ANNUAL PERFORMANCE PLAN

MTEF 2011/12 – 2013/14

ENDORCEMENT BY THE MEC FOR HEALTH

The Annual Performance Plan provides an indication of the approach the Department utilises to achieve its strategic goals and aligns to the Millennium Development Goals, the Negotiated Service Delivery Agreement and the National Health System Priorities.

The burden of disease continues to place pressure on our health system. The scourge of communicable diseases in the Province remains and the rising trend in diseases of lifestyle continue against a backdrop of trauma. The Province has unacceptably high infant mortality, child mortality and maternal mortality rates. The AIDS epidemic exacerbates the disease burden, and has increased morbidity and mortality in the Province. Challenges such as high levels of poverty, inadequate access to sanitation and safe water, and high unemployment rates, coupled with the population distribution and unique topography of the Province pose numerous challenges in providing accessible health care services to all.

A concurrent concern exists around Tuberculosis, which remains a major challenge for the Province. The Department scaled up implementation of the TB Control Programme based on the WHO DOTS Strategy, and a huge drive has been made to devolve the programme to the community-based and PHC clinic level to increase access to surveillance, treatment, follow-up and support. Multi- and extreme drug resistant TB still endanger TB outcomes in the Province. Due to resource constraints to manage these clients in facilities for extended periods, the Department initiated a pro-active community-based treatment and support programme, the first of its kind in the country that proved to be effective.

The Department has sustained its massive commitment towards HIV, AIDS and TB. Pivotal areas of emphasis revolve around integration of HIV/TB services and the intensification of HIV prevention programmes including Voluntary Male Medical Circumcision, the HCT campaign, increased activity in High Transmission Areas, improved condom distribution including high transmission areas. By the end of December 2010, a total of 419,273 active patients were on antiretroviral treatment highlighting the increasing needs and demands on health services.

In the forthcoming MTEF, the Department will reposition its strategic endeavours moving from the planning phase to the implementation phase of the newly developed Service Transformation Plan (STP). The ultimate aim of this 10-year plan is to transform the health system to improve equity and access to high quality health care which will ultimately result in improved health outcomes. Revitalisation of the PHC approach is seen as paramount in the transformation of health services and will form the cornerstone of intensified community participation and ownership of health in the Province.

In the year ahead, the Department will intensify programmes to improve maternal, child and women's health. The '*Maternal and Child Health Road Map to 2014*' will provide the blue print for evidence-based practice to reduce morbidities and mortalities of women and children.

Robust implementation of programmes to improve efficiency and quality in our hospitals will be prioritised including implementation of the National Core Standards for Quality in all facilities supported by further roll-out of the "Make me look like a Hospital" project.

Management development and training programmes will be implemented, including mentoring programmes and succession training, to ensure efficient management of services.

The Department heeds the clarion call of our esteemed President for job creation. Job opportunities will be created by the awarding of bursaries, strengthening the Community Caregiver programme, improving support at truck stops and supporting the green economy through waste management and recycling.

The Department is striving to create conditions conducive to a healthier lifestyle for all its citizens, and the staff of the Department remains committed to the central tenet of this approach. I have the greatest confidence that the management and staff will continue to rise to the challenge, embrace change and always remember who we serve. That despite the pressure, under which we function, will continue to remain committed to service delivery, and work together as a synergistic team to provide better health service to all.

The future heralds a period of renewal, revitalisation and innovative approaches to the challenges faced in the health care arena. In an endeavour to improve the quality of health care and take care of one's own health, I implore a paradigm shift for both staff and clients of "*NONE BUT OURSELVES*". It is with commitment and assurance that I endorse the Annual Performance Plan for 2011/12 – 2013/14.

Dr SM Dhlomo

MEC for Health

KwaZulu-Natal Department of Health

Date: 08/03/2011

FOREWORD BY THE HEAD OF DEPARTMENT

It is my pleasure to submit the 2011/12 – 2013/14 Annual Performance Plan following an intensive strategic review process. Foundation and resource documents that have guided the final Annual Performance Plan include the 2010 – 2014 Strategic Plan (tabled in 2010), the National Health System Priorities, and the Negotiated Service Delivery Agreement signed by our Honourable MEC with the National Minister of Health. The consultation, finalisation, and implementation of the Service Transformation Plan will be a key issue in the forthcoming year as eluded in the Annual Performance Plan.

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

The Annual Performance Plan in conjunction with the Service Transformation Plan will address the priorities of the Department and will provide an alignment between strategic direction and planning and budget and resource allocation. This will ensure that the activities of the Department will address health and service delivery needs and demands of all the people of the Province. All Cluster, District and Health Institution strategic and operational plans will be informed and guided by the aforementioned documents. This will ensure that all the activities of the Department are fully integrated and aligned to the strategic goals. This is particularly important where expansion of services have infrastructural and human resource implications. Thus, a comprehensive and cohesive approach will be adopted to ensure that appropriate quality, compassionate and accessible health care services are provided to our citizens.

An organisational review is underway to align structure to the service delivery mandate of the Department. The organisational configuration of the Department is the vehicle to ensure effective and efficient health service delivery in pursuance of the objectives set in the Strategic Plan, the Service Transformation Plan and the Annual Performance Plan of the Department. The Department uses the District Health System (DHS) as the vehicle to render the main functions of the Department through the PHC approach. The Department continues to align the roles and responsibilities of the different organisational layers of the Department towards the promotion of seamless service delivery.

In an effort to realise the vision of "*A long and Healthy Life for all South Africans*", the Department will focus on:

- Overhauling Provincial Health Services: Rationalisation of health services; revitalisation of PHC; improving governance; strengthening management capacity; eliminate bureaucracy; and decentralise delegations and accountability.

- Improving the efficiency and quality of Health Services: Implement the National Core Standards for Quality towards health facility accreditation; improve patient care, satisfaction and safety; and begin to prepare facilities for the forthcoming National Health Insurance.

- Reducing morbidity and mortality due to communicable diseases and non-communicable conditions and illnesses and develop an appropriate response to the burden of disease: Improve maternal, child and women's health; reduce HIV incidence and manage HIV prevalence; reduce TB incidence and improve TB outcomes; sustain programmes towards malaria control; improve detection, screening and management of non-communicable and chronic conditions; improve health promotion/ education and prevention of illness through a robust community-based strategy.

- Strengthening of inter-sector collaboration through signed Negotiated Service Delivery Agreements/ Memorandums of Understanding between the relevant MEC's and Heads of Departments; implementation of the Community-Based Model for Community Care Givers through Operation Sukuma Sakhe.

In line with the imperatives of the Annual Performance Plan and the Service Transformation Plan, additional funding has been allocated to strengthen PHC management and service delivery. New PHC clinic and Community Health Centre structures have been developed and their sustainability enhanced by newly formulated staffing norms. It is anticipated that the expanded structures and staffing complements will eliminate inefficiencies and duplication of services. Service delivery will be strengthened by the appointment of Medical Officers and Clinical Associates at Community Health Centres. The initiatives should also enhance the Departments ability to respond to demands of HIV and AIDS and TB. It is anticipated that such frontline primary intervention strategies will provide vital information for planning and disease prevention initiatives.

Health care is a significant and challenging area of government service. Despite fundamental constraints surrounding the recruitment and retention of critical and scarce skills and financial limitations, the future is a time for revitalization and honest assessment of current approaches, and our willingness to consider new innovative and evidence-based approaches for service delivery. We are committed to continue to progressively improve our service standards and performance, and embrace the changes we face, as it is our future.

This year I am committed to turn around quality of care, involvement of the community and other sector departments in health care and address the human resources challenges that are faced by the Department.

Dr SM Zungu

Head of Department

KwaZulu-Natal Department of Health

Date:

OFFICIAL SIGN-OFF OF THE KWAZULU-NATAL ANNUAL PERFORMANCE PLAN 2011/12 – 2013/14

It is hereby certified that the 2011/12 – 2013/14 Annual Performance Plan for the KwaZulu-Natal Department of Health:

- Was developed by the Provincial Department of Health in KwaZulu-Natal.
- Was developed under leadership of the Head of Department and MEC for Health and complies with the National Framework, the Negotiated Service Delivery Agreement, and the 2010 – 2014/15 Strategic Plan of the KwaZulu-Natal Department of Health.
- Accurately reflects the performance targets which the Provincial Department of Health in KwaZulu-Natal will endeavour to achieve given the resources and budget for 2011-12 – 2013/14.

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Mr J Govender

Acting General Manager: Health Service Planning, Monitoring & Evaluation

Date: 08/03/2011

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Mr N Biyela

Chief Financial Officer

Date: 8/3/2011

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Dr SM Zungu

Head of Department

Date: 08.03.2011

APPROVED BY:

.....

Dr SM Dhlomo

MEC for Health

Date: 08/03/2011

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PART A

1. STRATEGIC OVERVIEW

1.1 VISION

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

1.2 MISSION

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

1.3 VALUES

Trust built on truth;

Open communication;

Commitment to performance;

Integrity and reconciliation;

Transparency and consultation; and

Courage to learn, change and innovate

1.4 STRATEGIC GOALS

Table 1 (A1): Strategic Goals

Strategic Goal	Goal Statement	Rationale	Expected Outcomes
1. Overhaul Provincial Health Services.	Transform the Provincial health care system through implementation of the STP (including 10 core components) to improve equity, availability, efficiency, quality and effective management to enhance service delivery	An efficient and well functioning health care system with the potential to respond to the burden of disease and health needs in the Province.	▪ Transformation in line with STP imperatives and NHS 10-Point Plan. ▪ Improved access, equity, efficiency, effectiveness and utilisation of services. ▪ Improved Human Resource Management Services including reconfiguration of organisational structures, appropriate placement of staff (appropriate skills mix and competencies), appropriate norms and standards to respond to burden of disease and

Strategic Goal	Goal Statement	Rationale	Expected Outcomes
	and improve health outcomes of all citizens in the province.		package of services, strengthened performance management and decreased vacancy rates. ▪ Improved Financial & SCM efficiency and accountability to curb over-expenditure, improve return on investment and value for money, budget aligned with service delivery priorities and needs. ▪ Appropriate response to the burden of disease and consequent health needs. ▪ Improved governance including regulatory framework, policies and delegations to facilitate implementation of the Strategic Plan. ▪ Decentralised delegations, controls and accountability. ▪ Improved information systems, data quality and management and improved performance monitoring and reporting. ▪ Strengthened infrastructure to improve service delivery.
2. Improve the efficiency and quality of health services.	Achieving the best possible health outcomes within the funding envelope and available resources.	Improved compliance with legislative/ policy requirements and Core Standards for quality service delivery in order to improve clinical/ health outcomes.	▪ Accreditation of health facilities in line with National Core Standards for Quality. ▪ Improved management capacity. ▪ Improved health outcomes and increased life expectancy at birth as a result of improved clinical governance. ▪ Improved performance towards achieving the MDG targets. ▪ Patient satisfaction.
3. Reduce morbidity and mortality due to communicable diseases and non-communicable conditions and illnesses.	Implement integrated high impact strategies to improve prevention, detection, management and support of communicable diseases & non-communicable illnesses and conditions at all levels of care.	Reduction of preventable/ modifiable causes of morbidity and mortality at community and facility level contributing to a reduction in morbidity and mortality rates.	▪ Decrease in morbidity and mortality – with specific reference to preventable causes. ▪ Improved performance towards achievement of MDG targets i.e. ▪ HIV and AIDS; ▪ TB; ▪ Maternal & Child Health; ▪ Malaria. ▪ Change in trends of non-communicable disease patterns.

Source: 2010-2014/15 Strategic Plan

1.5 SITUATION ANALYSIS

Map 1: Province of KwaZulu-Natal

RURAL DEVELOPMENT NODES [Yellow]:

- Ugu
- Umzinyathi
- Zululand
- Umkhanyakude

PRIORITY MUNICIPALITIES - National Health Project [Red]

- Maphumulo in Ilembe
- Dannhauser in Amajuba
- Nongoma in Zululand
- Umhlabuyalingana in Umkhanyakude

PERCENTAGE POPULATION PER DISTRICT:

- Ugu: 6.92%
- Umgungundlovu: 9.64%
- Uthukela: 6.97%
- Umzinyathi: 4.83%
- Amajuba: 4.32%
- Zululand: 8.84%
- Umkhanyakude: 5.98%
- Uthungulu: 8.72%
- Ilembe: 5.14%
- Sisonke: 4.88%
- eThekwini: 33.8%

Source: Developed by the KZN Department of Health GIS Section (Stats SA)

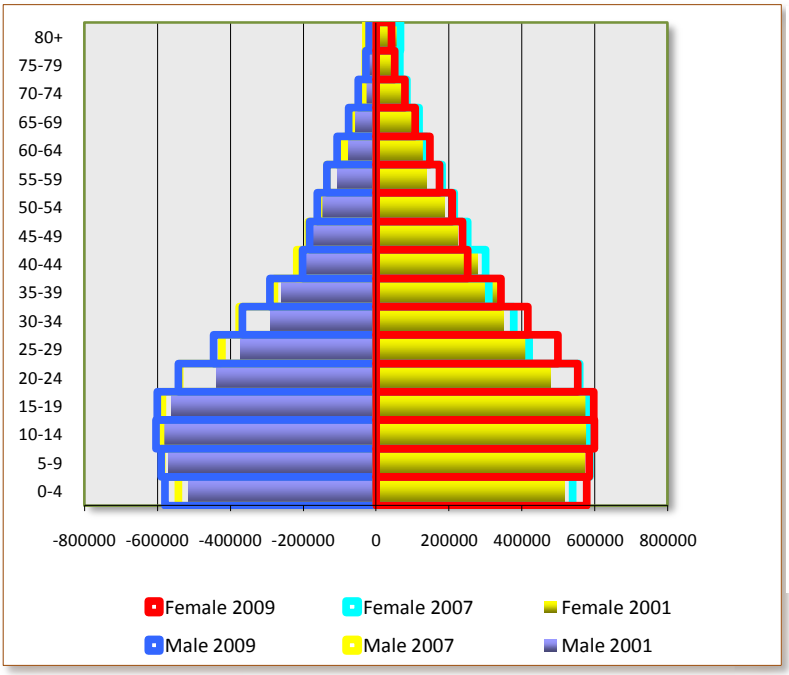
1.5.1 POPULATION PROFILE

The Province of KwaZulu-Natal comprises 1 Metro, 10 Districts, 50 Local Municipalities and 828 Wards. It stretches from the Eastern Cape Province in the south, to the borders of Swaziland and Mozambique in the north, Mpumalanga Province in the north-west, and the Free State Province and Lesotho in the west. The Indian Ocean, with two of the country's main import/export harbours, forms the eastern boarder of the Province.

KwaZulu-Natal is the second most populous Province in South Africa, occupying 7.6% (92,100sq km) of the total land surface of South Africa. The estimated total population is 10,467,466 (21.4% of the total South African population), and the estimated uninsured population is 9,159,033 (87.5% of the total Provincial population). The population density is estimated at ±107.52 people per sq km with the lowest density (±42 people per sq km) in Sisonke and highest (±1,394 people per sq km) in eThekwini.[1] The population pyramid in Figure 1 compares the Provincial population for the period 2001, 2007 and 2009.

There are slightly more females (51.8%) than males (48.2%); 10.7% of the population is under the age of 5 years; 33% under the age of 15 years; 62.4% between 15-64 years (economically active); and 4.6% of the population is 60 years and older.

Figure 1: Provincial Population Pyramid 2001; 2007; 2009



34% of the population is under the age of 14 years with slightly more males (35%) than females (32%), and 5% of the population 65+ years.

The proportion of young people ranges from 27% in eThekwini to 41% in Umgungundlovu, and the working age population ranges from 54% in Umzinyathi to 69% in eThekwini.

Ugu (6%) has the highest proportion of elderly with the lowest proportion in eThekwini and Uthungulu (4% each).

Life expectancy of males (47.3 years) is lower than the 51 years for females.

Source: Population data from Stats SA

[1] Statistical Release P0302 Mid-Year Population Estimates 2009

1.5.2 SOCIO-ECONOMIC PROFILE

The Province registered a positive growth of 3.7% in 2009 compared with 3.2% nationally. In the second quarter of 2010 the KZN economy is estimated to have grown by 3.3%, following a positive growth of 4.0% in the previous quarter (slightly above the national growth of 3.2%).[2]

The 2007 Community Survey defined 668,135 (27%) households in the Province as having no income at all or having an income of less than R400 a month, with the highest number of people with no income based in eThekwini, Umgungundlovu, Ugu and Umkhanyakude. The reported levels of hunger show a slight upward trend from 2007 at 2.4% for adults and 2.5% for children. Female headed households were more likely than male-headed households to have either hungry adults or children, which ties in with unemployment and migration trends.

Between 2001 and 2007 the employment rate in KZN declined by an average of 0.6% annually while the working age group population (15 – 64) grew at a rate of 1.75% annually. As a result, unemployment grew at an annual rate of 3.88% between 2001 and 2007.[2]

Table 2: Male versus female unemployment in KZN[2]

Year	Male	Female
2006	20%	24.1%
2007	20.4%	25%

Source: Based on data from Stats SA (2008a)

The female unemployment rate has been consistently higher than that for males since 2002. This is significant to the growing number of female households and the current burden of disease with associated health challenges.

In KZN, 39% (962,685) of households have access to piped water inside the dwelling; 19% (469,000) have access to piped water inside the yard; 21% (518,368) have access to piped water from an access point outside the yard; and 10% (246,842) get water from a river/stream. At the current rate of funding the Province will only achieve 100% availability to piped water in 2020.

40% (987,368) of households had access to flush toilets with a sewage system with 22% (543,052) using pit latrines with ventilation, and 10% (246,842) of households have no access to sanitation. At the current rate of funding the Province will only achieve 100% access beyond 2020.

73.4% of households in the Province have access to electricity. At the current rate of funding, the Province will be able to achieve 100% availability by 2021.

[2] KZN Department of Economic Development & Tourism: Economic Developments in Brief

The integrated Operation Sukuma Sakhe (Flagship Programme), borne out of the 2009 KZN Cabinet Indaba, gained momentum in 2010/11 aiming to accelerate:

- Economic growth;
- Community development;
- Job creation;
- Strengthening institutions; and
- Poverty alleviation through empowered communities.

The Department, in collaboration with the Department of Social Development, commenced with an integrated Youth Ambassador and Community Care Givers Programme as critical component of Operation Sukuma Sakhe and revitalisation of Primary Health Care (PHC). The programmes aim to improve integrated and comprehensive community-based services in line with Governments intention encapsulated in Outcome 2 of the Negotiated Service delivery Agreement (NSDA) "*A long and healthy life for all South Africans*".

1.5.3 EPIDEMIOLOGICAL PROFILE – BURDEN OF DISEASE

The national decline in life expectancy is considered to be largely due to HIV & AIDS and TB which constitute 46% of disability-adjusted life years (DALY) lost in SA. According to the 2010 Mid-Year Population Estimates (Stats SA) the life expectancy of both males and females in KZN increased over the period 2001-2006 and 2006-2011 from 46.4 to 49.1 years for males (52.2 national) and from 50.6 to 50.2 years for females (54.3 national). Fertility rates declined from an average of 3.03 children per woman in 2001 to 2.58 in 2010 compared with 2.18 nationally.

According to Statistics SA the ten leading underlying causes of death in KZN were:[3]

1. Intestinal infectious diseases 7.3%
2. Tuberculosis 6.9%
3. Influenza and pneumonia 5.7%
4. Cerebrovascular diseases 4.6%
5. Other forms of heart disease 3.9%
6. Human immunodeficiency virus [HIV] disease 3.6%
7. Diabetes mellitus 3.6%
8. Other viral diseases 2.9%
9. Hypertensive diseases 1.9%
10. Ischaemic heart diseases 1.9%

[3] Statistics SA - Statistical Release P0309.3: Mortality and causes of death in South Africa, 2008: Findings from death notification

Results from the KwaZulu-Natal PHC Disease Profile[4] indicate that diseases of lifestyle constitute a major part of the burden of disease in the Province. According to Profile results, non-communicable diseases constituted 31.54% of conditions seen at PHC with hypertension the most common at 12.4% of all cases. 25% of people visiting PHC services do so for reasons other than illness, mostly referring to contraceptive and antenatal care services.

Approximately 5% of the population has disabilities, much lower than the range of 12 – 19% as indicated by the World Health Organisation estimates, which translated to approximately 500,000 of the population in KwaZulu-Natal alone.

According to the Confidential Enquiry into Maternal Deaths[5] the Provincial maternal mortality rate is estimated at 210/100,000 live births. The Report estimated a significant proportion of maternal deaths to be outside health institutions (not reported) highlighting the need for improved community-based strategies to improve health seeking behaviour.

There are still conflicting data on child mortality rates. According to Stats SA (2010 projections) the infant mortality rate is estimated at 46.9/1000 live births in 2010. The AIDS Committee of Actuarial Society of South Africa estimated the infant mortality rate at 56.5/1000 live births and the under-5 mortality rate 87.7/1000 live births in 2010.

Pneumonia and diarrhoea are still the two leading causes of morbidity and mortality in children under-5 years. During 2009/10, the number of children under-5 years reporting to Provincial public health services with diarrhoea with dehydration increased from 46,511 in 2008/09 to 50,471 (+8.5%). Of these, 9,092 (18%) children were admitted in hospital. The number of pneumonia cases in children under-5 years seen at public health facilities increased from 194,914 in 2008/09 to 209,920 (+7.6%) in 2009/10. Of these, 8,924 (4.2%) children were admitted in hospital.

Rehle T. et al.[6] estimated the HIV incidence in KwaZulu-Natal at 1.7%, which is similar to the Health Systems Trust[7] estimate of 1.6%. KZN has consistently recorded the highest HIV prevalence in pregnant women since 1990. According to the National Survey of 2009 the Provincial HIV prevalence increased from 38.7% in 2008 to 39.5% in 2009 – still the highest in the country.

The 2009 TB incidence rate was 1,160/100,000 population, with the highest incidence rate in Sisonke (1,460/100,000) and the lowest in Uthukela (728/100,000).

Successful implementation of the malaria strategy achieved a reduction of 18% in morbidity and 75% in mortality. A total of 348 malaria cases (1 death) were reported in 2009/10 compared with 429 cases (4 deaths) in 2008/09.

[4] PHC Disease Profile in KwaZulu-Natal, 2009 - Dr A Tefera
[5] National Confidential Enquiries into Maternal – 2008, Deaths 2004-2007 (KZN Data)
[6] Rehle T et al 2007. National HIV incidence measures – new insights into the South African epidemic. South African Medical Journal 97:194-199
[7] Schaay N, Sanders D - International Perspective on Primary Health Care over the past 30 years - In Barron P, Roma-Reardon J, editors South African Health Review 2008 Durban: Health Systems Trust: 2008

1.6 PROVINCIAL SERVICE DELIVERY ENVIRONMENT

Table3 (A2): Trends in key Provincial service volumes

Indicator	2007/08 Actual	2008/09 Actual	2009/10 Actual	2010/11 Estimate
1. PHC headcount - total	21,260,261	23,838,854	*25,921,993	25,243,274
2. OPD headcount - new case not referred	New indicator	New indicator	New indicator	New indicator
3. Separations District Hospitals	329,406	361,244	360,524	304,250
4. Separations Regional Hospitals	351,169	355,778	*321 315	312,932
5. Separations Tertiary Hospital	12,016	11,919	10,755	11,742
6. Separations Central Hospital	14,405	20,886	20,204	20,248

1. Data with [*] reflect verified and corrected data since the 2009/10 Annual Report
2. Indicator 2 (OPD headcount – new case not referred) was included in the National Indicator Data Set (NIDS) and will be monitored from 2011/12 onwards.

Table 4 (A3): Progress towards the Millennium Development Goals

Indicator	Data Source	Actual Progress 2009/10[8]	Target 2015
GOAL 1: Eradicate Extreme Poverty And Hunger **TARGET: Halve, between 1990 and 2015, the proportion of people who suffer from hunger**			
Incidence of severe malnutrition in children (under 5 years of age)	DHIS	8/ 1 000	0.7% (National)
Prevalence of underweight children (under 5 years)	DHIS	0.6%	0% (National)
GOAL 4: Reduce Child Mortality **TARGET: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate**			
Under-five mortality rate	ASSA, 2010 - AIDS Committee of Actuarial Society of South Africa	87.7/1 000 live births	20/1 000 live births (National) 37/1000 live births (Provincial)
Infant mortality rate	*Medical Research Council*	55.8/1 000 live births	14.3/1 000 live births (National) 18/1 000 live births (NSDA)
Proportion of one-year-old children immunised against measles	DHIS	84.9%	100% (National) 90% (Provincial)

[8] 2010/11 data incomplete for comparison

Indicator	Data Source	Actual Progress 2009/10[8]	Target 2015
GOAL 5: Improve Maternal Health **TARGET: Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate**			
Maternal mortality ratio *Use facility mortality rate as proxy*	National Confidential Enquiries into Maternal Deaths 2004-2007 DHIS	210/100 000	38/100 000 live births (National) 135 or less/100 000 live births (Provincial)
Proportion of births attended by skilled health personnel	SADHS 2003	91.1%	100% (National)
GOAL 6: Combat HIV and AIDS, malaria and other diseases **TARGET: Have halted by 2015, and begin to reverse the spread of HIV and AIDS**			
HIV prevalence among 15- to 24-year-old pregnant women	National HIV & Syphilis Prevalence Survey of SA 2009	21.7% - national	22.8% (National)
Contraceptive prevalence rate	SADHS, 2003	76.8%	100% (National)
Malaria incidence rate	CDC Database	0.02/1 000 (244 cases)	<6,800 (National)
Incidence of TB	TB Database	1,160/100 000	<253/100 000 (National)
TB cure rate	TB Database	62.9% (2008/09 cases)	85%

1.6.1 NATIONAL HEALTH SYSTEM PRIORITIES FOR 2009-2014

Table 5 (A4): National Health Systems priorities for 2009-2014 (10 Point Plan)

Priority	Key Activities
1. Provision of strategic leadership and creation of social compact for better health outcomes	Ensure unified action across the health sector in pursuit of common goals
	Mobilise leadership structures of society and communities
	Communicate to promote policy and buy-in to support government programmes
	Review of policies to achieve goals
	Impact assessment and programme evaluation
	Development of a social compact
	Grassroot mobilisation campaign
2. Implementation of National Health Insurance (NHI)	Finalisation of NHI policies and implementation plan
	Immediate implementation of steps to prepare the introduction of the NHI e.g. budgeting, initiation of the drafting of legislation
3. Improving the quality of health	Focus on the 18 health districts

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

Priority	Key Activities
development	Commission research into the impact of social determinants of health and nutrition
	Support research studies to promote indigenous knowledge systems and the use of appropriate traditional medicines

Source: National Department of Health

The Department will continue to focus on strategies to fast track delivery on the 4 Key Outputs identified in the Negotiated Service Delivery Agreement namely:

1. Increasing life expectancy;
2. Decreasing Maternal and Child Mortality;
3. Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis; and
4. Strengthening Health Systems effectiveness.

