health
Department:
Health
PROVINCE OF KWAZULU-NATAL



STRATEGIC PLAN

2015 – 2019

FIGHTING DISEASE, FIGHTING POVERTY, GIVING HOPE

1. FOREWORD BY THE EXECUTIVE AUTHORITY

The National Development Plan 2030 aims to eliminate poverty and reduce inequality by 2030, and proposes a multidimensional framework to bring about a virtuous cycle of development, with progress in one area supporting advances in others.

During the next 5 years the Province of KwaZulu-Natal will strengthen the Provincial Flagship Programme (Operation Sukuma Sakhe) that fundamentally promotes inter-sectoral collaboration in line with the health imperatives in the National Development Plan, Medium Term Strategic Framework, and Provincial Growth and Development Plan.

The KZN Department of Health priorities for the next five years (and beyond) are aligned with the nine health goals prescribed in the National Development Plan 2030, building on past successes and further improving on others. The National Development Plan goals include:

1. Average male and female life expectancy increased to 70 years for both males and females
2. Tuberculosis (TB) prevention and cure progressively improved
3. Reduced maternal, infant and child mortality
4. Reduced prevalence of non-communicable chronic diseases by 28%
5. Reduced injury, accidents and violence by 50% from 2010 levels
6. Complete health systems reform
7. Primary Health Care Teams provide care to families and communities
8. Universal health care coverage achieved
9. Posts filled with skilled, committed and competent individuals

Long-term health outcomes are shaped by a wide variety of factors outside the health system e.g. lifestyle, diet and nutrition, education, sexual behaviour, exercise, road accidents and the level of violence. The Department will therefore increase its focus on these issues as part of health reform at community and Primary Health Care level. The re-engineering of PHC, with a strong focus on household coverage, will be strengthened to take health care to the people and to ensure that communities take ownership for their own health and wellbeing.

The strategic objectives in this document offer a detailed framework to achieve the maximum health outcomes for the people of KwaZulu-Natal within the available budget. I endorse the 2015-2019 Strategic Plan and commit to providing the necessary leadership for implementation. I invite all communities and stakeholders to actively participate in the process of advancing the provision of quality health care to all.

Dr SM Dhlomo

Member of the Executive Council (MEC)

KwaZulu-Natal Department of Health

Date: 03/03/2015

2. STATEMENT BY THE HEAD OF DEPARTMENT

The 2015-2019 Strategic Plan encapsulates the vision, mission, goals and objectives that will guide the operations of the Department for the period 2015-2019. It clearly articulates the priorities and approach that will be pursued by the Department in responding to the priorities of the new government.

The Strategic Plan is a product of intensive and widespread consultations with internal and external stakeholders. It was further shaped by the priorities of the National Development Plan 2030, the Medium Term Strategic Framework 2014-2019, the Provincial Growth and Development Plan 2030, the 2015 Cabinet Lekgotla Resolutions, other sector priorities and the burden of disease and demand for services.

The Strategic Plan adheres to all statutory requirements as defined in Chapter 5 of the Public Finance Management Act (Act No. 1of 1999), Chapter 1, Part III B, of the new Public Service Regulations of 2001, and Section 5.1.1 of the National Treasury Regulations which requires that at the beginning of an electoral cycle the Accounting Officer must prepare a new Strategic Plan and Annual Performance Plan for approval by the relevant Executive Authority.

The Department will pursue to the following five Strategic Goals during the next 5 years, which are fully aligned with sector priorities:

1. Strengthen health system effectiveness
2. Reduce and manage the burden of disease
3. Universal health coverage
4. Strengthen human resources for health
5. Improved quality of health care

Finalisation of the Department's Long Term Plan will set the tone for Annual Performance Plans and will provide for detailed Implementation Plans that will allow robust monitoring, evaluation and reporting on progress to stakeholders. The Plan will integrate the key elements of system strengthening, service delivery, human resources, infrastructure and finance as part of the long-term framework to guide annual planning and budget allocation. This will ensure that limited resources are optimally utilised to achieve the best return in service delivery and health outcomes in relation to investment made.

I hereby present the KwaZulu-Natal Department of Health Strategic Plan for 2015-2019, and pledge my commitment to lead the process of implementation.

Dr S.N. Zungu

Head of Department

KwaZulu-Natal Department of Health

Date: 02 . 03 . 2015

3. OFFICIAL SIGN-OFF: 2015-2019 STRATEGIC PLAN

It is hereby certified that this Strategic Plan:

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

Mrs E Snyman

Manager: Strategic Planning

Date: 2/3/2015

Mr J Govender

General Manager: Planning, Monitoring & Evaluation

Date: 2/3/2015

Mr S Mkhize 2/3/2015

Acting Chief Financial Officer

Date:

Dr SM Zungu

Accounting Officer

Date: 02.03.2015

Approved by:

Dr SM Dhlomo

Executive Authority

Date: 03/03/2015

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4. VISION, MISSION AND CORE VALUES

4.1 Vision

Optimal health for all persons in KwaZulu-Natal

4.2 Mission

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

4.3 Core Values

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

5. LEGISLATIVE AND OTHER MANDATES

5.1 Constitutional Mandates

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

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

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

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

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

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

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

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

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

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

5.2 Legislative Mandates

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

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

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

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

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

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

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

Health Professions Act (Act No. 56 of 1974): Provides for the regulation of health professions, in particular medical practitioners, dentists, psychologists and other related health professions, including community service by these professionals.

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

KwaZulu-Natal Health Act (Act No. 1 of 2009) and Regulations: Provides for a transformed Provincial Health System within framework of the National Health Act of 2003.

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

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

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

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

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

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

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

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

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

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

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

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

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

5.3 Policy Mandates

Clinical Policies and Guidelines: The Department will implement and monitor a considerable number of clinical health policies to improve management and clinical outcomes.

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

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

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

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

Policy on National Health Insurance (Green Paper 2011): Provides for systems strengthening to ensure universal access to health care. The Department will implement these policies in the three National Health Insurance Pilot Districts.

Policy on Management of Hospitals: Provides the policy imperatives for management of Public Health Hospitals. The Department will review and develop appropriate policies emanating from the Hospital Rationalisation Plan that will be developed in 2015/16 and implemented thereafter

Regulations Relating to Classification of Hospitals: Provides the policy framework for classification of Public Health Hospitals. The Department will review the classification of hospitals based on evidence and demand for services as included in the Hospital Rationalisation Plan.

5.4 Relevant Court Rulings

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

5.5 Planned Policy Initiatives

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

- *National Development Plan 2030*: Informs the Medium Term Strategic Framework 2014-2019 and Provincial Growth and Development Plan 2030 and provides the blueprint for Departmental strategies and plans.
- *Medium Term Strategic Framework 2014-2019*: Government framework, based on the National Development Plan, for the medium term period – guides the Provincial strategies priorities.
- *Millennium Development Goals*: Identified priorities and targets to achieve the health-related Millennium Development Goals.
- *Negotiated Service Delivery Agreement (Reviewed)*: The Department will monitor the reviewed Negotiated Service Delivery Agreement.
- *Provincial Growth and Development Plan 2030*: Review alignment and continued integration though established structures.
- *Provincial Long Term (Service Transformation) Plan:* Outstanding Chapters will be finalised in 2015/16 for implementation, monitoring and reporting thereafter.
- *KwaZulu-Natal Monitoring and Evaluation Framework*: The current Framework will be reviewed in 2015/16 to ensure appropriate monitoring of strategies and activities included in the Strategic Plan and consequent Annual Performance Plans.
- *National/ Provincial Human Resource for Health Strategy 2012-2016*: The Department will finalise the Long Term Human Resources Plan in 2015/16 for implementation, monitoring and reporting thereafter. Short term plans will be aligned annually thereafter taking into consideration the changed human resource landscape.
- *National Nursing Strategy 2012-2016*: The strategy will be operationalised in line with the Long Term Plan.
- *Data Management Policy*: Monitoring of the policy will be intensified to ensure compliance. Improved data quality and audit outcomes will be monitored at all levels.

- *User Asset Management Plan and Infrastructure Programme Management Plan:* The Medium and Long Term Infrastructure Plans will provide the blueprint for infrastructure projects during the reporting period.
- *Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA)*: Implementation will be intensified over the reporting period and outcomes will be actively monitored.
- *National and Provincial Contraceptive Strategies*: Implementation will be scaled up including the "Reaching 3 Million Young Women by 2015 campaign". This strategy is closely linked with the HIV/AIDS programme e.g. dual protection.
- *National and Provincial MNCWH Strategies 2012-2016*: Implementation will be scaled up and outcomes will be monitored and reported.
- *Provincial Neonatal Strategy*: The strategy will be rolled out and progress will be actively monitored and reported.
- *Integrated Chronic Disease Management Model*: Rollout and review of relevant policies and guidelines.
- *National and Provincial Strategic Plans for HIV, AIDS, STI and TB 2012-2016*: Provincial strategies have been aligned with these strategic plans and specific outcomes will be monitored.
- *Medical Male Circumcision Escalation Plan:* Massive scale up of this plan to reach more men.
- *National and Provincial Strategies for Non-Communicable Diseases 2014-2019*: The strategies will be finalised in 2015/16 to ensure effective operationalisation, implementation, monitoring and reporting. This will be aligned with the Provincial Long Term Plan.
- *PHC Re-Engineering:* Further scale-up of re-engineering strategies (within the funding envelope) with a strong focus on community-based services and stakeholder involvement. The appointment of District Health Councils, Hospital Boards and Clinic Committees will be prioritised.
- *Operation Phakisa: Ideal Clinic Realisation and Maintenance*: The Provincial Implementation Plan (within the National Framework) will be finalised in early 2015/16 to inform operationalised activities. Focus will be on the following streams: (1) Service delivery; (2) Waiting times; (3) Human resources; (4) Infrastructure; (5) Supply Chain Management; (6) Finance; (7) Institutional arrangements; and (8) Change Management, scale-up and sustainability. Cross cutting issues that will be addressed include: Leadership; Accountability; Capacity & skills; and Delegations.
- *Provincial Mental Health Care Strategy 2014-2019*: The strategy will be finalised in 2015/16 to inform the Implementation Plan, monitoring and reporting. This will be aligned with the Provincial Long Term Plan.
- *Rationalisation of Hospital Services*: The Department will develop a comprehensive Hospital Rationalisation Plan in 2015/16 to inform annual Implementation Plans. Progress will be monitored accordingly.
- *Emergency Medical Services*: The Department will review the current EMS strategy in 2015/16.
- *Forensic Pathology Services*: The Medico-Legal Mortuary Optimisation Plan will be finalised in 2015/16 for implementation, monitoring and reporting.

- *Clinical policies*: The Department will review policies where necessary and monitor implementation thereof as part of Clinical Governance.

- *KZN Poverty Eradication Master Plan*: The Department will contribute towards implementation of the KZN Poverty Eradication Master Plan through Provincial structures e.g. Operation Sukuma Sakhe. The 169 wards, worst affected by poverty (attached as Annexure), will be targeted in operationalising strategies.

6. SITUATIONAL ANALYSIS

6.1 Service Delivery Environment

6.1.1 Demographic Profile

Map 1: KwaZulu-Natal

The Province of KwaZulu-Natal comprises 1 Metropol, 10 Districts, 50 Municipalities and 828 Wards. Four Districts (Ugu, Umzinyathi, Zululand and Umkhanyakude) and 1 Municipality (Umzimkhulu in Harry Gwala) have been declared Rural Development Nodes. There are three National Health Insurance (NHI) pilot districts i.e. Umgungundlovu and Umzinyathi (national) and Amajuba (provincial).

The Province is situated on the eastern coast of South Africa, bordered by the Indian Ocean to the East and the Drakensberg, separating it from Lesotho, to the West. It shares borders with the Eastern Cape in the South, Free State and Lesotho in the West, Mpumalanga in the North West, and Swaziland and Mozambique in the North.

Two of the country's major natural harbours are located at Durban and Richards Bay, adjoined by three international countries with associated border posts namely:

- Lesotho: Sani Pass Post in the Harry Gwala District.
- Swaziland: Golela Post in the Zululand District.
- Mozambique: Manguze Post in the Umkhanyakude District.

The countryside is characterized by dispersed rural settlements and communal villages with households settling on the crests of hills or near rivers. This poses a number of unique challenges for development, service delivery and equity in health care.

According to StatsSA, the provincial population density is 107.52 people per km^2 ranging between 7 people per km^2 in Kwa Sani Municipality (Harry Gwala) and 1 502 people per km^2 in eThekwini Metro (1).

The most densely populated areas (including fast growing informal settlements) are mainly concentrated in eThekwini, Umgungundlovu and Uthungulu (Richards Bay), all considered fast growing economic hubs in the Province. The Newcastle area is also showing signs of rapid development.

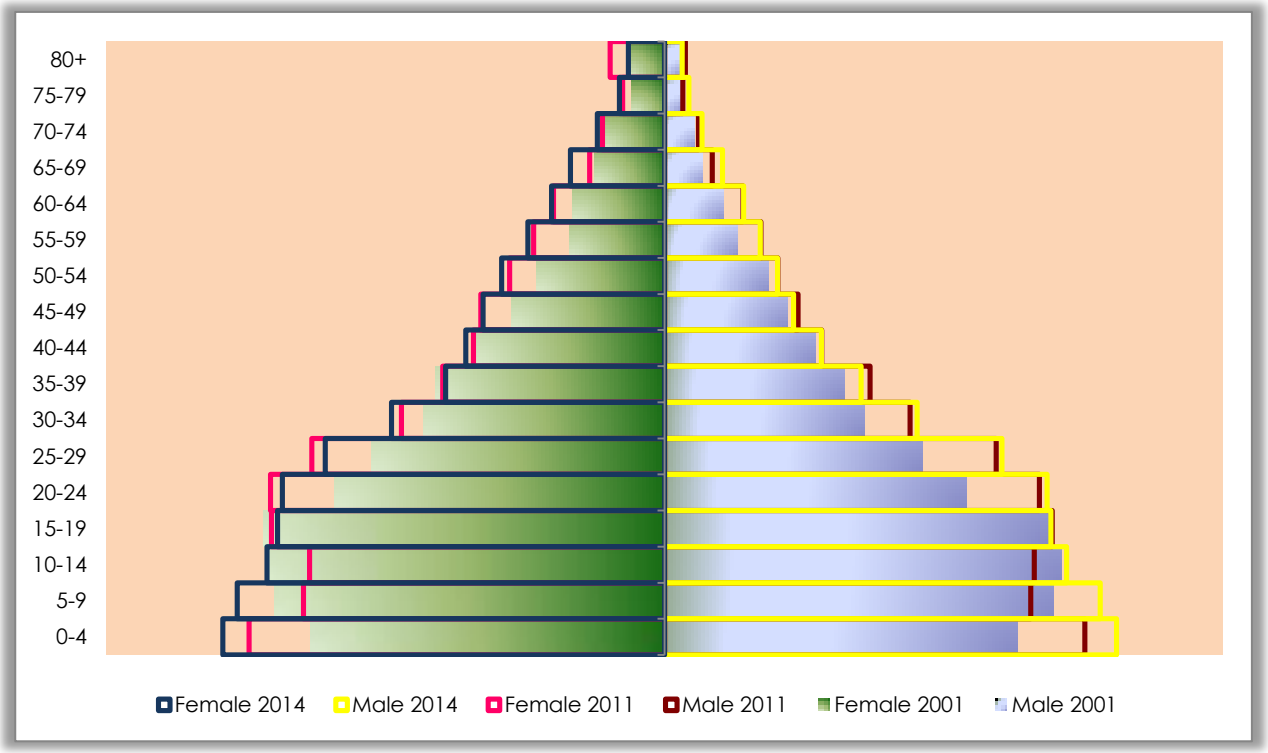
According to StatsSA, the Provincial population growth rate was 0.7% between 2001 and 2011 (2) and an estimated 1.8% between 2011 and 2013 (3).

Table 1: KZN demographic characteristics

Characteristics	2011	2014
Demographics		
KZN land surface	92 305 km^2	94 361 km^2
Share of SA land surface	7.6%	7.7%
Population		
Total Population	10 267 300	10 571 313
Uninsured population	9 137 897	9 378 989
Share of SA population	19.8%	19.8%
Gender Ratio		
Female	53.3%	52.2%
Male	46.7%	47.7%
Age Breakdown		
0-4 years	1 012 650	1 281 412
5-14 years	2 258 377	2 383 501
15-34 years	3 455 718	3 929 159
20-65 years	4 460 081	5 375 359
Population 65+ years	652 335	544 971

Source: Statistics South Africa Census 2011 and Mid-Year Population Estimates 2014 P0302

Figure 1: KZN population pyramid 2001 – 2014



Source: StatsSA: Census 2001 and 2011, 2014 mid-year population estimates, StatsSA (P0302)

The decline in fertility, combined with the increase in life expectancy (Table 2) impact on population ageing. The proportion of children under 15 years declines and the proportion of older persons (over 60 years) increases. The economically active population (15-59 years) is increasing which is an important factor and related to the potential for economic growth and basket of health services provided.

AIDS-related mortality, and the impact on the potential number of births, is still reshaping the age structure, with the reduced size of cohorts under the age of 15 years partly due to the deaths of an increased number of women during the reproductive age and the lower survival prospects of infected children.

Positive gains made in the reduction of mother to child transmission of HIV and increased access to ART however begun to show an impact on mortality trends related to HIV and related infections.

Table 2: Fertility rate and life expectancy at birth

	KwaZulu-Natal		South Africa	
	2001	**2014**	**2001**	**2014**
Fertility Rate				
	3.53	2.98	2.71	2.57
Life Expectancy at Birth				
Male	45.7	54.4	50	59.1
Female	50.2	59.4	55.2	63.1

Source: Stats SA Census 2001 and Mid-Year Population Estimates 2014, Statistical Release P0302

Table 3: Projected Population in KwaZulu-Natal 2011 - 2019

District	2011 (Census)	2013 DHIS	2014 DHIS	2015 Estimate	2016 Estimate	2017 Estimate	2018 Estimate	2019 Estimate
Ugu	722 484	733 228	741 541	750 215	759 134	767 181	775 248	783 388
Umgungundlovu	1 017 763	1 052 730	1 069 658	1 087 086	1 104 912	1 122 870	1 140 817	1 152 796
Uthukela	668 848	682 798	689 122	695 671	702 395	709 071	715 411	722 922
Umzinyathi	510 838	514 217	518 409	522 804	527 386	531 535	535 498	541 121
Amajuba	499 839	507 468	514 977	522 638	530 447	538 982	546 989	552 732
Zululand	803 575	824 091	834 251	844 531	854 893	866 095	876 743	885 949
Umkhanyakude	625 846	638 011	643 759	649 644	655 617	660 933	666 120	673 114
Uthungulu	907 519	937 793	947 925	958 267	968 620	978 488	988 079	998 454
Ilembe	606 809	630 464	640 790	651 445	662 413	673 017	683 610	690 788
Harry Gwala	461 419	471 904	478 536	485 309	492 203	499 599	506 528	511 929
eThekwini	3 442 361	3 464 205	3 492 345	3 520 558	3 548 516	3 577 005	3 604 697	3 642 546
KwaZulu-Natal	**10 267 300**	**10 456 909**	**10 571 313**	**10 688 168**	**10 806 536**	**10 924 776**	**11 039 740**	**11 155 657**

Source: 2011 (Census 2011); 2013 & 2018 (StatsSA Mid-Year Population Estimates as included in the DHIS).

- Rural Development Nodes (including Umzimkhulu Municipality in Harry Gwala) highlighted in light green.
- Projected population makes provision for declining fertility rates, and serves as estimated baseline for the 5-year planning period. Population will be reviewed/ adjusted annually during the 5 year planning period based on mid-year population estimates published by StatsSA.

Table 4: Projected Uninsured Population in KwaZulu-Natal 2011 – 2019

Districts	Uninsured Population	2011	2013	2014	2015 Estimate	2016 Estimate	2017 Estimate	2018 Estimate	2019 Estimate
Ugu	90.8%	656 015	665 771	673 321	681 195	689 294	696 600	703 925	711 316
Umgungundlovu	80.3%	817 264	845 342	858 935	872 930	887 244	901 665	916 076	925 695
Uthukela	93.7%	626 711	639 782	645 707	651 844	658 144	664 400	670 340	677 378
Umzinyathi	91.2%	465 976	468 966	472 787	476 797	480 976	484 760	488 374	493 502
Amajuba	88.2%	440 858	447 587	454 210	460 967	467 854	475 382	482 444	487 510
Zululand	91.8%	737 681	756 516	772 490	775 279	784 792	795 075	804 850	813 301
Umkhanyakude	95.1%	595 180	606 748	612 212	617 811	623 492	628 547	633 480	640 131
Uthungulu	84.2%	765 947	789 622	798 153	806 861	815 578	823 887	831 963	840 698
Ilembe	90.8%	550 983	572 461	581 836	591 512	601 471	611 099	620 718	627 236
Harry Gwala	92.1%	424 967	435 095	440 730	446 970	453 319	460 131	466 512	471 487
eThekwini	74.2%	2 554 231	2 570 440	2 591 322	2 612 254	2 632 999	2 654 137	2 674 685	2 702 769
KwaZulu-Natal	**87.7%**	**9 004 422**	**9 170 709**	**9 277 387**	**9 373 523**	**9 477 332**	**9 581 029**	**9 681 852**	**9 783 511**

- Uninsured population: Used estimated uninsured population(s) from the District Health Barometer 2012/13 (4).
- Rural Development Nodes (including Umzimkhulu Municipality in Harry Gwala) highlighted in light green.
- Although universal access (national/ provincial vision) includes both insured and uninsured people, the immediate challenge remains to improve access to the significant proportion of uninsured people in the Province. For that reason, the uninsured population will be used as one of levers to determe demand and supply.

6.1.2 Socio-economic Profile

Poverty is inextricably associated with disease and closely linked with the synergies of malnutrition, HIV and Tuberculosis (TB). Food insecurity leads to poor nutrition, which affects functioning of the immune system leading to increased susceptibility to disease (including HIV and TB). Food insecurity has been associated with increased HIV transmission rates, under-nutrition with poor prognosis in HIV and TB infection, and one of the reasons for non-adherence to anti-retroviral treatment (ART). Bates et al 2005 associated low body mass and food shortages with TB infection and progression from infection to the disease.

The inter-related complexities of poverty and deprivation therefore compel multi-sectoral community-based development interventions with robust monitoring and evaluation to determine the impact of interventions on disease outcomes. *This has been prioritised as part of the integrated implementation of the Provincial Growth and Development Plan (PGDP), Operation Sukuma Sakhe (OSS), and the KZN Poverty Eradication Master Plan under leadership of the Premier of KwaZulu-Natal.*

Of the 880 623 indigent households in KZN, 594 638 (68%) receive indigent water support and 172 780 (20%) indigent electricity support (10). Access to services shows a significant improvement between 2001 and 2013 (Table 5).

Table 5: Social determinants of health

	2001	2011
Households in KZN		
Number of households	2 117 274	2 539 429
Average household size	4.4	3.9
Socio-Economic Determinants		
Average household income	R 38 905	R 83 050
Unemployment rate	49%	33%
Youth unemployment rate	-	42.1%
Informal housing (households)	226 174	211 546
Access to Basic Services (Household)		
Households using electricity for cooking	1 008 491 *(47.6%)*	1 743 283 *(68.6%)*
Households with no access to piped water	582 600 *(27.5%)*	357 398 *(14.1%)*
Blue Drop Score	*65% (2010)*	*92.9% (2012)*
Households with no sanitation	339 497 *(16%)*	159 070 *(6.3%)*
Households with no refuge removal	219 673 *(10.4%)*	151 203 *(6%)*
Social Determinants		
Female-headed households	46.5%	46.6%
Child-headed households	0.8%	0.9%
Education		
Population 5-24 years not attending school	1 271 135	1 060 805

Source: Census 2011 Report No. 03-01-53

An estimated 306 076 households reside in a number of informal settlements in KZN (5). Of these households, an estimated 78% (239 436) reside in eThekwini (6). *This is particularly significant for service delivery including social determinants of health e.g. water, sanitation, waste removal, electricity, etc.*

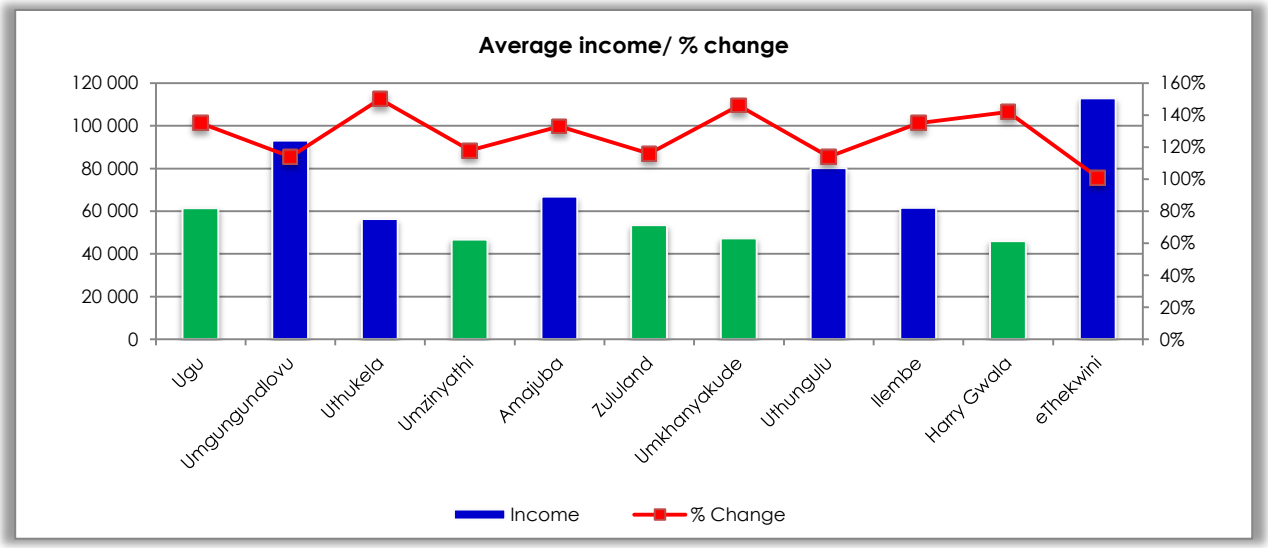
According to the GHS 2011, 25% of people dependent on social grants and social relief packages live in KZN with more than half (53%) of these recipients being female (5). In 2012, more than one-third of individuals in the province (36.1%) were grant beneficiaries translating to more than 3.7 million people; and 49.9% of households benefited from grants translating to more than 1.2 million households (5).

Children are still disproportionately affected by poverty with nearly three-quarters (73.5%) of children in the province living in poor households compared to 64.5% nationally. The percentage of children in households where no adults were employed increased from 38.2% (2001) to 40.6% (2012) compared to 32.4% nationally. The percentage of children that lived in households that reported hunger decreased from 37.3% (2001) to 16.9% (2012), and 34.3% of children lived in households that experienced inadequate or severely inadequate access to food compared to 30.6% nationally (8).

According to the 2009 Saving Childrens Report, 60% of children who die are malnourished and 50% have clinical evidence of AIDS (9), and the SANHANES-1 report shows that 15.8% of children are stunted and 5.3% wasted. The underweight for age under 5 years decreased from 19.4/1000 (2010/11) to 14/1000 in 2013/14 (DHIS).

Of the working age population in the province, 33.7% are employed either formally or informally compared to 39% in South Africa (7). The average household income in the Province increased from R38 905 in 2001 (ranging between R18 952 in Harry Gwala and R56 220 in eThekwini) to R83 050 in 2011 ranging between R45 903 in Harry Gwala to R112 830 in eThekwini (Graph 1).

Graph 1: Average household income 2012

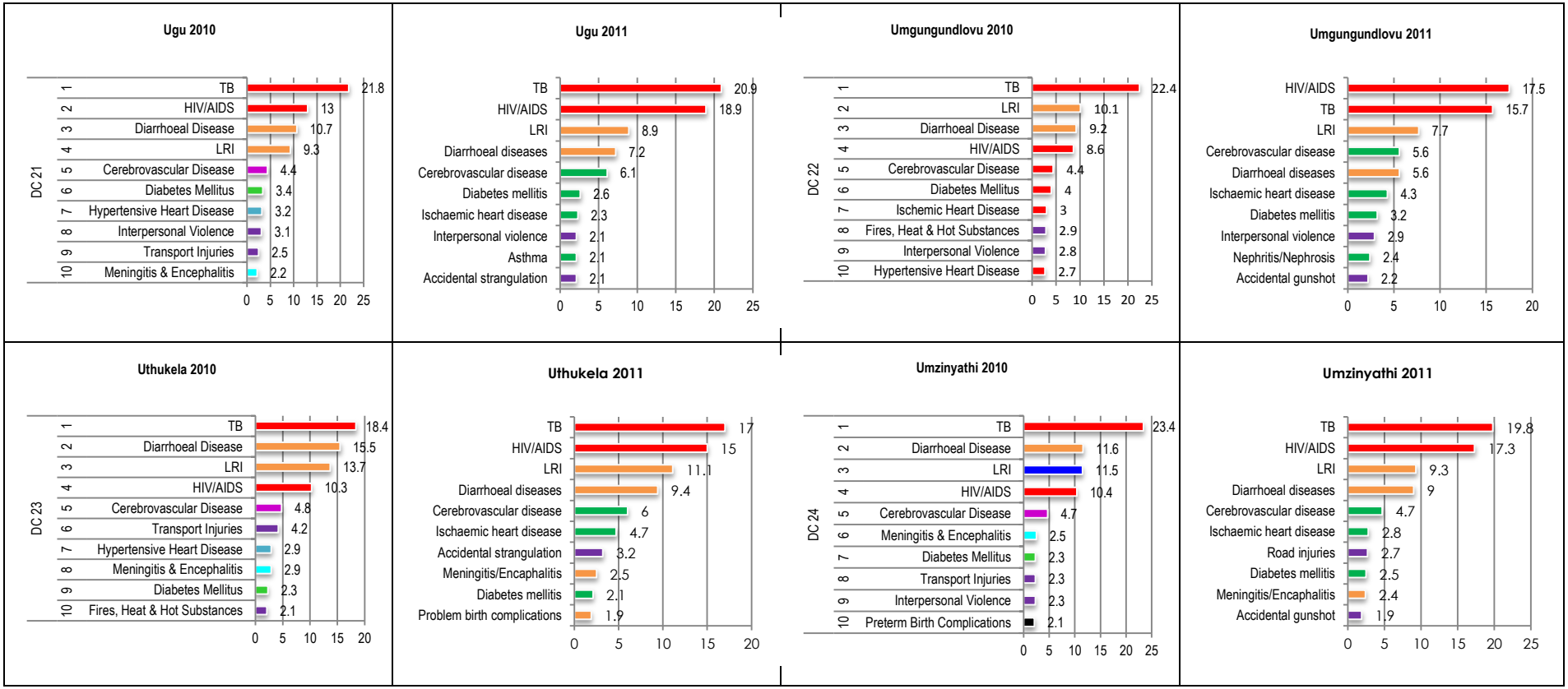


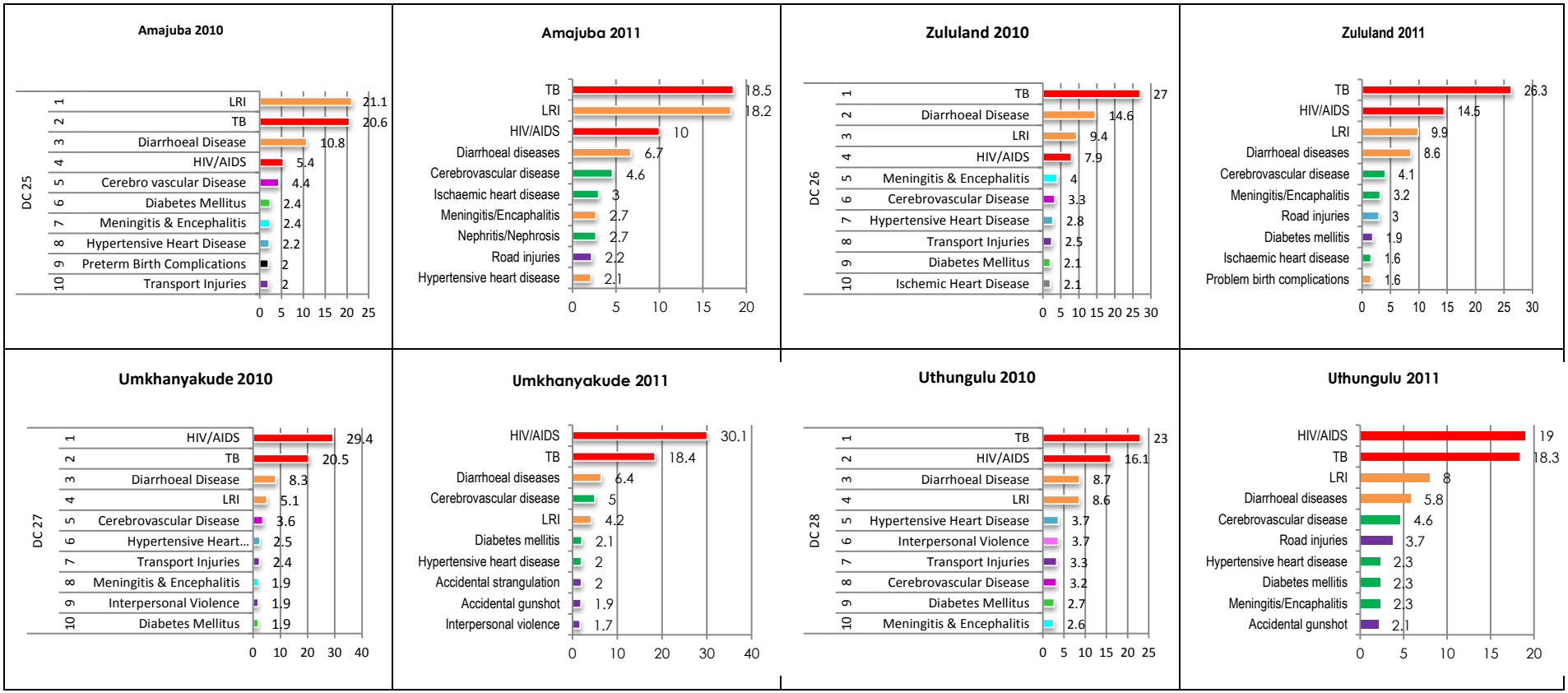
Source: Quantec Baseline

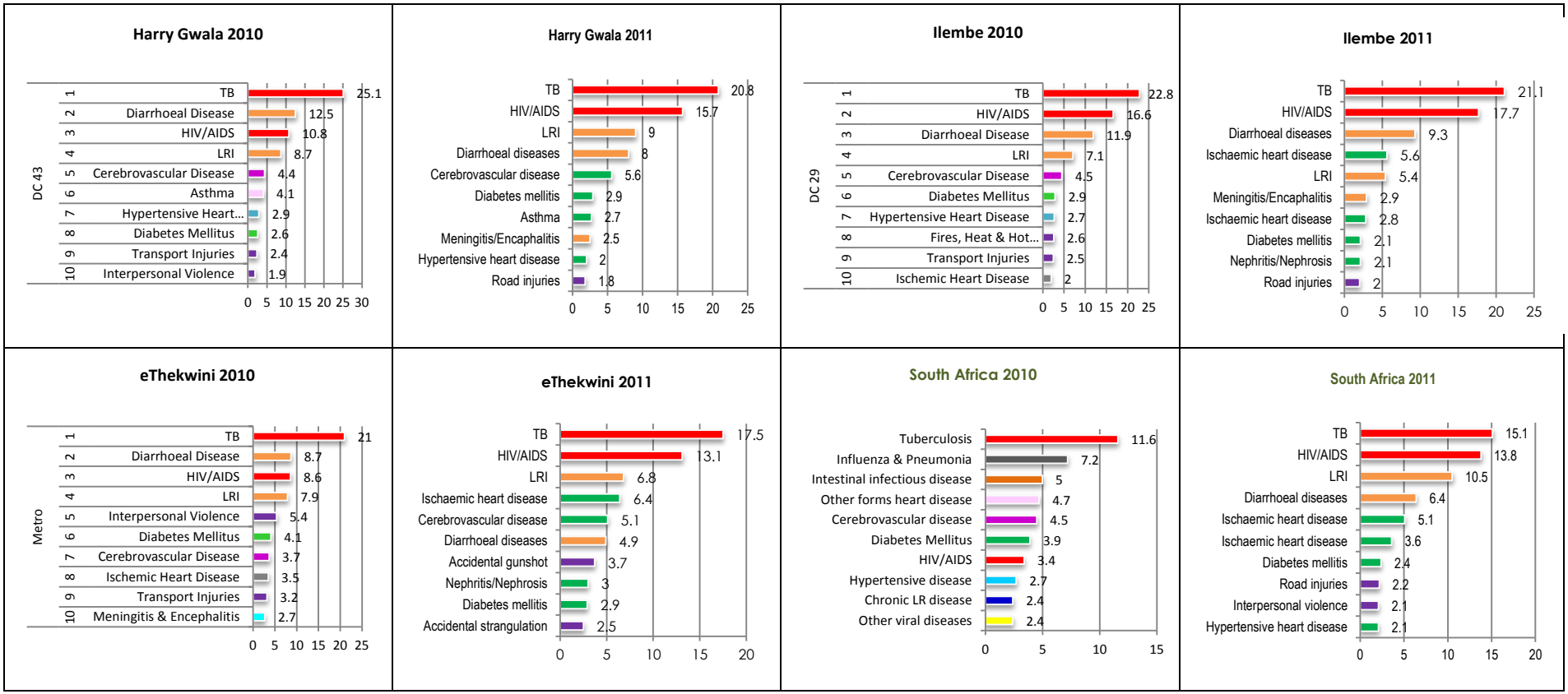
Note: Rural Development Nodes indicated in green bars

6.1.3 Epidemiological Profile

Figure 2: Ten leading causes of Years of Life Lost per District 2010 and 2011




Amajuba 2010
DC 25
1 LRI 21.1
2 TB 20.6
3 Diarrhoeal Disease 10.8
4 HIV/AIDS 5.4
5 Cerebro vascular Disease 4.4
6 Diabetes Mellitus 2.4
7 Meningitis & Encephalitis 2.4
8 Hypertensive Heart Disease 2.2
9 Preterm Birth Complications 2
10 Transport Injuries 2
0 5 10 15 20 25
Amajuba 2011
TB 18.5
LRI 18.2
HIV/AIDS 10
Diarrhoeal diseases 6.7
Cerebrovascular disease 4.6
Ischaemic heart disease 3
Meningitis/Encaphalitis 2.7
Nephritis/Nephrosis 2.7
Road injuries 2.2
Hypertensive heart disease 2.1
0 5 10 15 20
Zululand 2010
DC 26
1 TB 27
2 Diarrhoeal Disease 14.6
3 LRI 9.4
4 HIV/AIDS 7.9
5 Meningitis & Encephalitis 4
6 Cerebrovascular Disease 3.3
7 Hypertensive Heart Disease 2.8
8 Transport Injuries 2.5
9 Diabetes Mellitus 2.1
10 Ischemic Heart Disease 2.1
0 5 10 15 20 25 30
Zululand 2011
TB 26.3
HIV/AIDS 14.5
LRI 9.9
Diarrhoeal diseases 8.6
Cerebrovascular disease 4.1
Meningitis/Encaphalitis 3.2
Road injuries 3
Diabetes mellitis 1.9
Ischaemic heart disease 1.6
Problem birth complications 1.6
0 5 10 15 20 25 30
Umkhanyakude 2010
DC 27
1 HIV/AIDS 29.4
2 TB 20.5
3 Diarrhoeal Disease 8.3
4 LRI 5.1
5 Cerebrovascular Disease 3.6
6 Hypertensive Heart... 2.5
7 Transport Injuries 2.4
8 Meningitis & Encephalitis 1.9
9 Interpersonal Violence 1.9
10 Diabetes Mellitus 1.9
0 10 20 30 40
Umkhanyakude 2011
HIV/AIDS 30.1
TB 18.4
Diarrhoeal diseases 6.4
Cerebrovascular disease 5
LRI 4.2
Diabetes mellitis 2.1
Hypertensive heart disease 2
Accidental strangulation 2
Accidental gunshot 1.9
Interpersonal violence 1.7
0 10 20 30 40
Uthungulu 2010
DC 28
1 TB 23
2 HIV/AIDS 16.1
3 Diarrhoeal Disease 8.7
4 LRI 8.6
5 Hypertensive Heart Disease 3.7
6 Interpersonal Violence 3.7
7 Transport Injuries 3.3
8 Cerebrovascular Disease 3.2
9 Diabetes Mellitus 2.7
10 Meningitis & Encephalitis 2.6
0 5 10 15 20 25
Uthungulu 2011
HIV/AIDS 19
TB 18.3
LRI 8
Diarrhoeal diseases 5.8
Cerebrovascular disease 4.6
Road injuries 3.7
Hypertensive heart disease 2.3
Diabetes mellitis 2.3
Meningitis/Encaphalitis 2.3
Accidental gunshot 2.1
0 5 10 15 20



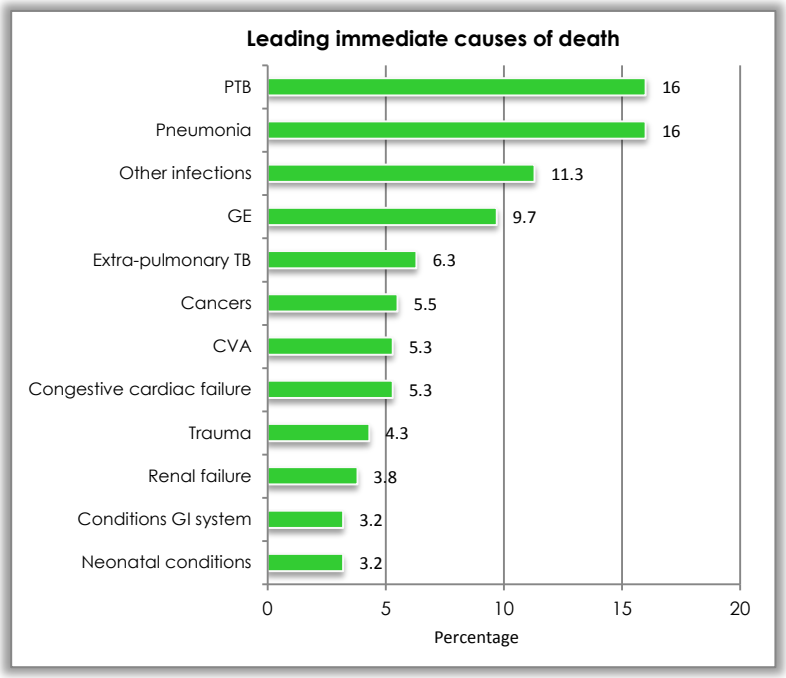
Source: District Health Barometer 2012/13 and 2013/14

According to the KZN Hospital Survey 2011 (11), 39% of patients admitted to public hospitals are admitted for infectious diseases; 37.4% for non-communicable conditions; and 23.6% for injuries. Nearly one third (24.3%) of female admissions is for normal vaginal delivery. Admissions with HIV as primary condition are rare, with most patients admitted with infections such as TB and pneumonia (22%) as primary cause and HIV as underlying cause.

