1.4% by 2016.
6. Reduce the proportion of TB patients with XDR-TB to 5% by 2016.

CHALLENGES: HAST

- TB/HIV integration – including integration into mainstream PHC services [re-engineering of PHC].
- Major infrastructure constraints in facilities to manage increased number of patients on ART/ TB.
- Tracking and tracing of ART clients remains a challenge resulting in high defaulter and loss to follow-up rates.
- Emerging HIV drug resistance.
- Failure to recruit ART Roving Teams for PHC clinics which limits provision of MMC and ART at PHC level.
- TB case finding, screening, follow-up and support.
- Infection prevention and control including nosocomial transmission in facilities.
- Inadequate MDR TB beds especially based on preliminary results of diagnosis using GeneXpert.
- Human resource constraints to manage increased patient numbers for HIV and TB.

2012/13 PRIORITIES: HAST

1. *Decrease HIV incidence and manage HIV prevalence*	▪ Implement and monitor the Multi-Sectoral Provincial Strategic Plan [KZNPSP] for HIV and AIDS, STIs and TB 2012 – 2016. ▪ Comprehensive HIV/TB integration. ▪ Increased access to ART [including decentralised access at PHC level]. ▪ Male Medical Circumcision. ▪ Counselling, testing, follow-up and support. ▪ Condom distribution. ▪ Monitoring & evaluation [3-TIER reporting and TB reporting systems]. ▪ Reducing STI incidence.
2. *Reduce TB incidence and improve TB outcomes*	▪ Expand Community-Based Management of MDR TB. ▪ Integrate DOT support, surveillance for early detection of TB, and follow up of defaulters into Operation Sukuma Sakhe and re-engineering of PHC. ▪ Roll-out of GeneXpert with improved service arrangements.

SITUATION ANALYSIS INDICATORS FOR HAST – 2010/11 [TREASURY REPORTING]

Table 37: (HIV1): Situation Analysis Indicators for HIV & AIDS, STI's AND TB Control – 2010/11

Indicator	Data Source	Provincial 2010/11	Ugu 2010/11	Umgungundlovu 2010/11	Uthukela 2010/11	Umzinyathi 2010/11	Amajuba 2010/11	Zululand 2010/11	Umkhanyakude 2010/11	Uthungulu 2010/11	Ilembe 2010/11	Sisonke 2010/11	eThekwini 2010/11
Total number of patients (children and adults) on ART	DHIS	408,238	43,608	52,828	32,544	26,140	16,666	36,990	35,026	47,398	24,097	19,586	103,355
Male condom distribution rate	DHIS	8.1	9.6	5.2	10.7	13.9	13.5	13.9	10.3	6.0	7.9	12	5.1
New smear positive PTB defaulter rate	ETR.Net	7%	8%	5.7%	5.2%	2.6%	2.9%	3.6%	4.7%	6.9%	7.9%	13.4%	9.8%
PTB two month smear conversion rate	ETR.Net	69%	68.1%	61.1%	62%	73.4%	78%	69%	51.7%	77.5%	73.6%	44.8%	67%
Percentage of HIV/TB co-infected patients placed on ART	DHIS	74.4%	66.3%	74.7%	99.5%	83.6%	87.5%	75.9%	44.9%	75.1%	53.2%	84.5%	78.6%
HCT testing rate	DHIS	80%	95%	92%	98%	87%	99%	92%	96%	56%	98%	93%	61.4%
New smear positive PTB cure rate	ETR.Net	68.2%	68%	71%	71%	81%	79.4%	61%	43.2%	79%	79.9%	60.2%	57.4%

- Condom distribution rate is low and has been identified as priority in 2012/13. The new condom distribution strategy was introduced in 2011/12 and will be scaled up in 2012/13.
- The increase in the number of ART patients without concomitant human resources is a challenge that will be addressed through the organisational review and filling of PHC posts.

PERFORMANCE INDICATORS FOR HAST [TREASURY REPORTING]

Table 38: (HIV3): Performance Indicators for HIV & AIDS, STI's and TB Control

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Total number of patients [children and adults] on ART	DHIS	No	225,863	319,015	408,238	526,666 *Target: 460,198*	785,431	846,919	1,143,341	-
2. Male condom distribution rate	DHIS	No	7	8	8.1	9 N: 34,043,562 D: 3,782,618 *Target: 12*	14	15	15	15
3. New smear positive PTB defaulter rate	ETR.Net	%	9.6%	8.1%	7%	6.7% N: 2,006 D: 29,631 *Target: 6.1%*	6%	5.5%	<5%	<5%
4. PTB two month smear conversion rate	ETR.Net	%	60.5%[24]	68.7%	69%	69% N: 21,568 D: 31,236 *Target: 70%*	74%	79.4%	85%	75%
5. Percentage of HIV/TB co-infected patients placed on ART	DHIS	%	Reporting not required	Reporting not required	74.4%	75% N: 8,618 D: 11,491 *Target: 80%*	90%	95%	95.5%	-
6. HCT testing rate	DHIS	%	Reporting not required	Reporting not required	80%	90% N: 2,189,646 D: 2,442,489 *Target: 90%*	93%	95%	95%	-
7. New smear positive PTB cure rate [Annual]	ETR.Net	%	62%	62.9%	68.2%	69.5% *Target: 72%*	73.3%	78.9%	85%	85%

[24] Data appearing in the Annual Report 2008/09 was noted as incomplete at 52.1% due to the non-submission of data therefore the figure of 60.5% (DHIS) is the most reliable figure

- The TB database [ETR.Net] has been upgraded in 2011/12 and the review of data with backlog being addressed.
- The "estimated performance" is based on confirmed mid-year data and projected quarter 3 and 4 data.
- The TB cure rate reflects actual mid-year data [provided by the TB Unit].
- The Department continues to exceed the target for patients in the ART programme, and previous targets have been reviewed to make provision for new policy changes.

PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR HAST

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

Table 39: (HIV2): Provincial Strategic Objectives and Annual Targets for HIV and AIDS

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
3.1) To scale up implementation of the integrated HIV & AIDS, STI and TB Strategic Plan to reduce HIV incidence to less than 1% by 2016	3.1.1) HIV incidence	0.85% [-50%]	ASSA and MRC	Reporting not required	1.7% [MRC]	1.7% [MRC]	1.8% [ASSA estimate] *Target: 0.85%*	1.7% [KZNPSP]	1.5%	1.4%
	3.1.2) Percentage qualifying HIV-positive patients on ART	90%	ART Register	Reporting not required	±60%	81%	83% *Target: 80%*	85%	86%	90%
	3.1.3) Number of neo-natal males circumcised [cumulative]	100% of target by 2014/15	DHIS	Reporting not required	Reporting not required	58	93 *Target: 71,288*	150	300	600
	3.1.4) Number of adult males circumcised [cumulative]	100% of target by 2014/15	DHIS	Reporting not required	Reporting not required	33,817	73,070 *Target: 373,406*	174,826	291,377	373,406
	3.1.5) *Percentage of HIV positive patients initiated on IPT	New indicator	DHIS	Reporting not required	Reporting not required	Reporting not required	52% *Baseline*	60%	70%	80%
	3.1.6) *Percentage of TB/HIV co-infected patients initiated on CPT	New indicator	DHIS	Reporting not required	Reporting not required	Reporting not required	69% *Baseline*	90%	90%	90%

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	3.1.7) STI treated new episode incidence	New indicator	DHIS	Reporting not required	Reporting not required	Reporting not required	2.7% *Baseline*	2.4%	1.5%[25]	1.3%

- The "estimated performance" is based on confirmed mid-year data and projected quarter 3 and 4 data.
- Indicator 3.1.1: The Strategic Plan target has been reviewed to comply with the KZNPSP target to reduce HIV incidence to less than 1% by 2016. Targets for 2012/13 and outer years have been reviewed accordingly.
- The targets for MMC [Indicators 3.1.3 and 3.1.4] have been reviewed since the Strategic Plan was published as targets were unrealistic and unattainable. The very slow uptake of neonatal circumcision has been discussed with bioethics experts at UKZN in an effort to address ethical objections to circumcision hence low target for 2012/13 and outer years.
- Indicators 3.1.5 to 3.1.7 have been added to the 2012/13 APP since tabling of the Strategic Plan to make provision for monitoring of intensified strategies related to HIV, STI and TB.
- STI incidence targets for the MTEF are aligned with the KZNPSP targets.
- Additional supporting sub-set indicators are included in the DORA Business Plan as well as Operational Plan to ensure comprehensive monitoring, analysis and reporting on expected outcomes.

[25] Target from the KZNPSP seems unrealistic although progress will be monitored.

QUARTERLY AND ANNUAL TARGETS FOR HAST – 2012/13

Table 40: (HIV4): Quarterly and Annual Targets for HIV & AIDS, STI's AND TB Control for 2012/13

Performance Indicators	Annual Targets 2012/13	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Total number of patients [children and adults] on ART [cumulative]	785,431	591,293	656,005	720,717	785,431
2. Male condom distribution rate	14	10	11	13	14
5. New smear positive PTB defaulter rate	6%	6.7%	6.5%	6.2%	6%
6. PTB two month smear conversion rate	74%	70%	72%	73%	74%
3. Percentage of HIV/TB co-infected patients placed on ART	90%	79%	80%	85%	90%
4. HCT testing rate	93%	90%	91%	92%	93%
7. Number of neo-natal males circumcised [cumulative]	150	114	125	135	150
8. Number of adult males circumcised [cumulative]	174,826	98,509	123,948	149,387	174,826
9. Percentage of HIV positive patients initiated on IPT	60%	54%	56%	58%	60%
10. Percentage of TBHIV co-infected patients initiated on CPT	90%	73%	80%	85%	90%
Annual Targets					
11. HIV incidence	1.7%				1.7%
12. Percentage qualifying HIV-positive patients placed on ART	85%				85%
13. New smear positive PTB cure rate	73.3%				73.3%
14. STI treated new episode incidence	2.4%				2.4%

- APP indicators and targets [annual and quarterly] from previous tables included for reporting in the Provincial Quarterly Performance Report to Treasury and National Health and District Quarterly Progress Reports that are submitted to the Monitoring and Evaluation Component for dissemination.
- Indicators are aligned with District Health Plans to ensure effective monitoring of priorities.
- Quarterly reviews will be inclusive of primary and secondary indicators as well as expenditure to ensure comprehensive and integrated reporting.
- Additional operational indicators [process, input and output] are included in Operational Plans and will be monitored quarterly.

5. MATERNAL, CHILD & WOMEN'S HEALTH AND NUTRITION

Maternal and Neonatal Health

The establishment of 'mothers waiting areas' have been prioritised for 2012/13. Thirteen [13] specialized obstetric ambulances have been deployed in districts to improve access to transport and treatment for pregnant women.

Infant and Child Health

The Saving Babies Report [29] stated that for every 1000 live births, 60 die by the age of 5. Of the under-5 deaths, 75% die in the first year [infant death] and 25% die in the first month [neonatal death]. Of concern is that it is estimated that 50% of infants died at home.

Intestinal infectious diseases are the most common cause of death in children under 5 years in KZN, causing 17.6% of all deaths in this age group. Influenza and pneumonia are the second most common causes of death, causing 9% of all deaths in this age group. Malnutrition is the direct cause of death in 3.1% of all deaths in the age group, and HIV 2.5%.

The severe malnutrition under 5 years incidence increased from 0.6% in 2007/08 to 0.7% in 2010/11 and the severe malnutrition fatality rate decreased from 22% in 2007/08 to 12.7% in 2010/11. Approximately 60% of children admitted in hospital have underlying malnutrition with other diseases e.g. HIV being the primary diagnosis.

Improved screening and early detection has led to an increase in admissions which can be expected to improve further as the re-engineering of PHC unfolds. The Medical Control Council has approved the issue of Vitamin A supplementation by CCGs which will be rolled out as part of re-engineering and Operation Sukuma Sakhe.

There are 36 accredited Baby-Friendly Hospitals in the Province decreasing from 44 in 2010/11. 2011/12 Mid-year DHIS data indicate that only 30% of mothers are exclusively breastfeeding at 14 weeks which is a concern for the PMTCT programme outcomes.

The Department is intensifying the implementation of the Infant, Youth, Child Feeding [IYCF] Policy and Guidelines to improve exclusive breastfeeding.

The PCV 13 catch-up drive, targeting children between 18 to 25 months [extended to 71 months for high risk children] is scheduled for February to May 2012. The drive is targeting 342,902 'well' children and 138,000 'high risk' children.

The challenges with data management are being addressed by the implementation of the Data Quality Self-Assessment strategy that started in February 2012. The actual impact of vaccines on diarrhoea and pneumonia is yet to be determined by research.

There are currently 88 School Health Teams that are allocated to clinics and wards. An additional 5 teams are in the process of being appointed and shortlisting has been completed for appointments for an additional 30 teams, bringing to total 123 teams. *See PHC*

PROGRAMME 2: DISTRICT HEALTH SERVICES

The report from National Department of Health places the mother to child transmission rate of HIV at 3% as of September 2011. This is based on the NHLS findings. The districts with the least transmission rates are Amajuba at 0.6% and Umzinyathi at 2%.

CHALLENGES: MNCWH&N

- The biggest challenge remains the impact of HIV on maternal and child health outcomes.
- Late booking for antenatal care continues to compromise the ability of medical personnel to identify and manage high risk patients effectively.
- The delay in reaching health facilities during labour is a major concern.

2012/13 PRIORITIES: MNCWH&N

1. *Reduce maternal morbidity and mortality*	▪ Improve antenatal [including early booking] and postnatal care. ▪ Scale up NIMART to improve HAART initiation for eligible women. ▪ Increase access to functional Basic Emergency Obstetric Care Units. ▪ Establish functional high care beds in all nurseries; neonatal resuscitation units in all labour wards and nurseries; and Kangaroo Mother Care in all hospitals. ▪ Establish waiting mothers' lodges in all hospitals.
2. *Reduce child morbidity and mortality*	▪ Strengthen the Expanded Programme on Immunisation. ▪ Strengthen nutrition programmes including implementation of the IYCF Policy; nutritional supplementation; Vitamin A coverage; and management of malnutrition. ▪ Strengthen the Integrated Management of Childhood Illnesses [IMCI]. ▪ Intensify the PMTCT Programme. ▪ Back to the basics of GOBI FFF (growth monitoring, oral rehydration therapy, breastfeeding, immunisation, family spacing, female education, food supplementation) through Operation Sukuma Sakhe.
3. *Improve women's health*	▪ Scale up implementation of the Phila Ma campaign. ▪ Implement the Contraceptive Strategy. ▪ Intensify programmes for Post Exposure Prophylaxis [PEP]. ▪ Improve access to Choice on Termination of Pregnancy services. ▪ Implement Youth Friendly and School Health Services.

SITUATION ANALYSIS INDICATORS FOR MC&WH AND NUTRITION – 2010/11 [TREASURY REPORTING]

Table 41: (MCWH1): Situation Analysis Indicators for MCWH&N

	Indicator	Data Source	Provincial 2010/11	Ugu 2010/11	Umgungundlovu 2010/11	Uthukela 2010/11	Umzinyathi 2010/11	Amajuba 2010/11	Zululand 2010/11	Umkhanyakude 2010/11	Uthungulu 2010/11	Ilembe 2010/11	Sisonke 2010/11	eThekwini 2010/11
1.	Immunisation coverage under-1 year	DHIS	86%	81%	74%	78%	93%	71%	79%	88%	95%	84%	67%	96%
2.	Vitamin A coverage 12 – 59 months	DHIS	32.6%	33.9%	22.4%	24.1%	33.3%	24.5%	29.3%	24.5%	31%	36%	28.2%	44.4%
3.	Measles 1st dose under 1 year coverage	DHIS	88%	86%	70%	80%	100%	78%	76%	89%	99%	87%	73%	99%
4.	Pneumococcal vaccine (PCV) 3rd dose coverage	DHIS	80%	78%	70%	81%	81%	75%	73%	79%	85%	84%	65%	89%
5.	Rota Virus (RV) 2nd dose coverage	DHIS	81%	83%	66%	88%	85%	73%	75%	86%	87%	83%	62%	87%
6.	Cervical cancer screening coverage	DHIS	57.4%	89.8%	42.4%	54.3%	108.7%	40.3%	68.1%	73.2%	42.9%	74.7%	60.1%	48.1%
7.	Antenatal visits before 20 weeks rate	DHIS	36%	34.8%	43.6%	35.4%	36.7%	35.6%	37.2%	41.7%	35.6%	31%	34%	34%
8.	Baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks	DHIS	6.8%	3.8%	6%	7%	4.8%	3.4%	5.5%	5.5%	7.5%	3.9%	4.6%	8.2%
9.	Couple year protection rate	DHIS	24.1%	28.8%	22.8%	24.3%	28%	24.8%	25.3%	28%	21%	24.6%	24%	22.7%
10.	Facility maternal mortality rate per	DHIS	195/100k	276/100k	182/100k	202/100k	71/100k	164/100k	90/100k	128/100k	411/100k	97/100k	87/100k	218/100k

Indicator	Data Source	Provincial 2010/11	Ugu 2010/11	Umgungundlovu 2010/11	Uthukela 2010/11	Umzinyathi 2010/11	Amajuba 2010/11	Zululand 2010/11	Umkhanyakude 2010/11	Uthungulu 2010/11	Ilembe 2010/11	Sisonke 2010/11	eThekwini 2010/11
100k													
11. Delivery rate for women under 18 years	DHIS	8.9%	10.7%	9.5%	9.6%	8.3%	9.7%	8.1%	10.7%	8%	8.5%	10.9%	8.1%
12. Facility infant mortality (under 1) rate	DHIS	9.1%	8.2%	13%	9.9%	9.8%	3.2%	12.3%	11.,5%	9.6%	14.9%	9.2%	7.3%
13. Facility child mortality (under 5) rate	DHIS	7.6%	7.5%	11.4%	8.4%	9.7%	4.5%	7.5%	9.4%	6.9%	9.6%	9.9%	4.9%

PERFORMANCE INDICATORS FOR MC&WH AND NUTRITION [TREASURY REPORTING]

Table 42: (MCWH3): Performance Indicators for MCWH&N

Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Immunisation coverage under 1 year	DHIS	%	85%	84.9%	86%	94.5% N: 204,499 D: 216,241 *Target: 90%*	90%	90%	90%	90%
2. Vitamin A coverage 12 – 59 months	DHIS	%	28.5%	37.4%	32.6%	63.4%* N: 709,401 D: 1,118,590 *Target: 55%*	40%	44.9%	50.9%	80%
3. Measles 1st dose under 1 year coverage	DHIS	%	89.3%	87.3%	88%	100.5% N: 217,500 D: 216,241	90%	90%	90%	90%

Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
						Target: 90%				
4. Pneumococcal vaccine (PCV) 3rd dose coverage	DHIS	%	New vaccine	75.9%	80%	97.4% N: 210,650 D: 216,241 *Target: 90%*	90%	90%	90%	90%
5. Rota Virus (RV) 2nd dose coverage	DHIS	%	New vaccine	58%	81%	106.9% N: 231,316 D: 216,241 *Target: 90%*	90%	90%	90%	90%
6. Cervical cancer screening coverage	DHIS	%	6.4%	5.9%	57.4%	73%* N: 127,135 D: 1,624,758 *Target: 50%*	75%	75%	75%	40%
7. Antenatal visits before 20 weeks rate	DHIS	%	30.5%	34.3%	36%	39.6% N: 85,604 D: 215,829 *Target: 60%*	50%	56%	60%	70%
8. Baby tested PCR positive six weeks after birth as proportion of babies tested at six weeks	DHIS	%	7% [26]	*10.3%	6.8%	4% N: 2,958 D: 73,267 *Target: <6%*	2%	<2%	<1%	-
9. Couple year protection rate [Annual]	DHIS	%	23%	25.1%	24.1%	26% *Target: 40%*	28.9%	40%	44.6%	70%
10. Facility Maternal mortality rate [Annual]	DHIS	No	205 /100k	169/100k	195/100k	184.7/100k* N: 182 D: 98,522 *Target: 115/100k*	200/100k	185/100k	165/100k	-
11. Delivery rate for women under 18 years [Annual]	DHIS	%	9.4%	8.6%	8.9%	9.3%* N: 9,328 D: 100,679	8.5%	8%	7.5%	10%

[26] Data from the Centre for Rural Health

Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
						Target: 8%				
12. Facility infant mortality (under 1) rate [Annual]	DHIS	%	9%	7.3%	9.1%	7.3%* N: 1,217 D: 16,736 *Target: 8.5%*	7.9%	7.7%	7.4%	-
13. Facility child mortality (under 5) rate [Annual]	DHIS	%	7%	6.3%	7.6%	5.2%* N: 1,442 D: 27,930 *Target: 6.8%*	6.8%	6.6%	6.5%	-

- Note: [*] Denotes data that has been corrected and verified since the 2010/11 Annual Report
- The "estimated performance" is based on confirmed 2011/12 mid-year and projected quarter 3 and 4 data.
- Indicators 1, 3, 4, and 5: Kept the Immunisation targets for the MTEF at the standard national target of 90% although reported performance exceeded 90% in some instances. It is suspected that population under-5 is incorrect which might impact on indicator performance.
- Indicator 2 [Vitamin A]: Validity of 2011/12 data questioned [although verified in DHIS system] – especially when compared with previous years' trends. The target of 40% is based on previous years' trends and will be closely monitored. If so indicated, targets for outer years will be reviewed based on 2012/13 performance.
- Indicator 6 [Cervical cancer screening coverage]: According to DHIS data the coverage is 73% [cumulative] which is questionable [data quality or calculation error suspected]. It is suspected that all Pap smears [screening, diagnostic and repeats] are reported as part of the indicator which will give a false value for screening. The Epidemiology and Health Research Component will investigate the indicator which will inform future targets. The 2012/13 target [75%] is based on current DHIS data.
- Indicator 9 [Couple year protection]: The significant increase between 2012/13 and 2013/14 are based on expected performance following implementation of the Contraceptive Strategy that commenced in the 4th quarter of 2011/12.
- Indicator 10 [Facility maternal mortality rate]: Based on slow reporting of maternal deaths, indications are that the 2011/12 MMR will be significantly higher than the reported 184.7/100k. The Programme Manager therefore advised a target based on current data, previous reporting patterns, and projections. The targets will be reviewed for outer years if indicated.
- Indicator 11 [Delivery rate under 18 years]: The significant reduction for the 2012/13 target informed by the intensified youth programmes that commenced in 2011/12.
- Indicators 12 and 13 [Facility infant and child mortality]: Estimated 2011/12 data is suspect and targets based on trends and current programmes for infant and child health.

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

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

Table 43: (MCWH2): Provincial Strategic Objectives and Annual Targets for MCWH&N

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
3.2) To scale up implementation of the Accelerated Plan for PMTCT to reduce mother to child transmission to <5% by 2012/13	3.2.1) % of pregnant women tested for HIV	100%	DHIS	96%	93%	91.8% N: 224,196 D: 244,013	114% N: 164,748 D: 163,240 *Target: 100%*	100%	100%	100%
	3.2.2) ANC Nevirapine uptake rate[27]	100%	DHIS	Reporting not required	79.4%	68.9%	60.9% N: 34,167 D: 56,142 *Target: 95%*	100%	100%	100%
	3.2.3) % of eligible pregnant women placed on HAART	90%	DHIS	Reporting not required	52.7%	75% N: 9,701 D: 12,911	78.8% N: 15,542 D: 19,726 *Target: 75%*	90%	90%	90%
	3.2.4) Baby Nevirapine uptake rate[28]	100%	DHIS	Reporting not required	75.2%	78.6%	97.9% N: 54,942 D: 56,942 *Target: 95%*	100%	100%	100%
3.3) Reduce child mortality to 30-45/1000	3.3.1) Number of diarrhoea cases – children under-5 years	Monitor trends	DHIS	231,595	232,397	181,083	146,350 *Target: -15%* *153,921*	131,715 [-10%]	118,544 [-10%]	106,690 [-10%]

[27] Previously monitored "% of pregnant women who are eligible placed on ARV prophylaxis"
[28] Previously monitored "% of HIV exposed infants receiving ARV's for PMTCT – indicator changed

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
live births by 2014/15	3.3.2) Number of pneumonia cases – children under-5 years	Monitor trends	DHIS	194,904	209,920	167,661	167,910 *Target: -20% 134,129*	151,119 [-10%]	136,008 [-10%]	122,408 [-10%]
	3.3.3) Underweight for age under 5 years incidence - annualised[29]	Replace – see footnote	DHIS	Reporting not required	26.3/ 1000	19.4/1000	23.7/1000* N: 19,416 D: 1,118,590 *Baseline*	23/1000	22/1000	21/1000
	3.3.4) Not gaining weight rate under 5 years	New indicator	DHIS	1.2%	1.3%	1.1%	1%* N: 29,539 D: 3,082,894 *Baseline*	1.1%	1%	<1%
	3.3.5) Severe malnutrition under 5 years incidence	6/1000	DHIS	7.6/1000	9.5/ 1000	7/ 1000	6.7/ 1000 N: 5,749 D: 1,118,590 *Target: 6/1000*	6.5/1000	6.3/1000	6/1000
3.4) Reduce maternal mortality to ≤ 100/ 100 000 by 2014/15	3.4.1) Postnatal care baby visits within 6 days rate	80%	DHIS	Reporting not required	42%	31% N: 58,054 D: 186,466	Babies 57.7% N: 56,831 D: 98,522 *Target: 50%*	70%	75%	80%
	3.4.2) Postnatal care mother visits within 6 days rate	80%	DHIS	Reporting not required	42%	31%	56.3% N: 56,684 D: 100,679 *Target: 50%*	70%	75%	80%

- [*] Denotes updated DHIS information since the 2010/11 Annual Report and new or reviewed indicators since development of the Strategic Plan and the 2011/12 APP
- Indicator 3.3.1 [Number of diarrhoea cases]: Diarrhoea with dehydration [as proportion of total diarrhoea cases] decreased from 22.3% in 2009/10 to 17% in 2010/11.
- Indicator 3.3.3 and 3.3.4 [Underweight for age under 5 years' incidence and not gaining weight rate]: Socio-economic factors and poor reporting of indicator caution against reducing the indicator [suspect higher incidence than that reported]. Target for 2012/13 takes that into consideration and the projected target for 2014/15 has also been reviewed.

[29] Replace "Reduce the prevalence of underweight children under-5 years" as the indicator is not included in DHIS [jeopardise monitoring performance]. The new indicator is included in DHIS.

QUARTERLY AND ANNUAL TARGETS FOR MCWH&N – 2012/13

Table 44: (MCWH4): Quarterly and Annual Targets for MCWH&N for 2012/13

Performance Indicators		Annual Targets 2012/13	Quarterly Targets			
			Q1	Q2	Q3	Q4
Quarterly Targets						
1.	Immunisation coverage under 1 year	90%	90%	90%	90%	90%
2.	Vitamin A coverage 12 – 59 months	40%	35%	37%	38%	40%
3.	Measles 1st dose under 1 year coverage	90%	90%	90%	90%	90%
4.	Pneumococcal Vaccine (PCV) 3rd Dose Coverage	90%	90%	90%	90%	90%
5.	Rota Virus (RV) 2nd Dose Coverage	90%	90%	90%	90%	90%
6.	Cervical cancer screening coverage	75%	73%	73%	74%	75%
7.	Antenatal visits before 20 weeks rate	50%	40%	44%	47%	50%
8.	Baby tested PCR positive six weeks after birth as proportion of babies tested at six weeks	2%	4%	3.5%	3%	2%
9.	% of pregnant women tested for HIV	100%	94%	96%	98%	100%
10.	ANC Nevirapine uptake rate	100%	75%	80%	90%	100%
11.	% of eligible pregnant women placed on HAART	90%	79%	82%	88%	90%
12.	Baby Nevirapine uptake rate	100%	97%	97%	99%	100%
13.	Number of diarrhoea cases – children under-5 years	131,715	32,928	32,928	32,928	32,931
14.	Number of pneumonia cases – children under-5 years	151,119	37,779	37,779	37,779	37,782
15.	Postnatal care mother visits within 6 days rate	70%	60%	65%	70%	70%
16.	Postnatal care baby visits within 6 days rate	70%	60%	65%	70%	70%
Annual Targets						
17.	Couple year protection rate	28.9%				28.9%
18.	Facility maternal mortality rate	200/100 000				200/100 000
19.	Delivery rate for women under 18 years	8.5%				8.5%
20.	Facility infant mortality (under 1) rate	7.9%				7.9%
21.	Facility child mortality (under 5) rate	6.8%				6.8%
22.	Underweight for age under 5 years incidence - annualised	25/1000				25/1000
23.	Not gaining weight rate under 5 years	1.1%				1.1%
24.	Severe malnutrition under 5 years incidence	6.5/1000				6.5/1000

- APP indicators and targets [annual and quarterly] as included in the Provincial Quarterly Performance Report to Treasury and District Quarterly Progress Report submitted to Monitoring and Evaluation.
- Indicators are aligned with District Health Plans to ensure effective monitoring of Provincial priorities.
- Additional operational indicators [process, input and output] are included in Operational Plans and will be reported on quarterly.
- Indicators highlighted in green must be consulted with Victoria and Lenore to determine reviewed targets.

6. DISEASE PREVENTION AND CONTROL [DPC]

Malaria Control

Successful implementation of malaria intervention strategies brought about the reduced incidence of malaria [<1/1000 population at risk].

Reported malaria cases reduced from 42,284 [342 deaths] in 2000 to 380 [5 deaths] in 2010. The late reporting to health facilities, co-morbidities, and the increasing number of cases in neighboring provinces and countries impact on the number of cases and deaths. Indoor residual spraying coverage for the previous season [2010/11] was above 90% with 1,544,875 people reached with malaria communication.

Cateract Surgery

The cataract surgery rate is low mainly due to inadequate resources including human resources for health. The Department aims to develop District Hospital Vision Centres with high volume refraction and cataract surgery capacity to improve access to services.

CHALLENGES

- Delay with the devolution of Municipal Health Services to Metropolitan and District Municipalities.
- Delayed appointment of Waste Management Officers at health facilities impacts negatively on monitoring and evaluation of safe collection, storage and final disposal of health care risk waste.
- Delay with the implementation of the reviewed malaria post establishment is posing a risk to the resurgence of malaria in the Province.
- Inadequate human resource capacity at operational level to scale up eye care services and cataract surgery.

2012/13 PRIORITIES: DISEASE PREVENTION AND CONTROL

1. *Maintain malaria incidence <1/1000 population and the malaria case fatality rate <1%*	▪ Ongoing assessment of antimalarial drug efficiency. ▪ Insecticide spraying of malarious areas. ▪ Improve early diagnosis and effective treatment.
2. *Revitalisation of Environmental Health Services*	▪ Expedite the devolution of Environmental Health Services. ▪ Port Health: Controlled ingress of PAX and consignments into the Province. ▪ Control Hazardous Substances [Green Economy]: Licensing of all hazardous substance dealers/ importers. ▪ Healthcare Risk Waste Disposal: Efficient collection and disposal of all health care risk waste from health facilities and generators.

3. *Improve the cateract surgery rate*	▪ Develop high volume Cateract Surgery Centres with appropriately skilled Ophthalmic Medical Officers. ▪ Scale up implementation of eye care services.

SITUATION ANALYSIS INDICATORS FOR DISEASE PREVENTION AND CONTROL – 2010/11 [TREASURY REPORTING]

Table 45: (DCP1): Situation Analysis Indicators for Disease Prevention and Control

Indicator	Data Source	Provincial 2010/11	Ugu 2010/11	Umgungundlovu 2010/11	Uthukela 2010/11	Umzinyathi 2010/11	Amajuba 2010/11	Zululand 2010/11	Umkhanyakude 2010/11	Uthungulu 2010/11	Ilembe 2010/11	Sisonke 2010/11	eThekwini 2010/11
1. Malaria fatality rate [Annual]	Malaria database	1.47%	0%	0%	0%	0%	0%	2.7%	2.1%	5.5%	0%	0%	0%
2. Cholera fatality rate	CDC database	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
3. Cataract surgery rate [Annual]	DHIS	757/1mil	463	909	105	982	360	0	899	1045	239	1300	886

PERFORMANCE INDICATORS FOR DISEASE PREVENTION AND CONTROL [TREASURY REPORTING]

Table 46: (DCP3): Performance Indicators for DPC

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Malaria case fatality rate [Annual]	Malaria database	%	0.7% (4/534)	0.9% (4/428)	1.3% (5/380)	1% N: 6 D: 599 *Target: <1%*	<1%	<1%	<1%	-

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
2. Cholera fatality rate [Annual]	CDC database	%	50% (1/2)	0%	0%	0% *Target: 0%*	0%	0%	0%	0%
3. Cataract surgery rate [Annual]	DHIS	No per 1mil	1,035/ 1mil	1,003/ 1 mil	757/1mil	566/1mil N: 6,016 D: 10,622,204 *Target: 138.28/1mil*	1,222/1mil [12,982 operations]	1,430/1 mil [16,200 operations]	1,835/1mil [19, 500 operations]	2,000/1 mil

- The services included under this section [Disease Prevention and Control] are based on the national template requirements although it is acknowledged that it form part of PHC and Hospital services.
- The "estimated performance" is based on confirmed mid-year data and projected quarter 3 and 4 data.
- Indicator 3 - Cataract surgery rate: The target for 2012/13 is based on 2011 population estimates. Outer year targets will have to be reviewed once the new StatsSA population estimates are available.

PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR DPC

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

Table 47: (DCP2): Provincial Strategic Objectives and Annual Targets for DPC

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
3.5) To maintain preventative strategies to reduce and maintain the	3.5.1) Malaria incidence per 1000 population at risk	<1/ 1000	Malaria database	0.05/1000	0.11/1000	0.03/1000 N: 380 D: 10,540,960	0.06/1000 N: 599 D: 10,622,204 *Target: 0.61/1000*	<1/ 1000	<1/ 1000	<1/ 1000

PROGRAMME 2: DISTRICT HEALTH SERVICES

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
malaria incidence at ≤ 1/1000 population	3.5.2) Indoor residual spraying coverage	New indicator	Malaria database	Reporting not required	Reporting not required	Reporting not required	90% *Baseline*	95%	95%	95%

- The "estimated performance" is based on confirmed mid-year data and projected quarter 3 and 4 data.

QUARTERLY AND ANNUAL TARGETS FOR DPC – 2012/13

Table 48: (DPC4): Annual Targets for DPC for 2012/13

Performance Indicator	Annual Target 2012/13	Quarterly Targets			
		Q1	Q2	Q3	Q4
Annual Targets					
1. Malaria case fatality rate	<1%				<1%
2. Malaria incidence per 1,000 population at risk	<1/ 1000				<1/ 1000
3. Indoor residual spraying coverage	95%				95%
4. Cholera fatality rate	0%				0%
5. Cataract surgery rate [per million population]	1,222/1mil [12,982 operations]				1,222/1mil [12,982 operations]

- All APP indicators and targets [annual and quarterly] are included the above table to ensure appropriate monitoring and reporting including the Provincial Quarterly Performance Report to Treasury and the National Department of Health and District Quarterly Progress Reports submitted to the Monitoring and Evaluation Component for dissemination.
- Indicators are aligned with District Health Plans to ensure effective monitoring of Provincial priorities.
- Additional operational indicators [process, input and output] are included in Operational Plans to ensure improved analysis, interpretation and reporting.

RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 49: (DHS11 (a)): District Health Services

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
R' thousands	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
District Management	150 532	121 875	133 675	150 275	166 152	175 357	200 149	210 713	224 502
Community Health Clinics	1 578 640	1 836 913	2 078 627	2 697 528	2 347 276	2 301 184	2 546 665	2 717 819	2 851 674
Community Health Centres	503 302	553 575	632 334	849 799	777 240	773 436	870 181	931 852	984 400
Community Based Services	92 769	98 850	101 399	206 571	40 000	33 204	-	-	-
Other Community Services	429 132	495 474	552 265	598 325	715 601	675 454	768 652	848 364	929 261
HIV and AIDS	1 239 365	1 534 546	1 500 250	1 925 452	1 907 312	1 907 312	2 225 423	2 652 072	3 073 536
Nutrition	21 635	90 637	36 614	64 200	56 935	56 935	47 642	50 270	51 980
Coroner Services	96 664	97 091	117 884	133 433	150 181	137 494	156 393	168 416	175 130
District Hospitals	4 020 233	4 359 717	4 677 061	5 114 241	4 739 463	4 783 082	5 138 614	5 301 777	5 750 954
Total economic classification	**8 132 272**	**9 188 678**	**9 830 109**	**11 739 824**	**10 900 160**	**10 843 458**	**11 953 719**	**12 881 283**	**14 045 437**

Source: BAS

Table 50: (DHS11 (b)): Summary of Provincial Expenditure Estimates by Economic Classification

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Current payments	**7 792 667**	**8 815 438**	**9 398 002**	**11 213 448**	**10 275 918**	**10 316 979**	**11 532 669**	**12 436 115**	**13 613 029**
Compensation of employees	5 264 489	5 723 862	6 452 713	7 742 028	7 147 265	7 182 366	8 014 328	8 627 440	9 442 149
Goods and services	**2 528 178**	**3 091 576**	**2 945 289**	**3 471 420**	**3 128 653**	**3 134 613**	**3 518 341**	**3 808 675**	**4 170 880**
Communication	57 244	52 113	43 919	48 309	48 309	44 645	46 215	48 741	50 407
Computer Services	42 587	41 717	29 544	43 003	27 623	39 672	46 379	55 402	57 081
Consultants, Contractors and special services	267 733	391 840	367 090	350 255	399 615	560 924	563 223	596 488	667 663
Inventory	1 544 145	1 999 918	1 966 564	2 367 480	2 078 439	1 941 054	2 263 435	2 452 187	2 717 039

PROGRAMME 2: DISTRICT HEALTH SERVICES

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Operating leases	37 220	30 795	36 802	41 661	37 854	18 354	17 057	18 032	18 649
Travel and subsistence	26 706	12 833	13 046	15 713	15 713	20 084	18 640	19 687	20 363
Interest and rent on land	-	-	-	-	-	-	-	-	-
Maintenance , repair and running costs	-	-	-	-	-	-	-	-	-
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	552 543	562 360	488 324	604 999	521 100	509880	563 392	618 138	639 678
Transfers and subsidies to	**282 953**	**345 058**	**399 201**	**334 819**	**350 004**	**348951**	**345 980**	**359 207**	**378 785**
Provinces and municipalities	50 883	82 483	124 913	94 173	96 029	96 750	86 293	84 928	89 174
Departmental agencies and accounts	-	-	-	-	-	-	-	-	-
Universities and technikons	40	-	-	-	-	-	-	-	-
Non-profit institutions	210 664	237 438	247 899	216 797	229 081	210 755	223 807	234 889	246 426
Households	21 366	25 137	26 389	23 849	24 894	41 446	35 880	39 390	43 185
Payments for capital assets	**56 570**	**28 182**	**29 921**	**191 557**	**274 200**	**177 488**	**75 070**	**85 961**	**53 623**
Buildings and other fixed structures	138	-	-	-	-	-	-	-	-
Machinery and equipment	56 432	28 182	29 921	191 557	274 200	177 488	**75 070**	**85 961**	**53 623**
Software and other intangible assets	-	-	-	-	-	-	-	-	-
Payment for financial assets	82	-	2 985	-	38	40	-	-	-
Total economic classification	**8 132 272**	**9 188 678**	**9 830 109**	**11 739 824**	**10 900 160**	**10 843 458**	**11 953 719**	**12 881 283**	**14 045 437**

Source: BAS

PERFORMANCE AND EXPENDITURE TRENDS

The significant allocation to Programme 2 supports the Departments' commitment to improve equity and access to re-engineered PHC. The gradual decrease in allocation from 47.5% of the annual budget in 2008/09, to 46% in 2014/15 relates mainly to restructuring of the Department including reviewed costing arrangements for previous "Combo" hospitals.

Further amounts were allocated for national priorities with carry-through costs across the 2012/13 MTEF to provide for capacity building and *Goods and Services*, funding for PHC Outreach [Family Health] Teams, improving hospital norms and standards, and additional funding for general policy adjustment. In addition, the NHI Conditional Grant will commence in 2012/13 to pilot NHI implementation in two districts. This funding provides for additional personnel, contracting private practitioners, and private services. The carry-through costs of these initiatives are reflected in 2014/15.

The reduction in the 2012/13 budget allocation relates to the planned provincialisation of most of the LG clinics with the exception of the eThekwini Metro and uMhlathuze Municipality. The allocation in 2012/13 includes funding for the first quarter to cover those institutions which are in the process of being taken over. The increase in the outer years of the 2012/13 MTEF reflects inflationary increases only.

The significant increases in the 2011/12 *Main and Adjusted Appropriation* provide for the replacement of the steadily deteriorating essential equipment at institutions as well as mobile clinics and other service delivery vehicles. In the 2012/13 MTEF funding are provided to replace essential equipment at a reduced rate.

Sub-Programme: District Management: The 2012/13 MTEF provides additional funding from the NHI Conditional Grant as well as carry-through costs of the relevant wage agreements and inflationary costs.

Sub-Programmes Community Health Clinics and Community Health Centres: The increase from 2011/12 is for funding of additional posts and *Goods and Services*, PHC Outreach [Family Health] Teams and expansion/ re-engineering of PHC. The reduction in the 2011/12 *Adjusted Appropriation* is due to the delayed filling of posts which also affected *Goods and Services.* Concrete plan on District specialist teams [Initial Budget R14 million; 2012/13 Budget –R67million].

Sub-Programme Community-Based Services: The Social Sector EPWP Incentive Grant for Provinces is being phased out from 2012/13 and a decision has been taken to place all Community Care Giver expenditure into the other Sub-Programmes within Programme 2 where costs are incurred, hence no funding from 2012/13 onward.

Sub-Programme Other Community Services: Included from the 2011/12 *Adjusted Appropriation* is additional funding for expanding School Health Teams and for the higher than anticipated 2011 wage agreement.

Sub-Programme HIV and AIDS: Additional funds were allocated in the 2012/13 MTEF to make provision for the increase of ART patients based on policy decision to initiate ART at a CD4 count of 350. The Comprehensive HIV and AIDS Grant has been reduced by R20.638 million and R22.980 million in the first two years of the 2012/13 MTEF respectively. In 2014/15, this Grant has been increased by R398.455 million to R3.074 billion. In 2014/15, an additional R198.455 million was included in *Compensation of Employees* from the Comprehensive HIV and AIDS Grant to improve treatment access.

Sub-Programme Nutrition: The decreasing trend from 2010/11 is due to cost-cutting.

Sub-Programme Coroner Services: From 2012/13, these services will be paid from the Department's Equitable Share.

Sub-Programme District Hospitals: Growth over the 2012/13 MTEF includes funding for national priorities to improve hospital efficiencies, as well as funding for OSD, capacity building and general policy adjustment.

7. RISK MANAGEMENT – PROGRAMME 2

Potential Risks	Mitigating Factors
1. Delays in the finalisation of Provincialisation of Local Government personal PHC/ EH services [Medium].	▪ PHC process commenced and additional funding allocated.
2. Major space constraints in clinics to accommodate increased demand for services [High].	▪ Alignment with Infrastructure Plan [based on audit] to improve access.
3. Delayed HR processes for filling of critical posts – organisational review [High].	▪ Alignment of HR Plan and finalisation of organisational review – expected in 2012/13.
4. Lack of community-based data to inform decision-making and planning [High].	▪ Pilot project commenced in Amajuba District [linked with Operation Sukuma Sakhe]. ▪ Epidemiology and Health Research Unit evaluate re-engineering of PHC to inform rollout. Assisting Amajuba District with pilot.

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

1. PROGRAMME PURPOSE AND STRUCTURE

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

Sub-Programme 3.1: Emergency Patient Transport [EPT]

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

Sub-Programme 3.2: Planned Patient Transport [PPT]

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

Sub-Programme 3.3: Disaster Management

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

There are no changes in the purpose of Programme 3: Emergency Medical Services since tabling of the 2010 – 2014 Strategic Plan.

Performance of all Programme 3 services/programmes, not specifically prioritised in the APP, are included in Operational Plans and monitored quarterly. Overall performance outcomes will be incorporated in the 2012/13 Annual Report.

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

At the end of quarter two of 2011/12, there were 185 operational ambulances out of a total of 501, which translates to 1 ambulance per 55,719 population compared with the national norm of 1 ambulance per 10,000 population. This shortage contributes to delayed response times and therefore compromise health outcomes as a result of delayed clinical intervention in emergency cases. The Department procured 274 new vehicles in 2011/12 currently awaiting conversion before distribution to districts.

The shortage of service providers for fleet maintenance increases the down time of ambulances for routine servicing and repairs. Within an optimal functioning system, ambulances should not exceed 250,000 km which is usually

reached within a three-year period. At present, 25% of ambulances fall within this usable lifespan.

There are 79 ambulance bases in the Province of which 50% are based in park homes. These structures require high maintenance and have to be replaced with suitable fixed structures. Wash bays and sluice facilities are inadequate.

The Department advertised 387 posts for Basic, Intermediate and Advanced Life Support Practitioners and appointed 332 Basic Life Support Practitioners during the 2nd quarter of 2011/12.

There is one Provincial Operations Centre which includes the flight desk for aero-medical services, and 11 District Control Centres [one per district]. Five Control Centres have been upgraded to computerized systems i.e. Centres in Ilembe, Ugu, Uthukela, Umgungundlovu and eThekwini.

The long-term EMS Plan makes provision for integration of the current 11 District and Provincial Communication Centres into 4 Communications Centres that will serve all districts and Head Office. This will reduce duplication particularly relevant to upgrading of Centres to computerized systems which are expensive and require continuous monitoring, maintenance and upgrade.

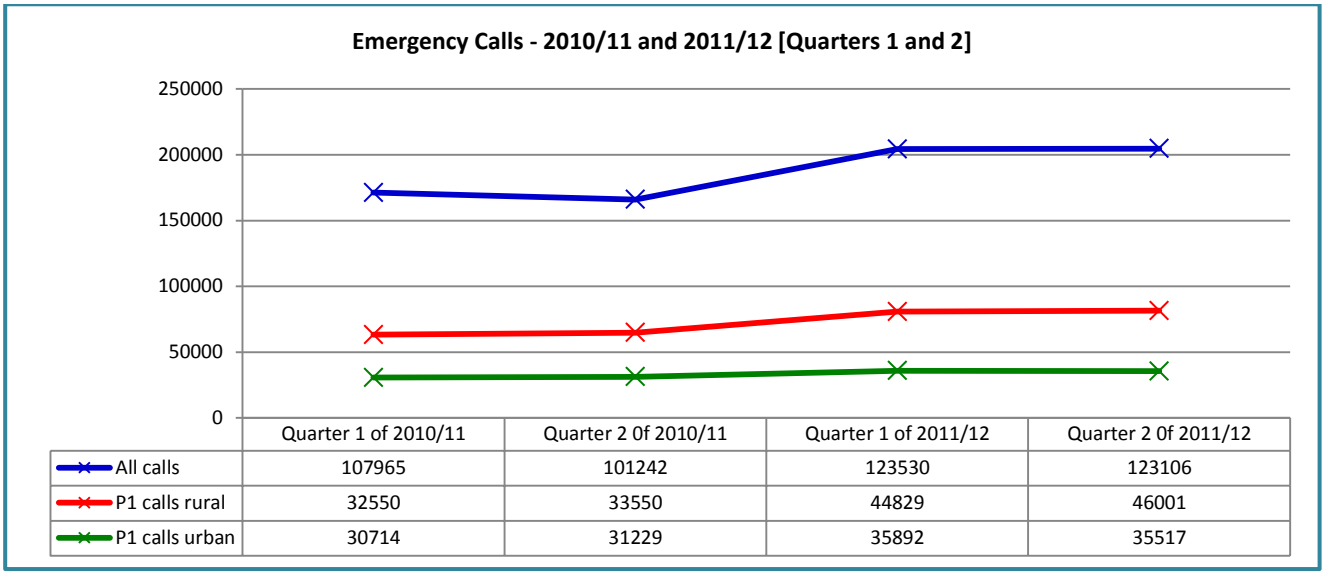
The 4 proposed Centres will cover:

- eThekwini: eThekwini, Ugu and Ilembe.
- Uthukela: Uthukela, Amajuba and Umzinyathi.
- Uthungulu: Uthungulu, Zululand, Umkhanyakude.
- Umgungundlovu: Umgungundlovu, Sisonke and Head Office.

The Department allocated 13 dedicated Obstetric Ambulance [1 per district and 2 each in eThekwini and Sisonke] for the transport of maternity cases. All maternity related cases are triaged as red code and dispatched accordingly. The Department plan to expand the number of dedicated Obstetric Ambulances including human resources [ILS and ECT staff] in 2012/13. The Department will in addition accelerate training courses on obstetric emergencies for staff manning Obstetric Ambulances, monitor compliance with referral protocols and appropriate use for obstetric emergency care, and align ambulance bases for specialised ambulances with strategically placed MOUs to cover an identified cluster of clinics linked with MOUs.

Response times are still far below the acceptable norm in both urban and rural areas and remain a serious challenge considering the increased demand for emergency services. The following graph shows the increase in emergency calls comparing quarters 1 and 2 in 2010/11 and 2011/12.

Graph 15: Emergency Calls - Quarters 1 and 2 of 2010/11 and 2011/12



	Quarter 1 of 2010/11	Quarter 2 0f 2010/11	Quarter 1 of 2011/12	Quarter 2 0f 2011/12
All calls	107965	101242	123530	123106
P1 calls rural	32550	33550	44829	46001
P1 calls urban	30714	31229	35892	35517

Source: EMS

Extended turn-around time for transporting patients between hospitals is a challenge as demand currently supersedes supply. It is estimated that approximately 50% of inter-facility transportation is emergency inter-facility transport and not Planned Patient Transport [PPT].

The Department established two PPT Hubs in Empangeni and eThekwini to improve patient care during inter-facility transfer. Post establishments have not been finalised yet and staff were seconded to both hubs in the interim [27 in Empangeni and 2 in eThekwini].

Air ambulance services are currently provided by Air Mercy Services [AMS] on a month to month agreement with EMS until National Treasury award the National Air Ambulance contract. There are currently two rotor wing aircraft [12hr days] and one fixed wing aircraft [24hr days]. One rotor wing is based in Richards's Bay airport and the other at King Shaka airport. The helicopter in Richards's Bay provides Air Ambulance services to Area 3 and the Midlands. It also provides access to Advanced Life Support skills to Area 3 due to the shortage of staff in the area. The helicopter assists with transfers from District Hospitals to Tertiary Hospitals in Empangeni and Durban which reduce travelling time of an ambulance by ±70%. The majority of these transfers require ALS skills which results in major delays and fatal outcomes when the rotor wing is unavailable. The helicopter also responds to clinics, road and farm accidents.

The Durban helicopter provides Air Ambulance services mainly to eThekwini, the rest of Area 1 and Area 2. It provides similar services as the Richards Bay helicopter although it has limitations in terms of availability. Due to the unpredictable weather conditions, the helicopter cannot always fly to Sisonke District that has a shortage of Advanced Life Support personnel.

The Fixed Wing Aircraft provides 24hr services for long distance transfers in/and outside the Province. The structure for Air Ambulance services has been approved and captured on Persal.

2. CHALLENGES

- Inadequate base infrastructure and EMS customised wash bays and sluice facilities.
- Increased referral to tertiary institutions with long travelling distances.
- Inadequate number of operational ambulances and inadequate staff with particular reference to Intermediate and Advanced Life Support.
- High accident rates and shortage of service providers for fleet maintenance resulting in increased down time of ambulances.
- Inadequate infrastructure including accommodation for staff, offices and vehicle bases.
- The EMS post establishment is not making provision for Communications Centres and PPT staff. As a result, operational staff have to be seconded to perform duties in Communications and PPT – perpetuating shortage of operational staff.

3. 2012/13 PRIORITIES: EMS

1. *Revitalisation of EMS*	▪ Implement the new EMS Service Delivery Model for modernisation of EMS.
2. *Improve access to EMS*	▪ Establish Media Liaison and Publicity Section to improve public awareness, marketing and utilisation.
3. *Improve quality of care and infection prevention and control*	▪ Recruitment of Intermediate Life Support, Mid–Level Workers [Emergency Care Technicians] and Advanced Life Support. – Ensure effective intervention [treatment] of pre-hospital emergencies. – Compulsory continuing Medical Education for all personnel.
4. *Improve human resource capacity*	▪ Implement development programmes for management and supervisory staff. – Finalise the staff establishment for EMS in line with the new Service Delivery Model.
5. *Improve Patient Transport Services*	▪ Introduce downward and upward referral guidelines clearly defining: – Non-Emergency Patient Transport. – Planned Patient Transport.
6. *Revitalisation of basic infrastructure*	▪ Commence with infrastructure for large ambulance stations in Ugu, Umgungundlovu, Umzinyathi, Wentworth, Umzimkhulu, Pomeroy, and Jozini.

7. *Improve ambulance response times*	▪ Introduce a new fleet of ambulances including Rapid Response vehicles, Obstetric Ambulances, and Rescue Units ▪ Clearly defined calls [call categorization].
8. *Improving the existing Communications network*	▪ Finalise the rationalisation of Emergency Management Centres. – Merge the Provincial Operations Centre, Umgungundlovu and Sisonke Emergency Management Centres. – Replace the old Repeaters in" dead spot" areas.
9. *Improve the management of vehicle and equipment*	▪ Introduce new Vehicle Monitoring Real- Time Tracking systems linked to Emergency Management Centres. – Employ suitably qualified Fleet Management Officers. – Introduce stringent control measures.

4. PERFORMANCE INDICATORS FOR EMS [TREASURY REPORTING]

Table 51: (EMS1): Situation Analysis Indicators for EMS – 2010/11

Indicators	Data Source	Province 2010/11	Ugu 2010/11	Umgungundlovu 2010/11	Uthukela 2010/11	Umzinyathi 2010/11	Amajuba 2010/11	Zululand 2010/11	Umkhanyakude 2010/11	Uthungulu 2010/11	Ilembe 2010/11	Sisonke 2010/11	eThekwini 2010/11
1. Rostered ambulances per 10,000 people	EMS Database	0.22	0.23	0.2	0.21	0.3	0.4	0.2	0.23	0.23	0.2	0.3	0.1
2. P1 calls with a response of time <15 minutes in an urban area	EMS Database	29%	10%	35%	9%	44%	79%	No urban reporting	No urban reporting	39%	5%	No urban reporting	8%
3. P1 calls with a response time of <40 minutes in a rural area	EMS Database	37%	17%	20%	25%	33%	83%	45%	21%	35%	21%	18%	44%
4. All calls with a response time within 60 minutes	EMS Database	53%	32%	39%	43%	57%	96%	65%	34%	49%	36%	24%	66%

- Note: Zululand, Sisonke and Umkhanyakude do not report on urban area response times. There is no current definition for urban/rural areas to guide reporting. This is being followed up by EMS.

5. PERFORMANCE INDICATORS FOR EMS [TREASURY REPORTING]

Table 52: (EMS3): Performance Indicators for EMS and Patient Transport

Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Rostered Ambulances per 10 000 people	EMS Database	No	0.25 [226]	0.24 [217]	0.2	0.17 N: 185 D: 10,622,204	0.45 [360]	0.5 [400]	0.6	1/10 000

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
						Target: 0.41				
2. P1 calls with a response of time <15 minutes in an urban area	EMS Database	%	28.1%	19%*	29%	12.3%* N: 8,780 D: 71,409 *Target: 15%*	30%	40%	50%	80%
3. P1 calls with a response time of <40 minutes in a rural area	EMS Database	%	39%	36%	37%	37.2% N: 33,812 D: 90,830 *Target: 45%*	50%	55%	60%	80%
4. All calls with a response time within 60 minutes	EMS Database	%	62.9%	53%	53%	55.9% N: 93,435 D: 166,766 *Target: 50%*	60%	63%	65%	100%

- Slow increase in response times calculated with due consideration to concomitant resource allocation and increasing demand for services.
- Estimated Performance 2011/12: Data refer to actual Quarter 2 data due to unavailability of relevant raw data for estimated projection.
- Indicator 2 – P1 calls with response times <15min in urban areas: Outliers [2009/10 and 2011/12] are being investigated. The targets for the MTEF have been based on the average performance [excluding outliers] – will be reviewed once data have been verified and corrected.
- Rural versus urban areas: EMS will determine standard definition to inform reporting.

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

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 53: (EMS2): Provincial Strategic Objectives and Annual Targets for EMS

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
1.12) To revitalise EMS and improve response times to ≥ 70% for rural and urban areas by 2014/15	1.12.1) Rostered ambulances per 10,000 people	1/10,000 (450)	EMS Database	0.25 [226]	0.24 [217]	0.22	0.17 N: 185 D: 10,622,204 *Target: 0.41*	0.45 [360]	0.5 [400]	0.6
	1.12.2) Total number of EMS emergency cases	1,435,951	EMS Database	Reporting not required	*713,923	642,760	582,110 *Target: 944,162*	1,085,786	1,248,653	1,373,518
	1.12.3) Total number of inter-facility transfers	187,224	EMS Database	Reporting not required	116,253	122,337	59,576 *Target: 140,665*	154,731	170,204	187,224
1.13) Improve the quality of care rendered by Emergency Care Personnel	1.13.1) Locally based staff with training in BLS (BAA)	20%	EMS Database	77%	71.5%	70.5%	71.5% *Target: 78%*	79%	81%	82%
	1.13.2) Locally based staff with training in ILS (AEA)	50%	EMS Database	21.4%	25%	26%	25% *Target: 28%*	27%	28%	29%
	1.13.3) Locally based staff with training as ECT (Emergency Care Technician)	5%	EMS Database	Reporting not required	0.5%	0.5%	0.5% *Target: 0.5%*	1%	1%	1%
	1.13.4) Locally based staff with training in ALS (Paramedics)	25%	EMS Database	1.6%	3%	3%	3% *Target: 4%*	3%	3%	3%

- Estimated Performance: Data reflect confirmed quarter 2 data.
- Indicator 1.13.1 - Locally based staff with training in BLS (BAA): The significant increase in the 2012/13 target is based on planned employment of ±9,000 BLS qualified service providers who are currently unemployed in KZN.

7. QUARTERLY AND ANNUAL TARGETS FOR EMS – 2012/13

Table 54: (EMS4): Quarterly and Annual Targets 2012/13

Performance Indicators	Annual Targets 2012/13	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. P1 calls with a response of time <15 minutes in an urban area	30%	20%	25%	27%	30%
2. P1 calls with a response time of <40 minutes in a rural area	50%	39%	42%	48%	50%
3. All calls with a response time within 60 minutes	60%	55%	56%	58%	60%
4. Total number of EMS emergency cases	1,085,786	271,446	271,446	271,446	271,448
5. Total number of inter facility transfers	154,731	38,682	38,682	38,682	38,685
Annual Targets					
6. Rostered Ambulances per 10,000 people	0.45 [360]				0.45 [360]
7. Locally based staff with training in BLS (BAA)	79%				79%
8. Locally based staff with training in ILS (AEA)	27%				27%
9. Locally based staff with training in ALS (Paramedics)	3%				3%
10. Locally based staff with training as ECT (Emergency Care Technician)	1%				1%

- APP indicators and targets [annual and quarterly] are included in the above table to ensure appropriate monitoring and reporting including the Provincial Quarterly Performance Report to Treasury and the National Department of Health and District Quarterly Progress Reports submitted to the Monitoring and Evaluation Component for dissemination.
- Indicators are aligned with District Health Plans to ensure effective monitoring of Provincial priorities.
- Additional operational indicators [process, input and output] are included in Operational Plans to ensure improved analysis, interpretation and reporting.

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

Table 55: (EMS5 (a)): Expenditure Estimates for EMS

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R' thousands	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Emergency Transport	636 096	741 331	809 447	883 803	1 001 027	996 638	1 007 942	1 037 149	1 097 201
Planned Transport	36 264	41 001	32 603	42 944	34 400	40 359	37 946	40 694	43 097
Total	**672 360**	**782 332**	**842 050**	**926 747**	**1 035 427**	**1 036 997**	**1 045 888**	**1 077 843**	**1 140 298**

Source: BAS

Table 56: (EMS5 (b)): Summary of provincial Expenditure estimates by Economic Classification

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Current payments	**590 257**	**710 728**	**753 033**	**809 271**	**864 147**	**865 164**	**971 966**	**1 043 610**	**1 105 738**
Compensation of employees	381 733	486 534	521 434	559 234	595 893	592 279	691 586	739 997	791 797
Goods and services	**208 524**	**224 194**	**231 599**	**250 037**	**268 254**	**272 885**	**280 380**	**303 613**	**313 941**
Communication	14 865	12 940	9 786	10 158	10 158	9 286	9 911	10 458	10 812
Computer Services	11 112	15 040	9 698	11 570	20 471	20 176	25 394	29 930	30 948
Consultants, Contractors and special services	58 304	66 454	68 725	81 568	80 672	83 741	80 230	84 723	87 602
Inventory	80 725	74 344	83 717	83 099	99 733	98 853	99 835	109 352	113 070
Operating leases	10 685	9 044	14 348	16 281	10 626	4 498	4 672	4 934	5 102
Travel and subsistence	3 170	4 999	3 266	3 781	3 781	5 354	5 158	5 447	5 632
Interest and rent on land	-	-	-	-	-	-	-	-	-
Maintenance , repair and running costs	-	-	-	-	-	-	-	-	-
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	29 663	41 373	42 059	43 580	42 813	50 977	55 180	58 769	60 775

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Transfers and subsidies to	**9 171**	**2 260**	**2 966**	**1 100**	**2 504**	**3 057**	**3 922**	**4 233**	**4 560**
Provinces and municipalities	511	1 232	1 461	-	924	1432	1 832	1 938	2 040
Departmental agencies and accounts	-	-	-	-	-	-	-	-	-
Universities and Technikons	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	8 660	1 028	1 505	1 100	1 580	1 625	2 090	2 295	2 520
Payments for capital assets	**72 932**	**69 344**	**85 781**	**116 376**	**168 776**	**168 776**	**70 000**	**30 000**	**30 000**
Buildings and other fixed structures			19						
Machinery and equipment	72 932	69 344	85 762	116 376	168 776	168 776	**70 000**	**30 000**	**30 000**
Software and other intangible assets	-	-	-	-	-	-	-	-	-
Payment for financial assets	**-**	**-**	270	**-**	**-**	**-**	**-**	**-**	**-**
Total economic classification	**672 360**	**782 332**	**842 050**	**926 747**	**1 035 427**	**1 036 997**	**1 045 888**	**1 077 843**	**1 140 298**

Source: BAS

9. PERFORMANCE AND EXPENDITURE TRENDS

Funding for vehicles has been reduced in the 2012/13 MTEF and will be revisited when funds are available. The 2012/13 MTEF allocations include carry-through costs for the various wage agreements and OSD payments, as well as funding to expand Emergency Medical Services.

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

The main cost drivers under *Goods and Services* are fuel and repairs to emergency vehicles, the latter being related to the rough terrain in rural areas. These costs will increase as the service expands, with a related increase in the size of the fleet. The allocations in the 2012/13 MTEF provide for inflation only.

The reduced amount in the *Main Appropriation and Adjusted Appropriation* over the 2012/13 MTEF relates to reprioritisation of funding, which will be reviewed during 2012/13.

10. RISK MANAGEMENT

Potential Risks	Mitigating Factors
1. Considerable variations in service levels between districts partly due to resource and capacity constraints [High].	▪ Implementation of the Revitalisation Strategy to address current challenges and provide for future service needs and demands
2. Organogram – Current organogram does not support current or future service demands and needs i.e. service delivery; seniority; and skills/competencies [High].	▪ A new organogram is currently being worked on for possible implementation after it has been approved. ▪ Competency assessments to be carried out on the current managers
3. Expensive temporary ambulance bases [Medium].	▪ New bases will be built in certain districts
4. Lack of managerial acumen and lazes' Faire attitude and apathy [High].	▪ Eligible staff will be sent on development courses and training to enhance their skills ▪ Instilling discipline and accountability
5. Inadequate and ageing fleet and lack of equipment [High].	▪ Replacement of old Beyond economic repair vehicles ▪ Replacement of old Beyond economic repair equipment

PROGRAMME 4: REGIONAL & SPECIALISED HOSPITALS

1. PROGRAMME PURPOSE AND STRUCTURE

Deliver accessible, appropriate, effective and efficient General Specialist Hospital Services.

Sub-Programme 4.1: Regional Hospitals

Render Regional Hospital Services at specialist level.

Sub-Programme 4.2: Specialised TB Hospitals

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

Sub-Programme 4.3: Specialised Psychiatric Hospitals

Render Hospital services for Mental Health.

Sub-Programme 4.4: Oral and Dental Training Centre

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

Sub-Programme 4.5: Step-Down and Rehabilitation Hospitals

Render Step-Down and Rehabilitation services to the chronically ill.

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

Performance measures, not specifically prioritised in the APP, will be included in Operational Plans and will be monitored quarterly. Overall performance outcomes will be reported in the Annual Report.

2. REGIONAL HOSPITALS

There are currently 14 Regional Hospitals in the Province, of which 12 are rendering some tertiary services to improve equity and access. There are no Regional Hospitals in Umzinyathi, Zululand, Umkhanyakude and Sisonke Districts [all Rural Development Nodes].

There are currently 8,173 approved regional beds [0.79 per 1000 population] compared with the proposed national norm of 0.23 per 1000 population.

According to Government Notice No R.655 of 12 August 2011 [14], two current Regional Hospitals have been re-classified namely:

- Ngwelezane Hospital [Uthungulu] to Tertiary Hospital [on the Revitalisation Programme].
- King Edward VIII Hospital [eThekwini] to Central Hospital [on the Revitalisation Programme].

- *The new service delivery platform in the two hospitals will be developed over time to ensure smooth transition of services*.

CHALLENGES REGIONAL HOSPITALS

- Effective costing model to determine expenditure per level of care in hospitals providing more than one service level [combo hospitals].
- Service delivery platform for regional services to ensure equity in access.
- Human resource constraints to ensure optimal service delivery in all hospitals i.e. rendering of the full package of Regional Hospital services.
- Management capacity.
- Poor compliance with national core standards.

2012/13 PRIORITIES: REGIONAL HOSPITALS

1. *Overhauling Regional Hospital services*	▪ Finalise and implement the reviewed service delivery platform [and Implementation Plan] for Regional Hospitals. ▪ Improve Human Resources for Health as per service delivery platform. ▪ Develop one High Volume Cataract Surgery Unit. ▪ Strengthen management capacity and accountability.
2. *Improve the quality and efficiency of Regional Hospital services*	▪ Implement the National Core Standards in all facilities and improve compliance to core standards of quality and efficiency of the 6 priority areas. ▪ Improve clinical governance including clinical support and mentorship to District Hospitals.

PROVINCIAL PERFORMANCE INDICATORS AND TARGETS FOR REGIONAL HOSPITALS

Table 57: (PHS2): Performance Indicators for Regional Hospitals

Indicator	Data Source	Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Caesarean section rate	DHIS	%	31.6%	38.8%	38.8%	38.3% N: 33,262 D: 86,815 *Target: 40%*	38%	37.5%	37%	25%
2. Separations - total	DHIS	No	355,778	355,231	372,902	388,419 *Target: 356,567*	403,956	420,114	436,919	-
3. Patient day equivalents - total	DHIS	No	2,797,350	2,903,847	3,238,319	3,531,050 *Target: 2,904,952*	3,672,292	3,819,184	3,971,951	-
4. OPD headcounts - total	DHIS	No	2,752,678	2,673,272	3,195,790	3,355,368 *Target: 2,817,960*	3,556,690	3,770,091	3,996,297	-
5. Average length of stay	DHIS	Days	5.3 days	5 days	5.4 days	5.4 days *Target: 5.2 days*	5.2 days	5.1 days	4.9 days	4.8 days
6. Bed utilisation rate	DHIS	%	71.3%	72.8%	63.6%	68.5% *Target: 74%*	70%	72%	74%	75%
7. Expenditure per patient day equivalent	BAS/ DHIS	R	R 1 175	R 1 421	R 1 380	R 1 534 N: 5 418 896 239 D: 3,531,050 *Target: R1600*	R 1 600	R 1 650	R 1 700	-
8. Percentage of complaints of users of Regional Hospital services resolved within 25 days	DHIS	%	56%	84%	79%	62.6% N: 360 D: 575 *Target: 100%*	80%	80%	80%	-
9. Percentage of Regional Hospitals with monthly mortality and morbidity meetings	DQPR	%	Reporting not required	100%	100%	100% N: 14 D: 14 *Target: 100%*	100%	100%	100%	100%

Indicator	Data Source	Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
10. Regional Hospital Patient Satisfaction rate [Annual]	Survey	%	Reporting not required	Reporting not required	Reporting not required	60% *Baseline*	80%	80%	90%	100%
11. Number of Regional Hospitals assessed for compliance with the 6 Priorities of the core standards [Annual]	Reports	No	Reporting not required	Reporting not required	Reporting not required	14 *Target: 14*	14	14	14	-

- The caesarean section rate target for 2011/12 was based on inaccurate data [deliveries and caesarean section] that has since been corrected.
- PDE and OPD data for 2010/11 was also corrected since tabling of the 2010/11 Annual Report.

PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND TARGETS FOR REGIONAL HOSPITALS

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 58: (PHS1 (a)): Provincial Strategic Objectives and Annual Targets for Regional Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
1.14) To rationalize hospital services in line with service delivery needs and STP imperatives	1.14.) Number of Regional Hospitals designated as Ophthalmic Centres of Excellence	New indicator	DQRS	Reporting not required	Reporting not required	Reporting not required	1 *Baseline: 1*	1 [2]	1 [3]	2 [5]

- New strategy will be implemented to improve eye care services [dependent on adequate funding as well as human resources for health].

PROGRAMME 4: REGIONAL & SPECIALISED HOSPITALS

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

Table 59: (PHS1 (b)): Provincial Strategic Objectives and Annual Targets for Regional and Specialised Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
2.3) To implement the National Core Standards in 100% of Regional Hospitals for accreditation of 100% facilities by 2012/13	2.3.1) Number of Regional Hospitals compliant with the 6 priority areas of Core Standards	14/14	National database	Reporting not required	Reporting not required	Nil	Nil *Target: 10*	4	6 [10]	4 [14]

- National assessment for accreditation/licensing is dependent on national processes for the establishment of the National Office of Standard Compliance. Internal processes however demand regular assessment of performance against 6 priority areas of Core Standards with supporting Quality Improvement Plans. Relevant secondary indicators will be monitored as part of Operational Plans.

QUARTERLY AND ANNUAL TARGETS FOR REGIONAL HOSPITALS

Table 60: (PHS4 a): Quarterly and Annual Targets for Regional Hospitals for 2012/13

Performance Indicators	Annual Targets 2012/13	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Caesarean section rate	38%	38.2%	38.2%	38.1%	38%
2. Separations - total	403,956	100,989	100,989	100,989	100,989
3. Patient day equivalents - total	3,672,292	913,073	913,073	913,073	913,073
4. OPD headcounts - total	3,556,690	889,172	889,172	889,172	889,174
5. Average length of stay	5.2 days	5.4 days	5.4 days	5.3 days	5.2 days
6. Bed utilisation rate	70%	68.5%	69%	70%	70%
7. Expenditure per patient day equivalent	R 1 600	R 1 540	R 1 580	R 1 600	R 1 600
8. Percentage of complaints of users of Regional Hospital services resolved within 25 days	80%	70%	70%	80%	80%
9. Percentage of Regional Hospitals with monthly mortality and morbidity meetings	100%	100%	100%	100%	100%
Annual Targets					
10. Regional Hospital Patient Satisfaction rate	80%				80%
11. Number of Regional Hospitals assessed for compliance with the 6 Priorities of the core standards	14				14
12. Number of Regional Hospitals compliant with the 6 priority areas of the Core Standards	4				4
13. Number of Regional Hospitals designated as Ophthalmic Centres of Excellence	1 [2]				1 [2]

- All APP indicators and targets [annual and quarterly] are included the above table to ensure appropriate monitoring and reporting including the Provincial Quarterly Performance Report to Treasury and the National Department of Health and District Quarterly Progress Reports submitted to the Monitoring and Evaluation Component for dissemination.
- Indicators are aligned with District Health Plans to ensure effective monitoring of Provincial priorities.
- Additional operational indicators [process, input and output] are included in Operational Plans to ensure improved analysis, interpretation and reporting.