This is consistent with the National Health System (NHS) 10 Point Plan, the 'health-related' Millennium Development Goals (MDG's), the Provincial Plan of Action, and the 2010/2014/15 Strategic Plan.

Specific strategies and targets to sustain Provincial momentum towards delivery on the identified targets are indicated in Table 7(A6).

1.6.2 HEALTH SECTOR NEGOTIATED SERVICE DELIVERY AGREEMENT (NSDA)

Table 6 (A6): Provincial contribution towards achievement of the NSDA Outputs

Provincial Priorities for 2011/12	Planned Strategies and Activities	Targets 2011/12 – 2014/15
OUTPUT 1: INCREASING LIFE EXPECTANCY		
Increase life expectancy to 58 years for males and 60 years for females by 2014/15. *"Delivery on other outputs will improve health outcomes and life expectancy."* Implement enhanced programmes for prevention, detection and treatment of non-communicable conditions and illnesses.	Improve detection and screening through the integrated community-based strategy linked with Operation Sukuma Sakhe and revitalisation of PHC.	Hypertension high risk cases incidence rate: baseline plus 6% per annum
		Diabetes high risk cases incidence rate: baseline plus 10% per annum
	Improve the cataract surgery rate	Increase the Cataract surgery rate to 160.12/1mil population by 2013/14 (1,800 operations).
	Maintain cholera strategies	Maintain the Cholera fatality rate at 0%
	Accelerate implementation of the integrated School Health and Health Promoting Schools services as part of revitalisation of PHC.	230 Accredited Health Promoting Schools by 2013/14.
		Increase the School Coverage (SHS) to 70% by 2014/15.
	Enhance capacity within the Youth Ambassador Programme to improve promotive and preventive activities targeting youth.	Implement the integrated Community-Based Model for Youth Ambassadors as part of Operation Sukuma Sakhe.
Halt malaria transmission and prevent re-introduction of malaria in non-endemic areas.	Maintain preventative strategies for malaria elimination.	Reduce the malaria incidence to 0.55/1 000 population at risk
		Reduce and maintain the malaria case fatality rate to <1% by 2011/12
		Increase the malaria spraying coverage to 98% by 2014/15.
Revitalisation of PHC services. *This will have an impact on all monitored indicators.*	Finalise and implement the integrated community/ facility-based PHC Model (including Operation Sukuma Sakhe).	Provincial PHC Model developed and implemented in 11 districts by 2011/12 as per STP Service Delivery Plan.
		Increase coverage at ward level (Operation Sukuma Sakhe) to 828 Wards by 2014/15. *Social Cluster initiative and not managed by the Department of Health – forms part of the community-based strategy*
Reduce and manage intentional and unintentional injuries.	Revitalisation of Emergency Medical Services (EMS) as per revitalisation strategy input, output and outcomes. *[The EMS Strategic Plan (too late for inclusion in this publication)*	Increase rostered ambulances to 1:10 000 population by 2014/15.
		Increase P1 calls with a response time of <40 minutes in a rural area to 70% by 2014/15.

Provincial Priorities for 2011/12	Planned Strategies and Activities	Targets 2011/12 – 2014/15
	makes provision for revitalisation of EMS and Planned Patient Transport. Addendum to quarterly review of performance information (strategic and operational) will be added once targets have been finalised]	Increase P1 calls with a response time <15 minutes in an urban area to 70% by 2014/15.
		Increase the percentage of calls responded to within 60 minutes to 80% by 2014/15.
		Increase the percentage of locally based staff with training in BLS (BAA) to 55% by 2013/14.
		Increase the percentage of locally based staff with training in ILS (AEA) to 35% by 2013/14.
		Increase the percentage of locally based staff with training in ALS (Paramedics) to 10% by 2013/14.
OUTPUT 2: DECREASING MATERNAL AND CHILD MORTALITY		
Reduce child morbidity and mortality	Implement the Maternal and Child Health Road Map to 2014.	Reduce the under-5 mortality rate to 37/1000 by 2014/15.
		Reduce child mortality to 30-45/1000 by 2014/15 (National).
	Scale up interventions for early detection and management of under-nutrition – part of community-based strategy.	Reduce the prevalence of underweight children (under 5 years) to 1% by 2014/15.
	Implement the WHO 10-Steps for Management of Children with Severe Malnutrition in all hospitals.	Reduce severe malnutrition under 5-years incidence to 6/1000 by 2014/15.
		Increase the Vitamin A coverage under-1 year to 95% in all districts by 2014/15.
		Increase the Vitamin A coverage 12-59 months to 90% in all districts by 2014/15.
	Reduce vaccine preventable morbidity and mortality by improving immunisation coverage	Increase immunisation coverage under-1 year to 90% in all districts by 2014/15.
		Increase the measles coverage under-1 year to 90% in all districts by 2014/15.
		Increase Pneumococcal 3rd dose coverage from 64% to 90% in 11 districts by 2014/15.
		Decrease the number of diarrhoea cases (children under-5) with 15% per annum.

Provincial Priorities for 2011/12	Planned Strategies and Activities	Targets 2011/12 – 2014/15
		Increase Rota Virus 2nd dose coverage from 25% to 90% in 11 districts by 2014/15.
		Decrease the number of pneumonia cases (children under-5) with 20% per annum.
	Strengthen mortality reviews and quality improvement plans at all hospitals.	Increase Child PIP[9] reporting sites to 40 by 2014/15.
		100% Maternity care units review maternal and peri-natal deaths and address identified deficiencies.
		Increase PPIP[10] reporting sites to 56 by 2014/15.
Decrease maternal and neonatal morbidity and mortality.	Implement the Maternal and Child Health Road Map to 2014.	Reduce maternal mortality to 135 (or less) per 100 000 live births by 2014/15.[11]
	Establish basic emergency obstetric care and strategically placed MOU's in all districts.	Establish 30 fully functional MOU's by 2014/15 [*dependent on final analysis which forms part of the STP process*]
	Introduce specialised ambulances for maternity and paediatric care.	Establish one dedicated obstetric ambulance (with team) per district by 2011/12. *[This also forms part of the revitalisation strategy of EMS services and targets will be monitored as per detailed plan]*
	Improve staff competencies/skills and improve quality of clinical care by introducing mentorship teams (including obstetrician and paediatrician).	Fully functional mentoring teams established in 11 districts by 2014/15.
	Establishing waiting mother's lodges in all District Hospitals.	*Dependent on final alignment of the Infrastructure Development Plan with the STP – not available by time of finalising the APP*
	Establish a Neonatal Experiential Learning Site and out-reach programme per service area.	Fully functional Neonatal Experiential Learning Site (and out-reach programme) per Service Area (x3) by 2012/13.
	Social mobilisation, partnerships with civil society and engagement in community-based strategies including Operation Sukuma Sakhe to improve maternal and neonatal health outcomes.	60% of mothers and 60% of newborn babies receive post partum care within 6 days after delivery by 2011/12 and 80% for both by 2014/15.
	Scale up implementation of BANC.	Increase ANC visits before 20 weeks to 90% by 2014/15.

[9] Child PIP: Child Problem Identification Programme
[10] Perinatal Problem Identification Programme
[11] Reviewed by Programme manager in January 2011

Provincial Priorities for 2011/12	Planned Strategies and Activities	Targets 2011/12 – 2014/15
Reduce the incidence of cervical cancer.	Implement the Phila Ma Campaign to improve Cervical Cancer Screening.	Increase cervical cancer screening coverage to 80% by 2014/15. *[The target will be reviewed based on review of screening versus total Pap smears]*
Reduce unplanned, unwanted and high-risk pregnancies.	Implement the Contraceptive Strategy.	Increase the women year protection rate to 50% by 2014/15.
Reduce the mother to child transmission of HIV by scaling up the PMTCT Programme.	Scale up access to Highly Active Anti-Retroviral Therapy (HAART) for pregnant women.	Reduce the proportion of babies testing PCR positive to <5% by 2014/15.
		90% of eligible pregnant women placed on HAART by 2013/14 and 95% by 2014/15.
		100% of pregnant women tested for HIV by 2011/12.
OUTPUT 3: COMBATING HIV AND AIDS AND DECREASING THE BURDEN OF DISEASE FROM TUBERCULOSIS		
Reduce HIV incidence and manage HIV prevalence.	Scale up implementation of the ART programme.	Reduce HIV incidence with 50% by 2011/12 (National Strategic Plan - NSP).
		90% Qualifying HIV-positive patients on ART by 2014/15 [80% by 2011/12 – NSP].
		Increase the number of patients initiated on ART to 695,557 by 2012/13.
	Strengthen HIV/TB integration.	100% TB-HIV co-infected patients with CD4 count of 350 or less initiated on ART by 2013/14.
		Increase the proportion of TB patients tested for HIV to 100% by 2012/13.
	Intensify the voluntary Male Medical Circumcision Campaign.	105,601 neonatal males circumcised by 2012/13.[12]
		373,406 adult males circumcised by 2012/13.[13]
	Expand the HIV Counselling and Testing Campaign (HCT).	100% facilities implement the HCT campaign by 2011.
		Test 3,059,234 clients by June 2011.[14]
		90% HCT testing rate by 2011/12.

[12] Acceptance rate of 80% of the KZN neonatal male population defined as the target group – 100% of target group circumcised per annum – target should be reviewed based on current performance

[13] Acceptance rate of 80% of the KZN male population between the age 15 – 49 years defined as the target group – 100% of target group circumcised over the 5-year period – should be reviewed based on current performance

[14] At the time of preparing the Strategic Plan final targets have not been identified

Provincial Priorities for 2011/12	Planned Strategies and Activities	Targets 2011/12 – 2014/15
		Condom distribution rate of 15 condoms per male by 2013/14.
	Scale up interventions in High Transmission Areas.	7 Truck Stops functional by 2014/15.
Reduce TB incidence, increase TB cure rate, and decrease TB defaulter rate	Scale up implementation of the TB Crisis Plan.	Increase the TB cure rate to 85% by 2014/15.
		Decrease the TB defaulter rate to <5% by 2014/15.
		Increase the smear conversion rate (2 months) to 85% by 2014/15.
	Strengthen TB ACSM (Advocacy, Communication and Social Mobilisation) and integrate TB DOTS support, surveillance for early detection of TB, and follow up of defaulters into activities of Operation Sukuma Sakhe and community-based strategies.	Increase the % of TB patients with DOTS supporters to 90% in 2014/15.
Scale up interventions to improve TB outcomes including MDR and XDR TB.	Expand the Community Management of MDR TB.	Expand the MDR TB treatment centres from 5 – 7 by 2012/13.
		Establish community-based management teams for MDR TB in 10 districts and 1 metro by 2013/14.
OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVENESS		
4.1 Health care financing and management		
Improve management capacity and accountability.	Implement reviewed delegations of authority for District & Hospital Managers/ CEO's.	100% District and Hospital Managers/CEO's sign delegation of authorities annually.
	Implement a Management Training Strategy including succession training and mentoring.	Training Programme for Managers implemented by 2011/12.
		100% of Hospital CEO's enrolled in training programmes by 2013/14.
Improve financial management and accountability.	Implement the Finance and Supply Chain Management (SCM) Turn-Around Strategy.	Annual unqualified audit opinion.
Align Provincial macro plans (within the funding envelope and in compliance with legislative prescripts) with the 10 Point Plan and NSDA priorities.	Finalise and implement the 2010-2020 Provincial Service Transformation Plan (STP).	Approved STP implemented as per Service Delivery Plan.
Improve governance and participation including collaboration with public, private	Establish Provincial and District Health Councils as per National Health Act, 2003 and convene annual meetings.	Establish Provincial Health Council and convene annual meetings.
		Establish 11 District Health Councils and convene 11 annual

Provincial Priorities for 2011/12	Planned Strategies and Activities	Targets 2011/12 – 2014/15
and civil society entities and labour.		meetings.
	Appoint Hospital Boards and Clinic Committees as per National Health Act, 2003. *[Current Hospital Boards and Clinic Committees not established as per National Health Act, 2003 imperatives – considered as interim structures]*	100% Hospital Boards established by 2012/13.
		70% Clinic Committees established by 2014/15.
4.2 Human resources for health		
Improve access to Human Resources for Health.	Scale up implementation of the Human Resources Turn-Around Strategy.	Turn-Around Strategy implemented as per Plan.
		Persal data cleaned up by 2011/12.
	Review and improve Performance Management and Development systems and policies.	100% Managers (District Managers, Hospital CEO's, and Managers at Head Office (level 13 and above) sign Performance Agreements in 2011/12 and annually thereafter.
	Review and implement the recruitment and retention strategy and fill vacant posts. *[Vacancy rates will be reviewed following organisational review (restructuring) and the cleanup of Persal data. This will in turn impact on ratios per 100 000 population. Annual and quarterly targets might therefore change during the reporting period]*	Vacancy rate for Professional Nurses <10%.
		Vacancy rate for Medical Officers <25%.
		Vacancy rate for Specialists <50%.
		Vacancy rate for pharmacists <75%.
		25.7 Medical officers per 100 000 people.
		12 Medical officers per 100 000 people in rural districts.
		107 Professional Nurses per 100 000 people.
		93 Professional nurses per 100 000 people in rural districts.
		4 Pharmacists per 100 000 people.
		2 Pharmacists per 100 000 people in rural districts.
	Sustain training and development programmes.	2,404 Nurse Student intakes in 2011/12.
		842 Students with bursaries from Province in 2011/12.
		1,400 Basic Nurse Students graduating in 2011/12.
		106 Advanced Midwifes graduating in 2011/12.

Provincial Priorities for 2011/12	Planned Strategies and Activities	Targets 2011/12 – 2014/15
		820 Professional Nurses graduating in 2011/12.
		647 Professional health care workers trained on Provider Initiated Counselling & Testing in 2011/12.
		100 Managers accessing the Management Skills Programmes.
		20 SMS members trained on MIP.
		700 Registrars in training (cumulative) by 2013/14.
		525 (75%) Registrars retained after qualifying in 2013/14.
4.3 Quality of health and accreditation of health establishments		
Improve quality and efficiency of PHC and Hospital services.	Implementation of the National Core Standards for quality towards accreditation of health facilities in preparation for National Health Insurance (NHI)[15] Expand the "Look like a Hospital" initiative. *[Targets for accreditation of facilities might be reviewed based on finalisation of national processes (establishment of the National Accreditation Body). The Look like a Hospital Project is also under review following the appointment of the new Senior Manager for Hospital Services]*	Core Standards implemented in 100% PHC facilities, CHC's and Hospitals by 2010/11.
		Facilities accredited [*dependent on establishment of the National Accreditation Body*]: – 50% of PHC clinics by 2014/15 (10% per year); – 100% CHC's by 2014/15; – 100% District Hospitals by 2014/15; – 100% Regional Hospitals by 2014/15; – 100% Tertiary and Central Hospitals by 2012/13.
		Average patient waiting time at CHC <2 hrs 2014/15.
		Average patient waiting time at OPD <2hrs 2013/14.
		Average patient waiting time at admissions <2hrs 2013/14.
	Improve patient satisfaction with public health services.	100% of facilities conduct annual Patient Satisfaction Surveys [includes PHC clinics, CHC's and all Hospitals] by 2011/12.
		100% Complaints of public health users resolved within 25 days by 2011/12.
	Improve clinical governance and strengthen clinical and mortality	100% PHC supervision rate by 2014/15.

[15] Cumulative numbers determined by Project Plan – Quality Improvement Plans forms part of the strategy and are not mentioned separately in the strategic & Annual Performance Plan (included in Operational Plans)

Provincial Priorities for 2011/12	Planned Strategies and Activities	Targets 2011/12 – 2014/15
	reviews at hospitals. *[Expenditure per PDE will be reviewed following analysis by Budget Office with specific reference to 'Combo' Hospital expenditure]*	100% of Hospitals conduct monthly maternal mortality and morbidity reviews.
		Caesarean section rate: District Hospitals (26%); Regional (32%); Tertiary (60%); Central (63%).
		Average length of stay: District Hospitals (4.5 days); Regional (4.9 days); Tertiary (6.5 days); Central (6.5 days).
		Bed occupancy rate: District Hospitals (75%); Regional (75%); Tertiary (75%); Central (75%).
		Expenditure per patient day equivalent: District Hospitals (R1500); Regional (R1800); Tertiary (R3400); Central (R6000).
Strengthen Pharmaceutical Services.	Improve management of Pharmaceutical service delivery.	Reduce tracer medicines stock out rate to <4% in 2013/14 and <1% by 2014/14.
		Reduce tracer medicine stock-out rate in bulk store (Institutions) to <4% in 2011/12 and <2% in 2014/15.
		Reduce average patient waiting times for Pharmacy to <1 hour by 2011/12.
	Pharmaceutical Warehouse licensed in line with Good Manufacturing Practice Regulations and Pharmacies graded as per SAPC standards.	60% of Pharmacies obtained A or B grading on inspection by 2011/12 and 80% by 2014.
		PPSD 100% compliant with Good Manufacturing Practice Regulations by 2012/13.
4.4 Health infrastructure		
Improved physical infrastructure for healthcare delivery.	Align Infrastructure Plans with STP and National Infrastructure Plan.	Health Infrastructure Plan aligned and implemented.
	Deliver new clinical infrastructure in line with the STP and approved Infrastructure Programme Implementation Plan (IPIP) - address infrastructure backlogs.	Planning for 12 projects completed in 2011/12.
		Design completed for 25 projects in 2011/12.
		Construction completed for 6 projects in 2011/12.
		Commissioning completed for 24 projects in 2011/12.
	To upgrade and renovate existing clinical infrastructure in	89 Projects fully commissioned by 2014/15.

Provincial Priorities for 2011/12	Planned Strategies and Activities	Targets 2011/12 – 2014/15
	accordance with the STP and approved IPIP.	2.8% Equitable share capital as % of total health expenditure by 2011/12.
		9 Hospitals on revitalisation programme.
		0.71% Expenditure on facility maintenance as % of total health expenditure.
		Average backlog of service platform in fixed PHC facilities R272 666 (maintenance) and R2 538 679 (replacement).
		Equitable share capital programme 2% of total health expenditure by 2013/14.
		8 Hospitals funded on the Revitalisation Programme by 2013/14.
		Expenditure on facility maintenance 1.4% of total health expenditure by 2013/14
4.5 Information, Communication and Technology and Health Information Systems		
Increase investment and revitalise Information, Communication and Technology Services.	Implement the Master Systems Plan.	Implement MSP as per Implementation Plan
Improve health information systems and data management.	Implement Information Management Turn-Around Strategy including Health Information Systems, Data Management, and Monitoring & Evaluation.	Annual unqualified audit opinion for performance information.
		Results-based performance monitoring: – Four (4) quarterly reports [Treasury]; – Four progress reports on 10-Point Plan targets; and – Approved Annual Report tabled.
	Establish Provincial Health Information Committee.	Established by 2011/12 and quarterly meetings convened.

1.7 PROVINCIAL ORGANISATIONAL ENVIRONMENT

There were 64,924 employees in the KwaZulu-Natal Department of Health in 2009/10 compared with 67,594 in 2008/09. The ratio per 100 000 uninsured population in 2009/10 was 27.3/100 000 for Medical Officers; 135/100 000 for Professional Nurses, and 4.3/100 000 for Pharmacists.

Vacancy rates are high in critical positions, as indicated in the table below, with consistent annual increased recorded for Medical Officers (38.6% to 41.6%); Professional Nurses (21.4% to 25.7%); and Pharmacists (75.4% to 76.4%). Considerable variances between services are investigated as part of the process to develop the Minimum Staff Establishments for all facilities. Vacancy rates will impact on service delivery including revitalisation of PHC services, up-scaling of priority programmes i.e. HIV and AIDS, TB, MNC&WH and out-reach services.

The annual turnover rate showed a 1.1% decrease from 8.3% in 2008/09 to 7.2% in 2009/10. There has been a significant increase in the turnover rates for Medical Officers (21.3% to 26.5%) and Pharmacists (38.4% to 42.5%).

Table 7: Vacancy rates in critical positions

Medical Officers	Medical Specialists	Professional Nurses	Pharmacists	Dental Practitioners	Dieticians and Nutritionists	Occupational Therapists	Physiotherapists	Psychologists	Social Workers	Optometrists and Opticians
41.6%	65.9%	25.7%	76.4%	33.8%	73.8%	58.8%	58.2%	64.5%	81.7%	62.2%

Source: 2009/10 Annual Report – Oversight Report

The 2010/11 (Q2) doctor clinical workload was 1:24 and the Professional Nurse workload 1:43 with significant variances between individual services which indicates inadequate placement of staff and allocation of resources. This will be addressed through applying the Minimum Staff Establishment methodology as well as service transformation through the Service Transformation Plan.

Methodologies to develop appropriate staffing norms remains a challenge due to the complexities of health services in the Province including the type of services (urban and rural), high and low density populations with different service needs and demands, disease patterns and epidemiological profiles. The lack of appropriate staffing norms in turn impacts on costing of services.

The Department commenced with the review of the Service Transformation Plan in November 2010 to ensure that it is aligned with the National Health System (NHS) 10 Point Plan; the Negotiated Service Delivery Agreement (for Health); the Millennium Development Goals, burden of disease and specific Provincial needs/demands. Two new national

developments gave new impetus to this process namely the Green Paper on National Strategic Planning released in August 2009 by the Ministry of Planning in the Presidency, and a directive from the National Health Council in October 2009 that departments must produce long-term plans aligned with the NHS 10-Point Plan for 2009/1014.

Table 8 (A7): Public Health Personnel in 2009/10

Categories	Number Employed	% of Total Employed	Number per 100 000 people	Number per 100 000 Uninsured People	Vacancy Rate	% of Total Personnel Expenditure	Annual Cost per Staff Member
Medical Officers	2,698	4.2%	25.78	29.46	44.5%	12.5%	R 377 640.11
Medical Specialists	444	0.7%	4.24	4.85	71.4%	3.7%	R 680 764.01
Dentists	94	0.1%	0.9	1.03	35.2%	0.4%	R 363 028.56
Dental Specialists	0	0%	0.06	0.06	100%	-	-
Professional Nurses	13,219	20.5%	126.29	144.33	25.2%	31.7%	R 195 917.93
Staff Nurses	8,520	13.2%	81.4	93.02	19.7%	10.0%	R 96 189.98
Nursing Assistant	6,130	9.5%	58.52	66.93	23.7%	5.8%	R 77 182.73
Student Nurses	2,269	3.5%	21.67	24.77	17.1%	1.7%	R 62 634.41
Pupil Nurses	822	1.3%	7.85	8.97	37.5%	0.5%	R 54 381.26
Pharmacists	437	0.7%	4.17	4.77	75.5%	1.7%	R 320 896.92
Physiotherapists	222	0.3%	2.12	2.42	55.9%	0.4%	R 141 000.41
Occupational Therapists	101	0.2%	0.96	1.1	59.6%	0.2%	R 129 739.34
Radiographers	469[16]	0.7%	4.48	5.12	49.2%	0.9%	R 154 105.83
Emergency Medical Staff	2,804	4.4%	26.79	30.61	32.3%	3.5%	R 102 371.20
Nutritionists	3	0.0%	0.03	0.03	75.5%	0.0%	R 73 587.00
Dieticians	114	0.2%	1.09	1.24	72.2%	-	-
Community Care-Givers	9.334[17]						
Total	**38,346**	**59.6%**	**346.78**	**418.66**	**30.2%**	**73.3%**	**R 156 059**

Source: 2009/10 Annual Report – HR Oversight Report. Number employed includes Permanent and Temporary staff.

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

[16] Includes 11 Supplementary Diagnostic Radiographers

[17] Includes Youth Ambassadors (309); Community Health Carers (4,868); Home Based Carers (3,936); and EPWP (221)

1.8 LEGISLATIVE MANDATES AND NEW POLICY INITIATIVES

No new legislative mandates since the last Annual Performance Plan.

1.9 OVERVIEW OF THE 2010/11 BUDGET AND MTEF ESTIMATES

In 2009 Cabinet approved a multi-year intervention plan to address the deteriorating state of the fiscal management in the Department. In August 2009, the KZN Treasury Team was tasked, in terms of Section 18 of the PFMA, to assist the Department with financial management. Key results achieved to date:

- The 2010/11 projected expenditure is within budget.
- Dedicated finance management posts at institutions were created and are being filled.
- Investigations into fraud and corruption, criminal investigations, trials and disciplinary action resulted in significant savings on fruitless and wasteful expenditure as well as direct recoveries from the proceeds of crime over this financial year. This is expected to increase if the legal processes currently underway are concluded in favour of the Department.
- Budget planning was institutionalised and aligned to national and provincial priorities.
- Practical tools for resource allocation and financial performance reporting were developed and are being rolled out.
- Supply Chain Management (SCM) reforms were implemented. The Department currently participates in 32 national contracts and is in the process of setting up provincial contracts.
- Delegations are under review and will be finalised and approved in early 2011/12.

Despite a significant improvement in the baseline allocation in 2010/11, it should be noted that a portion of the available funds could not be utilised for service enhancement as it was specifically ring-fenced to provide for an increase in the Conditional Grant allocations and the different categories of Occupational Specific Dispensation (OSD) for doctors, emergency care workers, therapists, and psychiatric nurses.