The burden of HIV is shared at District and Regional Hospital levels with 57.5% of HIV positive patients admitted in District Hospitals (25% of total admissions) and 42.5% in Regional Hospitals (20% of total admissions) ($p<.001$).

The five most common immediate causes of death in public hospitals were infectious diseases (59.3%). HIV infection was an underlying cause of death in 44.2% of deaths, while hypertension (6.7%) and diabetes (4.4%) recorded as the other main underlying diseases. TB remains by far the most common cause of death in KZN (Graph 2).

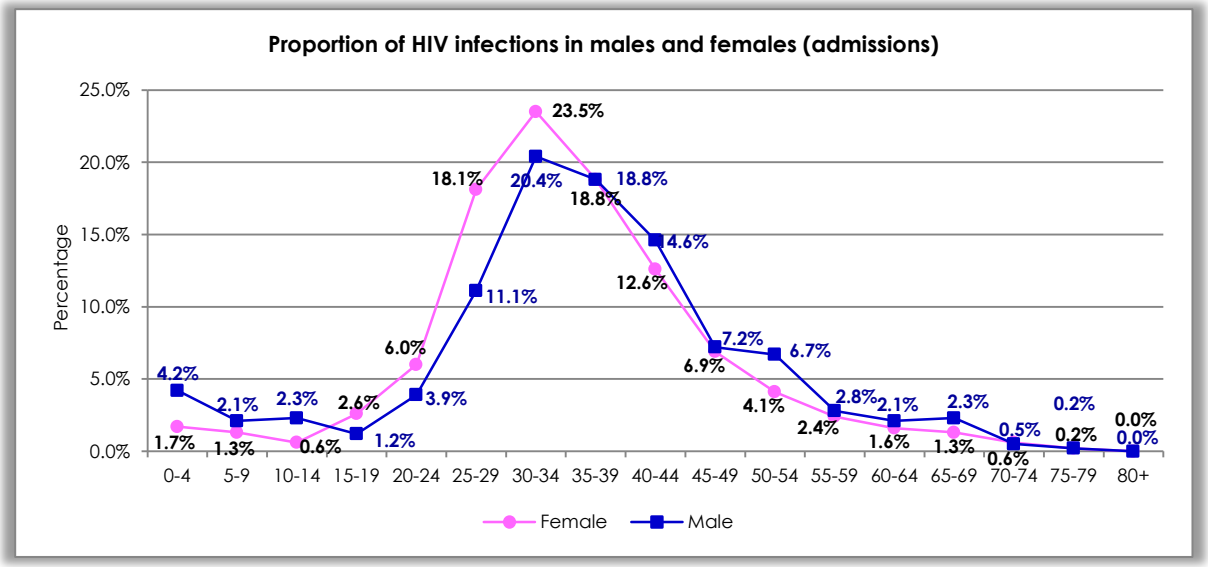
Graph 2: Immediate causes of death in KZN facilities



Source: Extracted from the KZN Hospital Survey, 2011

Patient profiles of admissions in Public Hospitals mirror several other studies showing an earlier peak of HIV infection in females, with males showing a higher proportion of HIV infection after the age of 40 years (Graph 3). Early sexual debut and unsafe sexual practices are considered contributory factors. *For that reason, the Department will scale up implementation of programmes for sexual, reproductive and youth health.*

Graph 3: Proportion HIV infections in males and females in hospital admissions



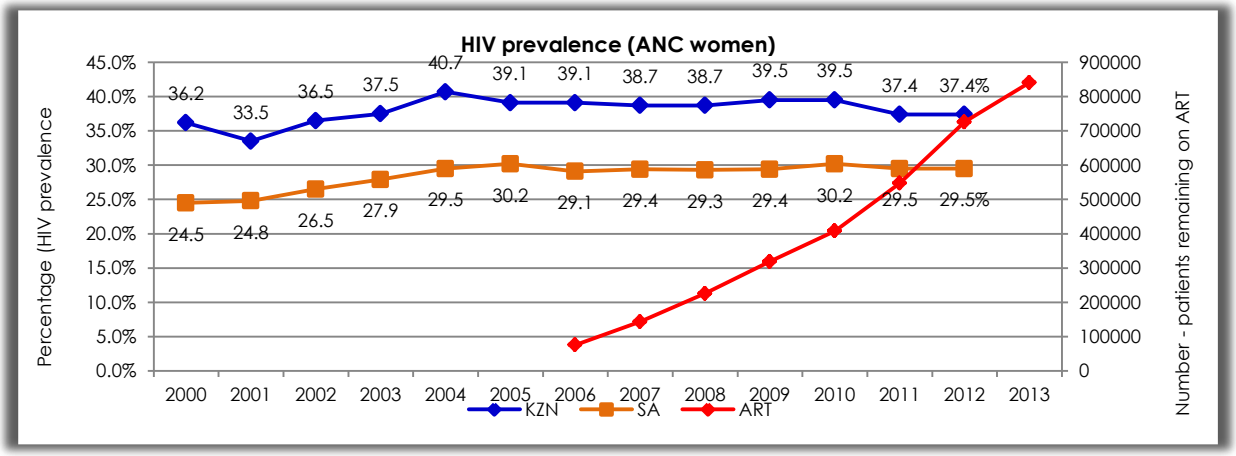
Source: Extracted from the KZN Hospital Survey, 2011

HIV, AIDS and STIs

KwaZulu-Natal carries the largest burden of HIV and related infections in South Africa, with the HIVTB co-infection rate estimated at approximately 70%. The high burden of HIV and AIDS, STI and TB places unparalleled demands on the health system, with the number of people remaining on ART increasing from 76 000 in 2006 to 840 738 at the end of March 2013 (Graph 4).

The Province continues to report the highest HIV prevalence among pregnant women for the past 13 years (Graph 4), reporting 37.4% (95% CI 36-38.7) in 2012 compared to 29.5% (95% CI 28.8-30.2) nationally (12).

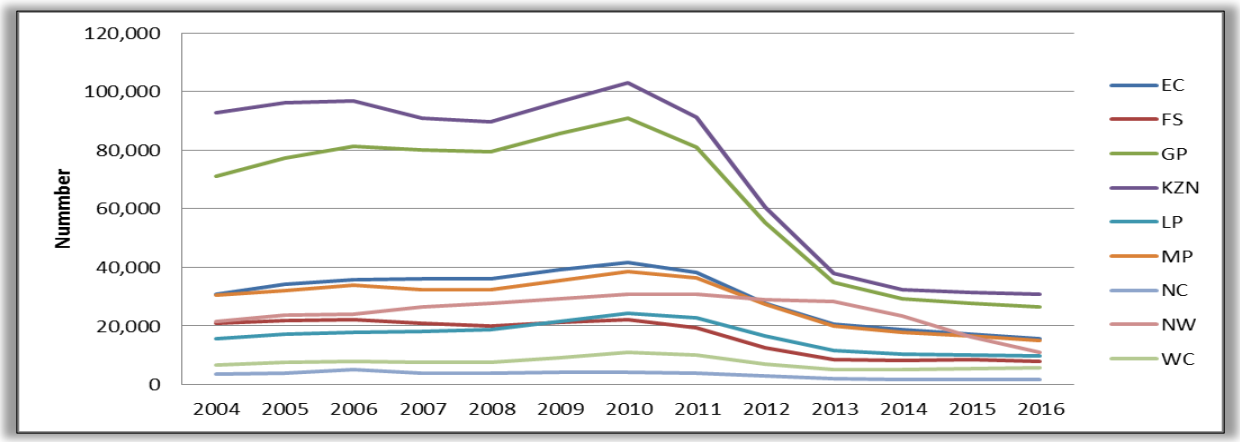
Graph 4: HIV prevalence (ANC women) and patients remaining on ART



Source: National Antenatal HIV Survey

The Provincial AIDS related deaths show a significant decrease since 2010 (UNAIDS Report) as illustrated in Graph 5. This is relevant to the reported increase in life expectancy at birth; the HIV prevalence among pregnant women which is showing signs of stabilizing for the past 6 years; and the significant drop in mother to child transmission of HIV as confirmed by the 2013 MRC Report.

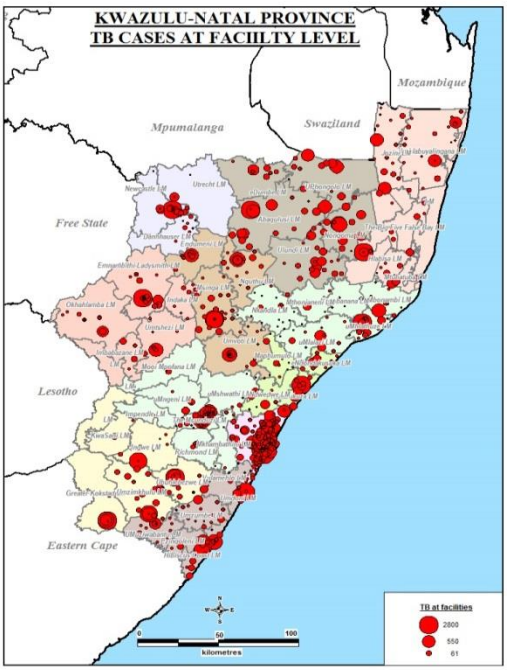
Graph 5: Annual Provincial AIDS deaths (2004 – 2016)



Tuberculosis

South Africa is among the World Health Organisation (WHO) 22 high burden countries for Tuberculosis (TB) which is estimated to be responsible for approximately 80% of global TB cases. The country has the highest incidence of TB (993 per 100 000 population) in the world and one of the largest drug-resistant TB epidemics globally. The incidence is much higher in high risk concentrated settings such as mines and prisons with an estimated incidence of 3 000 and 7 000 per 100 000 respectively.

Map 2: TB "Hot Spots" in fixed facilities



KwaZulu-Natal has the highest HIV and TB disease burden in SA with an estimated HIV/TB co-infection rate of 70%. The provincial TB notification per 100 000 population decreased from 1 128 (2011) to 898 in 2013 (Table 6).

Drug-resistant TB is increasing with a current incidence of 26.8 per 100 000 population. The mortality rates among MDR TB/HIV co-infected patients are exceedingly high (71% one year mortality) with approximately 15% of MDR TB/HIV co-infected patients receiving ART at the time of their diagnosis.

The principal driver of this rapid rise in MDR-TB cases appears to be nosocomial transmission to highly vulnerable HIV-infected patients. O'Donnell, et al [28] reviewed admissions for MDR and XDR TB from 2003 to 2008 at King Dinuzulu Hospital. They found that 4 941 people were hospitalised, 231 of whom were health care workers. The high number of health care workers showed that

occupational transmission could play a role in the transmission of MDR TB.

The above places high demands on infrastructure development to ensure a safe environment for both patients and staff. Health facilities do not (in general) comply with infection prevention and control specifications and thus being prioritised within a limited funding envelope.

Table 6: TB notification rate per 100 000 population

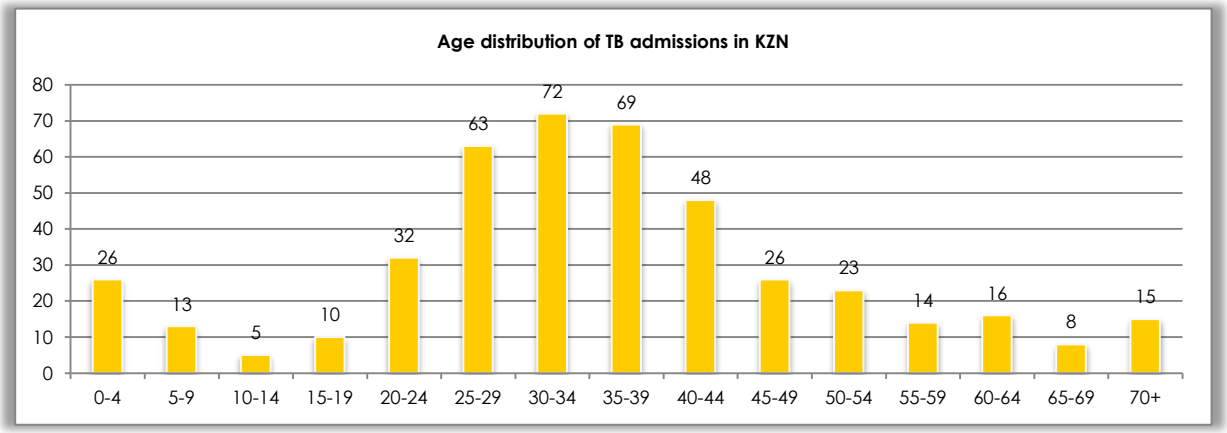
District	TB notification rate per 100 000 population		
	2011	2012	2013
Ugu	1 410	1 221	1 046
Umgungundlovu	1 100	884	831
Uthukela	782	686	686
Umzinyathi	1 000	810	677
Amajuba	730	654	506
Zululand	1 192	940	890
Umkhanyakude	1 145	907	850
Uthungulu	1 141	1 131	1 005
Ilembe	1 110	877	699
Harry Gwala	1 172	1 043	868
eThekwini	1 212	1 103	1 030
KZN	**1 128**	**1 016**	**897**

Source: ETR.Net – TB Programme

Note: Rural Development Nodes (including Umzimkhulu in Harry Gwala) highlighted in light green.

The majority of patients admitted for TB in KZN public hospitals (66.8%) are between 16 and 44 years old (Graph 6), while 71.7% of patients who had a primary admission for TB were also found to be HIV positive (p<.001) (11).

Graph 6: Age distribution of TB admissions in KZN



Source: Extracted from KZN Hospital Survey, 2011

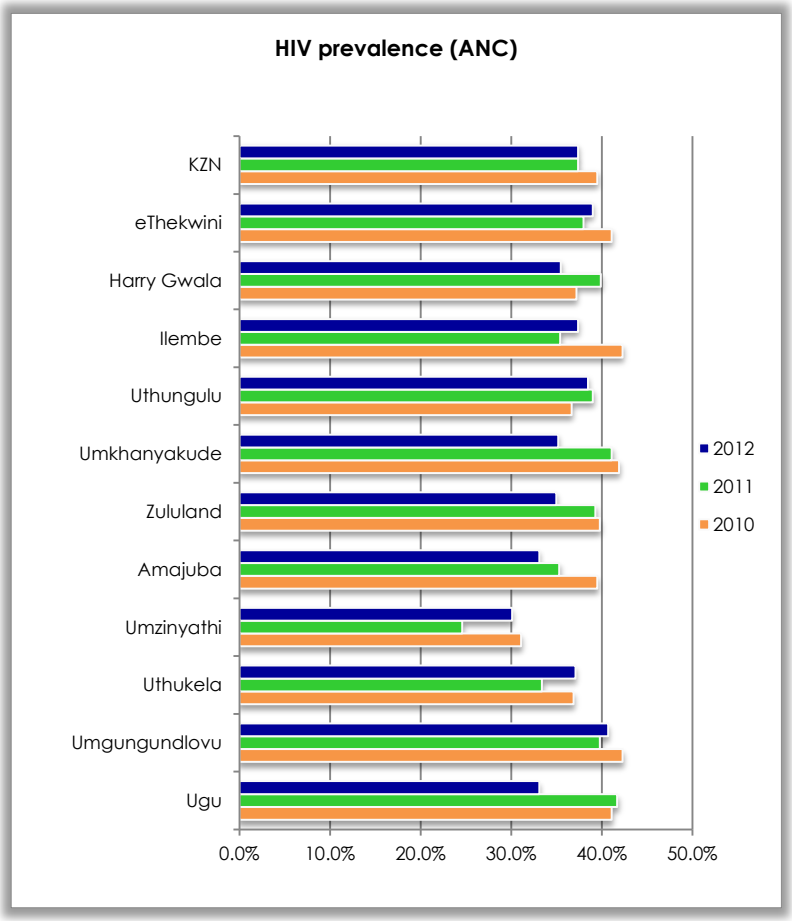
Maternal, Neonatal, Child & Women's Health and Nutrition

The institutional maternal mortality ratio (iMMR) in KZN shows a consistent decline between 2010 and 2013 from 195/100 000 live births (353 deaths) in 2010 to 147/100 000 live births (280 deaths) in 2013 (DHIS). The reported underlying causes of death include non-pregnancy related infections (43.1%); obstetric haemorrhage (12.4%); medical/surgical disorders (12.4%); hypertension (9.7%); and miscarriage (5.8%) (14).

The number of deliveries in public health facilities shows an insignificant increase between 2010 and 2013 (0.4%), although the deliveries to women under the age of 18 years increased with 1 124 or 6.8%. Approximately 40% of all deliveries occur in Regional and Tertiary Hospitals, 50% in District Hospitals and the remainder in PHC clinics and CHCs.

HIV prevalence rates stabilised since 2011, although there is significant variation in HIV prevalence rates between districts in KZN (Graph 7).

Graph 7: HIV prevalence (ANC)



Source: National ANC HIV Survey

Almost 5% of babies born in the Province have a birth weight below 2 000 grams and thus require admission to a neonatal nursery. More than 3 000 babies do not survive the neonatal period with a

neonatal mortality rate of 10.3/1000 (2013/14) and 65% of deaths occurring in District Hospitals. The early facility neonatal mortality ranges between 3.6/1000 in Amajuba to 19.1/1000 in Umgungundlovu.

According to the 2011 Hospital Survey, the most common reasons for admission in children were gastroenteritis (21%), pneumonia (20%) and neonatal conditions (14%) including sepsis, jaundice, preterm delivery/low birth weight, respiratory distress syndrome and congenital pneumonia.

According to the Child Health Problem Identification Programme, the infant and under-5 mortality rates in KZN were 32.9 and 44.6 respectively (2010) which equates to 1 in 22 children born in the province dying before their fifth birthday. Over a third of these deaths (38.7%) occurred outside the health service, and amongst those deaths occurring in the public health sector 56.5% of infant deaths occurred in District Hospitals. Regardless of the level of care, 2.6% of children presenting to the public sector were dead on arrival at the facility, 31.5% of deaths occur within the first 24 hours of admission and a further 25.7% between the first and third day of admission i.e. 57.2% of childhood deaths occur within 72 hours of admission to a hospital. One third (33%) of the children who died were severely malnourished and just over half (55%) were known to be HIV infected or exposed. *This confirms the need for intensified and integrated community-based programmes.*

Facility-based infant and child mortality rates show a downward trend between 2010/11 and 2013/14 (DHIS):

- Inpatient death under 1 year rate decreased from 9.1% to 6.9% (ranging between 4.4% in eThekwini and 10.8% in Umgungundlovu and Uthungulu);
- Inpatient death under 5 year rate decreased from 7.6% to 5.5% (ranging between 4.1% in eThekwini and 8.3% in Uthungulu);
- Diarrhoea case fatality rate decreased from 7.1% to 3.3% (ranging between 0.9% in Amajuba and 5.6% in Umzinyathi);
- Pneumonia case fatality rate decreased from 5.4% to 3.2% (ranging between 0.8% in Amajuba and 6.5% in Zululand);
- Severe malnutrition case fatality rate decreased from 12.1% to 9.7% (ranging between 3.2% in Ilembe and 26.9% in Zululand).

Non-Communicable Diseases

The WHO reports that non-communicable diseases constituted 63% of all deaths in 2008 including cardiovascular disease (48%), cancers (21%), chronic respiratory diseases (12%) and diabetes (3%). It is estimated that deaths due to non-communicable diseases will increase by 17-24% in the African Region over the next 10 years.

According to the 2012 General Household Survey (7), 19.8% of the total South African population and 20% of the population in KZN suffer from chronic diseases (Table 7).

Table 7: Chronic diseases in the general population

	Hypertension	Arthritis	Diabetes	HIV/AIDS	Asthma	Other	Cancer
KZN	6.2%	3.4%	3.3%	2.7%	2.6%	1.6%	0.3%
SA	7.5%	2.5%	2.8%	1.9%	2.5%	2.2%	0.4%

Source: General Household Survey, 2012

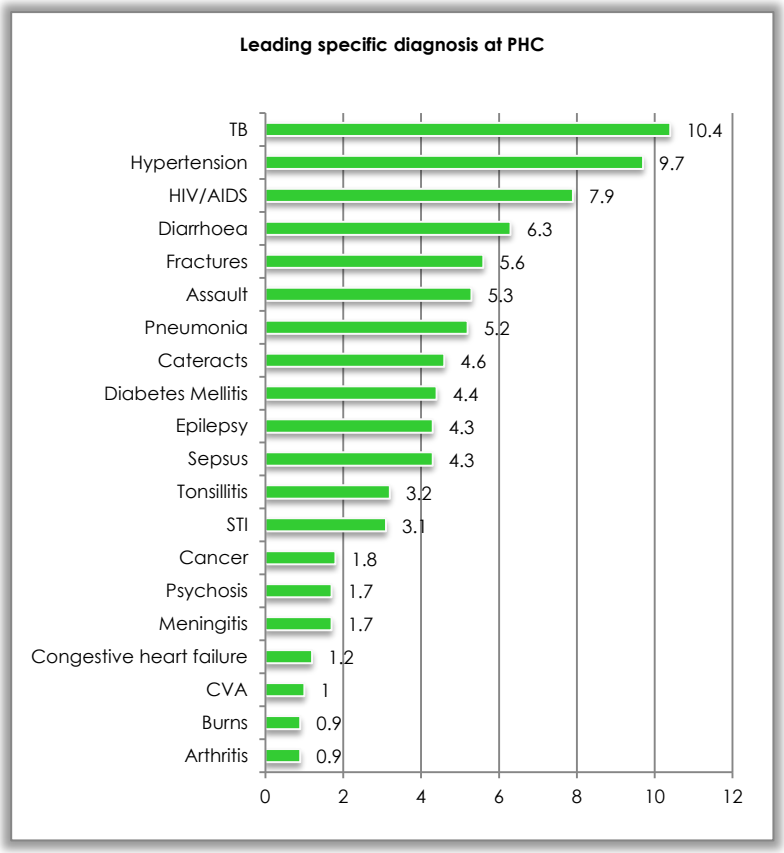
According to the KZN Hospital Survey, hypertension, cancer, diabetes (type 2 most common) and concurrent diabetes and hypertension are the most common non-communicable diseases admitted in KZN public health hospitals.

The most common cancers admitted in hospitals are cancer of the cervix, breast cancer and cancer of the oesophagus. Most cancers occurred after the age of 30.

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

Leading diagnosis at PHC facilities are reflected in Graph 8 which are in line with the KZN Hospital Survey (15).

Graph 8: Leading specific diagnosis at PHC



Source: PHC Survey 2010, KZN Department of Health

Mental Health

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

The co-morbidity between mental disorders, substance use disorders and physical conditions such as HIV/AIDS, heart disease, diabetes, trauma, etc. is significant with an estimated 43.7% of HIV infected individuals and 15-20% of perinatal mothers having a mental disorder.

Chronic mental disorders such as schizophrenia, bipolar disorder and major depressive disorder are independently associated with increased risk for metabolic syndrome, diabetes, heart disease and obesity.

Substance use disorders (including tobacco smoking and alcohol use) significantly increase the risk of cancer, heart disease, stroke, chronic pulmonary disease, liver disease (including hepatitis, cirrhosis and hepatic carcinoma), pancreatic disease (alcohol abuse) and renal disease (e.g. analgesic abuse), infectious diseases (such as Hep B and HIV due to mainlining heroin, etc.), and trauma-related injuries.

HIV/AIDS is associated with a significantly increased burden of neuropsychiatric disease and disability including depression, anxiety, psychosis and dementia. Mortality due to AIDS has a significant impact on especially children whom are orphaned and therefore placing them at increased risk for mental disorders.

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

Co-morbidity with other chronic physical conditions:

- Heart disease is associated with twice the risk for depression or anxiety disorders.
- 20-30% individuals post miocadial infarction have depression and untreated increases all-cause mortality and cardiac mortality by a factor of 2.4 and 2.6 respectively; while risk for a new cardiovascular event is increased by a factor of 1.95.
- Diabetes is associated with 1.5 times the risk for depression or anxiety disorders.
- Up to 30% of individuals' post-cardio vascular accident (stroke) develops depression.
- At 12-month follow-up after traumatic brain injury, 31% have a psychiatric disorder.

Specific groups of individuals are at increased risk for mental disorders. In a recent study in Durban (King Edward VIII Hospital), 400 antenatal women were screened for depression. In this sample, 38.5% of pregnant women were depressed and 38% had thought of harming themselves during the previous week. Being HIV+ was a significant risk factor for depression (16).

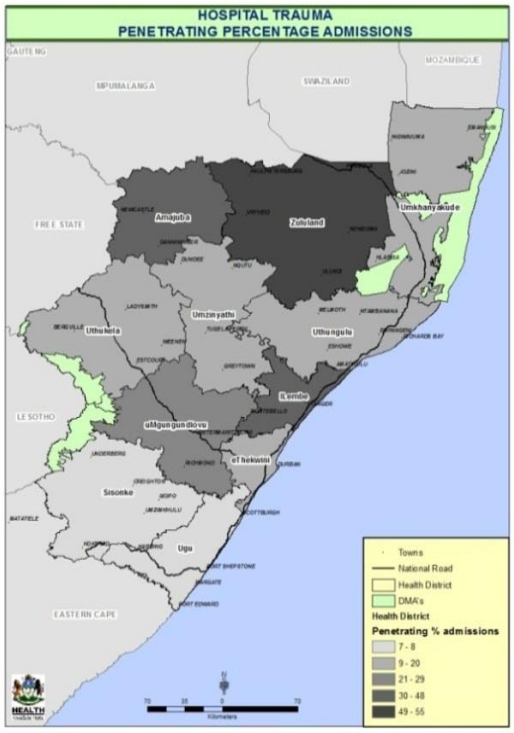
Intentional and Unintentional Injury

According to the 2011 Hospital Survey, the majority of admissions for injury (N=673) includes assault (35.5%), accidental injury (26.2%), motor vehicle accidents (19.6%), burns (8.9%), accidental poisoning (5.6%) and snake bites (4.2%). The pre-hospital trauma rate was approximately 11.6 per 1000 population and 12.9 per 1000 in public district and regional hospitals in 2010 (17). This equated to 100 000 EMS calls for trauma and around 160 000 visits per year in public hospitals in KZN. This has however been greatly exceeded with initial data (first 9 months) from the newly established provincial data-base.

The province established a limited data-set (Trauma Database) in April of 2012. Data from this dataset shows that the total trauma load for the public sector hospitals in KZN is 120 706 for the 9 months data prospectively captured, data including 41% interpersonal violence, 26% motor-vehicle related trauma and 33% non-intentional injury. Extrapolating this to a full year and including a 10% month-on-month variance suggests approximately 166 071 total trauma cases for 2012. Comparing this to the 2010 data it would imply an annual increase of 2% per year if the extrapolated value of around 160 000 is taken.

Maps 3 and 4, developed by the GIS Component using DHIS data, illustrate the burden of trauma in districts in KZN based on historical data.

Map 3: Trauma – Penetrating admissions



Map 4: Trauma – MVA admissions

Malaria

Approximately 10% of the total SA population lives in malaria endemic areas (Limpopo, Mpumalanga and KwaZulu-Natal). Three districts in KwaZulu-Natal (Umkhanyakude, Zululand and Uthungulu) are endemic to malaria, with approximately 2.5 million people (or ±22.7%) at risk of contracting the disease.

Between 2000 and 2010, malaria cases in South Africa declined by 89.41% (63 663 to 6 741 cases) and deaths decreased by 85.4% (453 to 66 deaths). South Africa (and KZN) exceeded the MDG target for 2015, and the WHO identified SA to enter the elimination phase of malaria control.

Between 2000 and 2010, the province reported the largest reduction (compared to other endemic areas) in new malaria cases (99.1% or 41 786 to 380 cases) and deaths (98.5% or 340 to 5 deaths).

A series of interventions have contributed to the decrease in incidence including drug policy changes from monotherapy to artemisinin combination therapy; insecticide change from pyrethroids back to DDT; cross border collaboration (South Africa with Mozambique and Swaziland through the Lubombo Spatial Development Initiative); and financial investment in the malaria control programmes.

Although there seems to be a gradual decrease in the number of cases since 2010/11, the increase in imported cases will be closely monitored.

6.1.4 Progress towards the Health-Related Millennium Development Goals

Table 8 : Millennium Development Goals

MDG Goal	Target	Indicator	Data Source for 2009 baseline	Baseline 2009	Progress (2014)	Target 2019/20
Goal 1 Eradicate extreme poverty and hunger	Halve, between 1990 and 2015, the proportion of people who suffer from hunger	Prevalence of underweight children (under five years)	DHIS	26.3/1000	14/1000 [1]	6/1000
Goal 4 Reduce child mortality	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Under-five mortality rate	StatsSA and Rapid Surveillance Report	67/1000	42.6/1000 [2]	40/1000
		Infant mortality rate		45/1000	31.6/1000	29/1000
		Proportion of one-year-old children immunised against measles	DHIS	87.3%	84.5%	
Goal 5 Improve maternal health	Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate	Maternal mortality ratio	Confidential Enquiries into Maternal Deaths in SA 2005-2007	169.78/ 100 000	147/100 000 live births [3]	100/ 100 000 live births
		Proportion of births attended by skilled health personnel	SADHS 2003	91.1%	84.3% [4]	100%

[1] Used underweight for age under 5 years incidence as proxy (DHIS). The indicator refers to facility data for children under the age of 5 years that were treated in public health services
[2] The impact of HIV and AIDS on child mortality is still significant and although there is a reduction in both indicators the Department will not be able to achieve the 2014/15 MDG targets
[3] Institutional maternal mortality ratio used as proxy (DHIS)
[4] Delivery rate in facility used as proxy (DHIS)

MDG Goal	Target	Indicator	Data Source for 2009 baseline	Baseline 2009	Progress (2014)	Target 2019/20
Goal 6 Combat HIV and AIDS, Malaria and other diseases	Have halted by 2015, and begin to reverse the incidence of HIV/AIDS, Malaria and other major diseases	HIV prevalence among 15 to 24 year old pregnant women	National HIV and Syphilis Prevalence Survey of South Africa 2011		25.8% (2012)	24%
		Contraceptive prevalence rate	SADHS [5] 2003	76.8%	45% [6]	75%
		Proportion of TB cases detected and cured under directly observed treatment short-course (DOTS)	ETR.Net	62.9%	81.8% [7]	85%

6.1.5 Performance Overview: Negotiated Service Delivery Agreement 2010-2014

Output 1: Increasing Life Expectancy

The increase in life expectancy is a good measure of mortality at all ages. The health sector is just one of many contributors to increasing life expectancy, which depends on a wide variety of other factors including broader development policies and other social, economic and environmental determinants of health. It is therefore better seen as an overarching measure of all aspects of development including but not limited to health. All sub-outputs are adding value to Output 1.

Sub-Output 1.1: Strengthened Governance Arrangements

Governance structures were strengthened with the establishment of the Provincial Health Council (12 August 2012) and appointment of 5 District Health Councils (2013) including Amajuba (April); Uthungulu (April); Umkhanyakude (July); Harry Gwala (July) and Umgungundlovu (November). The annual Provincial Consultative Health Forum summits were hosted annually since 2010/11. Four Mental Health Review Boards were established in line with requirements of the Mental Health Care Act; 90% of hospitals have Hospital Boards; and 89.5% CHCs and 95.1% clinics have Clinic Committees.

[5] South African Demographic and Health Survey 2003
[6] Couple year protection rate used as proxy (DHIS) although it is not considered an ideal marker of contraceptive prevalence. The target is set for "couple year protection rate" to ensure regular reporting
[7] New smear positive PTB cure rate used as proxy.

Sub-Output 1.2: Eradication of Malaria

Table 9: Malaria performance measures

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

There are 3 Malaria Parasitology Laboratories, 39 decentralised malaria camps, 39/287 malaria surveillance agent teams for active surveillance, and rapid tests are available in Umkhanyakude (the main endemic district). Ongoing assessment of antimalarial drug efficiency confirmed that anti-malaria drugs are still effective with no signs of resistance.

The indoor residual spraying coverage (92%) is jeopardised by modernisation (furnishing in homes making it difficult to spray indoors). In 2012/13, the Department invested R2.4 million in insecticides; vehicles; contracting of a Consultant Entomologist; expanding vector species surveillance; reviving bioassays for insecticide resistance; servicing all equipment in parasitology laboratories; and training of all Malaria Microscopists/ Technicians by the National Institute for Communicable Diseases (NICD).

Sub-Output 1.3: Strengthening Response to Social Determinants of Health

Devolution of Municipal Health Services commenced in all districts and has been concluded in Harry Gwala (August 2012) and Amajuba (January 2013). Umkhanyakude (90%) and Umgungundlovu (70%) will be finalised in 2014/15. Ward-based coverage of households has been improved through implementation of the integrated Provincial Flagship Programme (Operation Sukuma Sakhe) and integrated implementation of the PGDP.

Sub-Output 1.4: Revitalisation of Emergency Medical Services

Table 10: Emergency Medical Services performance measures

Indicator	Baseline (2010/11)	Target (2014/15)	Performance (2013/14)	
1. Rostered ambulances per 10 000 people	0.22 (225 ambulances)	0.34 (383 ambulances)	0.20 (212 ambulances)	
2. EMS P1 rural response under 40 min rate	37%	80%	31%	
3. EMS P1 urban response under 15 min rate	29%	50%	6%	
4. EMS P1 call response under 60 min rate	53%	70%	44%	

The ambulance to population ratio (1:49 558) is far below the national norm of 1 ambulance per 10 000 population. To comply with the national norm, the Department would need an additional 754 ambulances to fill the current gap at an approximate cost of R527.8 million (±R 700 000 per ambulance).

Air Medical Services are provided by Air Mercy Services (AMS) using 2 rotor wing aircraft (helicopters) based at Richard's Bay and King Shaka Airports and 1 fixed wing aircraft. During 2013/14, night availability of the 2 rotor wing aircraft was introduced to improve night access.

Flying doctor services: All flying doctor service flights are coordinated out of Durban (King Shaka international airport). During 2013/14 a total of 229 Specialists supported 43 Hospitals.

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

Inter-facility transport: Although inter-facility transport covers all institutions, demand superseded supply in 2013/14, with 192 814 inter-facility transfers and 443 262 patient transports. Approximately 50% of all inter-facility transportation was emergency inter-facility transport (not planned patient transport) which contributed to poor response times.

During 2013/14, the Department introduced 12 new 60-seater buses of which 5 were converted to accommodate stretcher patients. This is expected to reduce the demand on the emergency ambulances as well as assist in cases of disaster or mass casualty incidents.

Planned Patient Transport (PPT): During 2013/14, the PPT hub system has been introduced in Empangeni, Durban and Pietermaritzburg to improve PPT coordination.

Ambulance bases: There are 72 ambulance bases, with the following infrastructure projects in 2013/14: Wentworth refurbishment (100% complete); King Dinuzulu Medium Base (design phase); and Dannhauser Medium Base (CHC), Pomeroy Small Base (CHC) and Jozini Medium Base (CHC) in construction phase. The Umzinyathi large base project has not commenced as planned in 2013/14 as a result of budget cuts in Programme 8. The project has been re-prioritised for 2016/17.

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

Output 2: Decreasing Maternal and Child Mortality

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

Table 11: Child health performance measures

Indicator	Baseline (2010/11)	Target (2014/15)	Performance (2013/14)	
1. Child under 5 severe acute malnutrition case fatality rate	12.1%	10.2%	9.7%	
2. Child U5 diarrhoea case fatality rate	7.1%	3.6%	3.3%	
3. Child U5 pneumonia case fatality rate	5.4%	2.9%	3.2%	
4. Underweight for age U5 years incidence	19.4 per 1000	15 per 1000	14 per 1000	
5. Child U5 years severe acute malnutrition incidence	7 per 1000	6 per 1000	5.6 per 1000	
6. Vitamin A 12 – 59 months coverage	32.6%	51% in all districts	47.8% (2 less than 51%)	
7. Immunisation under 1 year coverage	85% (8 less then 90%)	90% in all districts	85.8% (9 less than 90%)	
8. Measles 1st dose under 1 year coverage	88% (8 less than 90%)	90% in all districts	84.5% (10 less than 90%)	
9. PCV 3rd dose coverage	97.9% (4 less than 90%)	90% in all districts	85.7% (10 less than 90%)	
10. Rota Virus 2nd dose coverage	90.9% (4 less than 90%)	90% in all districts	91.9% (10 less than 90%)	
11. Diarrhoea with dehydration incidence (children U5)	27/1000	14.2/1000	15/1000	

Indicator	Baseline (2010/11)	Target (2014/15)	Performance (2013/14)	
12. Pneumonia incidence (children U5)	147/1000	97.6/1000	92.2/1000	

The main causes of child morbidity and mortality remain diarrhoea, pneumonia, malnutrition, HIV/AIDS, and neonatal causes. The absence of reliable community-based surveillance systems to determine the impact of targeted child health programmes on morbidity and mortality remain a challenge.

The Department commenced with the establishment of community child growth monitoring centres (Phila Mntwana Centres) to promote and improve monthly growth monitoring, education and provision of oral rehydration, support for breastfeeding and identification of children with incomplete immunisation schedules. These posts will also serve as service points for OSS. Integration with PHC re-engineering and OSS has been prioritised to reach children at household level.

Immunisation (including surveillance) remained one of the fundamental child health programmes. The Reach Every District strategy, together with other community-based services, has been prioritised in especially districts with coverage below 90%. The province performed well in annual Polio and Measles Campaigns. During the 2013/14 campaign, a total of 1 675 084 children under 5 years were immunised against a target of 1.2 million.

The Department has implemented the National Integrated Nutrition Programme including Vitamin A supplementation to children and mothers; the promotion of exclusive breastfeeding; provision of therapeutic supplements including to ART clients; and the appropriate management and increased early detection of malnutrition may improve the situation.

The 2012 Draft Country Report indicated that undernourished children, whether they were underweight or severely malnourished, were not being identified, despite the fact that weighing of children was one of the major activities in PHC facilities. In response, there is greater engagement with OSS and household screening (Road to Health Booklet) which forms part of the "early warning strategy" to detect and manage malnutrition timeously.

To improve Vit A coverage, CCGs started administering Vitamin A at community level in 2012. There has been an overall increase in case detection in all categories of malnutrition i.e. mild, moderate and severe. In some districts under-performance was attributed to increased case detection at PHC level due to intensification of awareness undertaken by the PHC staff together with the IMCI training conducted.

Training on the assessment and classification of acute malnutrition in children <5 years was conducted for both in-patient and out-patient staff in hospitals. Output and outcome are being monitored. Case detection improved through active implementation of the Integrated Management of Childhood Illnesses (IMCI) and Integrated Childhood Severe Acute Malnutrition (ICSAM) "Find, Assess, Classify and Treat" Algorithm.

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

Table 12: Maternal and Neonatal performance measures

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

The biggest challenges to improved maternal and neonatal health outcomes remain (a) The negative impact of HIV and AIDS; (b) Late booking for antenatal care; (c) Poor post natal care; and (d) Delays in clients reaching health facilities during labour. The province launched CARMMA (Campaign on accelerated reduction of maternal and child mortality in Africa) in May 2012.

The province trained 191 Master Trainers and (at least) one clinician per hospital in ESMOE (Essential Steps in Management of Obstetric Emergencies), with complete midwife-doctor teams established at 51 hospitals.

The KZN PMTCT Programme received a nomination for the UN Dr LEE Jong-Wook Memorial Award in 2013/14 as a result of the remarkable results in the PMTCT programme..

The increased number of mobiles (93) that offer ANC services and improved community-based services contributed to the 16.6% increase in the number of pregnant women accessing antenatal care services before 20 weeks and the upward trend in postnatal follow-up (within 6 days of delivery).

Forty (40) specialised Obstetric Ambulances with an additional 13 Advanced Life Support personnel improve access to emergency care for pregnant women. The department established 10 Maternity Waiting Areas to accommodate high risk pregnant women – there are no facilities in Ilembe, Ugu and Umgungundlovu Districts. Twenty Midwifery Obstetric Units (MOUs) have been established to provide basic emergency obstetric care (bEOC).

Sub-Output 2.3: Improving Sexual and Reproductive Health

Table 13: Sexual and reproductive health performance measures

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

The Phila Ma Campaign (health promotion and screening for cervical and breast cancer) contributed to the positive trend in the cervical cancer screening coverage. The Department launched the Family Planning Five Point Plan in 2011 to improve family planning and reproductive health services.

The number of facilities providing choice on termination of pregnancy services increased from 16 (2012/13) to 19 in 2013/14, with 19 916 terminations conducted in 2013/14. Thirty health care workers

attended a five day Values Clarification workshop to improve attitudes towards provision of CTOP services, and 10 PNs completed a 5-day training course in Medical Abortion.

According to DHIS, termination of pregnancy increased with 80.5% between 2009/10 and 2012/13 (4 807 to 8 675); 2.5% (220) of these terminations was women under the age of 18 years.

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

Sub-Output 3.1: Reduce HIV Incidence and Manage HIV Prevalence

Table 14: HIV, AIDS and STI performance measures

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

The Province adopted a robust multi-sectoral approach in managing HIV and TB that involves a wide variety of stakeholders, led by the Honourable Premier, through the Provincial Council on Aids. This approach involves Government, Business, Labour and Civil Society and the formation of AIDS Councils at provincial, district and metropolitan, local government and municipality ward level.

The Provincial Council on AIDS is chaired by the Premier, while the District AIDS Councils and Local AIDS Councils are chaired by respective Mayors. The Ward AIDS Councils are chaired by Ward Councilors. In this respect, the province has achieved the principle of having one coordinating authority at the three levels of government and is moving towards fully achieving this at the fourth level, viz. ward level.

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

The Male Medical Circumcision (MMC) programme was introduced in March 2010. Northdale Hospital has been developed as the MMC Centre of Excellence. More than 1 158 providers have been trained on MMC including students from Mozambique, Uganda, Botswana and Tanzania. The Department plans two satellite centres at Ngwelezane and Clairwood Hospitals and plans to decentralise neonatal circumcision to the new sites.