PROGRAMME 4: REGIONAL & SPECIALISED HOSPITALS

3. SPECIALISED TB HOSPITALS

There are 12 Specialised TB Hospitals in the Province, and provision has been made for MDR TB in 6 Decentralised and 9 Satellite MDR TB Units that are attached to hospitals. There are no Specialised TB Hospitals in Uthukela, Amajuba, Umkhanyakude, Uthungulu and Ilembe. Acute TB beds are available in District Hospitals and referral arrangements in place for the referral of TB patients. King George V Hospital is the Centre of Excellence for MDR TB services.

There are currently 2,012 approved beds in Specialised TB Hospitals translating to 0.19 beds per 1000 population, and 410 MDR TB beds in Decentralised and Satellite MDR TB Units.

CHALLENGES

1. Equitable distribution of TB beds [including beds for effective management of drug-resistant TB].
2. Growing numbers of drug-resistant TB without concomitant increase in resources.
3. Integration of TB services with mainstream PHC services.
4. Human resource constraints especially relevant to the management of drug resistant TB.
5. Infrastructure constraints.

2012/13 PRIORITIES FOR SPECIALISED TB HOSPITALS

1. *Decentralised and Satellite MDR TB Units*	▪ Increase beds [and capacity] for MDR TB in Decentralised and Satellite Units. ▪ Community-based management of MDR TB linked with Decentralised and Satellite Units. ▪ Review post establishments and fast track appointment of critical skills to make adequate provision for the management of drug resistant TB in all districts.
2. *Overhaul Specialised TB Hospitals*	▪ Revitalisation of Specialised TB Hospitals in response to demand and equity. ▪ Implementation of national core standards to improve efficiencies and quality. ▪ Improved management capacity and accountability.

PROVINCIAL PERFORMANCE INDICATORS AND TARGETS FOR SPECIALISED TB HOSPITALS

Table 61: (PHS2 (b)): Performance Indicators for Specialised TB Hospitals

Indicator	Data Source	Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Separations - total	DHIS	No	8,452	9,113	9,289	9,181 *Target: 8,500*	9,344	9,922	10,722
2. Patient day equivalents - total	DHIS	No	*510,220	518,685	482,323	522,540 *Target: 521,781*	543,442	565,179	587,786
3. OPD headcounts - total	DHIS	No	59,554	64,853	136,853	138,080 *Target: 87,891*	141,064	144,768	151,994
4. Average length of stay	DHIS	Days	60.4 Days	54.5 Days	25.9 Days	25.1 Days *Baseline*	30 Days	30 Days	30 Days
5. Bed utilisation rate	DHIS	%	75.1%	70.1%	58.1%	54.1% *Target: 65%*	70%	73%	75%
6. Expenditure per patient day equivalent	DHIS/ BAS	R	R 1 432	R 1 516	R 1 750	R 1 594 *Target: R1676*	R 1 700	R 1 750	R 1 800

PROGRAMME 4: REGIONAL & SPECIALISED HOSPITALS

PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND TARGETS FOR SPECIALISED tb HOSPITALS

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

Table 62: (PHS1 (d)): Provincial Strategic Objectives and Annual Targets for Specialised TB Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
2.4) To implement the National Core Standards in 100% of Specialised TB Hospitals for accreditation of 100% hospitals by 2014/15	2.4.1) Number of Specialised TB Hospitals compliant with the 6 priorities of the Core Standards	10 / 10	National database	Reporting not required	Reporting not required	Nil	Nil *Target:10*	2	4 [6]	4 [10]

- National assessment for accreditation/licensing is dependent on national processes for the establishment of the National Office of Standard Compliance. Internal processes however demand regular assessment of performance against 6 priority areas of Core Standards with supporting Quality Improvement Plans. Relevant secondary indicators will be monitored as part of Operational Plans.

QUARTERLY AND ANNUAL TARGETS FOR SPECIALISED TB HOSPITALS

Table 63: (PHS4 (b)): Quarterly and Annual Targets for Specialised TB Hospitals for 2012/13

Performance Indicators	Annual Targets 2012/13	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Separations - total	9,344	2,336	2,336	2,336	2,336
2. Patient day equivalents - total	543,442	135,860	135,860	135,860	135,862
3. OPD headcounts - total	141,064	35,266	35,266	35,266	35,267
4. Average length of stay	30 Days	30 Days	30 Days	30 Days	30 Days
5. Bed utilisation rate	70%	64%	66%	68%	70%
6. Expenditure per patient day equivalent	R 1 700	R 1 600	R 1 650	R 1 700	R1 700
Annual Targets					
7. Number of Specialised TB Hospitals compliant with the 6 priorities of the Core Standards	2				2

- All APP indicators and targets [annual and quarterly] are included in the above table to ensure appropriate monitoring and reporting including District Quarterly Progress Reports submitted to the Monitoring and Evaluation Component for dissemination.
- Indicators are aligned with District Health Plans to ensure effective monitoring of Provincial priorities.
- Additional operational indicators [process, input and output] are included in Operational Plans to ensure improved analysis, interpretation and reporting.

4. SPECIALISED PSYCHIATRIC HOSPITALS

There are currently 6 Specialised Psychiatric Hospitals in the Province making provision for 3,244 beds translating to 0.31 beds per 1000 population.

- There is a shortfall of acute beds in eThekwini.
- Area 1 [Ugu, Ilembe and eThekwini] has a shortfall of acute beds and no forensic beds.
- Area 3 is severely under-resourced in terms of both acute and chronic beds.
- Umgungundlovu District has the biggest number of the Specialised Psychiatric Hospital beds - both acute and chronic.

CHALLENGES

- Increasing demand for mental health services without concomitant increase in resources.
- Extended waiting list for awaiting trial prisoners due to inadequate forensic services.
- Staff shortages of all categories of staff e.g. Psychiatrists, Psychologists and Psychiatric Nurses.
- Inadequate infrastructure including, but not limited to, seclusion rooms.
- Delays in the commissioning of King George V Hospital pose challenge in terms of the support that the hospital should be offering to District Hospitals. The hospital is currently operating with 60 beds instead of 130 beds.
- Utilisation/referral to specialized in/out-patient services is high due to lack of adequate resources at PHC level.

2012/13 PRIORITIES FOR PSYCHIATRIC HOSPITALS

1. *Revitalisation of Psychiatric [Mental Health] services*	▪ Review service delivery platform of Ekuhlengeni and Umgeni Waterfall Institute. ▪ Decentralisation of medium to long-term beds to hospitals in Areas 1 and 3 to reduce the beds in Umgeni and Fort Napier Hospitals. ▪ Review step-down facilities within Specialised Psychiatric Hospitals for continuity of care before discharge to community step-down facilities. ▪ Expedite revitalisation process for identified hospitals including the full commissioning of King George V Hospital. ▪ Integration of Mental Health services with re-engineering of PHC. ▪ Implementation of national core standards to improve quality and efficiency. ▪ Improve hospital management and accountability.

PROGRAMME 4: REGIONAL & SPECIALISED HOSPITALS

PROVINCIAL PERFORMANCE INDICATORS AND TARGETS FOR SPECIALISED PSYCHIATRIC HOSPITALS

Table 64: (PHS2 (c)): Performance Indicators for Specialised Psychiatric Hospitals

Indicator	Data Source	Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Separations – total	DHIS	No	2,073	1,965	2,945	2,872 *Target: 1,350*	3,089	3,241	3,391
2. Patient day equivalents - total	DHIS	No	647,211	628,878	644,750	650,514 *Target: 641,053*	657,645	670,798	684,214
3. OPD headcounts - total	DHIS	No	5,048	14,409	7,994	7,436 *Target: 12,500*	8,174	8,782	9,121
4. Average length of stay	DHIS	Days	1,788 Days	1,315 Days	37.9 Days	24 Days *Baseline*	24 Days	24 Days	24 Days
5. Bed utilisation rate	DHIS	%	61.23%	71.6%	73.8%	71.6% *Target: 70%*	73%	75%	75%
6. Expenditure per patient day equivalent	DHIS/ BAS	R	R 697.50	R 810.96	R 864	R 918 *Target: R1100*	R 1 100	R 1 150	R 1 200

- Indicator 3 – average length of stay: The 2010/11 average length of stay is not comparable to previous years for specialised hospitals due to a formula change which now includes day patients as part of the denominator [separations] – this was previously excluded.

PROGRAMME 4: REGIONAL & SPECIALISED HOSPITALS

PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND TARGETS FOR SPECIALISED psychiatric HOSPITALS

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

Table 65: (PHS1 (f)): Provincial Strategic Objectives and Annual Targets for Specialised Psychiatric Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
2.5) To implement the National Core Standards in 100% of Specialised Psychiatric Hospitals for accreditation of 100% hospitals by 2014/15	2.5.1) Number of Specialised Psychiatric Hospitals compliant with the 6 priorities of the Core Standards	6/ 6	National Database	Reporting not required	Reporting not required	Nil	Nil *Target: 1*	2	2 [4]	6

- National assessment for accreditation/licensing is dependent on national processes for the establishment of the National Office of Standard Compliance. Internal processes however demand regular assessment of performance against 6 priority areas of Core Standards with supporting Quality Improvement Plans. Relevant secondary indicators will be monitored as part of Operational Plans.

QUARTERLY AND ANNUAL TARGETS FOR SPECIALISED PSYCHIATRIC HOSPITALS

Table 66: (PHS4 (c)): Quarterly and Annual Targets for Psychiatric Hospitals for 2012/13

Performance Indicator		Annual Target 2012/13	Quarterly Targets			
			Q1	Q2	Q3	Q4
Quarterly Targets						
1.	Separations – total	3,089	772	772	772	775
2.	Patient day equivalents - total	657,645	164,411	164,411	164,411	164,412
3.	OPD headcounts - total	8,174	2,043	2,043	2,043	2,045
4.	Average length of stay	24 Days	24 Days	24 Days	24 Days	24 Days
5.	Bed utilisation rate	73%	72%	73%	73%	73%
6.	Expenditure per patient day equivalent	R 1 100	R 900	R 995	R 1 000	R 1 100
Annual Targets						
8.	Number of Specialised Psychiatric Hospitals compliant with the 6 priority areas of the Core Standards	2				2

- All APP indicators and targets [annual and quarterly] are included in the above table to ensure appropriate monitoring and reporting including District Quarterly Progress Reports submitted to the Monitoring and Evaluation Component for dissemination.
- Indicators are aligned with District Health Plans to ensure effective monitoring of Provincial priorities.
- Additional operational indicators [process, input and output] are included in Operational Plans to ensure improved analysis, interpretation and reporting.

5. ORAL AND DENTAL TRAINING CENTRE

The Oral and Dental Training Centre [ODTC] is situated at King George V Hospital in eThekwini and has two main functions namely training of Dental Therapists and Oral Hygienists and Public Health service delivery. The Centre is linked to the training programme for Dental Therapy and Oral Hygiene students at UKZN, and also provides basic dental services, specialized dental services, as well as limited tertiary services for teaching purposes. A total of 100 first year students enrolled for 2012, while the Centre produces an average of 30 students per year for combined degrees. The average patient headcount is 2,200 per month.

The package of services at the Centre includes:

- *Primary Health Care*: Examination and patient charting, education, and management of pain and sepsis.
- *Secondary and Tertiary services*: Prosthodontics, Orthodontics, Periodontics and Maxillofacial and Oral Surgery.

CORE CHALLENGES

- Lack of a Service Level Agreement between UKZN and the Department of Health weakening control, uneven split between supervision of students and daily operational duties, and challenges with distribution of resources between UKZN and the Department.
- High patient demand for extractions instead of preventive and restorative work.
- Long waiting time for dentures. *Expected to improve with opening of the dental laboratory at IALCH.*
- Shortage of dental chairs and lack of working stations for staff. *UKZN procured and replaced 22 new dental chairs in 2011 which will improve service delivery.*

2012/13 PRIORITIES OF THE ORAL AND DENTAL TRAINING CENTRE

1. *Revitalisation of the Oral and Dental Training Centre*	▪ Expand specialised treatment services i.e. Prosthodontics [60 patients per annum], Orthodontics [80 patients per annum]. ▪ Finalise and implement the Service Level Agreement between the Department and UKZN.

PROGRAMME 4: REGIONAL & SPECIALISED HOSPITALS

6. STEP-DOWN, REHABILITATION & CHRONIC HOSPITALS

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

Hillcrest Hospital in eThekwini [212 beds] provides long-term chronic care. Due to poor support at community level, the hospital length of stay is extended to sustain treatment gains and prevent costly relapses. Due to the low level of acuity of patients, treatment procedures falling within the scope of practice of a Staff Nurse [under the indirect supervision of a Professional Nurse and General Practitioner] are provided.

Specialised Rehabilitation Units have been established at Regional [R.K. Khan Hospital] and Tertiary [Grey's and IALCH] hospitals to provide, on an out-patient basis, specialised rehabilitative care services to patients affected by strokes and spinal injuries.

Two other Specialised Rehabilitation Centres in Phoenix and Pietermaritzburg were established in the Province prior to 1994 to provide specialised rehabilitation services to the Indian Community. 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. As such, access to these Institutions by patients from the rest of the Province is problematic. Services at the Phoenix Rehabilitation Centre are within the scope of practice of Physiotherapy, Occupational, Speech and Audio Therapists with outreach support by Psychologists attached to Hospitals.

CHALLENGES

- Inequity in access to services.

2012/13 PRIORITIES CHRONIC/ SUB-ACUTE HOSPITALS

1. *Revitalisation of Chronic and Sub-Acute Hospital services*	▪ Review service delivery platform of all institutions. ▪ Implement the national core standards to improve efficiency and quality. ▪ Improve management capacity and accountability.

PROVINCIAL PERFORMANCE INDICATORS AND TARGETS FOR CHRONIC HOSPITALS

Table 67: (PHS2 (d)): Performance Indicators for Chronic Hospitals

Indicator	Data Source	Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Separations – total	DHIS	No	5,144	4,344	3,591	3,904 *Target: 4,310*	4,060	4,223	4,391
2. Patient day equivalents - total	DHIS	No	147,821	150,513	174,525	199,810 *Target: 146,341*	207,802	216,114	224,759
3. OPD headcounts - total	DHIS	No	Not available	Not available	136,951	155,768 *Target: 3,877*	159,662	163,654	167,745
4. Average length of stay	DHIS	Days	471 Days	27 Days	24.3 Days	14 Days *Target: Audit*	24 Days	24 Days	24 Days
5. Bed utilisation rate	DHIS	%	74.9%	82.5%	63.4%	63.4% *Target: 75%*	67.5%	70%	75%
6. Expenditure per patient day equivalent	DHIS/ BAS	R	R 634.99	R 662.08	R 574	R 1 047 *Target: R943*	R 1 100	R 1 150	R 1 200

- Indicator 4 – average length of stay: The 2009/10 and subsequent data for this indicator is not comparable to previous years due to formula change. Calculation now includes day patients as part of the denominator [separations] which was previously excluded.

PROGRAMME 4: REGIONAL & SPECIALISED HOSPITALS

PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND TARGETS FOR REGIONAL AND SPECIALISED HOSPITALS

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

Table 68: (PHS1 (h)): Provincial Strategic Objectives and Annual Targets for Specialised Chronic Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
2.6) To implement the National Core Standards in 100% of Specialised Chronic Hospitals for accreditation of 100% hospitals by 2011/12	2.6.1) Number of Chronic Hospitals compliant with the 6 priority areas of the Core Standards	2	National Database	Reporting not required	Reporting not required	Nil	Nil *Target: 2*	1	1 [2]	2

- National assessment for accreditation/licensing is dependent on national processes for the establishment of the National Office of Standard Compliance. Internal processes however demand regular assessment of performance against 6 priority areas of Core Standards with supporting Quality Improvement Plans. Relevant secondary indicators will be monitored as part of Operational Plans.

QUARTERLY AND ANNUAL TARGETS FOR CHRONIC HOSPITALS

Table 69: (PHS4 d): Quarterly and Annual Targets for Chronic Hospitals for 2012/13

Performance Indicator		Annual Target 2012/13	Quarterly Targets			
			Q1	Q2	Q3	Q4
Quarterly Targets						
1.	Separations - total	4,060	1,015	1,015	1,015	1,015
2.	Patient day equivalents - total	207,802	51,950	51,950	51,950	51,952
3.	OPD headcounts - total	159,662	19,915	19,915	19,915	19,917
4.	Average length of stay	24 Days	24 Days	24 Days	24 Days	24 Days
5.	Bed utilisation rate	67.5%	66%	66%	67%	67.5%
6.	Expenditure per patient day equivalent (PDE)	R 1 100	R 1 100	R 1 100	R 1 100	R 1 100
Annual Targets						
7.	Number of Chronic Hospitals compliant with the 6 priority areas of the Core Standards	1				1

- All APP indicators and targets [annual and quarterly] are included in the above table to ensure appropriate monitoring and reporting including District Quarterly Progress Reports submitted to the Monitoring and Evaluation Component for dissemination.
- Indicators are aligned with District Health Plans to ensure effective monitoring of Provincial priorities.
- Additional operational indicators [process, input and output] are included in Operational Plans to ensure improved analysis, interpretation and reporting.

RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 70: (PHS4 (a)): Expenditure Estimates for Regional Hospital Services

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R' thousands	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
General [Regional] Hospitals	3 169 928	3 664 133	4 161 998	4 670 222	5 466 358	5 548 041	5 989 701	6 437 857	6 831 380
Tuberculosis Hospitals	653 625	787 273	837 104	976 783	907 127	800 107	787 875	843 900	896 988
Psychiatric Hospitals	451 429	509 621	540 326	592 947	597 802	581 596	655 155	702 227	746 171
Sub-acute, step-down and chronic medical hospitals	93 865	99 578	102 531	111 323	110 279	108 757	119 006	127 427	134 682
Dental training hospital	9 967	10 685	12 266	14 907	14 739	14 923	16 652	17 778	18 465
Other specialised hospitals	-	-	-	-	-	-	-	-	-
Total	**4 378 814**	**5 071 290**	**5 654 225**	**6 366 182**	**7 096 305**	**7 053 454**	**7 589 389**	**8 128 189**	**8 627 686**

Source: BAS

Table 71: (PHS4 (b)): Summary of Provincial Expenditure Estimates by Economic Classification

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Current payments	**4 299 744**	**4 994 773**	**5 563 408**	**6 195 587**	**6 895 024**	**6 890 388**	**7 490 163**	**8 036 151**	**8 550 909**
Compensation of employees	3 015 350	3 520 810	4 112 995	4 433 228	5 221 180	5 233 460	5 531 354	5 931 894	6 365 528
Goods and services	**1 284 394**	**1 473 963**	**1 450 413**	**1 762 359**	**1 673 844**	**1 656 928**	**1 958 809**	**2 104 257**	**2 185 381**
Communication	18 837	18 252	18 442	18 824	18 824	20 138	22 355	23 497	24 296
Computer Services	18 168	18 560	12 046	13 872	10 623	20 681	26 032	30 690	31 734
Consultants, Contractors and special services	271 495	316 266	129 860	276 812	207 991	116 625	283 886	304 287	323 957
Inventory	668 788	810 665	904 115	997 060	986 446	1 052 528	1 129 668	1 200 619	1 241 463
Operating leases	15 886	13 095	18 895	21 027	21 027	11 275	10 839	11 446	11 835
Rental and Hiring	-	-	-	-	-	-	-	-	-
Travel and subsistence	5 034	3 715	3 828	3 526	3526	6132	6 166	6 511	6 732

PROGRAMME 4: REGIONAL & SPECIALISED HOSPITALS

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Interest and rent on land	-	-	-	-	-	-	-	-	-
Maintenance , repair and running costs	-	-	-	-	-	-	-	-	-
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	286 186	293 410	363 227	431 238	425 407	429 549	479 863	527 207	545 364
Transfers and subsidies	**54 630**	**58 618**	**71 170**	**83 885**	**63 108**	**61 551**	**58 726**	**70 058**	**74 277**
Provinces and municipalities	131	235	318	-	738	713	600	625	640
Departmental agencies and accounts	-	-	-	-	-	-	-	-	-
Universities and technikons	-	-	-	-	-	-	-	-	-
Non-profit institutions	27 103	30 051	32 600	35 692	38 770	36 238	37 742	39 628	41 611
Households	27 396	28 332	38 252	48 193	23 600	24 600	20 384	29 805	32 026
Payments for capital assets	**24 440**	**17 884**	**17 730**	**86 710**	**138 158**	**101 500**	**19 500**	**21 980**	**2 500**
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Machinery and equipment	24 440	17 884	17 730	86 710	138 158	101 500	**19 500**	**21 980**	**2 500**
Software and other intangible assets	-	-	-	-	-	-	-	-	-
Payment for financial assets	-	**15**	**1 917**	**-**	**15**	**15**	-	-	-
Total economic classification	**4 378 814**	**5 071 290**	**5 654 225**	**6 366 182**	**7 096 305**	**7 053 454**	**7 568 389**	**8 128 189**	**8 627 686**

Source: BAS

PERFORMANCE AND EXPENDITURE TRENDS

Programme 4 shows an increase in the share of total funding from 25% in 2008/09 to 28% in 2014/15. The increase in the 2011/12 *Main Appropriation* and the *Adjusted Appropriation* relate to the need to replace essential equipment, especially at regional provincial hospitals on a once off basis. The reduced amount over the 2012/13 MTEF relates to reprioritisation of funding, which will be reviewed during 2012/13. The 2012/13 MTEF includes carry-through costs for previous wage agreements, an increase in general health capacity, as well as national priorities including health technology, registrars, improvement to public hospital norms and standards, etc.

Sub-Programme 4.2 - TB Hospitals: The steady growth from 2008/09 to 2011/12 mainly relates to wage agreements, OSD, and the provision of funding for the treatment of MDR/XDR TB, including the establishment of Specialised TB Hospitals. The reduction in the 2012/13 MTEF relates mainly to the decision to move funding to other categories of hospitals, which are also dealing with TB, primarily District Hospitals and Regional Hospitals.

Sub-Programme 4.3 - Psychiatric Hospitals: The 2012/13 MTEF includes the carry-through costs of previous wage agreements, OSD, and inflationary increases only.

Sub-Programme 4.5 - Sub-Acute, Step-Down and Chronic Medical Hospitals: The 2012/13 MTEF includes the carry-through costs of previous wage agreements, OSD and inflationary increases only.

7. RISK MANAGEMENT

Potential Risks	Mitigating Factors
1. Financial constraints as a result of increasing service demands [High].	▪ Cost containment strategies institutionalised. ▪ Monthly expenditure reviews including analysis of the cost drivers – intensified communication between province and institutions.
2. High vacancy and attrition rates and delays in filling of critical posts impacting on service delivery. [High].	▪ Minimum staff establishments for hospitals. ▪ Fast track filling of critical posts [HR Plans aligned, improved processes in Budget Control and HR]. ▪ Improve HRMS to decrease absenteeism and staff turnover. ▪ It is anticipated that OSD will impact positively on retaining scarce skills.
3. Lack of an effective costing system to determine expenditure for hospitals rendering more than one level of care [High].	▪ Alignment of budget with service delivery [package of services]. ▪ Review costing of hospitals [per level of care].

PROGRAMME 5: TERTIARY & CENTRAL HOSPITALS

1. PROGRAMME PURPOSE AND STRUCTURE

Rendering Quaternary and other Tertiary Health Services

Sub-Programme 5.1: Central Hospitals

Rendering Central and Quaternary Hospital Services

Sub-Programme 5.2: Tertiary Hospitals

Rendering Tertiary Hospital services

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

Performance measures of all Programme 5 services/programmes, not specifically prioritised in the APP, will be included in Operational Plans and monitored quarterly. Overall performance outcomes will be incorporated in the Annual Report.

Currently only Greys Hospital [530 approved beds] is classified as Tertiary Hospital and IALCH [810 approved beds] as Central Hospital.

Government Notice No R.655 [14] however classified Ngwelezane Hospital as Tertiary Hospital [currently Regional with 560 beds] and King Edward VIII Hospital as Central [currently Regional with 799 beds]. Development of the newly classified hospitals will be actioned in phases to ensure smooth transition of services.

Currently only Inkosi Albert Luthuli Hospital [eThekwini] provides 100% tertiary services. Greys Hospital in Umgungundlovu provides 80% tertiary services; Ngwelezane Hospital in Uthungulu 33% and Lower Umfolozi War Memorial Hospital in Uthungulu 37%. Limited tertiary services are provided in 12 Regional Hospitals to improve access to services.

Review of the service delivery platform commenced in 2011/12.

2. CHALLENGES

1. Compromised institutional management due to vacant CEO posts at Greys and Ngwelezane Hospitals. Both posts have been advertised in 2011/12.
2. High vacancy rate of Specialists impacting on access to the full package of services.
3. Lack of an appropriate costing model to ensure linkage of expenditure with service delivery.

PROGRAMME 5: TERTIARY & CENTRAL HOSPITALS

3. 2012/13 PRIORITIES: TERIARY AND CENTRAL HOSPITALS

1. *Overhaul Tertiary and Central Hospital services.*	▪ Review the service delivery platform for Tertiary and Central Hospitals. ▪ Develop a competent and sustainable workforce through improved Human Resource Planning, Development and Management. ▪ Review and establish effective referral systems in collaboration with EMS. ▪ Monitor the implementation of the National Tertiary Services Grant [NTSG] Business Plan.
2. *Improve quality and efficiency.*	▪ Implement the national core standards to improve efficiency and quality. ▪ Strengthen clinical governance and leadership. ▪ Strengthen management in all clinical disciplines. ▪ Improve facility management competencies and accountability. ▪ Improve clinical governance including training and development [Regional Hospitals].
3. *Provide appropriate health technology and infrastructure.*	▪ Establish appropriate hospital information systems. ▪ Establish effective training/ mentoring programmes through Telemedicine.

4. PERFORMANCE INDICATORS FOR TERTIARY HOSPITALS

Table 72: (THS2): Performance Indicators for Tertiary Hospitals [Greys Hospital]

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Caesarean section rate	DHIS	%	69.4%	62,6%	69.3%	68.9% N: 1,168 D: 1,694 *Target: 70%*	68.6% 1108 1694	67.7%	67.2%	30%
2. Separations - total	DHIS	No	11,919	10,755	12,633	13,914 Target: 12,266	14,371	14,949	15,351	-
3. Patient Day Equivalents - total	DHIS	No	193,913	180,119	191,274	189,698 Target: *192,938*	193,969	201,897	209,069	-
4. OPD headcounts - total	DHIS	No	196,857	203,358	208,223	210,960 Target: *181,793*	215,511	223,054	230,861	-
5. Average length of stay	DHIS	Days	9.9 days	10.4 days	12 days	10 days *Target: 9 days*	9.8 days	9.5 days	9 days	5.5 Days
6. Bed utilisation rate	DHIS	%	70.9%	65.4%	73.4%	70% *Target: 73%*	75%	75%	75%	75%
7. Expenditure per patient day equivalent (PDE)	BAS/DHIS	R	R 2 170	R 2 601	R 7 644*	R3 448 N: 636 867 930 D: 184,698 *Target: R3250*	R 3 500	R 3 650	R 3 600	-
8. Percentage of complaints of users of Tertiary Hospital services resolved within 25 days	DHIS	%	100%	100%	100%	89.1% N: 139 D: 156 *Target: 100%*	80%	80%	80%	-
9. Percentage of Tertiary Hospitals with monthly mortality and morbidity meetings	DHIS	%	100%	100%	100%	100% *Target: 100%*	100%	100%	100%	100%
10. Tertiary Hospital Patient Satisfaction rate [Annual]	DQPR	%	Reporting not required	Reporting not required	Reporting not required	Not available *Target: 100%*	80%	80%	80%	100%
11. Number of Tertiary Hospitals assessed for	DQPR	No	New indicator	New indicator	New indicator	1	1	1	1	-

PROGRAMME 5: TERTIARY & CENTRAL HOSPITALS

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
compliance with the 6 Priorities of the Core Standards [Annual]						*Target: 1*				

- Indicator 1: Caesarean section rate: The rate far exceeds the national target of 30%. Referral of complicated/high risk cases [often late], and the high burden of disease however continue to impact on the indicator. Improved ANC, including early booking, has been prioritised to improve management of high risk cases.
- Indicator 5: Average length of stay: Far exceeds the national target of 5.5 days mainly contributed to the burden of disease and challenges with down referral of patients. This will be addressed as part of the overhauling of hospital services.
- Indicator 7: Expenditure per PDE: 2010/11 data identified as outlier.

PROGRAMME 5: TERTIARY & CENTRAL HOSPITALS

5. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR TERTIARY HOSPITALS

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

Table 73: (THS1 (b)): Provincial Strategic Objectives and Annual Targets for Tertiary Hospitals [Greys Hospital]

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
2.7) To implement the National Core Standards in 100% of Tertiary Hospitals for accreditation of 100% facilities by 2011/12	2.7.1) Number of Tertiary Hospitals that comply with the 6 priorities of the core standards	1 / 1	DQPR	Reporting not required	Reporting not required	Nil	Nil *Target: 1*	1	1	1

- National assessment for accreditation/licensing is dependent on national processes for the establishment of the National Office of Standard Compliance. Internal processes however demand regular assessment of performance against 6 priority areas of Core Standards with supporting Quality Improvement Plans. Relevant secondary indicators will be monitored as part of Operational Plans.

6. QUARTERLY AND ANNUAL TARGETS FOR TERTIARY HOSPITALS

Table 74: (THS3): Quarterly and Annual Targets for Tertiary Hospitals [Greys Hospital]

Performance Indicators	Annual Target 2012/13	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Caesarean section rate	68.6%	70%	69%	68.9%	68.6%
2. Separations - total	14,371	3,592	3,592	3,592	3,595
3. Patient Day Equivalents - total	193,969	48,492	48,492	48,492	48,493
4. OPD headcounts - total	215,511	53,877	53,877	53,877	53,879
5. Average length of stay	9.8 days	10 days	9.9 Days	9.9 Days	9.8 days
6. Bed utilisation rate	75%	70%	73.5%	74%	75%
7. Expenditure per patient day equivalent	R 3 500	R 3 700	R 3 700	R 3 600	R 3 500
8. Percentage of complaints of users of Tertiary Hospital services resolved within 25 days	80%	80%	80%	80%	80%
9. Percentage of Tertiary Hospitals with monthly mortality and morbidity meetings	100%	100%	100%	100%	100%
Annual Targets					
10. Tertiary Hospital Patient Satisfaction rate	80%				80%
11. Number of Tertiary Hospitals assessed for compliance with the 6 Priorities of the Core Standards	1				1
12.) Number of Tertiary Hospitals that comply with the 6 priorities of the core standards	1				1

- All APP indicators and targets [annual and quarterly] are included in the above table to ensure appropriate monitoring and reporting including the Provincial Quarterly Performance Report to Treasury and the National Department of Health and District Quarterly Progress Reports submitted to the Monitoring and Evaluation Component for dissemination.
- Indicators are aligned with District Health Plans to ensure effective monitoring of Provincial priorities.
- Additional operational indicators [process, input and output] are included in Operational Plans to ensure improved analysis, interpretation and reporting.

7. PERFORMANCE INDICATORS FOR CENTRAL HOSPITALS

Table 75: (CHS2): Performance Indicators for Central Hospitals [IALCH]

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Caesarean section rate	DHIS	%	81.5%	74%	70.5%	68.9% N: 311 D: 451 *Target: 67%*	69.8%	69.1%	68.4%	50%
2. Separations - total	DHIS	No	20,886	20,204	22,371	24,370 *Target: 22,488*	25,053	25,975	26,738	-
3. Patient day equivalents - total	DHIS	No	242,334	253,344	250,387	282,724 *Target: 269,014*	294,033	305,794	318,026	-
4. OPD headcounts - total	DHIS	No	174,704	182,688	170,986	182,153 *Target: 185,111*	186,707	191,374	196,159	-
5. Average length of stay	DHIS	Days	8.8 days	9.1 days	8.6 days	10 days *Target: 8*	9 days	8.8 days	8.5 days	5.5 Days
6. Bed utilisation rate	DHIS	%	62.8%	66.2%	66.7%	69.8 % *Target: 69%*	75%	75%	75%	75%
7. Expenditure per patient day equivalent (PDE)	BAS/DHIS	R	R 6 307	R 8 396	R 9 171	R 8 775 N: 2 389 641 288 D: 282,724 *Target: R8 000*	R 9 000	R 9 100	R 9 200	-
8. Percentage of complaints of users of Central Hospital services resolved within 25 days	DHIS	%	62%	72%	75%	85.7% N: 18 D: 21 *Target: 100%*	90%	90%	90%	100%
9. Percentage of Central Hospitals with monthly mortality and morbidity meetings	DQPR	%	100%	100%	100%	100% *Target: 100%*	100%	100%	100%	100%
10. Central Hospital Patient Satisfaction rate [Annual]	DQPR	%	Reporting not required	Reporting not required	Reporting not required	Not available *Target: 100%*	80%	80%	80%	100%
11. Number of Central Hospitals assessed for	DQPR	No	New indicator	New indicator	New indicator	1/1	1/1	1/1	1/1	-

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
compliance with the 6 Priorities of the core standards [Annual]						*Target: 1*				

- Indicator 1: Caesarean section rate: Constantly exceeds the national target of 50%. Nature of referrals currently justifies caesarean sections.

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

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

Table 76: (CHS1 (b)): Provincial Strategic Objectives and Annual Targets for Central Hospital [IALCH]

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
2.8) To implement the National Core Standards in 100% of Central Hospitals for accreditation of 100% facilities by 2010/11	2.8.1) Number of Central Hospitals that comply with the 6 priorities of the core standards	1 / 1	DQPR	New indicator	New indicator	Nil	Nil *Target: 1*	1	1	1

- National assessment for accreditation/licensing is dependent on national processes for the establishment of the National Office of Standard Compliance. Internal processes however demand regular assessment of performance against 6 priority areas of Core Standards with supporting Quality Improvement Plans. Relevant secondary indicators will be monitored as part of Operational Plans.

9. QUARLTERLY AND ANNUAL TARGETS FOR CENTRAL HOSPITALS

Table 77: (CHS3): Quarterly and Annual Targets for Central Hospital [IALCH]

Performance Indicators	Annual Target 2012/13	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Caesarean section rate	69.8%	72.5%	71%	70%	69.8%
2. Separations - total	25,053	6,263	6,263	6,263	6,265
3. Patient day equivalents - total	294,033	73,508	73,508	73,508	73,510
4. OPD headcounts - total	186,707	46,676	46,676	46,676	46,678
5. Average length of stay	9 days	9.2 days	9.2 days	9.1 days	9 days
6. Bed utilisation rate	75%	75%	75%	75%	75%
7. Expenditure per patient day equivalent (PDE)	R 9 000	R 9 400	R 9 100	R 9 100	R 9 000
8. Percentage of complaints of users of Central Hospital services resolved within 25 days	90%	90%	90%	90%	90%
9. Percentage of Central Hospitals with monthly mortality and morbidity meetings	100%	100%	100%	100%	100%
Annual Targets					
10. Number of Central Hospitals assessed for compliance with the 6 Priorities of the Core Standards	1				1
11. Central Hospital Patient Satisfaction rate	80%				80%
12. Number of Central Hospitals that comply with the 6 priorities of the core standards	1				1

- All APP indicators and targets [annual and quarterly] are included in the above table to ensure appropriate monitoring and reporting including the Provincial Quarterly Performance Report to Treasury and the National Department of Health and District Quarterly Progress Reports submitted to the Monitoring and Evaluation Component for dissemination.
- Indicators are aligned with District Health Plans to ensure effective monitoring of Provincial priorities.
- Additional operational indicators [process, input and output] are included in Operational Plans to ensure improved analysis, interpretation and reporting.

10. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 78: (CH7 (a)): Expenditure Estimates for central and Tertiary Services

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R' thousands	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	
Central Hospitals	502 028	506 868	689 745	742 612	668 142	673 782	873 229	873 335	915 596
Tertiary Hospitals	1 319 193	1 552 267	1 413 678	1 731 370	1 790 286	1 725 058	1 786 130	1 919 989	2 038 163
Total	**1 821,221**	**2 059 135**	**2 103 423**	**2 473 982**	**2 458 428**	**2 398 840**	**2 659 359**	**2 793 324**	**2 953 759**

Source: BAS

Table 79: (CH7 (b)): Summary of Provincial Expenditure Estimates by Economic Classification

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	
Current payments	**1 547 758**	**1 747 565**	**1 882 846**	**2 193 724**	**2 197 498**	**2 145 870**	**2 410 552**	**2 573 886**	**2 797 709**
Compensation of employees	717 374	802 490	942 537	1 115 927	1 157 026	1 143 510	1 228 839	1 316 924	1 467 649
Goods and services	**830 384**	**945 075**	**940 309**	**1 077 797**	**1 040 472**	**1 002 360**	**1 181 713**	**1 256 962**	**1 330 060**
Communication	3 298	3 398	3 106	3 760	3 924	3 369	3 672	4 013	4 339
Computer Services	299	262	279	300	300	550	778	924	1 343
Consultants, Contractors and special services	56 040	60 403	31 080	56 983	35 448	12 799	9 677	10 218	10 566
Inventory	388 967	473 216	459 172	532 497	517 427	544 149	579 322	610 819	659 946
Operating leases	571	512	430	509	510	2 476	2 789	2 945	3 045
Travel and subsistence	1 391	589	701	798	798	1 653	1 610	1 700	1 758
Interest and rent on land	-	-	-	-	-	-	-	-	-
Maintenance , repair and running costs	-	-	-	-	-	-	-	-	-
Other including Assets<5000, training and development, property payments, operating expenditure and venues and	379 818	406 695	445 541	482 950	482 065	437 364	583 865	626 343	649 063

PROGRAMME 5: TERTIARY & CENTRAL HOSPITALS

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	
facilities									
Transfers and subsidies to	**8 187**	**2 661**	**7 817**	**3 645**	**3 000**	**2 126**	**8 807**	**9 458**	**9 789**
Provinces and municipalities	1	8	6	-	-	1	7	8	9
Departmental agencies and accounts	-	-	-	-	-	-	-	-	-
Universities and Technikons	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	8 186	2 653	7 811	3 645	3 000	2 125	8 800	9 450	9 780
Payments for capital assets	**265 276**	**3 08 909**	**212 705**	**276 613**	**257 930**	**250 844**	**240 000**	**209 980**	**146 261**
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Machinery and equipment	265 276	308 909	212 705	276 613	257 930	250 844	**240 000**	**209 980**	**146 261**
Software and other intangible assets	-	-	-	-	-	-	-	-	-
Payment for financial assets	**-**	**-**	**55**	**-**	**-**	**-**	**-**	**-**	**-**
Total economic classification	**1 821 221**	**2 059 135**	**2 103 423**	**2 473 982**	**2 458 428**	**2 398 840**	**2 659 359**	**2 793 324**	**2 953 759**

Data Source: BAS

11. PERFORMANCE AND EXPENDITURE TRENDS

The upward trend from 2008/09 to 2014/15 relates mainly to funding for the development and improvement of tertiary services in uMgungundlovu and uThungulu Districts. Reprioritised funding was also allocated for the enhancement of these services in line with modernisation of the tertiary services programme. The impact of OSD for medical personnel, higher than average medical inflation, and the rand/dollar exchange rate [especially in 2008/09] are reflected in the trends.

The 2012/13 MTEF includes carry-through costs for previous wage agreements, as well as national priorities for additional registrars and improvement to public hospital norms among others. In addition, the NHI Grant provides funding for a pilot study in two Tertiary Hospitals namely Inkosi Albert Luthuli Central Hospital and King Edward VIII Hospital, which will be used to provide training in International Classification of Disease and diagnostic grouping 10 codes [ICD 10].

Allocations for the 2012/13 MTEF include the carry-through costs for national priorities and funding from the NHI grant for the two pilot hospitals. The inflated figures in *Transfers and Subsidies to Households* in 2008/09 and 2010/11 relate to medico-legal claims against the Department. The increase in *Machinery and Equipment* in 2011/12 relates mainly to the modernisation and expansion of tertiary services and specific funding provided to Grey's Hospital. The reduced amount over the 2012/13 MTEF relates to reprioritisation of funding, which will be reviewed during 2012/13.

12. RISK MANAGEMENT

Potential Risks	Mitigating Factors
1. *Budget allocations:* Insufficient budget in relation to increase in burden of disease. [High]	▪ Manage the burden of disease at the appropriate level of care. ▪ Monitor expenditure quarterly.
2. *Recruitment Plan:* Unable to attract specialised professional staff. [High]	▪ Improve working conditions and negotiate Public Private Partnerships.
3. *PERSAL & EPMDS:* Retention of specialised professional staff. [High]	▪ Implement and monitor OSD and improve incentives.
4. *NTSG statistics:* Inaccurate data. [Medium]	▪ Establish adequate and effective patient information systems.
5. *Multiyear Infrastructure Plans:* Delays in commissioning of tertiary services. [Medium]	▪ Ensure alignment of plans and improved consultation with the Department of Works.

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

1. PROGRAMME PURPOSE AND STRUCTURE

The provisioning of training and development opportunities for existing and potential employees of the Department

Sub-Programme 6.1: Nurse Training College

Training of Nurses at both undergraduate and postgraduate level

Sub-Programme 6.2: EMRS Training College

Training of Emergency Care Practitioners

Sub-Programme 6.3: Bursaries

Provision of bursaries for students studying in health science programmes at undergraduate levels

Sub-Programme 6.4: PHC Training

Provision of PHC related training for Professional Nurses working in a PHC setting

Sub-Programme 6.5: Training [Other]

Provision of skills development interventions for all occupational categories

There is no change in the purpose of Programme 6 since tabling of the 2010 – 2014 Strategic Plan.

Performance of all services and programmes, not specifically prioritised in the APP, will be included in Operational Plans and monitored quarterly. Overall performance outcomes will be incorporated in the Annual Report.

Cuban Programme

The Cuban medical training programme is based on the PHC philosophy which supports the current drive to re-engineer PHC. In a new agreement with Cuba, under stewardship of the MEC for Health, a total of 434 medical students have been selected for the Cuban Training Programme in 2012/13.

Community Services

There are currently 425 Community Service Officers rendering services in the Province including:

- 152 Medical Officers;
- 57 Radiographers;
- 40 Physiotherapists;
- 37 Pharmacists;
- 34 Environmental Health Practitioners;
- 32 Occupational Therapists;
- 31 Dieticians;
- 30 Audio and Speech Therapists; and
- 12 Physiotherapists

Mid-Level Workers

- 18 Health Technology Engineering (HTE) students commenced their studies at the Tswane University;

- 256 New learners commenced nurse training for the 4 year programme in January 2011;
- 342 Professional Nurses commenced Community Service in 2011;
- 26 Students are registered with the University of Pretoria and WITS [Clinical Associates in Training] - 7 in their final year [2011]; 8 in their 2nd year; and 11 in their 1st year;
- 51 Occupational Therapy Technicians (OTT) will be trained over two years by UKZN. The first group completed their studies in April 2011.
- 24 Pharmacist Assistants were appointed in 2011/12.

Leadership, Management Development Programme

The Strategic Plan identified the lack of management competencies and skills as one of the root causes of poor service delivery especially at facility level. As immediate response, 24 Hospital CEO's enrolled for the Masters Programme in Public Health with the University of KZN [UKZN] in 2009/10. Nineteen [19] students completed their final year in 2011/12.

A customised training programme for managers, developed by a Consortium consisting of PricewaterhouseCoopers [PwC], Performance Solutions Africa, and UKZN in collaboration with the Department of Health is progress and will be piloted in 2012/13. The programme will have a strong mentoring foundation to ensure sustainable growth and development.

2. CORE CHALLENGES

- Physical Infrastructure in some Nursing Campuses/ Sub-Campuses no longer meets SANC training standards.
- Training gap and inadequate capacity for mentoring programmes.

3. 2012/13 PRIORITIES: HEALTH SCIENCES & TRAINING

1. *Align training with service delivery requirements as integral part of the HR Plan.*	▪ Align training and development plans with core business of the Department. ▪ Accreditation of the KZN College of Nursing [Higher Education Act].
2. *Implement a Management Training Strategy.*	▪ Develop and implement a Management training strategy including mentoring and succession training.
3. *Implement a Mid-Level Worker strategy.*	▪ Develop and implement a Mid-level Worker Strategy in line with service delivery needs.

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

4. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND TARGETS FOR HEALTH SCIENCES AND TRAINING

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

Table 80: (HST1 (b)): Provincial Strategic Objectives and Annual Targets for Health Sciences and Training – 2012/13

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
2.9) To implement a Training Strategy aligned with the core functions of the Department	2.9.1) Number of Professional Nurses graduating	560	Persal	910	792	846	972 *Target: 820*	820	820	820
	2.9.2) Number of Advanced Midwifes graduating per annum	50	Persal	42	46	105	127 *Target: 106*	106	100	Dependent on accreditation
	2.9.4) Number of Managers accessing the Management Skills Programmes.	120	Internal database	Reporting not required	80	28	300 *Target: 100*	550	550	600
	2.9.5) Number of SMS members trained on MIP	20	Internal database	Reporting not required	5	0	2 *Target: 20*	20	20	20

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

Table (HST2): Performance Indicators for Health Sciences and Training – 2012/13

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Intake of nurse students [Annual]	Persal	No	2,402	2,842	Not available	2,707 *Target: 2,404*	2,404	See Footnote[30]	See Footnote 2
2. Students with bursaries from the Province [Annual]	Bursary Database	No	296	896	601	832 *Target: 842*	800	770	770
3. Basic nurse students graduating [Annual]	Persal	No	1,508	1,477	846	1,597 *Target: 1,400*	1,400	1,000	900

[30] Dependent on the accreditation of the KZNCN as an Institute of Higher Education

5. QUARTERLY AND ANNUAL TARGETS - 2012/13

Table 81: (HST3): Quarterly and Annual Targets for 2012/13

Performance Indicators	Annual Targets 2012/13	Quarterly Targets			
		Q1	Q2	Q3	Q4
Annual Targets					
1. Intake of nurse students	2,404				2,404
2. Students with bursaries from the province	800				800
3. Basic nurse students graduating	1,400			1,400	
4. Number of Professional Nurses graduating	820				820
5. Number of Advanced Midwifes graduating per annum	106				106
6. Number of Managers accessing the Management Skills Programmes.	550				550
7. Number of SMS members trained on Massification Implementation Plan [MIP]	20				20

- All APP indicators and targets [annual and quarterly] are included in the above table to ensure appropriate monitoring and reporting. Quarterly Progress Reports are submitted to the Monitoring and Evaluation Component for dissemination.
- Additional operational indicators [process, input and output] are included in Operational Plans to ensure improved analysis, interpretation and reporting.

6. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 82: (HST4 (a)): Expenditure Estimates for Health Sciences and Training

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised estimate	Medium-Term Estimates		
R' thousands	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Nurse training colleges	336 812	362 719	386 132	424 816	406 550	381 806	415 128	442 235	470 956
EMS training colleges	16 969	19 338	14 118	19 234	13 379	12 656	19 842	16 531	17 086
Bursaries	44 894	42 454	54 272	63 142	80 160	78 116	107 738	133 818	141 572
PHC training	65 343	76 238	73 061	78 945	60 412	59 371	67 925	72 695	77 769
Other training	212 583	292 437	323 560	347 305	384 086	364 850	387 418	414 311	441 975
Total	**676 601**	**793 186**	**851 143**	**933 442**	**944 587**	**896 799**	**998 051**	**1 079 590**	**1 149 358**

Source: BAS

Table 83: (HST4 (b)): Summary of Provincial Expenditure Estimates by Economic Classification

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Current payments	**618 922**	**727 945**	**781 961**	**844 376**	**836 531**	**798 289**	**885 365**	**950 099**	**1 013 024**
Compensation of employees	528 940	662 000	717 464	779 597	731 630	722 499	783 252	834 757	893 189
Goods and services	**89 982**	**65 945**	**64 497**	**64 779**	**104 901**	**75 790**	**102 113**	**115 342**	**119 835**
Communication	1 730	1 573	1 424	1 373	1 373	1 239	1 302	1 373	1 420
Computer Services	14 505	14 361	9 130	10 117	23 862	19 917	25 829	30 451	31 486
Consultants, Contractors and special services	1 978	397	61	50	349	207	346	364	377
Inventory	5 424	4 704	3 996	4 858	5 298	4 653	5 886	5 400	5 584
Operating leases	9 664	6 570	11 134	11 600	8 725	1 587	1 622	1 713	1 771
Travel and subsistence	13 682	4 880	3 799	5 049	10 149	9 648	26 180	32 256	33 909
Maintenance , repair and running costs	-	-	-	-	-	-	-	-	-
Other including Assets<5000, training and development,	42 999	33 460	34 953	31 732	55 145	38 539	40 948	43 785	45 288

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
property payments, operating expenditure and venues and facilities									
Transfers and subsidies	**56 144**	**59 843**	**68 625**	**82 891**	**95 308**	**94 315**	**107 018**	**128 301**	**136 184**
Provinces and municipalities	8	14	25	-	6	16	30	32	34
Departmental agencies and accounts	5 827	6 784	7 637	8 166	8 588	8 588	9 360	9 813	10 730
Universities and Technikons	-	-	-	-	-	-	-	-	-
Non-profit institutions	5 967	11 357	8 510	14 298	15 414	14 411	15 130	15 886	16 681
Households	44 342	41 688	52 453	60 427	71 300	71 300	82 498	102 570	108 739
Payments for capital assets	**1 519**	**5 398**	**535**	**6 175**	**12 748**	**4 195**	**5 668**	**1 190**	**150**
Buildings and other fixed structures	116	-	-	-	-	-	-	-	-
Machinery and equipment	1 403	5398	535	6 175	12 748	4 195	**5 668**	**1 190**	**150**
Software and other intangible assets	-	-	-	-	-	-	-	-	-
Payments for financial assets	**16**	**-**	**22**	**-**	**-**	**-**	**-**	**-**	**-**
Total economic classification	**676 601**	**793 186**	**851 143**	**933 442**	**944 587**	**896 799**	**998 051**	**1 079 590**	**1 149 358**

Source: BAS

7. PERFORMANCE AND EXPENDITURE TRENDS

The increasing trend in Programme 6 can largely be attributed to the training drive, increased bursary allocation and the provision for the intake of medical interns, dentists, pharmacists and other interns. The significant increase in 2012/13 relates to funding for training of an additional 148 learners in Basic Life Support for Emergency Medical Rescue Services and training of additional doctors under the Cuban Doctor Training Programme. This funding is evident in the trends in the EMS Training Colleges and Bursaries sub-programmes, respectively. The trends are carried forward over the outer years of the 2012/13 MTEF.

Nurse Training Colleges and Primary Health Care Training: The 2012/13 MTEF reflects inflationary increases only.

EMS Training College: The 2012/13 MTEF includes inflationary increases only.

Training Other: The increase in the 2011/12 *Adjusted Appropriation* provides for the training of additional health personnel to address the current shortage in the Department. Additional funding for additional health personnel to address current shortages is also provided in the 2012/13 MTEF together with the wage related carry-through costs from previous years. The significant increase in *Goods and services* over the MTEF relates mainly to the provision of funding for travel and subsistence costs for the additional 265 participants in the Cuban Doctor Programme.

The increase in 2011/12 *Machinery and Equipment* relates to provision for additional equipment at the various training campuses. The reduced amount over the 2012/13 MTEF relates to reprioritisation of funding, which will be reviewed during 2012/13.

8. RISK MANAGEMENT

Potential Risks	Mitigating Factors
1. Physical Infrastructure in some Nursing Campuses/Sub-Campuses no longer meets SANC training standards [High].	a) Infrastructure for Nursing Campuses prioritised in the Infrastructure Plan and budget provided.
2. Lack of residential accommodation for learners and staff [High].	
3. Campuses at Madadeni and Port Shepstone are leased - possible termination of leases will have an impact on training [High].	
4. Inadequate resources to conduct a Provincial skills audit [Medium].	b) Awaiting outcome of national audit.
5. The new nursing qualifications may have an impact on the numbers and programmes for training. [Medium]	c) New Nursing Campuses and alternative arrangements to address inadequate clinical facilities.

PROGRAMME 7: PHARMACEUTICAL SERVICES

1. PROGRAMME PURPOSE AND STRUCTURE

Sub-Programme 7.1: Pharmaceutical Services (Medicine Trading Account)	Manage the supply of pharmaceuticals and medical sundries to Hospitals, Community Health Centres, Clinics and Local Authorities via the Medicine Trading Account.

There has been no change in the purpose of Programme 7 since tabling of the 2010 – 2014 Strategic Plan.

Performance outcomes, not specifically prioritised in the APP, are included in Operational Plans and will be monitored quarterly. Overall performance outcomes will be included in the Annual Report.

The Provincial Pharmaceutical Supply Depot [PPSD] is the only trading entity operating within the administration of the KwaZulu-Natal Department of Health. It is responsible for the procurement and delivery of pharmaceuticals as listed by National and Provincial Health Pharmaceutical Services, and pharmaceuticals are procured from suppliers and then distributed to the various institutions as requested.

2. CORE CHALLENGES

1. The PPSD Warehouse is not complying with Pharmacy Regulations and failed to acquire a license from the Medicine Control Council to operate as a Pharmaceutical Wholesaler. The Pharmacy Council gave the Department an exemption until alternative arrangements have been finalised.

   A new PPSD building has been approved, a site identified at Clairwood Hospital, and consultants appointed for the design.

   In the interim, two wards at Clairwood Hospital have been allocated to PPSD to alleviate space shortages although wards are unsuitable for summer storage.

2. Space constraints [PPSD and facilities] put a strain on pharmaceutical operations. Facilities designed before the current specifications need alterations for compliance. This increases the risk of stock-outs of essential medicines due to low stock holding.

   The Department is upgrading infrastructure although the backlog is significant. Newly built facilities [e.g. Turton CHC in Ugu] meet the prescribed specifications.

3. Shortage of experienced Pharmacy Managers jeopardizes effective management, security, and controls leading to an increased risk of leakage.

   Development and mentoring programmes [targeting Pharmacy Managers] on effective medicine supply management is planned for

2012/13. Pharmacy Stores Support Officers provide technical support and training to facilities.

4. The shortfall between the number of Pharmacists graduating annually and the demand from public and private sectors challenges recruitment and retention.

Pharmacy Technicians and Technical Assistants training programme will be fast tracked as soon as the National legislative framework has been finalised and Training Institutions capacity established.

3. 2012/13 PRIORITIES: PHARMACEUTICAL SERVICES

1. *Improve compliance with Pharmaceutical legislation.*	▪ Improve the percentage of pharmacies compliant with SAPC standards to 70%. ▪ PPSD 100% compliant with Good Wholesaling Practice Regulations.
2. *Improve availability of medicines.*	▪ Reduce tracer medicine stock-out rate in bulk stores [PPSD and Institutions] to <3%.
3. *Improve quality of Pharmaceutical services.*	▪ Reduce the average patient waiting time at pharmacies to <1 hour.

4. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR PHARMACEUTICAL SERVICES

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 84: (HCSS1): Provincial Strategic Objectives and Annual Targets for Health Care Support Services

Strategic Objective	Performance Indicator	Strategic Plan Target	Data source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1.13) Ensure compliance with Pharmaceutical Legislation with 90% pharmacies compliant by 2014/15 and PPSD 100% compliant by 2012/13	1.13.1) Percentage of Pharmacies that obtained A and B grading on inspection[31]	90%	Pharmacy Records	Reporting not required	Reporting not required	Reporting not required	58.6% N: 51 D: 87 *Target: 60%*	70%	80%	90%
	1.13.2) PPSD compliant with Good Wholesaling Practice Regulations	100% compliant	License from MMC	Reporting not required	Reporting not required	Reporting not required	Not compliant *Target: 100% compliant by 2012/13*	100% compliant	100% compliant	100% compliant

[31] Refers to being compliant with SAPC standards

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

Table 85: (HCSS1): Provincial Strategic Objectives and Annual Targets for Health Care Support Services

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
2.3) To improve medicine supply management systems at PPSD and facility level	2.3.1) Tracer medicine stock-out rate [PPSD]	<1%	DQPR	New indicator	New indicator	2.53%* [416/ 16,447]	7% N: 432 D: 9,515 *Target: <4%*	<3%	<2%	<1%
	2.3.2) Tracer medicine stock-out rate [Institutions]	<1%	DQPR	New indicator	New indicator	16,2%* [19/ 117]	5% N: 116 D: 639 *Target: <4%*	<3%	<2%	<1%

- [*] Denotes data that has been corrected and verified since the 2010/11 Annual Report

5. QUARTERLY AND ANNUAL TARGETS – 2012/13

Table 86: (HCSS2): Quarterly and Annual Targets for 2012/13

Performance Indicators	Annual Targets 2012/13	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly Targets					
1. Tracer medicine stock-out rate [PPSD]	<3%	7%	6%	5%	<3%
2. Tracer medicine stock-out rate [Institutions]	<3%	5%	4%	4%	<3%
Annual Targets					
3. Percentage of Pharmacies that obtained A and B grading on inspection[32]	70%				70%
4. PPSD compliant with Good Wholesaling Practice Regulations	100% compliant				100% compliant

- All APP indicators and targets [annual and quarterly] are included the above table to ensure appropriate monitoring and reporting. Quarterly Progress Reports are submitted to the Monitoring and Evaluation Component for dissemination.
- Indicators are aligned with District Health Plans to ensure effective monitoring of Provincial priorities.
- Additional operational indicators [process, input and output] are included in Operational Plans to ensure improved analysis, interpretation and reporting.

[32] Refers to being compliant with SAPC standards

6. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS – 2012/13

Table 87: (HCSS3 (a)): Expenditure Estimates for Health Care Support Services

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R' thousands	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Medicines trading account	34 209	27 528	10 764	13 971	13 971	13 971	15 170	16 004	18 000
Total	**34 209**	**27 528**	**10 764**	**13 971**	**13 971**	**13 971**	**15 170**	**16 004**	**18 000**

Source: BAS

Table 88: (HCSS3 (b)): Summary of Provincial Expenditure Estimates by Economic Classification

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Current payments	**79**	-	-	-	-	-	-	-	-
Compensation of employees	**-**	-	-	**-**	**-**	**-**	-	-	-
Goods and services	**79**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Computer Services	79	-	-	-	-	-	-	-	-
Transfers and subsidies to	**34 130**	**27 528**	**10 764**	**13 971**	**13 971**	**13 971**	**15 170**	**16 004**	**18 000**
Provinces and municipalities	-	-	-	-	-	-	-	-	-
Departmental agencies and accounts	34 130	27 528	10 764	13 971	13 971	13 971	15 170	16 004	18 000
Total economic classification	**34 209**	**27 528**	**10 764**	**13 971**	**13 971**	**13 971**	**15 170**	**16 004**	**18 000**

Source: BAS

7. PERFORMANCE AND EXPENDITURE TRENDS

The main aim of Programme 7 is to house the Provincial Medicine Supply Centre, which manages the supply of pharmaceuticals and medical sundries to hospitals, community health centres, clinics and local authorities via the Medicine Trading Account.

Funding enable the Provincial Medical Supply Centre to carry sufficient medical stock to meet service demands. The inflated amount in 2008/09, when compared with the rest of the trend, was due to higher demand for stock levels to cater for the increased demand for ART, as well as medication for MDR/ XDR TB. The reduction from 2010/11 relates to the lack of storage facilities to store additional stock. The trend over the 2012/13 MTEF reflects inflationary increases only.

8. RISK MANAGEMENT

Potential Risks	Mitigating Factors
1. Infrastructure challenges affecting storage and packing facilities, which in turn compromises security and the efficient handling, safety and efficacy of pharmaceuticals [High].	▪ Building of a new Provincial Pharmaceutical Supply Depot has been approved and the infrastructure process commenced in 2010/11. ▪ Centralised Chronic Medication Dispensing Unit (CCMDU) pilot project to improve efficiency to inform roll-out was completed. ▪ The infrastructure for CCMDU is provided for in the approved plan for the new PPSD.
2. Inadequate human resources with a high vacancy rate for Pharmacists [High].	▪ Mid-level Worker training: Pharmacist Assistant Basic & Post-basic Course.
3. Poor medicine management, security and controls leading to leakages with consequent increase in costs and stock-outs at facility level [High].	▪ Filling of vacant posts according to SAPC staffing norms. ▪ Improve supervision, support and capacity building programmes.

ANNUAL PERFORMANCE PLAN 2012/13 – 2014/15

PROGRAMME 7: PHARMACEUTICAL SERVICES

PROGRAMME 8: INFRASTRUCTURE DEVELOPMENT

1. PROGRAMME PURPOSE AND STRUCTURE

To provide new health facilities, upgrade and maintain existing health facilities, and manage the Hospital Revitalisation Programme and Conditional Grant.

Sub-Programme 8.1: Community Health Services including PHC clinics and Community Health Centres

Construction of new, and upgrading and maintenance of Community Health Centres, Primary Health Care Clinics and other Community-based PHC services

Sub-Programme 8.2: District Hospitals

Construction of new, and upgrading and maintenance of District Hospitals

Sub-Programme 8.3: Emergency Medical Services

Construction of new, and upgrading and maintenance of Emergency Medical Service facilities

Sub-Programme 8.4: Provincial/ Regional and Specialised Hospital Services

Construction of new, and upgrading and maintenance of Provincial/Regional and Specialised Hospitals

Sub-Programme 8.5: Tertiary and Central Hospital Services

Construction of new, and upgrading and maintenance of Tertiary and Central Hospitals

Sub-Programme 8.6: Other Facilities

Construction of other new, and upgrading and maintenance of other health facilities

There is no change in the purpose of Programme 8 since tabling of the 2010 – 2014 Strategic Plan.

Performance measures, not specifically prioritised in the 2012/13 Annual Performance Plan, will be included in Operational Plans and monitored quarterly. Annual performance outcomes will be reported in the Annual Report.

Infrastructure Development experienced numerous challenges during the previous reporting period including:

- Suspension of senior personnel which impacted negatively on management capacity to implement and manage implementing agents involved with infrastructure delivery.
- Lack of efficient procurement processes resulting in delays and poor expenditure.
- Lack of approved maintenance plans.
- Failure to spend the Hospital Revitalisation Grant and Equitable Share budget of the Infrastructure Grant resulted in a cut of the latter.

In 2011/12, the Department appointed a General Manager, Health Technology Manager for Hospital Revitalisation and a new Project Manager for the Lower Umfolozi/Ngwelezane Revitalisation project. The Department also engaged with the Development Bank of South Africa [DBSA] with the medium-term provision of technical experts that would primarily assist in the Hospital Revitalisation Programme and the infrastructure programme in general. This team is comprised of a Mechanical and Civil Engineer, three Quantity Surveyors and one Architect. The Department is currently advertising the project manager posts in the Hospital Revitalisation Grant in order to ensure sustainable capacity development within the Department.

In order to improve services delivery within the Health Technology Services, the Department appointed twenty one [21] Health Technology Learner Technicians in January 2011, who were sent for two weeks training at the Department's expense to Tshwane University of Technology and thereafter placed in the workshops to manage the repairing of the Health Technology equipment. In January 2012, the Department also appointed a further seventeen learner technicians who also attended similar training. Additionally, seven new technicians were appointed during 2011/12 and these supervise work in the various workshops.

Maintenance

The Department spent approximately R400 million on the Maintenance Programme during 2011/12. During 2011/12, Infrastructure Development coordinated the development of the facility and district maintenance plans. The capacity constraints were identified which mainly were due to insufficient capacity to deliver the required projects. The Department engaged with IDT to assist with additional capacity to implement the approved project list.

The Department plan to use the infrastructure maintenance programme to ensure sustainable employment as per call from the President and Premier of KZN. To date, 215 new maintenance posts have been advertised.

The Department plan to fill approximately 400 new maintenance posts during 2012/13 and a budget of approximately R18 million has been made available by Provincial Treasury for this purpose.

Management of Implementing Agents

The Department has two main implementing agents [Department of Public Works and Independent Development Trust] that are appointed to implement the projects of the Department. Infrastructure Programme Implementation Plans [IPIPs] of the Implementing Agents are approved and monitored by the Department. National Health attends progress meetings as part of the monitoring of progress.

2. CORE CHALLENGES

- Inadequate capacity to ensure effective implementation and monitoring of Infrastructure projects.
- Insufficient funding for addressing maintenance/ new infrastructure backlog.

3. 2012/13 PRIORITIES: INFRASTRUCTURE DEVELOPMENT

1. *Infrastructure Programme Implementation Plan (IPIP) – aligned and implemented.*	▪ Delivery of new clinical infrastructure - approved IPIP aligned with both the STP and the National Department of Health's Shock Treatment Plan. ▪ Upgrading and renovation of existing infrastructure as per IPIP.
2. *Create an enabling environment to support service delivery.*	▪ Creation of office accommodation for Provincial and District Offices.
3. *Hospital Revitalisation Programme.*	▪ Improvement of facilities - upgrading and renovation of existing infrastructure. ▪ Provide new infrastructure to improve service delivery: – Commence construction of the main building for Dr Pixley Ka Seme. – Finalise projects on site for King George V Hospital - commission last 200 beds. – Continuation of planning new facilities as per the approved PIP and approved Business cases: Madadeni Psychiatric Hospital and the District hospital as well as Dr John Dube Hospital. – Completion of the brief for the new Central Hospital for current King Edward VIII to commence through National Department of Health.

4. PROVINCIAL STRATEGIC OBJECTIVES FOR HFM – 2012/13

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 89: (HFM1): Provincial Strategic Objectives and Annual Targets for Health Care Support Services

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1.19) Delivery of new clinical infrastructure in line with the approved IPIP (Infrastructure Programme Implementation Plan)	1.19.1) Number of new clinical projects with completed construction	52	IRM; IPMP; Optimisation Plan; U-Amp	New indicator	New indicator	14	6 *Target: 6*	6	15	4
	1.19.2) Number of new clinical projects where commissioning is completed		IRM; IPMP; Optimisation Plan; U-Amp	New indicator	New indicator	23	24 *Target: 24*	6	6	15
1.20) Upgrading & renovation of existing clinical infrastructure in line with approved IPIP	1.20.1) Number of upgrading and renovation projects with completed construction	89	IRM; IPMP; Optimisation Plan; U-Amp	New indicator	New indicator	41	13 *Target: 14*	38	31	13
	1.20.2) Number of upgrading and renovation projects where commissioning is completed		IRM; IPMP; Optimisation Plan; U-Amp	New indicator	New indicator	3	54 *Target: 54*	14	37	31

5. QUARTERLY TARGETS FOR 2012/13

Table 90: (HFM3): Quarterly and Annual Targets for Health Facilities Management for 2012/13

Performance Indicators	Annual Target 2012/13	Quarterly			
		Q1	Q2	Q3	Q4
Annual Targets					
1. Number of new clinical projects with completed construction	6				6
2. Number of new clinical projects where commissioning is completed	6				6
3. Number of upgrading and renovation projects with completed construction	38				38
4. Number of upgrading and renovation projects where commissioning is completed	14				14

- All APP indicators and targets [annual and quarterly] are included the above table to ensure appropriate monitoring and reporting. Quarterly Progress Reports are submitted to the Monitoring and Evaluation Component for dissemination.
- Indicators are aligned with District Health Plans to ensure effective monitoring of Provincial priorities.
- Additional operational indicators [process, input and output] are included in Operational Plans to ensure improved analysis, interpretation and reporting.

6. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS – 2012/13

Table 91: (HFM4 (a)): Expenditure Estimates for Health Facility Management

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R' thousands	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Community Health Facilities	280 625	552 924	347 565	459 555	338 421	369 910	483 582	493 625	495 035
District Hospitals	615 946	482 159	424 314	562 308	517 732	602 413	600 408	780 206	842 371
EMS	4 734	1 201	428	5 093	3 700	4 160	6 460	30 324	666
Provincial Hospitals	111 763	187 320	204 691	449 393	508 323	516 709	568 303	546 403	546 774
Central Hospitals	15 401	35 161	11 982	28 177	-	-	51 763	41 425	44 289
Other facilities	75 089	119 484	98 267	182 010	473 840	348 824	206 588	222 333	240 657
Total	**1 103 558**	**1 378 249**	**1 087 247**	**1 686 536**	**1 842 016**	**1 842 016**	**1 917 104**	**2 114 316**	**2 169 792**

Source: BAS

Table 92: (HFM4 (b)): Summary of Provincial Expenditure Estimates by Economic Classification

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Current payments	**338 010**	**264 909**	**258 169**	**250 840**	**429 048**	**484 804**	**451 628**	**482 913**	**514 702**
Compensation of employees	5 510	3 448	5 037	5 329	10 500	10 500	28 270	24 239	25 578
Goods and services	**332 500**	**261 461**	**253 132**	**245 511**	**418 548**	**474 304**	**423 358**	**458 674**	**489 124**
Communication	803	228	333	1 659	11	9	411	511	542
Computer Services	12 595	2 872	2 178	3 183	3 575	4 224	4 709	5 370	5 301
Consultants, Contractors and special services	82 122	59 314	46 360	33 843	42 491	33 210	29 758	30 368	31 401
Inventory	80 599	52 154	45 974	51 186	6 523	6 417	5 884	6 216	6 510
Operating leases	54	65	26	44	31	35	209	219	310
Rental and hiring	41 764	59 048	55 796	57 797	66 481	65 698	70 010	73 931	76 445
Travel and subsistence	787	893	385	611	575	621	710	749	775
Interest and rent on land	-	-	-	-	-	-	-	-	-

PROGRAMME 8: INFRASTRUCTURE DEVELOPMENT

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Maintenance , repair and running costs	-	-	-	-	-	-	-	-	-
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	113 830	86 952	102 106	97 232	298 689	363 833	311 224	340 791	367 199
Transfers and subsidies to	**326**	-	-	-	-	10 000	20 000	20 000	-
Provinces and municipalities	-	-	-	-	-	-	-	-	-
Departmental agencies and accounts	-	-	-	-	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	10 000	20 000	20 000	-
Households	326	-	-	-	-	-	-	-	-
Payments for capital assets	**765 222**	**1 113 340**	**829 078**	**1 435 696**	**1 412 968**	**1 347 212**	**1 445 476**	**1 611 403**	**1 655 090**
Households	326	-	-	-	-	-	-	-	-
Machinery and equipment	129 883	108 082	49 550	77 758	350 840	295 073	360 005	293 541	261 632
Land and sub-soil assets	-	-	798	-	-	11	-	-	-
Total economic classification	**1 103 558**	**1 378 249**	**1 087 247**	**1 686 536**	**1 842 016**	**1 842 016**	**1 917 104**	**2 114 316**	**2 169 792**

7. PERFORMANCE AND EXPENDITURE TRENDS

The main activities of Programme 8 are to provide new health facilities and to rehabilitate, upgrade and maintain existing facilities. This includes the provision of additional PHC facilities, to ensure improved access to health services in the under-served areas of the Province, as well as the provision of major medical equipment.