The Department received significant additional funding for service enhancement and, along with reprioritisation, was able to strengthen key service delivery areas in line with national and provincial strategic priorities.

1.9.1 EXPENDITURE ESTIMATES

Table 9 (A8): Expenditure Estimates

Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Administration (1)	279 730	284 066	1 048 878	313 717	349 621	327 503	344 171	364 189	381 119
District Health Services (2)	7 209 609	8 132 272	9 188 678	10 392 247	10 393 762	10 042 432	11 739 824	12 631 495	13 682 800
Emergency Medical Services (3)	548 796	672 360	782 332	866 383	865 188	867 271	926 747	999 262	1 056 911
Provincial Hospital Services (4)	3 883 814	4 378 814	5 071 290	5 549 184	5 736 592	5 853 243	6 366 182	6 863 490	7 199 701
Central Hospital Services (5)	1 407 703	1 821 221	2 059 135	2 144 817	2 278 470	2 218 427	2 473 982	2 742 023	2 940 700
Health Sciences and Training (6)	524 333	676 601	793 186	808 491	893 227	864 093	933 442	998 695	1 064 081
Health Care Support Services (7)	12 649	34 209	27 528	10 764	10 764	10 764	13 971	15 170	16 004
Health Facilities Management (8)	1 092 807	1 103 558	1 378 249	1 572 018	1 592 562	1 454 411	1 686 536	1 710 800	1 848 108
Sub-total	**14 959 441**	**17 103 101**	**20 349 276**	**21 657 681**	**22 120 186**	**21 638 144**	**24 484 855**	**26 325 124**	**28 189 424**
Direct charges against the National Revenue Fund									
Total	**14 959 441**	**17 103 101**	**20 349 276**	**21 657 681**	**22 120 186**	**21 638 144**	**24 484 855**	**26 325 124**	**28 189 424**
Unauthorised expenditure (1st charge)			**(758 000)**						
Change to 2011/12 budget estimate	**14 959 441**	**17 103 101**	**19 591 276**	**21 657 681**	**22 120 186**	**21 638 144**	**24 484 855**	**26 325 124**	**28 189 424**

Source: BAS

Table 10 (A9): Summary of Provincial Expenditure Estimates by Economic Classification

Economic Classification	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Current payments	**13 543 139**	**15 467 893**	**17 550 235**	**19 489 701**	**19 895 546**	**19 483 495**	**21 844 207**	**23 590 845**	**25 479 507**
Compensation of employees	8 643 767	10 077 044	11 367 849	12 739 583	13 231 652	13 153 297	14 837 633	15 854 113	17 097 169
Goods and services	**4 899 372**	**5 390 849**	**6 182 386**	**6 750 118**	**6 663 894**	**6 330 198**	**7 006 574**	**7 736 732**	**8 382 338**
Communication	107 654	103 323	94 599	104 228	86 587	82 773	91 543	96 288	102 827
Computer Services	61 299	117 157	117 344	102 880	109 131	90 666	104 866	114 922	124 365
Consultants, Contractors and special services	694 510	745 782	905 262	935 911	868 568	687 795	810 683	908 245	1049 489
Inventory	2 567 864	2 774 215	3 420 796	3 817 436	3 786 904	3 726 096	4 043 398	4380 194	4 672 982
Operating leases	110 043	130 512	129 734	174 569	159 352	151 023	162 494	172 644	185 102
Travel and subsistence	81 473	66 148	37 430	47 329	41 382	38 597	43 789	46 939	55 820
Interest and rent on land									
Maintenance , repair and running costs	Included under Contractors and Inventory to avoid double counting								
Financial transactions in assets and liabilities	41	98	758 015		762	3 199			
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	1 276 529	1 453 712	1 477 221	1 567 765	1 611 970	1 553 248	1 749 801	2 017 500	2 245 117
Transfers and subsidies to	**345 325**	**446 661**	**495 327**	**518 832**	**565 661**	**573015**	**522 821**	**549 953**	**576 116**
Provinces and municipalities	62 810	50 493	81 058	90 920	135 256	135 051	94 173	98 884	104 320
Departmental agencies and accounts	17 119	39 957	34 312	18 640	18 401	18 401	22 137	24 133	25 009
Universities and technikons		40							

Economic Classification	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Non-profit institutions	199 011	243 734	278 846	313 614	296 617	296 617	266 787	280 227	295 639
Households	66 385	112 437	101 111	95 658	115 387	122 946	139 724	146 709	151 148
Payments for capital assets	**1 070 936**	**1 188 449**	**1 545 699**	**1 649 148**	**1 658 217**	**1 578 435**	**2 117 827**	**2 184 326**	**2 133 801**
Buildings and other fixed structures	623,762	635,593	1 005 258	1 097 525	1 117 217	916 524	1 357 938	1 295 069	1 436 729
Machinery and equipment	429 978	552 856	540 441	551 623	540 202	661 113	759 889	889 257	697 072
Software and other intangible assets	17,196								
Payment for financial assets	41	98	758 015		762	3 199			
Total economic classification	**14 959 441**	**17 103 101**	**20 349 276**	**21 657 681**	**22 120 186**	**21 638 144**	**24 484 855**	**26 325 124**	**28 189 424**
Unauthorised expenditure (1st charge) not available for spending			**(758 000)**						
Total	**14 959 441**	**17 103 101**	**19 591 276**	**21 657 681**	**22 120 186**	**21 638 144**	**24 484 855**	**26 325 124**	**28 189 424**

Source: BAS

1.10 RELATING EXPENDITURE TRENDS TO SPECIFIC GOALS

Table 11 (A10): Trends in Provincial Public Health Expenditure (R'000)

Expenditure	Audited/ Actual			Estimate	Medium Term Projections		
	2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
Current prices							
Total	R 14 959 441	R17 103 101	R19 591 276	R21 638 144	R24 484 855	R2 6 325 124	R 28 189 424
Total per person	R 1 460.65	R1 652.87	R1 874.92	R2 052.82	R2 305.06	R2 459.39	R 2 614.57
Total per uninsured person	R1 460.65	R1 652.87	R2142.76	R2 346.08	R2 634.36	R2 810.74	R 2 988.08
Constant (2008/09) prices							
Total	R 16 604 980	R17 103 101	R18 611 712	R19 474 330	R21 056 975	R22 639 607	R 24 242 905
Total per person	R 1 621.33	R1 652.87	R1 781.17	R1 847.54	R1 982.35	R2 115.08	R 2 248.53
Total per uninsured person	R 1 842.42	R1 878.26	R2 035.62	R2 111.47	R2 265.55	R2 417.23	R 2 569.75
% of Total spent on:-							
DHS	48.19%	47.55%	46.90%	46.41%	47.95%	47.98%	48.54%
PHS	25.96%	25.60%	25.89%	27.05%	26.00%	26.07%	25.54%
CHS	9.41%	10.65%	10.51%	10.25%	10.10%	10.42%	10.43%
All personnel	R 8 643 767	R10 077 044	R11 367 849	R13 153 297	R14 837 633	R15 854 113	R 17 097 169
Capital	R 736 636	R765 222	R1 137 536	R1 160 842	R1 435 696	R1 459 226	R1 547 188
Health as % of total public expenditure	33.6%	29.7%	29.4%	31.2%	31.0%	-	-

Source: BAS

Table 12 (A11): CPIX multipliers for adjusting current prices to constant 2007/08 prices

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

Source: National Department of Health

PART B

PROGRAMME 1. ADMINISTRATION

1.1. PROGRAMME PURPOSE AND STRUCTURE

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

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

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

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

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

There are no changes in the purpose of the Budget Programme (1) from information presented in the 2010 – 2014 Strategic Plan.

The performance of all support services (Administration), not specifically identified as priority in the Annual Performance Plan, will be included in Operational Plans and monitored quarterly to ensure effective performance and outcomes-based monitoring and reporting.

1.2. PRIORITIES

PRIORITY 1: Finalise the Service Transformation Plan (STP)

- Review the draft STP to incorporate new vision for health care delivery and service delivery needs/ demands.

PRIORITY 2: Implement the Financial Turn-Around Strategy to improve financial management and accountability

- Annual unqualified audit opinion on financial statements.
- Align budget with service delivery needs/demands - including STP imperatives.

PRIORITY 3: Improve Human Resource Management, Systems and Processes

- Review of organisational structure.
- Review and align the Provincial and District Human Resource Plans (HRP's) for Health with the STP and service delivery platform.

- Complete the Persal clean-up.
- Develop and implement training and development programmes including a Management Training Strategy; succession training; mentoring and team building programmes.
- Review Performance Management and Development policy, systems and processes.

PRIORITY 4: Implement the Health Information Turn-Around Strategy including Information Technology, Data Management and Monitoring & Evaluation.

- Implement the Master Systems Plan.
- Scale up implementation of Telemedicine.
- Establish the Provincial Health Information Committee as per National Health Act, 2003.
- Implement a data quality strategy to improve data completeness and quality and performance monitoring to ensure an annual unqualified audit opinion on performance information.
- Refine implementation of Results-Based Monitoring & Evaluation (M&E) and reporting.

SPECIAL PROJECTS COMMITTED TO DURING THE 2011/12 CABINET LEKGOTLA

Special Project outcomes will be monitored as part of Administration for feedback through the Social Cluster to the Premier. It however forms an integral part of the Provincial plans for the MTEF period.

- Green Economy: Recycling at hospitals, clinics, and exploring re-cycling of medical waste.
- Improve hotel aspects of institutions.
- Improve health technology equipment.
- Social sector opportunities i.e. Community Care Giver and Youth Ambassador Programmes.
- Out-reach programmes.
- HIV prevention.
- Cuban Programme.
- Bursary Programme.
- Mid-Level Worker Programme.

1.3. SITUATIONAL ANALYSIS AND PROJECTED PERFORMANCE FOR HUMAN RESOURCES

Table 13 (ADMIN1): Situation Analysis and Projected Performance for Human Resources

Indicators	Data Source	Type	Audited/ Actual Performance			Estimate[18]	Medium Term Targets		
			2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
1. Medical officers per 100,000 people	Persal	No	14.5	28	26	21.3	25.7	26	26
2. Medical officers per 100,000 people in rural districts	Persal	No	10.7	12	-	9.8	12	15	17
3. Professional nurses per 100,000 people	Persal	No	100.5	111	111	113.1	116.1	117	117
4. Professional nurses per 100,000 people in rural districts	Persal	No	95.2	50	-	95.6	98.2	99	100
5. Pharmacists per 100,000 people	Persal	No	13	5	4	3.7	3.9	3.9	3.9
6. Pharmacists per 100,000 people in rural districts	Persal	No	2.6	2	-	2.1	2.4	2.7	2.9
7. Vacancy rate for professional nurses	Persal	%	20.75%	21.3%	25.7%	32.1%	19%	18%	18%
8. Vacancy rate for doctors	Persal	%	35.2%	33.6%	41.6%	54.8%	32%	31%	30%
9. Vacancy rate for medical specialists	Persal	%	55.8%	61.6%	65.9%	73.3%	60%	59%	58%
10. Vacancy rate for pharmacists	Persal	%	73.8%	75.3%	76.4%	76.6%	75%	74%	73%

Source: Persal; 2010/11 APP

Note: Local Government Personnel have not been included

Rural Districts, for purpose of the above table, are Ugu, Umzinyathi, Zululand and Umkhanyakude (Rural Development Nodes). Note that all other districts have municipalities considered as rural.

The Department is in the process of restructuring and cleaning up Persal data. Vacancy rates and professionals per population ratios will as a result change following reviewed post establishments and verified Persal data. Targets are based on current Persal data and will therefore be reviewed during the cause of 2011/12.

[18] Estimate based on December 2010 Persal figures

1.4. PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR ADMINISTRATION

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 14 (ADMIN2): Provincial Strategic Objectives and Annual Targets for Administration

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
1.1) To finalise and implement Provincial Health Plans aligned with the NHS and MTSF priorities for 2010-2014.	1.1.1) Tabled 2011/12 – 2013/14 Annual Performance Plan (APP)	Annual tabling of APP as per Regulations	APP sign-off documents	Not relevant	Not relevant	Not relevant	Draft APP – compliant with timelines	APP tabled as per Regulations	-	-
	1.1.2) Number of approved 2011/12 District Health Plans	11 DHP's approved	DHP's sign-off documents	Not relevant	Not relevant	Not relevant	Draft DHP's – compliant with timelines	11 DHP's approved & signed off	-	-
1.2) To finalise and implement the approved 2010-2020 KZN STP.	1.2.1) Approved STP implemented as per Implementation Plan	Approved STP Implemented	STP	STP Phase 1	Phase 1 approved	Draft 2 of STP signed off by HOD and MEC	STP review & consultation commenced	STP approved, tabled and implemented	STP implemented Annual review	STP Implemented Annual review
1.3) To implement a decentralised Operational Model in 11 districts by 2011/12.	1.3.1) Number of District Managers who have signed delegations of authorities.	11/11	Signed delegations	New Indicator	New Indicator	New Indicator	4 / 11	11	11	11
	1.3.2) Number of Hospital Managers who have signed Performance Agreements (PA's).	75/75	Signed PA's	New Indicator	New Indicator	New Indicator	64 / 75	75	75	75

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
	1.3.3) Number of District Managers who have signed PA's.	11/11	Signed PA's	New Indicator	New Indicator	New Indicator	11 / 11	11	11	11
	1.3.4) Percentage of Head Office Managers (Level 13 and above) who have signed PA's.	100%	Signed PA's	New Indicator	New Indicator	New Indicator	21.8% (7/ 32)	100%	100%	100%
1.4) To implement the Financial Turn-Around Strategy to improve financial management and accountability in compliance with the PFMA.	1.4.1) Annual unqualified audit opinion for financial statements.	Unqualified audit opinion	Auditor-General's Report	New Indicator	New Indicator	Qualified audit opinion	Not yet audited	Unqualified audit opinion	Unqualified audit opinion	Unqualified audit opinion
	1.4.2) Zero over-expenditure.	Zero over-expenditure	BAS Annual Financial Statements	Over-expenditure R155 300m	Over-expenditure R1 034 013 billion	Over-expenditure R 1 320 116 billion	Annual Financial Statements not finalised.	Zero over-expenditure	Zero over-expenditure	Zero over-expenditure
	1.4.3) Number of approved District Health Expenditure Reviews (DHER).	11 Approved DHER Reports	Approved DHER sign-off documents	New indicator	New indicator	New indicator	10/11 DHER's approved & submitted	11	11	11
	1.4.4) Accurate financial disclosure of inventory and assets.	Unqualified audit opinion	Auditor General's Report	New indicator	New indicator	Qualified opinion	Annual Financial Statements not finalised	Unqualified audit opinion	Unqualified audit opinion	Unqualified audit opinion
1.5) To implement an Operational and Strategic Early Warning System.	1.5.1) Annual Departmental Risk Profile (Operational and Strategic).	Updated Risk profile and reports	Risk Profile and Reports	New indicator	New indicator	Commenced in Quarter 4	Risk Profile finalised	Risk profile monitored/ updated	Risk profile monitored/ updated	Risk profile monitored/ updated

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
1.6) Improve Human Resource management, systems and processes in line with Departmental business processes.	1.6.1) Persal data verified.	100% Persal data verified and system updated	Persal	New indicator	New indicator	New indicator	Persal clean-up commenced	100% Persal data verified and system updated	100% Persal data verified and system updated	100% Persal data verified and system updated
1.7) To implement an integrated Health Information Turn-Around Strategy to improve data quality and ensure annual unqualified audit opinion on performance information from the AGSA from 2010/11 – 2014/15.	1.7.1) Annual unqualified audit opinion on performance information.	Unqualified audit opinion	Auditor-General's Report	New indicator	New indicator	New indicator	Not yet audited	Unqualified audit opinion	Unqualified audit opinion	Unqualified audit opinion
	1.7.2) Master Systems Plan (MSP) implemented[19]	Approved MSP implemented	Business Plan and Reports	New indicator	New indicator	Tender cancelled	Tender awarded	MSP approved & implemented	MSP implemented	MSP implemented
	1.7.3) Table 2010/11 Annual Report.	Tabled as per Regulations	Annual Report tabling documents	Not relevant	Not relevant	Not relevant	2009/10 Annual Report tabled	2010/11 Annual Report tabled	-	-
	1.7.4) Four progress reports on implementation of the 10-Point Plan.[20]	Four progress reports	4 Reports	New indicator	New indicator	New indicator	3 Reports submitted	4/4 Reports submitted	4/4 Reports submitted	4/4 Reports submitted

[19] Implementation as per approved Implementation Plan
[20] The indicator has been changed from 4 quarterly reports to include the mid-term (6/12) and annual reports

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
1.8) Improve governance structures and social compact for health.[21]	1.8.1) Provincial Consultative Health Forum convened annually.	Established and convened annually	Minutes of meetings	New indicator	New indicator	New indicator	Convened	Convened annually	Convened annually	Convened annually
	1.8.2) Number of Districts that convened District Health Council meetings annually.	11/ 11 District Health Councils established and meetings convened annually	Minutes of meetings	New indicator	New indicator	New indicator	District Health Councils not established	3 District Health Councils established and annual meetings convened	6 District Health Councils established and annual meetings convened	7 District Council Health Councils established and annual meetings convened

Source: 2010/11 APP; 2009/10 Annual Report; Unit Managers

1.5. QUARTERLY TARGETS FOR 2011/12

Table 15 (ADMIN3): Quarterly Targets for 2011/12

Performance Indicators	Annual Targets 2011/12	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly					
1. Four progress reports on implementation of the 10-Point Plan.	4/ 4 Progress Reports	Progress report	Progress report	Progress report	Progress report
2. Vacancy rate for Professional Nurses	19%	It is expected that the vacancy rates will change with clean-up of Persal as well as review of organisational structures/staff establishments. These indicators/ targets will therefore be reviewed following finalisation of post establishments and Persal cleanup.			
3. Vacancy rate for Doctors	32%				
4. Vacancy rate for Medical Specialists	60%				
5. Vacancy rate for Pharmacists	75%				
Annual					
6. Persal data verified.	100% Persal data verified				100% Persal data verified
7. Tabled 2011/12 – 2013/14 APP	APP tabled as per Treasury Regulations	APP approved and tabled			
8. Number of approved 2011/12 District Health Plans	11 approved DHP's	11 DHP's approved			
9. Approved STP implemented as per Implementation Plan	STP approved, tabled and implemented				STP approved, tabled and implemented
10. Number of District Managers who have signed delegations of authorities.	11	11			
11. Number of District Managers who have signed Performance Agreements.	11	11			
12. Number of Hospital Managers/ CEO's who have signed Performance Agreements.	75	75			
13. Percentage of Head Office Managers (Level 13 and above) who have signed Performance Agreements.	100%	100%			

Performance Indicators	Annual Targets 2011/12	Quarterly Targets			
		Q1	Q2	Q3	Q4
14. Annual unqualified audit opinion for financial statements.	Unqualified audit opinion		Unqualified audit opinion		
15. Zero over-expenditure.	Zero over-expenditure				Zero over-expenditure
16. Number of District Health Expenditure Reviews (DHER) completed.	11	11			
17. Accurate financial disclosure of inventory and assets in Annual Financial Statements.	Unqualified audit opinion		Unqualified audit opinion		
18. Annual Departmental Risk Profile (Operational and Strategic).	Risk profile finalised/ monitored/ updated	Risk Profile finalised	Monitoring/reporting	Monitoring/reporting	Monitoring/reporting
19. Annual unqualified audit opinion on performance information.	Unqualified audit opinion		Unqualified audit opinion		
20. Master System Plan implemented[22]	MSP approved & implemented				MSP implemented as per Business Plan
21. Tabled Annual Report.	Annual Report tabled as per Regulations		Annual Report tabled		
22. Provincial Consultative Health Forum convened annually.	Meeting convened				Meeting convened
23. Number of District Health Councils convened annually.	3				3

[22] Implementation as per approved Implementation Plan

1.6. SPECIAL PROJECTS: 2011 PROVINCIAL CABINET LEKGOTLA

Table 16: Special Projects from Provincial Cabinet Lekgotla

Programmes	Projects	Potential Jobs Created	Timeframes	Comments
1. Green Economy	Recycling at hospitals	100	2011/12	All districts
	Recycling at clinics	580	2012/13	
	Explore re-cycling of medical waste	10	2011/12	
2. Improve Hotel Aspects of Health Facilities	Maintenance Teams	180	2011/12	5 Teams per district and 10 in eThekwini
3. Improving Health Technology Equipment	Training of Health Technology Engineers at Tswane University	23	2010/11	All districts identified in Operation Sukuma Sakhe
		30	2011/12	
		40	2012/13	
4. Social Sector Opportunities	Integration of the Community Care Giver and Youth Ambassador Programmes	14,548	2011/12 and ongoing	Equitable ward distribution
5. Outreach Programmes	Staff Nurses and Nursing Assistants – Tracer Teams, School Health, and Medical Male Circumcision Community Health Workers for extension of PHC	3,000	2011/12	Needs-based in all districts
6. HIV Prevention	Male condom distribution	66	Ongoing	2 Service providers per district
	Improve programmes at Truck Stops	8	2011/12	Ugu (Port Shepstone); Umgungundlovu (Mooi River)
		16	2012/13	Umkhanyakude (Jozini); Uthungulu (Umtunzini)
		24	2013/14	Uthukela (Harrismith and Estcourt); eThekwini (Marrianhill)
7. Cuban Programme	Bursaries	20	2011/12	Needs based in all districts
8. Bursary Programme	Skilling of Health Sciences Students	842	2011/12	Needs based in all districts

Programmes	Projects	Potential Jobs Created	Timeframes	Comments
9. Mid-Level Worker Programme (*See note)*	Up skilling employees	110 existing, anticipate to create 50 as project progresses	2011/15	Needs based in all districts

Source: From the 2011 Provincial Cabinet Lekgotla

NOTE: Mid-Level Worker Programme: Progress will depend on the availability of start-up funds for Tertiary Institutions - programmes are not available in their mainstream programmes. The Human Resource Development Directorate cannot allocate funds for start-up from the 1% budget allocated for Training and Development. The Department is expected to get funds from Grants.

1.7. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 17 (ADMIN4 (a): Expenditure estimates: Administration

Sub-Programme R' thousand	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
MEC's Office	11 898	13 782	12 441	16 792	15 454	13 336	16 491	17 425	17 674
Management	267 832	270 284	1 036 437	296 985	334 167	314 167	327 680	346 764	363 445
Sub-Total	**279 730**	**284 066**	**1 048 878**	**313 777**	**349 621**	**327 503**	**344 171**	**364 189**	**381 119**
Unauthorised expenditure (1st charge) not available for spending			**(758 000)**						
Total	**279 730**	**284 066**	**290 878**	**313 777**	**349 621**	**327 503**	**344 171**	**364 189**	**381 119**

Source: BAS

Table 18 (ADMIN4 (b): Summary of Provincial Expenditure Estimates by Economic Classification

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Current payments	**274 965**	**279 415**	**285 963**	**311 737**	**339 502**	**317 062**	**336 961**	**356 854**	**373 252**
Compensation of employees	141 966	163 648	168 705	196 478	184 269	189 057	202 290	216 450	231 601
Goods and services	**132 999**	**115 767**	**117 258**	**115 259**	**155 233**	**128 005**	**134 671**	**140 404**	**143 651**
Communication	9 594	6 546	6 095	5 941	9 941	5 911	7 460	7 843	8 084
Computer Services	13 036	17 812	24 532	19 098	25 574	21 545	22 821	23 952	24 665
Consultants, Contractors and special services	30 352	8 110	10 588	6 269	19 294	11 095	11 172	10 730	10 082
Inventory	9 266	5 899	5 795	8 155	7 285	6 428	7 218	7488	7 804

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Operating leases	10 212	14 722	10 670	17 073	18 500	14 891	13 619	14 415	14 753
Travel and subsistence	13 589	15 378	9 521	11 892	12 630	12 570	14 311	14 826	15 277
Interest and rent on land									
Maintenance , repair and running costs	Included under Contractors and inventory to prevent double counting								
Financial transactions in assets and liabilities	41		758 000						
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	46 950	47 300	50 057	46 831	62 009	55 565	58070	61 150	62 986
Transfers and subsidies to	**1 701**	**2 161**	**2273**	**1275**	**1275**	**1497**	**2510**	**2635**	**2767**
Provinces and municipalities	12	4							
Departmental agencies and accounts									
Universities and technikons									
Non-profit institutions									
Households	1 701	2 161	2273	1275	1275	1497	2510	2635	2767
Payments for capital assets	**3 023**	**2 490**	**2642**	**765**	**8844**	**8944**	**4700**	**4700**	**3100**
Buildings and other fixed structures									
Machinery and equipment	3 011	2 490	2642	765	8844	8944	4700	4700	3100
Software and other intangible assets	12								
Total economic classification	**279 730**	**284 066**	**1 048 878**	**313 777**	**349 621**	**327 503**	**344 171**	**364 189**	**381 119**
Unauthorised expenditure (1st charge) not available for spending			**(758 000)**						
Total	**279 730**	**284 066**	**290 878**	**313 777**	**349 621**	**327 503**	**344 171**	**364 189**	**381 119**

Source: BAS

1.8. PERFORMANCE AND EXPENDITURE TRENDS

In 2009/10, an instalment of R758 million was charged against the budget which was the first charge of previous years' over-expenditure. This is reflected as a footnote in Table Admin5 (a) and Table Admin5 (b) above. This was not continued in 2010/11 and a final decision regarding the historic over-spending will be taken by SCOPA.

The significant increase from 2009/10 (excluding the first charge) to the 2010/11 Main Appropriation relates mainly to the need to improve management capacity at Head Office, as well as the carry-through costs of the 2009 wage agreement. The notable increase in the 2010/11 Adjusted Appropriation results mainly from the reprioritisation of funding for the interim use of consultants to address capacity constraints and to provide for forensic investigations. An additional amount of R6 million was reprioritised to replace essential computer equipment to reduce the risk of critical financial data being lost. The reduction in the 2010/11 Revised Estimate is mainly due to the cost of SITA computer services, consultants and lease payments against *Goods and Services* being lower than anticipated.