To improve access to MMC, roving teams conduct the procedure in clinics, prisons, tertiary institutions, and Local Traditional Houses; 25 High Volume Sites were established where a minimum of 30 circumcisions are conducted per day; 56 Traditional Coordinators have been contracted for mobilization and marketing of the programme including responsible sexual behaviour and condom use and distribution in communities.

The Department established a formal partnership with the Department of Correctional Services (2012/13) to ensure a sustainable Prevention Action Campaign "Hlola Manje, Zivikele" in Correctional Services.

To improve testing for HIV, the Department entered into partnerships with retail pharmacies, metro-rail, farms and factories. Introduced the "Men know Campaign" in 2008 to increase HCT uptake by men with more than 5 000 men tested for HIV per month.

The "First Things First Campaign" (FTF) commenced in tertiary institutions in 2011 to encourage students to test for HIV. The National Minister of Health launched the FTF campaign at the Mangosuthu University of Technology in March 2013.

The High Transmission Area sites, providing ART services, increased from 89 in 2008 to 608 in 2012, mainly due to decentralisation of ART services to PHC. The number of patients initiated on ART increased with a staggering 142% between 2009/10 and 2012/13, which contributed to the 20.8% increase in PHC headcount over the last 4 years.

Decentralised ART initiation (PHC level) necessitated up-skilling of staff and complimenting inadequate skills mix with amongst other ART roving teams. Inadequate infrastructure (space e.g. consultation rooms and storage of medicines) remains a challenge with no immediate solution at facility level as a result of the dwindling infrastructure budget.

Funding support for the KZN response emanates from both internal and external sources. Government funding through the National Conditional Grant and provincial equitable share, while external funding is received either through direct funding to departments for specific projects/initiatives or through provision of technical support.

Expenditure for HIV and AIDS increased by 62% over the four years under review. The HIV/AIDS budget is inadequate to respond to the increasing demand for services (not exclusive to the ART programme) although there is considerable pressure against *Goods and services*, largely driven by the costs of ARV medication. The challenge of reprioritization of budget allocation with regards to *COE* versus *Goods and services* to accommodate increased demand for antiretroviral medication remains a challenge.

The Conditional Grant remains insufficient compared to demand and the Equitable Share allocation not sustainable with the declining baseline budget year on year.

Nurse Initiated and Managed ART (NIMART) strategically changed the emphasis from a doctor- to nurse-driven approach. A total of 1 978 nurses have been trained on Nurse Initiated and Managed ART. The 150 nurses that were trained as mentors and the 155 doctors who completed the Diploma in HIV and AIDS Management play a critical role in mentorship, clinical governance and support.

Sub-Output 3.2: Improve TB Outcomes

Table 15: TB performance measures

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

Improved TB outcomes are attributed to (amongst others) expansion of integrated community-based services (including community-based management of MDR-TB); scale up of outreach/surveillance teams, advances in diagnostic technology e.g. GeneXpert testing; and utilisation of evidence (research) to improve system efficiencies and clinical care.

Laboratory coverage for microscopy is good (80 microscopy centres), although culture services are still centralised in one laboratory at Inkosi Albert Luthuli Central Hospital. This impacts on result turn-around times which delays diagnosis and appropriate management. The TB AFB sputum result turn-around time under 48 hours rate increased from 58% (2009/10) to 70% in 2012/13.

TB case notifications decreased between 2009 and 2012 regardless of intensified case finding strategies including door to door TB screening, TB screening as part of HCT, and strengthened community-based services through PHC re-engineering and OSS. Total cases decreased from 127 939 in 2009 to 101 037 in 2012/13

There are 8 DR-TB management units in the province (7 decentralised and 1 centralised) with no units in Ilembe, Amajuba and Uthukela Districts. The extended waiting list at King Dinuzulu Hospital (managing all provincial TB drug resistant children and XDR-TB patients and referral from districts with inadequate resources) is a concern and confirms the urgency to develop more decentralised units to reduce waiting times and workload in King Dinuzulu. Between 2010 and 2012, a total of 5 680 diagnosed MDR-TB and 832 XDR-TB patients were put on treatment.

The community-based management of TB/DR-TB/HIV proved to be effective. A total of 122 TB/DR-TB and HIV outreach teams have been established to manage the programme. The Province received 73 GeneXpert machines in 2010 for systematic rollout in phases.

Output 4: Strengthening Health System Effectiveness

Sub-Output 4.1: Re-Engineering of PHC

Table 16: PHC re-engineering performance measures

Indicator	Baseline (2010/11)	Target (2014/15)	Performance (2013/14)	
1. PHC utilisation rate	2.5	3	3.1	
2. Utilisation under 5 years	4.5	5	4.4	
3. Number of Ward-Based PHC Teams	N/A	95	109	
4. PHC supervisor visit rate	63.3%	66.4%	62.2%	
5. Number of School Health Teams	87	159	176	
6. Number of District Clinical Specialist Teams	N/A	11	11 (nil complete)	

Local Government clinics in all districts, with exception of eThekwini Metro have been provincialised. Services in eThekwini is being rendered through a Service Level Agreement.

The past 4 years (2009/10 to 2012/13) focused on PHC re-engineering with the aim to improve equity towards universal access to health services. The first phase of the National Health Insurance (NHI) implementation plan (3 pilot districts) focusses on PHC and system strengthening which should therefore be directly aligned with PHC re-engineering. There has been an increase of 23.6% (6 083 712) in PHC headcount over the 4 year period. Provincial and municipal health services remain the main providers of PHC services with both increasing their "market" share by 1%. Provision of health services by other services providers has decreased overall by 2%, therefore placing an increased burden on provincial health services. The total headcount in mobile services increased with 16%.

The introduction of PHC Outreach Teams (2011/12), as one of the four pillars of PHC re-engineering, will have to be monitored actively to determine the impact of the intervention on the burden of disease, patient activity and economy of scale.

Implementation of the Ideal Clinic Realisation and Maintenance project commenced in 2014/15, with preliminary assessment results of compliance to the Ideal Clinic Dashboard indicators indicating that out of 288 targeted clinics, 68 (23.6%) scored between 0-49% (Red); 149 (51.7%) scored between 50-69% (Amber) and 70 (24.3%) scored between 70-100% (Green).

The professional nurse (PN) per 100 000 population increased from 120 to 145 showing an increase in the number of PN's at PHC level (net gain of 2 953 PN's or 23.3%) in relation to population. It is however evident that although the headcount has increased, the PN per 100 000 headcount (workload) remains consistent at 50 PN's per 100 000 headcount, indicating that the increase in staff has been parallel to the increase in headcount despite the increase in PN's per population.

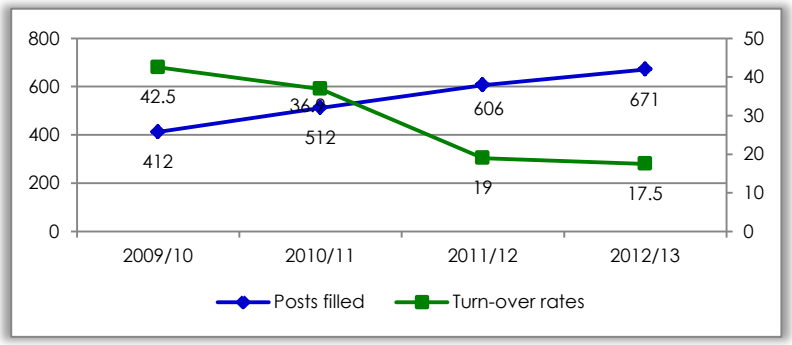
The workload continues to fluctuate over the review period and is influenced by numerous factors including the number of clinics in each district, extended opening hours and the vertical structures implemented at a PHC level for different programmes.

Sub-Output 4.2: Improving Patient Care and Satisfaction

Pharmaceutical Services

The Pharmacist pool (filled posts) shows a year on year increase while the turnover rate shows a positive decline over the same period (Graph 9).

Graph 9: Pharmacist posts filled vs. Turnover rate



Source: Persal

The Ministerial Task Team on Procurement Reform recommended the phasing out of Depots in favour of direct deliveries to facilities. The task team recommended implementation of the Central Chronic Dispensing Unit (Western Cape Model) and investigation of using retail pharmacies & other options for the supply of chronic medicines to patients.

KZN is adopting a Hybrid Model for procurement and distribution of pharmaceuticals inclusive of:

Direct Delivery Model: ±70% of volume distributed directly from suppliers to health facilities. Include outsourced Chronic Medication Dispensing Services with supplies delivered directly to the warehouse of contracted service provider(s) who dispense and distribute chronic medication for convenient collection by clients /patients. This strategy is aligned to the wider concept of universal access to health care as per the National Health Insurance (NHI) policy.

Depot Stock Holding: ±20% of volume distributed via PPSD.

Cross-Docking Model: ±10% of volume distributed to PPSD and immediately transited to facilities.

Sub-Output 4.3: Certification of Health Facilities for Compliance to National Core Standards

The MEC for Health announced the implementation of the Make Me Look Like a Hospital Project in 12 hospitals to improve hospital efficiency and quality in his budget speech in 2009. The 1st cohort of 12 hospitals were enrolled in 2009 and since increased to 24. The basic concept/principles of the National Core Standards apply including the 6 priority areas:

- Positive and caring staff attitudes
- Facility cleanliness
- Improved waiting times for patients
- Improved patient safety and security
- Infection prevention and control
- Availability of medicines and blood products

According to 2013/14 assessments conducted by the Health Systems Trust:

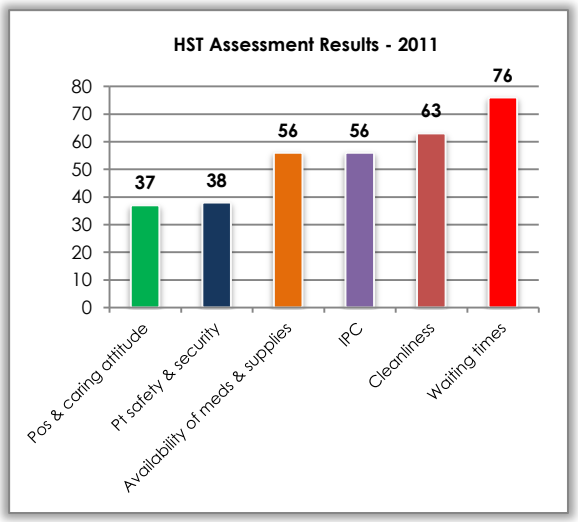
- 80% of facilities show improvement in staff attitudes.
- 83% of facilities demonstrate improvement in cleanliness (assisted by the National Cleanest Government Project Initiative).
- 92% of facilities are compliant with the Patient Safety and Security criteria.
- 100% of facilities are compliant with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

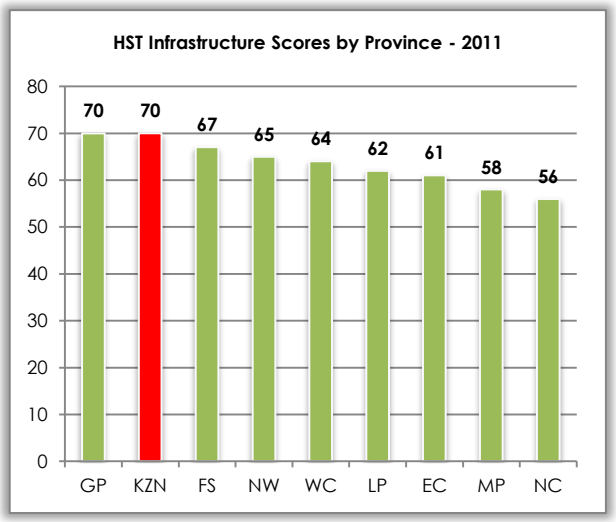
100% of facilities are implementing the Infection Prevention and Control policies and guidelines. No facility is compliant with criteria of infrastructure for IPC. Overall Best Practice in the Make Me Look Like a Hospital programme has been noted in Prince Mshiyeni Memorial; Benedictine; and Edendale Hospitals.

A number of initiatives have been introduced at various hospitals to address challenges including the War on Attitude Campaign, Greeting with a smile month, Staff member of the month, infection control monthly awards, etc. More recently the "Walk like a Nurse" project was introduced at Edendale Hospital, which involves all nurses, working towards addressing problems and challenges relating to poor staff attitude at the coal face of service delivery. This project will also be rolled out to other institutions.

On 9 May 2013, the Department hosted the Health Care Professionals Summit with the purpose to re-inculcate the ethos and values of health care professions and bring back the white uniform, using the theme "My Profession, My Pride!" The Department was subjected to a national health facility assessment conducted by Health Systems Trust in 2011 in preparation for the roll-out of the National Core Standards (Graphs 10 and 11).

Graph 10: HST facility assessment results 2011





Source: HST Facility Assessment

Sub-Output 4.4: Improving Health Infrastructure Availability

Between 2009/10 to date, the Department commissioned 31 new clinics, while 12 new clinics are currently under construction. Four CHCs have been commissioned including KwaMashu (eThekwini), Turton and Gamalakhe Phase 1 (Ugu) and St Chads (Uthukela) at an average cost of R200 million per CHC. Three new CHCs are under construction namely Dannhauser (Amajuba), Pomeroy (Umzinyathi) and Jozini (Umkhanyakude). Upgrades commenced at the Inanda and Phoenix CHCs (eThekwini) and Phase 2 construction commenced at the Gamalakhe CHC in Ugu.

To improve maternal and child health outcomes the following infrastructure projects have been completed: New maternity and paediatric wards at Untunjambili and Mosvold Hospitals; neonatal intensive care unit at Ladysmith Hospital; and Mother's Lodges at Niemeyer Memorial and Lower Umfolozi War Memorial (60 beds) Hospitals.

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

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

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

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

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

During 2013/14, the Department upgraded laundry equipment in 30 hospital on-site mini laundries, and invested R210 million on upgrading of the Prince Mshiyeni Laundry. The first line production is expected to open in August 2014 and second production line in 2015/16. This will improve service reach to 11 hospitals. Design of the Dundee Laundry is at an advanced stage.

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

Sub-Output 4.5: Improved Human Resources for Health

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

To improve management capacity, the Department enrolled Senior Managers in management/ leadership programmes including the Albertina Sisulu Executive Leadership Programme Masters in Public Health at University of Pretoria (11); Master's Degree at the University of Fort Hare (11); Master's in Public Health through the University of KwaZulu-Natal (12); Oliver Tambo Fellowship programme through the University of Cape Town (3 District Managers completed the programme); Applied Population Science and Research Programme (APSTAR) through UKZN (3). Seventy five (75) Chief Executive Officers from eleven Districts were trained on Financial Management facilitated by the University of Pretoria in partnership with National Treasury and Office of the Premier.

Seven students were enrolled in the Clinical Associates Programme at the Walter Sisulu University.

The programme for Medical Orthotics and Prosthetics (MOPs) commenced at the Durban University of Technology (DUT) in 2013/14. A total of 60 students were enrolled, with 43 of these students provided with a full bursary from the Department. Three Angolan students joined the programme as part of a commitment made by the MEC for Health during a study tour to Angola in August 2013.

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

The Department made significant progress in collaboration with UKZN with regard to the training of doctors and allied health professionals. Negotiations are in an advanced stage to conclude a new Memorandum of Understanding which will consolidate the training and development platform for these categories in a mutually beneficial manner. Development of a "new" Decentralised PHC Training Model for medical professionals is progressing well and will be a first for South Africa. The proposed model will support PHC re-engineering and ensure seamless alignment between the training and service delivery platforms. Selection of students and allocation of bursaries will be sensitive to quintile 1 and 2 areas to promote equity in opportunities and is expected to improve retention of staff.

During 2013, a total of 302 students commenced their medical training in Cuba - 292 of these students were funded by the Department and in some cases by parents. In February 2014, fourteen Cuban

doctors commenced service in various hospitals in the Province (mostly rural), and an additional 142 foreign health professionals were recruited through African Health Placements during the 2013/14 financial year.

The Department awarded 189 bursaries during the 2014 academic year. Cumulatively for the 2013 and 2014 academic years, a total of 1 481 bursaries were awarded to the value of R 205 880 040. A total of 181 bursary holders, who completed studies in the 2013 academic year, have been placed in various institutions as part of their service obligation.

During 2013/14, Community Service Officials were allocated throughout the Province including 199 Medical Officers; 32 Dentists; 44 Pharmacists; 12 Clinical Psychologists; 32 Dieticians; 8 Environmental Health Officers; 57 Occupational Therapists; 53 Physiotherapists; 67 Radiographers; 48 Speech Therapists & Audiologists; and 294 Professional Nurses.

During 2013/14, the Department career pathed 1 364 CCG's in to nursing and nutrition fields as Nursing Assistants and Nutritional Advisors as part of the development obligation and to strengthen community-based PHC re-engineering.

HR delegations of authority were reviewed, finalised and disseminated to all institutions. A further review will be necessary once the Regional Model has been finalised.

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

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

Output 5: Prevention and Management of Non-Communicable Diseases

Table 17: Non-communicable diseases performance measures

Indicator	Baseline (2010/11)	Target (2014/15)	Performance (2013/14)	
1. Hypertension incidence	29.8/1000	22.8/1000	21.9/1000	
2. Diabetes incidence	3/1000	2.1/1000	1.8/1000	
3. Number of accredited Health Promoting Schools	188	295	245	
4. Cataract surgery rate	757/1mil	749/1mil	758.1/ 1mil	

The Strategies for Non-Communicable Diseases and Mental Health Care will be finalised in 2015/16.

6.2 Organisational Environment

Approximately 87.8% of the KwaZulu-Natal total population are uninsured and dependent on public health services (DHB 2012/13). Table 18 includes the number of public health facilities in the province (2013/14 DHIS).

Table 18: Public Health Facilities in KZN (2014)

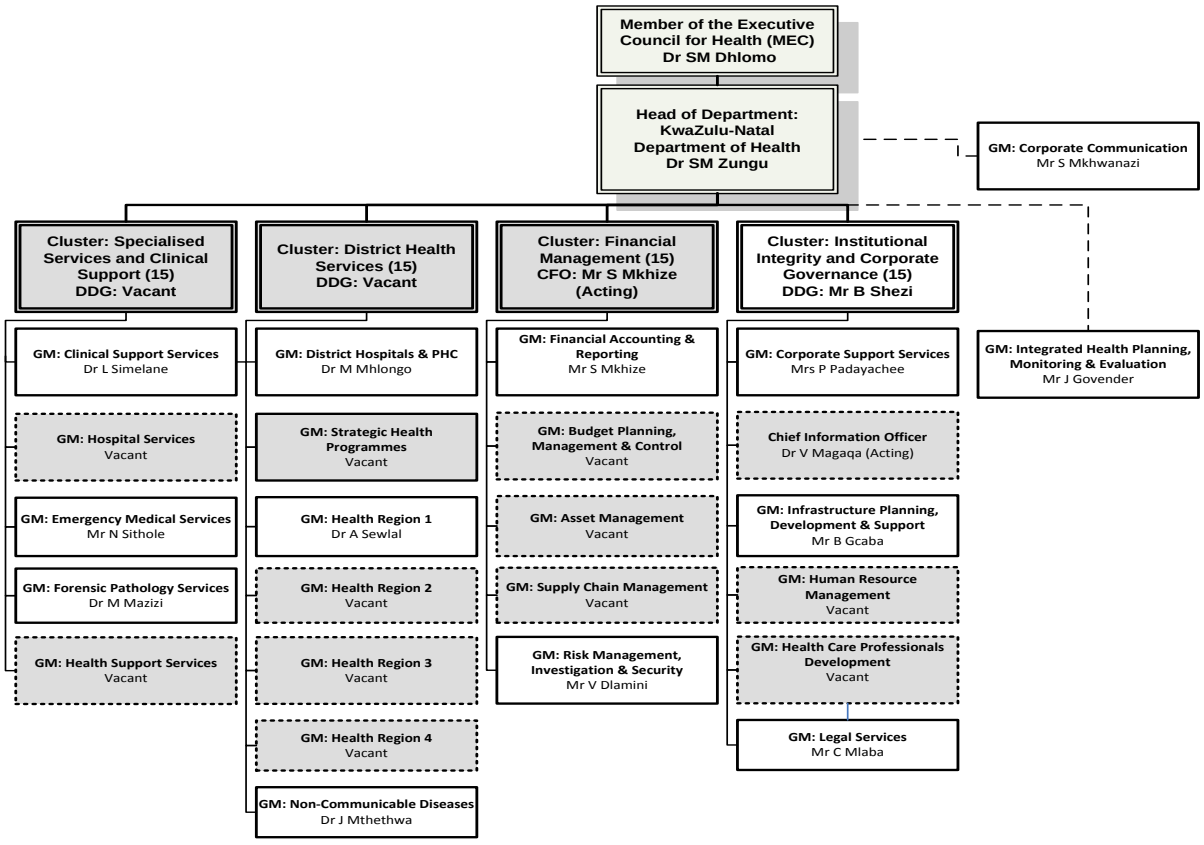
District	PHC Clinics (Provincial and LG)						Hospitals (Public + State Aided)						
	Clinics	Community Health Centres	Satellite Clinics	Mobile Service	Total PHC Facilities	Average catchment population per PHC facility	District	Regional	Tertiary	Central	Specialised TB	Specialised Psychiatric	Chronic/ Long-Term
Ugu	55	2	0	17	**74**	9 917	3	1	-	-	1	-	-
Umgungundlovu	51	3	1	16	**71**	14 827	2	1	1	-	2	3	-
Uthukela	35	1	0	14	**50**	13 655	2	1	-	-	-	-	-
Umzinyathi	49	0	0	11	**60**	8 570	4	0	-	-	1	-	-
Amajuba	25	0	0	7	**32**	15 858	1	2	-	-	-	-	-
Zululand	68	1	0	17	**86**	9 582	5	0	-	-	1	1	-
Umkhanyakude	56	0	0	17	**73**	8 739	5	0	-	-	-	-	-
Uthungulu	61	1	0	17	**79**	11 870	6	2	1	-	-	-	-
Ilembe	34	2	0	10	**46**	13 705	3	1	-	-	-	-	-
Harry Gwala	38	1	0	13	**52**	9 075	4	0	-	-	1	1	-
eThekwini	100	8	0	33	**141**	24 568	2	4	-	2	4	1	2
KZN	**572**	**19**	**1**	**172**	**764**	**13 687**	**37**	**13**	**2**	**2**	**10**	**6**	**2**

Table 19: Private Medical Practices and Hospitals

General Medical Practices	Group Practices/ Hospitals	Private Hospitals "A" Status	Private Hospitals "B" Status	Private Rehab (Acute) Hospitals
2 234	30	6	19	1

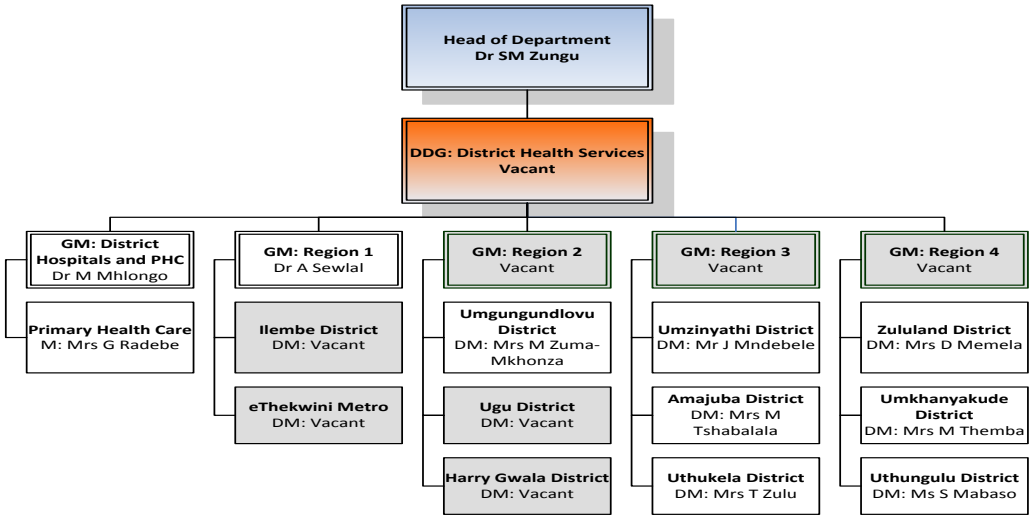
Source: National Department of Health database

Figure 3: Macro Organisational Structure



The organisational arrangements for the geographical management areas have been reviewed to strengthen oversight and leadership at Senior Management level. The reviewed arrangements make provision for four Health Regions, each managed by a General Manager (level 14) reporting to the Deputy Director General (Senior General Manager) District Health Services (Figure 4).

Figure 4: Regional Management Areas



6.3 Description of the Strategic Planning Process

Phase 1: Performance Reviews (April – July 2014)

- Review and analysis of actual performance against pre-determined performance targets with specific focus on health systems and processes and the burden of disease. This analysis informed preparation for strategic planning workshops to determine the 2015-2019 priorities and performance measures.
- Annual Report 2013/14 tabled in August 2014.
- District Health Expenditure Reviews 2013/14 – analysis of expenditure versus service delivery to inform planning and resource allocation (extensive consultation to strengthen capacity at district and facility level and ensure 'bottom-up' recommendations).

Phase 2: Strategic Vision and Strategic Priorities 2015-2019 (August – September 2014)

- 18-20 September 2014: Strategic Planning Workshop under leadership of the MEC for Health and Head of Department.
  - Attendance: Senior Management including ManCo, Regional and District Managers, Health Portfolio Committee Members, Organised Labour and Partners.
  - Through intensive group work and plenary sessions, 4 commissions reviewed the vision, mission, and core values of the Department; conducted a SWOT analysis of all sector departments; and formulated draft strategic goals, and core priorities with expected outcomes.
  - Strategic goals and core priorities have been aligned with the NDP 2030, MTSF 2014-2019 and PGDP 2030.
- 23 September 2014: Draft priorities and workshop resolutions presented to the Health Portfolio Committee as part of oversight.

Phase 3: 'Top-Down-Bottom-Up' consultation to refine Provincial Priorities (October – November 2014)

- Extended consultation with Senior Managers, Programme Managers (Head Office), District Management Teams, Hospitals, CHC's and Clinics, Development Partners, and Higher Education facilitated by the Strategic Planning Section. Programme priorities, performance measures and targets were identified for inclusion in the Strategic Plan and Annual Performance Plan.
- 24 November 2014: Consultation with University of KwaZulu-Natal (UKZN) with focus on alignment of the Provincial human resources for health priorities and the Decentralised Community-Based Training in PHC Model.

Phase 4: Finalise and Table – (December 2014 - February 2015)

- 8-10 December 2014: Strategic Planning Workshop under the leadership of the Head of Department with input from the MEC for Health.
  - Attendance: Senior Management including ManCo, Regional and District Managers, Programme Managers, Hospital CEO's, CHC Managers, Organised Labour, and Health Portfolio Committee.
  - Confirmed priorities, identified quick wins; first phase alignment of budget versus service delivery. Costing templates disseminated for completion by 15 January 2015 to inform final budget allocation.
- Final re-prioritisation, review of performance measures and targets and final budget allocation.
- Circulation of final draft to the Head of Department, Senior Management, and Health Portfolio Committee for final comments (January 2015).

Submission dates

- Draft Zero: 31 December 2014 – National Department of Health and Provincial Treasury
- Draft 1: 8 August 2014 – National Department of Health, Provincial Treasury and Provincial Health Portfolio Committee
- Draft 2: 21 November 2014 – National Department of Health and Provincial Treasury
- Draft 3: 10 December 2014 – National Department of Health
- Final Strategic Plan: 26 February 2015
- Table final Strategic Plan 2015-2019: 20 March 2015

Technical Notes

The Health Sector customised Strategic Plan template is an adaptation of the National Treasury Generic Framework for 5-year Strategic Plans. The main aim of the customised template is to ensure that all provincial strategic plans contribute to the achievement of national and international priorities including the National Development Plan 2030, Medium Term Strategic Framework 2014-2019 and Millennium Development Goals.

Purpose of Strategic Plan

- Set out the strategic policy priorities and plans for the next five years. The plan is intended to serve as a blueprint and roadmap for provincial plans over the next 5 years.
- Specify the strategic goals and strategic objectives for each main service delivery area that the department will strive to achieve over the next five years. This will lay the foundation for the development of A*nnual Performance Plans* for the next 5 years.
- The plan must be linked to a wide range of planning frameworks ranging from Government's Medium Term Strategic Framework (MTSF) 2014-2019 to the Department's own long-term plans.

Components of the Strategic Plan

Part A: Strategic overview of the health sector and the Provincial Department of Health specifying the strategic goals for the next 5 years. The customised health sector template includes national priorities, goals, strategic objectives and indicators per budget programme/sub-programme. A sub-set of these indicators are selected by the NDOH and National Treasury for quarterly reporting to both national departments. Provinces have the scope to add additional province-specific indicators per financial programme. All performance measures (national and provincial) are included in the provincial reporting system and reported quarterly and in the Annual Report.

Part B: Detailed planning information on budget programmes and sub-programmes including priorities, measurable objectives and targets that are linked with strategic goals specified in Part A.

Part C: Present information on linkages with other plans of the Provincial Department of Health with specific reference to long term plans including (but not exclusive to) the Service Transformation and Infrastructure Plans.

Part D: Annexures

Oversight and Reporting: From 2015/16 onwards, all provinces will report on customised indicators, which will be monitored by the Department Planning Monitoring and Evaluation in the Presidency to ensure comprehensive response towards priorities and targets in the NDP 2030 and MTSF 2014-2019.

7. NATIONAL AND PROVINCIAL PLANNING FRAMEWORKS

7.1 National Development Plan 2030

The National Development Plan (NDP) 2030 was adopted by government as its vision, and will be implemented over three electoral cycles of government. The MTSF 2014-2019 finds its mandate from the NDP 2030.

Vision

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

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

Goals and Expected Outcome

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

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

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

Goal 2: Tuberculosis prevention and cure progressively improved.

- Reduced TB rates among adults and children.
- Successful treatment completion.

- Progressive decline in the latent infection rate amongst school-age children.
- TB contact indices decreased.
- Increased number of latently infected people receiving six month IPT.

Goal 3: Reduced maternal, infant and child mortality.

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

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

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

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

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

Goal 6: Complete health systems reforms.

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

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

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

Goal 8: Universal health care coverage achieved.

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

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

- Increased capacity for training of health professionals.
- Train more health professionals to meet requirements of re-engineered PHC.
- Link training of health professionals to future diseases, especially categories of non-communicable diseases.

- Set procedures of competency criteria for appointment of hospital managers.
- Set clear criteria for removal of under-performing hospital managers.

Actions to achieve the 2030 NDP Vision

The NDP states explicitly that there are no quick fixes for achieving the nine goals outlined above, and therefore identifies a set of nine priorities and key interventions that will be required to achieve a more effective health system.

1. Address the social determinants affecting health and diseases.

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

2. Strengthen the health system.

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

3. Improve health information systems.

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

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

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

5. Financing the health system.

- Establish mechanisms to improve cost controls.

6. Improve human resources in the health sector.

- Community-based health care including PHC teams and CCG's (propose 6 CCGs per PHC team; one CCG to 250 households or 1 000 people).

- Accelerate production of appropriately skilled nurses; prioritise training of Advanced Midwifes; and review training curricula.
- Doctor and specialist support teams including increasing family physicians with a public health qualification.
- Rapid investment in health personnel development.

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

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

8. Improve quality by using evidence.

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

9. Meaningful public-private partnerships

7.2 Medium Term Strategic Framework 2014-2019

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

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

Sub-Outcome 2: Improved quality of health care.

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

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

- Expand coverage of ward-based PHC outreach teams.
- Accelerate appointment of district clinical specialist teams.
- Expand and strengthen integrated school health services.
- Ensure quality PHC services with optimally functional clinics by developing all clinics into Ideal Clinics.
- Improve intersectional collaboration with a focus on population wide community based interventions (promote healthy lifestyles) and address social and economic determinants of Non-Communicable Diseases.

- Reduce risk factors for Non-Communicable Diseases (NCD's) by designing and implementing a mass mobilisation strategy focusing on healthy options including the reduction of obesity.
- Improve awareness and management of prevalence of NCD's through screening and counselling for high blood pressure and raised blood glucose levels.
- Expand rehabilitation services.
- Screen the population for mental health disorders.
- Contribute to a comprehensive and inter-sectoral response by government to violence and injury.

Sub-Outcome 4: Reduced health care costs.

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

Sub-Outcome 5: Improved human resources for health.

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

Sub-Outcome 6: Improved health management and leadership.

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

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

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

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

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

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

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

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

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

7.3 KwaZulu-Natal Growth & Development Plan 2030

KZN Vision

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

PGDP Strategic Goals

Strategic Goal 1: Job Creation.

Strategic Goal 2: Human Resource Development.

Strategic Goal 3: Human and Community Development.

Objective: The health of the KZN population is improved.

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

Strategic Goal 4: Strategic Infrastructure.

Strategic Goal 5: Environmental Sustainability.

Strategic Goal 6: Governance and Policy.

Strategic Goal 7: Spatial Equity.

Table 20 shows the alignment of the Provincial Strategic Goals with the National Development Plan 2030, the Medium Term Strategic Framework 2014-2019, the Millennium Development Goals and the Provincial Growth and Development Plan 2030.

The Strategic Plan only reflects strategic goals and apex indicators which will be substituted in the five Annual Performance Plans between 2015 and 2019.

Table 20: Alignment of Provincial Strategic Goals

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

KZN Strategic Goals	National Development Plan	Medium Term Strategic Framework	Provincial Growth & Development Plan	Millennium Development Goals
coverage	coverage achieved **Priority e**: Financing universal health care coverage	coverage progressively achieved through implementation of NHI **Sub-Output 7**: Improved health facility planning & infrastructure delivery	equitable access to health services. **Strategic Objective 3.2d**: Implement the first phase of National Health Insurance pilot programme	
Strategic Goal 4: Strengthen human resources for health	**Strategic Goal 9**: Posts filled with skilled, committed & competent individuals **Priority f**: Improve human resources in the health sector **Priority g**: Review management positions and appointments and strengthen accountability mechanisms	**Sub-Output 5**: Improved human resources for health		
Strategic Goal 5: Improved quality of health care	**Priority h**: Improve quality by using evidence	**Sub-Output 2**: Improved quality of health care		

8. IMPACT INDICATORS AND TARGETS

Table 21: Impact indicators

Impact Indicator	Baseline (2009[8]) (South Africa)	Baseline (2012[9]) (South Africa)	2019 Targets (South Africa)	2012 Baseline (KwaZulu-Natal)	2019/20 Target (KwaZulu-Natal)
Life expectancy at birth: Total	56.5 years	60 years *(increase of 3.5 years)*	63 years by March 2019 *(increase of 3 years)*	51.5 years *(56.9 years in 2014)*	60.5 years *(increase of 3.6 years from 2014)*
Life expectancy at birth: Male	54 years	57.2 years *(increase of 3.2 years)*	60.2 years by March 2019 *(increase of 3 years)*	49.2 years *(54.4 years in 2014)*	58.4 years *(increase of 4 years from 2014)*
Life expectancy at birth: Female	59 years	62.8 years *(increase of 3.8 years)*	65.8 years by March 2019 *(increase of 3 years)*	53.8 years *(59.4 years in 2014)*	62.7 years *(increase of 3.3 years from 2014)*

[8] Medical Research Council (2013): Rapid Mortality Surveillance (RMS) Report 2012
[9] Medical Research Council (2013): Rapid Mortality Surveillance (RMS) Report 2012

Impact Indicator	Baseline (2009[8]) (South Africa)	Baseline (2012[9]) (South Africa)	2019 Targets (South Africa)	2012 Baseline (KwaZulu-Natal)	2019/20 Target (KwaZulu-Natal)
Under-5 mortality rate (U5MR)	56 per 1000 live births	41 per 1000 live births *(25% decrease)*	23 per 1000 live births by March 2019 *(20% decrease)*	43.4 per 1000 live births	40 per 1000 live births
Neonatal mortality rate	-	14 per 1000 live births	6 per 1000 live births	10.4 per 1000 live births	9 (or less) per 1000 live births
Infant mortality rate (IMR)	39 per 1000 live births	27 per 1000 live births *(25% decrease)*	18 per 1000 live births	32.1 per 1000 live births	29 per 1000 live births
Child under 5 years diarrhoea case fatality rate	-	4.2%	<2%	4.3%	2% (or less)
Child under 5 years pneumonia case fatality rate	-	-	-	2.6%	1.5% (or less)
Child under 5 years severe acute malnutrition case fatality rate	-	9%	<5%	10.9%	6% (or less)
Maternal mortality ratio	304 per 100 000 live births	269 per 100 000 live births	Downward trend <100 per 100 000 live births by March 2019		100 (or less) per 100 000 live births

9. STRATEGIC GOALS AND EXPECTED OUTCOMES

Table 22: Provincial Strategic Goals and Objectives

STRATEGIC GOAL 1: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS	
Goal Statement	Identifying and implementing changes in policy and/or practice to improve response to health and health system challenges and any array of initiatives and strategies that improves one or more of the functions of the health system that improves access, coverage, quality, or efficiency and strengthening performance and interconnectedness of the WHO health system building blocks including service delivery, health workforce, strategic information, commodities, health financing, and leadership and governance.
Expected Outcomes *Strategic Objectives & Strategic Objective Statements*	***Strategic Objective 1.1) Develop a Provincial Long Term Plan (10 years) to guide service transformation*** 1.1.1) Long Term Plan approved by March 2016 and implemented and monitored thereafter ***Strategic Objective 1.2) Improve financial management and compliance to PFMA prescripts*** 1.2.1) Annual unqualified audit opinion for financial statements and performance information from 2015/16 onwards 1.2.2) Maintain financial efficiency by ensuring under/ over expenditure within 1% of the

	annual allocated budget throughout the reporting cycle ***Strategic Objective 1.3) Improve Supply Chain Management*** 1.3.1) Costed Procurement Plan for minor and major assets by the end of April in each reporting year 1.3.2) Ensure that 100% sites registered on the system account for all assets by performing monthly reconciliation reports by March 2016 and annually thereafter ***Strategic Objective 1.4) Improve health technology and information management*** 1.4.1) Connectivity established at 100% public health facilities by March 2018 1.4.2) Web-based health information system established in 90% public health facilities by March 2020 (National 700 Clinic Project) 1.4.6) Reduce performance data error rate to 2% (or less) by March 2020 ***Strategic Objective 1.5) Accelerate implementation of PHC re-engineering*** 1.5.1) Accelerate implementation of PHC re-engineering by increasing household registration coverage with at least 15% per annum 1.5.2) Increase the number of ward based outreach teams in the 169 wards worst affected by poverty to 169 by March 2020 as part of the Poverty Eradication Programme 1.5.3) Increase the PHC utilisation rate to 3.1 visits per person per year by March 2020 1.5.4) Increase the PHC utilisation rate under 5 years to 4.8 visits per child by March 2020 ***Strategic Objective 1.6) Scale up implementation of Operation Phakisa Ideal Clinic Realisation & Maintenance*** 1.6.1) 100% Provincial fixed PHC facilities score above 80% on the Ideal Clinic Dashboard by March 2020 ***Strategic Objective 1.7) Improve hospital efficiencies*** 1.7.1) Maintain a bed utilisation rate of 75% (or more) 1.7.2) Develop and implement the approved Hospital Rationalisation Plan by March 2016 (specific performance outcomes will be included in Implementation Plan) ***Strategic Objective 1.8) Improve EMS efficiencies*** 1.8.1) Evidence-based EMS Model approved and implemented by March 2016 1.8.2) Increase the average number of daily operational ambulances to 550 by March 2020 1.8.3) Rationalise 4 clustered communication centres by March 2020 1.8.4) Improve P1 urban response times of under 15 minutes to 25% by March 2020 1.8.5) Improve P1 rural response times of under 40 minutes to 45% by March 2020 1.8.6) Increase the inter-facility transfer rate to 50% by March 2020 ***Strategic Objective 1.9) Strengthen health system effectiveness*** 1.9.1) Increase the number of operational Orthotic Centres to 11 by March 2020 1.9.2) Decrease and maintain zero clean linen stock outs in facilities from March 2018 onwards
STRATEGIC GOAL 2: REDUCE THE BURDEN OF DISEASE	
Goal Statement	Reduce and manage the burden of disease to ensure better health outcomes and an increase in life expectancy at birth.
Expected Outcomes *Strategic Objectives & Strategic Objective Statements*	***Strategic Objective 2.1) Increase life expectancy at birth*** 2.1.1) Increase the total life expectancy to 60.5 years by March 2020 2.1.2) Increase the life expectancy of males to 58.4 years by March 2020 2.1.3) Increase the life expectancy of females to 62.7 years by March 2020 ***Strategic Objective 2.2) Reduce HIV incidence*** 2.2.1) Reduce the HIV incidence to 1% (or less) by March 2020 (ASSA2008 estimates) 2.2.2) Test 9 million people (cumulative) for HIV by March 2020

	Strategic Objective 2.3) Manage HIV prevalence 2.3.1) Reduce the HIV prevalence among 15-24 year old pregnant women to 25% by March 2020 2.3.2) Increase the number of patients on ART to 1 450 000 (cumulative) by March 2018 ***Strategic Objective 2.4) Improve TB outcomes*** 2.4.1) Increase the TB new client treatment success rate to 90% (or more) by March 2020 2.4.2) Reduce the TB incidence to 400 (or less) per 100 000 by March 2020 2.4.3) Decrease the TB death rate to 2% by March 2020 2.4.4) Increase the MDR-TB treatment success rate to 75% (or more) by March 2020 ***Strategic Objective 2.5) Reduce infant mortality*** 2.5.1) Reduce the infant mortality rate to 29 per 1000 live births by March 2020 2.5.2) Reduce the mother to child transmission of HIV to less than 0.5% by March 2020 ***Strategic Objective 2.6) Reduce under 5 mortality*** 2.6.1) Reduce the under 5 mortality rate to 40 per 1000 live births by March 2020 2.6.2) Reduce severe acute malnutrition incidence under 5 years to 4.6 per 1000 by March 2020 ***Strategic Objective 2.7) Reduce maternal mortality*** 2.7.1) Reduce the maternal mortality in facility ratio to 100 (or less) per 100 000 live births by March 2020 2.7.2) Improve maternal health outcomes by establishing 11 District Caesarean Section Centres by March 2018 ***Strategic Objective 2.8) Improve women's health*** 2.8.1) Increase the couple year protection rate to 75% by March 2020 2.8.2) Maintain the cervical cancer screening coverage of 75% (or more) ***Strategic Objective 2.9) Reduce the incidence of non-communicable diseases*** 2.9.1) Decrease the hypertension incidence by at least 10% per annum 2.9.2) Decrease the diabetes incidence by at least 10% per annum ***Strategic Objective 2.10) Eliminate malaria*** 2.10.1) Zero new local malaria cases by March 2020 2.10.2) Reduce malaria case fatality rate to less than 0.5% by March 2020
STRATEGIC GOAL 3: UNIVERSAL HEALTH COVERAGE	
Goal Statement	All people receive the full spectrum of the essential health services package including health promotion, prevention, treatment and clinical care, rehabilitation and palliative care.
Expected Outcomes *Strategic Objectives & Strategic Objective Statements*	***Strategic Objective 3.2) Create job opportunities*** 3.2.1) Create 11 800 jobs through the Expanded Public Works Programme by March 2020 (cumulative) ***Strategic Objective 3.3) Improve health facility planning and infrastructure delivery*** 3.3.1) Commission 26 new projects by March 2020 3,3.2) Complete 35 upgrading & renovation projects by March 2018
STRATEGIC GOAL 4: STRENGTHEN HUMAN RESOURCES FOR HEALTH	
Goal Statement	Develop and maintain a capacitated workforce with the capacity to deliver the appropriate package of health services at all levels of the health care system.
Expected Outcomes *Strategic Objectives &*	***Strategic Objective 4.1) Improve human resources for health*** 4.1.1) Long Term Human Resources Plan approved by March 2016 and implemented and monitored thereafter

Strategic Objective Statements	4.1.2) Finalise 610 organisational structures by March 2020 4.1.3) Implement the Community Based Training in a PHC Model in collaboration with the University of KwaZulu-Natal with Phase 1 pilot commencing in 2016/17 4.1.4) Allocate 569 bursaries for first year medicine students between 2015/16 and 2019/20 4.1.5) Allocate 2 000 bursaries for fist year nursing students between 2015/16 and 2019/20 4.1.6) Increase intake of Mid-Level Workers with at least 10% per annum (based on need per category) 4.1.7) Increase the EMS skills pool by increasing the number of EMS personnel trained in ILS and ECT 4.1.8) Increase the number of MOP's who successfully completed the degree course at DUT to 90 (cumulative) by March 2020
STRATEGIC GOAL 5: IMPROVED QUALITY OF HEALTH CARE	
Goal Statement	Rendering services that are (1) Effective (adherent to an evidence base resulting in improved health outcomes); (2) Efficient (maximises resource utilisation and avoids waste; (3) Accessible (geographically reasonable, timely and provided in a setting where skills and resources are appropriate to medical need; (4) Acceptable and patient-centred (takes into account need and demand and the aspirations of users; (5) Equitable (services that does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status; and (6) Safe (minimises risks and harm to service users.
Expected Outcomes *Strategic Objectives & Strategic Objective Statements*	***Strategic Objective 5.1) Improve compliance to the Ideal Clinic and National Core Standards*** 5.1.1) Sustain a patient experience of care rate of 95% (or more) at all public health facilities by March 2020 5.1.2) 60% (or more) public health hospitals compliant with extreme and vital measures of the national core standards by March 2020 ***Strategic Objective 5.2) Improve quality of care*** 5.2.1) Increase the percentage pharmacies that comply with the SA Pharmacy Council Standards (A or B grading) to 100% by March 2020 5.2.2) PPSD compliant with good Wholesaling Practice Regulations by March 2016 5.2.3) Decrease medicine stock-out rates to less than 1% in PPSD and all health facilities by March 2020

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PART B: STRATEGIC OBJECTIVES & TARGETS

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

10. PROGRAMME 1 - ADMINISTRATION

10.1 Programme Purpose

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

10.2 Programme Structure

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

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

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

Policy formulation, overall management and administration support to ensure effective service delivery.