The significant increase over the last seven years comprises increasing amounts of Conditional Grant funding, especially the Hospital Revitalisation Grant and the Health Infrastructure Grant, as well as the Department's Equitable Share. Included in 2009/10 is under-expenditure of approximately R224.649 million against the Hospital Revitalisation Grant for which a roll-over to 2011/12 was requested, as the Department was not in a position to spend it in 2010/11. An amount of R63.953 million was approved for roll-over and was included in the 2011/12 *Main Appropriation.*

An amount of R63.953 million was approved for roll-over to 2011/12 and is included in the 2011/12 *Main Appropriation*. The significant increase in the 2011/12 *Main and Adjusted Appropriation* was mainly based on a decision from additional funding for essential equipment at various institutions in line with NHI requirements, as well as increases in the Health Infrastructure and Hospital Revitalisation Grants.

With regard to *Transfers and Subsidies to Non-Profit Institutions* in the 2011/12 *Revised Estimate* and the subsequent two years, the Department will transfer funds to the KZN Children's Hospital Trust for the development and refurbishment of the KZN Children's Hospital in eThekwini.

Additional funding provided for the 2012/13 MTEF, apart from the increases to the existing Conditional Grants, includes funding for the refurbishment of Nurses Training Colleges provided in the Nurses Colleges and Schools Grant and additional funding allocated under *Current Payments* to enable the Department to address capacity issues in order to provide better support to infrastructure management.

8. RISK MANAGEMENT

Potential Risks	Mitigating Factors
1. Poor and insufficient staff accommodation [High].	The Unit has prioritised a number of refurbishment projects on existing accommodation as well as building of additional accommodation, especially in the rural areas
2. Insufficient funding for addressing maintenance/ new infrastructure backlog [High].	Due to past poor performance, the Department is now faced with the backlog. The Department has demonstrated its capacity to spend both to Treasury and National Health. Various bids to increase the budget baseline are tabled
3. Poor integration and planning [High].	Pilot a Project Packaging Tool in 2012/13 aimed at systemising planning processes.
4. Supply Chain Management delays mainly due to Provincial	The Department is in consultation with Provincial Treasury to

Potential Risks	Mitigating Factors
Appeals Processes [High].	address the challenge.
5. Poor maintenance of health facilities [High].	Development of a maintenance strategy which will be implemented in 2012/ 13.

ANNUAL PERFORMANCE PLAN 2012/13 – 2014/15

PROGRAMME 8: INFRASTRUCTURE DEVELOPMENT

PART C

LINKS TO OTHER PLANS

ANNUAL PERFORMANCE PLAN 2012/13 – 2014/15

PART C

PART C: LINKS TO OTHER PLANS

1.1 LINKS TO THE LONG-TERM INFRASTRUCTURE AND OTHER CAPITAL PLANS

Table 93: (HFM6): Infrastructure Plan

Name of Project	Municipality	District	Status of project	Nature of Project	Projected Budget		
					MTEF 1 2011/12 (R'000)	MTEF 2 2012/13 (R'000)	MTEF 3 2013/14 (R'000)
Fuduka Clinic (Nongoma)	Abaqulusi	Zululand	Construction 25%	New	R 4 428	R 550	R -
Mbongolwane Hospital	Umlalazi	uThungulu	Construction 25%	Additions	R 10 822	R 5 000	R 475
Songozima Clinic	Msunduzi	uMgungundlovu	Construction 25%	Renovations	R 2 702	R 188	R -
Bhobhoyi Clinic	Hibiscus Coast	Ugu	Construction 25%	Renovations	R 995	R 150	
Mayizekanye Clinic	uMshwathi	uMgungundlovu	Construction 25%	Upgrading	R -	R -	R -
R K Khan Hospital	eThekwini	Metros KZ	Construction 25%	Upgrading	R 14 009	R 1 079	R -
Office and Accommodation Lease Agreements	uMgungundlovu	uMgungundlovu	Construction 25%	Maintenance - Recurrent	R 50 000	R 50 000	R 145 914
Lower Umfolozi Memorial	uMhlathuze	uThungulu	Construction 25%	Upgrading	R -	R -	R -
Hlabisa Hospital	Hlabisa	Umkhanyakude	Construction 25%	Upgrading	R 500	R -	R 76 657
King George v hospital	eThekwini	Metros KZ	Construction 25%	Upgrading	R 15 333	R 1 326	R -
Ngwelezane hospital	uMhlathuze	uThungulu	Construction 25%	Upgrading	R 1 666	R -	R -
Rietvlei Hospital	Umzimkhulu	Sisonke	Construction 25%	Upgrading	R 1 489	R 3 122	R -
Rietvlei Hospital	Umzimkhulu	Sisonke	Construction 25%	Upgrading	R 500	R -	R -
Rietvlei Hospital	Umzimkhulu	Sisonke	Construction 25%	Upgrading	R 521	R 2 314	R -
IDT Projects			Construction 25%	Upgrading	R -	R -	R -
Msizini Clinic	Msinga	Umzinyathi	Construction 25%	New	R 500	R -	
Rietvlei Hospital	Umzimkhulu	Sisonke	Construction 25%	Upgrading	R 23 279	R 11 784	R -
Mhlekazi Clinic	Jozini	Umkhanyakude	Construction 25%	Renovations	R 3 020	R 220	R -
Kwamteyi Clinic	Indaka	Uthukela	Construction 50%	Upgrading	R 865	R -	
Sibuyane Clinic	Umvoti	Umzinyathi	Construction 50%	Upgrading	R 1 458	R -	
Sgweje Clinic	Indaka	Uthukela	Construction 50%	New	R 6 122	R 778	
Manguzi Hospital	Mhlabuyalingana	Umkhanyakude	Construction 50%	Additions	R 4 151	R 526	R -
Appelsbosch Hospital	uMshwathi	uMgungundlovu	Construction 50%	Renovations	R 6 693	R 4 212	R -
Phateni Clinic	Richmond	uMgungundlovu	Construction 50%	New	R 5 026		
Kilman Clinic	Ingwe	Sisonke	Construction 50%	Renovations	R 1 925	R 75	
Health Facility Audit			Construction 50%	Maintenance - Recurrent	R -	R -	R -

PART C

Name of Project	Municipality	District	Status of project	Nature of Project	Projected Budget		
					MTEF 1 2011/12 (R'000)	MTEF 2 2012/13 (R'000)	MTEF 3 2013/14 (R'000)
Estcourt Hospital	Umtshezi	Uthukela	Construction 50%	Rehabilitation	R 3 931	R 450	R -
Rietvlei Hospital	Umzimkhulu	Sisonke	Construction 50%	Upgrading	R -	R 1 329	R -
Addington Hospital	eThekwini	Metros KZ	Construction 50%	Upgrading	R 6 959	R 224	R -
Dr Pixley ka Seme Hospital	eThekwini	Metros KZ	Construction 50%	Upgrading	R 698	R 240	
Lower Umfolozi Memorial	uMhlathuze	uThungulu	Construction 50%	Upgrading	R 1 000	R 5 098	R 4 695
Mkhonjane Clinic	Nquthu	Umzinyathi	Construction 75%	Upgrading	R -	R -	
Elandskraal Clinic	Msinga	Umzinyathi	Construction 75%	New	R 450	R -	
Mbabane Clinic	Dannhauser	Amajuba	Construction 75%	New	R 450	R -	R -
Charles Johnson Memorial Hospital	Nquthu	Umzinyathi	Construction 75%	Additions	R 8 988	R -	
Niemeyer Memorial Hospital	eMadlangeni	Amajuba	Construction 75%	Additions	R 1 485	R 500	R 250
Inhlwathi Clinic	Hlabisa	Umkhanyakude	Construction 75%	Renovations	R 167	R -	R -
Ntuze Clinic	uMhlathuze	uThungulu	Construction 75%	Renovations	R -	R -	R 33
Thokozani Clinic	uMhlathuze	uThungulu	Construction 75%	Renovations	R -	R -	R -
Phelandaba Clinic	Umhlabuyalingana	Umkhanyakude	Construction 75%	Renovations	R -	R -	R -
Eshowe Hospital	Umlalazi	uThungulu	Construction 75%	Upgrading	R 200	R -	R -
Itshelejuba Hospital	uPhongolo	Zululand	Construction 75%	Additions	R 3 600	R -	R -
G J Crookes Hospital	Umdoni	Ugu	Construction 75%	Additions	R 464	R -	
Port Shepstone Hospital	Hibiscus Coast	Ugu	Construction 75%	Additions	R 5 000	R -	
Christ The King Hospital	Ubuhlebezwe	Sisonke	Construction 75%	Renovations	R -	R -	R -
Efaye Clinic	uMshwathi	uMgungundlovu	Construction 75%	New	R 2 000	R 520	R -
Gwala Clinic	Ingwe	Sisonke	Construction 75%	Renovations	R 150	R -	
Baphumile Clinic	Umzumbe	Ugu	Construction 75%	Renovations	R 200	R -	
Gcilima Clinic	Hibiscus Coast	Ugu	Construction 75%	Renovations	R 100	R -	
Ludimala (Mlondi) Clinic	Hibiscus Coast	Ugu	Construction 75%	Renovations	R 325	R -	
Kwajali Clinic	uMuziwabantu	Ugu	Construction 75%	Renovations	R 670	R -	
Mbotho Clinic	uMuziwabantu	Ugu	Construction 75%	New	R 3 085	R 350	
Bhomela Clinic	Hibiscus Coast	Ugu	Construction 75%	Renovations	R 200	R -	
Thafamasi Clinic	Ndwedwe	iLembe	Construction 75%	Additions	R 862	R -	
King George V Hospital	eThekwini	Metros KZ	Construction 75%	New	R -	R -	R -
King George V Hospital	eThekwini	Metros KZ	Construction 75%	Upgrading	R 16 010	R 54	R -
Newcastle : SAPS Mortuary	Amajuba Municipality	Amajuba	Construction 75%	Upgrading	R 2 424	R 114	R -
Greytown Mortuary	Umvoti	Umzinyathi	Construction 75%	New	R 2 512	R 2 214	R -
KwaMashu CHC	eThekwini	Metros KZ	Construction 75%	New	R 6 058	R -	R -
Turton CHC	Umzumbe	Ugu	Construction 75%	New	R 16 047	R -	R -
St Chads CHC	Emnambithi	Uthukela	Construction 75%	New	R 21 000	R 8 181	R 3 849
King George V Hospital	eThekwini	Metros KZ	Construction 75%	Additions	R 68 184	R -	R -
King George V hospital	eThekwini	Metros KZ	Construction 75%	Upgrading	R 423	R -	R -
King George V hospital	eThekwini	Metros KZ	Construction 75%	Upgrading	R 3 590	R -	R -
Mumbe Ward 1 Clinic	Msinga	Umzinyathi	Construction 75%	New	R 252	R -	

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Name of Project	Municipality	District	Status of project	Nature of Project	Projected Budget		
					MTEF 1 2011/12 (R'000)	MTEF 2 2012/13 (R'000)	MTEF 3 2013/14 (R'000)
Ngabayena Clinic	Msinga	Umzinyathi	Construction 75%	New	R 500	R 249	
Catherine Booth Hospital	Umlalazi	uThungulu	Construction 75%	New	R -	R -	R -
Port Shepstone Hospital	Hibiscus Coast	Ugu	Construction 75%	Upgrading	R 170	R -	
Nanza professional fees			Construction 75%	Maintenance - Recurrent	R -	R -	R -
Durban Regional Laundry	eThekwini	Metros KZ	Construction 75%	Renovations	R 139	R -	R -
G J Crookes Hospital	Umdoni	Ugu	Construction 75%	Renovations	R 90	R -	R -
Greytown M2 Mortuary			Construction 75%	New	R 1 288	R -	R -
Ekuvukeni Clinic	Indaka	Uthukela	Construction started	Upgrading	R 1 475	R 125	
St Apollinaris Hospital	Ingwe	Sisonke	Construction started	Additions	R 13 900	R 6 673	R -
Nxamalala Clinic	Impendle	uMgungundlovu	Construction started	Replacement	R 1 700	R 100	R -
Pisgah Clinic	uMuziwabantu	Ugu	Construction started	Renovations	R 3 961	R 250	
Prince Mshiyeni Memorial Hospital	eThekwini	Metros KZ	Construction started	Upgrading	R 12 000	R 3 997	R 1 000
Pongola : SAPS Mortuary	uPhongolo	Zululand	Construction started	New	R -	R 8 000	R 15 278
Programme Management HRP	eThekwini	Metros KZ	Construction started	Upgrading			
Empangeni Hospital/Lower Umfolozi Memorial	uMhlathuze	uThungulu	Construction started	Additions	R 115 306	R 120 873	R 30 361
King George v hospital	eThekwini	Metros KZ	Construction started	Upgrading	R -	R -	R -
King George v hospital	eThekwini	Metros KZ	Construction started	Upgrading	R -	R -	R -
Mkhuphula Clinic	Msinga	Umzinyathi	Construction started	New	R 500	R -	
Appelsbosch Hospital	uMshwathi	uMgungundlovu	Construction started	Additions	R 5 000	R 550	R -
Essential Health Technology Equipment Programme	Msunduzi	uMgungundlovu	Construction started	Upgrading	R 40 000	R 73 000	R 73 000
King George v hospital	eThekwini	Metros KZ	Construction started	Additions	R -	R -	R -
King George v hospital	eThekwini	Metros KZ	Construction started	Additions	R -	R -	R -
Rietvlei Hospital	Umzimkhulu	Sisonke	Construction started	Upgrading	R 7 844	R -	R -
Hlengisizwe CHC	eThekwini	Metros KZ	Construction started	Renovations	R 150	R -	R -
Groutville Clinic	iLembe District Municipality	iLembe	Construction started	New	R -	R -	R -
Ezimwini Clinic	Mkhambathini	uMgungundlovu	Design	New	R -	R 8 200	R 4 039
Ingogo Clinic	Newcastle	Amajuba	Design	New	R -	R 1 000	R 11 947
Church Of Scotland Hospital	Msinga	Umzinyathi	Design	Replacement	R -	R 7 784	R 46 500
Nhlopheni Clinic	Abaqulusi	Zululand	Design	New	R -	R 12 000	R 8 967
Jozini Malaria Health Complex	Jozini	Umkhanyakude	Design	Renovations	R 1 374	R 90	R -
Ndlozana Clinic	Nongoma	Zululand	Design	New	R -	R 6 000	R 7 541
Kwashoba Clinic	uPhongolo	Zululand	Design	Renovations	R 3 000	R 3 844	R 430
Stedham Clinic	Ulundi	Zululand	Design	Renovations	R -	R 3 300	R 3 540
Mnqobokazi Clinic	The Big Five False Bay	Umkhanyakude	Design	Renovations	R 1 715	R 2 182	R 240
Ntambanana Clinic	Ntambanana	uThungulu	Design	Renovations	R 12 000	R 4 675	R 1 000

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Name of Project	Municipality	District	Status of project	Nature of Project	Projected Budget		
					MTEF 1 2011/12 (R'000)	MTEF 2 2012/13 (R'000)	MTEF 3 2013/14 (R'000)
Babanango Clinic	Ulundi	Zululand	Design	New	R -	R 5 000	R 12 567
Mpophomeni Clinic	Umhlabuyalingana	Umkhanyakude	Design	New	R 4 303	R 6 000	R 600
Ndundulu Clinic	Mthonjaneni	uThungulu	Design	Replacement	R -	R 6 200	R 6 963
Ekhombe Hospital	Nkandla	uThungulu	Design	Renovations	R 1 000	R 18 280	R 1 000
Thulasizwe Hospital	Ulundi	Zululand	Design	Upgrading	R 1 000	R 288	R -
Mbongolwane Hospital	Umlalazi	uThungulu	Design	Renovations	R -	R 5 200	R 5 170
Kwamagwaza Hospital	Mthonjaneni	uThungulu	Design	Upgrading	R -	R 5 650	R 350
Catherine Booth Hospital	Umlalazi	uThungulu	Design	Upgrading	R 9 000	R 8 390	R 1 000
Eshowe Hospital	Umlalazi	uThungulu	Design	Replacement	R 5 357	R 340	R -
Greys Hospital	Msunduzi	uMgungundlovu	Design	Additions	R -	R -	R 3 000
Appelsbosch Hospital	uMshwathi	uMgungundlovu	Design	Additions	R -	R -	R 6 000
Appelsbosch Hospital	uMshwathi	uMgungundlovu	Design	Additions	R 2 869	R 150	R -
Mbuthisweni Clinic (Inhlazuka)	Richmond	uMgungundlovu	Design	Renovations	R 2 874	R 116	R -
Shayamoya Clinic	Greater Kokstad	Sisonke	Design	New	R -	R -	R 8 000
Mqatsheni Clinic	Kwa Sani	Sisonke	Design	New	R 10 000	R 5 380	R 750
Hopewell Clinic	Richmond	uMgungundlovu	Design	New	R 3 000	R 7 901	R 600
Ndelu Clinic	Umzumbe	Ugu	Design	New	R 7 356	R 500	
Kwampande Clinic	Msunduzi	uMgungundlovu	Design	New	R -	R 4 814	R 4 190
Mahlutshini Clinic	Impendle	uMgungundlovu	Design	New	R 7 179	R 440	R -
Sokhela Clinic	Ingwe	Sisonke	Design	New	R 2 673	R 85	
Groutville Clinic	KwaDukuza	iLembe	Design	Disposal	R -	R 1 000	R 11 000
King Edward VIII Hospital	eThekwini	Metros KZ	Design	Renovations	R -	R -	R -
Stanger Hospital	KwaDukuza	iLembe	Design	Upgrading	R 13 583	R 650	R -
Stanger Hospital	KwaDukuza	iLembe	Design	Additions	R 15 187	R 3 000	R 900
Dr Pixley Ka Seme Hospital	eThekwini	Metros KZ	Design	New	R 20 000	R 659 094	R 313 430
King George V Hospital	eThekwini	Metros KZ	Design	Upgrading	R 142	R 1 024	R -
Madadeni Psychiatric Hospital	Amajuba District Municipality	Amajuba	Design	Rehabilitation	R -	R -	R -
Edendale Hospital	Msunduzi	uMgungundlovu	Design	Upgrading	R 550	R -	
Umzimkulu mortuary	Umzimkhulu	Sisonke	Design	Upgrading	R -	R 8 776	R 12 859
Maphumulo mortuary	Maphumulo	iLembe	Design	Upgrading	R -	R 8 014	R 10 000
Natalia Building	uMgungundlovu District Municipality	uMgungundlovu	Design	Replacement	R 2 600	R -	R -
KwaMakhutha Clinic	eThekwini	Metros KZ	Design	New	R -	R 1 000	R 9 000
Maphumulo Clinic	Maphumulo	iLembe	Design	New	R -	R 5 000	R 6 603
Pomeroy CHC	Msinga	Umzinyathi	Design	New	R -	R 5 000	R 107 410
Emambedweni Clinic	uMshwathi	uMgungundlovu	Design	New	R -	R 5 500	R 3 737
Jozini Clinic	Jozini	Umkhanyakude	Design	Upgrading	R 3 417	R 250	R -
Mambulu Clinic (Kranskop)	Umvoti	Umzinyathi	Design	Upgrading	R -	R 947	R 11 000

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Name of Project	Municipality	District	Status of project	Nature of Project	Projected Budget		
					MTEF 1 2011/12 (R'000)	MTEF 2 2012/13 (R'000)	MTEF 3 2013/14 (R'000)
Estcourt Hospital	Umtshezi	Uthukela	Design	New	R -	R 5 000	R 75 257
Estcourt Hospital	Umtshezi	Uthukela	Design	New	R -	R -	R 121 892
Phoenix Mortuary	eThekwini	Metros KZ	Design	New	R 45 000	R 23 522	R 4 000
Mtubatuba Mortuary	Mtubatuba	Umkhanyakude	Design	New	R -	R -	R 29 955
Ngwelezane hospital	uMhlathuze	uThungulu	Design	Upgrading	R -	R 560	R 885
King George V Hospital	eThekwini	Metros KZ	Design	Upgrading	R 10 892	R 715	R 892
Dr John Dube Memorial Hospital	eThekwini	Metros KZ	Design	New	R -	R -	R -
Hlabisa Hospital	Hlabisa	Umkhanyakude	Design	Upgrading	R 1 250	R 4 421	R -
Hlabisa Hospital	Hlabisa	Umkhanyakude	Design	Upgrading	R 540	R -	R -
King George V hospital	eThekwini	Metros KZ	Design	Upgrading	R 4 191	R 693	R 300
King George V hospital	eThekwini	Metros KZ	Design	Upgrading	R 28 169	R 1 609	R 2 869
King George V hospital	eThekwini	Metros KZ	Design	Upgrading	R 2 000	R 1 827	R 1 634
King George V hospital	eThekwini	Metros KZ	Design	Upgrading	R 510	R 2 716	R -
King George V hospital	eThekwini	Metros KZ	Design	New	R 5 363	R 135	
King George V hospital	eThekwini	Metros KZ	Design	Upgrading	R -	R 1 748	R 5 896
King george V hospital	eThekwini	Metros KZ	Design	Upgrading	R -	R -	R -
Madadeni Psychiatric Hospital	Amajuba District Municipality	Amajuba	Design	New		R -	R 18 000
Madadeni Psychiatric Hospital	Amajuba District Municipality	Amajuba	Design	Upgrading	R -	R -	R 12 000
Rietvlei Hospital	Umzimkhulu	Sisonke	Design	Upgrading	R 45 000	R 55 945	R 5 426
Rietvlei Hospital	Umzimkhulu	Sisonke	Design	Upgrading	R -	R -	R -
Ladybank Clinic	Dannhauser	Amajuba	Design	Renovations	R 261	R -	
Underberg Clinic	Kwa Sani	Sisonke	Design	Upgrading	R 600	R -	R -
KwaDabeka CHC	eThekwini	Metros KZ	Design	Renovations	R -	R -	R -
Pholela CHC	Ingwe	Sisonke	Design	Renovations	R 3 979	R 200	R -
Kwamagwaza Hospital	Mthonjaneni	uThungulu	Design	Upgrading	R -	R 4 450	R 250
Port Shepstone Hospital	Hibiscus Coast	Ugu	Design	Upgrading	R 2 714	R 643	R 124
Phoenix CHC	eThekwini	Metros KZ	Design	Rehabilitation	R -	R 5 000	R 12 883
King Edward VIII Hospital	eThekwini	Metros KZ	Design	Renovations	R 10 527	R 1 500	R -
Health CHC Design & Documents			Design	Upgrading	R -	R -	R -
Kwahhemlana Clinic	Nongoma	Zululand	Design	New	R -	R 7 000	R 4 032
Rosary Clinic	Newcastle	Amajuba	Design	Renovations	R 2 500	R 1 113	R 517
Edendale Hospital	Msunduzi	uMgungundlovu	Design	Upgrading	R 2 325	R -	R -
Edendale Hospital	Msunduzi	uMgungundlovu	Design	Upgrading	R 25 000	R 13 853	R 2 200
Edendale Hospital	Msunduzi	uMgungundlovu	Design	Upgrading	R 1 225	R 75	R -
King george V hospital	eThekwini	Metros KZ	Design	Upgrading	R 435	R 1 710	R 1 543
King george V hospital	eThekwini	Metros KZ	Design	Upgrading	R 1 500	R -	R -
King Edward VIII Hospital	eThekwini	Metros KZ	Design	Upgrading	R -	R -	R -

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Name of Project	Municipality	District	Status of project	Nature of Project	Projected Budget		
					MTEF 1 2011/12 (R'000)	MTEF 2 2012/13 (R'000)	MTEF 3 2013/14 (R'000)
King Edward VIII Hospital	eThekwini	Metros KZ	Design	Upgrading	R 12 988	R 6 000	R 500
Murchison Hospital	Hibiscus Coast	Ugu	Design	Upgrading	R 900	R -	R -
Dannhauser CHC	Dannhauser	Amajuba	Design	New	R -	R 5 000	R 79 747
Hillcrest Hospital	eThekwini	Metros KZ	Design	Renovations	R 100	R -	R -
King Shaka Airport	eThekwini	Metros KZ	Design	Upgrading	R -	R 500	R 9 500
Mwolokohlo Clinic	Ndwedwe	iLembe	Design	Additions	R 700	R 50	R -
Isithebe Clinic	Mandeni	iLembe	Design	Additions	R 300	R 3 250	R 1 050
Umphumulo Hospital	Maphumulo	iLembe	Design	Additions	R 1 000	R 6 000	R 20 000
Untunjambili Hospital	Maphumulo	iLembe	Design	Additions	R 5 514	R 2 000	R 400
Charles James Hospital	eThekwini	Metros KZ	Design	Additions	R 27	R -	R -
Mahatma Ghandhi Hospital	eThekwini	Metros KZ	Design	Additions	R 15	R -	R -
Hillcrest Hospital	eThekwini	Metros KZ	Design	Renovations	R 300	R -	R -
G J Crookes Hospital	Umdoni	Ugu	Design	Upgrading	R 400	R -	R -
Bruntville CHC	Mpofana	uMgungundlovu	Design	Additions	R 420	R -	R -
Bruntville CHC	Mpofana	uMgungundlovu	Design	Upgrading	R -	R -	R -
Fort Napier Hospital	Msunduzi	uMgungundlovu	Design	Renovations	R 300	R -	R -
UMgeni Hospital	Msunduzi	uMgungundlovu	Design	Upgrading	R 500	R -	R -
Umzimkhulu CHC	Umzimkhulu	Sisonke	Design	New	R 40 000	R 34 000	R 4 000
Umzimkhulu Hospital	Umzimkhulu	Sisonke	Design	Additions	R 100	R 5 200	R 400
Umzimkhulu Hospital	Umzimkhulu	Sisonke	Design	Additions	R 2 950	R 250	R -
Niemeyer Memorial Hospital	eMadlangeni	Amajuba	Design	Upgrading	R 2 215	R 875	R 350
Newcastle Hospital	Newcastle	Amajuba	Design	Renovations	R 600	R 5 922	R 1 950
Newcastle Hospital	Newcastle	Amajuba	Design	Additions	R 200	R 3 214	R 1 360
Greytown Hospital	Msinga	Umzinyathi	Design	Additions	R 600	R -	R -
Dundee Hospital	Msinga	Umzinyathi	Design	Additions	R 550	R 50	
Ceza Hospital	Nongoma	Zululand	Design	Renovations	R 2 430	R 150	R -
Vryheid Hospital	Abaqulusi	Zululand	Design	Additions	R 1 722	R 100	R -
Mosvold Hospital	Jozini	Umkhanyakude	Design	Upgrading	R 30	R -	R -
Mbongolwane Hospital	Umlalazi	uThungulu	Design	Renovations	R 1 500	R -	R -
Eshowe Hospital	Umlalazi	uThungulu	Design	Renovations	R 50	R -	R -
Eshowe Hospital	Umlalazi	uThungulu	Design	Upgrading	R 700	R -	R -
Mbongolwane Hospital	Umlalazi	uThungulu	Design	Renovations	R 800	R -	R -
Catherine Booth Hospital	Umlalazi	uThungulu	Design	Upgrading	R 1 627	R 100	R -
Newcastle Hospital	Newcastle	Amajuba	Design	Additions	R 1 800	R 5 625	R 17 250
Emmaus Hospital	Okhahlamba	Uthukela	Design	Additions	R -	R 3 690	R 14 310
Newcastle Hospital Mortuary	Newcastle	Amajuba	Design	Upgrading			
Gamalakhe CHC	Hibiscus Coast	Ugu	Design	Additions	R 7 500	R 1 800	R 639
Vryheid Hospital	Jozini	Umkhanyakude	Design	Upgrading	R 300	R -	R -
Ekuhlengeni Life Care Centre	eThekwini	Metros KZ	Design	Renovations	R 436	R -	R -

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Name of Project	Municipality	District	Status of project	Nature of Project	Projected Budget		
					MTEF 1 2011/12 (R'000)	MTEF 2 2012/13 (R'000)	MTEF 3 2013/14 (R'000)
Hartland Clinic	eDumbe	Zululand	Design	Renovations	R 50	R -	R -
Newcastle Hospital	Newcastle	Amajuba	Design	Additions	R 400	R -	
Vumani Clinic	Abaqulusi	Zululand	Design	New	R 550	R 5 100	R 4 992
Enhlekiseni Clinic	Abaqulusi	Zululand	Design	New	R 5 000	R 5 200	R 550
Ceza Hospital	Nongoma	Zululand	Design	Additions	R -	R -	R 10 230
Gwaliweni Clinic	Jozini	Umkhanyakude	Design	New	R 5 000	R 9 159	R 800
Charles Johnson Memorial Hospital	Nquthu	Umzinyathi	Design	Replacement	R 11 500	R 500	
Clairwood Hospital	eThekwini	Metros KZ	Design	Upgrading	R 20 000	R 17 000	R 2 700
Addington Hospital	eThekwini	Metros KZ	Design	Renovations	R 833	R -	R -
Dr Pixley ka Seme Hospital	eThekwini	Metros KZ	Design	New	R 50 000	R 3 698	R -
Nkandla Hospital	Nkandla	uThungulu	Design	New	R 3 000	R 5 300	R 450
Injisuthi Clinic	Imbabazane	Uthukela	Design	Upgrading			
Eshowe Clinic	Umlalazi	uThungulu	Feasibility	New	R -	R 300	R 8 000
Dr John Dube Memorial Hospital	eThekwini	Metros KZ	Feasibility	New	R -	R -	R -
Dr John Dube Memorial Hospital	eThekwini	Metros KZ	Feasibility	Upgrading	R -	R -	R -
Ikhwezi Lokusa Clinic	Ubuhlebezwe	Sisonke	Feasibility	New	R -	R 1 000	R 5 500
King George v hospital	eThekwini	Metros KZ	Feasibility	Rehabilitation	R -	R 7 883	
Dr John Dube Memorial Hospital	eThekwini	Metros KZ	Feasibility	Upgrading	R -	R -	R -
Dr John Dube Memorial Hospital	eThekwini	Metros KZ	Feasibility	Upgrading	R -	R -	R -
King George V hospital	eThekwini	Metros KZ	Feasibility	Upgrading	R 342	R 1 687	R 1 683
King George V hospital	eThekwini	Metros KZ	Feasibility	Upgrading	R 570	R 7 866	R 5 506
King George V hospital	eThekwini	Metros KZ	Feasibility	Upgrading	R 10 032	R 36 331	R 20 249
Madadeni Psychiatric Hospital	Amajuba District Municipality	Amajuba	Feasibility	New	R 8 000	R 9 487	R 35 000
Edendale Hospital	Msunduzi	uMgungundlovu	Feasibility	Upgrading	R -	R -	R -
Edendale Hospital	Msunduzi	uMgungundlovu	Feasibility	Upgrading	R 6 104	R 350	R -
Edendale Hospital	Msunduzi	uMgungundlovu	Feasibility	Upgrading	R 3 430	R 200	R -
Edendale Hospital	Msunduzi	uMgungundlovu	Feasibility	Upgrading	R -	R -	R -
Edendale Hospital	Msunduzi	uMgungundlovu	Feasibility	Upgrading	R 5 950	R 400	R -
King George V hospital	eThekwini	Metros KZ	Feasibility	Upgrading	R 6 000	R -	R -
King George V hospital	eThekwini	Metros KZ	Feasibility	Upgrading	R 500	R -	R -
King George V hospital	eThekwini	Metros KZ	Feasibility	Upgrading	R 850	R -	R -
Madadeni Psychiatric Hospital	Amajuba District Municipality	Amajuba	Feasibility	Additions	R 1 000	R -	R -
Rietvlei Hospital	Umzimkhulu	Sisonke	Feasibility	Upgrading	R 805	R -	R -
Mkhontokayise Clinic	uMhlathuze	uThungulu	Feasibility	Renovations	R 780	R 40	R -
Northdale Hospital	Msunduzi	uMgungundlovu	Feasibility	Renovations	R 700	R -	R -
Greys Hospital	Msunduzi	uMgungundlovu	Feasibility	Upgrading	R 5 400	R 400	R -
Bethesda Hospital	Jozini	Umkhanyakude	Feasibility	Upgrading	R 1 090	R 60	R -

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Name of Project	Municipality	District	Status of project	Nature of Project	Projected Budget		
					MTEF 1 2011/12 (R'000)	MTEF 2 2012/13 (R'000)	MTEF 3 2013/14 (R'000)
Mosvold Hospital	Jozini	Umkhanyakude	Feasibility	Upgrading	R 1 865	R 135	R -
Mosvold Hospital	Jozini	Umkhanyakude	Feasibility	Renovations	R 2 530	R 150	R -
Mbongolwane Hospital	Umlalazi	uThungulu	Feasibility	Renovations	R 4 000	R 10 000	R 750
Ekhombe Hospital	Umlalazi	uThungulu	Feasibility	Renovations	R 1 196	R -	R -
Umzimkhulu Hospital	Umzimkhulu	Sisonke	Feasibility	Upgrading	R 546	R -	R -
Acquisition Of Land And Buildings			Feasibility	Upgrading	R 27 452	R -	R -
Fort Napier Hospital	Msunduzi	uMgungundlovu	Feasibility	Renovations	R -	R 1 500	R 2 330
Nkandla Hospital	Nkandla	uThungulu	Identified	Upgrading	R -	R 1 500	R 342
Nyavini Clinic	Umzumbe	Ugu	Identified	Renovations	R 100	R 10 200	R 400
Ngwelezane hospital	uMhlathuze	uThungulu	Identified	Additions	R 60 000	R 60 000	R 48 317
Dr Pixley ka Seme Hospital	eThekwini	Metros KZ	Identified	Upgrading	R 1 000	R 2 000	R 3 500
Dr Pixley ka Seme Hospital	eThekwini	Metros KZ	Identified	Upgrading	R -	R -	R 123 180
Edendale Hospital	Msunduzi	uMgungundlovu	Identified	Upgrading	R 2 500	R 2 500	R 11 500
Edendale Hospital	Msunduzi	uMgungundlovu	Identified	Upgrading	R 598 339	R -	R -
Edendale Hospital	Msunduzi	uMgungundlovu	Identified	Upgrading	R 30 000	R 30 000	R 30 000
King george v hospital	eThekwini	Metros KZ	Identified	Upgrading	R 1 369	R 5 000	R 15 580
Madadeni Psychiatric Hospital	Amajuba District Municipality	Amajuba	Identified	New	R 32 500	R -	R 253 284
Niemeyer Memorial Hospital	eMadlangeni	Amajuba	Identified	Upgrading	R -	R -	
Umngungundlovu large EMRS station	uMgungundlovu District Municipality	uMgungundlovu	Identified	Renovations	R 1 000	R 17 000	R 2 000
eThekwini large EMRS Station	Umzinyathi District Municipality	Umzinyathi	Identified	Upgrading	R 1 000	R 17 000	R 2 000
Umzinyathi large EMRS station	Umzinyathi District Municipality	Umzinyathi	Identified	Upgrading	R 1 000	R 17 000	R 2 000
Rietvlei Hospital	Umzimkhulu	Sisonke	Identified	Upgrading	R -	R -	R -
Ngwelezane hospital	uMhlathuze	uThungulu	Identified	Upgrading	R 59 092	R 50 000	R 70 383
Ngwelezane hospital	uMhlathuze	uThungulu	Identified	Upgrading	R -	R -	R -
Ngwelezane hospital	uMhlathuze	uThungulu	Identified	Upgrading	R 1 114	R 5 046	R 6 425
Appelsbosch EMRS Training College	uMgungundlovu District Municipality	uMgungundlovu	Identified	Upgrading	R 2 850	R 150	R -
Empangeni Tertiary	uMhlathuze	uThungulu	Identified	New	R 750	R -	R -
King Edward VIII Hospital	eThekwini	Metros KZ	Identified	Upgrading	R 1 500	R -	R -
King Edward VIII Hospital	eThekwini	Metros KZ	Identified	Upgrading	R -	R -	R -
King Edward VIII Hospital	eThekwini	Metros KZ	Identified	Upgrading	R -	R -	R -
Rietvlei Hospital	Umzimkhulu	Sisonke	Identified	Upgrading	R 500	R -	R -
Edendale Nursing College	Msunduzi	uMgungundlovu	Identified	Renovations	R 3 600	R 20 000	R 16 000
Sundumbili CHC	Mandeni	iLembe	Identified	Additions	R 500	R 2 200	R 200
Ndwedwe CHC	Ndwedwe	iLembe	Identified	Additions	R -	R -	R 400