The minimal increase in *Compensation of Employees* in 2009/10 is due to the moratorium on the filling of non-critical posts. The reduction in the 2010/11 Adjusted Appropriation relates to the filling of posts being slower than expected. The increase over the 2011/12 MTEF allows for inflationary increases only.

In 2007/08, *Goods and Services* included once-off expenditure relating to the move to Trison Towers, as well as an amount of R3.600 million for legal fees related to interventions aimed at countering the effects of the nurses' strike. The negative growth from 2008/09 to the 2010/11 Main Appropriation results from the slowing down of the restructuring process at Head Office, as well as enforced savings to curb the Department's overall expenditure. Funding from other areas was reprioritised to this category in the 2010/11 Adjusted Appropriation to provide for interim personnel capacity and for forensic investigations.

The decreasing trend in *Machinery and Equipment* from 2008/09 to the 2010/11 Main Appropriation relates to the reprioritisation of the budget. The increase in the 2010/11 Adjusted Appropriation relates to the provision for essential computer equipment and for the replacement of motor vehicles at Head Office.

The fluctuating trend in *Transfers and Subsidies to Households* is due to the exit costs of staff.

1.9. RISK MANAGEMENT

Potential Risks	Mitigating Factors
▪ High vacancy rate at Senior Management level.	▪ Organisational review and filling of vacant posts - commenced in 2010/11.
▪ Lack of an approved and costed long-term planning framework – negative impact on resource allocation and service delivery.	▪ Review of the STP commenced in 2010/11 including Service Delivery Plan and Platform as vehicle through which plans will be aligned and costed.

Potential Risks	Mitigating Factors
▪ Alignment of budget and service delivery needs/demands – especially relevant to the lack of information on the current burden of disease and impact on service delivery.	▪ Analysis of budget versus service delivery needs/demands commenced in 2010/11. Regular expenditure/service delivery reviews, facilitated by the Budget and Service Delivery Units.
▪ Vertical and inadequate information systems and processes including DHIS, ETR.Net, Persal and BAS. This impact on accuracy of reporting and affect evidence-based planning, decision-making and resource allocation.	▪ Implementation of the information turn-around strategy (commenced in 2010/11).
▪ Inadequate management capacity and lack of development opportunities in the Department including training and development, succession training and mentoring programmes.	▪ Training and development programmes for managers including succession training, mentoring programmes to improve management capacity.

PROGRAMME 2. DISTRICT HEALTH SERVICES

2.1. PROGRAMME PURPOSE AND STRUCTURE

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

Sub-Programme 2.1: District Management

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

Sub-Programme 2.2: Community Health Clinics

To render a nurse driven primary health care service at clinic level including visiting points, mobiles and local government clinics.

Sub-Programme 2.3: Community Health Centres

To render primary health care services in respect of maternal child and women's health, geriatrics, occupational therapy, physiotherapy, psychiatry, speech therapy, communicable diseases, oral and dental health, mental health, rehabilitation and disability and chronic health.

Sub-Programme 2.4: Community-Based Services

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

Sub-Programme 2.5: Other Community Services

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

Sub-Programme 2.6: HIV and AIDS

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

Sub-Programme 2.7: Nutrition

To render nutrition services.

Sub-Programme 2.8: Forensic Pathology Services

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

Sub-Programme 2.9: District Hospitals

To render hospital services at general practitioner level.

There are no changes in the purpose of the Budget Programme (2) since the 2010 – 2014 Strategic Plan.

Programme performance for District Health Services, not specifically identified as priority in the Annual Performance Plan, will be included in Operational Plans and monitored quarterly to ensure effective performance and outcomes-based monitoring and reporting.

2.2. PRIORITIES

PRIORITY 1: Revitalisation of PHC.

- Implement the revised PHC Model (linked with Operation Sukuma Sakhe).
- Improve detection, screening and management of non-communicable diseases.
- Improve clinical governance.
- Maintain preventive strategies for malaria control/ elimination.
- Provincialisation of Local Government PHC services.

PRIORITY 2: Decrease HIV incidence and manage HIV prevalence.

- Scale up implementation of the National Strategic Plan for HIV & AIDS and STI's.
- Strengthen HIV-TB integration.
- Improve inter-sectoral collaboration for interventions in High Transmission Areas.
- Scale up access to ART services – expand ART initiation to PHC level.
- Intensify the voluntary Male Medical Circumcision campaign.
- Scale up the HIV Counselling and Testing (HCT) campaign.

PRIORITY 3: Reduce TB incidence and improve TB outcomes.

- Scale up implementation of the TB Crisis Plan.
- Expand Community Management of MDR TB.
- Strengthen TB Advocacy, Communication and Social Mobilisation.
- Integrate the DOT Support, surveillance for early detection of TB, and follow up of defaulters into Operation Sukuma Sakhe.

PRIORITY 4: Reduce maternal and child morbidity and mortality through implementation of the "Maternal and Child Health Road Map to 2014".

- **Maternal Health: Improving access to Basic and Emergency Obstetric Care**
  - Increase access to safe delivery through establishment of basic emergency obstetric care in strategic areas.
  - Improve referral and transport by introducing specialized ambulances for maternity and paediatric care.

- Improve HAART access for pregnant women by increasing capacity of Professional Nurses to initiate ARV's.
- Improve staff competency/ skills and improve quality of clinical care through the introduction of mentorship teams (including obstetricians and paediatricians).
- Establish waiting mother's lodges in all District Hospitals.
- Strengthen mortality reviews in hospitals.

- **Neonatal Health: Improve the quality of neonatal care in District and Regional Hospitals**
  - Establish a neonatal experiential learning site and outreach programme in each of 3 Service Areas.
  - Ensure functional neonatal resuscitation units in all labour wards and nurseries.
  - Ensure functional high care beds in all nurseries (1 per District Hospital and 2 per Regional Hospital).

- **Child Health: Implement a package of prevention programmes to reduce trends in morbidity and mortality.**
  - Implement the community-based Maternal and Child Health Framework and integrate with Operation Sukuma Sakhe.
  - Back to the basics of GOBI FFF (growth monitoring, oral rehydration therapy, breastfeeding, immunisation, family spacing (planning), female education, food supplementation) through Operation Sukuma Sakhe.
  - Scale up implementation of the Integrated Management of Childhood Illnesses (IMCI).

- Implement the Contraceptive Strategy to reduce unplanned, unwanted and unsafe pregnancies.
- Scale up the Phila Ma Campaign to reduce the incidence of cervical cancer through improved screening and management of abnormal Pap smears.
- Scale up implementation of the Accelerated PMTCT Programme.

PRIORITY 5: Improve the efficiency and quality of health services.

- Implement the National Core Standards for Quality and monitor Quality Improvement Plans in preparation for accreditation of facilities.
- Expand the "Look like a Hospital Project" to improve hospital efficiency, quality, patient safety and satisfaction.

  Note: *Accreditation by the National Accreditation Body will be dependent on national processes.*

2.3. DISTRICT HEALTH SERVICES

The PHC approach will be the underlying philosophy for transformation of the health system. The main focus over the next ten years will be to change the main service delivery focus from the management of "illness" to promoting and sustaining "health and wellness" in line with governments' commitment to improve the lives of all South Africans through improved integration, partnerships and consultation – shifting from a passive to a pro-active approach. The preferred model makes provision for:

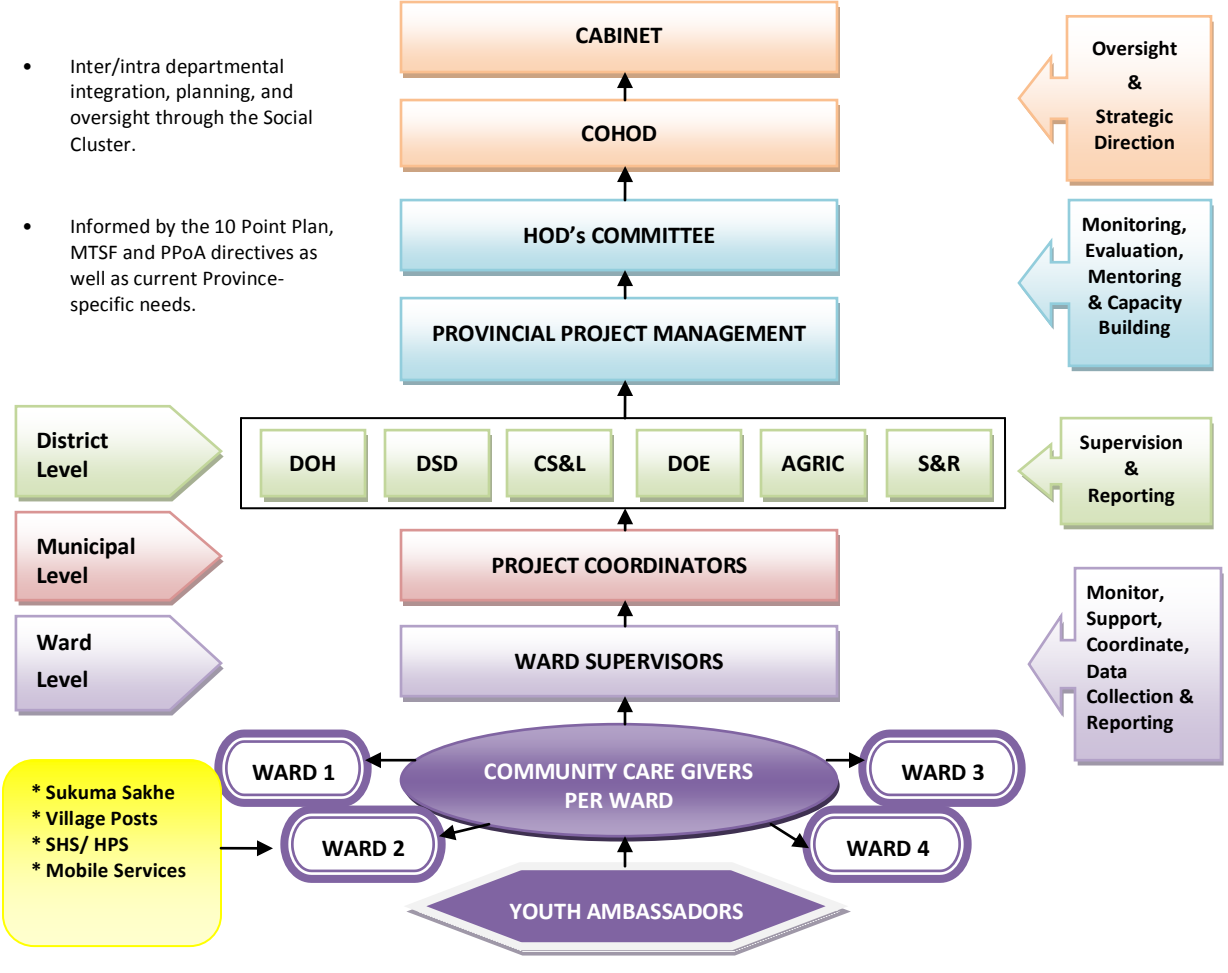
- A dynamic and flexible comprehensive and integrated PHC system that can adapt to changing disease profiles and community needs – not a "one size fits all" approach.
- The development of communities (through integrated community-based programmes) to promote self-reliance in personal and community health and well-being.
- Strengthening of the District Health System (DHS) to reduce bottlenecks in service delivery, improved resource management, and promote innovation and adaptability in response to evidence-based needs.
- Expanding the range of PHC services to address epidemiological and demographic transition.
- Integration of vertical programmes/services at community and facility level with the necessary oversight arrangements.
- Appropriate development, training and distribution of a balanced and skilled health workforce.
- Improved information technology, systems and management (including expansion of Telemedicine) to strengthen training and development and improve quality. This will improve collection and use of data thus addressing the perennial challenges of poor quality of data.
- Improved outcomes-based monitoring and evaluation including health determinants and co-morbidities; equity in service provision; responsiveness to service needs; user satisfaction; and community engagement.
- Strengthening of leadership and governance including capacity to formulate evidence-based health policies and strategic plans; and to promote the values of PHC.
- Commit to increased financing for PHC; partnerships; coordination and integration; and improved accountability and transparency in service delivery.

A development paradigm where community involvement is lacking is unsustainable and ineffective. An alternative paradigm that instils community self reliance, builds on indigenous and traditional coping mechanisms, and acknowledges and respects the close interconnectedness between people is critical to improve buy-in to programmes and involvement. There is thus a real challenge and opportunity for the Province to adjust service delivery and mechanisms for the development of communities through active engagement.

The implementation of integrated developmental community-based services, delivered by an integrated pool of cadres as the first point of contact for community-based services, and effectively linked with facility-based services, will assist in streamlining programmes and contribute to economies of scale and improved health outcomes as eluded to in the

National Health System 10 Point Plan and Negotiated Service Delivery Agreements. The figure below illustrates the community-based model that will form part of revitalisation of PHC over the coming years.

Figure 2: Integrated Community-Based Model



Facility-based PHC services will focus on issues of access, equity, utilisation, quality, appropriate referral, PHC infrastructure and maintenance, human resources for effective service delivery, appropriate package of services, training and development including mentoring and succession training, and provincialisation of Local Government PHC services.

Table 19 (DHS1): District Health Service Facilities by Health Districts in 2009/10

Health District	Facility Types	No.	Uninsured Population	Population per PHC Facility/ Hospital Bed[23]	Per Capita Utilisation
Ugu	Non-fixed clinics	15	711,637 (94%)	47,442	0.3
	Fixed clinics	51		13,954	2.1
	CHC's	0		0	0
	Sub-total	**66**		10,782	2.4
	District Hospitals	3		427	0.05
Umgungundlovu	Non-fixed clinics	17	890,884 (85%)	52,401	0.3
	Fixed clinics	47		18,954	1.7
	CHC's	4		222,721	0.9
	Sub-total	**68**		13,920	3.0
	District Hospitals	2		848	0.3
Uthukela	Non-fixed clinics	15	659,273 (95%)	43,952	0.4
	Fixed clinics	35		18,836	1.7
	CHC's	0		0	0
	Sub-total	**50**		12,208	2.1
	District Hospitals	2		768	0.3
Umzinyathi	Non-fixed clinics	11	484,359 (95%)	44,033	0.4
	Fixed clinics	40		12,109	1.9
	CHC's	0		0	0
	Sub-total	**51**		9,497	2.2
	District Hospitals	4		215	0.09
Amajuba	Non-fixed clinics	7	472,768 (93%)	67,538	0.2
	Fixed clinics	21		22,515	1.9
	CHC's	0		0	0
	Sub-total	**28**		16,885	2.1
	District Hospitals	1		4,221	0.01
Zululand	Non-fixed clinics	18	792,124 (94%)	44,007	0.4
	Fixed clinics	57		13,897	1.6
	CHC's	1		10,422	0.2
	Sub-total	**76**		10,423	2.2
	District Hospitals	5		311	0.06
Umkhanyakude	Non-fixed clinics	14	614,507 (95%)	43,893	0.4
	Fixed clinics	52		11,817	2.5

[23] District breakdown of headcounts (PHC; CHC's & Mobiles) and separations for District Hospitals

Health District	Facility Types	No.	Uninsured Population	Population per PHC Facility/ Hospital Bed[23]	Per Capita Utilisation
	CHC's	0		0	0
	Sub-total	**66**		9,311	2.9
	District Hospitals	5		299	0.07
Uthungulu	Non-fixed clinics	13		64,616	0.2
	Fixed clinics	54		15,556	2.2
	CHC's	1	840,006 (88%)	840,006	0.3
	Sub-total	**68**		12,353	2.8
	District Hospitals	6		372	0.04
Ilembe	Non-fixed clinics	10		57,256	0.2
	Fixed clinics	30		19,085	2.1
	CHC's	2	572,563 (92%)	28,628	0.7
	Sub-total	**42**		13,632	3.0
	District Hospitals	3		747	0.02
Sisonke NOTE: Umzimkulu identified as Rural Development Node.	Non-fixed clinics	13		36,401	0.3
	Fixed clinics	33		14,340	1.6
	CHC's	1	473,217 (94%)	473,217	0.1
	Sub-total	**47**		10,068	2.0
	District Hospitals	4		618	0.09
eThekwini	Non-fixed clinics	41		67,898	0.1
	Fixed clinics	113		24,636	1.8
	CHC's	8	2,783,814 (82%)	347,977	0.9
	Sub-total	**162**		17,184	2.9
	District Hospitals	4		1,723	0.02
Province	Non-fixed clinics	174		53,420	0.3
	Fixed clinics	533		17,439	1.9
	CHC's	17	9, 295,152 (88.6%)	546,774	0.5
	Sub-total	**724**		12,839	2.6
	District Hospitals	39		571	0.04

Source: 2009/10 Annual Report & DHER Reports

2.4. SITUATION ANALYSIS INDICATORS FOR DISTRICT HEALTH SERVICES

Table 20 (DHS2): Situation Analysis Indicators for District Health Services

Indicator	Data Source	Provincial 2009/10	Ugu 2009/10	Umgungundlovu 2009/10	Uthukela 2009/10	Umzinyathi 2009/10	Amajuba 2009/10	Zululand 2009/10	Umkhanyakude 2009/10	Uthungulu 2009/10	Ilembe 2009/10	Sisonke 2009/10	eThekwini 2009/10	National Average 2009/10
1. Provincial PHC expenditure per uninsured person	BAS Stats SA	R 260	R255	R 509	R 350	R 698	R 423	R 557	R 522	R 487	R 540	R 303	R 498	-
2. *PHC total headcount	DHIS	25,921,993	1,893,398	2,818,467	1,465,814	1,260,765	1,090,730	1,858,807	1,835,395	2,329,608	1,745,001	1,047,547	8,576,461	117,674,357
3. *PHC total headcount under 5 years	DHIS	5,184,242	358,196	467,960	323,310	346,017	246,356	432,102	376,063	490,892	319,120	230,544	1,593,682	22,882,694
4. Utilisation rate – PHC	DHIS	*2.6	2.5	*2.8	2.1	2.5	2.2	*2.4	*3.0	*2.5	*2.9	2.1	*2.7	2.5
5. Utilisation rate under 5 years - PHC	DHIS	*4.6	*4.2	4.0	4.0	5.1	4.6	*4.2	*4.3	*4.5	*4.8	3.5	*5.5	4.7
6. Fixed PHC facilities with a monthly supervisory visits rate	DHIS	*68%	*79%	*39%	*34%	*64%	*74%	*53%	*93%	*76%	*57%	*69%	*82%	-
7. Expenditure per PHC visit	BAS	R95	R93	R112	R96	R122	R111	R128	R81	R86	R119	R101	R81	-
8. CHC's with resident doctor	DQPR	17/17	-	4/4	-	-	-	1/1	-	1/1	2/2	1/1	8/8	70.6%
9. Percentage of	DQPR	New	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	-

Indicator	Data Source	Provincial 2009/10	Ugu 2009/10	Umgungundlovu 2009/10	Uthukela 2009/10	Umzinyathi 2009/10	Amajuba 2009/10	Zululand 2009/10	Umkhanyakude 2009/10	Uthungulu 2009/10	Ilembe 2009/10	Sisonke 2009/10	eThekwini 2009/10	National Average 2009/10
complaints of users of PHC services resolved within 25 days		indicator												
10. Number of PHC facilities assessed for compliance against the 6 priorities of the core standards	DQPR	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	-

Source: DHIS unless otherwise indicated

[*] denotes data that has been corrected and verified since the 2009/10 Annual Report

Rural Development Nodes (including Umzimkulu in Sisonke District) highlighted

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

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 21 (DHS3 (a): Provincial Strategic Objectives, Performance Indicators and Annual Targets for District Health Services

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Sources	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
1.9) Strengthen governance structures and social compact for health.[24]	1.9.1) Percentage of Clinic Committees (PHC) appointed (cumulative - 10% per annum).	50% of the total number of clinics	DQPR & Corporate Governance database	New indicator	81% Interim	82% 437/533 interim	72.9% 422/579 interim	20%[24]	30%[24]	40%[24]
	1.9.2) Percentage of Clinic Committees (CHC) appointed (cumulative per annum).	100% of total number of CHC's	DQPR & Corporate Governance database	New indicator	81% Interim	81% 14/17 interim	88.2% 15/17 interim	62%[24]	94%[24]	100%[24]
	1.9.3) Percentage of Hospital Boards appointed (cumulative per annum).	100% of total number of District Hospitals	DQPR & Corporate Governance database	New indicator	89% Interim	93% 69/75 interim	72.2% 54/75 interim	55%[24]	100%[24]	100%[24]
1.10) Revitalisation of PHC services as	1.10.1) Number of accredited Health Promoting Schools	230 (2013/14)	DQPR	79	131	170	172	190	228	230

[24] Appointment according to the National Health Act, 2003 (managed by Administration) and relevant to Programmes 2, 4 & 5 – current Committees and Boards are interim structures

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Sources	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
per STP imperatives and Implementation Plan[25]	1.10.2) School Health Services coverage	70% (2013/14)	DQPR	57%	46%	74%	75%[26]	75%	76%	78%

Source: 2010/11 APP for 2007/08 and 2008/09 actual data and medium term targets for 2011/12 & 2012/13; 2009/10 data from 2009/10 Annual Report unless otherwise indicated

Note: [*] denotes data that has been corrected and verified since the 2009/10 Annual Report – part of the Information Turn-Around strategy (data clean-up)

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

[26] From DQRS: Indicator reads: % of schools visited for Grade 1 assessments

GOAL 2: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

Table 22 (DHS3 (b): Provincial Strategic Objectives and Annual Targets for District Health Services

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
2.1) To implement the National Core Standards for Quality in 100% of facilities towards accreditation of 50% PHC clinics and 100% CHC's by 2014/15[27]	2.1.1) Percentage of PHC clinics accredited	50% by 2014/15	Accreditation Body database	New indicator	New indicator	New indicator	Accreditation Body not yet established	5%[28]	+10%[28]	+10%[28]
	2.1.2) Percentage of CHC's accredited	100% by 2014/15	Accreditation Body database	New indicator	New indicator	New indicator	Accreditation Body not yet established	19%[28]	37% - cumulative[28]	47% - cumulative[28]
	2.1.3) Percentage of CHC's conducting annual Patient Satisfaction Survey's	100%	DQPR	No data	No data	90% (12/17)	59%[29] (8/17)	100%	100%	100%
	2.1.4) Average patient waiting time in CHC's	≤1hr	DQPR	New indicator	New indicator	New indicator	Verified data not available	<4 ½ hrs	<4 hrs	<2hrs

Source: 2010/11 APP 2007/08 and 2008/09 actual & medium term targets for 2011/12 & 2012/13; 2009/10 Annual Report for 2009/10 Actual

[27] Accreditation of facilities will be dependent on national processes i.e. establishment of the National Accreditation Board and capacity to comply with demand for accreditation
[28] National accreditation of facilities is dependent on national processes – this will not deter from complying to norms and standards
[29] This is not including the facilities that are planning a survey before the end of the year – data therefore not a true reflection of performance

Table 23 (DHS4): Performance Indicators for District Health Services

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Provincial PHC expenditure per uninsured person	BAS Stats SA	R	R184.39	R232.29	R260.26	R271.05	R 303	R340	R 381	-
2. PHC total headcount	DHIS	No	21,260,261	23,838,854	*25,921,993	25,243,274	25,901,744	27,095,074	28,309,683	-
3. PHC total headcount under 5 years	DHIS	No	4,441,983	4,705,692	*5,184,242	5,036,238	5,670,572	6,100,204	6,500,563	-
4. Utilisation rate - PHC	DHIS	No	2.3	2.5	*2.6	2.4	2.8	2.9	3	3.5
5. Utilisation rate under 5 years - PHC	DHIS	No	4.2	4.4	*4.6	4.5	4.7	5	5.2	5.5
6. Percentage of fixed PHC facilities with a monthly supervisory visit	DHIS	%	54%	65%	*68%	63% (364/579)	80%	85%	90%	100%
7. Expenditure per PHC visit	BAS DHIS	R	R 97	R 89	R 95	R 99	R 110	R 115	R 120	R 180
8. CHC's with a resident doctor rate	DQPR	%	New indicator	New indicator	100%	84% (14/17)	100%	100%	100%	100%
9. Percentage of complaints of users of PHC services resolved within 25 days	DQPR	%	New indicator	New indicator	New indicator	New indicator	100%	100%	100%	100%
10. Percentage of PHC facilities assessed for compliance against the 6 priorities of the core standards	DQPR	Report	New indicator	New indicator	New indicator	New indicator	100%[30]	100%	100%	All facilities

Source: 2010/11 APP (2007/08 and 2008/09); 2009/10 Annual Report (2009/10 actual)

Note: [*] denotes data that has been corrected and verified since the 2009/10 Annual Report

[30] The indicator is not clear – if it means routine assessment (as part of supervision) it should be 100%.