The role of Management as Strategic Enabler comprises a host of support functions which is critical for effective and efficient service delivery. The policies that govern Administration stem from the prevailing transversal and sector specific legislative frameworks that governs the Public Service as a whole. The Department remains mindful of the democratic values and principles enshrined in Section 195 of the Constitution namely:

- A high standard of professional ethics;
- Efficient, economic and effective use of resources;
- Development orientated public administration;
- Services being provided impartially, fairly, equitably and without bias;
- Participative consultation and decision-making to ensure an appropriate response to people's needs;
- An accountable public administration;
- Transparency by providing the public with timely, accessible and accurate information;
- Good human resource management and career development practices to maximise human potential;
- A public administration broadly representative of the South African people.

10.3 Strategic Priorities

Priority 1: Finalise the integrated Long Term (Service Transformation) Plan

This high level strategic plan will encapsulate the Department's 10-year vision for transformation of health care services in KwaZulu-Natal. The Department fully acknowledges the intricate synergies between policy, systems, processes, burden of disease and service delivery demands as well as the collective contribution towards improved health systems reform. Salient processes, identified during the process of development and implementation thereafter, will therefore be incorporated in short and medium term plans to ensure that transformation processes stay evidence-based and relevant.

The purpose of the Long Term Plan is to develop an integrated, well consulted and evidence-based high level strategic plan that will inform and direct short, medium, and long-term plans of the KwaZulu-Natal Department of Health over the next 10 years and beyond. The plan will therefore serve as vehicle through which service transformation and delivery will take place. The framework of the plan will be inclusive of the following and will be reviewed annually:

Part A: Vision; Mission; Guiding principles; Critical success factors; Sectoral imperatives; and Situation analysis.

Part B: High level strategies to improve service delivery including: Background, Service demands, Service Delivery Platform and Plan for PHC re-engineering; Hospital Services (all categories); Emergency Medical Services; Forensic Pathology Services; and Community Based Training in a PHC Model (Business Plan).

Part C: High level strategies to improve systems and processes including Human resources for health; Infrastructure; Medicine supply and management; Information communication technology; Health information management; Quality improvement; Finance and Supply chain management; and Audit and risk.

Part D: Health financing; Monitoring and evaluation; Research and development; and Communication strategy (internal and external).

Priority 2: Improve Human Resources for Health

Finalise review of all organisational structures that will inform the development of annual Essential Posts Lists to address the rising costs of Compensation of employees and improve equitable distribution of essential resources so improving economies of scale. Staffing norms and standards, informed by the Workload Indicators of Staffing Needs (WISN) and research that commenced in 2014/15 under the KZN Health Epidemiology Component in partnership with the University of KwaZulu-Natal (UKZN) and Health Economics & HIV and AIDS Research Division (HEARD), will guide the finalisation of organisational structures.

The Human Resources for Health Strategy including a skills audit to inform training, development, mentoring and placement of staff; recruitment and retention strategies to improve recruitment of appropriately skilled personnel and reduce turnover rates; decrease turn around time for filling of posts; leave management; alignment of the skills development plan to identified training needs; and improve performance management and development will be prioritised over the reporting period.

Training of identified Mid-Level Workers and Clinical Associates will be explored in partnership with Higher Education.

The "Community-based training in a PHC model" will be prioritised over the reporting period in partnership with UKZN. Development of the decentralised Model is at an advanced stage and the Phase 1 pilot is expected to commence in 2016/17 in Region 4 (Uthungulu, Zululand and Umkhanyakude), after which it will be rolled out to Region 3 (Amajuba, Umzinyathi and Uthukela) and Region 2 (Ugu). The current training platforms in eThekwini and Umgungundlovu will be expanded in preparation of the large contingent Cuban students expected back in the Province in 2018/19.

Priority 3: Improve Financial and Supply Chain Management

The Department will actively pursue Operation Clean Audit to ensure clean audit results, transparency in reporting and improved service delivery.

The move to equitable and activity-based budgeting, which is expected to generate substantial cost savings (bottom-up budgeting based on service delivery information), commenced in late 2014/15 in preparation for the 2015/16 MTEF. This will be strengthened over the reporting period to ensure a budgeting approach that is realistic, equitable and inclusive to ensure that sufficient resources are allocated to facilities.

The implementation of effective systems e.g. automation of the SCM system and Inventory Management to improve contract management, improve budgeting, limit fraud and improve accuracy of information for improved decision-making have been prioritised.

Centralisation of SCM at district level to improve economies of scale, reduce irregular expenditure, support local market and job creation, standardise facility ordering processes and delegate procurement to facilities to reduce requisition delays for most items, and improve accountability. Delegations will be reviewed to support district mandates.

The automation of patient and administration systems to improve revenue collection, improve debt management, support revenue retention strategy and improve medical aid billing.

Priority 4: Improve Information Communication Technology

The Department will finalise the ICT Governance Framework and establish effective ICT governance structures.

ICT infrastructure will be improved to accommodate ICT priorities including (but not exclusive to) stable bandwith connectivity to enable the web-based reporting system for performance information and patient information system for institutions. Manual processes will be put in place to ensure a smooth transition.

Priority 5: Improve Information Management including Data Quality, Monitoring, Evaluation, Reporting and Research

The Data Management Turn-Around Strategy will be implemented to improve data quality, reduce the data error rate, towards a clean audit report for Performance Information from the Auditor General of SA.

Focussed quarterly performance reviews have been prioritised to improve data verification, information management for decision-making and planning and tracking of performance against targets.

Research for health, based on identified priorities to enhance evidence-based planning and decision-making, have been prioritised. The annual review of the Provincial Research Agenda for Health and partnerships with social partners and Institutions of Higher Learning to ensure relevance of research will be actively pursued during the reporting period.

Priority 6: Partnership with the University of KwaZulu-Natal

The Memorandum of Understanding between the KwaZulu-Natal Department of Health and University of KwaZulu-Natal was officially signed in December 2014 for a period of 5 years (2014-2019). *"Community Based Training in a PHC Model" (Business Plan available).* The development of decentralized clinical training platforms will expand to Tertiary, Regional, and District Hospitals, PHC clinics, CHC's and communities making provision for a strong rural development approach. The decentralized platforms will train students from all cadres of Health Care Professionals in a re-engineered PHC curriculum that will reflect a holistic, inter professional educational approach.

The development of the decentralized clinical training platforms in Regions 2, 3 and 4 will be done in a phased approach, starting in Region 4 (planned for 2016/17) with a small number of students with the aim to accommodate all students that will require clinical training in the decentralized platform in 2018/19. Lessons learned from trials and the phasing in of activities will be used to streamline the process to ensure efficient allocation and utilisation of resources and placement of students.

The Model will be aligned with the primary drivers for health in the Province and National Health Insurance to ensure optimal health service delivery to all communities and all members of the population. The PHC Curriculum will address service delivery and training of Health Care Professionals (HCPs) in the context of the re-engineering of PHC. This will necessitate an increase in training capacity, transformation of academic staff, transformation of the student body, the control and formalization of internship training, introduction of specialized training for mid-level career specific health care professionals, optimizing the training of Registrars/Specialists and the assurance that Continued Professional Development (CPD) is supported and provided from within the PHC context.

Commissions of the 2013 and 2014 Department of Health Strategic Planning workshops and ongoing discussions between the College of Health Sciences (CHS) and Department of Health Steering Committee focused on the needs for alignment of service and training needs. The CHS will increase the capacity of the clinical teaching platform to make provision for the clinical training of the large number of students that are being trained in medicine in Cuba and expected to return to the Province in 2018. Cuban trained students currently join the MBChB programme for an additional 18 months of training, which means that in 2018 the CHS and the Department need to make provision for the increase of approximately 350 clinical training placements.

The Nelson Mandela-Fidel Castro Collaboration Programme for training of medical students forms part of the South African government's drive to address the critical shortage of medical doctors particularly in the public health sector where 40% of medical doctors provide services to 87% of the population (uninsured). Cuba, with just more than one-fifth of the South African population, report a

ratio of 67 Medical Officers per 10 000 population, compared with 2.9 per 10 000 in KwaZulu-Natal (based on Stats SA 2014 mid-year population estimates). The Cuban training programme is prohibitively expensive especially in the current fiscal environment with National Treasury imposing 1, 2 and 3 per cent baseline cuts on all spheres of government over the next 3 years to curb the national deficit as public spending is growing faster than revenue collection. In addition, KZN received reduced equitable share allocations as a result of the reduced population reported in the 2011 Census. The increased intake of students by the CHS and the proposed Community-Based Model will therefore fill an important niche in increasing the skills pool.

10.4 Strategic Objectives and Expected Outcomes

Table 23: Strategic objectives and expected outcomes

Strategic Objective	Strategic Objective Statement	Indicator	Baseline 2013/14[10]	Target 2019/20
Strategic Goal 1: Strengthen health system effectiveness				
1.1) Finalise integrated long term health service improvement platform	1.1.1) Long Term Plan approved by March 2016 and implemented and monitored thereafter	Provincial Long Term Plan	Draft Plan	Long Term Plan implemented and monitored
1.2) Improve financial management and compliance to PFMA prescripts	1.2.1) Annual unqualified audit opinion for financial statements and performance information from 2015/16 onwards	Audit opinion from Auditor-General	Qualified opinion (2013/14)	Unqualified opinion from 2015/16 onwards
	1.2.2) Maintain financial efficiency by ensuring under/ over expenditure within 1% of the annual allocated budget throughout the reporting cycle	Percentage over/ under expenditure	New indicator	Expenditure within 1% of annual allocated budget
1.3) Improve Supply Chain Management	1.3.1) Costed Procurement Plan for minor and major assets by the end of April in each reporting year	Annual Procurement Plan	New indicator	Annual costed Procurement Plan
	1.3.2) Ensure that 100% sites registered on the asset system account for all assets by performing monthly reconciliation reports by March 2016 and annually thereafter	Number of registered sites performing monthly asset reconciliation reports	New indicator	All registered sites
1.4) Improve health technology and information management	1.4.1) Connectivity established at 100% public health facilities by March 2018	Percentage of public health facilities with stable bandwidth connectivity	New indicator	100%
	1.4.2) Web-based health information system established in 90% public health facilities by March 2020 (National 700 Clinic Project)	Percentage of public health facilities with a web-based health information system	New indicator	90%

[10] Baseline is based on one full year data (2013/14) unless otherwise indicated

Strategic Objective	Strategic Objective Statement	Indicator	Baseline 2013/14[10]	Target 2019/20
	1.4.6) Reduce performance data error rate to 2% (or less) by March 2020	Audit error rate (PHC clinics, CHC's and Hospitals)	New indicator	2% (or less)
Strategic Goal 4: Strengthen human resources for health				
4.1) Improve human resources for health	4.1.1) Long Term Human Resources Plan approved by March 2016 and implemented and monitored thereafter	Long Term Human Resources Plan	No Long Term HR Plan	Long Term HRP implemented and monitored
	4.1.2) Finalise 610 organisational structures by March 2020	Number of organisational structures finalised	Review approved Macro structure	610
	4.1.3) Implement the Community Based Training in a PHC Model in collaboration with the University of KwaZulu-Natal with Phase 1 pilot commencing in 2016/17	Community Based Training in a PHC Model	Draft Model and Business Plan	Model implemented

LINKS TO OTHER PLANNING FRAMEWORKS

National Development Plan 2030

Strategic Goal 6: Health system reforms completed

Strategic Goal 9: Posts filled with skilled, committed & competent individuals

Priority b: Strengthen the health system

Priority c: Improve health information systems

Priority f: Improve human resources in the health sector

Medium Term Strategic Framework 2014-2019

Sub-Output 4: Reduced health care cost

Sub-Output 5: Improved human resources for health

Sub-Output 6: Improved health management & leadership

Sub-Output 10: Efficient health information management system developed and implemented to improve decision-making

10.5 Resource Considerations

It is the Department's policy to keep the Programme 1 allocation at a maximum of two per cent of the total budget. The programme budget also includes the cost of medico legal claims and other central costs such as audit fees, recruitment and advertising fees. The negative growth in 2015/16 is attributed to a decision to utilise internal capacity to conduct disciplinary inquiries, with only complex cases referred to consultants.

The increasing trend in *Compensation of employees* from 2012/13 onwards relates to the need to improve management capacity at head office to address the challenges of service delivery.

The recruitment and retention of key skilled staff remains a challenge within this programme, especially relevant to key Senior Management posts which shows a high turnover rate over the past 3 years.

High cost drivers in the programme includes:

- Compensation of employees.
- Information Communication Technology including infrastructure, E-Health, M-Health and Telemedicine.
- Medico-legal claims (strategies which are included under improved quality of care and clinical governance) – component of the National Core Standards implemented by all facilities.

10.6 Risk Management

Table 24: Key Risk Factors

Key Risk Factors	Measures to Mitigate Risks
1. Inadequate funding envelope (in keeping with the 2 per cent allocation of the total budget) may delay or jeopardise execution of some priorities including (but not exclusive to): • Implementation of the Provincial Long Term Plan. *(High Risk)* • Funded organisational structures and filling of essential posts - minimum 3-month turnaround time. *(High Risk)* • Establishing essential ICT infrastructure for identified priorities including (but not exclusive to) automation of finance and SCM; web-based information system; patient information system; Telemedicine; FPS; EMS; Laundry services; etc. *(High Risk)* • Community-based training in PHC model: Accommodation and filling of essential posts as required by teaching and service delivery platforms. *(High Risk)*	• Re-prioritise strategic priorities over the next 5 years to ensure realistic financial forecasts on the basis of evidence and equitable allocation. • Activity-based budgeting (bottom-up and top-down) to facilitate cost saving. • Improve financial management and accountability. Robust monitoring of expenditure at all levels. • Limit ad-hoc in-year planning and unfunded mandates by aligning the planning and budgeting cycles. • Align Performance Agreements of Senior Managers with strategic priorities to ensure accountability.

Key Risk Factors	Measures to Mitigate Risks
2. SCM inefficiencies including delays in procurement of goods and services, and inadequate asset management which will impact on audit outcomes. *(High Risk)*	• Automation of the SCM system and inventory management. • Filling of essential posts. • Centralisation of SCM services at district level to reduce bottlenecks and improve turn-around times.
3. Poor data quality (performance and other) with significant risk to audit outcomes, evidence-based decision-making and planning, budget allocation, expenditure and service delivery outputs and outcomes. *(High Risk)*	• Implement the Information Management Turn-Around Strategy including (but not exclusive to) systems and processes to improve data capturing, validation, interpretation, reporting and utilisation of information. • Implementation of web-based system for performance information (700 clinic National Project) that will be rolled out over the next 5 years. • Routine Persal clean-up to improve quality of personnel information. • Quarterly reviews of performance information and expenditure to improve veracity of data and alert to red flags. • Audit and Risk strategy to monitor high risk factors and proactively address red flags.
4. Challenges in recruiting and retaining appropriately skilled human resources (administration and operational) aggravated by the limiting funding envelope. *(High Risk)*	• Human Resources Long Term Plan aligned with Departmental mandates and essential post list to inform filling of prioritised posts (within the available funding envelope). • Review recruitment and retention strategy. • Scale up implementation of leadership and management training and mentoring strategy.
5. Remuneration, including pay progression and Occupational Specific Dispensation (OSD) of health professionals remains a challenge especially within the current funding envelope. *(High Risk)*	• Improved financial management and re-pioritisation to make provision for compensation of employees pressures.

11. PROGRAMME 2 - DISTRICT HEALTH SERVICES

11.1 Programme Purpose

To render Primary Health Care Services and District Hospital Services

11.2 Programme Structure

Sub-Programme 2.1: District Management

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

Sub-Programme 2.2: Community Health Clinics

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

Sub-Programme 2.3: Community Health Centres

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

Sub-Programme 2.4: Community-Based Service

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

Sub-Programme 2.5: Other Community Services

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

Sub-Programme 2.6: HIV and AIDS

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

Sub-Programme 2.7: Nutrition

Render nutrition services aimed at specific target groups and combines direct and indirect nutrition interventions to address malnutrition.

Sub-Programme 2.8: Coroner Services

Render forensic and medico legal services in to establish the circumstances and causes surrounding unnatural death.

Sub-Programme 2.9: District Hospitals

Render hospital services at district level.

11.3 Provincial Priorities

Ten districts are managed by District Managers (level 13) and the eThekwini Metro by 2 District Managers (level 13). The Department started the process to demarcate the eThekwini Metro into 4 service management areas, which will be finalised within the reporting period. Four functional Regions have been established to decentralise more functions in order to reduce bottlenecks. One Regional Manager post is filled (level 14) and the remaining 3 vacant posts are in the process of being filled.

The Department provincialised all Local Government clinics in 2013/14 and 2014/15 except clinics in the eThekwini Metro. The Department has a service level agreement with eThekwini for the rendering of PHC services and R105mil, R111mil and R115mil have been allocated to the Metro for this purpose over the 2015/16 MTEF.

The establishment of District Health Councils will be concluded during the reporting period.

District Management Teams are providing oversight of all District Health Services within which a range of commumity and facility-based PHC and District Hospital services are being rendered. PHC clinics and CHC's provide oversight at community and facility levels and District Hospitals provide essential clinical governance and outreach/ support services to clinics and CHC's in their catchment areas.

Operationalisation of priorities at district and facility level will be monitored through the Monitoring and Evaluation Framework informed by robust quarterly reviews of performance and expenditure.

Priority 1: Re-engineering of PHC

Operation Phakisa Ideal Clinic Realisation and Maintenance (ICRM), one of the Presidential priorities, will be prioritised over the next 5 years. The programme is based on the Malaysian 8-step problem solving methodology commonly known as "Big Fast Results". The Presidency renamed the Model "Operation Phakisa" to fast-track delivery on the NDP 2030 priorities and in this case fast track initiatives to improve the efficiencies and quality at PHC clinics and CHCs. National Cabinet approved implementation of the ICRM Lab (23 October – 21 November 2014) with the goal to produce a highly detailed national implementation plan including a strong theory of change, responsible owners of activities; timelines; targets; and monitoring and evaluation, reporting and accountability framework. All stakeholders will be accountable for delivery and progress will be monitored by the Presidency (Department of Planning Monitoring & Evalation).

ICRM implementation focusses on 8 main streams including: (1) Service delivery; (2) Waiting times; (3) Supply chain management; (4) Financial management; (5) Infrastructure; (6) Human resources for health; (7) Institutional arrangements; and (8) Scale up and sustainability. The programme output and outcomes will be monitored using the core standards incorporated in the Ideal Clinic Dashboard (version 15) which has been aligned with the National Core Standards which is monitored by the Office of Standard Health Compliance.

Community-based services including health promotion, prevention initiatives, health screening and detection at household level will be scaled up over the reporting period. It is expected that intensified community-based services will reduce facility-based pressures as well as capacitate community members to take ownership of their own health and play a more active role in prevention and treatment adherence. These services will have a strong link with Operation Sukuma Sakhe to ensure multi-sectoral collaboration to address the social determinants of health and other identified priorities incorporated in the Provincial Growth and Development Plan.

Mobile services will be expanded to cover areas with poor access to fixed facilities and services.

Community-based outreach teams including teams for PHC, School Health, Mental Health, and TB/ MDR/ XDR-TB will be expanded prioritising the 169 wards worst affected by poverty (list of wards attached as Annexure) as part of the KZN Poverty Eradication Master Plan. Teams will be attached to PHC clinics from which oversight will be rendered.

Fully functional *District Clinical Specialist Teams*, with a minimum staff composition of a Paediatrician, Gynaecologist, Family Physician, Specialist PHC Nurse, Advanced Midwife and Paediatric Nurse, will be appointed in all districts to provide clinical governance and support in districts. National composition of teams includes an Anaethetis which proofs to be extremely difficult to recruit for these teams.

Regionalisation will be concluded including finalisation of the organisation structure and filling of essential posts.

The Chronic Medication Dispensing and Supply Model will be expanded to improve access to pre-packed chronic medication at community level. This will ensure that patients receive their pre-packed chronic medication at venues closer to home, and will reduce waiting times in clinics, CHC, hospitals and pharmacies.

The *National Health Insurance pilot* will continue in the 3 pilot districts of Umgungundlovu, Umzinyathi and Amajuba. Lessons learned will be duplicated in other districts and included in the Provincial Long Term Plan. Medical Officer coverage will be increased through contracts with General Practitioners.

Priority 2: Rationalisation of Hospital Services to improve Equity, Efficiency and Quality

There are 37 District Hospitals in the Province. Twenty nine (29) of these hospitals have Gateway clinics to ensure that PHC clients enter the health system at the appropriate level of care. The high number of unreferred PHC patients attending outpatient services in hospitals without Gateways is evidence that Gateway clinics play a critical role in decongesting hospitals resulting in considerable cost savings.

The public hospital system is central to successful implementation of the PHC approach. Challenges of inequity, inefficiency and poor quality of services must therefore be addressed to bring the public hospital system in line with the National Health System transformation process. Hospitals absorb the major share of health expenditure in the Province, and as the demand for hospital care increases and the cost of provision rises, it is essential to make more efficient use of the resources already devoted to hospitals.

A Hospital Rationalisation Plan (as part of the Provincial Long Term Plan) will be finalised in 2015/16 to guide service transformation of hospital services in the Province. There will be a strong focus on:

Efficiency (output in relation to input) and affordability: Analysis of unit costs, workload ratios per level of care, and general hospital performance taking into account the package of services and service quality to define the parameters of performance to guide and monitor hospital management and efficiency.

Trends as a result of changes in medical technology and clinical care will be analysed to project the impact on inpatient care e.g. due to advances in technology the average length of stay will reduce hence throughput per bed will increase. This will result in higher costs per bed night (patients treated more intensively over a short period instead of staying longer for a period of recovery which typically has a lower cost per day). Such trends imply that in order to control costs and maintain efficiency the number of hospital beds has to be reduced while the number of patients will rise because the average length of stay will reduce.

Analysis of population structure and geographical distribution, access to care (insured versus uninsured population) and likely utilisation of hospital services (admission ratios per level of care). Projections of staffing workloads (taking into consideration demography and burden of disease) to project staffing and good and services needs per service level and speciality/ sub-speciality.

The Plan will make provision for *(also relevant to Programmes 4 and 5)*:

- Review of hospital classification based on the package of services and efficiencies.
- Package of services with required support functions for successful implementation and expansion (funding allowed).
- A human resources plan, including staffing norms and standards to inform organisational structures.
- Decentralisation of hospital management including delegation of authorities, capacity development and accountability.
- Oversight and clinical governance arrangements including improved outreach services and mentorship programmes.
- Development of hospital complexes and centres of excellence.
- Establishment of District Hospital Caesarean Section Centres to improve maternal and neonatal health outcomes.
- Support and transversal services including Food, Security, Laundry and Clinical Support services.
- Establishment of hospital boards to improve accountability to communities and improve enegagement with local lmanagement structures.
- Consultation and communication: Planned reforms will be widely consulted and communicated to staff, other stakeholders and the community. This will form part of the overall Communication Strategy.
- Implementation Plan – including performance measures, targets and timelines that will be monitored and reported to stakeholders.

All hospitals will continue to implement the National Core Standards focussing on the 7 identified domains each with a number of standards and criteria intended to improve quality and efficiency of health establishments. (1) Patient rights; (2) Patient safety, clinical governance & care; (3) Clinical support services; (4) Public health; (5) Leadership and corporate governance; (6) Operational management; and (7) Facilities & infrastructure.

The six "fast track" areas include: (1) Values and attitudes of staff; (2) Cleanliness; (3) Waiting times; (4) Patient safety and security; (5) Infection prevention and control; and (6) Availability of basic medicines and supplies. The Office of Health Standard Compliance will independently assess hospitals for accreditation.

Priority 3: Reduce HIV Incidence and Manage HIV Prevalence

The Province remains committed to implementation of the Comprehensive and Integrated Plan for HIV, AIDS and STI's. The Provincial Cabinet endorsed the Multi-Sectoral Provincial Strategic Plan (KZNPSP) for HIV and AIDS, STI and TB 2012 – 2016, which has been aligned with the National Strategic Plan and provides the roadmap for intensified action. The KZNPSP is aligned with the Provincial Growth and Development Strategy. The service delivery approach is re-enforced by Operation Sukuma Sakhe, the PHC re-engineering Model, and National Health Insurance Policy. The current plan sets ambitious targets to curb new infections and reduce morbidity and mortality.

During the reporting period the Province will accelerate implementation of integrated HIV, AIDS and TB prevention programmes through Operation Sukuma Sakhe including mass mobilisation and community dialogue, targeting key populations e.g. institutions of higher learning ("Graduate Alive") prisons, farm workers and taxi ranks (counselling, testing, and condom distribution, and increase medical male circumcision using mobile services and roving teams.

The ART programme will be expanded to ensure that all eligible patients receive treatment and support. Adherence management will be scaled up (including community based initiatives e.g. Mpilonde chronic clubs). Decanting of patients from hospital to PHC level will continue although resources at PHC level continue to pose a challenge which is hampered by funding constraints.

Priority 4: Improve TB Outcomes

The Department will identify TB "hot spots" with particular attention to informal settlements and key populations e.g. prisons, to scale up services for active case finding, door to door training, follow-up and support to strengthen prevention, support and adherence management.

TB Injection Teams will be increased as part of the scale up of the community-based MDR/XDR-TB programme. Decentralied MDR-TB Initiation sites will be established in Amajuba, Ilembe and Uthukela to improve access to services and to reduce service pressures on King Dinuzulu Hospital in eThekwini where patients are currently initiated on treatment.

TB Teams will be deployed in the 169 wards worst affected by poverty as part of the Provincial Poverty Eradication Strategy.

Priority 5: Reduce Maternal, Neonatal and Child Morbidity and Mortality and Improve Women's Health

Improving maternal, child and women's health services is key to achieving Millennium Development Goals 4 and 5. Services include antenatal. Intra-partum and postnatal care, neonatal care and child health services at all levels and sexual and reproductive health services – supported by nutrition services. Staff are up-skilled through various programmes such as the IMCI (Integrated Management of Childhood Illnesses), infant feeding, BANC (Basic Antenatal Care), ESMOE (Essential Steps in Management of Obstetric and Neonatal Emergencies), contraceptive training and CTOP (Choice on Termination of Pregnancy).

Maternal and child morbidity and mortality have improved over the past decade as a consequence of the introduction of ARV treatment, success of the PMTCT (prevention of mother to child transmission) programme, and other interventions targeting women and children.

During the planning cycle, the Department will *strengthen business processes* including the development and implementation of service standards, standard operating procedures, the client charter for quality of care; and maternal, infant and child mortality reviews.

Community-based health promotion and prevention programmes will be strengthened through Operation Sukuma Sakhe to ensure an integrated comprehensive approach in addressing the social determinants of health and to accelerate community participation and ownership of programmes. The *scope of practice of CCG's* will be reviewed to make provision for limited therapeutic functions including issuing of Vitamin A, emergency contraceptives, deworming medication, and doing pregnancy testing at community level.

The Department will continue to intensify implementation of CARMMA (Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa) and Siyanqoba (MDG countdown focussing on (1) Reaching 3 million young women and girls as part of the contraceptive campaign; (2) District response plans to the 16 +2 key interventions of Siyanqoba; (3) Hospital Siyanqoba Quality Improvement programme including standard operating procedures for completeness of the partogram, responsiveness of the health system, and emergency response; (4) Linking the CCGs to the pregnant and postnatal women and neonates; and (5) Immunisation catch-up and oral rehydration campaign).

Focus for maternal health will include optimising caesarean section management by establishing District Hospital Caesarean Section Centres at identified hospitals; placement of Advanced Midwifes in PHC/ CHCs and District Hospitals; establishing Midwifery Obstetric Units at Regional Hospitals and strengthen Units at 24hour PHC clinics (CHCs) and Waiting Mothers Lodges; scaling up the Partograms Quality Improvement project (monthly auditing of completeness and correctness of partograms); and EMS harmonisation i.e. location of specialised EMS vehicles at high volume delivery facilities. Early detection/ treatment of HIV and TB in pregnant women. PMTCT

Focus for neonatal care will be on implementation of the integrated management of newborn care package; establishment of Neonatal Intensive Care Units (ICUs) at identified hospitals (in districts where there are no regional hospitals); Kangaroo Mother Care (KMC) for all low birth weight babies in all hospitals and CHCs; appropriate staffing and equipment at all nurseries; and daily ward rounds in all paediatric wards and neonatal wards including weekends.

Phila Mntwana sites will be rolled out to all war rooms (Operation Sukuma Sakhe) to expand access to services for oral rehydration, deworming, growth monitoring, nutritional supplements and education on nutrition and other relevant health matters.

Cervical and breast cancer programmes remain at the core of priority programmes to reduce morbidity and mortality. The screening, early detection and treatment of breast and cervical cancers remains a priority as part of the Phila Ma campaign. The Department will strengthen *Family Planning* services through the "Reaching 3 Million Young Women by 2015 campaign" with the main focus on prevention of unplanned, unwanted or high risk teenage pregnancy. Access to *Choice on Termination of Pregnancy* services will be expanded to all hospitals and CHCs (medical and surgical termination) with a strong emphasis on counselling and support.

Poverty and deprivation remain key "upstream" factors making children vulnerable to preventable diseases like lower respiratory tract infections, diarrhoea and malnutrition.

Malnutrition remains a major contributing factor to child morbidity and mortality and the Department will therefore scale up active case finding of children with malnutrition as well as the effective management of mild and severe malnutrition in children. Through Operation Sukuma Sakhe the Province will expand poverty reduction strategies to decrease malnutrition where it is an underlying condition of child and women mortalities – starting in the 169 wards worst affected by poverty.

Priority 6: Reduce Incidence of Non-Communicable Diseases and Manage Prevalence

The Provincial 5 year strategies for Non-Communicable Diseases and Mental Health are awaiting final approval. The strategies make provision for implementation plans and targets over the next 5 years and will set the tone for identification of priorities.

There will be a strong focus on health promotion, healthy lifestyle programmes, mass screening and early detection and effective management of all chronic conditions. Counselling and screening for cancer, diabetes, hypertension, blindness, hearing and genetic defects will be prioritised during the reporting period.

The Department will continue to integrate services in the 6 mobile dental units (3 fully equipped and operational in Umzinyathi, Umgungundlovu and eThekwini Districts and 3 units awaiting registration) and the NHI mobile bus allocated and operational in eThekwini. Eye and dental care services, rehabilitation and PHC services are provided daily and mobiles have been fully integrated with the School Health Programme and community based initiatives as part of Operation Sukuma Sakhe.

Rationalisation of comprehensive eye care services in the McCords Hospital in eThekwini has been prioritised for the 2015/16 MTEF. The organisational structure has been finalised (awaiting approval) and infrastructure renovation to the value of R4 million has been completed. Telemedicine plans are in an advanced stage of development and expected to be activated in 2015/16. Consolidation of eye care services at Addington and St Aidens Hospitals are at an advanced stage which will significantly increase the number of cataract operations per year.

Priority 7: Reduce Malaria Incidence

The Department will continue with strategies for prevention, early diagnosis and treatment of malaria.

11.4 Strategic Objectives and Expected Outcomes

Table 25: Strategic objectives and expected outcomes

Strategic Objective	Strategic Objective Statement	Indicator	Baseline 2013/14 [11]	Target 2019/20
Life Expactancy				
Strategic Goal 2: Reduce and manage the burden of disease				
2.1) Increase life expectancy at birth	2.1.1) Increase the total life expectancy to 60.5 years by March 2020	Life expectancy at birth: Total	56.9 years in 2014	60.5 years (increase of 3.6 years from 2014)
	2.1.2) Increase the life expectancy of males to 58.4 years by March 2020	Life expectancy at birth: Male	54.4 years in 2014	58.4 years (increase of 4 years from 2014)
	2.1.3) Increase the life expectancy of females to 62.7 years by March 2020	Life expectancy at birth: Female	59.4 years in 2014	62.7 years (increase of 3.3 years from 2014)
Primary Health Care				
Strategic Goal 1: Strengthen health system effectiveness				
1.5) Accelerate implementation of PHC re-engineering	1.5.1) Accelerate implementation of PHC re-engineering by increasing household registration coverage with at least 15% per annum	Outreach household registration visit coverage (annualised)	35.3%	90%
	1.5.2) Increase the number of ward based outreach teams in the 169 wards worst affected by poverty to 169 by March 2020 as part of the Poverty Eradication Programme	Number of ward based outreach teams in the 169 wards worst affected by poverty (cumulative)	New indicator	169
	1.5.3) Increase the PHC utilisation rate to 3.1 visits per person per year by March 2020	PHC utilisation rate (annualised)	3	3.1

[11] Baseline is based on one full year data (2013/14) unless otherwise indicators

Strategic Objective	Strategic Objective Statement	Indicator	Baseline 2013/14 [11]	Target 2019/20
	1.5.4) Increase the PHC utilisation rate under 5 years to 4.8 visits per child by March 2020	PHC utilisation rate under 5 years (annualised)	4.4	4.8
1.6) Scale up implementation of Operation Phakisa Ideal Clinic Realisation and Maintenance (ICRM)	1.6.1) 100% Provincial fixed PHC facilities score above 80% on the Ideal Clinic Dashboard by March 2020	Percentage of fixed PHC facilities scoring above 80% on the Ideal Clinic Dashboard	6.25%	100%
Strategic Goal 5: Improved quality of health care				
5.1) Improve compliance to the Ideal Clinic and National Core Standards	5.1.1) Sustain a patient experience of care rate of 95% (or more) at all public health facilities by March 2020	Patient experience of care rate	75%	95% (or more)
HIV, AIDS and STIs				
Strategic Goal 2: Reduce and manage the burden of disease				
2.2) Reduce HIV Incidence	2.2.1) Reduce the HIV incidence to 1% (or less) by March 2020 (ASSA2008 estimates)	HIV incidence	1.01% (ASSA2008 estimate)	1% (or less)
	2.2.2) Test 9 million people (cumulative) for HIV by March 2020	Client tested for HIV (including ANC)	2 373 268 (estimate 2014/15)	9 million (cumulative)
2.3) Manage HIV prevalence	2.3.1) Reduce the HIV prevalence among 15-24 year old pregnant women to 25% by March 2020	HIV prevalence among 15-24 year old pregnant women	25.8% (2012)	25%
	2.3.2) Increase the number of patients on ART to 1 450 000 (cumulative) by March 2018	Total clients remaining on ART	926 416 (2014/15 estimate)	1 450 000

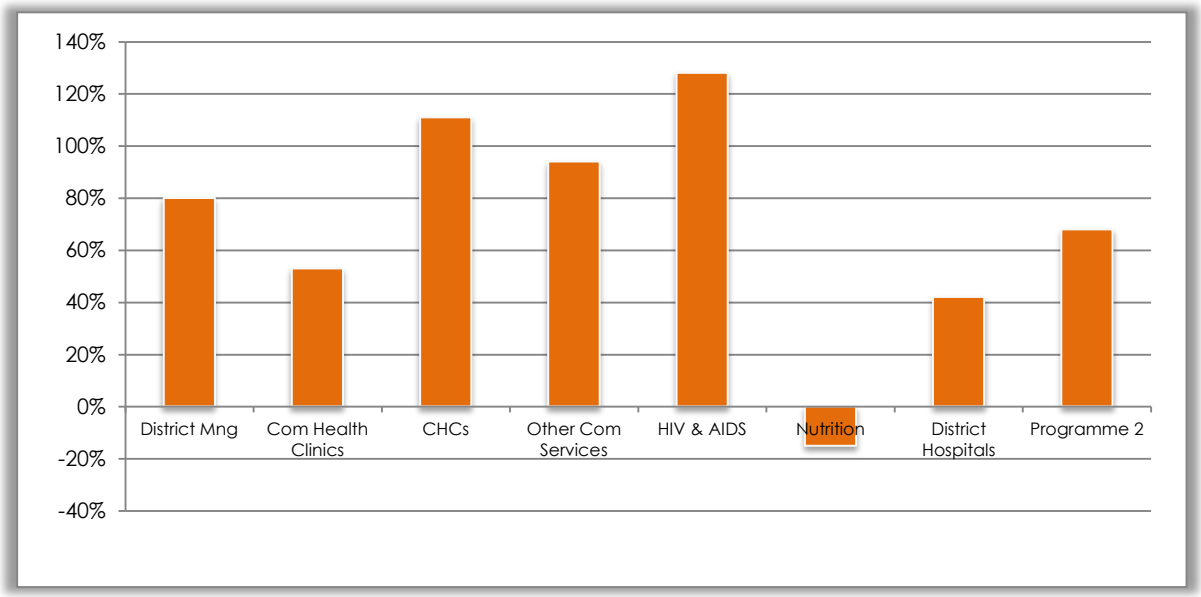
Strategic Objective	Strategic Objective Statement	Indicator	Baseline 2013/14 [11]	Target 2019/20
Tuberculosis				
Strategic Goal 2: Reduce and manage the burden of disease				
2.4) Improve TB outcomes	2.4.1) Increase the TB new client treatment success rate to 90% (or more) by March 2020	TB new client treatment success rate	85%	90%
	2.4.2) Reduce the TB incidence to 400 (or less) per 100 000 by March 2020	TB incidence (per 100 000 population)	898 per 100,000 (2013/14)	400 (or less) per 100,000
	2.4.3) Decrease the TB death rate to 2% by March 2020	TB death rate	4.7%	2%
	2.4.4) Increase the MDR-TB treatment success rate to 75% (or more) by March 2020	MDR-TB treatment success rate	62%	75% (or more)
Maternal, Neonatal, Child & Women's Health and Nutrition				
Strategic Goal 2: Reduce and manage the burden of disease				
2.5) Reduce infant mortality	2.5.1) Reduce the infant mortality rate to 29 per 1000 live births by March 2020	Infant mortality rate	31.4 per 1000 live births	29 per 1000 live births
	2.5.2) Reduce the mother to child transmission of HIV to less than 0.5% by March 2020	Infant 1st PCR test positive around 6 weeks rate	1.6%	Less than 0.5%
2.6) Reduce under 5 mortality	2.6.1) Reduce the under 5 mortality rate to 40 per 1000 live births by March 2020	Under 5 mortality rate	42.6 per 1000 live births	40 per 1000 live births
	2.6.2) Reduce severe acute malnutrition incidence under 5 years to 4.6 per 1000 by March 2020	Child under 5 years severe acute malnutrition incidence (annualised)	5.6 per 1000	4.6 per 1000
2.7) Reduce maternal mortality	2.7.1) Reduce the maternal mortality in facility ratio to 100 (or less) per 100 000 live births by March 2020	Maternal mortality in facility ratio (annualised)	147 per 100 000 live births	100 (or less) per 100 000 live births
2.8) Improve women's health	2.8.1) Increase the couple year protection rate to 75% by March 2020	Couple year protection rate	45%	75%
	2.8.2) Maintain the cervical cancer screening coverage of 75% (or more)	Cervical cancer screening coverage	75.3%	75% (or more)

Strategic Objective	Strategic Objective Statement	Indicator	Baseline 2013/14 [11]	Target 2019/20
Non-Communicable Diseases				
Strategic Goal 2: Reduce and manage the burden of disease				
2.9) Reduce incidence of non-communicable diseases	2.9.1) Decrease hypertension incidence by at least 10% per annum	Hypertension incidence (annualised)	21.9 per 1000	11.4 per 1000
	2.9.2) Decrease diabetes incidence by at least 10% per annum	Diabetes incidence (annualized)	1.5 per 1000	0.65 per 1000
2.10) Eliminate malaria	2.10.1) Zero new local malaria cases by March 2020	Malaria incidence per 1000 population at risk	0.11 per 1000 population at risk	Zero new local malaria cases
	2.10.2) Reduce malaria case fatality rate to less than 0.5% by March 2020	Malaria case fatality rate	1.7%	Less than 0.5%
District Hospitals				
Strategic Goal 1: Strengthen health system effectiveness				
1.7) Improve hospital efficiencies	1.7.1) Maintain a bed utilisation rate of 75% (or more)	Inpatient bed utilisation rate	64.5%	75% (or more)
	1.7.2) Develop and implement the approved Hospital Rationalisation Plan by March 2016	Hospital Rationalisation Plan	No Rationalisation Plan	Plan implemented
Strategic Goal 2: Reduce and manage the burden of disease				
2.7) Reduce maternal mortality	2.7.2) Improve maternal health outcomes by establishing 11 District Caesarean Section Centres by March 2018	Number of fully functional District Caesarean Section Centres (cumulative)	0	11
Strategic Goal 5: Improved quality of health care				
5.1) Improve compliance to the Ideal Clinic and National Core Standards	5.1.1) Sustain a patient experience of care rate of 95% (or more) at all public health facilities by March 2020	Patient experience of care rate	88.2%	95% (or more)
	5.1.2) 60% (or more) public health hospitals compliant with extreme and vital measures of the national core standards by March 2020	Percentage of hospitals compliant with all extreme and vital measures of the national core standards	0%	60% (or more)

Strategic Objective	Strategic Objective Statement	Indicator	Baseline 2013/14 [11]	Target 2019/20
LINKS TO OTHER PLANNING FRAMEWORKS				
National Development Plan 2030				
Strategic Goal 2: TB prevention & cure progressively improved				
Strategic Goal 3: Maternal, infant and child mortality reduced				
Strategic Goal 4: Prevalence of NCD's reduced by 28%				
Strategic Goal 6: Health system reforms completed				
Strategic Goal 7: PHC teams deployed to provide care to families & communities				
Priority a: Address the social determinants that affect health and diseases				
Priority b: Strengthen the health system				
Priority d: Prevent and reduce the disease burden and promote health				
Priority h: Improve quality by using evidence				
Medium Term Strategic Framework 2014-2019				
Sub-Output 2: Improved quality of health care				
Sub-Output 3: Implement the re-engineering of PHC				
Sub-Outputs 4: Reduced health care cost				
Sub-Output 6: Improved health management & leadership				
Sub-Output 8: HIV, AIDS & TB prevented & successfully managed				
Sub-Output 9: Maternal, infant & child mortality reduced				
Provincial Growth and Development Plan 2030				
Strategic Objective 3.2a: PHC re-engineering				
Strategic Objective 3.2b: Accelerate HIV, AIDS & STI prevention programmes				
Strategic Objective 3.2e: Promote healthy lifestyle and mental health programmes				
Strategic Objective 3.2f: Accelerate programmes to improve maternal, child & women's health outcomes				
Strategic Objective 3.2g: Accelerate programmes to improve TB outcomes				
Millennium Development Goals				
Goal 1: Eradicate extreme poverty & hunger (nutrition)				
Goals 4: Reduce child mortality				
Goal 5: Improve maternal health				
Goal 6: Combat HIV, Malaria & other diseases				

11.5 Resource Considerations

Graph 11: Percent change in Programme 2 equitable share budget (2011/12 – 2017/18)



Between 2011/12 – 2017/18, the Programme 2 budget for District Health Services (excluding Coroner Services) shows a total increase of 69% (10 159 914 – 17 148 963), which is evidence that the Department prioritised PHC re-engineering. During the same period, the budget for Compensation of employees increased with 65% (6 846 189 - 11 326 737) and Goods and services with 78% (2 977 285 - 5 298 172). During the same period, the Compensation of employees budget was 67% and 66% of the total budget for District Health Services which is within the acceptablel norm.