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					MTEF 1 2011/12 (R'000)	MTEF 2 2012/13 (R'000)	MTEF 3 2013/14 (R'000)
Umphumulo Hospital	Maphumulo	iLembe	Identified	Upgrading	R 200	R 4 350	R 450
Montebello Hospital	Ndwedwe	iLembe	Identified	Upgrading	R -	R 600	R 13 000
Osindisweni Hospital	eThekwini	Metros KZ	Identified	Renovations	R -	R 150	R 3 500
Dunstan Farrell	Hibiscus Coast	Ugu	Identified	Renovations	R 850	R 50	R -
Imbalenhle CHC	Msunduzi	uMgungundlovu	Identified	Upgrading	R 500	R -	R -
Fort Napier Hospital	Msunduzi	uMgungundlovu	Identified	Renovations	R 300	R -	R -
UMgeni Hospital	Msunduzi	uMgungundlovu	Identified	Upgrading	R 4 450	R 250	R -
Umzimkhulu Hospital	Umzimkhulu	Sisonke	Identified	Upgrading	R 478	R -	R -
Niemeyer Memorial Hospital	eMadlangeni	Amajuba	Identified	Additions	R 1 375	R 3 850	R 275
Thulasizwe Hospital	Ulundi	Zululand	Identified	Upgrading	R -	R -	R -
Kwamagwaza Hospital	Umhlabuyalingana	Umkhanyakude	Identified	Upgrading	R 3 000	R 5 300	R 450
Dundee Regional Laundry	Newcastle	Amajuba	Identified	Renovations	R -	R -	R -
Mseleni Hospital	Umhlabuyalingana	Umkhanyakude	Identified	Renovations	R -	R -	R -
Ixopo Mortuary	Sisonke District Municipality	Sisonke	Identified	Renovations	R -	R -	R -
Addington Hospital	Nquthu	Umzinyathi	Identified	Renovations	R 16 100	R 850	R -
Charles Johnson Memorial Hospital	Nquthu	Umzinyathi	Identified	Additions	R 651	R -	R -
Queensburg EMRS	eThekwini	Metros KZ	Identified	Renovations	R 600	R -	R -
Addington Nursing College	eThekwini	Metros KZ	Identified	Renovations	R 5 650	R 350	R -
New PHC Facilities: Furniture			Identified	Additions	R 4 464	R -	R -
Bulwer Mortuary			Identified	Upgrading	R -	R -	R -
Clairwood Hospital	eThekwini	Metros KZ	Identified	Upgrading	R 758	R 100	R -
Phoenix Mortuary	eThekwini	Metros KZ	Identified	New	R -	R -	R -
Port Shepstone Hospital	Hibiscus Coast	Ugu	Identified	Upgrading	R 2 050	R 250	R -
Ugu EMRS Large Station	Ugu District Municipality	Ugu	Identified	New	R 1 000	R 17 000	R 2 000
Emmaus Hospital	Okhahlamba	Uthukela	Identified	Additions	R 600	R -	R -
Ladysmith Provincial Hospital	Emnambithi/Ladysmith	Uthukela	Identified	Additions	R -	R -	R -
Greytown Hospital	Msinga	Umzinyathi	Identified	Upgrading	R 4 325	R 275	R -
Zululand EMRS Station	Zululand District Municipality	Zululand	Identified	New	R 1 000	R 17 000	R 2 000
Townhill Hospital	Msunduzi	uMgungundlovu	Identified	Renovations	R 10 000	R 28 100	R 2 000
Mbangweni Clinic	Msinga	Umzinyathi	Retention	Renovations	R -	R -	
Ncibidwane Clinic	Imbabazane	Uthukela	Retention	Upgrading	R 400	R -	
Wembezi Clinic	Indaka	Uthukela	Retention	Renovations	R -	R -	
Ntinini Clinic	Nquthu	Umzinyathi	Retention	Upgrading	R 100	R -	
Gunjane Clinic	Msinga	Umzinyathi	Retention	Upgrading	R 190	R -	
Greenock Clinic - (Umzinyathi Region)	Dannhauser	Amajuba	Retention	Upgrading	R -	R -	

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Name of Project	Municipality	District	Status of project	Nature of Project	Projected Budget		
					MTEF 1 2011/12 (R'000)	MTEF 2 2012/13 (R'000)	MTEF 3 2013/14 (R'000)
Madadeni Clinic 1	Newcastle	Amajuba	Retention	Upgrading	R 83	R -	
Madadeni Mortuary	Newcastle	Amajuba	Retention	Replacement	R -	R -	R -
Newcastle Hospital	Newcastle	Amajuba	Retention	Additions	R 320	R -	
Mduku Clinic	The Big Five False Bay	Umkhanyakude	Retention	Renovations	R 250	R -	R 1 416
Samungu Clinic	Umlalazi	uThungulu	Retention	Renovations	R -	R -	R -
Ombimbini Clinic (Nongoma)	Ulundi	Zululand	Retention	New	R 487	R -	R -
Ensingweni Clinic	Umlalazi	uThungulu	Retention	Renovations	R 100	R -	R -
Sovane Clinic	Nongoma	Zululand	Retention	Renovations	R 150	R -	R -
Vulindlela Clinic	uMhlathuze	uThungulu	Retention	Renovations	R 70	R 50	R -
Maphophoma Clinic	Nongoma	Zululand	Retention	Replacement	R 600	R -	R -
Dinuntuli Clinic	Nkandla	uThungulu	Retention	New	R -	R -	R -
Kwamsane Clinic	Mtubatuba	Umkhanyakude	Retention	Renovations	R -	R -	R -
Mahlungulu Clinic	Umhlabuyalingana	Umkhanyakude	Retention	Renovations	R -	R -	R -
Phaphamani Clinic	uMhlathuze	uThungulu	Retention	Renovations	R 71	R -	R -
Nkanini Health Centre	Umlalazi	uThungulu	Retention	New	R 56	R -	R -
Mosvold Hospital	Jozini	Umkhanyakude	Retention	New	R 1 350	R -	R -
Mseleni Hospital	Umhlabuyalingana	Umkhanyakude	Retention	Additions	R 1 145	R -	R -
Nkandla Hospital	Nkandla	uThungulu	Retention	Additions	R 652	R -	R -
Vryheid Hospital	Abaqulusi	Zululand	Retention	Upgrading	R 295	R -	R -
Manguzi Hospital	Umhlabuyalingana	Umkhanyakude	Retention	Renovations	R 125	R -	R -
Mosvold Hospital	Jozini	Umkhanyakude	Retention	Upgrading	R 1 296	R -	R -
Thulasizwe Hospital	Ulundi	Zululand	Retention	Additions	R -	R -	R -
St Francis Hospital	Ulundi	Zululand	Retention	Additions	R -	R -	R -
Old Greys Complex (Orthopaedic Services)	Msunduzi	uMgungundlovu	Retention	Renovations	R 150	R -	R -
St Apollinaris Hospital	Ingwe	Sisonke	Retention	Additions	R -	R -	R -
Gamalakhe CHC	Hibiscus Coast	Ugu	Retention	Upgrading	R 2 000	R -	
Sandanezwe Clinic	Ingwe	Sisonke	Retention	Renovations	R 260	R -	R -
Emtulwa Clinic	uMshwathi	uMgungundlovu	Retention	Renovations	R 160	R -	R -
Sondelani Clinic (Ngubeni Clinic No.107)	Msunduzi	uMgungundlovu	Retention	Renovations	R 125	R -	R -
Gqumeni Clinic	Ingwe	Sisonke	Retention	Renovations	R 280	R -	R -
Ncwadi Clinic	Ingwe	Sisonke	Retention	Renovations	R 65	R -	R -
Tsatsi Memorial Clinic	Kwa Sani	Sisonke	Retention	Renovations	R 1 095	R 50	R -
Santombe Clinic	uMuziwabantu	Ugu	Retention	New	R -	R -	R -
Richards Bay : Saps Mortuary	uMhlathuze	uThungulu	Retention	Upgrading	R -	R -	R -
Durban : Gale Street Saps Mortuary	eThekwini	Metros KZ	Retention	Upgrading	R -	R -	R -
Empangeni Hospital/Lower Umfolozi Memorial	uMhlathuze	uThungulu	Retention	Upgrading	R -	R -	R -
King George V Hospital	eThekwini	Metros KZ	Retention	Rehabilitation	R -	R -	R -

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Name of Project	Municipality	District	Status of project	Nature of Project	Projected Budget		
					MTEF 1 2011/12 (R'000)	MTEF 2 2012/13 (R'000)	MTEF 3 2013/14 (R'000)
Eshowe : SAPS Mortuary	Umlalazi	uThungulu	Retention	New		R -	R -
Port Shepstone : SAPS Mortuary	Hibiscus Coast	Ugu	Retention	Upgrading	R 5 709	R -	R -
Estcourt Mortuary	Umtshezi	Uthukela	Retention	New	R 534	R -	R -
Dundee Mortuary	Endumeni	Umzinyathi	Retention	New	R 1 000	R 3 841	R -
KwaMbiza Clinic	Umtshezi	Uthukela	Retention	New	R 765	R -	R -
Manguzi PMTCT Clinic	Umhlabuyalingana	Umkhanyakude	Retention	New	R -	R -	R -
Kwasenge Clinic	Umvoti	Umzinyathi	Retention	New	R 342	R -	
Manyiseni Clinic	Umhlabuyalingana	Umkhanyakude	Retention	New	R -	R -	R -
Kwadukuza/Stanger PMCT Clinic	KwaDukuza	iLembe	Retention	Additions	R 300	R -	R -
Pietermaritzburg M6 Mortuary	uMgungundlovu District Municipality	uMgungundlovu	Retention	New	R 3 500	R -	R -
Park Ryne M3 Mortuary	Hibiscus Coast	Ugu	Retention	New	R 2 921	R -	R -
Tobolsk Clinic	uPhongolo	Zululand	Retention	Renovations	R 85	R -	R -
King george v hospital	eThekwini	Metros KZ	Retention	Rehabilitation	R -	R -	R -
Empangeni Hospital/Lower Umfolozi Memorial	uMhlathuze	uThungulu	Retention	Upgrading	R -	R -	R -
Rietvlei Hospital	Umzimkhulu	Sisonke	Retention	Upgrading	R -	R -	R -
Cornfields Clinic	Umtshezi	Uthukela	Retention	Renovations	R -	R -	
Mgangeni Clinic	Umdoni	Ugu	Retention	New	R -	R -	
Bhekuzulu Clinic	Abaqulusi	Zululand	Retention	Renovations	R 200	R -	R -
Nomdiya Clinic	Ulundi	Zululand	Retention	New	R 154	R -	R -
Estcourt Hospital	Umtshezi	Uthukela	Retention	Upgrading	R 50	R -	R -
Manguzi Hospital	Umhlabuyalingana	Umkhanyakude	Retention	Additions	R 400	R -	R -
Wentworth Hospital	eThekwini	Metros KZ	Retention	Upgrading	R -	R -	R -
Addington Hospital	eThekwini	Metros KZ	Retention	Upgrading	R 1 366	R -	R -
Addington Hospital	eThekwini	Metros KZ	Retention	Renovations	R 1 112	R -	R -
R K Khan Hospital	eThekwini	Metros KZ	Retention	Upgrading	R 316	R -	R -
Rietvlei Hospital	Umzimkhulu	Sisonke	Retention	Upgrading	R -	R -	R -
Mbongolwane Hospital	Umlalazi	uThungulu	Retention	Renovations			
Edumbe CHC	eDumbe	Zululand	Retention	Additions	R -	R -	R -
Greys Hospital	Msunduzi	uMgungundlovu	Retention	Upgrading	R 2 000	R 2 000	R 440
Edendale Hospital	Msunduzi	uMgungundlovu	Retention	Upgrading	R 5 200	R 683	R -
King george V hospital	eThekwini	Metros KZ	Retention	Upgrading	R 4	R -	R -
Ngwelezane hospital	uMhlathuze	uThungulu	Retention	Upgrading		R -	R -
Chibini Clinic	Ndwedwe	iLembe	Tender	Upgrading	R -	R 2 541	R 142
Madadeni Clinic No 7	Newcastle	Amajuba	Tender	Renovations	R 2 188	R 150	R -
Emmaus Hospital	Okhahlamba	Uthukela	Tender	Additions	R 30 000	R 30 000	R 27 480
Mathungela Clinic	Umlalazi	uThungulu	Tender	Renovations	R 1 857	R 100	R -
Nogajuluka Clinic	Mthonjaneni	uThungulu	Tender	New	R -	R -	R 8 000

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Name of Project	Municipality	District	Status of project	Nature of Project	Projected Budget		
					MTEF 1 2011/12 (R'000)	MTEF 2 2012/13 (R'000)	MTEF 3 2013/14 (R'000)
Lomo Clinic	Ulundi	Zululand	Tender	Renovations	R 1 650	R 2 081	R 250
Macambini Clinic	KwaDukuza	iLembe	Tender	Renovations	R 2 800	R 682	R 120
Thalaneni Clinic	Nkandla	uThungulu	Tender	Renovations	R 5 000	R 5 429	R 499
Makhatini Clinic	Jozini	Umkhanyakude	Tender	Renovations	R 5 252	R 350	R -
Altona Clinic	uPhongolo	Zululand	Tender	Renovations	R 3 116	R 253	
Ngwelezane Clinic	uMhlathuze	uThungulu	Tender	Renovations	R 3 760		R -
Nkandla Hospital	Nkandla	uThungulu	Tender	Upgrading	R -	R 7 500	R 8 478
Manguzi Hospital	Umhlabuyalingana	Umkhanyakude	Tender	Upgrading	R 2 103	R 150	
St Andrews Hospital	uMuziwabantu	Ugu	Tender	Upgrading	R 7 700	R 437	R -
Murchison Hospital	Hibiscus Coast	Ugu	Tender	Additions	R -	R 12 000	R 6 639
Greys Hospital	Msunduzi	uMgungundlovu	Tender	Renovations	R -	R 3 000	R 695
Townhill Hospital	Msunduzi	uMgungundlovu	Tender	Renovations	R 8 410	R 500	R -
Northdale Hospital	Msunduzi	uMgungundlovu	Tender	Renovations	R 835	R 5 000	R 7 664
G J Crookes Hospital	Umdoni	Ugu	Tender	Renovations	R 37 000	R 37 000	R 41 200
Ixopo Clinic	Ubuhlebezwe	Sisonke	Tender	Renovations	R -	R 8 472	R 483
Shongweni Dam Clinic	eThekwini	Metros KZ	Tender	New	R -	R 6 000	R 4 917
Wosiyane Clinic	Ndwedwe	iLembe	Tender	Disposal	R -	R 4 000	R 2 194
Kwanyuswa Clinic	Ndwedwe	iLembe	Tender	Additions	R 200	R -	
Highway House : Mayville	eThekwini	Metros KZ	Tender	Additions	R 12 000	R 2 801	R 2 800
Addington Hospital	eThekwini	Metros KZ	Tender	Renovations	R 2 169	R 67	R -
King George V Hospital	eThekwini	Metros KZ	Tender	Additions	R 3 327	R 897	R 1 424
King George V Hospital	eThekwini	Metros KZ	Tender	Renovations	R 502	R 2 168	R -
Sundumbili CHC	Mandeni	iLembe	Tender	Renovations	R -	R 2 978	R 2 324
Manguzi Hospital	Umhlabuyalingana	Umkhanyakude	Tender	Additions	R 12 000	R 5 993	R 1 000
Ndulinde Clinic	KwaDukuza	iLembe	Tender	Renovations	R 2 492	R 150	
Ngwelezane hospital	uMhlathuze	uThungulu	Tender	Upgrading	R 41 930	R 23 590	R 9 398
Dr Pixley ka Seme Hospital	eThekwini	Metros KZ	Tender	Upgrading	R 4 000	R 4 000	R -
Edendale Hospital	Msunduzi	uMgungundlovu	Tender	Upgrading	R 1 000	R 3 500	R 5 200
King george v hospital	eThekwini	Metros KZ	Tender	New	R 14 934	R 6 510	R -
Ngwelezane hospital	uMhlathuze	uThungulu	Tender	Upgrading	R 15 209	R 3 607	R 1 200
Ngwelezane hospital	uMhlathuze	uThungulu	Tender	Upgrading	R 6 987	R 500	R 1 300
Empangeni Hospital/Lower Umfolozi Memorial	uMhlathuze	uThungulu	Tender	Upgrading	R 37	R -	R -
Natalia Building	uMgungundlovu District Municipality	uMgungundlovu	Tender	Upgrading	R 1 600	R -	R -
Bhekabantu Clinic	Umhlabuyalingana	Umkhanyakude	Tender	Renovations	R 2 379	R 200	R -
East/Boom CHC	Msunduzi	uMgungundlovu	Tender	Renovations	R -	R -	R -
Specialised Hospitals			Tender	Renovations	R -	R -	
Umzinto EMRS	Umdoni	Ugu	Tender	Upgrading	R -	R -	R -

Name of Project	Municipality	District	Status of project	Nature of Project	Projected Budget		
					MTEF 1 2011/12 (R'000)	MTEF 2 2012/13 (R'000)	MTEF 3 2013/14 (R'000)
Uthungulu EMRS	uMhlathuze	uThungulu	Tender	Upgrading			
Head Office: Informatics	uMgungundlovu District Municipality	uMgungundlovu	Tender	Maintenance - Recurrent	R -	R -	
Umbonambi Clinic	Umfolozi	uThungulu	Tender	Rehabilitation	R 6 000	R 8 062	R 750
Edendale Hospital	Msunduzi	uMgungundlovu	Tender	Upgrading	R 4 550	R 200	R -
King george V hospital	eThekwini	Metros KZ	Tender	Upgrading	R 1 500	R -	R -
Ngwelezane hospital	uMhlathuze	uThungulu	Tender	Upgrading	R 6 276	R 1 365	R 450
Sihleza Clinic	Umzimkhulu	Sisonke	Tender	Upgrading	R -	R -	R -
Loudres Clinic	Umzimkhulu	Sisonke	Tender	Upgrading	R 1 455	R -	R -
Ibisi Clinic	Umzimkhulu	Sisonke	Tender	Upgrading	R 2 650	R 150	R -
Pholela CHC	Ingwe	Sisonke	Tender	Renovations	R 334		R -
Bethesda Hospital	Jozini	Umkhanyakude	Tender	Upgrading	R 385	R -	R -
Nhlabane Clinic	Umlalazi	uThungulu	Tender	Additions	R 1 275	R 75	R -
Bethesda Hospital	Ulundi	Zululand	Tender	Renovations	R 5 014	R 250	R -
Greytown Hospital	Msinga	Umzinyathi	Tender	Upgrading	R -	R -	R -
Inanda C Clinic	eThekwini	Metros KZ	Tender	Additions	R -	R 14 633	R 13 722

Source: Infrastructure Multiyear Plan

1.2 CONDITIONAL GRANTS

Table 94: Conditional Grants

Name of Conditional Grant	Purpose of the Grant	Performance Indicators	Outputs
1. Expanded Public Works Programme Incentive Grant to Provinces. At this stage, no funding is provided for the outer years of the MTEF.	▪ To enhance the number of full time jobs created through labour intensive infrastructure programmes.	▪ Number of people employed through EPWP. ▪ Average duration of work.	▪ Increased contribution to the objective of halving poverty and unemployment by 2014. ▪ Improved income per EPWP beneficiary.
2. Infrastructure Grant to Provinces Previously the *Infrastructure Grant to Provinces or IGP*.	▪ To accelerate construction, maintenance, upgrading and rehabilitation of new and existing	▪ Backlog of projects. ▪ Number of infrastructure projects.	▪ Quality and quantity of serviceable health infrastructure. ▪ Improved rates of employment and

Name of Conditional Grant	Purpose of the Grant	Performance Indicators	Outputs
This Grant was reduced as a result of National Treasury discontinuing the IGP in its current form from 2011/12, and replacing it with a specific Grant for Education, Health and Transport. The Grant will supplement the existing infrastructure budget and will function in a similar manner to the IGP.	health infrastructure. ▪ To enhance the application of labour intensive methods to maximize job creation and skills development as encapsulated in the Expended Public Works Programme (EPWP) guidelines; and to enhance capacity to deliver infrastructure. ▪ Assist Provinces reducing infrastructure delivery and improvement backlog.		skills development. ▪ Aligned and coordinated approach to infrastructure development. ▪ Improved infrastructure expenditure patterns. ▪ Reduced backlogs in infrastructure projects.
3. Hospital Revitalisation Grant	▪ To provide funding to enable provinces to plan, manage, modernise, rationalise and transform the infrastructure, health technology, monitoring and evaluation of hospitals. ▪ To transform hospital management and improve quality of care in line with national policy objectives	▪ Backlog of projects. ▪ Number of revitalisation projects.	▪ Hospital projects implemented according to approved Project Implementation Plan.
4. Comprehensive HIV and AIDS Grant	▪ To develop an effective integrated response to HIV and AIDS. ▪ To support implementation of the National and Provincial Integrated Strategic Plan for HIV & AIDS, STIs and TB 2012 – 2016. ▪ To subsidise the ARV Programme [in part].	▪ The Business Plan incorporates all HIV and AIDS indicators monitored at operational and management levels.	▪ Decentralised management of the ART Programme. ▪ Improved coverage of community-based services through CCGs, Youth Ambassadors and other care givers. ▪ Improved access to services in High Transmission Areas. ▪ Improved support and access to the PMTCT Programme with improved health outcomes. ▪ Increase in the number of Step-Down Facilities.
5. National Tertiary Services Grant	▪ To plan, modernise, rationalise and transform the Tertiary Hospital service delivery platform in line with national policy objectives, including improving access and equity.	▪ Efficiency and quality indicators. ▪ Information systems operational.	▪ Provision of designated national tertiary services as agreed between the Province and the National Department of Health.

Name of Conditional Grant	Purpose of the Grant	Performance Indicators	Outputs
6. Health Professions Training & Development Grant A decision was taken in 2011/12 to use the grant to fund the personnel costs of registrars only.	▪ To provide funding for operational costs associated with the training and development of health professionals, development and recruitment of medical specialists and to strengthen under-graduate teaching and training.	▪ Number of registrars. ▪ Number of specialists in outreach programmes to support learning activities.	▪ Improved quality of health services. ▪ Reducing the training gap.
7. National Health Insurance Grant	▪ To provide financial support for the development of projects directed at improving service delivery in line with the national requirements for implementation of NHI.	▪ Indicators based on Project and Business Plans.	▪ Improved service delivery. ▪ Implementation of national and provincial projects.
8. Nursing Colleges and Schools Grant	▪ To supplement funding for infrastructure to accelerate the provision of health facilities including office furniture and related equipment, and maintenance of provincial health infrastructure for nursing colleges and schools.	▪ Indicators based on Infrastructure Plan and Business Plans.	▪ Improved health infrastructure.

- Source: Forensic Pathology Services Conditional Grant Business Plan 2010/11, Health Professionals Training and Development Conditional Grant Business Plan 2010/11, National Tertiary Services Conditional Grant Business Plan 2010/11, Comprehensive HIV and AIDS, STI, TB Integrated Business Plan for 2010/11, and Business Plan for EPWP
- The *Social Sector EPWP Incentive Grant for Provinces* was provided to subsidise non-profit organisations in home community-based care programmes to provide stipends to previously unpaid volunteers to maximize job creation and skills development in line with the EPWP guidelines. Note that this grant has ceased from 2012/13.

1.3 PUBLIC ENTITIES

Table 95: Public Entities

Name of Public Entity	Mandate	Current Annual Budget (R'000)	Date of next Evaluation
Austerville Halfway House	PHC	R 525	Annual Evaluation
Azalea House	PHC	R 485	Annual Evaluation
Bekulwandle Bekimpelo	PHC	R 7 600	Annual Evaluation
Benedictine Clinic	PHC	R 381	Annual Evaluation
Claremont Day Care Centre	PHC	R 371	Annual Evaluation
Day Care Club 91	PHC	R 101	Annual Evaluation
Durban School for the Deaf	PHC	R 203	Annual Evaluation
Elandskop Clinic	PHC	R 458	Annual Evaluation
Enkumane Clinic	PHC	R 276	Annual Evaluation
Happy Hour Various	PHC	R 2 598	Annual Evaluation
Hlanganani Ngothando	PHC	R 210	Annual Evaluation
Ikwezi Cripple Care	PHC	R 1 515	Annual Evaluation
Ikwezi District Nursing Services	PHC	R 175	Annual Evaluation
Jewel House	PHC	R 337	Annual Evaluation
John Peattie House	PHC	R1 348	Annual Evaluation
Jona Vaughn Centre	PHC	R 2 359	Annual Evaluation
Lynn House	PHC	R590	Annual Evaluation
Madeline Manor	PHC	R 849	Annual Evaluation
Masada Workshop	PHC	R 75	Annual Evaluation
Masibambeni Day Care Centre	PHC	R 148	Annual Evaluation
Matikwe Oblate Clinic	PHC	R 496	Annual Evaluation
Mhlumayo Clinic	PHC	R 588	Annual Evaluation
Noyi Bazi Oblate Clinic	PHC	R 501	Annual Evaluation
Prenaid A L P	PHC	R 101	Annual Evaluation
Rainbow Haven	PHC	R 393	Annual Evaluation
Scadifa Centre	PHC	R 959	Annual Evaluation
Sparkes Estate	PHC	R1 067	Annual Evaluation
St Lukes Home	PHC	R 730	Annual Evaluation
Sunfield Home	PHC	R 309	Annual Evaluation
Umlazi Halfway House	PHC	R 263	Annual Evaluation
Ekuhanyeni Clinic	HIV and AIDS	R 876	Annual Evaluation
Ethembeni Care Centre	HIV and AIDS	R 4 731	Annual Evaluation
Genesis Care Centre	HIV and AIDS	R 2 891	Annual Evaluation
Philanjalo Hospice	HIV and AIDS	R 3 232	Annual Evaluation
Pongola Hospital	District Hospital	R 4 029	Annual Evaluation
Montebello Chronic Sick Home	Psychiatric / Mental Hospital	R 4 969	Annual Evaluation
KZN Children's Hospital Trust	Children's Hospital (New)	R 20 000	Annual Evaluation
McCords Hospital	Various	R 94 564	Annual Evaluation
Mountain View Hospital	Various	R 9 971	Annual Evaluation

Name of Public Entity	Mandate	Current Annual Budget (R'000)	Date of next Evaluation
Siloah Hospital	Various	R 16 487	Annual Evaluation
St Mary's Hospital Marianhill	Various	R 106 718	Annual Evaluation
Earmarked for further negotiations	Various	R 2 200	Annual Evaluation

Source: Vote 7, Summary of Departmental Transfers to Other Entities

1.4 PUBLIC-PRIVATE PARTNERSHIP [PPP]

Table 96: Public Private Partnerships

Name of PPP	Purpose	Outputs	Current Annual Budget (R'000)	Date of Termination	Measures to ensure smooth transfer of responsibilities
Inkosi Albert Luthuli Central Hospital Department in partnership with Impilo Consortium (Pty) Ltd and Cowslip Investments (Pty) Ltd	1. Supply and maintain equipment and information systems. 2. Supply and replace non-medical equipment. 3. Provide the necessary services to manage project assets in accordance with best industry practice. 4. Maintain and replace assets in accordance with Schedules 30 (*FM Output Specifications*) and 24 (*FM Replacement Programme*). 5. Provide or procure utilities, consumables and surgical Instruments. 6. Provide facility management services to ensure that the Department is, at all times, able to provide clinical services that achieve and maintain the hospital output specifications.	Schedule 6 Output Projections	R1,404,849	Year 2017	Termination arrangements are detailed in the project agreement in clauses 35,36,37 and the penalty regime (Schedule 15)

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PART C

1.5 REVISED STRATEGIC OBJECTIVES, INDICATORS AND TARGETS - 2010-2014 STRATEGIC PLAN AND 2012/13 ANNUAL PERFORMANCE PLAN

Blue highlighted cells reflect objectives and/or indicators that have been included in the 2010-2014 Strategic Plan and removed from the 2012/13 APP.

PROGRAMME 1: ADMINSTRATION

Strategic Plan Strategic Objectives	Strategic Plan Indicators	Strategic Plan Target	Comments
Strategic Goal 1: : Overhaul Provincial Health Services			
To prepare and submit the KZN Health Act (1 of 2009) Regulations for promulgation in 2010.	Regulations for the KZN Health Act 2009 promulgated	Regulations promulgated and commencement of the KZN Health Act 2009.	Moved to the Operational Plan – submitted to the Office of the Premier.
To implement an integrated Health Information Turn-Around Strategy to improve data quality and ensure annual unqualified audit opinion on performance information from the AGSA from 2010/11 – 2014/15.	Master System Plan (MSP) implemented	Integrated information systems as per MSP.	Master Systems Plan finalised. Secondary indicators included in Operational Plan as per reviewed ITC Strategy.
	Approved M&E Framework implemented	Results-based performance monitoring as per M&E Framework.	Achieved and Framework implemented – removed.
To implement a Finance & SCM Turn-Around Strategy to improve compliance with the PFMA and Treasury Regulations, eliminate over-expenditure by 2012/13 and ensure an annual unqualified audit opinion on financial statements from the AGSA.	Expenditure versus allocated budget	Expenditure within budget by 2012/13 and annually thereafter.	Removed – disjuncture in reporting/MTEF cycle. Monitored in Operational Plan.
	Percentage procurement spend on specific & transversal contract management	80% procurement spent on specific & transversal contract management by 2014/15.	Moved to the Operational Plan.
	Percentage of assets accounted for in the composite Asset Register	100% assets accounted for in the Asset Register by 2014/15.	Moved to the Operational Plan – forms part of unqualified audit opinion.
To align the Human Resources Plan with the STP and implement as part of the Human Resources Turn-Around Strategy.	Aligned HRP published and implemented	HR Plan published and implemented.	The HRMS Strategic Objective changed in line with the National Human Resources for Health Strategy [*Implement the Provincial Human Resource Plan aligned with the Strategic Priorities of the Human Resources for Health SA Strategy*]. All HRMS [including Nursing College] indicators form part of this objective and are included as per Strategic Plan and APP.
	Persal data verified	Accurate Persal data for planning and budgeting purposes.	Indicator removed. Persal verification and clean-up is ongoing.

ANNUAL PERFORMANCE PLAN 2012/13 – 2014/15

PART C

PROGRAMME 2: DISTRICT HEALTH SERVICES [INCLUDING DISTRICT HOSPITAL SERVICES]

Strategic Plan Strategic Objectives	Strategic Plan Indicators	Strategic Plan Target	Comments
Strategic Goal 1: : Overhaul Provincial Health Services			
Revitalise PHC as per STP Implementation Plan.	Provincial PHC Strategy implemented	PHC strategy implemented in 11 districts by 2010/11 as per implementation plan	Achieved and removed. The PHC re-engineering model has been approved and is being implemented in all districts.
	PHC budget as % of total budget	PHC budget 44% of total budget PHC budget 49% of total budget by 2014/15	Removed to the Operational Plan.
Strategic Goal 2: To improve the efficiency and quality of health services			
Implementation of National Core Standards towards accreditation of 50% PHC clinics, 100% CHC's and 100% District Hospitals by 2014/15.	Number of PHC clinics accredited	279/ 558 (10% per year)	Same indicator now reads: *Percentage of clinics fully compliant with the 6 priorities of the National Core Standards.* Target has been reviewed to 2% of PHC clinics in 2012/13.
	Number of CHC's accredited	16/ 16 (100%)	Same indicator now reads: *Percentage of CHCs fully compliant with the 6 priorities of the National Core Standards.* Target has been reviewed to 31% CHCs in 2012/13.
	Number of District Hospitals accredited	37/ 37 (100%)	Same indicator now reads: *Number of District Hospitals fully compliant with the 6 priorities of the National Core Standards.* Target has been reviewed to 5 District Hospitals in 2012/13.
Strategic Goal 3: Reduce morbidity and mortality due to communicable diseases and non-communicable illnesses and conditions			
Reduce morbidity and mortality by reducing the HIV incidence with 50% by 2011/12 and 60% by 2014/15.	HIV incidence	Reduce HIV incidence by 50% by 2011[33]	Based on a National directive the source of data has been reviewed. ASSA 2008 estimate used for future reference. Current projected incidence: 1.8%. The target has been reviewed based on the KZNPSP target of 1.7% for 2012/13.
	Percentage qualifying HIV-positive patients on ART	90% of HIV-positive qualifying patients on treatment[34]	Target has been reviewed based on current performance: Increase from 83% in 2011/12 to 85% in 2012/13.
Reduce morbidity and mortality by reducing mother to child transmission to ≤ 5% by 2014/15.	MTCT rate	MTCT rate ≤ 5%	Same indicator now reads: *Baby tested PCR positive six weeks after birth as proportion of babies tested at six weeks*. Target has been reviewed based on current performance from 4% in 2011/12 to 2% in 2012/13.

[33] National target

[34] The NSP target is 80% of clients by 2011

Strategic Plan Strategic Objectives	Strategic Plan Indicators	Strategic Plan Target	Comments
Reduce morbidity and mortality by improving the TB cure rate to 70% by 2014/15.	TB cure rate	TB cure rate 70%[35]	Same indicator now reads: New smear positive PTB cure rate. Target has been reviewed based on current performance, from 69.5% in 2011/12 to 73.3% in 2012/13.
	TB treatment interruption rate	TB treatment interruption rate <5%	Same indicator now reads: New smear positive PTB defaulter rate. Target has been reviewed from 6.7% in 2011/12 to 6% in 2012/13.
Reduce maternal mortality to ≤ 100/ 100000 by 2014/15.	Maternal mortality ratio	Maternal mortality ratio 224.4/100 000[36]	Maternal mortality ratio is not routinely collected and dependent on research. The Department use as proxy [using facility data]: *Facility Maternal mortality rate*. Indicator has been reviewed based on current performance to 200/100 000 live births.
Reduce child mortality to 30-45/1000 live births by 2014/15.	Child mortality rate	Child mortality rate 30-45/1000 live births[37]	Dependent on research and not routinely collected by the Department. Research results quoted in narrative reports and Situation Analysis.
Reduce under-5 mortality to 29/1000 live births by 2014/15.	Under-5 mortality rate	Under-5 mortality rate 29/1000[5]	Same comment as above. The Department is using a proxy indicator [facility data]: Facility child mortality (under 5) rate. Target has been reviewed based on trends from 7.6% in 2010/11 to 6.8% in 2012/13.

PROGRAMME 4: REGIONAL AND SPECIALISED HOSPITALS

Strategic Plan Strategic Objectives	Strategic Plan Indicators	Strategic Plan Target	Comments
Strategic Goal 1: : Overhaul Provincial Health Services			
To implement the nationally approved delegations for Hospital Managers by 2010/11.	Number of CEO's who have signed the national delegation of authorities for Hospital CEO's	14/14 Hospital Managers signed reviewed delegations of authorities by 2010/11 and annually thereafter[38]	Moved to the Operational Plan as part of HRMS and Finance Strategies.

[35] The national target of 85% is not realistic for the province especially in light of the high HIV infection rate – all although will however be made to exceed the current provincial target
[36] Confidential Enquiry into Maternal Deaths – KZN 2004-2007
[37] National target
[38] This is dependent on reviewed delegations as per National Strategic Plan 2010/11 – 2012/13

Strategic Plan Strategic Objectives	Strategic Plan Indicators	Strategic Plan Target	Comments
To implement the Financial Turn-Around Strategy to eliminate over-expenditure in 100% Regional Hospitals by 2012/13.	Number of Regional Hospitals with zero over-expenditure	14/14 Regional Hospitals with zero over-expenditure by 2012/13	Indicator not SMART and removed. Not considered an appropriate measure of efficiency as it does not consider under-expenditure or efficient finance management. Expenditure monitored by Budget Control.
To rationalise hospital services in line with the approved STP and Service Delivery Plan.[39]	Rationalisation of Regional Hospital services as per STP Implementation Plan.	Rationalisation of Regional Hospital services as per approved STP Implementation Plan.	Indicator not SMART and removed.
Strategic Goal 2: To improve the efficiency and quality of health services			
To implement the National Core Standards in 100% Regional Hospitals by 2010/11 for accreditation of 14/14 Regional Hospitals by 2012/13.	Number of Regional Hospitals accredited	14/14 by 2012/13	Same indicator now reads: *Number of Regional Hospitals compliant with the 6 priority areas of Core Standards.* Target has been reviewed to 4 hospitals in 2012/13.
	Average patient waiting time at OPD	≤1 hour by 2014/15	Indicator moved to Operational Plan. It forms part of the National Core Standards and will be monitored as part of that process.