2.4.2. QUARTERLY TARGETS FOR DISTRICT HEALTH SERVICES

Table 24 (DHS5): Quarterly Targets for District Health Services 2011/12

Performance Indicators	Annual Targets 2011/12	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly					
1. Provincial PHC expenditure per uninsured person	R 303	R 279	R 287	R 295	R 303
2. PHC total headcount	25,901,744	6,475,436	6,475,436	6,475,436	6,475,436
3. PHC total headcount under 5 years	5,670,572	1,417,643	1,417,643	1,417,643	1,417,643
4. Utilisation rate - PHC	2.8	2.6	2.6	2.7	2.8
5. Utilisation rate under 5 years - PHC	4.7	4.6	4.6	4.7	4.7
6. Percentage of fixed PHC facilities with a monthly supervisory visit	80%	68%	70%	74%	80%
7. Expenditure per PHC visit	R 110	R 100	R 100	R 105	R 110
8. CHC's with resident doctor rate	100%	88%	88%	94%	100%
9. Percentage of complaints of users of PHC services resolved within 25 days[31]	100%	100%	100%	100%	100%
Annual					
10. Number of accredited Health Promoting Schools	190				190
11. School Health Services coverage	75%				75%
12. Percentage of PHC clinics accredited	5%				5%
13. Percentage of CHC's accredited	19%				19%
14. Percentage of CHC's conducting annual Patient Satisfaction Survey's	100%				100%
15. Average patient waiting time in CHC's	<4 ½ hrs				<4 ½ hrs
16. Percentage of PHC facilities assessed for compliance against the 6 priorities of the Core Standards	Routine 100%				Routine 100%
17. Percentage of Clinic Committees (PHC) appointed (cumulative - 10% per annum).	20%				20%
18. Percentage of Clinic Committees (CHC) appointed (cumulative per annum).	62%				62%
19. Percentage of Hospital Boards appointed (cumulative per annum).	55%				55%

[31] Refers to the complaints resolved within 25 days of receiving it – not the number resolved per month

2.6. SITUATION ANALYSIS INDICATORS FOR DISTRICT HOSPITALS

Table 25 (DHS6): Situation Analysis Indicators for District Hospitals

Indicator	Data Source	Provincial 2009/10	Ugu 2009/10	Umgungundlovu 2009/10	Uthukela 2009/10	Umzinyathi 2009/10	Amajuba 2009/10	Zululand 2009/10	Umkhanyakude 2009/10	Uthungulu 2009/10	Ilembe 2009/10	Sisonke 2009/10	eThekwini 2009/10	National Average 2009/10
1. Caesarean section rate	DHIS	*26.5%	41%	26.4%	*24.8%	*14.5%	0[32]	*28%	23%	*31.1%	23.5%	*26.4%	34.2%	16.2%
2. Total separations	DHIS	*360 524	*41,654	*29,221	*27,038	*57,469	*2,656	*45,513	*39,716	*37,073	*14,230	*31,812	*34,142	1,716,911
3. Total patient day equivalents	DHIS	*3,023,443	*286,934	*315,414	*171,635	*368,752	*45848	*354,503	*356,549	*390,386	*174,187	*178,615	*380,621	10,740,610
4. Total OPD headcounts	DHIS	*3,069,671	*227,984	*482,828	*83,620	*375,249	39,310	*287,763	*263,194	*369,642	*172,415	*246,184	521,482	7,486,845
5. Average length of stay	DHIS	*4.7 Days	*5.1 Days	5.4 Days	5.2 Days	*6 Days	3.7 Days	*4.9 Days	*6.8 Days	*6.7 Days	*6.3 Days	*3.6 Days	*4.1 Days	4.3 Days
6. Bed utilisation rate	DHIS	*65.4%	*90%	*74%	*66%	*59%	*50%	*59%	*77%	*64%	*60%	*62%	*82%	73.2%
7. Expenditure per patient day equivalent	DHER	R1 639	R1 137	R594	R1 143	R1 081	R789	R1 380	R1 296	R977	R725	R1 247	R1 462	R1 049
8. Percentage of complaints of users of District Hospital services resolved within 25 days	DQPR	79%	69%	99%	67%	87%	94%	79%	73%	58%	93%	61%	98%	-

[32] Small District Hospital not doing caesarean sections – referring to Regional Hospitals in Newcastle

Indicator	Data Source	Provincial 2009/10	Ugu 2009/10	Umgungundlovu 2009/10	Uthukela 2009/10	Umzinyathi 2009/10	Amajuba 2009/10	Zululand 2009/10	Umkhanyakude 2009/10	Uthungulu 2009/10	Ilembe 2009/10	Sisonke 2009/10	eThekwini 2009/10	National Average 2009/10
9. Percentage of District Hospitals with monthly Maternal mortality and morbidity meetings	DQPR	93%	100%	100%	100%	100%	100%	100%	40%	100%	100%	100%	100%	-
10. Percentage of users of District Hospitals satisfied with services received	DQPR	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	-
11. Percentage of District Hospitals assessed for compliance against the 6 Priorities of the core standards	DQPR	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	-

Source: 2009/10 Annual Report – DHIS: [*] denotes data that has been corrected and verified since the 2009/10 Annual Report – part of the Information Turn-Around strategy (data clean-up)

2.6.1. PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR DISTRICT HOSPITALS

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 26 (DHS7 (a): Provincial Strategic Objectives and Annual Targets for District Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
1.11) To rationalise hospital services in line with service delivery needs and STP imperatives[33]	1.11.1) Number of CEO's who have signed delegation of authorities	39/ 39	Signed delegations	New indicator	New indicator	New indicator	24/ 39	39	39	39

Source: 2010/11 APP for 2007/08 and 2009/10; 2009/10 Annual Report for 2009/10

[*] denotes data that has been corrected and verified since the 2009/10 Annual Report – part of the Information Turn-Around strategy (data clean-up)

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

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

Table 27 (DHS7 (b): Provincial Strategic Objectives and Annual Targets for District Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
2.2) To implement the National Core Standards in 100% of facilities towards accreditation of 100% District Hospitals by 2014/15[34]	2.2.1) Number of District Hospitals accredited[35]	39/ 39	Accreditation Body database	New indicator	New indicator	New indicator	Accreditation Body not yet established	9	13	39
	2.2.2) Number of District Hospitals conducting annual Patient Satisfaction Surveys	39/ 39	DQPR	37/ 42 (88%)	37/ 42 (88%)	39/ 39	30/ 39 (76%)[36]	39	39	39
	2.2.3) Average patient waiting time in OPD	<1 hr	DQPR	New indicator	New indicator	New indicator	Data questionable	< 4½ hrs	< 4 hrs	<2 hrs
	2.2.4) Average patient waiting time at admissions	<1 hr	DQPR	New indicator	New indicator	New indicator	Data questionable	< 4½ hrs	< 4 hrs	<2 hrs

Source: 2010/11 APP for 2007/08 and 2008/09 data; 2009/10 Annual Report for 2009/10 data

Note: [*] denotes data that has been corrected and verified since the 2009/10 Annual Report

[34] Accreditation is dependent on national processes
[35] Cumulative numbers as determined by implementation plan – also linked with the "Look like a Hospital Project"
[36] Annual indicator – current value might therefore change by the end of year

Table 28 (DHS8): Performance Indicators for District Hospitals

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Caesarean section rate	DHIS	%	21%	22.7%	*26.5%	27.9%	27%	26.5%	26%	15%
2. Separations – total	DHIS	No	329,406	361, 244	*350,524	304,250	352,307	362,876	378,534	-
3. Patient day equivalents – total	DHIS	No	2,756,285	2,804,928	*3,023,443	2,781,062	3,160,237	3,255,044	3,294,133	-
4. OPD headcount – total	DHIS	No	2,168,440	2,775,255	*3,069,671	2,612,088	3,198,675	3,230,562	3,290,624	-
5. Average length of stay	DHIS	Days	4 Days	5.6 Days	*4.7 Days	5.8 Days	5 Days	4.8 Days	4.6 Days	3.5 Days
6. Bed utilisation rate	DHIS	%	68%	62.6%	*65.4%	64.4%	70%	72%	73%	75%
7. Expenditure per patient day equivalent (PDE)	DHIS	R	R 1 351	R 1 441	R1 639	R1 593	R 1 500	R 1 500	R1 550	-
8. Percentage of complaints of users of District Hospital services resolved within 25 days	DQPR	%	New indicator	79%	79%	57%	100%	100%	100%	-
9. Percentage of District Hospitals with monthly Maternal mortality and morbidity meetings	DQPR	%	New indicator	New indicator	New indicator	93%	100%	100%	100%	-
10. Percentage of users of District Hospitals satisfied with services received	DQPR	%	New indicator	New indicator	New indicator	New indicator	Establish baseline	Target based on baseline	Target based on baseline	-
11. Number of District Hospitals assessed for compliance against the 6 Priorities of the core standards	DQPR	No	New indicator	New indicator	New indicator	New indicator	Routine 39/39	Routine all	Routine all	-

Source: 2010/11 APP for 2007/08 and 2008/09; 2009/10 Annual Report for 2009/10; DHIS

Note: [*] denotes data that has been corrected and verified since the 2009/10 Annual Report

2.6.2. QUARTERLY TARGETS FOR DISTRICT HOSPITALS

Table 29 (DHS9): Quarterly Targets for District Hospitals

Performance Indicators	Annual Targets 2011/12	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly					
1. Caesarean section rate	27%	27.8%	27.6%	27.4%	27%
2. Separations - total	352,307	88,076	88,076	88,076	88,079
3. Patient day equivalents - total	3,160,237	790,059	790,059	790,059	790,060
4. OPD headcount - total	3,198,675	799,668	799,668	799,668	799,671
5. Average length of stay	5 Days	5.7 Days	5.5 Days	5.2 Days	5.0 Days
6. Bed utilisation rate	70%	65%	67%	69%	70%
7. Expenditure per patient day equivalent (PDE)	R 1 500	R1 550	R1 500	R1 500	R1 500
8. Percentage of complaints of users of District Hospital services resolved within 25 days	100%	100%	100%	100%	100%
9. Percentage of District Hospitals with monthly Maternal mortality and morbidity meetings	100%	100%	100%	100%	100%
Annual					
10. Percentage of users of District Hospitals satisfied with services received	Establish baseline				Establish baseline
11. Number of District Hospitals assessed for compliance against the 6 priorities of the core standards	Routine 39				Routine 39
12. Number of District Hospital CEO's who have signed delegation of authorities	39				39
13. Number of District Hospitals accredited[37]	9				9
14. Number of District Hospitals conducting annual Patient Satisfaction Surveys	39				39
15. Average patient waiting time at OPD	< 4 ½ hrs				< 4 ½ hrs
16. Average patient waiting time at admissions	< 4 ½ hrs				< 4 ½ hrs

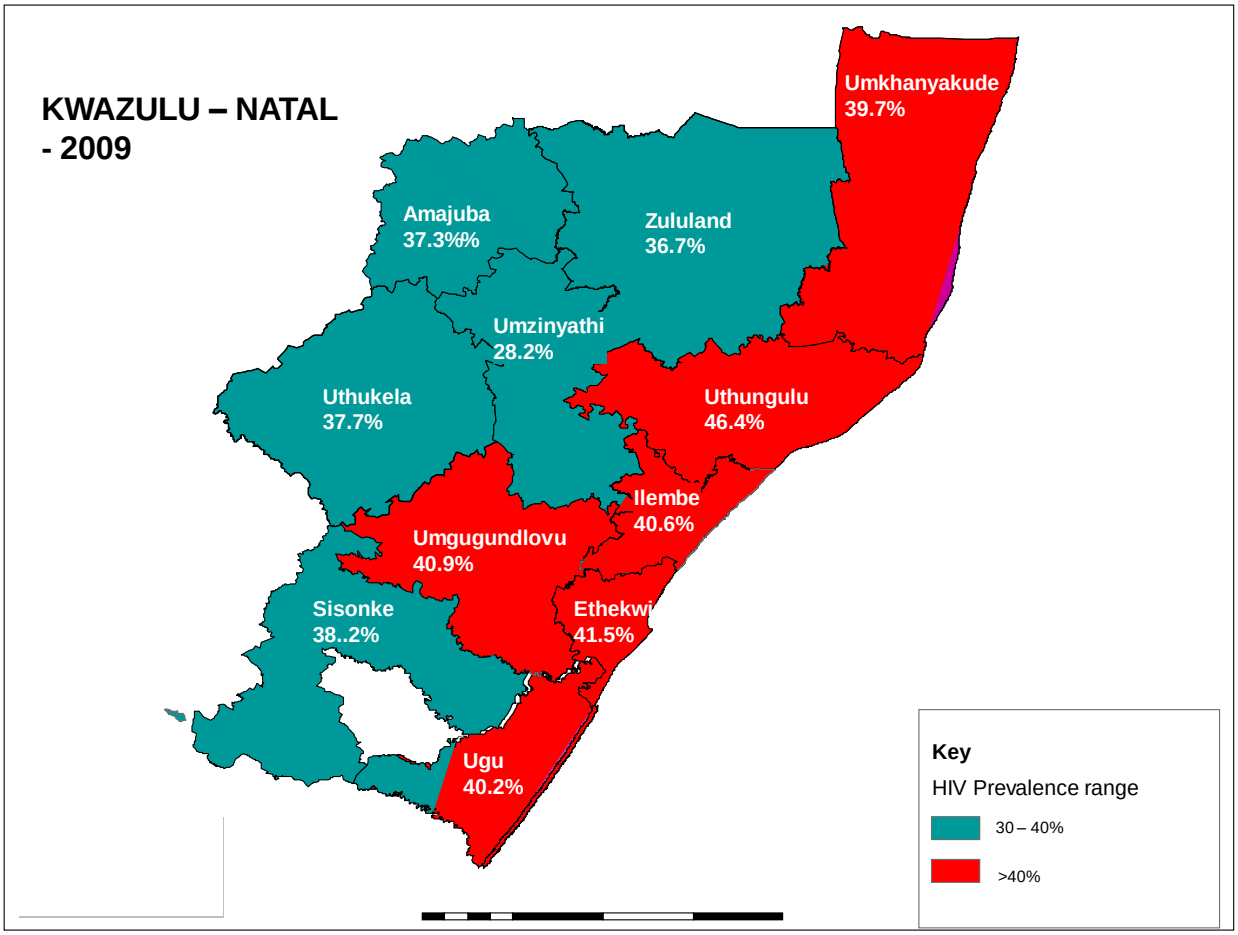
[37] Cumulative numbers – dependent on national processes which will not deter from compliance to core standards at a provincial level

2.7. SUB-PROGRAMME: HIV & AIDS, STI'S AND TB CONTROL (HAST)

HIV AND AIDS

According to the 2009 HIV and Syphilis Prevalence Survey amongst Antenatal Clients, 6/11 districts had an HIV prevalence of more than 40% as compared with 3 districts in 2008. Only Umzinyathi shows a steady decrease since 2007 and is currently the only district with a prevalence below 30%.

Map 2: HIV prevalence under antenatal clients 2009



Source: National HIV prevalence trends amongst antenatal clinic attendees, South Africa 2009 – 2008

PREVENTION

- *Condoms* are distributed in 100% of public sector facilities and further extended to non-traditional outlets (tertiary institutions, farms, taverns) and high transmission areas (truck stops). To increase distribution and promote safer sexual behaviour, two service providers per district have been appointed to install condo-cans and educate communities on safer sexual behaviour.
- *HIV Counselling and Testing (HCT) Campaign*: Between April 2010 and January 2011 more than 1,626,192 people have been tested for HIV – approximately 74% of the target. The preparation for school-based HCT commenced as an inter- and intra-departmental project including the Office of the Premier, Departments of Health, Social

Development, and Education, Non-Governmental Organisations, Faith-Based Organisations, Private Sector, Trade Unions, and Traditional Leadership.

- *Voluntary Male Medical Circumcision (MMC)*: There are currently 37 sites offering voluntary MMC (all hospitals and CHCs). By December 2010, a total of 24,600 voluntary circumcisions had been done as part of the campaign.

MANAGEMENT AND TREATMENT

- There are currently 63 hospitals accredited as antiretroviral therapy service points; 324 clinics that are initiating antiretroviral therapy including CHC's; 5 correctional services; and 4 Non-Governmental Organisations. At the end of December 2010, the total number of patients ever initiated on ARV treatment since 2004 were 480,643. The total number of active patients on ARV treatment (end of December 2010) were 419, 273. Of these, 252,735 were females, 128,018 males, and 38,520 children.
- The approach for ART initiation is shifting from doctor to nurse driven - Nurse Initiated and Managed Antiretroviral Therapy (NIMART). Doctors are currently initiating treatment and providing mentorship for nurses.
- *Reduction of HIV/TB co-infection*: In 2010/11, 89% of HIV positive patients were screened for TB.

CARE AND SUPPORT

- *Home Based Care*: The Department is funding 136 Non-Governmental Organizations and 84 Community Care Centres (NIP sites) to render Home-Based Care services to Orphans and Vulnerable Children. From April 2011, the Department will take over the administration of Home-Base Carers who will be individually contracted. Service outputs for the programme include:
  - Home Based Carers receiving stipends: 3,745 out of 10,380 active Carers.
  - Home visits conducted by HBC's: 1,007,569 (including household visits conducted through Operation Sukuma Sakhe)
  - Number of Orphans and Vulnerable Children served in the programme: 89,823
  - Number of Child Headed Households: 24,137

TUBERCULOSIS

- *Implementation of the DOTS Strategy:* Adherence to the TB Guidelines is improving as indicated by the improvement of bacterial coverage from 71.5% to 77.4% during 2010/11.

- *Intensified case finding and detection and diagnosis of TB and MDR TB:*
  - Suspect register implemented in 100% of facilities – averaging a 91% reporting rate;
  - Transport system is in place to ensure daily specimen collection from all facilities;
  - SMS printers were installed in 354 facilities to date to ensure rapid return of specimen results to facilities;
  - The impact of the above two interventions is evident in the improved 48hr turn-around-time from 51% to 65%.

- *Improved cased management, case retention, and treatment adherence:*

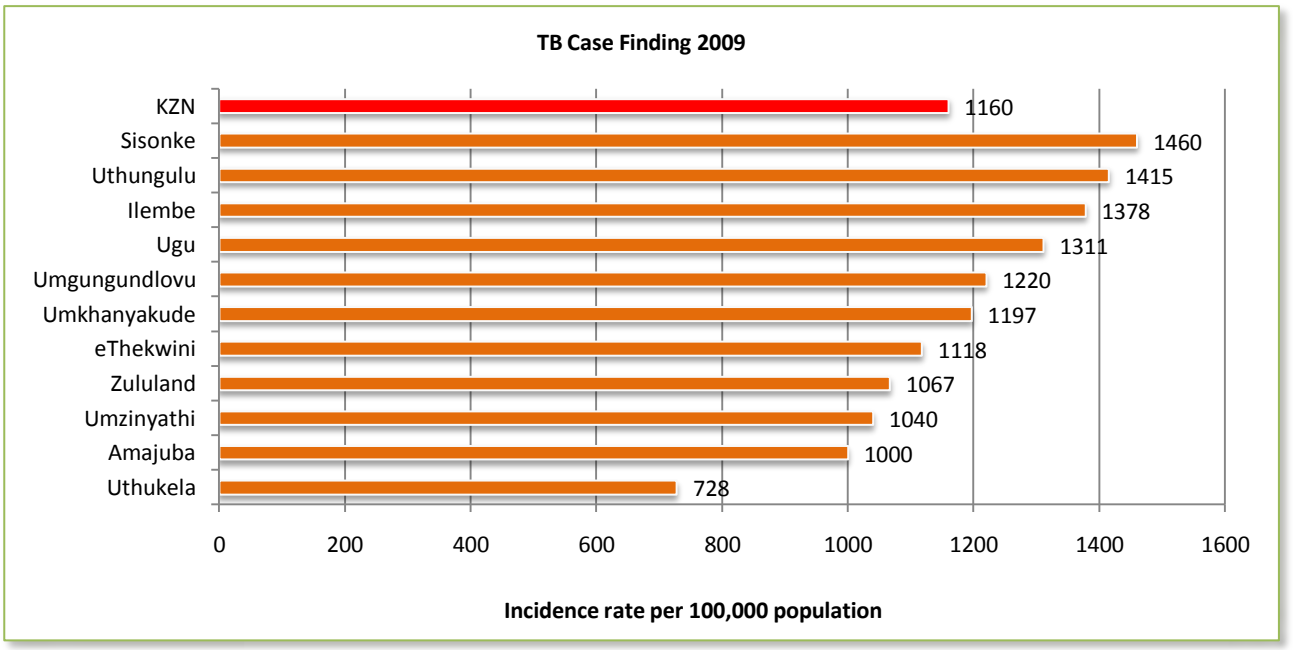
- Cure rate improved from 62.9% to 67.2%; and
- Defaulter rate decreased from 8.1% to 7.1%.

- *Improved management of TB/HIV Co-infected patients:*
  - 67.7% of all new TB patients counselled for HIV testing (2010/11);
  - 78% of counselled patients tested for HIV and 69.4% tested positive;

- *Improved capacity to manage M(X)DR TB:*
  - 113 HCWs have been trained in MDR TB management in 2010/11;
  - There are 4 decentralized MDR TB centers i.e. Thulasizwe, M3 Greytown, Murchison, and Manguzi Hospital Units;
  - Five sites have been identified for conversion to MDR TB management sites during 2011/12 i.e. Charles Johnson Memorial, Madadeni, Estcourt, Stanger, and Hlabisa Hospitals;
  - There are 16 mobile injection teams doing community-based management of MDR TB treatment (11 teams in Umzinyathi and 5 teams in Umkhanyakude). Programme will be rolled out to all districts during 2011/12.

- *Improve the quality of TB data:*
  - Data Capturers Project (1 year contract, employment/ training opportunity): Appointed 272 data capturers;
  - 254 HCW's trained in TB reporting and recording;
  - New Sequel Server Software ETR.Net version has been piloted in KZN and will continue in 2011/12;
  - CDC/MRC data validation Operational Research project in progress.

Table 30: TB case finding 2009 – Incidence rate per 100,000 population



Source: ETR.Net

Table 31 (HIV1): Situation Analysis Indicators for HIV & AIDS, STI's AND TB Control

Indicator	Data Source	Provincial 2009/10	Ugu 2009/10	Umgungundlovu 2009/10	Uthukela 2009/10	Umzinyathi 2009/10	Amajuba 2009/10	Zululand 2009/10	Umkhanyakude 2009/10	Uthungulu 2009/10	Ilembe 2009/10	Sisonke 2009/10	eThekwini 2009/10	National Average 2009/10
Quarterly Indicators														
1. Total number of patients (children and adults) on ART	DHIS	319,015	32,005	41,126	26,722	15,894	16,557	22,910	34,302	37,437	20,576	15,076	77,861	-
2. Male condom distribution rate	DHIS	8	9	5	11	11	*15	12	11	5	12	10	*6	12.4
3. New smear positive PTB defaulter rate	ETR.Net DQPR	8.1% (DQPR)	8%	8%	0%	1%	2%	2%	4%	No data	9%	7%	10%	-
4. PTB two month smear conversion rate	ETR.Net DQPR	68.7%	68%	66%	58%	83%	74%	75%	52%	60%	49%	54%	53%	-
5. Percentage of HIV-TB co-infected patients placed on ART	DQPR	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	-
6. HCT testing rate	DHIS	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	-
Annual Indicators														
7. New smear positive PTB cure rate	ETR.Net	62.9%	63%	62%	60%	83%	71%	70%	54%	75%	70%	67%	54%	-

Source: 2009/10 Annual Report; DHIS; ETR.Net

Note: [*] denotes data that has been corrected and verified since the 2009/10 Annual Report

Note: TB data is an estimate due to upgrade of TB database and backlog of data

2.7.1. PROVINCIAL STRATEGIC OBJECTIVES FOR HAST

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

Table 32 (HIV2): Provincial Strategic Objectives and Annual Targets for HIV and AIDS

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
3.1) To scale up implementation of the integrated HIV and AIDS strategic plan to reduce HIV incidence by 50% by 2011/12	3.1.1) HIV incidence	0.85% - 50% reduction	Research	New indicator	New indicator	1.7%[38]	Not available	Reduce by 50%[39]	-	-
	3.1.2) Percentage qualifying HIV-positive patients on ART	90%	HAST	New indicator	New indicator	Approximate 60%	Not available	80%	85%	86%
	3.1.3) Percentage of people with HIV-TB co-morbidity initiated on ART at a CD4 count of 350 or less	100%	DQPR	New indicator	New indicator	New indicator	56%	80%	100%	100%
	3.1.4) Number of neo-natal males circumcised	100% of target group.[40]	DHIS	New indicator	New indicator	New indicator	20	71,288 / 95,051[41] (75%)	96,001/ 96,001	105,601/ 105,201

[38] MRC – HST estimated the HIV incidence in the Province at 1.6%
[39] Target taken from the National Strategic Plan for HIV and AIDS and STI's
[40] Target group is 80% of male neonatal born
[41] Target is unrealistic and must be reviewed!

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
	3.1.5) Number of adult males circumcised[42]	100% of target group.[43]	DHIS	New indicator	New indicator	New indicator	26,862	373,406/ 1,867,030[44] (20% new & 30% cumulative)	373,406/ 1,867,030 (20% new & 50% cumulative)	373,406/ 1,867,030 (20% new & 70% cumulative)

Source: 2010/11 APP for 2007/08 and 2008/09 data; 2009/10 Annual Report for 2009/10 data; DHIS; ETR.Net

Note: [*] denotes data that has been corrected and verified since the 2009/10 Annual Report

Note: TB data is an estimate as the TB database is being upgraded

Table 33 (HIV3): Performance Indicators for HIV & AIDS, STI's AND TB Control

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Quarterly Indicators										
1. Total number of patients (children and adults) on ART	DHIS	No	143,526	225,863	319,015	380,641	460,198	571,647	681,847	-
2. Male condom distribution rate	DHIS	No	7	7	8	8	12	14	15	15
3. New smear positive PTB defaulter rate	TBR.Net	No	12.9%	9.6%[45]	8.1%	6.7%	6.1%	5.5%	5%	5%
4. PTB two month smear conversion rate	TBR.Net	%	54.9%	60.5%[46]	68.7%	67%	70%	72%	75%	75%

[42] Targets for circumcision were taken from a presentation by the Senior Manager of Priority Programmes
[43] Target group is all males 15 – 49 years old with an 80% acceptance rate
[44] Target is unrealistic and must be reviewed!
[45] The DQPR 2008/09 reports 7% however this is due to the non-submission of data on this report and therefore the figure of 9.6% (DHIS) is the more reliable figure
[46] Data appearing in the Annual Report 2008/09 was noted as incomplete at 52.1% due to the non-submission of data therefore the figure of 60.5% (DHIS) is the most reliable figure

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
5. Percentage of HIV-TB co-infected patients placed on ART	TBR.Net	%	New indicator	New indicator	New indicator	56%	80%	100%	100%	-
6. HCT testing rate	DHIS	%	New indicator	New indicator	New indicator	74.3% (1,442,791/ 1,940,708)	90%	90%	90%	-
Annual Indicators										
7. New smear positive PTB cure rate	TBR.Net	%	40%	62%[47]	62.9%	70%	72%	73%	75%	85%

Source: 2010/11 APP & National Template for 2007/08 and 2008/09 data; 2009/10 Annual Report for 2009/10 data (unless otherwise indicated); TBR.Net

Note: TB data is an estimate as the TB database is being upgraded

[47] Data from the TB Unit, however data to still be verified and confirmed

2.7.2. QUATERLY TARGETS FOR HAST

Table 34 (HIV4): Quarterly Targets for HIV & AIDS, STI's AND TB Control for 2011/12

Performance Indicators	Annual Targets 2011/12	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly					
1. Total number of patients (children and adults) on ART	460,198	400,530	420,419	440,307	460,198
2. Male condom distribution rate	12	9	10	11	12
3. New smear positive PTB defaulter rate	6.1%	6.6%	6.4%	6.3%	6.1%
4. PTB two month smear conversion rate	70%	67%	67%	69%	70%
5. Percentage of HIV-TB co-infected patients placed on ART	80%	56%	65%	72%	80%
6. HCT testing rate	90%	74.3%	78%	80%	90%
8. Percentage of people with HIV- TB co-morbidity initiated on ART at a CD4 count of 350 or less	80%	60%	70%	75%	80%
9. Number of neo-natal males circumcised[48] (*This target is unrealistic and should be reviewed)*	71,288 / 95,051 (75%)	17,822	17,822	17,822	17,822
10. Number of adult males circumcised *(This target is unrealistic and should be reviewed)*	373,406 / 1,867,030 (20% new & 30% cumulative)	93,352	93,352	93,351	93,351
Annual					
11. New smear positive PTB cure rate	72%				72%
12. HIV incidence	0.85%				0.85%
13. Percentage qualifying HIV-positive patients on ART	80%				80%

[48] Targets for circumcision were taken from a formal presentation by the Senior Manager for Priority Programmes

2.8. MATERNAL, CHILD & WOMEN'S HEALTH AND NUTRITION (MCWH&N)

In KZN, at least one woman dies every day from pregnancy and child-bearing related conditions highlighting the inequities that still remain in South Africa. These mortality numbers are indefensible considering that 95.1% of women attend antenatal care and more than half of women give birth in a medical facility. The graph below shows the actual number of reported maternal deaths per year in KZN.