There is no dedicated budget for maternal, child and women's health services as budgets are allocated from various budget sub-programmes including Community Services, PHC, and Hospital services (District, Regional, Tertiary and Central).

The Nutrition allocation shows a negative growth as budgets have been transferred to Hospital Sub-Programmes to ensure effective allocation at district level. The significant increase for CHCs is due to additional CHCs being commissioned during the reporting period. Three additional CHCs will be commissioned during the reporting cycle which places significant pressures on the budget.

The increase in the HIV allocation is due to the increased number of patients on ART as a result of policy changes (earlier initiation on treatment) as well as an evolving prevention programme. The HIV and AIDS Programme has the additional benefit of the HIV/AIDS Conditional Grant.

Additional funding for District Hospitals has been allocated from Specialised Hospital Sub-Programmes to cover costs for TB decentralised units at Manguzi, Hlabisa, and Catherine Booths Hospitals.

The filling of District Management posts is essential to ensure effective operationalisation of strategies and oversight.

It is expected that the increase for District Hospitals will stabilise as efficiencies increase. This has been targeted for the reporting cycle.

11.6 Risk Management

Table 26: Key Risk Factors

Key Risk Factors	Measures to Mitigate Risks
1. Increase in demand of services as a result of the high burden of disease, poor access to essential services and high deprivation levels in the majority of districts. Annual budget cuts, imposed by National Treasury, would require annual re-prioritisation of intended input and output to align priorities with the funding envelope. *(High Risk)*	• Annual alignment of service delivery and budget re-prioritisation. • Activity-based budgeting using evidence as foundation for allocation. • Social determinants of health addressed as part of the inter-sectoral collaboration through implementation of the Provincial Growth and Development Plan and Operation Sukuma Sakhe.
2. High demand for PHC infrastructure upgrade and maintenance, especially provincialised Local Government facilities. Space constraints in many facilities due to the increased demand at PHC level (decanting of ART patients to PHC, pharmaceutical requirement for storage of medicine, rehabilitation services, etc.) further increase demand for expansion and upgrade. Limited budget for infrastructure projects might therefore delay projects with an impact on realisation of targets e.g. Ideal Clinic Realisation and Maintenance. *(High Risk)*	• Maintenance, upgrade and refurbishment prioritised in the Infrastructure Long Term and User Asset Management Plans. • Ideal Clinic self-assessments (against Ideal Clinic Dashboard) inform infrastructure priorities. Infrastructure represented on Provincial Task Team for scale up of the Ideal Clinic Project.
3. Lack of finalised organisation structures for Regional and District Offices, PHC clinics, CHC's and District Hospitals impact on the filling of essential posts to ensure the equitable distribution of resources as well as effective leadership, management and oversight. *(High Risk)*	• The development of costed organisational structures has been prioritised and will be in line with the Long Term Human Resources Plan. • The development of an Essential Post List based on critical gaps and the funding envelope will guide filling of essential posts based on need and demand.
4. Poor integration of services resulting in inadequate oversight and clinical governance, duplication, missed opportunities, under-utilisation of resources, inefficient budget allocation and poor economies of scale. *(High Risk)*	• Integration of services forms an integral part of the scale up plan for Operation Phakisa ICRM. • Review of organisation structures and job functions will clarify issues pertaining to oversight and support.

Key Risk Factors	Measures to Mitigate Risks
5. Poor data quality and information management at both service delivery and management levels will impact on evidence-based decision-making and planning. Inadequate information systems, with specific reference to community-based information, might jeopardise intensions of the data management turn-around strategy. *(High Risk)*	• ICT infrastructure to expand the web-based information system which will lend itself to more frequent monitoring, verification and use of data. • Implementation of the Information Management Strategy including robust quarterly monitoring of implementation of policies, guidelines and SOPs in support of improved data capturing, verification, analysis, reporting and management. • Strategy aligned with the strategy for Clean Audit 2015/16 onwards.

12. PROGRAMME 3 - EMERGENCY MEDICAL SERVICES

12.1 Programme Purpose

To render pre-hospital Emergency Medical Services including Inter-hospital Transfers and Planned Patient Transport

12.2 Programme Structure

Sub-Programme 3.1: Emergency Medical Services

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

Sub-Programme 3.2: Planned Patient Transport (PPT)

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

12.3 Provincial Priorities

Priority 1: Reviewed Emergency Medical Services Model

The Department prioritised review of the current EMS model to improve efficiencies of Emergency Medical Services including Patient Transport Services. The Model will determine the organisational and service arrangements at provincial, district and facility levels taking into consideration the current gaps, challenges, strengths and opportunities.

Priority 2: Improve the Efficiency of Emergency Medical Services

The current ambulance to population ratio is 1: 48 660 compared to the 1:10 000 norm. The Department is planning to increase the number of daily operational ambulances from 212 to 550 by March 2020 to increase response times for both urban and rural settings (including emergency, obstetric and inter-facility transport). Obstetric ambulances and trained personnel will be increased as part of the Maternal and Child Health and EMS harmonization strategy to improve maternal and child health outcomes. Planned Patient Transport hubs (inter and intra district transport) will be introduced in all Regions to improve coordination of EMS.

Governance structures will be strengthened, and training of managers will be prioritised to improve management and quality. The KZN College of Emergency Care will increase EMS accredited courses to respond to the dire need to increase the pool of resources in especially Intermediate and Advanced Life Support. Short courses in driving training will be increased to reduce the high number of accidents with consequent extended downtime of ambulances. *(See Programme 6 for KZN College of Emergency Care).*

Ambulance bases will be increased including the King Dinuzulu Medium Base (design phase); Dannhauser Medium Base, Pomeroy Small Base and Jozini Medium Base (construction phase). The Umzinyathi Large Base project was postponed to 2016/17 as a result of cost constraints.

The vehicle management and recovery system for real time tracking (contract awarded to Altech Netstar in 2013/14) will be installed in all vehicles to improve efficient management of vehicles. Software will be installed at all Communications Centres and training will be conducted for Operations Management responsible for the EMS fleet and District Management.

A strategic business unit will be established for Aero Medical Services to improve revenue generation and improve economies of scale. The partnership with Air Mercy Services (or relevant agency) will be strengthened to ensure effective response to red code emergencies. The flying doctor service will be expanded in line with the decentralised community-based training planned between the Department and UKZN.

Communication Centres will be rationalised to 4 clustered Communication Centres which will reduce costs and improve efficiencies. The organisational structures for centres will be finalised and appropriately trained staff will be appointed.

Information and education campaigns (internal and external) will be conducted as part of the Provincial Communication Strategy as part of the EMS response to the reduction of accidents and emergencies.

Priority 3: Improve Data and Information Management

Appropriate ICT infrastructure (including mobile data terminals) and computers will be installed at all ambulance bases to ensure access to on-line facilities to improve data accuracy and availability. An appropriate electronic patient booking system will be introduced to improve appropriate response to emergency calls.

12.4 Strategic Objectives and Expected Outcomes

Table 27: Strategic objectives and expected outcomes

Strategic Objective	Strategic Objective Statement	Indicator	Baseline 2013/14 [12]	Target 2019/20
Strategic Goal 1: Strengthen health system effectiveness				
1.8) Improve EMS efficiencies	1.8.1) Evidence-based EMS Model approved and implemented by March 2016	Approved revised EMS Model	Current EMS Model	Approved Model implemented
	1.8.2) Increase the average number of daily operational ambulances to 550 by March 2020	Average number of daily operational ambulances	212	550
	1.8.3) Rationalise 4 clustered communication centres by March 2020	Number of clustered communications centres established and operational	1	4
Strategic Goal 5: Improved quality of health care				
1.8) Improve EMS efficiencies	1.8.4) Improve P1 urban response times of under 15 minutes to 25% by March 2020	EMS P1 urban response under 15 minutes rate	6%	25%
	1.8.5) Improve P1 rural response times of under 40 minutes to 45% by March 2020	EMS P1 rural response under 40 minutes rate	31%	45%
	1.8.6) Increase the inter-facility transfer rate to 50% by March 2020	EMS inter-facility transfer rate	31.6%	50%
LINKS TO OTHER PLANNING FRAMEWORKS ***National Development Plan 2030*** Strategic Goal 6: Health system reforms completed Priority b: Strengthen the health system Priority h: Improve quality by using evidence ***Medium Term Strategic Framework 2014-2019*** Sub-Output 2: Improved quality of health care				

[12] Baseline data is based on one full year data (2013/14) unless otherwise indicated

12.5 Resource Considerations

Between 2011/12 and 2017/18 the budget for Emergency Transport increase with 13% and Inter Facility Transport with 66%. The significant shortfall of 754 ambulances, at an approximate cost of R527.8 million (±R 700 000 per ambulance), impose significant pressure on the budget taking into consideration the increasing fuel costs, carry-through costs for the various wage agreements, OSD payments, as well the carry-through costs of the danger allowance.

Inflation for some elements of Air Mercy Services, critical for appropriate response in areas with poor access, occurs at an increased rate of more than 40% because costs are Euro linked in respect of maintenance of aircrafts.

The reviewed strategy for EMS is not fully costed and funded therefore targets may not be possible without augmented funding. Efficient co-ordination of EMS is partly dependent on an effective Information Communication Technology solution which enables quick patient access and prompt ambulance dispatch. The cost of the complete EMS ICT solution is yet to be determined and specific funding for this purpose is not allocated in the MTEF.

Achieving intended targets for purpose built wash bays and sluice facilities, construction of new ambulance bases, and rationalisation of communication centres is under pressure due to limitations in the Infrastructure budget.

12.6 Risk Management

Table 28: Key Risk Factors

Key Risk Factors	Measures to Mitigate Risks
1. The efficiency and effectiveness of EMS depends on its ability to receive and locate emergency calls and dispatch and control resources in response. The current budget constraints limits appropriate response to challenges of aging infrastructure, fleet and equipment, technology and consumables, and increased demand for services. *(High Risk)*	• A business plan to scope the total EMS requirements and cost will be developed informed by an external audit of EMS. • EMS ICT Solution, as key enabler, has been prioritised (pending adequate ICT funding).
2. High attrition rate, high absenteeism and turnover rates impact on the number of daily operational ambulances and consequent response times in both urban and rural areas. The ratio of staff per operational ambulance (8:1) is below the national norm of 10:1 which affect quality and efficiency. *(High Risk)*	• Review retention strategy, improve working conditions and support through improved employee wellness programmes. • Scale up of training of intermediate and advanced life support over the next 5 years (EMS Emergency College – Programme 6).
3. Labour unrest and staff dissatisfaction with conditions of service impact on service delivery and staff satisfaction. *(High Risk)*	• Develop a new communication and Employee Wellness strategy to address identified issues.

Key Risk Factors	Measures to Mitigate Risks
4. Vehicle capital and running costs (including varying fuel costs) escalating at a greater rate than inflation and allocated budget. High accident rates and vehicle down time add to the cost burden, impact on available daily operational vehicles/ambulances. *(High Risk)*	• District Fleet Officers actively engage with Transit Solutions (appointed to increase the pool of service providers to reduce vehicle downtime). • Defensive driver training will be conducted by the KZN College of Emergency Care to reduce the accident rate. • The Department instituted a vehicle tracking and monitoring system to monitor fleet (real time) more effectively.
5. Inadequate base infrastructure including EMS customised wash bays and sluice facilities, long travelling distances to especially tertiary facilities, and increased demand for referral all impact on operational targets. *(High Risk)*	• EMS infrastructure (including customised wash bays and sluice facilities) included in the Infrastructure Long Term Plan to reduce vehicle down time and improve operational ambulances (dependent on Infrastructure funding envelope).

13. PROGRAMME 4 - PROVINCIAL HOSPITAL SERVICES

13.1 Programme Purpose

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

13.2 Programme Structure

Sub-Programme 4.1: General (Regional) Hospitals

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

Sub-Programme 4.2: Specialised Tuberculosis Hospitals

Convert present Tuberculosis hospitals into strategically placed centres of excellence in which a small percentage of patients may undergo hospitalisation under conditions, which allow for isolation during the intensive phase of treatment, as well as the application of the standardized multi-drug resistant (MDR) protocols.

Sub-Programme 4.3: Specialised Psychiatric/ Mental Health Hospitals

Render a specialist psychiatric hospital service for people with mental illness and intellectual disability and provide a platform for the training of health workers and research.

Sub-Programme 4.4: Chronic Medical Hospitals

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

Sub-Programme 4.5: Oral and Dental Training Centre

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

13.3 Provincial Priorities

There are 13 Regional Hospitals (none in Umzinyathi, Zululand, Umkhanyakude and Harry Gwala); 10 Specialised TB Hospitals (none in Uthukela, Amajuba, Umkhanyakude, Uthungulu and Ilembe); 6 Specialised Psychiatric Hospitals (none in Ugu, Uthukela, Umzinyathi, Amajuba, Umkhanyakude, Uthungulu and Ilembe); and 2 Chronic/Long Term Hospitals in eThekwini.

Priority 1: Rationalisation of Hospital Services (all levels of care) to improve Efficiencies and Quality

A Hospital Rationalisation Plan (as part of the Provincial Long Term Plan) will be finalised in 2015/16 to guide service transformation of hospital services in the Province. *(See Hospital Rationalisation Plan in Programme 2 – Sub-Programme District Hospitals)*.

The plan will make provision for Regional Hospitals to provide the appropriate Specialist led services in each of the eight core specialties, namely Anaesthetics, Radiology, Medicine, Surgery, Psychiatry, Obstetrics & Gynaecology, Orthopaedic Surgery, and Paediatric Medicine - in line with the Regional Hospital Package of Care. This will improve the capability of Regional Hospitals to provide specialist-led care in relatively close proximity to the patient's residence.

Hospital classification of all hospitals will be reviewed based on the package of services, norms and standards (informed by current research that includes a comprehensive gap analysis and revised norms and standards for clinical specialities). The following hospital classifications and package of services will be reviewed: Mahatma Ghandi Memorial once the Pixley ka Isaka Seme Regional Hospital has been commissioned; King Dinuzulu based on the 400 level 1 beds commissioned in 2013/14; King Edward VIII based on the package of services and the intended new Central/Teaching hospital planned by the National Department of Health. The establishments of the 2 Mother and Child Hospitals (Newcastle and Lower Umfolozi War Memorial) will be reviewed to make provision for the package of services *(included under Improved Human Resources for Health strategy in Programme 1)*.

The service arrangements for hospital complexes e.g. Ngwelezana (Developing Tertiary Hospital) and Lower Umfolozi War Memorial and Newcastle and Madadeni will be reviewed to ensure effective utilisation of resources within a limited funding envelope.

The development of Centres of Excellence will be defined to inform service transformation of identified hospitals e.g. McCords Hospital as Centre of Excellence for eye care services.

Emergency Units will be rolled out to identified hospitals based on the burden of trauma as well as resource envelope.

Consultation and communication: Planned reforms will be widely consulted and communicated to staff, other stakeholders and the community as part of a comprehensive communication plan. The performance measures, targets and timelines will be included in the Rationalisation Plan and will be monitored and reported to stakeholders to ensure transparancy.

Priority 2: Improve Quality of Services

All hospitals will continue to implement the National Core Standards focussing on the 7 identified domains each with a number of standards and criteria intended to improve quality and efficiency of health establishments. (1) Patient rights; (2) Patient safety, clinical governance & care; (3) Clinical

support services; (4) Public health; (5) Leadership and corporate governance; (6) Operational management; and (7) Facilities & infrastructure.

The six "fast track" areas include: (1) Values and attitudes of staff; (2) Cleanliness; (3) Waiting times; (4) Patient safety and security; (5) Infection prevention and control; and (6) Availability of basic medicines and supplies. The Office of Health Standard Compliance will independently assess hospitals for accreditation.

The Clinical Governance Policy will be reviewed and appropriate structures will be put in place to improve quality and efficiency.

The Department prioritised the implementation of a patient information system to improve evidence-based decision-making including activity-based costing. The implementation of ICD 10 coding will be rolled out in a phased approach.

Priority 3: Improved Human Resources for Health

Organisational structures will be reviewed to make provision for adequate human resources to deliver on the package of services and will take into consideration the current research to develop appropriate staffing norms and standards. The Long Term Human Resources Plan will make provision for adequate staffing required for the teaching and service delivery platforms in implementation of the community-based training in a PHC approach that will commence in Uthungulu in 2016/17 *(Programme 1 – Human Resources for Health)*.

Intensified training programmes to improve leadership and management competencies have been prioritised – including mentorship programmes.

Priority 4: Clinical Support Services

Clinical support services including Food, Security and Laundry Services will be strengthened during the reporting period. The rationalization of medical equipment (costed essential equipment lists per level of care and efficient system to manage) will be included as part of the Hospital Rationalisation Plan.

13.4 Strategic Objectives and Expected Outcomes

Table 29: Strategic objectives and expected outcomes

Strategic Objective	Strategic Objective Statement	Indicator	Baseline 2013/14 [13]	Target 2019/20
Strategic Goal 1: Strengthen health system effectiveness				
1.7) Improve hospital efficiencies	1.7.1) Maintain a bed utilisation rate of 75% (or more)	Inpatient bed utilisation rate *Regional* *Specialised TB* *Specialised Psychiatric* *Chronic/ Long-Term*	 77.4% 56.5% 70.1% 64%	75% (or more)
	1.7.2) Develop and implement the approved Hospital Rationalisation Plan by March 2016	Hospital Rationalisation Plan	No Hospital Rationalisation Plan	Plan implemented
Strategic Goal 4: Strengthen human resources for health				
4.1) Improve human resources for health	4.1.3) Implement the Community Based Training in a PHC Model in collaboration with the University of KwaZulu-Natal with Phase 1 pilot commencing in 2016/17 *(included under Programme 1)*	Community Based Training in a PHC Model	Draft Model & Business Plan	Model implemented
Strategic Goal 5: Improved quality of health care				
5.1) Improve compliance to the Ideal Clinic and National Core Standards	5.1.1) Sustain a patient experience of care rate of 95% (or more) at all public health facilities by March 2020	Patient experience of care rate	95.6%	95% (or more)
	5.1.2) 60% (or more) public health hospitals compliant with extreme and vital measures of the national core standards by March 2020	Percentage of hospitals compliant with all extreme and vital measures of the national core standards	8% (Regional)	60% (or more)

[13] Baseline data is based on one full year data (2013/14) unless otherwise indicated

Strategic Objective	Strategic Objective Statement	Indicator	Baseline 2013/14 [13]	Target 2019/20
LINKS TO OTHER PLANNING FRAMEWORKS ***National Development Plan 2030*** Strategic Goals 6: Health system reforms completed Strategic Goal 9: Posts filled with skilled, committed & competent individuals Priority b: Strengthen the health system Priority c: Improve health information systems Priority f: Improve human resources in the health sector Priority h: Improve quality by using evidence ***Medium Term Strategic Framework 2014-2019*** Sub-Output 2: Improved quality of health care Sub-Output 4: Reduced health care cost Sub-Output 5: Improved human resources for health Sub-Output 6: Improved health management & leadership Sub-Output 10: Efficient health information management system developed and implemented to improve decision-making				

13.5 Resource Considerations

The programme remains under pressure as indicated by projected growth in allocation between 2014/15 and 2017/18: Regional (22%); Specialised TB (18%); Specialised Psychiatric (18%); Chronic/ Long Term (9%).

Reliable hospital information systems is critical to assist managers in determining priorities and ensuring effective and efficient service delivery in all levels of delivery.

Various wage agreements, OSD for medical personnel, high inflation rates on medical supplies and services, NHLS costs, carry-through costs of MDR/XDR-TB facilities commissioned at Greytown, Murchison and Thulasizwe Hospitals all put pressure on the limited funding envelope which will require careful prioritisation over the reporting period to ensure delivery.

The limited funding envelope seriously jeopardises the expansion of services (specialities) as it competes with current demands outweighing resources.

13.6 Risk Management

Table 30: Key Risk Factors

Key Risk Factors	Measures to Mitigate Risks
1. The reduced funding envelope will impact on resource allocation, filling of essential posts and expansion of services as demand currently outstrips supply. *(High Risk)*	• Re-prioritisation as part of the Rationalisation Plan commenced through consultation and based on evidence. Processes will be phased in over the cycle to ensure equitable distribution of services. • Institutionalisation of cost containment strategies and strategies to improve financial management. Expenditure trends, including analysis of expenditure versus service delivery, will be actively monitored to ensure improved control of identified cost drivers.
2. Alignment of classification of facilities, package of services, referral pathways/ policy (including harmonisation of EMS), organisation structures, delegations, vacancy rates in essential posts, and management competencies in Regional and Specialised Hospitals. *(High Risk)*	• Commenced with the development of a comprehensive Hospital Rationalisation Plan (2014/15) to inform transformation of hospital services (all levels). • The Implementation Plan will address all identified challenges and will be implemented over the next 5 years. The development of an Essential Post List, based on identified priorities, will be developed to address human resources for health.
3. Inadequate patient information system and poor quality of health information to inform decision-making. *(Medium Risk)*	• Implement patient-based information system in phased approach. • Implement ICD 10 coding (identified hospitals – phased approach).

Key Risk Factors	Measures to Mitigate Risks
4. Inadequate clinical governance structures and processes impacting on quality of care including medico-legal claims. *(High Risk)*	• Establish governance structures/ processes as part of implementation of the National Core Standards and the Hospital Rationalisation Plan.
5. Poor management and leadership at facility level, and difficulty to attract and retain appropriately skilled personnel for various positions. *(High Risk)*	• Instituting appropriate leadership and management training programmes including mentoring, coaching and support. • HR Plan aligned with identified service needs.

14. PROGRAMME 5 - TERTIARY AND CENTRAL HOSPITAL SERVICES

14.1 Programme Purpose

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

14.2 Programme Structure

Tertiary and Central Hospitals

Render highly specialised medical health and quaternary services on a national basis and serve as platform for the training of health workers and research.

14.3 Provincial Priorities

There are 2 Tertiary Hospitals i.e. Greys (Umgungundlovu) and Ngwelezana (Developing Tertiary in Uthungulu) and 1 Central Hospital (Inkosi Albert Luthuli Central (eThekwini). King Edward VIII has been Gazetted as Central Hospital (referring to the intended new Central/Teaching hospital planned by the National Department of Health. The hospital is rendering regional and some tertiary services and not regarded as a central hospital.

Key success factors for these highly specialised hospitals include a critical mass of scare skills and competencies, with interdependencies across disciplines. Key categories of staff include medical specialists and sub-specialists, specialised nursing, anaesthetists, clinical technologists and clinical engineers. The delivery of tertiary services is also dependant on the availability of expensive equipment and related technology.

Tertiary Hospitals provide a comprehensive set of specialist-led services to a defined geographical catchment population (determined by transport access criteria and not by provincial borders). Services include key referral specialties not available at regional hospital level, such as Ear Nose and Throat, Infectious Diseases, Ophthalmology, Paediatric Surgery, Plastic & Reconstructive Surgery, Urology, and Vascular Surgery. Tertiary Hospitals should act as hub for the provision of specialised Emergency and Trauma care within its catchment area, providing a specialised Major Trauma Centre, a full ICU service under the supervision of a Specialist Intensivist (including dedicated Paediatric ICU), and a dedicated Burns Unit. It would ideally also house a multidisciplinary Rehabilitation Centre, incorporating dedicated stroke care and spinal injury beds. It will however take several years of sustained investment to develop the full range of Tertiary Hospital Services in the Province. Ngwelezana Hospital, designated as Developing Tertiary Hospital, will develop over time to a full Tertiary Hospital providing all specialities and sub-specialities.

Priority 1: Rationalisation of Hospital Services

The Hospital Rationalisation Plan will be finalised in 2015/16 *(See Hospital Rationalisation Plan in Programme 2 – Sub-Programme Hospital Services and Programme 4: Rationalisation of Hospitals)*.

Tertiary and Central Hospitals manage support and outreach services to level two (general specialist) platform of services and as such strengthen clinical governance.

Specialities and sub-specialities will be reviewed starting with Oncology, Nephrology, Orthopaedic and Neurosurgery services in 2015/16. The Dialysis Business Plan has been finalised for approval after which it will be rolled out (pending funding).

The electronic patient information management system will be phased in starting with Greys Hospital in 2015/16. This will strengthen information management and evidence-based planning and decision-making. The implementation of ICD 10 coding will be rolled out in a phased approach.

Priority 2: Improving Human Resources for Health

Organisational structures will be reviewed to make provision for adequate human resources to deliver on the package of services and will take into consideration the current research to develop appropriate staffing norms and standards. The Long Term Human Resources Plan will make provision for adequate staffing required for the teaching and service delivery platforms in implementation of the community-based training in a PHC approach that will commence in Uthungulu in 2016/17 *(Programme 1 – Human Resources for Health)*.

Intensified training programmes to improve leadership and management competencies have been prioritised – including mentorship programmes.

Priority 3: Implementation and Monitoring of the National Core Standards

All hospitals will continue to implement the National Core Standards focussing on the 7 identified domains each with a number of standards and criteria intended to improve quality and efficiency of health establishments. (1) Patient rights; (2) Patient safety, clinical governance & care; (3) Clinical support services; (4) Public health; (5) Leadership and corporate governance; (6) Operational management; and (7) Facilities & infrastructure.

The six "fast track" areas include: (1) Values and attitudes of staff; (2) Cleanliness; (3) Waiting times; (4) Patient safety and security; (5) Infection prevention and control; and (6) Availability of basic medicines and supplies. The Office of Health Standard Compliance will independently assess hospitals for accreditation.

The Clinical Governance Policy will be reviewed and appropriate structures will be put in place to improve quality and efficiency.

14.4 Strategic Objectives and Expected Outcomes

Table 31: Strategic objectives and expected outcomes

Strategic Objective	Strategic Objective Statement	Indicator	Baseline 2013/14 [14]	Target 2019/20
Strategic Goal 1: Strengthen health system effectiveness				
1.7) Improve hospital efficiencies	1.7.1) Maintain a bed utilisation rate of 75% (or more)	Inpatient bed utilisation rate *Tertiary* *Central*	 *83.9%* *73.5%*	75% (or more)
	1.7.2) Develop and implement the approved Hospital Rationalisation Plan by March 2016	Hospital Rationalisation Plan	No Hospital Rationalisation Plan	Plan implemented
Strategic Goal 4: Strengthen human resources for health				
4.1) Improve human resources for health	4.1.3) Implement the Community Based Training in a PHC Model in collaboration with the University of KwaZulu-Natal with Phase 1 pilot commencing in 2016/17 *(included in Programme 1)*	Community Based Training in a PHC Model	Draft Model & Business Plan	Model implemented
Strategic Goal 5: Improved quality of health care				
5.1) Improve compliance to the Ideal Clinic and National Core Standards	5.1.1) Sustain a patient experience of care rate of 95% (or more) at all public health facilities by March 2020	Patient experience of care rate	95%	95% (or more)
	5.1.2) 60% (or more) public health hospitals compliant with extreme and vital measures of the national core standards by March 2020	Percentage of hospitals compliant with all extreme and vital measures of the national core standards	0%	60% (or more)
LINKS TO OTHER PLANNING FRAMEWORKS ***National Development Plan 2030*** Strategic Goals 6: Health system reforms completed Strategic Goal 9: Posts filled with skilled, committed & competent individuals				

[14] Baseline is based on one full year data (2013/14) unless otherwise indicatated

Strategic Objective	Strategic Objective Statement	Indicator	Baseline 2013/14 [14]	Target 2019/20
Priority b: Strengthen the health system Priority c: Improve health information systems Priority f: Improve human resources in the health sector Priority h: Improve quality by using evidence ***Medium Term Strategic Framework 2014-2019*** Sub-Output 2: Improved quality of health care Sub-Output 4: Reduced health care cost Sub-Output 5: Improved human resources for health Sub-Output 6: Improved health management & leadership Sub-Output 10: Efficient health information management system developed and implemented to improve decision-making				

14.5 Resource Considerations

Programme 5 is funded from the Equitable Share budget as well as the National Tertiary Services Grant. The Health Professions Training and Development Grant is used to fund training of Registrars.

The National Tertiary Service Grant aims to fund the supra-provincial nature of tertiary service provision and to assist provinces to plan, modernize, rationalize and render tertiary services in line with national policy objectives. The Grant funding is however inadequate for the pressures in tertiary and quaternary services.

The Health Professional Training and Development Grant supports the funding of service costs associated with the training of health professionals in the services platform towards the national aim of expanding the number of health professionals. This Grant is currently being used for the training of Registrars due to the severe limitations in Equitable Share allocation to the Province especially with the 1, 2 and 3 per cent budget cuts imposed on the Province by National Treasury. This places severe limitations on the training capacity in the Province which could jeopardise service delivery in the foreseeable future.

The Programme 5 Equitable Share budget increased with 42% between 2011/12 and 2017/18, with Compensation of employees comprising of 54% of the allocated budget.

It is unlikely that the Province will be able to expand services at the intended pace as a result of budget limitations and re-prioritisation will be essential to ensure that resources are distributed in the most cost effective manner.

14.6 Risk Management

Table 32: Key Risk Factors

Key Risk Factors	Measures to Mitigate Risks
1. Poor patient information system resulting in inadequate and in accurate clinical information with poor audit trail of patient information and financial transactions and inadequate reporting on patient information and economies of scale. This jeopardise evidence-based decision-making and planning. *(Medium Risk)*	• Phased implementation of a patient-based information system targeting Greys Hospital in 2015/16. Ngwelezana will be targeted next. • Robust information reviews and analysis of service delivery and clinical data will be prioritised to inform development of the Hospital Rationalisation Plan.
2. Ineffective clinical governance structures leading to adverse events and high medico-legal litigation costs. *(High Risk)*	• Included as component of the rationalisation of hospital services (targeted for 2015/16 onwards).
3. Challenge to develop highly specialised services in line with demand and changing disease patterns due to decreased funding envelope for tertiary and central services. Leads to increased workload and contributes towards demotivation of staff. *(High Risk)*	• Re-prioritise service priorities within the funding envelope and develop innovative strategies to ensure optimal utilisation of resources.

Key Risk Factors	Measures to Mitigate Risks
4. Increasing service demands without concomitant resources. *(High Risk)*	• Re-prioritisation to ensure effective utilisation of existing resources. • Perform regular staff satisfaction surveys and implement measures to promote staff satisfaction and retention. • Optimal utilisation of Performance Monitoring and Development to recognise good performance and implementing appropriate staff development interventions including mentoring.
5. Inadequate service delivery platform to accommodate the proposed decentralised training model (in early development phase). *(High Risk)*	• Included in the Business Plan for the Decentralised Training Model (in early stage of development).

15. PROGRAMME 6 - HEALTH SCIENCES & TRAINING

15.1 Programme Purpose

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

15.2 Programme Structure

Sub-Programme 6.1: Nurse Training College

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

Sub-Programme 6.2: EMS Training College

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

Sub-Programme 6.3: Bursaries

Provide bursaries for health science training programmes at both under-graduate and post-graduate level. Target group includes actual and potential employees.

Sub-Programme 6.4: PHC Training

Provide PHC related training for personnel provided by the regions.

Sub-Programme 6.5: Training (Other)

Provide skills development interventions for all occupational categories in the Department. Target group includes actual and potential employees.

15.3 Provincial Priorities

Priority 1: Accreditation of KZN College of Nursing (KZNCN) as Institution of Higher Education

The KZNCN prioritised implementation of the Accreditation Plan. Amalgamation of Campuses and Sub-Campuses has been identified based on functionality and resources. This has been aligned with the Infrastructure Long Term Plan and the process will be guided by the funding envelope. Student intake will be determined according to service demands as reflected in the Human Resources Plan.

Appropriate information systems to improve monitoring and management have been incorporated into the ICT Strategy and Plan and will be implemented as such.

Priority 2: Implement the Provincial Human Resources Development (HRD) Strategy

The HRD strategy and annual implementation plan will be aligned with the Human Resource Plan. A competency profile assessment of targeted occupational categories will be prioritised to inform both plans. The skills audit that commenced in 2014/15 will be completed in 2015/16 and will form the foundation for skills development plans including leadership and management training courses. Ongoing analysis of education, training and development requirements for specific priority occupational groups will be informed by the annual Workplace Skills Plan. Information will be supplemented by the outcomes of competency profile assessments.

Partnerships with Institutions of Higher Learning will be strengthened to ensure appropriate training and support of all cadres of professionals working in public health institutions and management. The training of Mid-Level Workers will be prioritised in partnership with Higher Education to address pressures as a result of challenges to recruit and retain professionals in specific critical areas. Bursaries and intake of Heath Sciences students will be based on identified needs and demand, and adequate provision will be made to absorb qualified professionals.

The Department commenced with training in sign language to improve access to essential services in the public health domain.

The development and implementation of e-learning, m-learning and telemedicine will be prioritised – pace of implementation determined by ICT budget.

Priority 3: Improve Emergency Medical Training

The revitalisation of the KZN College for Emergency Care, including acquiring suitable student accommodation, has been prioritised for the reporting period. The relocation of the Northdale Campus to McCords Campus will be completed during the reporting cycle.

The development of new training courses (in partnership with Durban University of Technology - DUT) including an entry level (Emergency Care Assistant) and Mid-Level qualification (Emergency Care Technician) started in 2014/15 and will be expanded over the next 5 years.

The College will scale up the number of 1 and 5 day refresher programmes for Basic, Intermediate and Advanced Life Support as well as training programmes on Management, Rescue, Driver Training, Emergency Medical Dispatch, Motivation and Aviation Health Care Provider.

Priority 4: Implement the Management Training and Leadership Development Strategy

The Department will conduct a competency profile for Managers and implement training programmes based on the outcome of the audit. Implementation of national training programmes for managers will continue.

The Department will analyse management evaluations/ assessments to improve productivity through training, mentoring and the performance management system.

15.4 Strategic Objectives and Expected Outcomes

Table 33: Strategic objectives and expected outcomes

Strategic Objective	Strategic Objective Statement	Indicator	Baseline 2013/14 [15]	Target 2019/20
Strategic Goal 4: Strengthen human resources for health				
4.1) Improve human resources for health	4.1.4) Allocate 569 bursaries for first year medicine students between 2015/16 and 2019/20	Number of bursaries awarded for first year medicine students	379 (77 RSA + 302 Cuban)	569
	4.1.5) Allocate 2 000 bursaries for fist year nursing students between 2015/16 and 2019/20	Number of bursaries awarded for first year nursing students	New indicator	2 000
	4.1.6) Increase intake of Mid-Level Workers with at least 10% per annum (based on need per category)	Number of new students enrolled in Mid-Level Worker training courses	New indicator	167
	4.1.7) Increase the EMS skills pool by increasing the number of EMS personnel trained in ILS and ECT	Number of Intermediate Life Support graduates per annum	44	360
		Number of Emergency Care Technician graduates per annum	0	150
LINKS TO OTHER PLANNING FRAMEWORKS ***National Development Plan 2030*** **NDP:** Strategic Goal 9: Posts filled with skilled, committed & competent individuals Priority f: Improve human resources in the health sector Priority g: Review management positions and appointments and strengthen accountability mechanisms ***Medium Term Strategic Framework 2014-2019*** Sub-Output 5: Improved human resources for health				

[15] Baseline is based on one full year data (2013/14) unless otherwise indicated

15.5 Resource Considerations

Between 2011/12 and 2017/18 the budget increase with 41% with Nurse Training College (-8%), EMS College (-54%), Bursaries (+307%), PHC training (+7%), and Other training (+52%). The increase in the budget relates mainly to the increased number of medical officers in the Cuban Training Programme - evident in the trends in the Bursaries Sub-Programme.

Training programmes will be aligned with the funding envelope although it is clear that all targets might not be met as a result of the current and projected budget pressures in this programme. The Department will reduce the number of Cuban students as a result of budget limitations which should be mitigated by the increase in student intakes at the University of KwaZulu-Natal.

15.6 Risk Management

Table 34: Key Risk Factors

Key Risk Factors	Measures to Mitigate Risks
1. Delays in accreditation of the KZN College of Nursing (KZNCN) as Institution of Higher Learning will impact on accreditated courses and bi-annual student intake. *(High Risk)*	• Implementation of the KZNCN Implementation Plan for Accreditation. • Infrastructure requirements (Nursing Colleges/ Schools included in the Infrastructure Long Term Plan and U-AMP. • Training intake will be aligned with identified gaps and plans for expansion of services.
2. The limited funding envelope will impact on the expansion of training programmes including leadership and management training and intake of students to address critical skills gaps at service delivery level. *(High Risk)*	• HRD Plan aligned with Human Resources Plan to make provision for crtical skills gaps. • The number of Cuban students will decrease over time in tandum with increased intake of medical students at UKZN.
3. Lack of an effective Human Resource Development database/ information system impacting on effective monitoring and prioritisation of training programmes; placement of critical skills based on competencies. *(Medium Risk)*	• ICT Strategy makes provision for the design of an HRD information system (pending available funding). • Mannual system will be upgraded in the interim to ensure effective monitoring and control.
4. All posts on the current organisation structure not funded which contributes towards poor absorption of graduates post training. This will also impact negatively on workloads, availability of service packages at the appropriate levels of care, quality of services, staff/ patient satisfaction, and retention of staff. *(High Risk)*	• Organisational structures will be reviewed and finalised over the reporting period to make provision for filling of essential posts and absorption of trained professionals. • Long Term HR Plan will be aligned with service delivery needs and be aligned with training plans, intake of students and absorption of successful candidates.

Key Risk Factors	Measures to Mitigate Risks
5. Significant costs to maintain the Cuban training programme for duration of training in Cuba and 18 months in South Africa. *(High Risk)*	• UKZN increase medical student intakes, starting in 2015/16 and progressively thereafter, to reduce students on the Cuban Programme.

16. PROGRAMME 7 - HEALTH CARE SUPPORT SERVICES

16.1 Programme Purpose

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

16.2 Programme Structure

Sub-Programme 7.1: Laundry Services

Render laundry services to hospitals, care and rehabilitation centres and certain local authorities.

Sub-Programme 7.2: Engineering Services

Render a maintenance service to equipment and engineering installations, and minor maintenance to buildings.

Sub-Programme 7.3: Forensic Services

Render specialised forensic and medico-legal services in order to establish the circumstances and causes surrounding unnatural death.

Sub-Programme 7.4: Orthotic and Prosthetic Services

Render specialised orthotic and prosthetic services.

Sub-Programme 7.5: Medicine Trading Account

Manage the supply of pharmaceuticals and medical sundries to hospitals, Community Health Centres and local authorities.