PROGRAMME 5: TERTIARY AND CENTRAL HOSPITALS

Strategic Plan Strategic Objectives	Strategic Plan Indicators	Strategic Plan Target	Comments
Strategic Goal 1: : Overhaul Provincial Health Services			
To implement the nationally approved delegations for Hospital Managers by 2010/11.	Number of CEO's who have signed the national delegation of authorities for Hospital CEO's	2 Hospital Managers signed reviewed delegations of authorities by 2010/11 and annually thereafter	Moved to the Operational Plan as part of HRMS and Finance Strategies.
To implement the Financial Turn-Around Strategy to eliminate over-expenditure by 2012/13.	Number of Tertiary/ Central Hospitals with zero over-expenditure	2/2 Tertiary/ Central Hospitals reported over-expenditure in 2009/10 2/2 Tertiary/ Central Hospitals with zero over-expenditure by 2012/13	Indicator not SMART and removed. Not considered an appropriate measure of efficiency as it does not consider under-expenditure or efficient finance management. Expenditure monitored by Budget Control.
To rationalise hospital services in line with the approved STP Implementation Plan.[40]	Rationalisation of Tertiary/ Central Hospital services as per STP timelines.	Rationalisation of Tertiary/ Central Hospital services as per approved STP Implementation Plan.	Indicator not SMART and removed
Strategic Goal 2: To improve the efficiency and quality of health services			

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

Strategic Plan Strategic Objectives	Strategic Plan Indicators	Strategic Plan Target	Comments
To implement the National Core Standards in 2/2 Tertiary/ Central Hospitals by 2010/11 and accredit 2/2 hospitals by 2012/13.	Number of Tertiary/ Central Hospitals accredited	1 Tertiary and 1 Central Hospital by 2012/13	Same indicator now reads: *Number of Tertiary/Central Hospitals compliant with the 6 priority areas of Core Standards.* Target has been reviewed to 1 Tertiary and 1 Central hospital in 2012/13.
	Average patient waiting time at OPD	≤ 1 hour by 2014/15	Indicator moved to Operational Plan. It forms part of the National Core Standards and will be monitored as part of that process.

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

Strategic Plan Strategic Objectives	Strategic Plan Indicators	Strategic Plan Target	Comments
Strategic Goal 1: : Overhaul Provincial Health Services			
To develop and implement a Learning Strategy for Managers based on the skills audit results and enrol 100% Hospital Managers by 2012/13.	Learning Strategy	Learning Strategy approved	Indicator removed from Programme 6. Development and mentoring programmes forms part of the new Human Resources for Health Strategy and will be monitored through that programme.
	Number of Hospital Managers who completed the Masters for Public Health	24 Hospital Managers enrolled in Management course – 7 dropped out 75 Hospital Managers completed Hospital Management course	Indicator removed. Managers completed the Masters Programme and no new intakes registered.

PROGRAMME 7: PHARMACEUTICAL SERVICES

Strategic Plan Strategic Objectives	Strategic Plan Indicators	Strategic Plan Target	Comments
Strategic Goal 1: : Overhaul Provincial Health Services			
Improve compliance with Pharmaceutical Regulations and legislation with 80% of pharmacies obtaining A or B grading on inspection by 2014/15 and PPSD being fully compliant with Regulations by 2012/13.	Percentage of Pharmacies compliant with SAPC standards.	80% of Pharmacies obtained A or B grading on inspection by 2014.	Same indicator now reads: *Percentage of Pharmacies that obtained A and B grading on inspection*. Target has been reviewed based on current performance to 70% in 2012/13.

Strategic Plan Strategic Objectives	Strategic Plan Indicators	Strategic Plan Target	Comments
	PPSD building compliant with Good Manufacturing Practice Regulations.	PPSD 100% compliant with Good Manufacturing Practice Regulations by 2012/13.	Same indicator now reads: *PPSD compliant with Good Wholesaling Practice Regulations.* The target remains the same.
Strategic Goal 2: To improve the efficiency and quality of health services			
Reduce tracer medicine (including ARV and TB medicines) stock-out rate to <1% by 2014.	Tracer medicine stock-out rate.	Tracer medicines stock out rate <1% by 2014.	Same indicator divided: *Tracer medicine stock-out rate [PPSD].* Target <3% by 2012/13. *Tracer medicine stock-out rate [Institutions].* Target <3% by 2012/13.

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

Strategic Plan Strategic Objectives	Strategic Plan Indicators	Strategic Plan Target	Comments
Strategic Goal 1: : Overhaul Provincial Health Services			
To deliver new clinical infrastructure in line with the STP and approved Infrastructure Programme Implementation Plan (IPIP).	Infrastructure Programme Implementation Plan	Fully aligned IPIP	Target has been achieved and indicator removed.
	Number of projects for new clinical infrastructure fully commissioned	52 Projects fully commissioned by 2014/15.	Same indicator divided into: *Number of new clinical projects with completed construction* *Number of new clinical projects where commissioning is completed*
To upgrade and renovate existing clinical infrastructure in accordance with the STP and approved IPIP.	Number of upgrade and renovation projects fully commissioned	89 Projects fully commissioned by 2014/15.	Same indicator divided into: *Number of upgrading and renovation projects with completed construction* *Number of upgrading and renovation projects where commissioning is completed*
To undertake the acquisition of properties including vacant land for building purposes.	Implementation Plan to optimise Departmental accommodation needs	Plan implemented	Target achieved and indicator removed.

1.6 CONCLUSION

The 2012/13 Annual Performance Plan presented the strategic goals, objectives, priorities and targets that the KwaZulu-Natal Department of Health will be pursuing during the 2012/13 – 2014/15 MTEF. The Plan is aligned with the National Health System 10 Point Plan and Negotiated Service Delivery Agreement of the Department of Health, and makes provision for Provincial priorities as articulated during the Provincial Cabinet Lekgotla and Strategic Planning workshops.

The Annual Performance Plan reflects the strategic priorities with primary indicators while sub-set or secondary indicators are included in Operational Plans to ensure comprehensive recording, analysis and reporting against national and provincial priorities. Great discipline will be exercised to ensure that all health services are provided in line with service obligations and mandates for delivery of quality health care.

District Health Plans have been aligned with the Annual Performance Plan to ensure that strategic priorities are translated into service delivery at operational level. Supporting operational indicators have been included in the quarterly reporting system through the Monitoring & Evaluation Framework and quarterly reporting system. Quarterly in-depth reviews are being formalized to navigate improved analysis of performance information and expenditure. This will assist with improved accountability in service delivery.

The Negotiated Service Delivery Agreement will serve as framework within which the Department will monitor progress towards achieving the national priorities and in so doing contributing to “A healthy life for all South Africans”.

The commitment of the Department is unwavering and every effort will be made to achieve the goals and objectives set in the 5-year Strategic Plan and the 2012/13 Annual Performance Plan.

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ABBREVIATIONS & ACRONYMS

ABBREVIATION	FULL DESCRIPTION
AIDS	Acquired Immune Deficiency Syndrome
ALOS	Average Length of Stay
ALS	Advanced Life Support.
ANC	Ante Natal Care
APP	Annual Performance Plan
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BANC	Basic Ante Natal Care
BAS	Basic Accounting System
BLS	Basic Life Support
BOD	Burden of Disease
BOR	Bed Occupancy Rate
CCG's	Community Care Givers
CCMDU	Central Chronic Medication Dispensing Unit
CCMT	Comprehensive Care Management & Treatment
CDC	Communicable Disease Control
CEO	Chief Executive Officer
CHC	Community Health Centre
Child PIP	Child Problem Identification Programme
CHW	Community Health Worker
COE	Compensation of Employees
COEC	College of Emergency Care.
CPSS	Central Pharmaceutical Supply Store
CPT	Cotrimoxinol Preventive Therapy
CRH	Centre for Rural Health
CTOP	Choice on Termination of Pregnancy
DHER	District Health Expenditure Review
DHIS	District Health Information System
DHP's	District Health Plans
DHS	District Health System
DOE	Department of Education
DOH	Department of Health
DOTS	Directly Observed Treatment Short Course
ECP	Emergency Care Practitioner
EH	Environmental Health
EHP	Environmental Health Practitioner
EMS	Emergency Medical Services
EPI	Expanded Programme on Immunisation

ABBREVIATION	FULL DESCRIPTION
EPT	Emergency Patient Transport
ESV	Emergency Services Vehicle
ETBR	Electronic Tuberculosis Register
ETR.net	Electronic Register for TB
FEP	First-Episode Psychosis
FTE	Full Time Equivalent
GIS	Geographic Information System
HAART	Highly Active Ante-Retroviral Therapy
HAST	HIV, AIDS, STI and TB
HBC	Home Based Carer
HCBC	Home & Community Based Carers
HCT	HIV / AIDS Counseling and Testing
HIV	Human Immuno Virus
HOD	Head of Department
HP	Health Promotion
HPS	Health Promoting Schools
HR	Human Resources
HRD	Human Resource Development
HRKM	Health Research & Knowledge Management
HRP	Human Resource Plan
HST	Health Systems Trust.
HTA's	High Transmission Areas
IACT	Integrated Access of Care and Treatment
IALCH	Inkosi Albert Luthuli Central Hospital
IDT	Independent Development Trust
IGR	Inter-Governmental Relations
ILS	Intermediate Life Support
IMCI	Integrated Management of Childhood Illnesses
INDS	Integrated National Disability Strategy
IPC	Infection Prevention & Control
IPD	In-Patient Days
IT	Information Technology
IYCF	Infant, Youth and Child Feeding
KZN	KwaZulu-Natal
M&E	Monitoring and Evaluation
MC&WH	Maternal Child & Women's Health
MDG	Millennium Development Goals
MDR TB	Multi Drug Resistant Tuberculosis
MEC	Member of the Executive Council
MHCA	Mental Health Care Act.

ABBREVIATION	FULL DESCRIPTION
MO	Medical Officer
MRC	Medical Research Council
MSP	Master Systems Plan
MTEF	Medium Term Expenditure Framework
MTS	Modernisation of Tertiary Services
MTSF	Medium Term Strategic Framework
NGO's	Non-Governmental Organisations
NHC	National Health Council
NHI	National Health Insurance
NHIS	National Health Information System.
NHS	National Health System.
NHLS	National Health Laboratory Services
NIP	National Integrated Nutrition Programme.
NSP	National Strategic Plan.
NVP	Nevirapine
ODTC	Oral and Dental Training Centre
OPD	Out-Patient Department.
OSD	Occupation Specific Dispensation.
PCR	Polymerase Chain Reaction
PCV	Pneumococcal Vaccine
PDE	Patient Day Equivalent
PEP	Post Exposure Prophylaxis.
Persal	Personnel and Salaries System.
PFMA	Public Finance Management Act
PHC	Primary Health Care
PITC	Patient Initiated Testing & Counselling
PLHIV	People living with HIV
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
PN	Professional Nurse
PNC	Post Natal Care
PPIP	Peri-Natal Problem Identification Programme
PPSD	Provincial Pharmaceutical Supply Depot
PPT	Planned Patient Transport
PTB	Pulmonary Tuberculosis
RV	Rota Virus
SADHS	South African Demographic & Health Survey

ABBREVIATION	FULL DESCRIPTION
SAPS	South African Police Services
SCM	Supply Chain Management.
SHS	School Health Services
SMS	Senior Management Service
Stats SA	Statistics South Africa
STI's	Sexually Transmitted Infections
STP	Service Transformation Plan
TB	Tuberculosis
TOP	Termination of Pregnancy
UKZN	University of KwaZulu-Natal
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation
XDR TB	Extreme Drug Resistant Tuberculosis

ANNEXURE 1

INDICATOR DEFINITIONS

ANNEXURE 1 – INDICATOR DEFINITIONS

Table 97: Trends in Key Provincial Service Volumes

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
PHC headcount - total	Number of PHC patients seen during the reporting period in PHC facilities (clinics, mobiles and CHCs). Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen.	Tracks the uptake of PHC services at each PHC facility for the purposes of allocating staff and other resources.	DHIS	Total PHC headcounts during the reporting period.	Accuracy of headcount depends on the reliability of PHC record management at facility level.	Output	Number	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system.	PHC Manager
OPD headcount - new case not referred	Number of general OPD clinic new cases (seeking medical attention for a condition for the first time) that report to the general OPD without being referred from a PHC facility or doctor during the reporting period in all Hospitals (district, regional, tertiary and central) as a percentage of the OPD general headcount new visits total. Patients with general OPD follow-up visits, visiting specialised OPD clinics and emergency patients are not counted in denominator, because this is not regarded as PHC level of care.	Tracks the utilisation of hospitals by patients to access PHC services, which in fact should be accessed at PHC services. This could also points to the needs for PHC services or gaps in PHC service delivery.	DHIS	**Numerator**: OPD headcount new case not referred. **Denominator**: Sum of: • OPD headcount new cases referred • OPD headcount new cases not referred	Accuracy of headcount depends on the reliability of hospital record management at facility level.	Output	Number	Quarterly	Yes	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system.	Hospital Service Manager PHC Manager
Separations (District/ Regional/	Recorded completion of treatment and/or accommodation of	Monitoring the service volumes.	DHIS	**Sum**: • Inpatient deaths	Accuracy dependant on quality of data from	Output	Number	Quarterly	No	Higher levels of uptake may indicate an increased burden of	Hospital Service Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Tertiary/ Central Hospitals)	patients in hospitals. Separations include inpatients who were discharged, transferred out to other hospitals or who died and includes day patients.			• Inpatient discharges • Inpatient transfer out • Day patient	reporting facility.					disease, or greater reliance on public health system.	

Table 98: Millennium Development Goals

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Underweight for age rate children under 5 years incidence - annualised	A child under 5 years identified as being BELOW the third centile but EQUAL TO or OVER 60% of Estimated Weight for Age (EWA) on the Road-to-Health chart. Include any such child irrespective of the reason for the underweight - malnourishment, premature birth, genetic disorders etc.	Growth monitoring to identify children at risk and ensure timely intervention.	DHIS	**Numerator:** Underweight for age under 5 years new cases **Denominator:** Number of children under 5 years weighed	Accuracy dependent on quality of data from reporting facility.	Outcome	Percentage	Quarterly	No	Reduced incidence of underweight for age.	Nutrition Manager
Incidence of severe malnutrition in children (under 5 years of age)	The number of children who weigh below 60% Expected Weight for Age (new cases per month) per 1000 children in the target population.	Essential for growth monitoring in children.	DHIS	**Numerator:** The number of children who weigh below 60% Expected Weight for Age during the reporting period **Denominator:** Children under 5 years	Accuracy dependent on quality of data from reporting facility.	Outcome	Number per 1000	Quarterly (Indicator must be annualised)	No	Lower levels of prevalence of underweight (children under 5) are desired.	Nutrition Manager
Under-5 mortality rate *Proxy: Facility child mortality rate (see MC&WH)*	Number of children less than five years old who die in one year, per 1000 live births during that year.	Monitors trends in under-5 mortality.	South African Demographic and Health Survey (SADHS)	**Numerator:** Number of children under 5 years who die in one year **Denominator:** Total number of live births during that year	Data are not frequently available. Empirical data are available from the SADHS, which is conducted every 5 years.	Outcome	Number per 1000 live births	Empirical data are provided by the SADHS every 5 years	No	Reduced infant mortality rate.	MC&WH Manager
Infant mortality	Number of children less than one year old	Monitors trends in	South African	**Numerator:**	Data are not frequently available. Empirical data	Outcom	Number per 1000 live	Empirical data are	No	Reduced infant	MC&WH

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
rate *Proxy: Facility infant mortality rate (see MC&WH)*	who die in one year, per 1000 live births during that year.	infant mortality.	Demographic and Health Survey (SADHS)	Number of children less than one year old who die in one year **Denominator:** Total number of live births during that year	are available from the SADHS, which is conducted every 5 years.	e	births	provided by the SADHS every 5 years		mortality rate.	Manager
Proportion of one-year-old children immunised against measles	Percentage of children under 1 year who received their first measles dose.	Prevention of vaccine preventable diseases.	DHIS	**Numerator:** Measles 1st dose before 1 year of age **Denominator:** Population under 1 year	Accuracy of population estimates (StatsSA) and quality of data at facility level.	Output	Percentage	Quarterly	No	Eliminate measles.	MC&WH Manager
Maternal mortality ratio *Proxy: Facility maternal mortality rate (see MC&WH)*	Number of women who die as a result of childbearing, during pregnancy or within 42 days of delivery or termination of pregnancy in one year, per 100,000 live births during that year.	Monitors trends in maternal mortality.	SADHS	**Numerator:** Number of women who die as a result of childbearing, during pregnancy or within 42 days of delivery or termination of pregnancy in one year **Denominator:** Total number of live births during that year	Data is not frequently available. Empirical data are available from the SADHS, which is conducted every 5 years.	Outcome	Number per 100,000 live births	Empirical data are provided by the SADHS every 5 years	No	Reduced maternal morbidity and mortality.	Health Information, Epidemiology and Research Programme MCWH Programme
HIV prevalence among 15-24 year old pregnant women	Pregnant women between the ages of 15-24 living with HIV during a specific year.	Tracks prevalence of HIV in women between 15-24 years to inform intervention strategies and monitor impact of interventions.	Annual Antenatal HIV and Syphilis Survey	**Numerator:** Women aged 15 – 19 years who tested HIV positive during the survey **Denominator:** Women aged 15 – 19 years who were tested for HIV during the survey	Reflects prevalence in surveyed women not the entire population.	Outcome	Percentage	Annual	No	Reduce incidence of HIV and manage HIV prevalence.	HAST Manager
Contraceptive prevalence rate *Proxy: Couple year protection rate (see MC&WH)*	Percentage of women of reproductive age (15-44) who are using (or whose partner is using) a modern contraceptive method. Contraceptive methods include female and male sterilisation, injectable and oral hormones, intrauterine devices, diaphragms, spermicides and condoms, natural family planning	Track the extent of the use of contraception (any method) amongst women of child bearing age.	SADHS	Data available from the 5-year SADHS. The indicator is not monitored routinely	Data is not frequently available. Empirical data are available from the SADHS, which is conducted every 5 years.	Output	Percentage	Empirical data are provided by the SADHS every 5 years	No	Higher contraceptive prevalence rates to reduce high-risk pregnancies and consequent reduction of maternal morbidity and mortality.	MC&WH Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
	lactational amenorrhoea.										
Malaria incidence rate	New malaria cases as proportion of 1000 population at risk.	Monitor the new malaria cases as proportion of the population at risk to monitor performance in relation to MDG 6.	Malaria Database	**Numerator:** Number of new malaria cases reported **Denominator:** Total population	Accuracy dependant on quality of data and effective information systems.	Outcome	Percentage per 1000 population	Annual	No	Reduced incidence indicates improved prevention strategies.	Malaria Control Manager
TB cure rate	Percentage of new smear positive PTB cases cured at first attempt.	Monitor the TB cure rate to determine the effectiveness of the TB programme.	ETR.Net	**Numerator:** New smear positive cured **Denominator:** New smear positive newly registered	Data quality	Outcome	Percentage	Annual	No	Improved cure rate resulting in improved TB outcomes.	TB Programme Manager

PROGRAMME 1: ADMINISTRATION

Table 99: Human Resources

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of Medical Officers per 100,000 people	Medical Officers in posts on the last day of March of that particular year per 100,000 people.	Tracks the number of filled Medical Officer's posts as part of monitoring Human Resources for Health.	Persal	**Numerator:** Number of Medical Officers in posts - total **Denominator:** Total population	Dependant on accuracy of Persal data	Input	Ratio per 100,000 population	Annual	No	Increase in the number of Medical Officers to improve access to and quality of clinical care.	HRMS
Number of Medical Officers per 100,000 people in rural districts	Medical Officers in posts employed in rural districts on last day of March in that particular year per 100,000 people.	Tracks the number of filled Medical Officer posts in rural districts to monitor equity in allocation and distribution of Human Resources for Health.	Persal	**Numerator:** Number of Medical Officers in posts in rural areas **Denominator:** Total population in rural districts	Dependant on accuracy of Persal data	Input	Ratio per 100,000 population	Annual	No	Increase in the number of Medical Officers to improve access to and quality of clinical care.	HRMS
Number of Professional Nurses per 100,000 people	Professional Nurses in posts on the last day of March in that particular reporting year per 100,000 people.	Tracks the number of filled Professional Nurses posts as part of monitoring availability of Human Resources for Health.	Persal	**Numerator:** Number of Professional Nurses in posts - total **Denominator:** Total population	Dependant on accuracy of Persal data	Input	Ratio per 100,000 population	Annual	No	Increase in the number of Professional Nurses contributes to improving access to and quality of health services.	HRMS

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of Professional Nurses per 100,000 people in rural districts	Professional Nurses in posts employed in rural districts on last day of March in that particular reporting year per 100,000 people.	Tracks the number of Professional Nurses in rural districts as part of monitoring equity and distribution of Human Resources for Health in Rural Districts.	Persal	**Numerator:** Number of Professional Nurses in posts in rural areas **Denominator:** Total population in rural districts	Dependant on accuracy of Persal data	Input	Ratio per 100,000 population	Annual	No	Increase in the number of Professional Nurses in rural districts contributes to improving access to and quality of health services rural districts.	HRMS
Number of Pharmacists per 100,000 people	Pharmacists in posts on last day of March in that particular reporting year per 100,000 people.	Tracks the number of filled Pharmacist posts to monitor availability of Human Resources for Health.	Persal	**Numerator:** Number of Pharmacists in posts - total **Denominator:** Total population	Dependant on accuracy of Persal data	Input	Ratio per 100,000 population	Annual	No	Increase in the number of Pharmacists improves pharmaceutical management and quality of care.	HRMS
Number of Pharmacists per 100,000 people in rural districts	Pharmacists employed in rural districts on last day of March in that particular reporting year per 100,000 people.	Tracks the number of Pharmacist posts filled in rural districts to monitor allocation and distribution of Human Resources for Health.	Persal	**Numerator:** Number of Pharmacists in posts in rural districts **Denominator:** Total population in rural districts	Dependant on accuracy of Persal data	Input	Ratio per 100,000 population	Annual	No	Increase in the number of Pharmacists improves pharmaceutical management and quality of care.	HRMS
Vacancy rate for Professional Nurses	Percentage of funded vacant Professional Nurses posts on the last day of the reporting period.	Tracks the number of funded vacant Professional Nurses posts to monitor availability of Human Resources for Health.	Persal	**Numerator:** Total number of funded vacant Professional Nurses posts **Denominator:** Total number of funded Professional Nurse posts in the Province	Dependant on accuracy of Persal data	Process	Percentage	Quarterly	No	Decreased vacancy rate and growth in Professional Nurses employed.	HRMS
Vacancy rate for Medical Officers	Percentage of funded vacant Medical Officer posts on the last day of the reporting period.	Tracks the number of funded vacant Medical Officer posts to monitor availability of Human Resources for Health.	Persal	**Numerator:** Total number of funded vacant Medical Officer posts on the last day of the reporting period **Denominator:** Total number of Medical Officer funded posts in the Province	Dependant on accuracy of Persal data	Process	Percentage	Quarterly	No	Decreased vacancy rate and growth in the number of Medical Officers employed.	HRMS

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Vacancy rate for Medical Specialists	Percentage of funded vacant Medical Specialists posts on the last day of the reporting period.	Tracks the number of funded vacant Medical Specialists posts to monitor availability of Human Resources for Health.	Persal	**Numerator:** Total number of funded vacant Medical Specialists posts on the last day of the reporting period **Denominator:** Total number of Medical Specialists funded posts in the Province	Dependant on accuracy of Persal data	Process	Percentage	Quarterly	No	Decreased vacancy rate and growth in the number of Medical Specialists employed.	HRMS
Vacancy rate for Pharmacists	Percentage of funded vacant Pharmacist posts on the last day of the reporting period.	Tracks the number of funded vacant Pharmacist posts to monitor availability of Human Resources for Health.	Persal	**Numerator:** Total number of funded vacant Pharmacists posts on the last day of the reporting period **Denominator:** Total number of funded Pharmacists posts in the Province	Dependant on accuracy of Persal data	Process	Percentage	Quarterly	No	Decreased vacancy rate and growth in the number of Pharmacists employed.	HRMS

Table 100: Administration

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Tabled Annual Performance Plan (APP)	Clearly defined strategic priorities for the coming reporting period as per requirements of the National Health Act, 2003 and aligned with Strategic Plan, NHS 10-Point Plan, and NSDA endorsed by the HOD and MEC and tabled in the Legislature.	Clearly articulate annual priorities and targets to ensure effective monitoring, evaluation and reporting.	APP	APP signed off and tabled in the Legislature as per Treasury Regulations	None	Process	Yes/ No	Annual	No	Provide necessary leadership in implementation and monitoring of national and provincial priorities based on evidence-based needs.	Strategic Planning Manager.
Number approved District Health Plans (DHPs)	DHP's developed and approved in line with requirements of the National Health Act 2003.	Clearly articulate annual district priorities and targets to ensure appropriate monitoring and reporting.	DHP's	Number of approved and signed off DHP's	None	Process	Yes/ No	Annual	No	Unified action in addressing health priorities and needs.	District Managers Strategic Planning Manager
Published Service Transformation	Long-term (10-year) strategic plan to guide health service	Inform short, medium and long-term planning and ensure	STP	Signed off STP	None	Process	Yes/ No	Annual	No	Integrated long-term planning including costing to guide service	Strategic Planning

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Plan (STP)	transformation.	adequate provision/allocation of resources for revitalisation of health services.								transformation.	Manager
Number of Hospital Managers who have signed Performance Agreements (PA's)	Signed performance commitment, based on expected deliverables.	Improved accountability and service delivery.	Signed PA's	Number of Hospital Managers who signed Performance Agreements	None	Input	Number	Annual	No	Improved accountability and service delivery outcomes.	HRMS
Number of District Managers who have signed PA's	Signed performance commitment, based on expected deliverables.	Improved accountability and service delivery.	Signed PA's	Number of District Managers who signed Performance Agreements	None	Input	Number	Annual	No	Improved accountability and service delivery outcomes.	HRMS
Percentage of Head Office Managers (Level 13 and above) who have signed PA's	Signed performance commitment, based on expected deliverables.	Improved accountability and service delivery.	Signed PA's	**Numerator:** Number of Head Office Managers (level 13 and above) who signed Performance Agreements **Denominator:** Total number of Head Office Managers (level 13 and above)	None	Input	Number	Annual	No	Improve accountability and service delivery outcomes.	HRMS
Annual unqualified audit opinion for financial statements	The Auditor General of South Africa (AGSA) declares the Annual Financial Statements compliant with the PFMA and Treasury Regulations.	Monitor improved financial management and compliance with the PFMA.	AGSA Audit Opinion	Unqualified audit opinion for financial statements by the AGSA	Accuracy of financial data	Outcome	Audit Opinion	Annual	No	Improved financial management and compliance with PFMA.	CFO & Finance Manager
Number of approved District Health Expenditure Reviews (DHERs)	Analysis of expenditure trends at district/ facility level in compliance with the National Health Act 2003.	Determine expenditure trends, linked with service delivery, to inform financial allocation and management.	DHER's	Number of approved DHER Reports	Accuracy of data (Persal, BAS & DHIS)	Input	Number	Annual	No	Annual review and analysis of expenditure and service delivery trends at district & facility levels.	District Manager Strategic Planning Manager CFO
Annual unqualified audit opinion on performance information	The AGSA declare the performance information in published reports accurate and a true reflection of performance.	Monitor quality and accuracy of performance information.	AGSA Audit Opinion	Unqualified audit opinion for performance information by the AGSA	Accuracy of data at service point to Provincial level	Outcome	Audit opinion	Annual	No	Improved information management and reporting.	Data Management Manager
Annual Report tabled	Annual Report as per requirement of the National Health Act	Monitor performance against targets set in previous years' APP.	Tabled Annual Report	Approved and tabled Annual Report	None	Output	Yes/ No	Annual	No	Appropriate and accurate reporting to inform evidence-based	Strategic Planning Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
	2003. Comprehensive reporting on achievement with regards to relevant APP and performance targets.									decision-making and planning.	
Number of progress reports on implementation of the 10-Point Plan	Quarterly performance reports based on expected outcomes/targets in the APP, 10 Point Plan and NSDA.	Performance monitoring, evaluation and reporting towards evidence-based planning.	Progress Reports	Number of reports submitted	No limitations for submission of reports, although quality of data may impact on quality of reporting	Output	Number	Quarterly	No	Evidence-based decision-making and planning.	M&E Manager
Number of Registrars in training – cumulative	Number of Registrars who are registered in training with the DoH.	Track number of Registrar's in training.	Persal	Number of Registrar's in training	None	Input	Number	Annual	No	Increased number of Medical Registrars.	HRMS
Number of Registrars retained after qualifying	Number of Medical Specialists that stays in the public health service after graduation.	Track retention of Registrars after graduation.	Persal	Number of Registrars retained after graduation	None	Outcome	Number	Annual	No	Increased pool of Medical Specialists.	HRMS
Number of Medical Registrars graduating	Number of Registrars who successfully completed their degree.	Track number of graduates.	Persal	Number of Registrars graduating	None	Output	Number	Annual	No	Increased pool of Medical Specialists.	HRMS
Number of Provincial Consultative Forum meetings	Governance structure to improve consultation for health.	Improved social compact for health.	Minutes of meeting	Number of meetings convened with Provincial Consultative Forum	None	Output	Number	Annual	Yes	Improved social compact.	Corporate Governance Manager
Provincial Health Council convened by-annually	Provincial governance structure convened as per National Health Act 2003 to improve social compact for health through participation and consultation.	Improved consultation and participation.	Minutes of meetings	Number of Provincial Health Council meetings convened	None	Output	Number	Annual	Yes	Improved social compact for better health outcomes.	Corporate Governance Manager
Number of District Health Councils established	Governance structure as per National Health Act, 2003 to improve community participation and consultation at district level.	Improved consultation and collaboration.	Corporate Governance records	Number of District Health Councils established	None	Process	Number	Annual	No	Improved social compact to improve participation.	Corporate Governance Manager
Number of District Health Council meetings	Meetings with District Health Councils convened to improve social compact for	Improve consultation and participation at district level.	Minutes of meetings	Number of District Health Council meetings convened	None	Output	Number	Annual	No	Improved social compact at district level.	Corporate Governance Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
	health through participation and consultation.										
Number of functional Tele-medicine sites	Training and diagnostic services provided through Information technology solutions.	To support and improve healthcare delivery and access to healthcare in KwaZulu-Natal through the integration of appropriate telemedicine solutions as an integral part of the Health Services Transformation Plan of the Province.	Information Technology	Number of active telemedicine sites	None	Output	Number	Annual	Yes	Improved development through information technology.	IT Manager

PROGRAMME 2: DISTRICT HEALTH SERVICES

Table 101: Primary Health Care Services

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Provincial PHC expenditure per uninsured person	Total PHC expenditure per uninsured population (population without medical aid).	To monitor adequacy of funding levels for PHC services.	BAS/ DHIS	**Numerator:** Total expenditure on PHC services (Programme 2) **Denominator:** Number of uninsured people in the Provinces as indicated in STATSSA or Council for Medical Scheme data	Accuracy of data	Input	Annual	Annual	No	Higher levels of expenditure reflect prioritisation of PHC services.	PHC Manager Budget Manager
PHC total headcount	Number of PHC patients seen during the reporting period. Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen.	Track the uptake/ utilisation of PHC services to inform resource allocation and service expansion.	DHIS	Total PHC headcount during the reporting period	Accuracy of data	Output	Number	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, greater reliance on public health system, improved access and/or equity.	PHC Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
PHC total headcount – under 5 years	Number of PHC patients under the age of 5 years seen during the reporting period. Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen.	Track uptake/ utilisation of PHC by children under 5 years to inform resource allocation and service development.	DHIS	Total PHC headcount under 5 years during the reporting period	Accuracy of data	Output	Number	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease amongst children, greater reliance on public health system, improved equity and access to services.	PHC Manager
Utilisation rate - PHC	Rate at which PHC services are utilised represented as the average number of visits per person per year.	Track uptake/ utilisation of PHC services to inform decision-making and planning.	DHIS StatsSA	**Numerator:** PHC total headcount **Denominator:** Total Population	Accuracy of population estimates and quality of data	Output	Rate	Quarterly	No	Improved uptake of PHC services.	PHC Manager
Utilisation rate under 5 years - PHC	Rate at which PHC services are utilised by children under-5 years represented as the average number of visits per child under-5 years per year.	Tracks the uptake of PHC services to inform decision-making.	DHIS StatsSA	**Numerator:** PHC headcount under 5 years **Denominator:** Population under 5 years	Accuracy of population estimates and quality of data	Output	Rate	Quarterly	No	Improved uptake of PHC services.	PHC Manager
Fixed PHC facilities monthly supervisory visit rate	Percentage of fixed PHC facilities that were visited by a Supervisor at least once a month and an official supervisor report completed.	Improved clinical governance and quality.	DHIS	**Numerator:** Number of fixed PHC facilities that were visited by a supervisor once a month **Denominator:** Total number of fixed PHC facilities	Interpretation of indicator	Quality	Percentage	Quarterly	No	Improved clinical governance, quality and health outcomes.	PHC Manager
Expenditure per PHC Headcount	Expenditure per PHC client utilising public health services in the Province.	Determines the cost per patient at PHC level.	DHIS BAS	**Numerator:** Total PHC expenditure **Denominator:** PHC total headcount	Reliability of PHC record management at facility level and accuracy of expenditure data	Efficiency	Rand	Quarterly	No	Improved efficiency and cost benefit.	PHC Manager Budget Manager
Community Health Centres (CHCs) and Community Day Centres (CDCs) with resident doctor rate	Percentage of CHCs and CDCs with at least one resident Doctor.	Adequate availability of Medical Officers at CHC/CDC level to render the full package of services that will contribute to decongestion of hospitals.	DHIS	**Numerator:** Total number of CHCs/CDCs with at least one resident Doctor **Denominator:** Total number of CHCs/CDCs	None	Input	Rate	Annual	No	Improved access to services.	District Manager