Graph 1: Provincial maternal deaths in health facilities per year

Source: DHIS and MAMMAS database

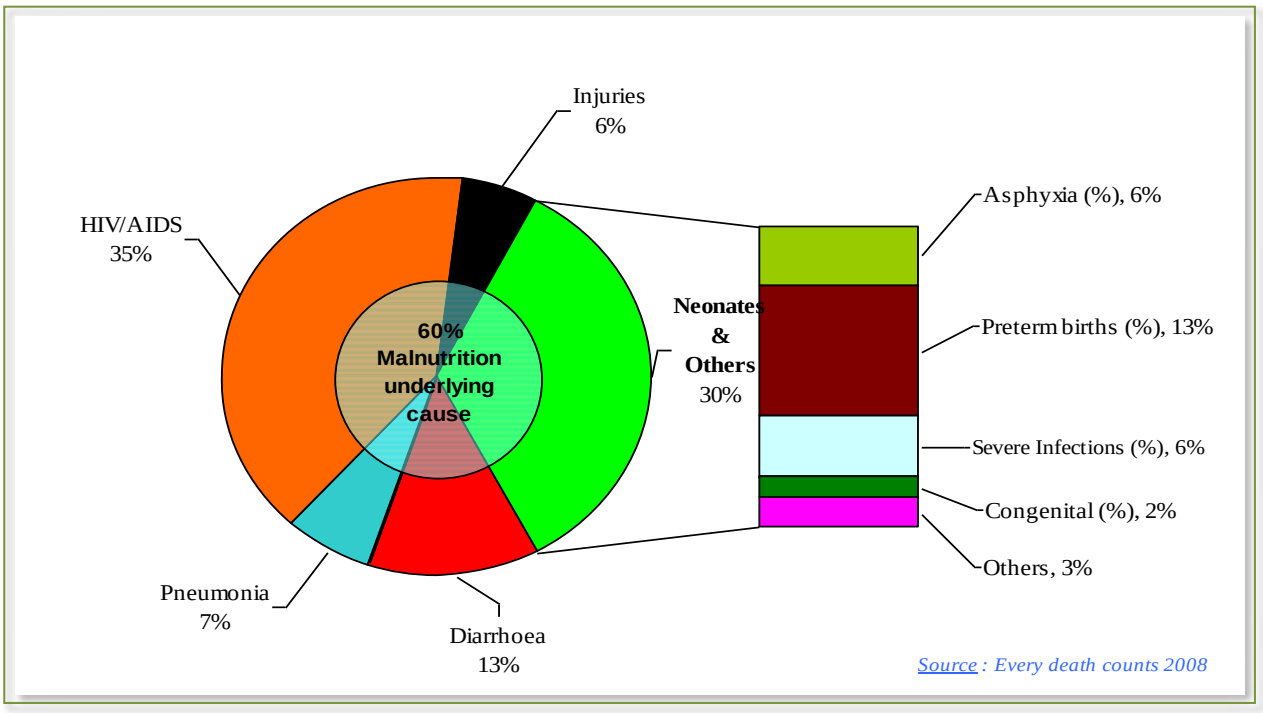
Early Booking for antenatal care: Most pregnant women start antenatal care very late in their pregnancy. The proportion of women who book antenatal care before 20 weeks has increased by a mere 10% over the past five years. This denies women the opportunity of early diagnosis of danger signs, management of high risk conditions, and timely initiation of HAART for qualifying women.

Initiation on HAART: According to the Confidential Enquiry into Maternal Deaths, HIV contributed to 43% of maternal deaths for the period 2004 - 2007. Early initiation on lifelong HAART will therefore make a significant impact on the reduction of maternal mortality.

Contraceptive Prevalence: Prevention of unwanted/ unplanned and unsafe pregnancies will contribute significantly towards reduction of maternal mortality. Mortality from pregnancy induced hypertension is common in the younger age group. In KZN the women year protection rate (used as proxy indicator for contraceptive coverage) shows a steady decline to the current 23.3%.

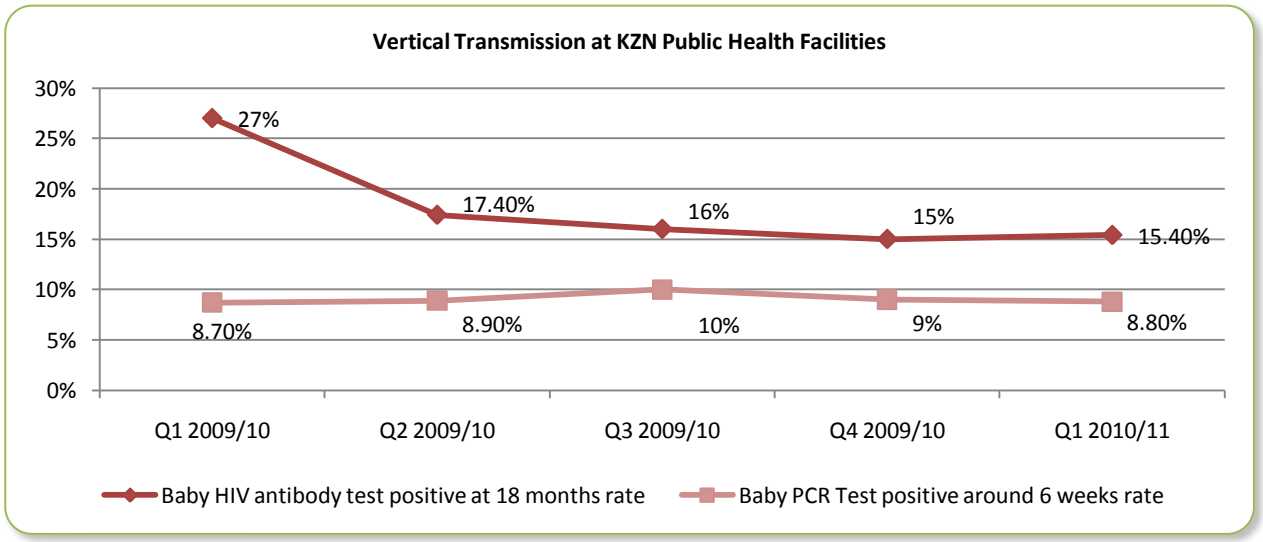
Child Mortality: The Country Report on MDG's shows an increase in the under-five mortality rate from 59/1000 to 104/1000 live births between 1994 and 2010. Infant mortality rate has remained the same for the same period, at 53 deaths per 1000 live births in 2007 – significantly higher than the expected 20 deaths per 1000 live births by 2014. The commonest causes of death amongst children under-five are shown by the graph below.

Graph 2: Commonest causes of death in children under 5 years



Prevention of mother to child transmission of HIV begins to show results as indicated in the graph below.

Graph 3: Vertical transmission in health facilities



Source: DHIS

There is convincing evidence that many of the health and nutrition needs of women and children in high-burden countries can be met through interventions that are proven to work. These include amongst others:

- Increased availability of basic and comprehensive emergency obstetric care;
- Functioning referral system with specialised emergency response vehicles;
- Community-based maternal, neonatal and child health;
- Accountability for provider's performance; and
- Mentorship programmes.

Table 35 (MCWH1): Situation Analysis Indicators for MCWH&N

Indicator	Data Source	Provincial 2009/10	Ugu 2009/10	Umgungundlovu 2009/10	Uthukela 2009/10	Umzinyathi 2009/10	Amajuba 2009/10	Zululand 2009/10	Umkhanyakude 2009/10	Uthungulu 2009/10	Ilembe 2009/10	Sisonke 2009/10	eThekwini 2009/10	National Average 2009/10
QUARTERLY INDICATORS														
1. Immunisation coverage under-1 year	DHIS	84.9%	77%	72%	77%	89%	75%	83%	76%	99%	88%	67%	97%	89.5%
2. Vitamin A coverage 12 – 59 months	DHIS	37.4%	34%	29%	27%	37%	28%	46%	33%	34%	35%	29%	49%	-
3. Measles 1st dose under 1 year coverage	DHIS	87.3%	82%	69%	80%	93%	87%	88%	79%	93%	91%	70%	101%	91.7%
4. Pneumococcal Vaccine (PCV) 3rd Dose Coverage	DHIS	75.9%	74.4%	67.1%	77.2%	85.3%	76.5%	76.5%	65.7%	76.7%	88.5%	56.1%	78.9%	-
5. Rota Virus (RV) 2nd Dose Coverage	DHIS	58%	54.6%	46%	59.5%	60.1%	51.2%	58.4%	47.1%	50.6%	62.9%	40.2%	66.2%	-
6. Cervical cancer screening coverage	DHIS	5.9%	8%	5.9%	5.5%	16.8%	4.2%	10.1%	10.5%	4.5%	8%	6%	3.7%	43.9%
7. Antenatal visits before 20 weeks rate	DHIS	34.3%	34%	44%	34%	30%	37%	34%	34%	30%	31%	31%	35%	32.5%
8. Baby tested PCR	DHIS	10.3%	10.9%	7.9%	7.4%	8.1%	7.1%	7.5%	9.2%	10.5%	4.2%	12.8%	9.4%	-

Indicator	Data Source	Provincial 2009/10	Ugu 2009/10	Umgungundlovu 2009/10	Uthukela 2009/10	Umzinyathi 2009/10	Amajuba 2009/10	Zululand 2009/10	Umkhanyakude 2009/10	Uthungulu 2009/10	Ilembe 2009/10	Sisonke 2009/10	eThekwini 2009/10	National Average 2009/10
positive six weeks after birth as a proportion of babies tested at six weeks		(DHIS)												
ANNUAL INDICATORS														
9. Couple year protection rate	DHIS	25.1%	29%	26%	26%	28%	26%	27%	27%	20%	27%	30%	23%	31.9%
10. Facility maternal mortality rate	DHIS	169/ 100 000	198/ 100 000	267/ 100 000	171/ 100 000	88/ 100 000	130/ 100 000	142/ 100 000	175/ 100 000	28/ 100 000	318/ 100 000	74/ 100 000	205/ 100 000	-
11. Delivery rate for women under 18 years	DHIS	8.6%	8.5%	9.3%	9.1%	6.2%	9.4%	9%	10.7%	7.3%	10.5%	7.6%	8.5%	8.8%
12. Facility Infant mortality (under 1) rate	DHIS	7.3%	11.1%	5%	7.8%	9.2%	5.5%	11.3%	8.6%	9.1%	8.1%	8.8%	3.4%	-
13. Facility Child mortality (under 5) rate	DHIS	6.3%	7.3%	6.2%	6.5%	7.5%	3.9%	7%	5%	6.4%	6.1%	7.3%	2.3%	-

Source: 2010/11 APP and National Template

All data in the above table have been cleaned up as part of the information turn-around strategy – explained variances from 2009/10 Annual Report

2.8.1. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR MCWH&N

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

Table 36 (MCWH2): Provincial Strategic Objectives and Annual Targets for MCWH&N

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
3.2) To scale up implementation of the Accelerated Plan for PMTCT to reduce mother to child transmission to <5% by 2012/13	3.2.1) Proportion of HIV exposed babies testing PCR positive	2-5% by 2014/15	DHIS	New indicator	7% [49]	*10.3%	11.5%	<6%	<5%	2-5%
	3.2.2) % of pregnant women tested for HIV	100%	DHIS	80%	96%	93%	96%	100%	100%	100%
	3.2.3) % of pregnant women who are eligible placed on ARV prophylaxis	100%	DHIS	New indicator	New indicator	87%	82%	95%	100%	100%
	3.2.4) % of eligible pregnant women placed on HAART	90%	DHIS	New indicator	New indicator	52.7%	58.7%	75%	85%	90%
	3.2.5) % of HIV exposed infants receive ARV's for PMTCT	100%	DHIS	New indicator	New indicator	98.7%	Not available	95%	100%	100%

[49] Data from research done by the Provincial Research Centre for Rural Health

Strategic Objectives	Performance Indicators	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
3.3) Reduce child mortality to 30-45/1000 live births by 2014/15	3.3.1) Number of diarrhoea cases – children under-5 years	Monitor trends	DHIS	*48,172	46,511	50,471 (with dehydration)	31,156 (with dehydration)	Decrease diarrhoea cases with 15% per annum	Monitor and review	Monitor and review
	3.3.2) Number of pneumonia cases – children under-5 years	Monitor trends	DHIS	*188,477	194,904	209,920	154,992	Decrease pneumonia cases with 20% per annum	Monitor and review	Monitor and review
3.4) Reduce maternal mortality to ≤ 100/ 100 000 by 2014/15	3.4.1) % of mothers and newborn babies who received post partum care within 6 days after delivery	80%	DHIS	New indicator	New indicator	42%	Mothers 48% Babies 34%	50% mothers and babies	55% mothers and babies	60% mothers and babies
	3.4.2) Number of maternity care units that review Maternal and Peri-Natal deaths and address identified deficiencies[50]	100%	DQPR	100%	100%	100%	94%	100%	100%	100%

Source: 2010/11 APP for 2007/08 and 2008/09; 2009/10 Annual Report for 2009/10; DHIS

[*] denotes updated DHIS information since last report

[50] This includes hospitals only

Table 37 (MCWH3): Performance Indicators for MCWH&N

Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Quarterly Indicators										
1. Immunisation coverage under 1 year	DHIS	%	81.1%	85%	84.9%	76%	90%	90%	90%	90%
2. Vitamin A coverage 12 – 59 months	DHIS	%	31.9%	28.5%	37.4%	30%	55%	60%	70%	80%
3. Measles 1st dose under 1 year coverage	DHIS	%	84.5%	89.3%	87.3%	84%	90%	90%	90%	90%
4. Pneumococcal Vaccine (PCV) 3rd Dose Coverage	DHIS	%	New indicator	New indicator	75.9%	93%	90%	90%	90%	90%
5. Rota Virus (RV) 2nd Dose Coverage	DHIS	%	New indicator	New indicator	58%	79%	90%	90%	90%	90%
6. Cervical cancer screening coverage	DHIS	%	4.9%	6.4%	5.9%	41%	50%	60%	70%	40%
7. Antenatal visits before 20 weeks rate	DHIS	%	26.7%	30.5%	34.3%	36%	60%	70%	75%	70%
8. Baby tested PCR positive six weeks after birth as proportion of babies tested at six weeks	DHIS	%	New indicator	7% [51]	*10.3%	11.5%	<6%	<5%	2-5%	-
Annual Indicators										
9. Couple year protection rate	DHIS	%	22.1%	23%	25.1%	23.3%	40%	50%	60%	70%
10. Maternal mortality rate in facility	DHIS	No	225 /100 000	205 /100 000	169/100 000	172/100 000	115/ 100 000	110/ 100 000	105/100 000	-
11. Delivery rate for women under 18 years	DHIS	%	8.4%	9.4%	8.6%	8.8%	8%	7.8%	7.5%	10%
12. Facility Infant mortality (under 1) rate	DHIS	%	8.9%	9%	7.3%	11.8%	8.5%	8.3%	8.1%	-
13. Facility Child mortality (under 5) rate	DHIS	%	7.1%	7%	6.3%	9.8%	6.8%	6.6%	6.4%	-

Source: 2010/11 APP for 2007/08 and 2008/09 data; 2009/10 Annual Report for 2009/10; DHIS

Note: [*] denotes data that has been corrected and verified since the 2009/10 Annual Report – part of the Information Turn-Around strategy (data clean-up)

[51] Data from the Centre for Rural Health

2.8.2. QUARTERLY TARGETS FOR MCWH & N

Table 38 (MCWH4): Quarterly Targets for MCWH&N for 2011/12

Performance Indicators	Annual Targets 2011/12	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly					
1. Immunisation coverage under 1 year	90%	80%	85%	88%	90%
2. Vitamin A coverage 12 – 59 months	55%	37%	42%	49%	55%
3. Measles 1st dose under 1 year coverage	90%	84%	86%	88%	90%
4. Pneumococcal Vaccine (PCV) 3rd Dose Coverage	90%	90%	90%	90%	90%
5. Rota Virus (RV) 2nd Dose Coverage	90%	79%	83%	88%	90%
6. Cervical cancer screening coverage	50%	41%	45%	47%	50%
7. Antenatal visits before 20 weeks rate	60%	39%	46%	54%	60%
8. % of pregnant women tested for HIV	100%	96%	97%	98%	100%
9. % of pregnant women who are eligible placed on ARV prophylaxis	95%	82%	87%	92%	95%
10. % of eligible pregnant women placed on HAART	75%	60%	65%	70%	75%
11. % of HIV exposed infants receive ARV's for PMTCT	95%	90%	92%	94%	95%
12. % of mothers and newborn babies who received post partum care within 6 days after delivery	50%	Mothers 48% Babies 34%	Mothers 49% Babies 38%	Mothers 50% Babies 46%	Mothers 50% Babies 50%
13. Number of maternity care units that review Maternal and Peri-Natal deaths and address identified deficiencies[52]	100%	94%	100%	100%	100%
Annual					
14. Proportion of HIV exposed babies testing PCR positive	<6%				<6%
15. Couple year protection rate	40%				40%
16. Maternal mortality rate in facility	115/ 100 000				115/ 100 000
17. Delivery rate for women under 18 years	8%				8%
18. Facility Infant mortality (under 1) rate	8.5%				8.5%
19. Facility Child mortality (under 5) rate	6.8%				6.8%

2.9.

[52] This includes only hospitals. No CHC's or PHC Clinics have been included in the totals for this indicator

2.10. DISEASE PREVENTION AND CONTROL (DPC)

Table 39 (DCP1): Situation Analysis Indicators for Disease Prevention and Control

Indicator	Data Source	Provincial 2009/10	Ugu 2009/10	Umgungundlovu 2009/10	Uthukela 2009/10	Umzinyathi 2009/10	Amajuba 2009/10	Zululand 2009/10	Umkhanyakude 2009/10	Uthungulu 2009/10	Ilembe 2009/10	Sisonke 2009/10	eThekwini 2009/10	National Average 2009/10
1. Malaria fatality rate (annual)	DQPR	2.9%	0%	0%	0%	0%	50% (1 death)	0%	0%	0%	0%	0%	0%	1.06%
2. Cholera fatality rate	CDC	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	-
3. Cataract surgery rate (annual)	DQPR	695.01 / 1 million pop	446	1,106	105	613	449	0	534	406	232	607	3,017	1,059 per million pop

Source: 2010/11 APP

2.10.1. PROVINCIAL STRATEGIC OBJECTIVES FOR DPC

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

Table 40 (DCP2): Provincial Strategic Objectives and Annual Targets for DPC

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
3.5) To maintain preventative strategies to reduce and maintain the malaria incidence at ≤ 1/1000 population	3.5.1) Malaria incidence per 1000 population at risk	< 1/ 1000	DQPR	New target	New target	0.11/1000	0.01/1000	0.61 / 1000	0.56 / 1000	0.55/1000

Source: 2009/10 APP

Table 41 (DCP3): Performance Indicators for DPC

Indicator	Data Source	Type	Audited/ Actual Performance			Estimate	Medium Term Targets			National Target
			2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Malaria case fatality rate	DQPR	%	1.5% [53]	1.1% (5/429)	10%	2.9%	<1%	<1%	<1%	-
2. Cholera fatality rate	CDC	%	0%	50% (1/2)	0%	0%	0%	0%	0%	0%
3. Cataract surgery rate (per million population)	DQPR	No	772/ 1mil	703.53/ 1mil	695.01 / 1 mil	655.17/1mil (DHIS)	138.28/ 1mil (target 1,500 operations)	144.88/ 1mil (target 1,600 operations)	160.12 / 1 mil (target 1,800 operations)	-

Source: 2010/11 APP

[53] Data from the DHIS – data from Environmental Health was reported at 0.8% (direct reporting)

2.10.2. QUARTERLY TARGETS FOR DPC

Table 42 (DPC4): Quarterly Targets for DPC for 2011/12

Performance Indicator	Annual Target 2011/12	Quarterly Targets			
		Q1	Q2	Q3	Q4
Annual					
1. Malaria case fatality rate	<1%				<1%
2. Malaria incidence per 1,000 population at risk	0.61 / 1000				0.61 / 1000
3. Cholera fatality rate	0%				0%
4. Cataract surgery rate (per million population)	138.28/ 1mil (1,500 operations)				138.28/ 1mil (1,500 operations)

2.11. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 43 (DHS11 (a): District Health Services

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
R' thousands	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
District Management	145 144	150 532	121 875	165 505	143 248	143 973	150 275	155 298	165 805
Community Health Clinics	1 294 981	1578640	1836913	2145578	2231091	2131643	2697528	2836274	3036214
Community Health Centres	435 897	503 302	553 575	628 739	668 504	640 844	849 799	895 790	959 703
Community Based Services	103 291	92 769	98 850	116491	116 632	101 814	206 571	221 114	236 343
HIV and AIDS	1 058 570	1 239 365	1 534 546	1 930 006	1 656 585	1 611 098	1 925 452	2 329 897	2 773 535
Nutrition	84 647	21 635	90 637	106 016	63 052	50 357	64 200	67 410	69 432
Forensic Pathology Services	1 07 176	96 664	97 091	124 289	114 289	122 769	133 433	141 510	149 293
District Hospitals	3 568 351	4 020 233	4 359 717	4 580 576	4 809 036	4 671 647	5 114 241	5 3459 75	5 625 991
Total	**7 209 609**	**8 132 272**	**9 188 678**	**10 392 47**	**10 392 762**	**10 042 432**	**11 739 824**	**12 631 495**	**13 682 800**

Source: BAS

Table 44 (DHS11 (b): Summary of Provincial Expenditure Estimates by Economic Classification

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Current payments	**6 857 271**	**7 793 057**	**8 816 863**	**9 963 076**	**9 943 106**	**9 579 972**	**11 213 448**	**12 088 307**	**13 251 243**
Compensation of employees	4 473 898	5 264 489	5 723862	6 514 794	6 581 150	6 495 929	7 742 028	8 284 193	8 943 578
Goods and services	**2383 373**	**2 528 568**	**3 093 001**	**3 448 282**	**3 361 956**	**3 084 043**	**3 471 420**	**3 804 114**	**4 307 665**
Communication	55 595	57 244	52 113	56 787	45 000	44 101	48 309	49 751	52 251
Computer Services	22 345	42 587	41 717	39 697	39 000	34 150	43 003	48 104	51 708

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Consultants, Contractors and special services	227 677	267 733	391 840	444 642	360 184	286 407	350 255	406415	524 532
Inventory	1 439 419	1 543 821	1 999 918	2 252 443	2 327 648	2 170 144	2 367 480	2 501 618	2 771 219
Operating leases	33 327	37 220	30 795	38 925	31 000	37 634	41 661	46 603	51 263
Travel and subsistence	44 122	26 706	12 833	20 466	15 000	12 678	15 713	17 576	24 932
Interest and rent on land									
Maintenance , repair and running costs									
Financial transactions in assets and liabilities		82			456	1823			
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	560 888	553 257	563 785	595 322	544 124	498 929	604 999	734 047	831 760
Transfers and subsidies to	**236 328**	**282 563**	**343 633**	**383 085**	**407 814**	**408 620**	**334 819**	**351 630**	**369 589**
Provinces and municipalities	62 810	50 493	81 058	90 920	135 256	135 051	94 173	98 884	104 320
Departmental agencies and accounts									
Universities and technikons		40							
Non-profit institutions	160 499	210 664	237 438	269 262	249 455	249 455	216 797	227 705	240 228
Households	13 019	2 1366	25 137	22 903	22 903	24 114	23 849	25 041	25 041
Payments for capital assets	**116 010**	**56 570**	**28 182**	**46 086**	**42 586**	**52 017**	**191 557**	**191 558**	**61 968**
Buildings and other fixed structures	1 124	138							
Machinery and equipment	114 886	56 432	28 182	46 086	42 586	52 017	191 557	191 558	61 698
Software and other intangible assets									
Total economic classification	**7 209 609**	**8 132 272**	**9 188 678**	**10 392 247**	**10 393 762**	**10 042 432**	**11 739 824**	**12 631495**	**13 682 800**

Source: BAS

2.12. PERFORMANCE AND EXPENDITURE TRENDS

The significant increases in trends over the seven-year period relate to the higher than anticipated annual wage agreements, the filling of unbudgeted posts in 2007/08, the carry-through costs of the various OSD's for medical personnel in 2009/10 and in the 2010/11 Adjusted Appropriation. Also contributing was additional funding to assist with inflationary increases in medical supplies and services; increase to improve infant and child health, and substantial increase in the funding for HIV and AIDS annually. Amounts allocated for national priorities over the 2011/12 MTEF provide for capacity building for personnel and *Goods and Services*, funding for Family Health Team pilots/models, improving hospital norms and standards, and additional funding for general policy adjustment.