16.3 Provincial Priorities

Priority 1: Improve management of laundry services

Laundry Services are managed through in-house capacity at the KwaZulu Central Provincial Laundry, Regional Laundries (Cato Manor, Durban and Coastal, and Northern Natal) and Facility Laundries. The outsourcing facilities including McCords, Addington, Prince Mshiyeni and Inkosi Albert Luthuli are indispensable if in-house capacity is compromised. Private laundries are under-utilised hence they are able to accommodate Departmental linen. Installation of new laundry machines has been completed in 67% of hospitals with the outstanding 34 hospitals targeted for the second phase of installation during the reporting period.

The Department will introduce an appropriate Laundry Management System to reduce the break down of laundry machinery and improve the availability of daily clean laundry at facility level. A 3 year tender for linen procurement has been advertised to ensure adequate linen supply and to eliminate clean linen stock outs at facilities. The Department will explore the development of trolleys that

separately cater for both dirty and clean linen to improve efficiencies and economies of scale. The Department invested R210 million on upgrading of the Prince Mshiyeni Laundry with the second production line expected to open in 2015/16. This will improve the service reach to 11 hospitals. The design of the Dundee Laundry is at an advanced stage and construction will be prioritised over the reporting period.

Priority 2: Strengthen Forensic Pathology Services

The Department will implement the Mortuary Rationalisation Plan making provision for rationalising mortuaries from 40 to 22 that will improve management of mortuaries; the fewer larger and better equipped mortuaries are hoped to attract more skilled personnel with a lower turnover rate resulting in improved management and quality; reduction in the size of vehicle fleet resulting in long-term cost saving, and all service points being compliant with the minimum standards for Medico-Legal Mortuaries. The Mortuary Infrastructure Development Plan makes provision for the following proposed new mortuaries (pending available funding): Mkhuze M3 (Umkhanyakude), Ixopo M2 (Harry Gwala), and Nongoma M2 and Vryheid M2 (Zululand).

The Department will target the repair of fridges in identified facilities; procurement of Lodox machines for Gale Street, Phoenix and Pietermaritzburg Mortuaries.

The organisational structures for mortuaries will be finalised in 2015/16 that will fast track filling of essential posts to improve management, service delivery and quality.

Priority 3: Decentralisation of Orthotic and Prosthetic Services

Orthotics and Prosthetics that is dealing with physical rehabilitations as a result of trauma, deformities and loss of function, are considered one of the scarce skills in the Department. The Wentworth Orthotics and Prosthetics Centre is the only operational center in KwaZulu-Natal, serving 41 clinics with 10 Medical Ortho/Prosthetists (MOPs) on the establishment. Due to shortage of appropriately trained staff and inadequate facilities, most of the services are rendered as outreach programmes.

The Department plans to establish one MOP Center per district to improve access and reduce waiting times. To date, R 30 million has been spent on the upgrading of earmarked facilities in preparation of establishing these identified Centres. Capital planning commenced for the establishment of centres in earmarked hospitals over the next 5 years including: Port Shepstone, Christ The King, Stanger, Ngwelezana, Ladysmith, Dundee, Madadeni, Nongoma, and Mseleni Hospitals.

The training agreement between the Department and the DUT will continue over the reporting period for the 4-year degree course for Medical Orthotists and Prosthetists (bursaries will be provided to a total of 90 students). Qualified MOPs will be absorbed in the decentralised centres. DUT further agreed to train 259 Orthotic and Prosthetic Technicians and Orthopaedic Footwear Technicians (bursaries provided by the Department) over the reporting period.

Priority 4: Improve Pharmaceutical Services Management

The Department is implementing the Centralised Chronic Medicine Dispensing and Distribution (CCMDD) Model in the National Health Insurance Districts which will be rolled out to the rest of districts over the reporting period.

The implementation of an Early Warning System Pilot (in collaboration with the National Department of Health) for monitoring the stock levels of essential medicines at PHC clinics (Stock Visibility Solution) in

partnership with the Vodacom Foundation (National initiative) is progressing well and lessons learned will be applied for rollout to all districts post pilot phase. Work on the work-flows and processes to formalise this into Standard Operating Procedures, training manuals and change management documents for PHC clinics will be prioritised.

The Department will continue to implement reforms for Pharmaceutical Procurement and Distribution. The Provincial Medicine Procurement Unit (PMPU) is being established to coordinate procurement and distribution in the Province. The Direct Delivery and Cross-Docking Models are being strengthened and introduced respectively. These models will relieve pressure on the Depot and allow the Depot to hold stock of a select number of items as buffer stock to ensure uninterrupted availability of essential medicines and related supplies.

16.4 Strategic Objectives and Expected Outcomes

Table 35: Strategic objectives and expected outcomes

Strategic Objective	Strategic Objective Statement	Indicator	Baseline 2013/14 [16]	Target 2019/20
Orthotic and Prosthetic Services				
Strategic Goal 1: Strengthen health system effectiveness				
1.9) Strengthen health system effectiveness	1.9.1) Increase the number of operational Orthotic Centres to 11 by March 2020	Number of operational Orthotic Centres (cumulative)	1	11
Strategic Goal 4: Strengthen human resources for health				
4.1) Improve human resources for health	4.1.8) Increase the number of MOP's who successfully completed the degree course at DUT to 90 (cumulative) by March 2020	Number of MOP's that successfully completed the degree course at DUT *(Programme 6)*	30	90
Laundry Services				
Strategic Goal 1: Strengthen health system effectiveness				
1.9) Strengthen health system effectiveness	1.9.2) Decrease and maintain zero clean linen stock outs in facilities from March 2018 onwards	Percentage of facilities reporting clean linen stock outs	10%	Zero clean linen stock outs
Pharmaceutical Services				
Strategic Goal 5: Improved quality of health care				
5.2) Improve quality of care	5.2.1) Increase the percentage pharmacies that comply with the SA Pharmacy Council Standards (A or B grading) to 100% by March 2020	Percentage of Pharmacies that obtained A and B grading on inspection	81%	100%
	5.2.2) PPSD compliant with good Wholesaling Practice Regulations by March 2016	PPSD compliant with good Wholesaling Practice Regulations	Not compliant	Compliant

[16] Baseline is based on one full year data (2013/14) unless otherwise indicated

Strategic Objective	Strategic Objective Statement	Indicator	Baseline 2013/14 [16]	Target 2019/20
	5.2.3) Decrease medicine stock-out rates to less than 1% in PPSD and all health facilities by March 2020	Tracer medicine stock-out rate (PPSD)	5.7%	Less than 1%
		Tracer medicine stock-out rate (Institutions)	1.8%	Less than 1%

LINKS TO OTHER PLANNING FRAMEWORKS

National Development Plan 2030

Strategic Goal 6: Health system reforms completed

Strategic Goal 9: Posts filled with skilled, committed & competent individuals

Priority b: Strengthen the health system

Priority f: Improve human resources in the health sector

Priority h: Improve quality by using evidence

Medium Term Strategic Framework 2014-2019

Sub-Output 2: Improved quality of health care

Sub-Output 5: Improved human resources for health

16.5 Resource Considerations

Between 2011/12 and 2017/18 the allocated budget for *Laundry Services* increased with 51% mainly for additional linen and laundry vehicles for the commissioning of the Central Laundry as well as installation of new laundry machines.

The budget for *Medical Orthotic and Prosthetic services* increased with 53% during the same period and includes costs for the decentralised centres.

Forensic Pathology Services: Infrastructure, including maintenance, upgrades and the construction of new facilities, as part of the rationalisation process remains a priority. Implementation of the Infrastructure Plan has been severely impacted on by inadequate funding which resulted in most facilities not being compliant to minimum standards for Medici-Legal Mortuaries. Completion of the Newcastle and Greytown Mortuaties has been prioritised as part of the rationalisation in Amajuba and Umzinyathi Districts. Building of the new mortuaries in Umkhanyakude, Harry Gwala and Zululand will enable the closure of 5 service points currently considered inefficient.

The budget for the Medicine Trading Account increased with 42% between 2011/12 and 2017/18 making provision for the supply of pharmaceuticals and medical sundries.

16.6 Risk Management

Table 36: Key Risk Factors

Key Risk Factors	Measures to Mitigate Risks
1. Laundry Services: Required upgrading of laundry services will be restricted as a result of the limited funding envelope. This is regarded as one of the essential support services. *(High Risk)*	• Centralise procurement of linen and develop linen distribution centres/ hubs to increase circulation of clean linen to facilities. • Implement the costed Maintenance Plan for laundry machines to reduce long turn-around time for repairs.
2. Medico-Legal Mortuaries: Poor infrastructure and inadequate funding envelope for infrastructure demand – including rationalisation of medico-legal mortuaries. Reliance on stakeholders to deliver on the Forensic Pathology Service mandate remains a high risk including identification of the deceased; processing of toxicology and blood alcohol samples to inform the post-mortem findings; response and adequate management of major incidents. *(High Risk)*	• Phased implementation of the Mortuary Rationalisation Plan and Mortuary Infrastructure Development Plan – aligned with the Infrastructure Long Term Plan. • Collaboration with stakeholders. • Submission of Business Cases for rationalisation and upgrade of identified medico-legal mortuaries to secure ring-fenced budgets.
3. Pharmaceutical Services: Non-compliance with the SAPC Regulations plus inadequate storage at PPSD and facilities (especially PHC facilities as a result of increase in patient activity). *(High Risk)*	• Explore alternative medicine storage strategies for PHC clinics.

Key Risk Factors	Measures to Mitigate Risks
4. Shortage of medication and medicine stockouts.	• Develop and implement relevant policies and procedures for prevention and management of medicine stockouts. • Improve Stock Management Systems.
5. Expiry of medication.	• Enforce the functionality of Board of Surveys. • Automation of Expired Medication Alerts - improve the Stock Management System. • Revise the Waste Management Policy. • Explore Use of Loss Control & Irregular Expenditure system.

17. PROGRAMME 8 - HEALTH FACILITIES MANAGEMENT

17.1 Programme Purpose

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

17.2 Programme Structure

Sub-Programme 8.1: Community Health Facilities:

Construction of new facilities and refurbishment, upgrading and maintenance of existing Community Health Centres, Primary Health Care clinics and facilities.

Sub-Programme 8.2: Emergency Medical Services:

Construction of new facilities and refurbishment, upgrading and maintenance of existing EMS facilities.

Sub-Programme 8.3: District Hospitals:

Construction of new facilities and refurbishment, upgrading and maintenance of existing District Hospitals.

Sub-Programme 8.4: Provincial (Regional) Hospital Services:

Construction of new facilities and refurbishment, upgrading and maintenance of existing Provincial/ Regional Hospitals and Specialised Hospitals.

Sub-Programme 8.5: Central Hospital Services:

Construction of new facilities and refurbishment, upgrading and maintenance of existing Tertiary and Central Hospitals.

Sub-Programme 8.6: Other Facilities:

Construction of new facilities and refurbishment, upgrading and maintenance of other health facilities including forensic pathology facilities and nursing colleges and schools.

17.3 Strategic Priorities

See Infrastructure Long Term Plan (Table 40).

The Department currently uses the following Implementing Agents (IA's) for health infrastructure namely the Department of Health, Department of Public Works and the Independent Development Trust. Budgets have been allocated according to the "Nature of Investment" as defined by National Treasury.

The Department has developed a 10-year User Asset Management Plan (U-AMP) requesting an average annual budget of R1.9 billion over the next three years. This is based on service delivery pressures and a number of projects which have already been designed.

Umgungundlovu and eThekwini continue to receive higher infrastructure budgets over the next 5 years based on the increasing demand as a result of fast increasing populations, population density and burden of disease (Table 37).

Table 37: Infrastructure Split per District

Total Infrastructure Cost Assignment per District						
Assigned to PIA		**MTEF Year 1**	**MTEF Year 2**	**MTEF Year 3**	**MTEF Year 4**	**MTEF Year 5**
		2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**
		R'000	**R'000**	**R'000**	**R'000**	**R'000**
Total Infrastructure Cost		**1 491 471**	**1 583 796**	**1 732 757**	**2 357 948**	**679 427**
1	Amajuba	90 505	71 355	13 223	8 109	8 515
2	Ilembe	81 295	36 792	39 042	49 494	32 969
3	Harry Gwala	35 370	48 523	91 783	831 216	47 866
4	Ugu	34 039	22 549	47 485	38 785	17 623
5	Umgungundlovu	201 025	151 645	101 851	94 044	96 346
6	Umkhanyakude	30 053	59 836	55 407	59 751	21 754
7	Umzinyathi	59 952	21 929	60 258	66 021	27 322
8	Uthukela	8 846	8 239	11 651	19 083	29 537
9	Uthungulu	152 306	142 743	182 921	184 771	113 509
10	Zululand	53 740	38 212	20 255	56 109	71 915
11	eThekwini	657 840	905 473	1 032 881	902 045	207 424
12	**KZN**	**86 500**	**76 500**	**76 000**	**48 520**	**4 647**

Priority 1: Specialised TB Hospitals, Decentralised MDR-TB Units and Infection Prevention and Control

St Margaret Hospital: Finalise the new Master Plan including the new MDR-TB wards within the existing premises, installation of new autoclaves, and upgrading of the sewer infrastructure that commenced in 2014/15. Hlengisizwe CHC: Provide ART/TB park homes to accommodate the increased patient numbers. Ndwedwe CHC: Construction of new HIV/AIDS Unit and TB Clinic and upgrade water and sewer system. Osindisweni Hospital: Replacement of the old TB ward. Murchison Hospital: Completion of the 97-bed TB ward. King Dinuzulu Hospital (new TB complex): Installation of new air conditioning for the new TB multi-storey block and TB surgical OPD. The Department will continue to improve ventilation in all health facilities as part of infection prevention and control.

Priority 2: New clinical buildings and infrastructure and Upgrading and Maintenance of Existing Infrastructure

The Department will deliver new clinical Infrastructure according to the approved U-AMP and Infrastructure Programme Management Plan (IPMP) and within the approved infrastructure budget.

Twelve (12) new clinics and three (3) new CHCs (Dannhauser in Amajuba, Pomeroy in Umzinyathi and Jozini in Umkhanyakude) are currently under construction and will be completed in the reporting period. Upgrades commenced at Inanda and Phoenix CHCs in eThekwini, and Phase 2 construction commenced at the Gamalakhe CHC in Ugu.

Two major hospital projects over the next 5 years include the construction of the Dr Pixley ka Isaka Seme Regional Hospital in eThekwini and the 192 bed multi-storey surgical block in the Ngwelezana Hospital in Uthungulu which will take at least one third of the total infrastructure budget annually.

The following hospital projects are currently under construction and will be completed: Greys (neonatal intensive care unit); Bethesda (new paediatric ward and 20-bed mother's lodge); Stanger (new labour and neonatal block); Church of Scotland (new paediatric ward); Prince Mshiyeni War Memorial (nursery); KwaMagwaza (maternity upgrade); and Emmaus (maternity and nursery). The Department will prioritise the upgrade and improvement of the physical infrastructure of existing hospitals as part of the improved health service platform.

The Department is in the process to commission the new Phoenix forensic mortuary (460-body storage) to a value of R92.9 million which is in line with the Medico-Legal Mortuary Rationalisation Plan.

Maintenance of all facilities will be prioritised throughout the reporting period.

17.4 Strategic Objectives and Expected Outcomes

Table 38: Strategic objectives and expected outcomes

Strategic Objective	Strategic Objective Statement	Indicator	Baseline 2013/14 [17]	Target 2019/20
Strategic Goal 3: Universal health coverage				
3.2) Create job opportunities	3.2.1) Create 11 800 jobs through the Expanded Public Works Programme by March 2020 (cumulative)	Number of jobs created through the Expanded Public Works Programme	3 398	11 800
3.3) improve health facility planning and infrastructure delivery	3.3.1) Commission 28 new projects by March 2020	Number of new clinical projects with completed construction	11	8
		Number of new clinical projects where commissioning is complete	6	28
	3.3.2) Complete 35 upgrading & renovation projects by March 2018	Number of upgrading and renovation projects with completed construction	67	35
LINKS TO OTHER PLANNING FRAMEWORKS ***National Development Plan 2030*** Strategic Goal 8: Universal health coverage achieved ***Medium Term Strategic Framework 2014-2019*** Sub-Output 1: Universal health coverage progressively achieved through implementation of NHI Sub-Output 7: Improved health facility planning & infrastructure delivery ***Provincial Growth and Development Plan*** Strategic Objectives 3.2c: Ensure equitable access to health services. Strategic Objective 3.2d: Implement the first phase of National Health Insurance pilot programme				

[17] Baseline is based on one full year data (2013/14) unless otherwise indicated

17.5 Resource Considerations

Due to the reduction of budgets over the last few years, the Department was forced to shelve a number of planned projects to ensure that MTEF Plan(s) balance with allocated budget(s). There will however be a high risk for implementation of projects over the next five years due to two big projects namely the new Dr Pixley Isaka Ka Seme Regional Hospital and the 192 bed multi-storey surgical block in the Ngwelezane Hospital which will take at least one third of the total infrastructure budget annually. The Department will implement vigorous project monitoring of both these projects to prevent over/ under expenditure through unforeseen circumstances.

The costed Infrastructure Long Term Plan, reviewed annually, will inform priorities over the next 5 years.

17.6 Risk Management

Table 39: Key Risk Factors

Key Risk Factors	Measures to Mitigate Risks
1. Level of competency of service providers and capacity within the Implementing Agencies to deliver on infrastructure projects. *(High Risk)*	• Close monitoring of the appointed Service Providers and IAs and enforcement of penalties in case of default.
2. Lack of maintenance management systems which may impact on timely completion of projects. *(High Risk)*	• Develop and implement a maintenance management system.
3. Limited financial resources to meet the increasing infrastructure needs including excessive cost of the two major infrastructure projects namely Dr Pixley Isaka Ka Seme and Ngwelezana. *(High Risk)*	• Put construction of new facilities on hold with more emphasis on maintenance. • The costed Long Term Plan makes provision for prioritised projects over 5 year period.
4. Shortages of technical skilled staff. *(High Risk)*	• Filling of all technical posts to ensure delivery on mandates.
5. Unfunded mandates/ projects in-year. *(High Risk)*	• Align new (in-year mandates) with the Long Term Plan.

PART C: LINKS TO OTHER PLANS

- Long-Term Infrastructure & other Capital Plans
- Conditional Grants
- Public Entities
- Public Private Partnerships

18. LONG-TERM INFRASTRUCTURE PLAN

Table 40: Long-Term Infrastructure Plan

No.	Project name	Type project details	Project status	Implementing Agent Name	District Municipality Name	Primary Source of funding	Total project Cost (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)
	Total						**R 9 527 595**	**R 1 491 471**	**R 1 583 796**	**R 1 732 757**
MAINTENANCE PROJECTS										
1	Acquisition of Land and Buildings	Real Estates - Acquisition of properties	Construction 1% - 25%	KZN-DoPW	KZN Province	Equitable Share	R 10 000	R 3 500	R 3 500	R 3 000
2	Addington Hospital	Upgrade / replace 5 Otis Lifts, 2 Kone Lifts and 7 Schindler Lifts	Construction 1% - 25%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 13 000	R 12 500	R 400	-
3	Addington Hospital	Replacement of 3 x Autoclaves	Retention	Health	eThekwini Metro	Equitable Share	R 986	R 24	-	-
4	Addington Hospital	Phase 3: Replacement of 1 x Autoclave	Retention	Health	eThekwini Metro	Equitable Share	R 350	R 9	-	-
5	Charles Johnson Memorial Hospital	Phase 3: Replacement of 1 x Autoclave	Retention	Health	Umzinyathi	Equitable Share	R 350	R 9	-	-
6	Charles Johnson Memorial Hospital	Upgrade / replace 2 Schindler Lifts	Retention	KZN-DoPW	Umzinyathi	Health Facility Revitalisation Grant	R 1 750	R 44	-	-
7	Church of Scotland Hospital	Phase 3: Replacement of 1 x Autoclave	Retention	Health	Umzinyathi	Equitable Share	R 350	R 9	-	-
8	Church of Scotland Hospital	Replacement of the Theatre and CSSD Chiller	Retention	KZN-DoPW	Umzinyathi	Health Facility Revitalisation Grant	R 1 000	R 100	-	-
9	E.G & Usher Memorial Hospital	Replacement of 2 x Autoclaves	Retention	Health	Harry Gwala	Equitable Share	R 658	R 16	-	-
10	Edumbe CHC	Replacement of 1 x Autoclave	Retention	Health	Zululand	Equitable Share	R 373	R 9	-	-
11	EPWP: Maintenance of Gardens/Grounds	EPWP Maintenance of Gardens and Grounds for Health Facilities (Co-Funded under Other/ Equitable Share)	Construction 1% - 25%	Health	uMgungundlovu	Equitable Share	R 64 000	R 17 000	R 17 000	R 17 000
12	Eshowe Hospital	Upgrade / replace 4 Otis Lifts	Construction 1% - 25%	KZN-DoPW	uThungulu	Health Facility Revitalisation Grant	R 5 000	R 4 850	R 150	-
13	Eshowe Hospital	Phase 3: Replacement of 1 x Autoclave	Retention	Health	uThungulu	Equitable Share	R 350	R 9	-	-

No.	Project name	Type project details	Project status	Implementing Agent Name	District Municipality Name	Primary Source of funding	Total project Cost (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)
14	Feasibility Investigations	Feasibility Investigations, Multi Year Plans	Feasibility	KZN-DoPW	uMgungundlovu	Equitable Share	R 3 000	R 1 000	R 1 000	R 1 000
15	Food Services	Repair 56 and Replace 34 Cold Rooms (31 Institutions)	Feasibility	KZN-DoPW	KZN Province	Equitable Share	R 30 000	R 1 000	R 3 000	R 3 000
16	Food Services	Repair 19 and Replace 24 Freezers (17 Institutions)	Feasibility	KZN-DoPW	KZN Province	Equitable Share	R 7 000	R 1 000	R 2 000	R 2 000
17	Food Services	Replace 13 Stainless Steel Shelving for Cold Rooms and Freezers (10 Institutions)	Feasibility	KZN-DoPW	KZN Province	Equitable Share	R 1 000	R 1 000	-	-
18	Food Services	Replace 15 Stainless Steel for Dry Storerooms (10 Institutions)	Feasibility	KZN-DoPW	KZN Province	Equitable Share	R 1 000	R 1 000	-	-
19	Greys Hospital	Replacement of 11 lifts in the DQ and at Nurses Residents	Retention	KZN-DoPW	uMgungundlovu	Equitable Share	R 7 654	R 667	-	-
20	Greytown Hospital	Replacement of the Theatre Chiller	Feasibility	KZN-DoPW	Umzinyathi	Health Facility Revitalisation Grant	R 350	-	-	-
21	Greytown Hospital	Replacement of the Theatre and CSSD Chiller	Retention	KZN-DoPW	Umzinyathi	Health Facility Revitalisation Grant	R 1 000	R 100		-
22	Highway House : Mayville	Upgrading of A/C (Replacement of Cenral plant compressors)	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 7 500	R 7 320	R 104	-
23	Institutional Maintenance: Amajuba District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Amajuba	Health Facility Revitalisation Grant	R 77 710	R 2 810	R 2 950	R 3 098
24	Institutional Maintenance: Amajuba District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Amajuba	Equitable Share	R 52 894	R 4 325	R 4 405	R 4 625
25	Institutional Maintenance: eThekwini District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	eThekwini Metro	Health Facility Revitalisation Grant	R 280 756	R 19 511	R 20 426	R 21 447
26	Institutional Maintenance: eThekwini District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	eThekwini Metro	Equitable Share	R 345 642	R 26 979	R 28 196	R 29 550
27	Institutional Maintenance: Harry Gwala District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Harry Gwala	Health Facility Revitalisation Grant	R 194 146	R 4 561	R 4 789	R 5 029

No.	Project name	Type project details	Project status	Implementing Agent Name	District Municipality Name	Primary Source of funding	Total project Cost (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)
28	Institutional Maintenance: Harry Gwala District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Harry Gwala	Equitable Share	R 64 499	R 5 128	R 5 384	R 5 654
29	Institutional Maintenance: Head Office District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	uMgungundlovu	Equitable Share	R 56 041	R 1 970	R 2 068	R 1 786
30	Institutional Maintenance: Head Office District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	uMgungundlovu	Equitable Share	R 32 675	R 3 100	R 3 255	R 2 756
31	Institutional Maintenance: Ilembe District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	iLembe	Health Facility Revitalisation Grant	R 69 989	R 3 356	R 3 524	R 3 700
32	Institutional Maintenance: Ilembe District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	iLembe	Equitable Share	R 60 960	R 4 855	R 5 098	R 5 342
33	Institutional Maintenance: Ugu District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Ugu	Health Facility Revitalisation Grant	R 146 003	R 6 368	R 6 627	R 6 949
34	Institutional Maintenance: Ugu District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Ugu	Equitable Share	R 103 211	R 8 266	R 8 658	R 9 036
35	Institutional Maintenance: Umgungundlovu District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	uMgungundlovu	Health Facility Revitalisation Grant	R 256 276	R 11 010	R 11 560	R 11 874
36	Institutional Maintenance: Umgungundlovu District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	uMgungundlovu	Equitable Share	R 314 110	R 25 428	R 26 699	R 27 435
37	Institutional Maintenance: Umkhanyakude District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Umkhanyakude	Health Facility Revitalisation Grant	R 125 597	R 6 306	R 6 621	R 6 952

No.	Project name	Type project details	Project status	Implementing Agent Name	District Municipality Name	Primary Source of funding	Total project Cost (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)
38	Institutional Maintenance: Umkhanyakude District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Umkhanyakude	Equitable Share	R 73 395	R 5 852	R 6 145	R 6 430
39	Institutional Maintenance: Umzinyathi District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Umzinyathi	Health Facility Revitalisation Grant	R 132 711	R 7 536	R 7 913	R 9 078
40	Institutional Maintenance: Umzinyathi District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Umzinyathi	Equitable Share	R 70 337	R 5 628	R 5 699	R 6 180
41	Institutional Maintenance: uThukela District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Uthukela	Health Facility Revitalisation Grant	R 87 853	R 3 217	R 3 378	R 3 547
42	Institutional Maintenance: uThukela District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Uthukela	Equitable Share	R 58 227	R 4 629	R 4 861	R 5 104
43	Institutional Maintenance: Uthungulu District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	uThungulu	Health Facility Revitalisation Grant	R 118 584	R 9 428	R 9 899	R 10 394
44	Institutional Maintenance: Uthungulu District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	uThungulu	Equitable Share	R 150 769	R 12 071	R 12 674	R 13 197
45	Institutional Maintenance: Zululand District	Budget allocated to institutions for Prevent Deterioration or Failure	Construction 1% - 25%	Health	Zululand	Equitable Share	R 81 077	R 6 446	R 6 768	R 7 107
46	Institutional Maintenance: Zululand District	Budget allocated to institutions to Restore the buildings to its specific level of operation	Construction 1% - 25%	Health	Zululand	Equitable Share	R 93 957	R 7 470	R 7 844	R 8 236
47	King Edward VIII Hospital	Replacement of 1 x Autoclave	Retention	Health	eThekwini Metro	Equitable Share	R 350	R 9	-	-
48	Madadeni Hospital	Replacement of Boiler	Retention	KZN-DoPW	Amajuba	Health Facility Revitalisation Grant	R 9 800	R 100	-	-
49	Madadeni Hospital	Condition Assessment Maintenance	Construction 1% - 25%	IDT	Amajuba	Health Facility Revitalisation Grant	R 85 000	R 35 191	R 34 000	R 2 500
50	Mahatma Ghandhi Hospital	Replacement of 2 x Autoclaves	Retention	Health	eThekwini Metro	Equitable Share	R 704	R 18	-	-

No.	Project name	Type project details	Project status	Implementing Agent Name	District Municipality Name	Primary Source of funding	Total project Cost (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)
51	Mbongolwane Hospital	Phase 3: Replacement of 1 x Autoclave	Retention	Health	uThungulu	Equitable Share	R 350	R 8	-	-
52	Mosvold Hospital	Phase 3: Replacement of 1 x Autoclave	Retention	Health	Umkhanyakude	Equitable Share	R 350	R 9	-	-
53	Newcastle Hospital	Upgrade 7 lifts	Retention	KZN-DoPW	Amajuba	Equitable Share	R 6 818	R 170	-	-
54	Newcastle Hospital	Replacement of 1 x Autoclave	Retention	Health	Amajuba	Equitable Share	R 353	R 9	-	-
55	Newcastle Hospital	Condition Assessment Maintenance	Construction 1% - 25%	IDT	Amajuba	Health Facility Revitalisation Grant	R 72 000	R 43 500	R 30 000	R 2 000
56	Northdale Hospital	Upgrade / replace 4 Otis Lifts	Construction 1% - 25%	KZN-DoPW	uMgungundlovu	Health Facility Revitalisation Grant	R 4 000	R 3 900	R 100	-
57	Nseleni CHC	Replacement of 1 x Autoclave	Retention	Health	uThungulu	Equitable Share	R 348	R 9	-	-
58	Office and residential Accommodation lease agreements	Manage 168 Lease Agreements For KZN - Health(Office And Residential Accommodation)	Construction 1% - 25%	KZN-DoPW	KZN Province	Health Facility Revitalisation Grant	R 332 033	R 66 000	R 66 000	R 66 000
59	PHC Clinics Planning	Grant budget for training	Feasibility	Health	KZN Province	Health Facility Revitalisation Grant	R 10 000	R 10 000	-	-
60	Phoenix Assessment Centre	Install 1 x 100 KVA with new	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 500	R 125	-	-
61	Port Shepstone Hospital	Replacement of 2 x Autoclaves	Retention	Health	Ugu	Equitable Share	R 618	R 15	-	-
62	R K Khan Hospital	Upgrading of 4 lifts: Nurses Home	Construction 1% - 25%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 2 000	R 1 500	R 500	-
63	Radio Repeater Site	Radio Repeater high sites throughout KZN: Maintenance and Licence Fees	Construction 1% - 25%	KZN-DoPW	KZN Province	Equitable Share	R 6 000	R 2 000	R 2 000	R 2 000
64	St Aidens Hospital	Replacement of 1 x Autoclave	Retention	Health	eThekwini Metro	Equitable Share	R 370	R 9	-	-
65	St Apollinaris Hospital	Replacement of 1 x Autoclave	Retention	Health	Harry Gwala	Equitable Share	R 353	R 9	-	-
66	St. Margaret's hospital	Replacement of 1 x Autoclave	Retention	Health	Harry Gwala	Equitable Share	R 342	R 8	-	-
67	Stanger Hospital	Replacement of 3 Chiller for the entire Hospital (Theatre/ Wards Chillers)	Retention	KZN-DoPW	iLembe	Health Facility Revitalisation Grant	R 2 200	R 50	-	-

No.	Project name	Type project details	Project status	Implementing Agent Name	District Municipality Name	Primary Source of funding	Total project Cost (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)
68	Stanger Hospital	Upgrade / replace 1 Otis Lifts and 1 Hoist	Construction 1% - 25%	KZN-DoPW	iLembe	Health Facility Revitalisation Grant	R 2 200	R 2 150	R 50	-
69	Vryheid Hospital	Upgrade / replace 2 Otis Lifts	Construction 1% - 25%	KZN-DoPW	Zululand	Health Facility Revitalisation Grant	R 2 000	R 1 950	R 50	-
REFURBISHMENT PROJECTS										
70	Addington Hospital	Replace and install 1 x 500kVA with larger unit	Construction 1% - 25%	KZN-DoPW	eThekwini Metro	Equitable Share	R 1 500	R 1 450	R 50	-
71	Addington Hospital	Upgrade 3rd Floor Theatres	Retention	IDT	eThekwini Metro	Health Facility Revitalisation Grant	R 30 000	R 350	-	-
72	Appelsbosch Hospital	Maternity ward	Identified	KZN-DoPW	Umgungundlovu	Equitable Share	R 20 000		-	-
73	Appelsbosch Hospital	New Staff Accommodation U.T.B Additions And Alterations To Staff & Nurses Accommodation	Retention	KZN-DoPW	uMgungundlovu	Health Facility Revitalisation Grant	R 17 495	R 610	-	-
74	Appelsbosch Hospital	Erect Lockable Garaging For 20 Vehicles	Retention	KZN-DoPW	uMgungundlovu	Equitable Share	R 2 058	R 110	-	-
75	Appelsbosch Hospital	Replace and install 1 x 300kVA with larger unit	Construction 1% - 25%	KZN-DoPW	uMgungundlovu	Health Facility Revitalisation Grant	R 1 000	R 975	R 25	-
76	Benedictine Hospital (Nursing College)	Student Nurses Accommodation (40 beds), Phase 1	Construction 1% - 25%	IDT	Zululand	Health Facility Revitalisation Grant	R 38 446	R 15 000	R 22 000	R 412
77	Bethesda Hospital	Demolish existing Nurses Units, relocate Water Chlorifying Room & Extraction Room and Built New Paeds Ward and 20 Mother lodge ward	Retention	KZN-DoPW	Umkhanyakude	Health Facility Revitalisation Grant	R 25 004	R 1 131	-	-
78	Bruntville CHC	Construct sheltered walkways, install ramps and waiting shelter. Extend pharmacy	Tender	KZN-DoPW	uMgungundlovu	Equitable Share	R 5 000	R 300	R 4 570	-
79	Catherine Booth Hospital	Demolish existing wards and rebuild new Wards 105 beds	Design	KZN-DoPW	uThungulu	Equitable Share	R 95 000	-	R 10 000	R 40 000
80	Catherine Booth Hospital	Replace and install 1 x 200kVA with larger unit	Construction 1% - 25%	KZN-DoPW	uThungulu	Health Facility Revitalisation Grant	R 800	R 780	-	-
81	Catherine Booth Hospital	New water storage tank and replacement of galvanised pipes.	Retention	KZN-DoPW	uThungulu	Equitable Share	R 5 840	R 200	-	-

No.	Project name	Type project details	Project status	Implementing Agent Name	District Municipality Name	Primary Source of funding	Total project Cost (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)
82	Ceza Hospital	New female & male ward and replacement of burnt house	Feasibility	KZN-DoPW	Zululand	Equitable Share	R 50 000	-	-	R 2 500
83	Charles Johnson Memorial Hospital	Replace and install 1 x 500kVA with larger unit	Construction 1% - 25%	KZN-DoPW	Umzinyathi	Health Facility Revitalisation Grant	R 1 500	R 1 450	R 500	-
84	Charles Johnson Memorial Hospital (Nursing Colleges)	New staff Accommodation for 40 staff (incl. Comm serve Doctors)	Design	IDT	Umzinyathi	Equitable Share	R 60 000	-	R 2 000	R 20 000
85	Church Of Scotland Hospital	Replace Paediatric Ward With Male And Female TB Ward	Construction 76% - 99%	KZN-DoPW	Umzinyathi	Health Facility Revitalisation Grant	R 56 110	R 2 500	R 1 500	-
86	Church Of Scotland Hospital	Install 1 x 200 KVA and 1x300 KVA with larger units	Retention	KZN-DoPW	Umzinyathi	Health Facility Revitalisation Grant	R 2 000	R 500	-	-
87	Clairwood Hospital	Repairs and renovations to FM1 and FM2 for TB	Design	KZN-DoPW	eThekwini Metro	Equitable Share	R 22 000	-	R 2 000	R 13 000
88	Dunstan Farrell Hospital	Install 1 x 100 KVA with larger units	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 850	R 213	-	-
89	E.G & Usher Memorial Hospital	Replace and install 1 x 500kVA with larger unit	Retention	KZN-DoPW	Harry Gwala	Health Facility Revitalisation Grant	R 1 500	R 1 450	R 50	-
90	Edendale Hospital	Implementation of a new CDC Clinic and ARV facility	Retention	KZN-DoPW	uMgungundlovu	Health Facility Revitalisation Grant	R 58 106	R 700	-	-
91	Edendale Hospital	Upgrade existing Accident & Emergency Unit and OPD	Construction 76% - 99%	KZN-DoPW	uMgungundlovu	Health Facility Revitalisation Grant	R 74 750	R 6 000	R 1 868	-
92	Edendale Hospital	Convert steam reticulation to electrical reticulation	Construction 76% - 99%	KZN-DoPW	uMgungundlovu	Health Facility Revitalisation Grant	R 21 180	R 4 000	-	-
93	Edendale Nursing College	Extensive renovations and additions to existing building	Retention	KZN-DoPW	uMgungundlovu	Health Facility Revitalisation Grant	R 48 963	R 700	-	-
94	Ekhombe Hospital	• Complete repairs and renovations to Kitchen • Complete repairs and renovations to Doctors Flats • Complete Upgrades and Additions to Male and Female Wards • Replace existing CSSD and Theatre with new facility	Design	IDT	uThungulu	Equitable Share	R 53 810	-	-	R 500
95	Ekhombe Hospital	New staff Accommodation for 38 staff (Nursing staff and Medical officers) and 3x3 bedroom Doctors house	Retention	IDT	uThungulu	Equitable Share	R 17 729	R 443	-	-

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96	Ekuhlengeni Life Care Centre	Complete renovations of the Hospital	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 42 150	R 1 000	-	-
97	Ekuphumuleni Clinic	Upgrade and Additions (MOU) & minor repairs to Kitchen roofs and ablutions	Feasibility	KZN-DoPW	uThungulu	Equitable Share	R 8 000	R 1 000	R 3 000	R 4 000
98	Emmaus Hospital	New OPD, Casualty/Trauma Unit, X-Ray And Related Facilities	Retention	KZN-DoPW	Uthukela	Health Facility Revitalisation Grant	R 132 236	R 1 000	-	-
99	Eshowe Hospital	Upgrade Maternity complex , Medical gas & Nursery	Feasibility	KZN-DoPW	uThungulu	Equitable Share	R 25 000	-	R 2 000	R 3 000
100	Eshowe Hospital	Construction of new roof for all Hospital buildings	Retention	KZN-DoPW	uThungulu	Health Facility Revitalisation Grant	R 11 400	R 285	-	-
101	Ex-Old Boys Model School - Offices	Conversion of existing building to new SCM offices	Construction 1% - 25%	KZN-DoPW	uMgungundlovu	Health Facility Revitalisation Grant	R 48 806	R 18 000	R 2 500	-
102	Food Services	Replace Flooring for Cold Rooms (5 Hospitals)	Feasibility	KZN-DoPW	KZN Province	Equitable Share	R 1 000	R 1 000	-	-
103	Fort Napier Hospital	Renovations to Peter De Vos Building Nurses Residence, Ward 3, Forensic Ward, Dining room, Jabula Ward and Laundry	Retention	IDT	uMgungundlovu	Equitable Share	R 17 188	R 375	-	-
104	G J Crookes Hospital	Construction of Redesigned Access and traffic handling facility	Design	KZN-DoPW	Ugu	Equitable Share	R 20 000	-	-	R 5 000
105	G J Crookes Hospital	Phase 2-4 Casualty, Trauma, Admissions (Completion Contract)	Retention	KZN-DoPW	Ugu	Health Facility Revitalisation Grant	R 138 000	R 3 500	-	-
106	G J Crookes Hospital	Upgrade the roof and plumbing in maternity ward	Feasibility	KZN-DoPW	Ugu	Equitable Share	R 15 000	R 10 786	R 3 214	R 1 000
107	Gale Street Mortuary	Reconfigure 2nd floor to a new Forensic Pathology Lab for National Health	Construction 1% - 25%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 9 900	R 4 559	R 245	-
108	Gamalakhe CHC	Phase 2- HAST (including ARV) Unit, Admin, Child Health, CSSD, Special Clinics, Lab & Stores	Retention	KZN-DoPW	Ugu	Health Facility Revitalisation Grant	R 36 000	R 900	-	-
109	Greys Hospital	Conversion of M2 Ward into New NICU Facilities	Retention	KZN-DoPW	uMgungundlovu	Health Facility Revitalisation Grant	R 9 688	R 230	-	-
110	Greytown Hospital	Replace and install 1 x 300kVA with larger unit	Construction 1% - 25%	KZN-DoPW	Umzinyathi	Health Facility Revitalisation Grant	R 1 000	R 975	R 25	-
111	Greytown TB Hospital	Replace and install 1 x 50kVA with larger unit	Retention	KZN-DoPW	Umzinyathi	Health Facility Revitalisation Grant	R 250	R 6	-	-

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112	Hillcrest Hospital	Replace and install 1 x 200kVA with larger unit	Construction 1% - 25%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 750	R 730	R 20	-
113	Hlabisa Hospital	Replace and install 1 x 500kVA with larger unit	Construction 1% - 25%	KZN-DoPW	Umkhanyakude	Health Facility Revitalisation Grant	R 1 500	R 1 450	R 50	-
114	Hlabisa Hospital	Upgrade Pharmacy, OPD	Design	IDT	Umkhanyakude	Health Facility Revitalisation Grant	R 120 000	-	R 40 000	R 40 000
115	Hlengisizwe CHC	Provision of ARV-TB and MMC Parkhomes	Retention	Health	eThekwini Metro	Equitable Share	R 7 000	R 45	-	-
116	IDMS Posts	Programme Management	Construction 1% - 25%	Health	uMgungundlovu	Health Facility Revitalisation Grant	R 44 430	R 20 000	R 20 000	R 25 000
117	Imbalenhle CHC	Install 1 x 200 KVA with larger units	Retention	KZN-DoPW	uMgungundlovu	Health Facility Revitalisation Grant	R 950	R 238	-	-
118	Inanda C Clinic	Additions and Alterations to administration block(and multi-year plan)	Retention	KZN-DoPW	eThekwini Metro	Equitable Share	R 27 210	R 2 121	R 600	-
119	Isithebe Clinic	Construction of Nurses Residents	Retention	KZN-DoPW	iLembe	Equitable Share	R 18 700	R 900	-	-
120	Kilman Clinic	Security, General R & R To Clinic & Residences, Liliput Syst (Completion of Contract)	Retention	KZN-DoPW	Harry Gwala	Equitable Share	R 861	R 88	-	-
121	King Dinuzulu Hospital	Additional work to Level 1 Hospital	Construction 76% - 99%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 8 630	R 1 917	R 215	-
122	King Dinuzulu Hospital	New Psychiatric closed unit (Previously known as alterations and additions)	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 12 847	R 300	-	-
123	King Dinuzulu Hospital	TB Surgical Outpatients	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 32 322	R 800	-	-
124	King Dinuzulu Hospital	Initial Planning: Disbursement for resident personnel and other related costs	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 26 745	R 983	-	-
125	King Dinuzulu Hospital	New Aircon to TB Multi storey	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 23 012	R 893	-	-
126	King Dinuzulu Hospital	New Psychiatric Hospital Phase 2, upgrade to existing water reservoir, new covered walkway, Helistop and Taxi Stop	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 68 544	R 1 730	-	-
127	King Dinuzulu Hospital	Provide roofs to TB Surgical wards, walkways and ramps, and Reconfigure used building to EMS Base	Design	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 13 000	-	R 7 000	R 1 000