ANNUAL PERFORMANCE PLAN 2012/13 – 2014/15

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Percentage of PHC facilities assessed for compliance against the 6 priorities of the core standards	Percentage of PHC facilities routinely assessed for compliance against the 6 priorities of the national core standards.	Routine assessment for compliance informs Quality Improvement Plans to ensure improved performance and efficiencies.	Quality Assurance	**Numerator:** Total number of PHC facilities assessed against the national core standards **Denominator:** Total number of PHC facilities	None	Process	Percentage	Annual	No	Routine assessment and developing Quality Improvement Plans.	Quality Assurance Manager
Percentage of PHC clinics/ CHC fully compliant with the 6 priorities of the national core standards *The indicator is the same for PHC clinics and CHCs – not repeated*	Reduced facility-acquired infections, caring service provider attitude, acceptable waiting times for users, user satisfaction, environmental cleanliness, lower rates accidental harm/ medical errors and complaints, and availability of medication and supplies.	Improved efficiencies and quality of public health services.	DHIS	**Numerator:** Number of PHC clinics/CHCs fully compliant with the 6 priorities of national core standards **Denominator:** Total number of PHC clinic/CHCs	None	Outcome	Percentage	Annual	No	Improved efficiency and quality of public health services.	Quality Assurance Manager
Percentage of CHCs conducting annual Patient Satisfaction Survey's	The number of CHCs that conducted a Patient Satisfaction Survey (using the standard national template) in the last 12 months to determine patient satisfaction with health services.	Measure patient satisfaction with public health services.	Quality Assurance	**Numerator:** Number CHCs that conducted a Patient Satisfaction Survey in the last 12 months **Denominator:** Total number of CHCs	Limitation not related to number of surveys conducted – rather the response to surveys and monitoring of outcomes.	Output	Percentage	Annual	No	Annual surveys inform Quality Improvement Plans and track performance towards improved quality and patient satisfaction.	Quality Assurance Managers
Percentage of Clinics/CHCs with functional Clinic Committees *The same indicator is used for PHC clinics and CHC's*	Number of clinics/CHCs with Clinic Committees that fully participate in clinic matters and serve as link between clinic/CHC and the community they serve.	Improve community participation, consultation and information sharing.	DQPR	**Numerator:** Total number of clinics/CHCs with a functional Clinic Committee **Denominator:** Total number of clinics/CHCs	None	Output	Percentage	Annual	No	All clinics/CHCs have active functional Clinic Committees.	PHC Manager
Number of accredited Health Promoting Schools	The number of schools that are officially accredited by an external Assessment Team as fully compliant with the norms and standards for HPS.	Implementation of HPS in line with the Ottawa Charter's 5 Action Areas to expand the role of learners as partners in health and to improve accountability for health at household	DQPR	Total number of schools formally accredited by an external assessment team as HPS	None	Output	Number	Annual	No	All schools implement HPS norms and standards to increase number of schools playing an active part in health promotion.	PHC Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
		level.									
School Health Services coverage	The total number of schools visited by a School Health Team for basic screening services and health promoting/ education during the reporting period.	Track the total number of schools that receive at least one SHS visit per year from an integrated School Health Team to render services as per Provincial School Health Services Policy.	DQPR	**Numerator:** Number of schools visited by a School Health Team **Denominator:** Total number of schools	Quality of data	Output	Percentage	Quarterly	No	Improved school health coverage as per Provincial School Health Services Policy Implementation Plan.	MC&WH Manager PHC Manager
Number of operational PHC Outreach [Family Health] Teams	Number of PHC Outreach [Family Health] Teams rendering PHC services at household level [linked with a PHC re-engineering].	Re-engineering of PHC with core focus on community-based (at household level) services.	DQPR	Number of operational PHC Outreach [Family Health] Teams	None	Input	Number	Annual	Yes	Improved PHC at household level as part of PHC re-engineering.	PHC Manager
Number of operational School Health Teams	Number of School Health Teams serving schools clustered to a PHC clinic as part of the re-engineering of PHC.	Re-engineering of PHC with specific reference to learners in schools.	DQPR	Number of operational School Health Teams	None	Output	Number	Annual	Yes	Improved PHC at community level [targeting learners].	MC&WH Manager
Number of operational District Specialist Teams	Number of District Specialist Teams providing clinical mentorship and oversight at district level [community-based and facility-based].	Re-engineering of PHC with specific reference to clinical governance and mentoring.	DQPR	Number of operational District Specialist Teams	None	Output	Number	Annual	Yes	Improved mentoring and oversight to improve clinical governance.	District Manager
Dental extractions to restoration rate	The rate between the number of extractions and restorations.	Key indicator for dental service quality. Large number of extractions might be an indication of poor quality, poor oral hygiene and a lack of regular dental check-up.	DHIS	**Numerator:** Total number of tooth extractions **Denominator:** Total number of tooth restorations	Poor reporting and recording at service delivery level	Output	Rate	Quarterly	Yes	Reduction in rate indicating improved access and general health behaviour.	Oral Health Manager
Hypertension case put on treatment – new	Newly diagnosed hypertensive patient initiated on treatment.	Reduce morbidity and mortality due to non-communicable diseases.	DHIS	Number of hypertension cases put on treatment - new	Data quality	Output	Number	Quarterly	Yes	Improved detection, screening and management to reduce morbidity and mortality due to non-communicable diseases.	PHC Manager
Diabetes Mellitus case put on treatment - new	Newly diagnosed patient with Diabetes Mellitus initiated on treatment	Reduce morbidity and mortality due to non-communicable diseases	DHIS	Number of Diabetes Mellitus cases put on treatment - new	Data quality	Output	Number	Quarterly	Yes		PHC Manager

PROGRAMMES 2/ 4/ 5: HOSPITAL SERVICES

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
The indicators for Hospital services in this table are the same for all categories of hospitals (District, Regional, Specialised, Tertiary and Central) and therefore not repeated. Calculation focusses on specific category hospital data.											
Caesarean section rate	Caesarean section deliveries in hospitals expressed as a percentage of all deliveries in hospitals.	Track the performance of obstetric care.	DHIS	**Numerator:** Number of caesarean sections performed **Denominator:** Total number of deliveries in facility	Data quality	Output	Percentage	Quarterly	No	Reduced caesarean section rate and improved maternal health outcomes.	Hospital Service Manager
Total separations	Recorded completion of treatment and/or the accommodation of a patient in hospitals. Separations include inpatients who were discharged, transferred out to other hospitals or who died and includes Day Patients.	Monitoring hospital service volumes.	DHIS	**Sum:** • Inpatient deaths • Inpatient discharges • Inpatient transfer out • Day patients	Data quality	Output	Number	Quarterly	No	Monitored patient activity to inform resource allocation and service provision.	Hospital Service Manager
Patient Day Equivalent	Patient day equivalent is a weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All hospital activity expressed as a equivalent to one inpatient day.	Monitoring hospital service volumes.	DHIS	**Sum:** • Inpatient days -total • 1/2 Day patients • 1/3 OPD headcount - total • 1/3 Emergency Headcount **OPD Headcount sum:** • OPD specialist clinic headcount + • OPD general clinic headcount	Data quality	Output	Number	Quarterly	No	Monitored patient activity to inform resource allocation and service provision.	Hospital Service Manager
OPD Headcount – Total	Headcount of all patients attending an outpatient clinic at the hospital.	Monitoring hospital service volumes.	DHIS	**Sum:** • OPD specialist clinic headcount • OPD general clinic headcount	Data quality	Output	Number	Quarterly	No	Monitored patient activity to inform resource allocation and service provision.	Hospital Service Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Average length of stay	Average number of patient days that an admitted patient in the hospital stays before separation.	To monitor hospital efficiency.	DHIS	**Numerator:** Inpatient days + 1/2 Day patients **Denominator:** Separations	Data quality	Efficiency	Days	Quarterly	No	Reduced length of stay to ensure efficient use of resources.	Hospital Service Manager
Bed utilisation rate (based on usable beds)	Patient days during the reporting period, expressed as a percentage of the sum of the daily number of usable beds.	Track the over/under utilisation of hospital beds in hospitals.	DHIS	**Numerator:** Inpatient days + 1/2 Day patients **Denominator:** Number of usable bed days	Data quality	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of beds and improved management efficiencies.	Hospital Service Manager
Expenditure per patient day equivalent (PDE)	Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All hospital activity expressed as a equivalent to one inpatient day.	Track the expenditure per patient day equivalent in hospitals.	BAS / DHIS	**Numerator:** Total Expenditure in hospitals **Denominator:** Patient Day Equivalent (PDE)	Data quality and inability to differentiate between expenditure on different levels of care in hospitals	Efficiency	Rand	Quarterly	No	Lower expenditure indicating efficient use of financial resources.	Hospital Service Manager
Percentage of complaints of users of (category) hospital services resolved within 25 days	Proportion of complaints of users of hospital services resolved within 25 days.	Monitor the management of the complaints of users in hospitals.	Quality Assurance	**Numerator:** Total number of complaints resolved within 25 days in reporting period **Denominator:** Total number of complaints received during the same reporting period	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in hospitals.	Quality Assurance Manager
Percentage of (category) hospitals with monthly mortality and morbidity meetings	Percentage of hospitals conducting monthly mortality and morbidity review meetings to inform quality improvement programmes and evidence-based intervention.	To monitor clinical governance at hospital level.	Quality Assurance	**Numerator:** Number of (category) hospitals that conducted monthly mortality and morbidity meetings **Denominator:** Total number of (category) hospitals	None	Quality	Percentage	Quarterly	No	Higher percentage suggests improved clinical governance.	Quality Assurance Manager

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Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
(Category) Hospital patient satisfaction rate	The percentage of users of public hospitals that participated in the annual Patient Satisfaction Survey that were satisfied with services they receive.	Track patient satisfaction.	Quality Assurance	**Numerator:** Total number of users that were satisfied with the services they received in (category) Hospitals **Denominator:** Total number of users that participated in the (category) hospital Client Satisfaction Survey	Generalised - depends on the number of users participating in the survey	Output	Rate	Annual	Yes	Higher percentage indicates improved service delivery and patient satisfaction.	Quality Assurance Manager
Number of (category) Hospitals assessed for compliance against the 6 priorities of the core standards	Number of (category) Hospitals routinely assessed for compliance against the core standards of 6 priority areas to improve quality and efficiency of hospital services.	Compliance to core standards of quality and efficiency.	Quality Assurance	Total number of (category) Hospitals assessed against the 6 priority areas of the core standards	None	Process	Number	Annual	No	Higher number indicates better compliance with the core standards in Hospitals.	Quality Assurance Manager
Percentage of (category) hospitals with functional Hospital Boards	Total number of Hospitals with active functional Hospital Boards.	Improve community consultation and participation and improved information sharing.	DQPR	**Numerator:** Total number of (category) Hospitals with functional Hospital Boards **Denominator:** Total number of (category) Hospitals	None	Output	Percentage	Annual	No	All Hospitals have functional boards to improve community consultation and participation.	Hospital Service Manager
Number of (category) Hospitals compliant with the 6 priorities of the national core standards	Reduced facility-acquired infections, caring service provider attitude, acceptable waiting times for users, user satisfaction, environmental cleanliness, lower rates accidental harm/ medical errors and complaints, and availability of medication and supplies.	Improved efficiencies and quality of public hospital services.	DHIS	Number of (category) Hospitals fully compliant with the 6 priorities of national core standards	None	Outcome	Number	Annual	No	Improved efficiency and quality of public health services.	Quality Assurance Manager

SUB-PROGRAMME: HIV AND AIDS, TB AND STI CONTROL

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Total number of patients (Children and Adults) on ART	Number of patients on an ARV regimen.	Track the number of patients on ARV treatment.	DHIS	Cumulative total of the number of patients on an ARV regimen	Data quality and completeness	Output	Number	Quarterly	No	Improved management of HIV prevalence.	HAST Manager
Male condom distribution rate	Number of male condoms distributed within the Province at public health facilities per male population 15 years and older.	Monitor prevention strategies.	DHIS	**Numerator:** Male condoms distributed at public health facilities **Denominator:** Male population 15 and older	Data quality and accurate population estimates	Process	Rate	Quarterly	No	Improved prevention strategies.	HAST Manager
New smear positive PTB defaulter rate	Percentage of smear positive PTB cases where patients defaulted as the proportion of all new smear positive PTB cases.	Monitor effectiveness of TB management.	ETR.Net	**Numerator:** All smear positive TB cases defaulted from treatment **Denominator:** New smear positive cases – total	Data quality and completeness	Output	Rate	Quarterly	No	Reduced defaulter rate reflect improved case holding and contributes to improved TB outcomes.	TB Manager
PTB two month smear conversion rate	Percentage of new smear positive PTB cases that converted to smear negative after being on treatment for 2 months.	Monitor treatment success rate.	ETR.Net	**Numerator:** New smear positive PTB cases that converted to smear negative at 2 months **Denominator:** New smear positive PTB cases registered	Data quality	Outcome	Rate	Quarterly	No	Improved smear conversion rates indicates improved TB outcomes.	TB Manager
Percentage of HIV-TB co-infected patients placed on ART	Proportion of patients with HIV/TB on ART.	Monitor ART coverage.	DHIS	**Numerator:** Total number of HIV/TB co-infected patients on ART **Denominator:** Total number of co-infected patients with a CD4 count of 350 or less.	Data quality	Output	Percentage	Quarterly	No	Higher percentage indicate improved management of HIV and TB	TB Manager HAST Manager
HCT testing rate	Percentage of clients tested to those counselled for testing.	Monitor HIV counselling and testing.	DHIS	**Numerator:** Total number clients tested for HIV **Denominator:** Total number of clients pre-test counselled	Data quality	Process	Rate	Quarterly	No	Higher percentage indicates increased population knowing their HIV status.	HAST Manager
New smear positive PTB cure	Percentage of new smear positive PTB cases cured at first	Monitor successful TB treatment outcomes.	ETR.Net	**Numerator:** New smear positive TB cases	Data quality	Outcome	Rate	Annual	No	Higher percentage indicate improved TB	TB Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
rate	attempt.			cured **Denominator:** New smear positive TB cases - total						outcomes.	
HIV incidence	New HIV infections.	Monitor the impact of HIV & AIDS interventions.	Research	**Numerator:** New HIV infections **Denominator:** Total population	Dependent on research and projections	Impact	Percentage	Annual projections	No	Reduction in new infections.	HAST Manager
Percentage qualifying HIV positive patients on ART	The proportion of eligible HIV positive clients who are on appropriate treatment.	Monitor effectiveness of the HIV treatment programme.	HIV Registers	**Numerator:** The number of eligible HIV positive clients on a treatment regime **Denominator:** Total number of eligible HIV positive clients	Data quality	Output	Percentage	Annual	No	Successful treatment programme.	HAST Manager
Number of neo-natal males circumcised	The number of neonatal males circumcised as proportion of total male live births during the reporting period.	Monitor the male medical circumcision strategy to reduce HIV incidence.	DHIS	**Numerator:** Number of neonatal males circumcised **Denominator:** Number of male live births	Data quality	Output	Number	Quarterly	No	Reduction of HIV incidence.	HAST Manager
Number of adult males circumcised	The number of males circumcised as proportion of males between 15 – 49 years old.	Monitor as strategy to reduce HIV incidence.	DHIS	**Numerator:** Number of males 15 – 49 years circumcised **Denominator:** Number of males 15 – 49 years	Data quality	Output	Number	Quarterly	No	Reduction of HIV incidence.	HAST Manager
Percentage of HIV positive patients initiated on IPT	The proportion of clients newly eligible for INH as prophylaxis for TB that started treatment during the reporting period	Preventive therapy for TB	DHIS	**Numerator:** HIV positive new patients started on IPT **Denominator:** HIV test positive new (excluding ANC) + ANC client test positive new + ANC re-test positive	Data quality	Output	Percentage	Quarterly	Yes	Reduction of TB incidence	HAST Manager
Percentage of TB/HIV co-infected patients initiated on CPT	The proportion of TB/HIV positive clients newly eligible started co-trimoxazole prophylaxis during the reporting period	Preventive therapy	DHIS	**Numerator:** TB/HIV positive new patients started on co-trimoxazole prophylaxis **Denominator:** HIV test positive new (excluding ANC) + ANC client tested HIV positive new	Data quality	Output	Percentage	Quarterly	Yes	Manage TB/HIV prevalence	HAST Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
STI treated new episode incidence	The proportion of people, 15 years and older, that have been treated for a new episode of STI (annualised).	Monitor effectiveness of prevention strategies.	DHIS	**Numerator:** STI treated – new episode **Denominator:** Population 15 years and older	Data quality. Only refer to users of public health services	Outcome	Percentage	Annual	Yes	Decrease in incidence.	HAST Manager

SUB-PROGRAMME: MATERNAL, CHILD AND WOMAN HEALTH

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Immunisation coverage under 1 year	Percentage of all children under 1 year who complete their primary course of immunisation during the month (annualised).	Reduction of vaccine preventable diseases.	DHIS	**Numerator:** Immunised fully under 1 year - new **Denominator:** Population under 1-year	Data quality and accurate estimated population	Output	Percentage	Quarterly	No	Reduction in vaccine preventable diseases.	MC&WH Manager
Vitamin A coverage under 12 – 59 months	Percentage of children 12-59 months receiving vitamin A 200,000 units twice a year.	Monitor Vitamin A supplementation to children as part of child health strategy to reduce morbidity and mortality.	DHIS	**Numerator:** Vitamin A supplement to 12-59 months child **Denominator:** Population 1-4 years x 2	Data quality and accurate population estimates	Output	Percentage	Quarterly	No	Improved nutritional support as part of strategy to reduce child morbidity and mortality.	Nutrition Manager
Measles 1st dose under 1 year coverage	Percentage of children under 1 year who received their 1st measles dose before their first birthday.	Elimination of measles.	DHIS	**Numerator:** Measles 1st dose before 1 year **Denominator:** Population under 1 year	Data quality and accurate population estimates	Output	Percentage	Quarterly	No	Elimination of measles.	MC&WH Manager
Pneumococcal vaccine 3st dose coverage	Percentage of children under 1 year who received their Pneumococcal 3st dose vaccine.	Monitor in relation to trends (reduction) in pneumonia cases in children under-5 years.	DHIS	**Numerator:** Pneumococcal 3rd dose before 1 year **Denominator:** Population under 1 year	Data quality and accurate population estimates	Output	Percentage	Quarterly	No	Reduction in pneumonia cases under-5 years.	MC&WH Manager
Rota Virus 2nd dose coverage	Percentage of children under 1 year who received their Rota Virus 2nd dose vaccine.	Monitor in relation to trends (reduction) in diarrhoea cases in children under 5 years	DHIS	**Numerator:** Rota Virus 2nd dose before 1 year **Denominator:** Population under 1 year	Data quality and accurate population estimates	Output	Percentage	Quarterly	No	Reduction in diarrhoea under 5 years.	MC&WH Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Cervical cancer screening coverage	Percentage of women from 30 years and older who received a routine Pap smear to screen for abnormal cancer cells of the cervix.	Improved screening and management of abnormal smears contributes to reduction in cervical cancer.	DHIS	**Numerator:** Cervical smear in woman 30-years and older **Denominator:** 10% of female population 30 years and older	Data quality (including differentiation between routine and diagnostic smears) and accurate population estimates	Output	Percentage Annualised	Quarterly	No	Improved screening coverage (ultimate 70% of target population) improves management of abnormal smears and ultimately reduce incidence of cervical cancer.	MC&WH Manager
Antenatal visits before 20 weeks rate	The percentage of pregnant women who have an antenatal care booking (first visit) before their 20th week of pregnancy.	Early antenatal care (ANC) ensures early intervention and appropriate management of high risk pregnancies.	DHIS	**Numerator:** ANC 1st visits before 20 weeks **Denominator:** ANC 1st visits	Data quality	Process	Rate	Quarterly	No	Early ANC attendance and more effective management of high risk pregnancies to reduce morbidity and mortality.	MC&WH Manager
Baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks	The number of babies who test positive for HIV at 6 weeks as a proportion of the total number of babies tested at 6 weeks.	Track mother to child transmission of HIV.	DHIS	**Numerator:** Number of babies who tested PCR positive at 6 weeks after birth **Denominator:** Total number of babies tested for HIV at 6 weeks after birth	Data quality	Outcome	Percentage	Quarterly	No	Lower percentage indicates that the PMTCT programme is effective.	MC&WH Manager
Couple year protection rate	Percentage of women of reproductive age (15-44) who are using (or whose partner is using) a modern contraceptive method. Contraceptive methods include female and male sterilisation, injectable, and oral hormones, intrauterine devices, diaphragms, spermicides and condoms.	Track contraception use as part of prevention programmes to reduce morbidity and mortality.	DHIS	**Numerator:** Contraception years dispensed (including sterilisation) **Denominator**: Female population 15-44 years	Data quality	Output	Rate	Annual	No	High rate indicating improved protection against high risk pregnancies.	MC&WH Manager
Facility maternal mortality rate	Number of maternal deaths in facilities expressed per 100,000 live births. A maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the	Monitoring and assessing causes of reported maternal deaths to reduce preventable causes of death and reduce maternal and neonatal mortality.	DHIS	**Numerator:** Number of maternal deaths in facility **Denominator:** Number of live births in facility	Effective reporting of maternal deaths including reporting in private facilities	Outcome	Ratio per 100,000 live births	Annual	No	Effective reporting and assessment reduce avoidable causes of death and reduce maternal and neonatal morbidity and mortality.	MC&WH Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
	duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (as cited in ICD 10).										
Delivery rate for women under 18 years	Percentage of deliveries where the mother is under the age of 18 years on the day of delivery.	Monitor teenage pregnancies/ deliveries to inform prevention strategies.	DHIS	**Numerator:** Total number of deliveries to woman under 18 years **Denominator:** Total deliveries in facilities	Data quality	Outcome	Rate	Annual	No	Delivery rate will provide an indication of effectiveness of prevention programmes.	MC&WH Manager
Facility infant mortality (under 1 years) rate	The percentage of children who have died in a health facility between birth and their first birthday, expressed per thousand live births in facility.	Monitor trends to determine effectiveness of prevention and promotion strategies, health behaviour and burden of disease.	DHIS	**Numerator:** Number of inpatient deaths under 1 year **Denominator:** Inpatients separations under 1 year (Sum of Inpatient discharge <1 year and Inpatient transfer out <1)	Data quality	Outcome	Rate	Annual	No	Decreased infant mortality rate.	MC&WH Manager
Facility child mortality (under 5 years) rate	The number of children who have died in a health facility between birth and their fifth birthday, expressed per 1000 live births in facility.	Monitor trends to determine effectiveness of prevention and promotion strategies, health behaviour and burden of disease.	DHIS	**Numerator:** Total number of inpatient deaths under 5 years **Denominator:** Inpatients separations under 5 year (Sum of Inpatient discharge < 5 year and Inpatient transfer out < 5)	Data quality	Outcome	Rate	Annual	No	Decreased child mortality rate.	MC&WH Manager
% of pregnant women tested for HIV	The proportion of pregnant women who have been tested for HIV during their ANC period.	Track the number of ANC clients tested for HIV in support of improved PMTCT Programme and reduction of maternal mortality.	DHIS	**Numerator:** Number of ANC clients tested for HIV **Denominator:** Total number of ANC clients	Data quality	Output	Percentage	Quarterly	No	Increased testing positively impact on the success of the PMTCT and HIV Programme.	MC&WH Manager
ANC Nevirapine uptake rate	HIV positive ANC clients (not on HAART) who took Nevirapine during labour as proportion to live births to HIV positive women.	Improved PMTCT outcomes.	DHIS	**Numerator:** Antenatal client who took Nevirapine during labour **Denominator:** Live births to HIV positive women	Data quality	Output	Rate	Quarterly	Yes	Improved PMTCT outcomes.	MC&WH Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Baby Nevirapine uptake rate	Babies (including born before arrival and known home deliveries) given Nevirapine within 72 hours after birth as proportion to live births to HIV positive women.	Improved PMTCT outcomes.	DHIS	**Numerator:** Babies given Nevirapine within 72 hours after birth **Denominator:** Live births to HIV positive women	Data quality	Output	Rate	Quarterly	Yes	Improved PMTCT outcomes.	MC&WH Manager
Percentage of eligible pregnant women placed on HAART	HIV-positive antenatal (ANC) clients initiated on HAART as a proportion of HIV-positive antenatal clients with CD4 count under the specified threshold and/or WHO staging of 4.	Monitor the effective implementation of the PMTCT Programme.	DHIS	**Numerator:** Number of HIV-positive ANC clients initiated on HAART during current pregnancy **Denominator:** Number of HIV-positive ANC clients with a CD4 count under the specified threshold and/or a WHO staging of 4	Data quality	Output	Percentage	Quarterly	No	Improved PMTCT outcomes.	MC&WH Manager
Number of diarrhoea cases – children under-5 years – new ambulatory	The total number of diarrhoea cases (children under 5 years) seen in public health facilities. (Formally defined as 3 or more watery stools in 24 hours – but any episode diagnosed or treated is counted).	Monitor the trend in diarrhoea cases – link with rotavirus vaccine coverage and child mortality (MDG 4).	DHIS	Number of diarrhoea cases in children under 5 years – new ambulatory (including diarrhoea with and without dehydration)	Data quality	Outcome	Number per 1000	Quarterly	No	Reduction in reported cases of diarrhoea.	MC&WH Manager
Number of pneumonia cases – children under-5 years	The total number of pneumonia cases (children under 5 years) seen in public health facilities.	Monitor the trend in pneumonia cases – link with pneumococcal vaccine coverage and child mortality (MDG 4).	DHIS	Number of pneumonia cases – new ambulatory in children under 5 years	Quality of data from reporting facility and effective reporting system	Outcome	Number	Quarterly	No	Track progress towards MDG's.	MC&WH Manager
Postnatal care mother visits within 6 days rate	The proportion of mothers and babies, compared to the total deliveries in the facility that receive follow-up care at a health facility within 6 days of the delivery.	Monitor access and utilisation of postpartum care.	DHIS	**Numerator:** Postnatal care mother within 6 days of delivery **Denominator:** Total deliveries in facility	Data quality	Output	Rate	Quarterly	No	Reduced morbidity and mortality.	MC&WH Manager
Postnatal care baby visits within 6 days rate			DHIS	**Numerator:** Postnatal care baby within 6 days of birth **Denominator:** Total deliveries in facility	Data quality	Output	Rate	Quarterly	No	Reduced morbidity and mortality.	MC&WH Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Not gaining weight rate under 5 years	The proportion of children weighed who has had an episode of growth faltering or failure during the same period.	Early detection and treatment of malnutrition.	DHIS	**Numerator:** Number of children under 5 years not gaining weight **Denominator:** Children under 5 years weighed	Data quality	Outcome	Rate	Quarterly	Yes	Improved detection of nutritional deficiencies as part of prevention and management to improve child health outcomes.	Nutrition Manager
Underweight for age under 5 years incidence (annualised)	The proportion of all children under 5 years weighed who were identified as being below the third centile but equal to or over 60% of estimated weight for age on the Road to Health Chart (excluding newborn babies).		DHIS	**Numerator:** Underweight for age under 5 years – new cases **Denominator:** Children under 5 years weighed	Data quality	Outcome	Percentage	Annual	Yes		Nutrition Manager
Severe malnutrition under 5 years incidence	The number of severely malnourished children detected per 1000 population under 5 years.	Monitor nutritional status of children as critical component of child health.	DHIS	**Numerator:** Severe malnutrition under 5 years – new ambulatory **Denominator:** Population under 5 years	Data quality	Outcome	Percentage	Annual	Yes	Reduced incidence may be an indication of improved socio-economic conditions, prevention and promotion and improved management of malnutrition.	Nutrition Manager

SUB-PROGRAMME: DISEASE CONTROL AND PREVENTION

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Cholera fatality rate	Deaths from cholera as a percentage of the total number of cases reported.	Monitor the number deaths caused by Cholera.	CDC	**Numerator:** Number of deaths from cholera **Denominator:** Total number of cholera cases reported	Data quality	Outcome	Rate	Annual	No	Lower percentage indicates a decreasing burden of cholera.	CDC Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Malaria case fatality rate	Deaths from malaria as a percentage of the number of cases reported.	Monitor the number deaths caused by malaria to assess effectiveness of intervention strategies.	Malaria database	**Numerator:** Number of deaths from malaria **Denominator:** Total number of malaria cases reported	Data quality	Outcome	Rate	Annual	No	Lower percentage indicates a decreasing burden of malaria and effective intervention strategies towards eradication of malaria.	CDC Manager
Malaria incidence per 1000 population at risk.	New malaria cases as proportion of 1000 population at risk.	Monitor the new malaria cases as proportion of the population at risk to monitor performance in relation to MDG 6.	CDC	**Numerator:** Number of new malaria cases reported **Denominator:** Total population	Data quality	Outcome	Percentage per 1000 population	Annual	No	Reduced incidence indicates improved prevention strategies.	CDC & Environmental Health Managers.
Indoor residual spraying coverage	Proportion of houses sprayed as strategy to prevent malaria.	Monitor spraying as part of prevention strategy.	CDC	**Numerator:** Number of residences sprayed **Denominator:** Total number of residences	Data quality	Output	Percentage	Annual	Yes	Improved spraying contributing to maintaining prevention strategies.	CDC Manager
Cataract surgery rate	Cataract operations completed per 1mil population.	Monitor the number of cataract surgeries compared with need.	DHIS	**Numerator:** Cataract operations completed **Denominator:** Total population	Data quality	Outcome	Rate per 1mil population	Annual	No	Higher levels reflects a good contribution to sight restoration, especially amongst the elderly population.	Chronic Diseases Manager

PROGRAMME 3: EMERGENCY MEDICAL & PATIENT TRANSPORT SERVICES

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
P1 calls with a response of time <15 minutes in an urban area	Percentage of P1 call-outs to urban locations with response times within 15 minutes.	Monitor response times to determine efficiency and quality of EMS.	EMS	**Numerator:** Number of P1 urban call outs with response time under 15 minutes **Denominator:** Total number of P1 call outs in urban areas	Data quality	Quality	Percentage	Quarterly	No	Higher percentage indicates improved efficiency.	EMS Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
P1 calls with a response time of <40 minutes in a rural area	Percentage of P1 call-outs to rural locations with response times within 40 minutes.	Monitor response times to determine efficiency and quality of EMS.	EMS	**Numerator:** Number of P1 rural call outs with response time under 40 minutes **Denominator:** Total number of P1 call outs in rural areas	Data quality	Quality	Percentage	Quarterly	No	Higher percentage indicates improved efficiency.	EMS Manager
All calls with response time within 60 minutes	Percentage of all call-outs with response times within 60 minutes.	Monitor response times to determine efficiency and quality of EMS.	EMS	**Numerator:** Number of call outs with a response time under 60min **Denominator:** Total number of call outs	Data quality	Quality	Percentage	Quarterly	No	Higher percentage indicates improved efficiency.	EMS Manager
Rostered ambulances per 10,000 people	Number of rostered ambulances per 10,000 population.	Monitor availability of resources to render effective EMS.	EMS	**Numerator:** Total number of rostered ambulances **Denominator:** Total population	None	Input	Number per 10,000 population	Annual	No	Higher number of rostered ambulances will improve efficiency and effectiveness of EMS.	EMS Manager
Total number of EMS emergency cases	Number of patients transported by ambulance for emergency cases.	Monitor service volumes and capacity.	EMS	Number of patients transported by ambulance for emergency cases	Data quality	Output	Number	Quarterly	No	Increasing numbers may indicate increased dependence on public health services or more efficient EMS.	EMS Manager
Total number of inter facility transfers	The number of patients transferred between facilities by appointment.	Track patient activity between facilities.	EMS	Number of patients transported between facilities by appointment	Data quality	Output	Number	Quarterly	No	Increasing number might be indication of effective referral system or increasing burden of disease.	EMS Manager
Number of locally based staff with training in BLS (BAA)	The number of EMS staff that completed an accredited training course for Basic Life Support.	Monitor allocation of appropriate Human Resources for Health to ensure effective EMS.	EMS	Number of EMS staff with a BLS qualification	None	Input	Number	Annual	No	Appropriate allocation of staff improves efficiency and quality of EMS.	EMS Manager
Number of locally based staff with training in ILS (AEA)	The number of EMS staff that completed an accredited training course for Intermediate Life Support.		EMS	Number of EMS staff with an ILS qualification	None	Input	Number	Annual	No		EMS Manager
Number of locally based staff with training in ALS (Paramedics)	The number of EMS staff that completed an accredited training course for Paramedics.		EMS	Number of EMS staff with an ALS/Paramedic qualification	None	Input	Number	Annual	No		EMS Manager

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of Professional Nurses graduating	Number of Professional Nurses graduating after completion of the basic nursing course.	Monitoring production of Human Resources for Health.	SANC Persal	Number of Professional Nurses graduating	None	Output	Number	Annual	No	Number of Professional Nurses graduating in direct response to service needs.	Nursing College Manager
Number of Advanced Midwifes graduating per annum	Number of Advanced Midwifes who graduate with a post basic nursing qualification in Advanced Midwifery.	Monitor training of Advanced Midwifes in response to NSDA priority of MC&WH.	SANC Persal	Number of Advanced Midwifes graduating	None	Output	Number	Annual	No	Training more Advanced Midwifes in response to MC&WH Strategy to improve maternal health.	Nursing College Manager
Number of Managers accessing the Management Skills Programme	Managers attending Leadership & Management training programmes to improve management.	Track the number of Managers that attend Leadership & Management training programmes.	HRD	Number of Managers who attended Leadership & Management training programmes	None	Output	Number	Annual	No	Improved management and leadership competencies.	HRD Manager
Number of SMS members trained on Massification Implementation Plan (MIP)	SMS members attending MIP for Senior Managers.	Track the number of Senior Managers attending the MIP.	HRD	Number of SMS members attending MIP	None	Output	Number	Annual	No	Higher attendance will improve service delivery.	HRD Manager
Intake of nurse students	Number of nurses entering the first year of nursing training.	Track the training of nurses to manage Human Resources for Health.	HRD	Total intake of Student Nurses	None	Input	Number	Annual	No	Higher levels of intake are desired to increase the availability of nurses in future.	Nursing College Manager
Students with bursaries from the Province	Number of students provided with bursaries by the Provincial Department of Health.	Tracks the numbers of Health Science students sponsored by the Province to undergo training as future health care providers.	HRD	Number of students with bursaries from the Province	None	Input	Number	Annual	No	Higher numbers of students provided with bursaries are desired to increase Human Resources for Health.	HRMS
Basic Nurse Students graduating	Number of students who graduate from the basic nursing course.	Tracks the production of nurses.	Nursing College	Number of students graduating	None	Output	Number	Annual	No	Desired performance level is that higher numbers of nursing students should be graduating.	Nursing College Manager

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Percentage of Pharmacies that obtained A or B grading on inspection	The proportion of Pharmacies that comply with Pharmaceutical prescripts on inspection.	Track compliance with Pharmaceutical prescripts.	Pharmacy	**Numerator:** Number of Pharmacies with A or B grading on inspection **Denominator:** Total number of Pharmacies	Accurate records of inspections conducted	Quality	Percentage	Annual	No	Improved compliance will improve quality and efficiency of Pharmaceutical services.	Pharmacy Manager
Tracer medicine stock-out rate (PPSD)	Any item on the Tracer Medicine List that had a zero balance in the Bulk Store (PPSD) on a Stock Control System.	Monitor shortages in tracer medicines.	Pharmacy	Any tracer medicine stock-out in bulk store (PPSD)	Data quality	Efficiency	Percentage	Quarterly	No	Targeting zero stock-out.	Pharmacy Manager
Tracer medicine stock-out rate (Institutions)	Any item on the Tracer Medicine List that had a zero balance in Bulk Store (facilities) on the Stock Control System. Percentage of fixed facilities with tracer medicine stock-outs (>0) during the reporting period. A facility should be counted once as having a stock-out during the reporting period.	Monitor shortages in Tracer medicines.	DHIS	**Numerator:** Any tracer medicine stock-out in facilities **Denominator:** Number of fixed facilities	Data quality	Efficiency	Percentage	Quarterly	No	Targeting zero stock-out of all tracer medicines.	Pharmacy Manager
PPSD compliant with Good Warehouse Regulations	Compliance with legislative prescripts with regards to operating warehouse functions	Safe warehousing practice	License	**License issued to PPSD**	None	Output	Yes/No	Annual	No	Licensed	Pharmacy Manager

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

Indicator Title	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
The number of new clinical infrastructure (clinics, etc.) completed.	Monitor progress in Infrastructure projects as per Infrastructure Plans.	IRM; IPMP; Optimisation Plan; U-Amp	Number of new infrastructure projects with construction completed	None	Process	Number	Quarterly	No	Effective monitoring of performance and progress.	Infrastructure Development Manager
The number of new clinical infrastructure (clinics, etc.) fully commissioned.			Number of new infrastructure projects commissioned	None	Process	Number	Quarterly	No	Effective monitoring of performance and progress.	Infrastructure Development Manager
The number of upgrading and renovation projects constructed.			Number of upgrading and renovation projects with construction completed	None	Process	Number	Quarterly	No	Effective monitoring of performance and progress.	Infrastructure Development Manager
The number of upgrading and renovation projects fully commissioned.			Number of upgrading and renovation projects commissioned	None	Process	Number	Quarterly	No	Effective monitoring of performance and progress.	Infrastructure Development Manager

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