The decrease in the District Management Sub-Programme in 2009/10 is a result of enforced savings and the non-filling of posts in an effort to remain within budget. The reduction in the 2010/11 Adjusted Appropriation relates to savings as a result of the moratorium on filling of non-critical posts. The increase in the 2010/11 Adjusted Appropriation and the Revised Estimate, when compared to 2009/10, is due to the inclusion of funding for the higher than anticipated 2010 wage agreement, as well as funding for OSD for medical personnel. The 2011/12 MTEF includes the carry-through costs of the relevant wage agreements and inflationary costs only.

The notable increase in 2009/10 and the strong growth thereafter in the Community Health Clinics and Community Health Centre Sub-Programmes includes additional funding for the various wage agreements, OSD for medical personnel, funding for inflationary costs in medical related goods and services and reducing infant and child mortality. Also affecting growth in 2010/11 is additional funding for OSD. The reduction in the 2010/11 Revised Estimate results from the non-filling of non-critical posts. The 2011/12 MTEF increases are due to national priority funding for additional posts and goods and services, family health team pilots/models and for the general policy adjustment.

The decrease in the Community Based Services Sub-Programme in 2008/09 results from the absorption of Community Health Workers (previously paid by stipend) into District Hospitals as full-time employees. The significant increase over the 2011/12 MTEF relates to the Department's decision to take over the management of the HIV and AIDS NIP sites from NGO's in an effort to minimise fraud.

The notable increase in 2009/10 in the Other Community Services Sub-Programme is due to the introduction of community nursing services and the additional intake of community doctors resulting from the extension of the medical intern programme to two years, as well as the expenditure for OSD for medical personnel.

The steady increase in the HIV and AIDS Sub-Programme over the seven years relates mainly to increasing provision of the Comprehensive HIV and AIDS Grant to cater for increasing uptake of ARV therapy. An additional R20 million was provided in the 2010/11 Adjusted Appropriation towards the male medical circumcision programme. Despite this allocation, there was an overall decrease in this Sub-Programme in the 2010/11 Adjusted Appropriation resulting from the decision to move equitable share funding to the Community Health Clinics and Community Health Centres Sub-

Programmes to improve access for HIV and AIDS. Additional funds were allocated in 2012/13 and 2013/14 to assist with the increasing demand for ARV's.

The high expenditure in the Nutrition Sub-Programme in 2007/08 resulted from an arrangement with the Department of Social Development whereby the latter department agreed to fund the Department of Health to provide food parcels to patients living with HIV & AIDS and TB. The expenditure relating to nutrition was reduced in 2008/09 due to spending pressures. The 2009/10 amount includes funding for food packs for TB and HIV & AIDS patients, which was consolidated into this programme. The decreasing trend in the 2010/11 Adjusted Appropriation is due to cost-cutting. The trend over the 2011/12 MTEF period is for inflationary increases only.

The Forensic Pathology Services Sub-Programme which was transferred from the South African Police Services from April 1, 2006 is funded through the Forensic Pathology Services Grant. The high 2007/08 amount includes a roll-over from 2006/07. Figures over the seven years include the various wage agreements and inflationary increases. The decrease of R10 million in the 2010/11 Adjusted Appropriation relates to savings due to cost-cutting being reprioritised to Programme 8: Health Facilities Management to offset spending pressures on the infrastructure portion of the Grant.

The significant increase in 2008/09 in the District Hospitals Sub-Programme is attributed to the OSD for medical personnel, the high inflation rate especially on medical services and supplies, catering services, and the take-over of the Provincial laboratory services by the NHLS. The high figure in 2009/10 relates to OSD for medical personnel, the 2009 wage agreement, as well as the escalating costs of laboratory services and inflationary expenditure on medical services and supplies. The increase in the 2010/11 Adjusted Appropriation is due to the 2010 wage agreement, additional funding for OSD for medical personnel, and funding reprioritised from other areas to offset the spending pressures. The decrease in the 2010/11 Revised Estimate relates to the delay in allocating the budget at institutional level due to restructuring of the service delivery programmes in line with national priorities, and the slower than expected filling of posts. Growth over the 2011/12 MTEF includes funding for national priorities to improve hospital norms and standards, as well as funding for the various OSD's, capacity building and the previously mentioned general policy adjustment.

The increase in *Compensation of Employees* from 2008/09 onwards is mainly due to OSD for medical personnel and various wage agreements. The decrease in the 2010/11 Revised Estimate relates to the slower than anticipated filling of posts.

The fluctuating trend in *Goods and Services* is mainly due to the variable inflation rate over the period, higher than anticipated medical inflation, the increase in the cost of NHLS, as well as the increase in the number of HIV & AIDS and TB patients on treatment. The reduction in the 2010/11 Adjusted Appropriation relates to the decision by the Department to reduce the equitable share of the HIV & AIDS Sub-Programme to offset expenditure for HIV & AIDS services. The decrease in the 2010/11 Revised Estimate relates to the decrease in the inflation on medicines, especially ARV's, due to the strengthening of the rand and improved contract negotiation, as well as pegging the NHLS

expenditure to the previous year's contract. Included in the 2010/11 Main Appropriation is a significant increase in the Comprehensive HIV & AIDS Grant, as well as the carry-through costs for combating infant and child mortality. The 2010/11 Adjusted Appropriation includes an additional R20 million for the voluntary male medical circumcision programme provided under the Grant. In addition to carry-through costs from previous allocations, funding for national priorities in the 2011/12 MTEF provides for Family Health Teams, general policy adjustment, capacity building and, in 2012/13 and 2013/14, additional amounts of R81.289 million and R74.825 million to increase access to ART.

The fluctuations in *Transfers and Subsidies to Provinces and Municipalities* are mainly due to the uncertainty of the provincialisation of Local Government PHC clinics, as well as non-signing of SLA's. The increase in 2009/10 results from the signature of some of the 2008/09 SLA's. The increase in the 2010/11 Adjusted Appropriation provides for payment of those SLA's that were not signed in 2008/09 and 2009/10. After provincialisation of clinics, the 2011/12 MTEF baseline includes inflationary increases only.

The high spending against *Machinery and Equipment* in 2007/08 relates mainly to the purchasing of motor vehicles, particularly for Forensic Pathology and TB services within the district offices and clinics. The reduction in 2008/09 and 2009/10 results from enforced savings. The minimal increase in 2010/11 relates to the need to provide additional motor vehicles for the TB programme as well as essential equipment at the District Hospitals, which had been steadily deteriorating. The significant increase in 2011/12 and 2012/13 cater for the replacement of essential equipment at institutions, and for mobile clinics and other service delivery related vehicles.

2.13. RISK MANAGEMENT

Potential Risks	Mitigating Factors
▪ Budget allocation inadequate for expansion of PHC services (curative versus promotive and preventive PHC).	▪ Alignment with service delivery needs commenced in 2010 with a stronger focus PHC including preventive and promotive health.
▪ Poor integration of services resulting in duplication, missed opportunities and poor utilisation of existing resources.	▪ Revitalisation of PHC with stronger emphasis on community-based services – through Operation Sukuma Sakhe as vehicle for promotive and preventive strategies.
▪ Inequities in allocation of resources resulting in high vacancy rates and increased workloads in some facilities which contribute to poor quality and inefficiencies.	▪ Implementation of the STP (10-year plan) will make provision for adequate allocation of resources.
▪ Increasing burden of disease. Inadequate data to measure the impact of burden of disease on service delivery jeopardise effective planning and decision-making.	▪ Identification of research priorities and coordination of research that benefit public health services – included as component of the STP.
▪ Current focus on curative services.	▪ The model for revitalisation of PHC makes provision for a paradigm shift towards promotive and preventive health care.

PROGRAMME 3. EMERGENCY MEDICAL SERVICES

3.1. PROGRAMME PURPOSE AND STRUCTURE

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

Sub-Programme 3.1: Emergency Patient Transport (EPT)

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

Sub-Programme 3.2: Planned Patient Transport (PPT)

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

Sub-Programme 3.3: Disaster Management

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

There are no changes in the purpose and structure of this Budget Programme from information presented in the 2010 – 2014 Strategic Plan.

3.2. PRIORITIES

1. **PRIORITY 1: Revitalisation of Emergency Medical Services (EMS)**

   Revitalisation will encapsulate the following:

- Organogram; Human Resources
- Accident and Emergency Services
- Emergency Medicine
- Aero Medical Services
- Emergency Management / Communications Centres
- College for Emergency Care/ Training
- Disaster Management
- Patient Transport Services
- Rescue Services
- Infrastructure
- Operations
- Clinical governance
- Finance/ Revenue collection
- Norms and standards
- Equipment/ Distribution and location of resources
- Vehicles
- Driver Training
- Information Communication Technology/ Strategy
- Media and publicity
- Patient and public feedback
- Labour relations
- Partnerships
- Branding

PLANNED PATIENT TRANSPORT (PPT)

Inter-facility transport is currently divided into:

- Planned Patient Transport which requires booking; general buses/kombis are appropriate;
- Inter-facility transport: ambulances are usually required;
- ICU transfers: ambulances are required;
- Obstetric transport: ambulances are usually required.

Extended turn-around-time transporting patients between hospitals remain a challenge due to demand currently superseding supply and distance between facilities. It is estimated that around 50% of inter-facility transportation is currently emergency inter-facility transport and not planned patient transport and inter-facility emergency transfers have to compete for ambulances with emergency cases.

In 2009/10, 99% of hospitals within the Province were covered with inter-district Planned Patient Transport (PPT) services; 68% of hospitals were covered with intra-district PPT services; and 47% of CHC's/ clinics were covered with intra-district PPT services. During the same period, 151,646 patients were transported for inter-district PPT services and 167,427 patients were transported for intra-district PPT services.

Table 45: Emergency Services Vehicles Gap

District	Current ESV's	Required ESV's	Gap
Ugu	17	71	54
Umgungundlovu	22	99	77
Uthukela	15	71	56
Umzinyathi	17	50	33
Amajuba	21	44	23
Zululand	16	90	74
Umkhanyakude	15	61	46
Uthungulu	20	89	69
Ilembe	15	53	38
Sisonke	16	50	34
eThekwini	43	347	304
KZN	**217**	**1,025**	**808**

Source: EMS database

EMS attended to more than 800,000 emergency cases and 100,000 inter-facility transfers per year. The population per ambulance is currently 473,786 compared with the national norm of 1 ambulance per 10,000 population. This places huge pressure on service delivery and impact on service and health outcomes.

Response times in both urban and rural areas are well below Provincial targets due to these resource constraints which will be addressed as part of the revitalisation strategy for Emergency Medical Services.

At present, KZN has 79 ambulances bases, with the majority based at existing health facilities. There are no custom built base stations with 50% of bases using park homes. Park homes are high maintenance and will have to be replaced with fixed structures.

UTILISATION AND DEMAND FOR SERVICES

Table 46: EMS Emergency Trauma and Emergency Medical Cases

EMS Emergency Trauma	24%
Assault cases	36%
Other trauma cases	26%
Motor vehicle accident cases	19%
Domestic accident cases	14%
Burns cases	2%
Gunshot cases	2%
Sexual assault cases	0.2%
Child abuse cases	0.1%
Industrial accident cases	0.1%

EMS Emergency Medical	76%
Other medical cases	67%
Maternity cases	21%
Asthmatic cases	5%
Acute cardiac condition cases	2%
Diabetic cases	2%
Hypertension cases	2%
CVA (stroke) cases	2%

Source: EMS database

The EMS cases attended to are categorized as either trauma or medical. In 2009/10, 24% of the cases were trauma and 76% medical. The table outlines the categories within each.

COMMUNICATION CENTRE AND SYSTEMS

There are currently eleven Control Centres in the Province, five of which have been upgraded to the computerized system (Ilembe, Ugu, Uthukela, Umgungundlovu and eThekwini). There is one Provincial Health Operations Centre dealing with the flight desk for aero-medical services and Provincial health issues.

RESPONSE TO MATERNITY EMERGENCIES

The Department has implemented a dedicated Obstetric Ambulance per district, consisting of the current 11 vehicles for the transport of maternity cases only. All maternity related cases are triaged as red code and dispatched accordingly.

Table 47 (EMS1): Situation Analysis Indicators for EMS

Indicators	Data Source	Province wide value 2009/10	Ugu 2009/10	Umgungundlovu 2009/10	Uthukela 2009/10	Umzinyathi 2009/10	Amajuba 2009/10	Zululand 2009/10	Umkhanyakude 2009/10	Uthungulu 2009/10	Ilembe 2009/10	Sisonke 2009/10	eThekwini 2009/10	National Average 2009/10
1. Rostered ambulances per 10,000 people	EMS Database	0.2	0.2	0.2	0.6	0.1	0.3	0.2	0.3	0.2	0.2	0.3	0.2	0.8
2. P1 calls with a response of time <15 minutes in an urban area	EMS Database	19%	5%	17%	10%	35%	84%	0%	0%	44%	6%	0%	11%	54.11%
3. P1 calls with a response time of <40 minutes in a rural area	EMS Database	36%	15%	18%	28%	39%	92%	43%	28%	44%	19%	39%	26%	53.08%
4. All calls with a response time within 60 minutes	EMS Database	53%	30%	31%	52%	70%	99%	62%	34%	59%	28%	56%	91%	67.97%

Source: 2009/10 Annual Report

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

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 48 (EMS2): Provincial Strategic Objectives and Annual Targets for EMS

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
1.12) To revitalise EMS and improve response times to ≥ 70% for rural and urban areas by 2014/15	1.12.1) Rostered ambulances per 10,000 people[54]	1/10,000 (450)	EMS Database	0.26 (241)	0.25 (226)	0.24 (217)	0.2 (220)	0.41 (320)	0.45 (360)	0.5 (400)
	1.12.2) Total number of EMS emergency cases	1,435,951	EMS Database	New indictor	New indicator	*713,923	821,011	944,162	1,085,786	1,248,653
	1.12.3) Total number of inter-facility transfers	187,224	EMS Database	New indictor	New indictor	116,253	127,878	140,665	154,731	170,204
1.13) To establish effective training programmes to provide an adequate skills base for EMS services in accordance with national norms	1.13.1) Locally based staff with training in BLS (BAA)	20%	HPCSA	76%	77%	72%	72%	78%	80%	82%
	1.13.2) Locally based staff with training in ILS (AEA)	50%	HPCSA	23%	21.4%	25%	24%	28%	31%	35%
	1.13.3) Locally based staff with training in ALS (Paramedics)	30%	HPCSA	2.3%	1.6%	3%	3%	4%	6%	10%

Source: 2010/11 APP for 2007/08 and 2008/09 data; 2009/10 Annual Report for 2009/10 data

Note *: Data has been adjusted since the Annual Report 2009/10 – targets reviewed based on updated data

[54] Indicator incorrectly calculated previously, is now corrected. Uninsured population utilised in calculation

Table 49 (EMS3): Performance Indicators for EMS and Patient Transport

Indicators	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Rostered Ambulances per 10,000 people[55]	EMS Database	No	0.26 (241)	0.25 (226)	0.24 (217)	0.2 (220)	0.41 (320)	0.45 (360)	0.5 (400)	1/10,000
2. P1 calls with a response of time <15 minutes in an urban area	EMS Database	%	41%	28.1%	19%	13%	15%	20%	25%	80%
3. P1 calls with a response time of <40 minutes in a rural area	EMS Database	%	45%	39%	36%	39%	45%	50%	55%	80%
4. All calls with a response time within 60 minutes	EMS Database	%	57%	62.9%	53%	43%	50%	55%	60%	100%

Source: 2010/11 APP for 2007/08 and 2008/09 data; 2009/10 Annual Report for 2009/10 data

[55] Previous indicator read: 'Rostered ambulances per 10,000 population

3.4. QUARTERLY TARGETS FOR EMS

Table 50 (EMS4): Quarterly Targets for EMS for 2011/12

Performance Indicators	Annual Targets 2011/12	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly					
1. P1 calls with a response of time <15 minutes in an urban area	15%	13%	14%	15%	15%
2. P1 calls with a response time of <40 minutes in a rural area	45%	39%	41%	44%	45%
3. All calls with a response time within 60 minutes	50%	43%	45%	48%	50%
4. Total number of EMS emergency cases	944,162	165,634	201,040	270,040	307,448
5. Total number of inter facility transfers	140,665	35,166	35,166	35,167	35,166
Annual					
6. Rostered Ambulances per 10,000 people	0.41 (320)				0.41 (320)
7. Locally based staff with training in BLS (BAA)	78%				78%
8. Locally based staff with training in ILS (AEA)	28%				28%
9. Locally based staff with training in ALS (Paramedics)	4%				4%

3.5. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 51 (EMS5 (a): Expenditure Estimates for EMS

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R' thousands	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Emergency Transport	528 185	636 096	741 331	819 853	821 974	826 982	883 803	953 296	1 008 742
Planned Transport	20 611	36 264	41 001	46 530	43 214	40 289	42 944	45 966	48 169
Total	**548 796**	**672 360**	**782 332**	**866 383**	**865 188**	**867 271**	**926 747**	**999 262**	**1 056 911**

Source: BAS

Table 52 (EMS5 (b): Summary of provincial Expenditure estimates by Economic Classification

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Current payments	**522 768**	**590 768**	**711 960**	**756 992**	**771 510**	**757 164**	**809 271**	**874 912**	**925 727**
Compensation of employees	341 040	381 733	486 534	537 268	552 073	522 649	559 234	598 380	640 267
Goods and services	**181 728**	**209 035**	**225 426**	**219 724**	**219 437**	**234 515**	**250 037**	**276 532**	**285 460**
Communication	16 344	14 865	12 940	14 608	10 500	9 235	10 158	11 117	12 228
Computer Services	1 561	11 112	15 040	11 469	12 500	10 519	11 570	12 727	13 999
Consultants, Contractors and special services	12 297	58 304	66 454	72 973	64 536	77 514	81 568	85 646	86 934
Inventory	109 024	80 725	74 344	66 369	73 520	75 300	83 099	98 887	102 411
Operating leases	6 905	10 685	9 044	11 587	9 100	15 216	16 281	17 420	18 639
Travel and subsistence	4 234	3 170	4 999	3 832	4 000	3 590	3 781	3 970	4 089
Interest and rent on land									

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Maintenance , repair and running costs									
Financial transactions in assets and liabilities	12				34	146			
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	31 363	30 174	42 605	38 886	45 281	43 141	43 580	46 765	47 160
Transfers and subsidies to	**442**	**8 660**	**1 028**	**594**	**847**	**1 145**	**1 100**	**1 155**	**1 213**
Provinces and municipalities	130	511					964	990	1 112
Departmental agencies and accounts									
Universities and Technikons									
Non-profit institutions									
Households	442	8 660	1 028	594	847	1 145	1 100	1 155	1 213
Payments for capital assets	**25 586**	**72 932**	**69 344**	**108 797**	**92 797**	**108 816**	**116 376**	**123 195**	**129 971**
Buildings and other fixed structures	576					18			
Machinery and equipment	24 998	72 932	69 344	108 797	92 797	108 798	116 376	123 195	129 971
Software and other intangible assets	12								
Total economic classification	**548 796**	**672 360**	**782 332**	**866 383**	**865 188**	**867 271**	**926 747**	**999 262**	**1 056 911**

Source: BAS

3.6. PERFORMANCE AND EXPENDITURE TRENDS

Tables EMS5 (a) and EMS5 (b) summarise payments and budgeted estimates pertaining to Programme 3. The increase from 2008/09 is largely due to funding provided to appoint additional staff and to purchase additional vehicles to accommodate the expansion of the programme in preparation for the 2010 World Cup. The increasing trend from 2008/09 onward is in line with the planned expansion of Emergency Medical Services to the under-served areas in KZN. A portion of the increase in 2008/09 relates to the preparation of Call Centres for the 2010 World Cup. The significant increase in 2009/10 is due to the higher than anticipated 2009 wage agreement, the OSD for emergency medical workers, and additional costs incurred through preparations for the 2010 World Cup. The Main Appropriation for 2010/11 includes an additional R60 million for the 2010 World Cup, which contributed towards the drive to meet the national norms for this service. The MTEF allocations include funding to continue this drive.

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

The increase in *Compensation of Employees* in 2009/10 relates to the higher than anticipated 2009 wage agreement, the introduction of OSD for medical personnel, as well as reprioritisation of funding to bring the salaries of the emergency medical workers in line with those in the other provinces in order to retain staff and to avoid strike action. The main cost drivers under *Goods and Services* are fuel and repairs to emergency vehicles, the latter being related to the rough terrain in the rural areas of the Province. These costs will increase as the service expands, with a related increase in the size of the fleet. The increase in the 2010/11 Revised Estimate relates mainly to an increase in fuel costs and the cost of maintaining vehicles.

With regard to *Transfers and Subsidies to Households,* the increase in 2008/09 pertains to a legal claim against the Department by the First Aid League.

The increase in 2008/09 against *Machinery and Equipment* relates to the late delivery of emergency vehicles ordered in 2007/08. In 2009/10, funding was moved from this category to *Compensation of Employees* in order to align the salaries of the emergency medical workers with those in the other provinces. The sharp increase from 2010/11 provides for the purchasing of additional emergency vehicles, contributing towards the drive to meet the national norms for this service.

3.7. RISK MANAGEMENT

Potential Risks	Mitigating Factors
▪ Considerable variations in service levels between districts	▪ Implementation of the Revitalisation Strategy to address current challenges and provide for future service needs and demands.
▪ Organogram – Current organogram does not support current or future service demands and needs i.e. service delivery; seniority; and skills/competencies.	
▪ Temporary Ambulance Bases expensive – should be replaced with permanent infrastructure.	
▪ Lack of managerial acumen; ▪ Lazes' Faire attitude and apathy	
▪ Inadequate and ageing fleet; ▪ Lack of equipment	

PROGRAMME 4. PROVINCIAL HOSPITALS

4.1. PROGRAMME PURPOSE AND STRUCTURE

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

Sub-Programme 4.1: Regional Hospitals

Render Regional Hospital Services at specialist level

Sub-Programme 4.2: Specialised TB Hospitals

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

Sub-Programme 4.3: Specialised Mental Health Hospitals

Render Hospital services for Mental Health

Sub-Programme 4.4: Dental Health Hospitals

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

Sub-Programme 4.5: Step-Down and Rehabilitation Hospitals

Render Step-Down and Rehabilitation services to the chronically ill

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

The strategies and performance indicators of all services (Regional and Specialised Hospitals) not specifically identified as priority in the Annual Performance Plan, will be included in Operational Plans and monitored quarterly to ensure effective performance and outcomes-based monitoring and reporting.

4.2. PRIORITIES

PRIORITY 1: Rationalisation of hospital services

- Finalise service delivery platform for Regional Hospital services as part of STP process.
- Review post establishments to ensure adequate allocation of financial and human resources.
- Review and establish effective referral systems in collaboration with EMS.
- Review delegations to ensure more effective decentralised operational management, accountability and control.

PRIORITY 2: Improve the quality and efficiency of Regional and Specialised Hospital services

- Improve clinical governance.
- Improve mortality reviews and Quality Improvement Programmes.

- Implement the National Core Standards towards national accreditation of facilities.
- Expand the “Look like a Hospital Project”.
- Improve community participation and consultation through appointment and training of Hospital Boards.