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128	King Dinuzulu Hospital	New TB complex	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 78 054	R 1 693	-	-
129	King Dinuzulu Hospital	Renovate Staff Accommodation	Feasibility	KZN-DoPW	eThekwini Metro	Equitable Share	R 80 000	R 2 000	R 30 000	R 46 000
130	King Edward VIII Hospital	Unblocking and repair of stormwater pipes (to include sub drainage)	Design	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 35 000	-	R 15 000	R 15 000
131	King Edward VIII Hospital	Health Technology Equipment	Retention	IDT	eThekwini Metro	Health Facility Revitalisation Grant	R 30 644	R 2 000	-	-
132	King Edward VIII Hospital	Repairs and Renovations to MOPD and Upgrade to Theatres, ICU, Nursery and High Care wards in Block 'S'	Design	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 248 000	-	R 20 341	R 80 000
133	King Edward VIII Hospital	Repairs and Renovations to Family Clinic, Male and Female Psychiatric patients wards and Kitchens in Theatre Block and Conversion of N Theatre Block Offices	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 37 407	R 935	-	-
134	King Edward VIII Hospital	Staff Residence renovation Phase 2	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 73 211	R 1 830	-	-
135	Kwamagwaza Hospital (St Mary's)	Additions & redesign to maternity	Retention	KZN-DoPW	uThungulu	Health Facility Revitalisation Grant	R 9 400	R 350	-	-
136	KwaMagwaza Hospital (St Mary's)	Upgrade Kitchen Floor, Waterproofing Roof	Design	KZN-DoPW	uThungulu	Equitable Share	R 4 000	-	-	R 500
137	KwaMashu CHC	Provision of new Kitchen and Tuckshop	Feasibility	KZN-DoPW	eThekwini Metro	Equitable Share	R 3 000	-	-	R 300
138	KwaShoba Clinic	Clinic Maintenance & Upgrading Programme Phase 1 (Completion of cancelled contract)	Retention	KZN-DoPW	Zululand	Equitable Share	R 5 700	R 135	-	-
139	KwaZulu Central Provincial Laundry	Shelving	Feasibility	KZN-DoPW	eThekwini Metro	Equitable Share	R 2 000	R 2 000	-	-
140	KwaZulu Provincial Central Laundry (PMMH)	Repair & Install Plant: Durban Regional Laundry (Co-funded from HIG)	Retention	KZN-DoPW	eThekwini Metro	Equitable Share	R 198 037	R 2 000	-	-
141	KZN Childrens Hospital	Refurbish : Phase 2A and Phase 2B	Construction 26% - 50%	Health	eThekwini Metro	Equitable Share	R 300 000	-	R 20 000	R 40 000
142	Ladysmith Provincial Hospital	Extension of OPD and Reconfiguration	Feasibility	Health	Uthukela	Equitable Share	R 40 000	-	-	R 3 000

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143	LUWMH	Health Technology Equipment	Construction 76% - 99%	IDT	uThungulu	Health Facility Revitalisation Grant	R 73 072	R 5 752	-	-
144	LUWMH	Alteration and Additions to existing Hospital	Construction 76% - 99%	KZN-DoPW	uThungulu	Health Facility Revitalisation Grant	R 427 521	R 24 955	-	-
145	LUWMH	Maternity ward -OT & Emergency unit	Identified	KZN-DoPW	uThungulu	Equitable Share	R 50 000	-	-	R 5 000
146	Makhathini Clinic	Maintenance For 2001/2002 Programme (Completion contract)	Retention	KZN-DoPW	Umkhanyakude	Health Facility Revitalisation Grant	R 6 200	R 150	-	-
147	Mayor's Walk CPS	Upgrade / replace 1 Hoist	Retention	KZN-DoPW	uMgungundlovu	Health Facility Revitalisation Grant	R 750	R 19	-	-
148	Mbongolwane Hospital	New Theatre & CSSD, Refurbish Existing Theatre Into New Male (Completion of Terminated Contract)	Retention	KZN-DoPW	uThungulu	Equitable Share	R 20 662	R 200	-	-
149	Mbongolwane Hospital	Demolish existing houses at Jabulani Village, rebuild with 6 single units, repairs and renovations to existing dormitories, R&R to existing 7 house at Hosp, new access roads and parking to staff accommodation	Retention	KZN-DoPW	uThungulu	Health Facility Revitalisation Grant	R 20 100	R 1 364	-	-
150	Mbongolwane Hospital	Construction of a new Pharmacy	Retention	KZN-DoPW	uThungulu	Equitable Share	R 15 700	R 2 151	-	-
151	McCords Hospital	Complete Renovations	Identified	KZN-DoPW	eThekwini Metro	Equitable Share	R 40 000		R 2 000	R 3 000
152	Mnqobokazi Clinic	Clinic Maintenance & Upgrading Programme : 2006-2007 Phase 1 (Completion contract)	Retention	KZN-DoPW	Umkhanyakude	Health Facility Revitalisation Grant	R 3 800	R 180	-	-
153	Montebello Hospital	Replace and install 1 x 300kVA with larger unit	Construction 1% - 25%	KZN-DoPW	iLembe	Health Facility Revitalisation Grant	R 1 000	R 975	R 25	-
154	Mosvold Hospital	Replace and install 1 x 300kVA with larger unit	Construction 1% - 25%	KZN-DoPW	Umkhanyakude	Health Facility Revitalisation Grant	R 1 500	R 1 450	R 50	-
155	Mseleni Hospital	Install 1 x 250 KVA with larger units	Retention	KZN-DoPW	Umkhanyakude	Equitable Share	R 1 250	R 313	-	-
156	Murchison Hospital	General & T.B. Wards	Retention	KZN-DoPW	Ugu	Health Facility Revitalisation Grant	R 66 000	R 1 650	-	-
157	Murchison Hospital	Construction of new MDR unit	Feasibility	KZN-DoPW	Ugu	Equitable Share	R 20 000	-	R 3 000	R 10 000
158	Murchison Hospital	Construction of new OPD, casualty, x-ray etc.	Feasibility	KZN-DoPW	Ugu	Equitable Share	R 25 000	-	-	R 500

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159	Mwolokohlo Clinic	Additions and Upgrading to the Clinic and construction of Nurses Residents	Retention	KZN-DoPW	iLembe	Health Facility Revitalisation Grant	R 12 000	R 1 234	-	-
160	Natalia Building	Relocate EMS Provincial Health Operational Centre from 16th floor to Ground floor West Wing and remove wall carpet on all floors	Construction 1% - 25%	IDT	uMgungundlovu	Health Facility Revitalisation Grant	R 110 000	R 48 000	R 50 000	R 4 000
161	Natalia Building	Phase 2 Electrical Upgrade	Construction 1% - 25%	IDT	uMgungundlovu	Health Facility Revitalisation Grant	R 15 000	R 13 000	R 1 000	-
162	Ndumo Clinic	Add consulting rooms, PMTCT, Ambulance Base to existing clinic and build residences	Construction 76% - 99%	KZN-DoPW	Umkhanyakude	Health Facility Revitalisation Grant	R 33 000	R 3 000	R 500	-
163	Ndundulu Clinic	Replacement Clinic: K2, R2 X 3, R3x1,Guard House, Car Port, (Completion contract)	Retention	KZN-DoPW	uThungulu	Health Facility Revitalisation Grant	R 16 325	R 447	-	-
164	Ndwedwe CHC	Replace and install 1 x 200kVA with larger unit	Construction 1% - 25%	KZN-DoPW	iLembe	Health Facility Revitalisation Grant	R 1 000	R 975	R 25	-
165	Ndwedwe CHC	Construction of new HAST Unit/ TB Clinic and upgrade water and sewer system	Design	KZN-DoPW	iLembe	Equitable Share	R 18 000	-	-	R 3 000
166	Newcastle Hospital	Construction of new VCT & ART	Retention	KZN-DoPW	Amajuba	Equitable Share	R 18 658	R 200	-	-
167	Newcastle Hospital	Construction of a new Pharmacy and Physio Department	Retention	KZN-DoPW	Amajuba	Equitable Share	R 11 808	R 200	-	-
168	Ngwelezane Clinic	Repairs And Renovations (Completion contract)	Retention	KZN-DoPW	uThungulu	Equitable Share	R 2 500	R 153	-	-
169	Ngwelezane Hospital	Upgrade MV and LV electrical reticulation including generators, lighting protection to remaining building, upgrade water reticulation and existing corridors	Retention	KZN-DoPW	uThungulu	Health Facility Revitalisation Grant	R 125 000	R 4 823	-	-
170	Ngwelezane Hospital	Construct 2 New Wards (Demolish Wards A & B)	Retention	KZN-DoPW	uThungulu	Health Facility Revitalisation Grant	R 55 000	R 200	-	-
171	Ngwelezane Hospital	Health Technology Equipment	Retention	IDT	uThungulu	Health Facility Revitalisation Grant	R 60 771	R 2 000	-	-
172	Ngwelezane Hospital	Security Upgrade	Feasibility	KZN-DoPW	uThungulu	Health Facility Revitalisation Grant	R 10 000	-	R 5 000	R 4 000

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173	Ngwelezane Hospital	Construct new 192 beds medical wards to replace wards E,F,G,H and demolish the existing Crisis Centre Parkhome and construct new Crisis centre, demolish old wards E,F,G,H.	Construction 1% - 25%	KZN-DoPW	uThungulu	Health Facility Revitalisation Grant	R 320 000	R 80 000	R 100 000	R 80 330
174	Ngwelezane Hospital	8 New Theatres, CSSD, 20 bed ICU, infectious disease isolation unit, 30 bed high care ward, theatre specialist offices, overnight doctors accommodation, IT training rooms and fencing of the remainder of the Ngwelezane site. Upgrades to kitchen, laundry, supplies department, cafeteria and occupational therapy department	Design	KZN-DoPW	uThungulu	Health Facility Revitalisation Grant	R 360 000	-	-	R 20 000
175	Niemeyer Memorial Hospital	Re-design upgrade of CCMT waiting area	Identified	KZN-DoPW	Amajuba	Equitable Share	R 10 000	-	-	R 1 000
176	Nkandla Hospital	Construction of a new pharmacy	Retention	KZN-DoPW	uThungulu	Equitable Share	R 8 100	R 500	-	-
177	Nkonjeni Hospital	Reconfigure existing Neonatal Facility and renovate existing Casualty and OPD	Design	KZN-DoPW	Zululand	Equitable Share	R 3 250	R 3 000	R 250	-
178	Nkonjeni Hospital	Renovate existing Casualty and OPD	Feasibility	KZN-DoPW	Zululand	Equitable Share	R 60 000	-	-	R 2 000
179	Nkonjeni-Ulundi Residential Accommodation	Renovations to 7 x 3 Bedrooms house with Double garages	Tender	KZN-DoPW	Zululand	Equitable Share	R 8 600	R 8 000	R 600	-
180	Ntambanana Clinic	Clinic Maintenance & Upgrading Programme : 2006-2007 Phase 2 (Completion of cancelled contract)	Retention	KZN-DoPW	uThungulu	Health Facility Revitalisation Grant	R 6 500	R 328	-	-
181	Osindisweni Hospital	Replace and install 1 x 200kVA with larger unit	Construction 1% - 25%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 1 000	R 975	R 25	-
182	Osindisweni Hospital	Replace TB ward	Design	KZN-DoPW	eThekwini Metro	Equitable Share	R 90 350	-	-	R 20 000
183	Phoenix CHC	Extension of patient waiting area (Rehabilitation of Community Health Centre	Retention	KZN-DoPW	eThekwini Metro	Equitable Share	R 21 620	R 1 014	-	-
184	Phoenix CHC	Install 1 x 200 KVA with larger units	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 750	R 187	-	-
185	Phoenix CHC	Construction of Admin Block, Block F, Parking - Phase2	Design	KZN-DoPW	eThekwini Metro	Equitable Share	R 15 000	-	-	R 7 500

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186	Pholela CHC	Accommodation for 39 staff and provision for Parkhome	Retention	IDT	Harry Gwala	Equitable Share	R 26 107	R 500	-	-
187	Port Shepstone Hospital	Repair roofing to kitchen and laundry area/Urgent structural evaluation of roofing to kitchen and adjacent area.(Completion contract)	Retention	KZN-DoPW	Ugu	Equitable Share	R 2 300	R 223	-	-
188	Port Shepstone Hospital	Conversion of A Ward to 15 bedded Psychiatric Unit	Design	KZN-DoPW	Ugu	Equitable Share	R 30 000	-	R 1 000	R 15 000
189	Prince Mshiyeni Memorial Hospital	Upgrade fire protection system and water reservoir	Tender	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 67 000	R 20 000	R 35 000	R 2 000
190	Prince Mshiyeni Memorial Hospital	Upgrade Maternity Ward and Nursery	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 19 614	R 218	-	-
191	Prince Mshiyeni Memorial Hospital	Upgrade fire system	Construction 1% - 25%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 64 000	R 40 000	R 1 600	-
192	R K Khan Hospital	Completion of P Block (Completion contract) including Repairs to collapsing bank	Construction 76% - 99%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 35 242	R 8 418	R 1 700	-
193	Rietvlei Hospital	Phase 3B : Admin, Kitchen, Audio, ARV, New Staff Accommodation, Renovate existing accommodation	Retention	KZN-DoPW	Harry Gwala	Health Facility Revitalisation Grant	R 127 097	R 3 178	-	-
194	Rietvlei Hospital	Connection of electricity to the sewer treatment works plant	Retention	KZN-DoPW	Harry Gwala	Health Facility Revitalisation Grant	R 614	R 20	-	-
195	Siphilile Clinic	Reconfigure existing Clinic. perimeter fence, double vehicle entrance and pedestrian gates	Identified	KZN-DoPW	uThungulu	Equitable Share	R 18 000	-	-	R 2 000
196	St Andrews Hospital	Replace and install 1 x 300kVA with larger unit	Construction 1% - 25%	KZN-DoPW	Ugu	Health Facility Revitalisation Grant	R 1 500	R 1 450	R 50	-
197	St Apollinaris Hospital	Reconfigure existing building to provide for a neonatal nursery	design	KZN-DoPW	Harry Gwala	Equitable Share	R 2 500	R 2 000	R 500	-
198	St. Margaret's hospital	Building a new male/female TB Wards	Identified	KZN-DoPW	Harry Gwala	Equitable Share	R 50 000	-	R 4 000	R 20 000
199	St. Margaret's hospital	Sewer Reticulation	Feasibility	KZN-DoPW	Harry Gwala	Equitable Share	R 7 000	-	-	R 500
200	Stanger Hospital	Replacement of entire roof in OPD and Paeds Wards	Identified	KZN-DoPW	iLembe	Equitable Share	R 18 000	-	-	R 1 000

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201	Stanger Hospital	New Labour And Neo-Natal Ward	Construction 26% - 50%	KZN-DoPW	iLembe	Health Facility Revitalisation Grant	R 155 000	R 65 000	R 25 000	R 5 000
202	Sundumbili CHC	Maintenance	Retention	KZN-DoPW	iLembe	Health Facility Revitalisation Grant	R 8 453	R 120	-	-
203	Sundumbili CHC	Replace and install 1 x 100kVA with larger unit	Construction 1% - 25%	KZN-DoPW	iLembe	Health Facility Revitalisation Grant	R 850	R 730	R 20	-
204	Tongaat CHC	Replace and install 1 x 100kVA with larger unit	Construction 1% - 25%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 850	R 730	R 20	-
205	Townhill Hospital	Replacement or Renovations to Roof - Admin Block, North Park, Uitsag Wards, Hillside Wards, Occupational Therapy and Pharmacy	Retention	KZN-DoPW	uMgungundlovu	Equitable Share	R 50 000	R 2 100	-	-
206	Umphumulo Hospital	Install 1 x 300 KVA with larger units	Construction 1% - 25%	KZN-DoPW	iLembe	Health Facility Revitalisation Grant	R 1 000	R 950	R 50	-
207	Umphumulo Hospital	Construction of OPD With X-Ray, Admin Block Pharmacy ,neonatal and Physiotherapy	Design	KZN-DoPW	iLembe	Equitable Share	R 45 000	-	-	R 1 000
208	Umzimkhulu Hospital	Install 1 x 100 KVA with larger units	Retention	KZN-DoPW	Harry Gwala	Health Facility Revitalisation Grant	R 850	R 212	-	-
209	Umzinyathi Clinics	Construction of Septic Tanks	Construction 1% - 25%	KZN-DoPW	Umzinyathi	Equitable Share	R 15 000	R 13 500	R 500	-
210	Vryheid Hospital	Reconfigure existing building to provide for a neonatal nursery	Design	KZN-DoPW	Zululand	Equitable Share	R 2 000	R 1 600	R 200	-
NEW FACILITIES PROJECTS										
211	Dannhauser CHC	Construction of a new CHC	Retention	IDT	Amajuba	Health Facility Revitalisation Grant	R 186 186	R 4 000	-	-
212	Dr Pixley Ka Isaka Seme Hospital	New 500 Bed Regional Hospital	Construction 1% - 25%	IDT	eThekwini Metro	Health Facility Revitalisation Grant	R 2 912 459	R 400 000	R 673 127	R 704 014
213	Dr Pixley ka Isaka Seme Hospital	Payment for Levies	Construction 1% - 25%	Health	eThekwini Metro	Health Facility Revitalisation Grant	R 2 567	R 60	R 65	R 70
214	Dundee EMS	Construction of large EMS Base	Design	KZN-DoPW	Umzinyathi	Equitable Share	R 65 000		R 2 500	R 25 000
215	Emambedwini Clinic	New Clinic	Retention	KZN-DoPW	uMgungundlovu	Health Facility Revitalisation Grant	R 8 600	R 1 593	-	

No.	Project name	Type project details	Project status	Implementing Agent Name	District Municipality Name	Primary Source of funding	Total project Cost (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)
216	Equiping of Completed New/Upgraded Facilities	Furniture and Equipment for new and upgraded facilities	Construction 1% - 25%	Health	uMgungundlovu	Equitable Share	R 48 434	R 20 000	R 10 000	R 10 000
217	Groutville Clinic	Replacement Of Clinic Phase 9 (including a separate PMTCT unit)	Design	KZN-DoPW	iLembe	Equitable Share	R 55 000	-	R 3 000	R 20 000
218	Gwaliweni Clinic	Construction of a new clinic, guard house and repairs and renovations	Retention	KZN-DoPW	Umkhanyakude	Health Facility Revitalisation Grant	R 13 153	R 346	-	-
219	Hluhluwe Clinic	Construction of a new Clinic with residences	Retention	IDT	Umkhanyakude	Health Facility Revitalisation Grant	R 34 202	R 485	-	-
220	Jozini CHC	Construction of a new CHC	Construction 76% - 99%	IDT	Umkhanyakude	Health Facility Revitalisation Grant	R 268 502	R 5 000	R 5 000	-
221	Mahehle / Ncakubana Clinic	Construct New Clinic	Tender	KZN-DoPW	Harry Gwala	Health Facility Revitalisation Grant	R 18 000	R 9 200	R 6 500	R 100
222	Malaria Control Programme	Camp at Manguzi	Feasibility	KZN-DoPW	Umkhanyakude	Equitable Share	R 1 000	-	R 975	R 25
223	Manxili Clinic	Construction of a Medium clinic with residence	Retention	IDT	Umzinyathi	Health Facility Revitalisation Grant	R 16 097	R 166	-	-
224	Mashona Clinic	Construction of a new medium Clinic	Retention	IDT	Zululand	Equitable Share	R 23 160	R 200	-	-
225	Mkhuphula Clinic	Construction Of A Small Clinic,B2 Residential Accommodation And Guard House (Completion contract)	Construction 26% - 50%	IDT	Umzinyathi	Equitable Share	R 10 235	R 7 500	R 250	-
226	Mkhuze Mortuary	New Forensic Mortuary	Design	KZN-DoPW	Umkhanyakude	Equitable Share	R 20 000	-	-	R 2 000
227	Mpophomeni Clinic	Phase 8 : New Clinic	Construction 76% - 99%	KZN-DoPW	Umkhanyakude	Equitable Share	R 11 126	R 4 381	R 495	-
228	Msizini Clinic	Construction Of A Small Clinic,B2 Residential Accommodation And Guard House (Completion contract)	Construction 26% - 50%	IDT	Umzinyathi	Equitable Share	R 8 282	R 6 000	R 283	-
229	Muden Clinic	Construction of a new medium clinic with double accommodation	Construction 51% - 75%	IDT	Umzinyathi	Health Facility Revitalisation Grant	R 16 878	R 6 154	R 450	-
230	Ngabayena Clinic	Construction Of A Small Clinic,B2 Residential Accommodation And Guard House (Completion Contract)	Retention	IDT	Umzinyathi	Equitable Share	R 5 059	R 3 750	R 309	-

No.	Project name	Type project details	Project status	Implementing Agent Name	District Municipality Name	Primary Source of funding	Total project Cost (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)
231	Ofafa/ Ntakama Clinic	Construct New Clinic	Tender	KZN-DoPW	Harry Gwala	Health Facility Revitalisation Grant	R 18 000	R 9 000	R 7 300	R 500
232	Phoenix Mortuary	New M6 Forensic Mortuary	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 92 925	R 2 500	-	-
233	Pisgah Clinic	Int & Ext R & R, New Roof Sheeting, Upgrade Pathways/Driveway (2nd Completion Contract)	Retention	KZN-DoPW	Ugu	Health Facility Revitalisation Grant	R 4 500	R 881	-	-
234	Pomeroy CHC	Construction Of A New CHC With Residence	Retention	IDT	Umzinyathi	Health Facility Revitalisation Grant	R 188 593	R 4 025	-	-
235	Shongweni Dam Clinic	Construction of a New Clinic (Phase 9)	Retention	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 11 209	R 2 185	-	-
236	St Aidens Hospital	Purchase of Hospital	Construction 51% - 75%	KZN-DoPW	eThekwini Metro	Health Facility Revitalisation Grant	R 60 000	R 60 000	-	-
237	Umzimkhulu CHC	Construct new CHC	Design	KZN-DoPW	Harry Gwala	Equitable Share	R 200 000	-	R 20 000	R 60 000
238	Usuthu Clinic	Replacement of Medium Clinic	Construction 51% - 75%	IDT	Zululand	Equitable Share	R 20 970	R 9 930	R 500	-

19. CONDITIONAL GRANTS

Table 41: Conditional Grants

Name of Conditional Grant	Purpose of the Grant	Performance indicators	Continuation/ Discontinuation over the next 5 years	Motivation for continuation/ discontinuation
Comprehensive HIV/AIDS Grant	To enable the health sector to develop an effective response to HIV and AIDS including universal access to HIV Counselling and Testing. To support implementation of the National Operational Plan for Comprehensive HIV and AIDS Treatment and Care. To subsidise in-part funding for the Antiretroviral Treatment Plan.	Total number of fixed public health facilities offering ART services Total clients started on ART during this month -naïve Number of beneficiaries served by Home-Based Carers Number of active Home-Based Carers receiving stipends Number of male condoms distributed Number of female condoms distributed Number of High Transmission Area intervention sites (new and old) Number of HIV positive clients screened for TB Number of HIV positive clients started on IPT Number of Lay Counsellors receiving stipends Number of clients pre-test counselled on HIV testing (including antenatal) Number of clients tested for HIV (including antenatal) Number of fixed health facilities offering MMC services Number of public health facilities offering Post Exposure Prophylaxis for sexual assault cases Number of sexual assault cases offered ARV prophylaxis (new) Number of Step Down Facilities/ Units	No	Significant contribution of HIV and AIDS to the burden of disease as well as increased demand for treatment and management of HIV prevalence.

Name of Conditional Grant	Purpose of the Grant	Performance indicators	Continuation/ Discontinuation over the next 5 years	Motivation for continuation/ discontinuation
National Tertiary Services Grant	To ensure provision of tertiary health services for all South African citizens. To compensate tertiary facilities for the costs associated with provision of these services including cross border patients.	Number of National Central and Tertiary Hospitals providing components of Tertiary services	No	Significant cost of rendering tertiary services including development of Ngwelezane from regional to tertiary hospital as per classification.
Health Professional Training and Development Grant	Support provinces to fund service costs associated with training of health science trainees on the public service platform. Co-funding of the National Human Resources Plan for Health in expanding undergraduate medical education for 2012 and beyond (2025).	Number of Registrars supervised	No	Increasing demand for development of human resources to deliver on determined package of services.
National Health Grant	To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health, including inter alia, health technology, organisational systems (OD) and quality assurance (QA). Supplement expenditure on health infrastructure delivered through public-private partnerships	Number of new clinical projects with completed construction Number of new clinical projects where commissioning is complete Number of upgrading and renovation projects with completed construction	No	Tremendous infrastructure pressures due to old infrastructure.
National Health Insurance Grant	Develop frameworks and models that can be used to roll out the National Health Insurance (NHI)	Review referral systems Medical equipment procured	No	Part of the National Health Insurance Pilot in identified district

Name of Conditional Grant	Purpose of the Grant	Performance indicators	Continuation/ Discontinuation over the next 5 years	Motivation for continuation/ discontinuation
	pilots in districts and central hospitals critical to achieving the phased implementation of NHI			(National priority).

20. PUBLIC ENTITIES

Table 42: Public Entities

Name of Public Entity	Mandate	Current annual budget (R'000)
1. Austerville Halfway House	2.2: Community Health Clinics	520
2. Azalea House	2.2: Community Health Clinics	480
3. Bekimpelo Bekulwandle Trust Clinic	2.2: Community Health Clinics	7 904
4. Benedictine Clinic	2.2: Community Health Clinics	175
5. Budget Control Holding Funds	2.2 Community Health Clinics	52 092
6. Claremont Day Care Centre	2.2: Community Health Clinics	367
7. Day Care Club 91	2.2: Community Health Clinics	100
8. Ekukhanyeni Clinic (AIDS Step-Down Care)	2.2: Community Health Clinics	911
9. Elandskop Clinic	2.2: Community Health Clinics	449
10. Enkumane Clinic	2.2: Community Health Clinics	270

Name of Public Entity	Mandate	Current annual budget (R'000)
11. Ethembeni Step-Down Centre	2.6: HIV and AIDS	4 881
12. Genesis Care Centres	2.6: HIV and AIDS	2 919
13. Happy Hour Amaoti	2.2: Community Health Clinics	490
14. Happy Hour Durban North	2.2: Community Health Clinics	245
15. Happy Hour Kwaximba	2.2: Community Health Clinics	392
16. Happy Hour Marianhill	2.2: Community Health Clinics	123
17. Happy Hour Mpumalanga	2.2: Community Health Clinics	392
18. Happy Hour Ninikhona	2.2: Community Health Clinics	245
19. Happy Hour Nyangwini	2.2: Community Health Clinics	257
20. Happy Hour Overport	2.2: Community Health Clinics	184
21. Happy Hour Phoenix	2.2: Community Health Clinics	245
22. Hlanganani Ngothando DCC	2.2: Community Health Clinics	208
23. Humana People to People	2.2: Community Health Clinics	2 828
24. Ikwezi Cripple Care	2.2: Community Health Clinics	1 136
25. John Peattie House	2.2: Community Health Clinics	1 335
26. Jona Vaughn Centre	2.2: Community Health Clinics	2 335
27. KwaZulu-Natal Childrens Hospital	Programme 4.1: Hospital Services	20 000
28. Lynn House	2.2: Community Health Clinics	584
29. Madeline Manor	2.2: Community Health Clinics	841
30. Masada Workshop	2.2: Community Health Clinics	74
31. Masibambeni Day Care Centre	2.2: Community Health Clinics	147

Name of Public Entity	Mandate	Current annual budget (R'000)
32. Matikwe Oblate Clinic	2.2: Community Health Clinics	491
33. McCords Hospital	4.1: Hospital Services	52 765
34. Mountain View Specialised TB	4.2: Specialised TB	9 871
35. Noyi Bazi Oblate Clinic	2.2: Community Health Clinics	496
36. Philanjalo Hospice (Step-Down Centre)	2.6: HIV and AIDS	2 551
37. Prenaid ALP NGO	2.2: Community Health Clinics	100
38. Pongola Hospital	Programme 2.7: District Hospitals	2 300
39. Rainbow Haven	2.2: Community Health Clinics	385
40. Scadifa Centre	2.2: Community Health Clinics	949
41. Siloah Hospital	4.2: Specialised TB	18 958
42. St Luke Home	2.2: Community Health Clinics	430
43. St Mary's Hospital Marianhill	2.7: District Hospitals	117 046
44. Sunfield Home	2.2: Community Health Clinics	303
45. Umlazi Halfway House	2.2: Community Health Clinics	260

Note: Funding proposals for all Public Entities are evaluated annually

21. PUBLIC-PRIVATE PARTNERSHIP (PPP)

Table 43: Public Private Partnership

Name of PPP	Purpose	Output	Current annual budget (R'Thousand)	Date of next evaluation
Inkosi Albert Luthuli Central Hospital The Department in partnership with Impilo Consortium (Pty) Ltd and Cowslip Investments (Pty) Ltd	Supply equipment and information management and technology (IM&T) systems and replace the equipment and IM&T systems to ensure that they remain state of the art. Supply and replace non-medical equipment. Services necessary to manage Project Assets in accordance with Best Industry Practice. Maintain and replace Departmental Assets in terms of the replacement schedules. Provide or procure Utilities, Consumables and Surgical Instruments. Facility Management Services.	Delivery of non-clinical services to IALCH	965 976	The 15 year contract with Impilo Consortium (Pty) Ltd will terminate in 2016/17. Termination arrangements are detailed in the project agreement in clauses 35, 36, 37 and the penalty regime (Schedule 15). The Provincial Treasury PPP Unit is rendering assistance to the Department of Health regarding its exit strategy.

22. CONCLUSION

The 2015-2019 Strategic Plan presents the strategic goals, objectives, priorities and targets that the KwaZulu-Natal Department of Health will be pursuing during the strategic planning period. The Plan is aligned with National priorities as expressed in the National Development Plan 2030, Medium Term Strategic Framework 2014-2019, Millennium Development Goals, National Health System 10 Point Plan, and other national priorities. It has also been aligned with the Provincial Growth and Development Plan as well as priorities highlighted in the State of the Province Address, Vote 7 priorities, priorities identified during the February 2015 Provincial Cabinet Lekgotla and priorities identified during a range of strategic planning workshops during 2014 and 2015.

The Province is committed to implementation of this plan (within the funding envelope) and to exercise transparency in reporting on progress throughout the reporting period.

ABBREVIATIONS

Abbreviation	Description
A	
AIDS	Acquired Immune Deficiency Syndrome
AMS	Air Mercy Services
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV(s)	Anti-Retroviral(s)
ASSA	AIDS Committee of Actuarial Society of South Africa
B	
BANC	Basic Ante Natal Care
bEOC	Basic Emergency Obstetric Care
C	
CARMMA	Campaign on Accelerated Reduction of Maternal and child Mortality in Africa
CCG(s)	Community Care Giver(s)
CDC	Communicable Disease Control
CEO(s)	Chief Executive Officer(s)
CHC(s)	Community Health Centre(s)
CHS	College of Health Sciences
COE	Compensation of Employees
CPD	Continued Professional Development
CTOP	Choice on Termination of Pregnancy
D	
DCST(s)	District Clinical Specialist Team(s)
DHB	District Health Barometer
DHIS	District Health Information System
DPME	Department Performance Monitoring and Evaluation
DR-TB	Drug Resistant Tuberculosis
DUT	Durban University of Technology
E	
EMS	Emergency Medical Services
EMS P1 Calls	Emergency Medical Services Priority 1 calls
EPWP	Expanded Public Works Programme
ESMOE	Essential Steps in Management of Obstetric Emergencies
ETR.net	Electronic TB Register
F	
FPS	Forensic Pathology Services

Abbreviation	Description
FTF	First Things First
G	
GHS	General Household Survey
GIS	Geographic Information System
H	
HCP(s)	Health Care Professional(s)
HCT	HIV Counselling and Testing
HEARD	Health Economics and HIV AIDS Research Division
HIV	Human Immuno Virus
HR	Human Resources
HRD	Human Resource Development
HRP	Human Resources Plan
I	
IA(s)	Implementing Agent(s)
IALCH	Inkosi Albert Luthuli Central Hospital
ICRM	Ideal Clinic Realisation and Maintenance
ICSAM	Integrated Childhood Severe Acute Malnutrition
ICT	Information Communication Technology
ICU(s)	Intensive Care Unit(s)
IDMS	Infrastructure Delivery Management Programme
IFT	Inter Facility Transfer
IMCI	Integrated Management of Childhood Illnesses
iMMR	Institutional Maternal Mortality Ratio
IPMP	Infrastructure Programme Management Plan
IPT	Ionized Preventive Therapy
K	
KMC	Kangaroo Mother Care
KZN	KwaZulu-Natal
KZNCN	KwaZulu-Natal College of Nursing
L	
LTP	Long Term Plan
M	
MDG(s)	Millennium Development Goal(s)
MDR-TB	Multi Drug Resistant Tuberculosis
MEC	Member of the Executive Council
MMC	Medical Male Circumcision
MOP	Medical Ortho Prosthetics

Abbreviation	Description
MOU(s)	Midwifery Obstetric Unit(s)
MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework
N	
NCD(s)	Non-Communicable Disease(s)
NDOH	National Department of Health
NICD	National Institute of Communicable Diseases
NDP	National Development Plan
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NIMART	Nurse Initiated and Managed Antiretroviral Therapy
O	
OPD	Out-Patient Department
OSD	Occupation Specific Dispensation
OSS	Operation Sukuma Sakhe
P	
PCR	Polymerase Chain Reaction
PERSAL	Personnel and Salaries System
PGDP	Provincial Growth and Development Plan
PHC	Primary Health Care
PHREC	Provincial Health Research and Ethics Committee
PMPU	Provincial Medicine Procurement Unit
PMTCT	Prevention of Mother to Child Transmission
PN	Professional Nurse
PPSD	Provincial Pharmaceutical Supply Depot
PPT	Planned Patient Transport
PTB	Pulmonary Tuberculosis
Q	
QIP(s)	Quality Improvement Plan(s)
S	
SA	South Africa
SADHS	South African District Health Survey
SCM	Supply Chain Management
SOP(s)	Standard Operating Procedure(s)
StatsSA	Statistics South Africa
STI(s)	Sexually Transmitted Infection(s)
STP	Service Transformation Plan

Abbreviation	Description
SWOT	Strengths, Weaknesses, Opportunities and Threats
T	
TB	Tuberculosis
U	
UKZN	University of KwaZulu-Natal
U-AMP	User–Asset Management Plan
UN	United Nations
W	
WHO	World Health Organisation
WISN	Workload Indicators of Staffing Need
X	
XDR-TB	Extreme Drug Resistant Tuberculosis

PART D:
ANNEXURES

- Indicator Definitions
- Provincial Deprivation Index 2001 - 2011
- Wards worst affected by poverty 2011

ANNEXURE 1: INDICATOR DEFINITIONS

PROGRAMME 1: ADMINISTRATION

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Provincial Long Term Plan	Ten year health service transformation (Long Term) Plan	Inform service transformation and inform resource allocation over 10 years	Long Term Plan	Long Term Plan	**Categorical**	Categorical	Annual	None	Long Term Plan approved	Strategic Planning Manager
Audit opinion from Auditor-General	Outcome of the audit conducted by Office of the Auditor General	Monitor effective and efficient financial and information management	Annual Report-AGSA Findings	Annual Report – AGSA Findings	**Categorical**	Categorical	Annual	None	Unqualified opinion	CFO; all Managers
Percentage over/ under expenditure	Expenditure within 1% of the annual allocation per classification based on BAS reports	Monitor financial management and expenditure trends	BAS Reports	BAS Reports	**Numerator** Expenditure **Denominator** Allocated budget	%	Quarterly	None	Lower deviation indicates more effective financial management	CFO, DDG's, District and Facility Managers
Annual Procurement Plan	Development of a costed Procurement Plan making provision for minor and major assets	Inform budget allocation and effective management of expenditure on procurement	Procurement Plan	Procurement Plan	**Categorical**	Categorical	Annual	None	Annual approved Procurement Plan	CFO and District/ Facility Managers
Number of registered sites performing monthly asset reconciliation reports	Registered sites monitoring and reporting assets under their control by completing monthly reconciliation reports	Monitor financial and supply chain management efficiencies	Monthly reconciliation reports	Monthly reconciliation reports	**Numerator** Number of registered sites submitting monthly reconciliation reports on assets	No	Quarterly	None	High number indicates compliance	CFO and District/ Facility Managers
Percentage of public health facilities with stable bandwidth connectivity	Proportion of public health facilities with stable bandwidth connectivity	Monitor ICT infrastructure and connectivity of facilities	Evidence of connectivity	IT database	**Numerator** Total number of public health facilities with bandwidth connectivity **Denominator** Total number of public health facilities	%	Annual	None	Increased access to bandwidth connectivity	IT Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Percentage of public health facilities with a web-based health information system	Complete system design for a National Integrated Patient-Based Information System	Monitor integrated web-based patient information system and reporting	Web-based reporting	Web-based reporting	**Numerator** Number of public health facilities submitting reports on the web-based reporting system **Denominator** Number of public health facilities	%	Annual	None	Higher percentage an indication of improved information reporting system	IT and Data Management Managers
Audit error rate (PHC clinics, CHC's and Hospitals)	Deviation between facility data collection tools and DHIS data	Monitor data accuracy and quality	Internal audit reports	Internal audit reports	**Numerator** Deviation range between collection tools and DHIS **Denominator** Number of facilities audited	%	Quarterly	Sample of audited facilities by internal teams might be inadequate to generalise	Lower deviation indicates improved data quality	Data Management Manager
Long Term Human Resources Plan	Ten year Human Resources Plan	Inform resource allocation based on gaps, demand and need	Long Term Human Resource Plan	Long Term Human Resource Plan	**Categorical**	Categorical	Annual	None	Approved Plan	HRMS Manager
Number of organisational structures finalised	The number of costed organisational and post structures	Monitor effective provision for human resource needs	Organisational and post structures	Organisational and post structures	**Numerator** Number of organisational and post structures developed	No	Annual	None	Higher number indicates higher efficiency	HRMS Manager
Community Based Training in a PHC Model	Medical training (doctors, nurses and allied workers) changing focus from hospicentric to PHC approach in line with PHC re-engineering	Monitor progress and impact of change in training approach on output and outcome	Business Plan and Task Team Reports	Business Plan and Task Team Reports	**Categorical**	Categorical	Annual	None	Model approved and implemented	Provincial Task Team (Department and UKZN)

PROGRAMME 2: SUB-PROGRAMME DISTRICT HEALTH SERVICES

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Life expectancy at birth – Total	The average expected life expectancy at birth	Track improved quality of life	StatsSA Mid-Year Estimates	StatsSA Mid-Year Estimates	Quote from the published StatsSA mid-year population estimates. Not routinely monitored by the Department	Years	Annual	None	Increase in life expectancy indicates improved quality of life	Planning, M&E Managers
Life expectancy at birth – Male	The expecte3d life expectancy at birth for males	Track improved quality of life	StatsSA Mid-Year Estimates	StatsSA Mid-Year Estimates	Quote from the published StatsSA mid-year population estimates. Not routinely monitored by the Department	Years	Annual	None	Increase in life expectancy indicates improved quality of life	Planning, M&E Managers
Life expectancy at birth – Female	The expected life expectancy at birth for females	Track improved quality of life	StatsSA Mid-Year Estimates	StatsSA Mid-Year Estimates	Quote from the published StatsSA mid-year population estimates. Not routinely monitored by the Department	Years	Annual	None	Increase in life expectancy indicates improved quality of life	Planning, M&E Managers
Outreach household registration visit coverage (annualised)	Outreach households (OHH) registered by Ward Based Outreach Teams as a proportion of OHH in the population. The population is divided by 12 in the formula to make provision for annualisation	Monitors implementation of PHC re-engineering with focus on community-based outreach services	Outreach registers StatsSA	DHIS StatsSA (households)	**Numerator** OHH registration visits **Denominator** OHH in population	%	Quarterly	Poor record keeping and reporting especially in DHIS Module	All households covered by community outreach teams	PHC Manager
Number of Ward-Based Outreach Teams in the 169 wards worst affected by poverty (cumulative)	The number of ward-based outreach teams in the 169 wards identified with the highest poverty levels in the SAMPI[18] as part of the Provincial Poverty Eradication Strategy	Monitor household coverage in the 169 wards worst affected by poverty (SAMPI Index Score)	PHC database/ Persal	PHC database	**Numerator** Number of Ward Based Outreach Teams (including PHC Outreach, School Health, TB, HIV/AIDS Teams) in the identified 169 wards (cumulative)	Number (cumulative)	Annual	Accuracy of reporting	Ward Based Outreach Teams deployed in all 169 identified wards	PHC Manager

[18] SAMPI: South African Multi Poverty Index

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
PHC utilisation rate (annualised)	Average number of PHC visits per person per year in the population. The population is divided by 12 in the formula to make provision for annualisation	Monitors PHC access to services and utilisation of the services	PHC tick registers	DHIS	**Numerator** PHC headcount total **Denominator** Total population	Rate	Quarterly	Dependant on the accuracy of reporting and estimated population from StatsSA	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system	PHC Manager
PHC utilisation rate under 5 years (annualised)	Average number of PHC visits per year per person under 5 years in the population. The population is divided by 12 in the formula to make provision for annualisation	Monitors PHC access and utilisation by children under 5 years	PHC tick register	DHIS	**Numerator** PHC headcount under 5 years **Denominator** Population under 5 years	Rate	Quarterly	Dependant on the accuracy of collected data and estimated population under 5 years from StatsSA	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	PHC Manager
Percentage of fixed PHC facilities scoring above 80% on the ideal clinic dashboard	Percentage of fixed PHC facilities that score above 80% on the Ideal Clinic Dashboard – developed to monitor compliance to the minimum standards of quality	Monitor compliance to the standards of Ideal Clinic Realisation and Maintenance – fully aligned with the National Core Standards (independent assessment)	Ideal Clinic assessment records	Ideal Clinic Dashboard	**Numerator** Number of fixed PHC facilities scoring above 80% on the ideal clinic dashboard. **Denominator** Number of fixed PHC facilities that conducted an assessment to date in the current financial year	%	Quarterly	Poor reporting at facility level	Improved quality of care evidenced by compliance to Ideal Clinic Standards (Dashboard)	PHC and QA Managers
Patient experience of care rate	Average patient satisfaction score of all (Category) Hospitals that conducted the annual Patient Experience of Care (PEC) Survey	Tracks patient satisfaction with public health services	PEC results	PEC Module	**Numerator** Sum of patient satisfaction scores in (Category) Hospitals that conducted a PEC to date in the current financial year **Denominator** Total number of (Category) Hospitals that conducted a PEC Survey to date in the current financial year	%	Annual	Generalised - depends on the number of users participating in the PEC survey	Increased patient satisfaction with public health services	QA Manager

PROGRAMME 2, 4 AND 5 - HOSPITAL SERVICES

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Inpatient bed utilisation rate	Inpatient bed days used as proportion of maximum inpatient bed days available	Monitors effectiveness and efficiency of Inpatient management at hospital level	Midnight census	DHIS calculates	**Numerator** Inpatient days total + Day patients **Denominator** Inpatient bed days available	%	Quarterly	Accurate reporting sum of daily usable beds	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels	Hospital/ DHS Managers
Hospital Rationalisation Plan	Approved Hospital Rationalisation Plan	Plan making provision for rationalisation and optimisation of hospital services (all categories) including classification, package of services, staffing (according to staffing norms), bed allocation per clinical domain, specialities, complexes and centres of excellence, etc.	Improved hospital efficiencies and quality as per plan	Approved Hospital Rationalisation Plan	**Categorical**	Categorical	Annual	None	Plan approved and implemented	Clinical and DHS Managers
Number of fully functional District Caesarean Section Centres (cumulative)	Re-directing resources to create caesarean section centres in identified district hospitals to improve maternal health outcomes	Monitor maternal and neonatal health outcomes	Caesarean Section Centres	Caesarean Section Centres	**Numerator** Number of operating District Caesarean Section Centres	Number	Annual	None	Functional District Caesarean Section Centres	DHS and MC&WH Managers
Community Based Training in a PHC Model	Medical training (doctors and allied workers) change focus from hospicentric to PHC approach in line with PHC re-engineering	Monitor progress and impact of change in training approach on output and outcome	Business Plan and Task Team Reports	Business Plan and Task Team Reports	**Categorical**	Categorical	Annual	None	Model approved and implemented	Provincial Task Team (Department and UKZN)

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Patient experience of care rate	Average patient satisfaction score of all (Category) Hospitals that conducted the annual PEC Survey	Tracks patient satisfaction with public health services	PEC Survey results	PEC Survey	**Numerator** Sum of patient satisfaction scores in (Category) Hospitals that conducted a PEC Survey to date in the current financial year **Denominator** Total number of (Category) Hospitals that conducted a PEC Survey to date in the current financial year	%	Annual	Generalised - depends on the number of users participating in the survey	Increased patient satisfaction with public health services	QA Manager
Percentage of hospital compliant with all extreme and vital measures of the National Core Standards (NCS)	(Category) Hospitals that are compliant to all extreme measures and at least 90% of vital measures of NCS in self-assessment as a proportion of (Category) Hospitals	Track compliance to the NCS's	Assessment records	DHIS – NCS Module	**Numerator** Total number of (Category) Hospitals that are compliant to all extreme measures and at least 90% of vital measures of NCS's **Denominator** Number of (Category) Hospitals that conducted NCS self-assessment to date in the current financial year	%	Quarterly	Reliant on accuracy of reporting at facility level	Higher percentage indicates active implementation of the NCS	Hospital & DHS Managers

PROGRAMME 2: SUB-PROGRAMME HIV, AIDS, STI AND TB CONTROL

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
HIV incidence	New HIV infections in the general population	Monitor the impact of the HIV and AIDS Programmes on new HIV infections	ASSA2008 projections	ASSA2008 projections	Quote from ASSA2008 published projections. The Department is not routinely monitoring indicator	% (Projection)	Annual	Not routinely collected therefore using ASSA2008 or Stats SA projections	Reduced incidence desired – effective prevention programmes	HIV/AIDS Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Client tested for HIV (incl. ANC)	Number of clients tested for HIV including under 15 years and antenatal clients	Monitors annual testing of persons who are not known HIV positive to increase the proportion of the population with known HIV status and to inform resource allocation e.g. test kits and staffing	HIV Register	DHIS	**Numerator** Client tested for HIV (Incl ANC)	Number	Quarterly	Record keeping at facility level while non-reporting of testing outside public health facilities skew total testing numbers	Higher number indicated better response to increased "know your status" initiative	HIV/AIDS Manager
HIV prevalence among 15 to 24 year old pregnant women	The HIV positive pregnant women 15 to 24 years as proportion of the total number of pregnant women 15 to 24 years tested for HIV	Monitor the HIV prevalence rate of pregnant women between 15 and 24 years (MDG Target)	National ANC Surveillance	National ANC Surveillance	Quote from the Annual National Antenatal HIV Surveillance Report. The Department is not routinely monitoring indicator	%	Annual	Availability of National Survey data	Reduced prevalence over time	HIV/AIDS Manager
Total clients remaining on ART	Cumulative total of patients on any ARV regimen	Track the number of patients on ARV treatment	ART Register	TIER.Net/ DHIS	Clients remaining on ART equals Naïve [including PEP and PMTCT] + experienced + Transfer-in + Restart minus [Died + lost to follow-up + Transfer-out]	Number (cumulative)	Quarterly	Dependent on accurate reporting	Higher total indicates a larger population on ART treatment – positive response to managing the prevalence of HIV	HIV/AIDS Manager
TB new client treatment success rate	TB clients successfully completed treatment as a proportion of TB clients who started on treatment	Monitors success of TB treatment for all types of TB	TB Register	ETR.Net	**Numerator** TB client successfully completed treatment **Denominator** TB client start on treatment	%	Quarterly	Accuracy dependent on quality of data from reporting facilities	Higher percentage indicate better treatment success rate	TB Manager
TB incidence (per 100 000 population)	The number of new TB infections per 100 000 population	Monitor new TB infections	TB Register	ETR.Net StatsSA	***Numerator*** New confirmed TB cases ***Denominator*** Total population	Number per 100,000 population	Annual	Dependent on accuracy of data from reporting facilities	Reduced incidence desired – improved prevention of TB	TB Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
TB death rate	TB clients who died during treatment as a proportion of TB clients that started on treatment	Monitors death during the TB treatment period. The cause of death may not necessarily be due to TB	TB Register	ETR.Net	**Numerator** TB client died during treatment **Denominator** TB client start on treatment	%	Quarterly	Accuracy dependent on quality of data from reporting facility	Reduced percentage indicates better treatment success	TB Manager
MDR-TB treatment success rate	MDR-TB client successfully treated as a proportion of TB-MDR confirmed clients started on treatment	Monitors success of MDR-TB treatment	MDR-TB Register	ETR.Net	**Numerator** TB MDR client successfully treated **Denominator** TB MDR confirmed client start on treatment	%	Annual	Accuracy dependent on quality of data from reporting facility	Increased percentage indicates improved management of MDR-TB	TB Manager

PROGRAMME 2: SUB-PROGRAMME MATERNAL, NEONATAL, CHILD & WOMEN'S HEALTH AND NUTRITION

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Infant mortality rate	Proportion of children less than one year old who die in one year per 1000 population under 1 year	Monitor trends in infant mortality - MDG 4	StatsSA and RMS[19] (2012 onwards)	StatsSA and RMS (2012 onwards)	Use data from StatsSa and RMS – the Department is not routinely monitoring this data	Number per 1000 population	Annual	Empirical population-based data are not frequently available	Lower mortality rate desired	MNCWH Manager
Infant 1st PCR test positive around 6 weeks rate	Infants tested PCR positive for the first time around 6 weeks after birth as proportion of Infants PCR tested around 6 weeks	Monitors positivity in HIV exposed infants around 6 weeks	ART Register	DHIS	**Numerator** Infant 1st PCR test positive around 6 weeks **Denominator** Infant 1st PCR test around 6 weeks	%	Quarterly	Accuracy of reporting at facility level	Reduced percentage indicates improved outcomes of PMTCT	MC&WH Manager

[19] Rapid Mortality Surveillance

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Under 5 mortality rate	Proportion of children less than five years old that die in one year per 1000 population under 5 years	Monitor trends in under-5 mortality - MDG 4	StatsSA and RMS (2012 onwards)	StatsSA and RMS (2012 onwards)	Use data from StatsSa and RMS – the Department is not routinely monitoring this data	Number per 1000 population	Annual	Empirical population-based data are not frequently available	Lower mortality rate desired	MNCWH Manager
Child under 5 years severe acute malnutrition incidence (annualised)	Children under 5 years newly diagnosed with severe acute malnutrition per 1,000 children under-5 years in the population. The population will be divided by 12 in the formula to make provision for annualisation	Monitors prevention and diagnosis of severe acute malnutrition in children under-5 years. Count only once when diagnosed. Follow-up visits for the same episode of malnutrition not counted	PHC tick register/ StatsSA	DHIS	**Numerator** Child under 5 years with severe acute malnutrition new **Denominator** Population under 5 year	Number per 1000 (annualised)	Quarterly	Reliant on accuracy of reported data at facility level and population estimates by StatsSA	Lower incidence indicates improved health outcomes	Nutrition Manager
Maternal mortality in facility ratio (annualised)	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 1000 live births in a facility	Proxy for the population-based maternal mortality rate, aimed at monitoring trends in health facilities between official surveys.	Maternity Register/ Death records	DHIS	**Numerator** Maternal death in facility **Denominator** Live birth in facility	Number per 100 000 live births	Annual	Reliant on accuracy of classification of inpatient death	Lower institutional rate indicate fewer avoidable deaths	MNCWH Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Couple year protection rate	Women protected against pregnancy by using modern contraceptive methods, including sterilisations, as proportion of female population 15-49 year. The population will be divided by 12 in the formula to make provision for annualisation	Monitors access to and utilisation of modern contraceptives to prevent unplanned pregnancies. Serves as proxy for the indicator contraceptive prevalence rate by monitoring trends between official surveys	PHC Tick Register	DHIS	**Numerator** Contraceptive years dispensed: Total of (Oral pill cycles/13) + (Medroxyprogesterone injection/4) + (Norethisterone enanthate injection/6) + (IUCD x4) + (Subdermal implant x3) + (Male condoms distributed/200) + (Female condoms distributed/200) + (Male sterilisation x20) + (Female sterilisation x10). **Denominator** Population 15-49 years females	%	Quarterly	Reliant on accuracy of data collection and reporting	Higher protection levels are desired – increased percentage	MNCWH Manager
Cervical cancer screening coverage	Cervical smears in women 30 years and older as a proportion of 10% of the female population 30 years and older. The population will be divided by 12 in the formula to make provision for annualisation	Monitors implementation of policy on cervical screening	PHC Tick Register	DHIS	**Numerator** Cervical cancer screening in women 30 years and older **Denominator** Population 30 years and older female/10	%	Quarterly	Reliant on accuracy of reporting and population estimates (StatsSA)	Higher percentage indicates better coverage of screened women – reduced cervical cancer	MC&WH Manager

PROGRAMME 2: SUB-PROGRAMME DISEASE PREVENTION AND CONTROL

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Hypertension incidence (annualised)	Newly diagnosed hypertension cases initiated on treatment per 1000 population 40 years and older. The number of hypertension clients under 40 years is very small hence monitoring population 40 years and older who is the main risk group	Monitor disease trends (including hypertension) to inform preventative strategies	Tick Register PHC Register OPD StatsSA	DHIS	***Numerator*** Hypertension client treatment new ***Denominator*** Population 40 years and older	Number per 1000 population (annualised)	Quarterly	Accuracy is dependent on quality of data from reporting facility	Lower incidence desired – improved management of hypertensive patients	NCD Manager
Diabetes Incidence (annualised)	Newly diagnosed diabetes clients initiated on treatment per 1000 population	Monitor disease trends (including diabetes) to inform preventative strategies	Tick Register PHC Register OPD Stats SA	DHIS	***Numerator*** Diabetes clients treatment new ***Denominator*** Population total	Number per 1000 population	Quarterly	Accuracy is dependent on quality of data from reporting facility	Lower incidence desired – improved management of diabetic patients	NCD Manager
Malaria incidence per 1000 population at risk	New malaria cases as proportion of 1000 population at risk (high-risk areas based on malaria cases)	Monitor the new malaria cases in endemic areas as proportion of the population at risk - MDG 6	Tick Register PHC CDC Surveillance database StatsSA	Malaria database	***Numerator*** Number of malaria cases (new) ***Denominator*** Population Umkhanyakude [20]	Number per 1000 population	Annual	Dependent on accuracy of reporting.	Lower incidence desired – improved prevention towards elimination of malaria	Malaria Control Manager
Malaria case fatality rate	Deaths from malaria as a percentage of the number of cases reported	Monitor the number deaths caused by Malaria	Malaria database	Malaria database	**Numerator** Deaths from malaria **Denominator** Total number of Malaria cases reported	%	Quarterly	Accuracy dependant on quality of data from health facilities	Lower percentage indicates a decreasing burden of malaria and improved management of malaria cases	Malaria Control Manager

[20] (Population at risk referring to endemic areas – Umkhanyakude District in KZN identified as endemic district

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Approved Revised EMS Model	Evidence-based EMS Model to inform short, medium and long-term operational plans to improve EMS efficiencies	Monitor short, medium and long term EMS plan(s)	EMS Model	EMS Model	**Categorical**	Categorical	Annual	None	Revised EMS Model approved and operationalised	EMS Manager
Average number of daily operational ambulances	The average number of operational ambulances to respond to call outs	Monitor the number of operational ambulances versus the number of available ambulances	EMS database EMS call centre records EMS tick register	EMS database	Average number of daily operational ambulances (average of total number available per day)	Number	Annual	Data completeness at EMS Stations	Higher number indicates improved management of available ambulances	EMS Manager
Number of clustered communication Centres established and operational	Combining identified Communication Centres to improve optimisation of scarce resources	Monitor optimisation of resources	Infrastructure Project Records Communicatio n Centre	EMS database	Number of clustered Communication Centres operational	Number	Annual	None	Clustered centres optimise utilisation of resources	EMS Manager
EMS P1 urban response under 15 minutes rate	Emergency P1 calls in urban locations with response times under 15 minutes as a proportion of all P1 urban call outs. Response time is calculated from the time the call is received to the time of the first dispatched medical resource arrival on scene	Monitor compliance with the norm for critically ill or injured patients to receive EMS within 15 minutes in urban areas	EMS Registers	DHIS	**Numerator** EMS P1 urban response under 15 minutes **Denominator** EMS P1 urban calls	%	Quarterly	Accuracy dependant on quality of data from reporting EMS station	Higher percentage indicate better response times in urban area	EMS Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
EMS P1 rural response under 40 minutes rate	Emergency P1 calls in rural locations with response times under 40 minutes as a proportion of all P1 rural call outs. Response time is calculated from the time the call is received to the time of the first dispatched medical resource arrival on scene	Monitor compliance with the norm for critically ill or injured patients to receive EMS within 40 minutes in rural areas	EMS Registers	DHIS	**Numerator** EMS P1 rural response under 40 minutes **Denominator** EMS P1 rural calls	%	Quarterly	Accuracy dependant on quality of data from reporting EMS station	Higher percentage indicate better response times in rural area	EMS Manager
EMS inter-facility transfer rate	Inter-facility (from one inpatient facility to another inpatient facility) transfers as proportion of total EMS patients transported	Monitor use of ambulances for inter-facility transfers as opposed to emergency responses	EMS inter-facility register	DHIS	**Numerator** EMS inter-facility transfer **Denominator** EMS clients total	%	Quarterly	Reliant on accuracy of reporting	Increase percentage might be indication of effective referral system or increasing burden of disease	EMS Manager

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of bursaries awarded for first year medicine students	Number of Bursaries awarded for first year medicine students	Monitor bursary allocation in relation to need and demand	Bursary records	Bursary records	Number of bursaries awarded to first year medicine students	Number	Annual	None	Increased number indicates appropriate response to need/ demand	HRMS Manager
Number of bursaries awarded for first year nursing student	Number of Bursaries awarded for first year nursing students	Monitor bursary allocation in relation to need and demand	Bursary records	Bursary records	Number of bursaries awarded to first year nursing students	Number	Annual	None	Increased number indicates appropriate response to need/ demand	HRMS Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of new students enrolled in Mid-Level Worker training courses	Number of Mid-Level Workers that enrol for one of the available training courses at Institutions of Higher Learning	Monitor intake of Mid-Level Workers in response to identified human resources gap	Student enrolment register	HRD student enrolment register	Sum of the total number of new Mid-Level Worker students enrolled in training courses	Number	Annual	None	Higher number implies increase in pool of human resources for health	HRD Manager
Number of Intermediate Life Support graduates per annum	Number of students obtaining a qualification in Intermediate Life Support.	Monitor production of EMS personnel.	Student registration	EMS College	Number of Intermediate Life Support students graduated	Number	Annual	None.	Higher number desired – improved EMS capacity.	EMS Unit
Number of Emergency Care Technician graduates per annum	Number of students obtaining the qualification of Emergency Care Technician.	Monitor production of EMS personnel.	Student registration	EMS College	Number of Emergency Care Technician students graduating	Number	Annual	None.	Higher number desired – improved EMS capacity.	EMS Unit

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of operational Orthotic Centres (cumulative)	Centres providing the package of services for Orthotic and Prosthetic services	Monitor access to Orthotic and Prosthetic services	Centre data	Orthotic and Prosthetic database	Number of Orthotic Centres providing the basic package of services	Number	Annual	None	Decentralised access to the complete package of services	Orthotic and Prosthetic Manager
Number of MOP's that successfully completed the degree course at DUT	Number of MOP's that successfully completed the degree course at DUT	Medical Orthotic and Prosthetic students that completed the prescribed course successfully	Monitor pool of resources	Training Register Qualification	Number of students that successfully completed the prescribed training course	Number	Annual	None	Increase in students who completed course indicate increased in resource pool	MOP Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Percentage of facilities reporting clean linen stock outs	The number of facilities with inadequate linen supply for a specific period	To monitor linen availability and management	Linen register at facility level	Provincial Laundry Reports	**Numerator** Number of facilities reporting clean linen stock out **Denominator** Facilities total	%	Quarterly	Accuracy of reporting at facility level and lack of appropriate data information system for ;laundry services	Lower percentage indicates improved availability and management of linen	Laundry Manager
Percentage of Pharmacies that obtained A or B grading on inspection[21]	The proportion of Pharmacies that comply with Pharmaceutical prescripts on inspection	Track compliance with Pharmaceutical prescripts	Certificates	Certificates	**Numerator** Number of Pharmacies with A or B grading on **Denominator** Number of Pharmacies	%	Annual	Accurate records of inspections conducted	Improved compliance will improve quality and efficiency of Pharmaceutical services	Pharmacy Manager
PPSD compliant with good Wholesaling Practice Regulations	Provincial Pharmaceutical Supply Deport Warehouse compiles with Pharmacy Regulations and is licensed by Medicine Control Council to operate as Pharmaceutical	Safe warehousing practice	Certificate of compliance	License issued by the Medicine Control Council	**Categorical**	Categorical	Annual	None	PPSD compliant with good wholesaling practice regulation	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 records	DHIS	**Numerator** Number of tracer medicines out of stock **Denominator** Total number of medicines expected to be in stock	%	Quarterly	Accuracy of reporting at facility level	Targeting zero stock-out	Pharmacy Manager

[21] Refers to being compliant with SAPS standards

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Tracer medicine stock-out rate (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	Pharmacy records	DHIS	**Numerator** Number of tracer medicines stock out in bulk store **Denominator** Number of tracer medicines expected to be stocked in the bulk store	%	Quarterly	Accuracy of reporting at facility level	Targeting zero stock-out of all tracer medicines	Pharmacy Manager

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of jobs created through the Expanded Public Works Programme (EPWP)	Job creation through EPWP	Track job creation	Project reports/ plan	IRS and EPWP Quarterly reports	Number of jobs created through EPWP in reporting period	Number	Quarterly	None	Higher number – improved job opportunities	Infrastructure Manager
Number of new clinical projects with completed constructed	New clinical projects with completed construction	Monitor project plans and delivery of infrastructure as per U-AMP	Project reports/ plan	IRM, PMIS and monthly reports	Number of new clinical projects with completed construction in reporting period	Number	Quarterly	None	As per project plan	Infrastructure Manager
Number of new clinical projects where commissioning is compete	New clinical projects commissioned	Monitor project plans and delivery of infrastructure as per U-AMP	Project reports/ plan	IRM, PMIS and monthly reports	Number of new clinical projects commissioned during reporting period	Number	Quarterly	None	As per project plan	Infrastructure Manager

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Type	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility
Number of upgrading and renovation projects with completed construction	Upgrading and renovation projects with completed construction	Monitor project plans and delivery of infrastructure as per U-AMP	Project reports/ plan	IRM, PMIS and monthly reports	Number upgrading and renovation projects completed during reporting period	Number	Quarterly	None	As per project plan	Infrastructure Manager

ANNEXURE 2: WARDS WORST AFFECTED BY POVERTY IN KWAZULU-NATAL

Table 44: Wards worst affected by poverty in KZN

			Census 2001			Census 2011			
District	Local Municipality	Ward Code	Headcount	Intensity	SAMPI Index Score	Headcount	Intensity	SAMPI Index Score	Deprived Ward Ranking Number
Umzinyathi	Msinga	52404016	64.0%	43.0%	0.28	50.7%	45.0%	0.23	1
Umzinyathi	Endumeni	52402001	76.3%	46.9%	0.36	51.2%	41.5%	0.21	2
Umzinyathi	Msinga	52404006	65.9%	43.0%	0.28	47.1%	45.1%	0.21	3
Umzinyathi	Msinga	52404008	76.4%	44.7%	0.34	51.0%	40.9%	0.21	4
Umzinyathi	Msinga	52404003	63.1%	45.8%	0.29	45.2%	45.1%	0.20	5
Umzinyathi	Msinga	52404015	66.9%	45.0%	0.30	45.2%	44.1%	0.20	6
Umkhanyakude	Umhlabuyalingana	52701013	64.2%	43.7%	0.28	41.9%	44.6%	0.19	7
Umkhanyakude	Umhlabuyalingana	52701006	61.2%	44.1%	0.27	40.9%	45.0%	0.18	8
Umkhanyakude	Umhlabuyalingana	52701009	65.5%	45.8%	0.30	42.6%	42.7%	0.18	9
Ugu	Vulamehlo	52101005	44.4%	40.5%	0.18	42.7%	41.5%	0.18	10
Uthukela	Umtshezi	52304007	68.9%	48.6%	0.33	39.8%	44.3%	0.18	11
Umzinyathi	Msinga	52404010	55.5%	44.1%	0.25	40.1%	43.9%	0.18	12
Uthungulu	Nkandla	52806007	56.6%	43.1%	0.24	41.4%	42.5%	0.18	13
Uthukela	Umtshezi	52304005	39.3%	46.6%	0.18	38.9%	43.9%	0.17	14
Umzinyathi	Umvoti	52405006	51.1%	41.4%	0.21	41.2%	41.4%	0.17	15
Umkhanyakude	Umhlabuyalingana	52701014	60.1%	45.9%	0.28	39.5%	42.9%	0.17	16
Uthukela	Indaka	52303009	57.6%	43.7%	0.25	39.1%	43.0%	0.17	17
Ugu	Umzumbe	52103001	41.3%	42.1%	0.17	37.2%	43.4%	0.16	18
Harry Gwala	Ubuhlebezwe	54304005	38.5%	40.8%	0.16	39.5%	40.8%	0.16	19

			Census 2001			Census 2011			
District	Local Municipality	Ward Code	Headcount	Intensity	SAMPI Index Score	Headcount	Intensity	SAMPI Index Score	Deprived Ward Ranking Number
Umgungundlovu	Mpofana	52203004	53.2%	48.2%	0.26	39.1%	41.2%	0.16	20
Umzinyathi	Msinga	52404002	65.0%	43.3%	0.28	36.7%	43.6%	0.16	21
Zululand	Abaqulusi	52603004	43.2%	41.5%	0.18	35.7%	44.1%	0.16	22
Harry Gwala	Ingwe	54301001	55.6%	42.5%	0.24	37.4%	41.8%	0.16	23
Umzinyathi	Msinga	52404007	63.9%	43.6%	0.28	37.0%	41.6%	0.15	24
Ugu	Umzumbe	52103008	50.2%	41.9%	0.21	36.7%	41.6%	0.15	25
Umzinyathi	Msinga	52404013	66.8%	44.8%	0.30	36.4%	41.9%	0.15	26
Umzinyathi	Msinga	52404009	52.0%	41.1%	0.21	36.3%	42.0%	0.15	27
Umzinyathi	Msinga	52404014	58.3%	46.4%	0.27	34.9%	43.4%	0.15	28
Uthukela	Indaka	52303010	70.3%	46.3%	0.33	34.9%	43.4%	0.15	29
Umzinyathi	Msinga	52404018	66.7%	43.1%	0.29	35.0%	43.2%	0.15	30
Umzinyathi	Msinga	52404005	47.5%	45.2%	0.21	34.7%	43.4%	0.15	31
Uthukela	Indaka	52303007	53.6%	42.8%	0.23	34.8%	42.9%	0.15	32
Uthungulu	Nkandla	52806002	53.2%	44.8%	0.24	37.9%	39.2%	0.15	33
Uthungulu	Nkandla	52806014	45.8%	42.4%	0.19	34.4%	42.8%	0.15	34
Ugu	Umzumbe	52103007	50.0%	43.6%	0.22	35.2%	41.6%	0.15	35
Ugu	Vulamehlo	52101007	47.8%	44.1%	0.21	35.2%	41.4%	0.15	36
iLembe	Maphumulo	52904003	48.6%	43.2%	0.21	35.6%	40.8%	0.15	37
Harry Gwala	Umzimkhulu	54305003	42.1%	43.0%	0.18	33.4%	43.4%	0.14	38
Umzinyathi	Msinga	52404001	60.1%	42.2%	0.25	34.1%	42.4%	0.14	39
Umkhanyakude	Umhlabuyalingana	52701012	53.2%	44.0%	0.23	34.6%	41.7%	0.14	40

			Census 2001			Census 2011			
District	Local Municipality	Ward Code	Headcount	Intensity	SAMPI Index Score	Headcount	Intensity	SAMPI Index Score	Deprived Ward Ranking Number
Amajuba	Emadlangeni	52503001	47.2%	42.2%	0.20	33.6%	42.8%	0.14	41
Umkhanyakude	Umhlabuyalingana	52701016	60.6%	44.8%	0.27	34.3%	41.7%	0.14	42
Umgungundlovu	Mkhambathini	52206005	36.5%	42.9%	0.16	34.9%	40.4%	0.14	43
Uthukela	Indaka	52303008	47.4%	43.2%	0.21	31.6%	44.2%	0.14	44
Umkhanyakude	Jozini	52702010	49.4%	41.7%	0.21	32.2%	43.2%	0.14	45
Zululand	Ulundi	52606007	49.2%	41.6%	0.20	30.6%	44.5%	0.14	46
iLembe	Maphumulo	52904002	57.6%	42.0%	0.24	35.2%	38.5%	0.14	47
Uthungulu	Nkandla	52806009	71.6%	43.7%	0.31	33.1%	41.0%	0.14	48
iLembe	Ndwedwe	52903016	58.4%	44.0%	0.26	32.4%	41.9%	0.14	49
Harry Gwala	Umzimkhulu	54305001	53.7%	43.1%	0.23	32.8%	41.2%	0.14	50
Harry Gwala	KwaSani	54302001	41.7%	41.3%	0.17	32.5%	41.6%	0.14	51
iLembe	Ndwedwe	52903004	40.7%	40.9%	0.17	31.7%	42.4%	0.13	52
Umkhanyakude	Jozini	52702013	50.9%	43.2%	0.22	29.4%	45.7%	0.13	53
Harry Gwala	Umzimkhulu	54305006	53.6%	43.2%	0.23	30.9%	43.3%	0.13	54
Umzinyathi	Msinga	52404017	47.3%	44.6%	0.21	31.5%	42.3%	0.13	55
Ugu	Umuziwabantu	52104009	53.1%	42.4%	0.23	32.6%	40.8%	0.13	56
Umkhanyakude	Jozini	52702012	54.7%	44.6%	0.24	29.9%	44.3%	0.13	57
Ugu	Umdoni	52102009	29.0%	42.3%	0.12	29.5%	44.7%	0.13	58
Ugu	Vulamehlo	52101010	57.6%	43.0%	0.25	32.1%	40.8%	0.13	59
Uthukela	Okhahlamba	52305004	43.1%	43.3%	0.19	30.5%	43.0%	0.13	60
Umzinyathi	Endumeni	52402009	42.1%	43.1%	0.18	31.0%	42.2%	0.13	61

			Census 2001			Census 2011			
District	Local Municipality	Ward Code	Headcount	Intensity	SAMPI Index Score	Headcount	Intensity	SAMPI Index Score	Deprived Ward Ranking Number
Ugu	Umzumbe	52103006	43.2%	41.8%	0.18	31.8%	41.1%	0.13	62
Ugu	Umzumbe	52103009	43.0%	40.7%	0.18	31.2%	41.9%	0.13	63
Umzinyathi	Msinga	52404004	53.8%	45.5%	0.24	30.5%	42.7%	0.13	64
Uthungulu	Umlalazi	52804001	45.4%	41.2%	0.19	31.2%	41.7%	0.13	65
Umzinyathi	Endumeni	52402002	54.7%	42.3%	0.23	30.9%	42.1%	0.13	66
Zululand	Nongoma	52605002	44.0%	43.6%	0.19	30.1%	43.1%	0.13	67
Uthungulu	Umlalazi	52804006	45.2%	42.0%	0.19	32.2%	40.3%	0.13	68
Umkhanyakude	Umhlabuyalingana	52701008	44.7%	45.2%	0.20	30.4%	42.6%	0.13	69
Umkhanyakude	Jozini	52702015	57.0%	43.6%	0.25	30.3%	42.7%	0.13	70
Umzinyathi	Umvoti	52405008	50.0%	44.6%	0.22	31.4%	41.2%	0.13	71
Ugu	Vulamehlo	52101008	45.4%	42.6%	0.19	32.6%	39.6%	0.13	72
Zululand	Nongoma	52605001	54.1%	42.5%	0.23	29.5%	43.0%	0.13	73
Harry Gwala	Umzimkhulu	54305018	41.9%	44.2%	0.18	29.5%	43.0%	0.13	74
Ugu	Umzumbe	52103002	40.8%	42.2%	0.17	30.8%	41.0%	0.13	75
Uthungulu	Mthonjaneni	52805003	49.1%	42.4%	0.21	31.1%	40.4%	0.13	76
Umkhanyakude	Jozini	52702004	46.7%	43.3%	0.20	30.0%	41.8%	0.13	77
Umkhanyakude	The Big 5 False Bay	52703002	50.6%	44.7%	0.23	29.3%	42.7%	0.13	78
Ugu	Vulamehlo	52101004	37.0%	40.4%	0.15	29.9%	41.7%	0.12	79
Ugu	Umzumbe	52103012	45.6%	41.6%	0.19	30.6%	40.2%	0.12	80
Harry Gwala	Umzimkhulu	54305015	47.2%	42.2%	0.20	28.5%	43.1%	0.12	81
Umzinyathi	Msinga	52404012	59.0%	44.4%	0.26	29.8%	41.1%	0.12	82

			Census 2001			Census 2011			
District	Local Municipality	Ward Code	Headcount	Intensity	SAMPI Index Score	Headcount	Intensity	SAMPI Index Score	Deprived Ward Ranking Number
Uthungulu	Umlalazi	52804014	40.1%	42.4%	0.17	30.8%	39.6%	0.12	83
Umzinyathi	Umvoti	52405005	35.9%	42.0%	0.15	28.0%	43.3%	0.12	84
iLembe	Ndwedwe	52903002	34.5%	41.2%	0.14	30.0%	40.1%	0.12	85
Umkhanyakude	Jozini	52702017	63.5%	44.3%	0.28	28.5%	42.2%	0.12	86
iLembe	Maphumulo	52904011	48.2%	43.2%	0.21	29.1%	41.3%	0.12	87
Zululand	Ulundi	52606001	52.8%	41.9%	0.22	30.1%	39.9%	0.12	88
iLembe	Ndwedwe	52903018	32.6%	42.2%	0.14	30.1%	39.8%	0.12	89
Uthungulu	Nkandla	52806013	46.0%	41.4%	0.19	29.7%	40.1%	0.12	90
Umzinyathi	Msinga	52404019	48.6%	41.2%	0.20	28.2%	42.3%	0.12	91
iLembe	Maphumulo	52904005	46.0%	42.9%	0.20	27.9%	42.3%	0.12	92
Harry Gwala	Umzimkhulu	54305004	47.9%	43.2%	0.21	27.5%	43.0%	0.12	93
Umzinyathi	Msinga	52404011	50.0%	45.4%	0.23	27.3%	43.3%	0.12	94
Umkhanyakude	Hlabisa	52704006	39.9%	42.3%	0.17	26.8%	44.0%	0.12	95
Umkhanyakude	Jozini	52702018	43.3%	43.9%	0.19	27.5%	42.9%	0.12	96
Zululand	Abaqulusi	52603002	38.9%	43.7%	0.17	27.7%	42.4%	0.12	97
Uthungulu	Umlalazi	52804005	43.9%	41.3%	0.18	29.6%	39.6%	0.12	98
Uthungulu	Ntambanana	52803001	40.4%	41.5%	0.17	27.5%	42.4%	0.12	99
iLembe	Maphumulo	52904008	36.8%	42.5%	0.16	28.6%	40.7%	0.12	100
Umkhanyakude	Umhlabuyalingana	52701010	45.7%	43.1%	0.20	28.2%	41.3%	0.12	101
Umkhanyakude	Umhlabuyalingana	52701007	51.4%	43.6%	0.22	27.7%	41.9%	0.12	102
iLembe	Maphumulo	52904006	50.6%	42.8%	0.22	28.7%	40.4%	0.12	103

			Census 2001			Census 2011			
District	Local Municipality	Ward Code	Headcount	Intensity	SAMPI Index Score	Headcount	Intensity	SAMPI Index Score	Deprived Ward Ranking Number
iLembe	Ndwedwe	52903019	40.3%	42.8%	0.17	27.8%	41.7%	0.12	104
Uthukela	Okhahlamba	52305005	50.5%	47.0%	0.24	26.1%	44.4%	0.12	105
Harry Gwala	Ingwe	54301002	41.5%	42.9%	0.18	28.8%	40.0%	0.12	106
Umgungundlovu	Umngeni	52202001	28.8%	45.3%	0.13	25.2%	45.6%	0.11	107
Harry Gwala	Umzimkhulu	54305005	45.9%	42.4%	0.19	26.7%	42.9%	0.11	108
Umkhanyakude	Jozini	52702009	44.8%	41.4%	0.19	26.9%	42.5%	0.11	109
Uthukela	Okhahlamba	52305007	34.4%	44.8%	0.15	26.3%	43.4%	0.11	110
Umkhanyakude	Umhlabuyalingana	52701015	46.5%	43.7%	0.20	27.4%	41.4%	0.11	111
Umgungundlovu	Mkhambathini	52206007	43.3%	41.9%	0.18	28.4%	39.9%	0.11	112
Zululand	Abaqulusi	52603003	51.2%	45.3%	0.23	26.1%	43.0%	0.11	113
Uthukela	Imbabazane	52306008	52.9%	42.5%	0.22	26.6%	42.2%	0.11	114
Amajuba	Emadlangeni	52503004	42.1%	42.2%	0.18	27.3%	40.9%	0.11	115
Umkhanyakude	Jozini	52702001	43.4%	43.6%	0.19	25.7%	42.8%	0.11	116
Ugu	Vulamehlo	52101009	30.6%	42.3%	0.13	27.2%	40.4%	0.11	117
Umkhanyakude	Jozini	52702019	52.4%	42.9%	0.23	26.1%	42.1%	0.11	118
Zululand	Nongoma	52605003	47.6%	44.1%	0.21	26.5%	41.5%	0.11	119
Uthukela	Okhahlamba	52305003	55.5%	47.1%	0.26	25.1%	43.7%	0.11	120
iLembe	Ndwedwe	52903010	37.3%	43.1%	0.16	26.3%	41.5%	0.11	121
Umkhanyakude	Umhlabuyalingana	52701011	41.0%	46.5%	0.19	25.7%	42.5%	0.11	122
Harry Gwala	Ubuhlebezwe	54304003	40.2%	41.5%	0.17	27.4%	39.6%	0.11	123
Umkhanyakude	Umhlabuyalingana	52701002	35.1%	41.5%	0.15	24.9%	43.6%	0.11	124

			Census 2001			Census 2011			
District	Local Municipality	Ward Code	Headcount	Intensity	SAMPI Index Score	Headcount	Intensity	SAMPI Index Score	Deprived Ward Ranking Number
Harry Gwala	Ubuhlebezwe	54304001	38.6%	44.6%	0.17	24.8%	42.9%	0.11	125
Uthungulu	Mthonjaneni	52805006	50.2%	41.8%	0.21	25.1%	42.4%	0.11	126
iLembe	Maphumulo	52904007	41.3%	40.5%	0.17	26.1%	40.6%	0.11	127
Uthungulu	Nkandla	52806012	41.7%	44.0%	0.18	26.9%	39.4%	0.11	128
Umkhanyakude	Jozini	52702003	55.1%	44.2%	0.24	25.5%	41.3%	0.11	129
Zululand	Abaqulusi	52603005	48.6%	43.1%	0.21	25.3%	41.4%	0.10	130
Ugu	Umdoni	52102006	31.5%	49.0%	0.15	22.5%	46.7%	0.10	131
Ugu	Umzumbe	52103013	36.7%	42.1%	0.15	25.6%	40.9%	0.10	132
Umkhanyakude	Umhlabuyalingana	52701004	46.0%	45.0%	0.21	24.4%	42.8%	0.10	133
Umkhanyakude	The Big 5 False Bay	52703004	49.5%	45.1%	0.22	25.0%	41.7%	0.10	134
eThekwini	eThekwini	59500089	38.4%	46.3%	0.18	23.6%	43.6%	0.10	135
Uthukela	Umtshezi	52304006	36.8%	46.7%	0.17	22.9%	44.6%	0.10	136
Umkhanyakude	Jozini	52702006	42.1%	42.9%	0.18	23.8%	42.7%	0.10	137
Ugu	Vulamehlo	52101006	30.0%	40.4%	0.12	24.8%	40.8%	0.10	138
Uthungulu	Nkandla	52806006	54.9%	42.5%	0.23	24.4%	41.4%	0.10	139
iLembe	Ndwedwe	52903008	38.1%	41.8%	0.16	23.9%	42.0%	0.10	140
iLembe	Ndwedwe	52903007	36.0%	41.8%	0.15	24.8%	40.2%	0.10	141
iLembe	Kwadukuza	52902001	35.5%	42.7%	0.15	24.3%	41.0%	0.10	142
Harry Gwala	Ingwe	54301007	38.5%	44.6%	0.17	23.7%	41.9%	0.10	143
Ugu	Umzumbe	52103011	42.3%	43.0%	0.18	25.0%	39.5%	0.10	144
Uthungulu	Nkandla	52806008	39.9%	43.5%	0.17	23.5%	42.1%	0.10	145

			Census 2001			Census 2011			
District	Local Municipality	Ward Code	Headcount	Intensity	SAMPI Index Score	Headcount	Intensity	SAMPI Index Score	Deprived Ward Ranking Number
Umzinyathi	Endumeni	52402008	37.3%	42.1%	0.16	24.6%	39.9%	0.10	146
Ugu	Vulamehlo	52101002	19.2%	45.8%	0.09	22.6%	43.4%	0.10	147
Zululand	UPhongolo	52602006	40.0%	42.5%	0.17	22.8%	43.0%	0.10	148
Umzinyathi	Endumeni	52402004	37.8%	42.2%	0.16	23.7%	41.3%	0.10	149
Harry Gwala	Umzimkhulu	54305013	42.2%	44.5%	0.19	23.2%	41.9%	0.10	150
Harry Gwala	Umzimkhulu	54305009	49.1%	45.1%	0.22	23.1%	42.0%	0.10	151
Harry Gwala	Ingwe	54301003	46.7%	42.4%	0.20	23.5%	41.4%	0.10	152
Uthukela	Emnambithi	52302019	34.3%	45.2%	0.16	22.9%	42.3%	0.10	153
Umzinyathi	Endumeni	52402010	40.0%	43.2%	0.17	22.6%	42.8%	0.10	154
Umzinyathi	Endumeni	52402003	35.8%	42.1%	0.15	22.8%	42.3%	0.10	155
iLembe	Ndwedwe	52903011	31.7%	43.7%	0.14	23.0%	41.9%	0.10	156
Zululand	Abaqulusi	52603007	39.4%	45.5%	0.18	22.5%	42.6%	0.10	157
Uthungulu	Ntambanana	52803003	40.8%	40.0%	0.16	23.3%	40.9%	0.10	158
Uthungulu	Umlalazi	52804003	47.2%	42.1%	0.20	25.0%	38.0%	0.10	159
Harry Gwala	Ubuhlebezwe	54304009	40.1%	43.2%	0.17	22.4%	42.3%	0.09	160
Zululand	UPhongolo	52602001	46.6%	45.4%	0.21	23.4%	40.5%	0.09	161
Zululand	Ulundi	52606002	47.3%	47.0%	0.22	24.0%	39.3%	0.09	162
Harry Gwala	Ubuhlebezwe	54304008	35.7%	43.9%	0.16	23.0%	41.1%	0.09	163
Harry Gwala	Ubuhlebezwe	54304004	33.4%	44.7%	0.15	21.0%	44.7%	0.09	164
Harry Gwala	Umzimkhulu	54305002	40.9%	43.8%	0.18	22.5%	41.7%	0.09	165
Harry Gwala	Umzimkhulu	54305019	38.6%	43.0%	0.17	22.1%	42.6%	0.09	166

			Census 2001			Census 2011			
District	**Local Municipality**	**Ward Code**	**Headcount**	**Intensity**	**SAMPI Index Score**	**Headcount**	**Intensity**	**SAMPI Index Score**	**Deprived Ward Ranking Number**
Uthungulu	Nkandla	52806011	44.7%	42.7%	0.19	22.9%	41.1%	0.09	167
Umzinyathi	Umvoti	52405001	54.1%	40.1%	0.22	23.0%	40.8%	0.09	168
Ugu	Hibiscus Coast	52106015	29.8%	45.2%	0.13	22.4%	41.6%	0.09	169

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