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

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 53 (PHS1 (a): Provincial Strategic Objectives and Annual Targets for Regional and Specialised Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
1.14) To rationalize hospital services in line with service delivery needs and STP imperatives[56]	1.14.1) Number of CEO's (Regional Hospitals) who have signed delegation of authorities	14/ 14	Signed delegations	New indicator	New indicator	New indicator	14	14	14	14
	1.14.2) Number of CEO's (Specialised TB Hospitals) who have signed delegation of authorities	10/ 10	Signed delegations	New indicator	New indicator	New indicator	10	10	10	10
	1.14.3) Number of CEO's (Specialised Psychiatric Hospitals) who have signed delegation of authorities	6/ 6	Signed delegations	New indicator	New indicator	New indicator	6	6	6	6
	1.14.4) Number of CEO's (Specialised Chronic Care Hospitals) who have signed delegation of authorities	2/ 2	Signed delegations	New indicator	New indicator	New indicator	2	2	2	2

Source: 2010/11 APP

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

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

Table 54 (PHS1 (b): Provincial Strategic Objectives and Annual Targets for Regional and Specialised Hospitals

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
2.3) To implement the National Core Standards in 100% of Regional Hospitals for accreditation of 100% facilities by 2012/13[57]	2.3.1) Number of Regional Hospitals accredited[58]	14/ 14	National database	New indicator	New indicator	New indicator	Accreditation Body not established	10[59]	4 (14)	14
	2.3.2) Number of Regional Hospitals conducting annual Patient Satisfaction Surveys	14/ 14	DQPR	Data not available	11/14[60]	12/14	5/14	14	14	14
	2.3.3) Average patient waiting time at OPD	≤1 hr	DQPR	New indicator	New indicator	New indicator	Data not verified	<4 ½ hrs	<4 hrs	<2hrs
	2.3.4) Average patient waiting time at admissions	≤1 hr	DQPR	New indicator	New indicator	New indicator	Data not verified	<4 ½ hrs	<4 hrs	<2 hrs
2.4) To implement the National Core Standards in 100% of Specialised TB Hospitals for accreditation of 100% hospitals by 2014/15[61]	2.4.1) Number of Specialised TB Hospitals accredited annually	10 / 10	National database	New indicator	New indicator	New indicator	Accreditation Body not established	3	3 (6)	4 (10)

[57] Accreditation is dependent on the National processes
[58] Accreditation of health facilities is dependent on the National Department of Health processes
[59] Must review target based on delayed national process
[60] Data incomplete
[61] Accreditation is dependent on established National Accreditation Body

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
2.5) To implement the National Core Standards in 100% of Specialised Psychiatric Hospitals for accreditation of 100% hospitals by 2014/15[62]	2.5.1) Number of Specialised Psychiatric Hospitals accredited annually	6/ 6	National Database	New indicator	New indicator	New indicator	Accreditation Body not established	1	5 (6)	6
2.6) To implement the National Core Standards in 100% of Specialised Chronic Hospitals for accreditation of 100% hospitals by 2011/12[63]	2.6.1) Number of Specialised Chronic Care Hospitals accredited annually	2/ 2	National Database	New indicator	New indicator	New indicator	Accreditation Body not established	2	2	2

Source: 2010/11 APP

[62] Accreditation is dependent on the National processes
[63] Accreditation is dependent on the National processes

Table 55 (PHS2 (a): Performance Indicators for Regional Hospitals

Indicator	Data Source	Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Caesarean section rate	DHIS	%	32%	31.6%	38.8%	43%	40%	39%	38%	25%
2. Separations - total	DHIS	No	351,169	355,778	355,231	312,932	356,567	361,084	362,173	-
3. Patient day equivalents - total	DHIS	No	2,663,297	2,797,350	2,903,847	2,822,164	2,904,952	2,983,100	2,990,241	-
4. OPD headcounts - total	DHIS	No	2,702,113	2,752,678	2,673,272	2,691,646	2,817,960	2,875,498	2,912,112	-
5. Average length of stay	DHIS	Days	4.8 Days	5.3 Days	5 Days	5.6 Days	5.2 Days	5.1 Days	5 Days	4.8 Days
6. Bed utilisation rate	DHIS	%	66%	71.3%	72.8%	74%	74%	75%	75%	75%
7. Expenditure per patient day equivalent (PDE)	BAS/ DHIS	R	R 1 119	R 1 175	R1 421	R1 459	R 1 600	R1 700	R1 750	-
8. Percentage of complaints of users of Regional Hospital services resolved within 25 days	DQPR	%	New indicator	56%	84%	81%	100%	100%	100%	-
9. Percentage of Regional Hospitals with monthly maternal mortality and morbidity meetings	DQPR	%	New indicator	New indicator	100%	100%	100%	100%	100%	-
10. Percentage of users of Regional Hospital services satisfied with services received	DQPR	%	New indicator	New indicator	New indicator	New indicator	Establish baseline	Targets based on baseline	Targets based on baseline	-
11. Number of Regional Hospitals assessed for compliance with the 6 Priorities of the core standards	DQPR	No	New indicator	New indicator	New indicator	New indicator	Routine 100%	Routine 100%	Routine 100%	-

Source: 2010/11 APP and National Template

4.4. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND TARGETS FOR SPECIALISED HOSPITALS

Table 56 (PHS2 (b): Performance Indicators for Specialised TB Hospitals

Indicator	Data Source	Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Separations - total	DHIS	No	9,425	8,452	9,113	8,072	8,500	8,900	9,200	-
2. Patient day equivalents - total	DHIS	No	*514,774	*510,220	518,685	422,186	521,781	550,374	583,653	-
3. OPD headcounts - total	DHIS	No	56,372	59,554	64,853	78,556	87,897	96,348	109,042	-
4. Average length of stay	DHIS	Days	51.4 Days	60.4 Days	54.5 Days	46.3 Days	Data audit to set target	Target review	Target review	-
5. Bed utilisation rate	DHIS	%	64.8%	75.1%	70.1%	57%	65%	70%	73%	-
6. Expenditure per patient day equivalent (PDE)	DHIS BAS	R	R1 073.33	R1 432.18	R1 516.95	R1 557.47	R1 676	R1 700	R1 750	-

Source: 2010/11 APP and National Template

Table 57 (PHS2 (c): Performance Indicators for Specialised Psychiatric Hospitals

Indicator	Data Source	Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Separations – total	DHIS	No	3,875	2,073	1,965	1,340	1,350	1,410	1,550	-
2. Patient day equivalents - total	DHIS	No	683,845	647,211	628,878	477,908	641,053	646,201	652,457	-
3. OPD headcounts - total	DHIS	No	6,166	5,048	14,409	10,720	12,500	13,000	13,800	-
4. Average length of stay	DHIS	Days	1,543 Days	1,788 Days	315 Days -	354 Days -	Data audit to	Review target	Review target	-

Indicator	Data Source	Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
					questionable	questionable	review target			
5. Bed utilisation rate	DHIS	%	61.79%	61.23%	71.6%	68%	70%	73%	75%	-
6. Expenditure per patient day equivalent (PDE)	DHIS BAS	R	R 598.86	R 697.50	R810.96	R1 041	R 1 100	R 1 250	R1 300	-

Source: 2010/11 APP and National Template

Table 58 (PHS2 (d): Performance Indicators for Specialised Chronic Hospitals

Indicator	Data Source	Type	Audited /Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Separations – total	DHIS	No	4,592	5,144	4,344	3,160	4,310	4,510	4,690	-
2. Patient day equivalents - total	DHIS	No	133,093	147,821	150,513	127,370	146,341	150,763	159,751	-
3. OPD headcounts - total	DHIS	No	Not available	Not available	Not available	3,746	3,877	3,998	4,113	-
4. Average length of stay	DHIS	Days	414.4 Days	471 Days	27 Days - questionable	40 Days - questionable	Data audit to review target	Review target	Review target	-
5. Bed utilisation rate	DHIS	%	75.4%	74.9%	82.5%	71%	75%	75%	75%	-
6. Expenditure per patient day equivalent (PDE)	DHIS BAS	R	R 693.98	R 634.99	R662.08	R730.66	R 943	R 960	R1 000	-

Source: 2010/11 APP and National Template

4.5. QUARTERLY TARGETS FOR GENERAL HOSPITALS

Table 59 (PHS4): Quarterly Targets for Regional Hospitals for 2011/12

Performance Indicators	Annual Targets 2011/12	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly					
1. Caesarean section rate	40%	43%	42%	41%	40%
2. Separations - total	356,567	89,141	89,141	89,144	89,141
3. Patient day equivalents - total	2,904,952	726,238	726,238	726,238	726,238
4. OPD headcounts - total	2,817,960	704,490	704,490	704,490	704,490
5. Average length of stay	5.2 Days	5.6 Days	5.4 Days	5.3 Days	5.2 Days
6. Bed utilisation rate	74%	74%	74%	74%	74%
7. Expenditure per patient day equivalent (PDE)	R 1 600	R1 470	R1 500	R1 550	R1 600
8. Percentage of complaints of users of Regional Hospital services resolved within 25 days	100%	100%	100%	100%	100%
9. Percentage of Regional Hospitals with monthly maternal mortality and morbidity meetings	100%	100%	100%	100%	100%
Annual					
10. Percentage of users of Regional Hospital services satisfied with services received	Establish baseline				Establish baseline
11. Number of Regional Hospitals assessed for compliance with the core standards	Routine 14				14
12. Number of CEO's (Regional Hospitals) who have signed delegation of authorities	14	14			
13. Number of Regional Hospitals accredited[64]	10[65]				10
14. Number of Regional Hospitals conducting annual Patient Satisfaction Surveys	14				14
15. Average patient waiting time at OPD	<4 ½ hrs				<4 ½ hrs
16. Average patient waiting time at admissions	<4 ½ hrs				<4 ½ hrs

[64] Accreditation of health facilities is dependent on the National Department of Health processes
[65] Target must be reviewed based on delayed national process

Table 60 (PHS4): Quarterly Targets for Specialised TB Hospitals for 2011/12

Performance Indicators	Annual Targets 2011/12	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly					
1. Separations - total	8,500	2,125	2,125	2,125	2,125
2. Patient day equivalents - total	521,781	130,445	130,445	130,446	130,445
3. OPD headcounts - total	87,897	21,974	21,974	21,974	21,975
4. Average length of stay	Data audit	Data audit	-	-	-
5. Bed utilisation rate	65%	57%	59%	62%	65%
6. Expenditure per patient day equivalent (PDE)	R1 676	R1 557	R1 600	R1 650	R1 676
Annual					
7. Number of CEO's (Specialised TB Hospitals) who have signed delegation of authorities	10	10			

Table 61 (PHS4): Quarterly Targets for Specialised Psychiatric Hospitals for 2011/12

Performance Indicator	Annual Target 2011/12	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly					
1. Separations – total	1,350	337	337	337	338
2. Patient day equivalents - total	641,053	160,263	160,263	160,264	160,263
3. OPD headcounts - total	12,500	3,125	3,125	3,125	3,125
4. Average length of stay	Data audit for target	Data audit	-	-	-
5. Bed utilisation rate	70%	68%	68%	68%	70%
6. Expenditure per patient day equivalent (PDE)	R 1 100	R1 041	R1 100	R1 100	R1 100
Annual					
7. Number of CEO's (Specialised Psychiatric Hospitals) who have signed delegation of authorities	6	6			
8. Number of Specialised Psychiatric Hospitals accredited annually	1				1[66]

[66] Achievement of this target is dependent on establishment of the National Accreditation Body

Table 62 (PHS4): Quarterly Targets for Specialised Chronic Hospitals for 2011/12

Performance Indicator	Annual Target 2011/12	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly					
1. Separations - total	4,310	1,077	1,077	1,077	1,079
2. Patient day equivalents - total	146,341	36,585	36,585	36,585	36,586
3. OPD headcounts - total	3,877	3,778	3,811	3,844	3,877
4. Average length of stay	Data audit for target	Data audit	-	-	-
5. Bed utilisation rate	75%	71%	73%	74%	75%
6. Expenditure per patient day equivalent (PDE)	R 943	R 783	R 837	R 890	R 943
Annual					
7. Number of CEO's (Specialised Chronic Care Hospitals) who have signed delegation of authorities	2	2			
8. Number of Specialised Chronic Care Hospitals accredited annually	2				2[67]

[67] Dependent on establishment of the National Body

4.6. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 63 (PHS4 (a): Expenditure Estimates for Provincial Hospital Services

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R' thousands	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
General (Regional) Hospitals	2 890 364	3 169 928	3 664 133	3 975 671	4 160 345	4 262 986	4 670 222	5 092 143	5 322 070
Tuberculosis Hospitals	481 772	653 625	787 273	885 059	880 283	894 395	976 783	1 009 067	1 071 897
Psychiatric Hospitals	409 527	451 429	509 621	564 416	578 418	577 885	592 947	632 004	667 472
Sub-acute, step-down and chronic medical hospitals	92 364	93 865	99 578	112 463	104 896	104 070	111 323	114 421	121 414
Dental training hospital	9 787	9 967	10 685	11 575	12 650	13 907	14 907	15 855	16 848
Other specialised hospitals									
Total	**3 883 814**	**4 378 814**	**5 071 290**	**5 549 184**	**5 736 592**	**5 853 243**	**6 366 182**	**6 863 490**	**7 199 701**

Source: BAS

Table 64 (PHS4 (b): Summary of Provincial Expenditure Estimates by Economic Classification

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Current payments	**3 793 371**	**4 299 875**	**4 994 008**	**5 465 809**	**5 640 286**	**5 752 467**	**6 195 587**	**6 688 685**	**7 076 895**
Compensation of employees	2 703 673	3 015 350	3 520 810	3 938 568	4 124 279	4 188 187	4 433 228	4 709 521	5 063 859
Goods and services	**1 089 698**	**1 284 525**	**1 474 198**	**1 527 241**	**1 516 007**	**1 564 280**	**1 762 359**	**1 979 164**	**2 013 036**
Communication	18 634	18 837	18 252	19 512	16 000	18 767	18 824	20 227	20 553
Computer Services	8 680	18 168	18 560	17 922	13 758	13 798	13 872	15 405	15 598

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Consultants, Contractors and special services	190 610	271 495	316 266	290 641	310 107	219 415	276 812	304 414	311 050
Inventory	599 320	668 780	810 665	874 694	822 000	912 350	997 060	1 116 474	1 095 735
Operating leases	16 264	15 886	13 095	19 503	14 000	19 652	21 027	22 498	24 072
Travel and subsistence	7 047	5 034	3 715	5 307	3000	3 509	3 526	3 789	4 272
Interest and rent on land									
Maintenance , repair and running costs									
Financial transactions in assets and liabilities			15		268	1 179			
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	249 143	286 325	293 645	299 662	337 142	376 789	431 238	496 357	541 756
Transfers and subsidies	**50 986**	**54 499**	**58 383**	**56 874**	**69 537**	**69 463**	**83 885**	**88 096**	**88 096**
Provinces and municipalities									
Departmental agencies and accounts									
Universities and technikons									
Non-profit institutions	33 703	27 103	30 051	31 975	33 672	33 672	35 692	37 493	39 555
Households	17 283	27 396	28 332	24 899	35 865	35 791	48 193	50 603	48 541
Payments for capital assets	**39 457**	**24 440**	**17 884**	**26 501**	**26 501**	**30 134**	**86 710**	**86 79**	**34 710**
Buildings and other fixed structures	337								
Machinery and equipment	39 120	24 440	17 884	26 501	26501	30 134	86 710	86 709	34 710
Software and other intangible assets									

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimate		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Payment for financial assets			15		268	1 179			
Total economic classification	3 883 814	4 378 814	5 071 290	5 549 184	5 736 592	5 853 243	6 366 182	6 863 490	7 199 701

Source: BAS

4.7. PERFORMANCE AND EXPENDITURE TRENDS

The sustained growth in this programme caters for the various wage agreements and includes the carry-through costs of new MDR/XDR TB facilities that opened at Greytown, Murchison and Thulasizwe Hospitals. The cost of the introduction of OSD for medical personnel and the higher than anticipated wage agreements is evident in the significant annual increases. Another factor which has influenced the significant growth trend is the high rate of inflation, particularly in 2008/09 and 2009/10 on *Goods and Services*, especially on medical supplies and services, including NHLS and catering. The large increase in the 2010/11 Adjusted Appropriation is mainly due to the 2010 wage agreement and the reprioritisation of funds from the HIV and AIDS equitable share to this programme to offset the cost of unfunded mandates resulting mainly from OSD for medical personnel.

The carry-through costs are reflected in the 2011/12 MTEF, including funding for national priorities such as improving hospital norms and standards, capacity building, the previously mentioned general policy adjustment and health technology. Also affecting the 2011/12 MTEF is further funding for OSD as well as a significant amount for essential equipment.

The increase in the General (Regional) Hospitals Sub-Programme from 2008/09 relates mainly to various OSD's and wage agreements, the high inflation rate on foodstuffs and medical supplies and services, as well as the take-over of the laboratory services by NHLS in 2008/09. The significant increase in 2009/10 is also due to increased patient demand for services. The increase in the 2010/11 Adjusted Appropriation and Revised Estimates includes additional funding for OSD for medical personnel, as well as the higher than anticipated 2010 wage agreement. The significant increase over the 2011/12 MTEF relates to funding for national priorities for goods and services, registrars, improvement of public norms and standards, OSD for medical personnel and health technology and substantial additional funding to replace essential machinery and equipment, especially in 2011/12 and 2012/13.

The Tuberculosis Hospitals Sub-Programme shows a steady growth over the seven-year period, with a significant increase in 2008/09 related to the provision of funding for the treatment of MDR/XDR TB. Additional funding originally allocated in the 2008/09 MTEF grows significantly in 2011/12 as reflected in the figures going forward. Additional funding was also provided for goods and services, including linen and patient clothing, in the 2011/12 MTEF.

The increasing trend in the Psychiatric/Mental Hospitals Sub-Programme relates mainly to the various wage agreements and OSD. Additional funding was provided in 2010/11 for the OSD for medical personnel. The carry-through costs for these increases are reflected in the 2011/12 MTEF.

The increase in the Sub-Acute, Step-Down and Chronic Medical Hospitals Sub-Programme in 2010/11 relates to the movement of the Montebello Chronic Sick Home from Programme 2 - more appropriately placed here with regard to service delivery. Included in the increasing trend are the higher than anticipated annual wage agreements, OSD

expenditure and carry-through costs thereof. Additional funding was provided in 2011/12 to purchase patient clothing and bed linen.

The increase from 2007/08 against *Compensation of Employees* relates mainly to the introduction of OSD and wage agreements. The increase from 2011/12 includes a portion of the funding for the improvement of the general health capacity provided as a national priority in the 2009/10 MTEF, as well as the carry-through costs of OSD and wage agreements. Funding has also been provided in the 2011/12 MTEF for national priorities including capacity building, registrars, improving hospital norms and standards, and general policy adjustment.

The significant increase against *Goods and Services* from 2007/08 to 2008/09 pertains mainly to the high inflation rate, especially on foodstuffs and medical supplies and services, as well as the cost of the NHLS. The notable increase from 2008/09 to 2009/10 is mainly due to significant increases in laboratory services fees and the cost of medicines and medical supplies, as well as the high rate of inflation. The increase in the 2010/11 Revised Estimate relates to the increase in municipal charges, such as electricity, and the cost of ensuring the continuation of services during the extended strike in 2010. Included in the trend for the 2011/12 MTEF is national priority funding for improving norms and standards at public hospitals, additional capacity for purchasing goods and services and funding for the general policy adjustment.

Transfers and Subsidies to Non-Profit institutions show a downward trend from 2007/08 to 2008/09 due to the previously mentioned provincialisation of two life-care institutions in June 2007 (Richmond Chest and Ekuhlengeni Psychiatric Hospitals). Since provincialisation, these institutions are catered for under *Current Payments*. The increase in 2009/10 relates to the introduction of OSD for doctors in those institutions which qualify. The higher than anticipated wage agreements also impact on this category. Increases over the 2011/12 MTEF are for inflationary purposes only.

Machinery and Equipment in 2007/08 included the once-off purchase of vehicles and ventilator equipment for the TB crisis in KZN. This accounts for the decrease in 2008/09, as well as a drive in that year to reduce overall expenditure. The decrease in 2009/10 relates mainly to cost-cutting. The increase from 2010/11 relates to the need to replace essential equipment, especially at Regional Hospitals.

4.8. RISK MANAGEMENT

Potential Risks	Mitigating Factors
▪ Deteriorating infrastructure and delays/ backlogs in infrastructure projects and maintenance.	▪ Integrated Infrastructure Plan and improved management of infrastructure maintenance at facility level.
▪ High vacancy rates for Specialists impact on implementation of package of services and continuum of care – especially relevant to more rural areas.	▪ Review of service delivery platform and retention strategies.

Potential Risks	Mitigating Factors
▪ Lack of management competencies and appropriate development programmes.	▪ Establishment of appropriate training and development programmes.
▪ Inadequate clinical governance.	▪ Improved clinical governance including oversight arrangements.

PROGRAMME 5. TERTIARY AND CENTRAL HOSPITALS

5.1. PROGRAMME PURPOSE AND STRUCTURE

Rendering Quaternary and other Tertiary Health Services

Sub-Programme 5.1: Central Hospitals

Rendering Central and Quaternary Hospital Services

Sub-Programme 5.2: Tertiary Hospitals

Rendering Tertiary Hospital services

There are no changes in the purpose of this Budget Programme from information presented in the 2010 – 2014 Strategic Plan.

Strategies and activities for Tertiary and Central Hospitals not specifically identified as priority in the Annual Performance Plan, will be included in Operational Plans of hospitals and monitored quarterly to ensure effective performance and outcomes-based monitoring and reporting.

5.2. TERTIARY HOSPITAL

5.2.1. PRIORITIES

PRIORITY 1: Rationalisation of hospital services

- Review service delivery platform including hospital structures and post establishments.
- Review and establish effective referral systems in collaboration with EMS.
- Monitor the implementation of the National Tertiary Services Grant (NTSG) Business Plan.

PRIORITY 2: Improve quality of care through improved clinical governance, accountability and oversight

- Implementation of the National Core Standards and the Quality Improvement Plans towards national accreditation of facilities.
- Improve clinical governance.
- Strengthen mortality (including maternal and neonatal morbidity and mortality) reviews.

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

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 65 (THS1 (a): Provincial Strategic Objectives and Annual Targets for Tertiary Hospital (Greys Hospital)

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
1.15) To rationalize hospital services in line with service delivery needs and STP imperatives[68]	1.15.1) Number of CEO's (Tertiary Hospital) who have signed delegation of authorities	1/1	Signed delegations	New indicator	New indicator	New indicator	1	1	1	1

Source: 2010/11 APP

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

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

Table 66 (CHS1 (b): Provincial Strategic Objectives and Annual Targets for Tertiary Hospital (Greys Hospital)

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
2.7) To implement the National Core Standards in 100% of Tertiary Hospitals for accreditation of 100% facilities by 2011/12 [69]	2.7.1) Number of Tertiary Hospitals accredited annually	1 / 1	National Database	New target	New target	New target	National Body not established	1	1	1
	2.7.2) Number of Tertiary Hospitals conducting Annual Patient Satisfaction Surveys	1 / 1	DQPR	Data not available	1/ 1	1/1	1/1	1	1	1
	2.7.3) Average patient waiting time at OPD	<1 hour	DQPR	New indicator	New indicator	New indicator	2hrs	<4 ½ hrs	<4 hrs	<2 hrs
	2.7.4) Average patient waiting time at admissions	<1 hour	DQPR	New indicator	New indicator	New indicator	No data available	<4 ½ hrs	<4 hrs	<2 hrs

Source: 2010/11 APP

[69] Accreditation is dependent on the National processes

Table 67 (THS2): Performance Indicators for Tertiary Hospital (Greys Hospital)

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Caesarean section rate	DHIS	%	61.2%	69.4%	62,6%	70%	70%	68%	68%	30%
2. Separations - total	DHIS	No	12,016	11,919	10,755	11,742	12,266	12,967	13,217	-
3. Patient Day Equivalents - total	DHIS	No	186,627	193,913	180,119	191,240	192,938	194,136	195,279	-
4. OPD headcounts - total	DHIS	No	194,346	196,857	203,358	179,236	181,793	190,893	198,996	-
5. Average length of stay	DHIS	Days	10.3 Days	9.9 Days	10.4 Days	10.3 Days	9 Days	8 Days	7 Days	5.5 Days
6. Bed utilisation rate	DHIS	%	75.5%	70.9%	65.4%	72%	73%	74%	75%	75%
7. Expenditure per patient day equivalent (PDE)	BAS	R	R1 949	R 2 170	R2 601	R2 427	R 3 250	R 3 300	R 3 400	-
8. Percentage of complaints of users of Tertiary Hospital services resolved within 25 days	100%	%	New indicator	100%	100%	No data available	100%	100%	100%	-
9. Percentage of Tertiary Hospitals with monthly maternal mortality and morbidity meetings	100%	%	New indicator	100%	100%	100%	100%	100%	100%	-
10. Percentage of users of Tertiary Hospital services satisfied with services received	DQPR	%	New indicator	New indicator	New indicator	New indicator	Establish Baseline	Target based on baseline	Target based on baseline	-
11. Number of Tertiary Hospitals assessed for compliance with the 6 Priorities of the core standards	DQPR	No	New indicator	New indicator	New indicator	New indicator	Routine 1	Routine 1	Routine 1	-

Source: 2010/11 APP for 2007/08 and 2008/09 data; 2009/10 Annual Report for 2009/10 data

5.2.4. QUARTERLY TARGETS FOR TERTIARY HOSPITALS

Table 68 (THS3): Quarterly Targets for Tertiary Hospital (Greys Hospital)

Performance Indicators	Annual Target 2011/12	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly					
1. Caesarean section rate	70%	70%	70%	70%	70%
2. Separations - total	12,266	3,066	3,066	3,066	3,068
3. Patient Day Equivalents - total	192,938	48,234	48,234	48,234	48,236
4. OPD headcounts - total	181,793	45,448	45,448	45,448	45,449
5. Average length of stay	9 Days	10 Days	9.5 Days	9 Days	9 Days
6. Bed utilisation rate	73%	72%	72%	73%	73%
7. Expenditure per patient day equivalent (PDE)	R3 250	R2 427	R2 550	R3 000	R3 250
8. Percentage of complaints of users of Tertiary Hospital services resolved within 25 days	100%	100%	100%	100%	100%
9. Percentage of Tertiary Hospitals with monthly maternal mortality and morbidity meetings	100%	100%	100%	100%	100%
Annual					
10. Percentage of users of Tertiary Hospital services satisfied with services received	Establish baseline				Baseline established
11. Number of Tertiary Hospitals assessed for compliance with the 6 Priorities of the core standards	Routine 1				Routine 1
12. Number of CEO's who have signed delegation of authorities	1	1			
13. Number of Tertiary Hospitals accredited annually	1				1
14. Number of Tertiary Hospitals conducting Annual Patient Satisfaction Surveys	1				1
15. Average patient waiting time at OPD	< 4 ½ hrs				< 4 ½ hrs
16. Average patient waiting time at admissions	< 4 ½ hrs				< 4 ½ hrs

5.3. CENTRAL HOSPITAL

NAME OF HOSPITAL: INKOSI ALBERT LUTHULI CENTRAL HOSPITAL (IALCH)

5.3.1. PRIORITIES

PRIORITY 1: Rationalisation of hospital services

- Review service delivery platform including hospital structures and post establishments.
- Review and establish effective referral systems in collaboration with EMS.
- Monitor the implementation of the National Tertiary Services Grant (NTSG) Business Plan.

PRIORITY 2: Improve quality of care through improved clinical governance, accountability and oversight

- Implementation of the National Core Standards and the Quality Improvement Plans towards national accreditation of facilities.
- Improve clinical governance.
- Strengthen mortality (including maternal and neonatal morbidity and mortality) reviews.

PRIORITY 3: Review the PPP with Impilo Consortium (Pty) Ltd.

5.3.2. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND TARGETS FOR IALCH

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 69 (CHS1 (a): Provincial Strategic Objectives and Annual Targets for IALCH

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
1.16) To rationalize hospital services in line with service delivery needs and STP imperatives[70]	1.16.1) Number of CEO's who have signed delegation of authorities	1 / 1	Signed delegations	New indicator	New indicator	New indicator	1	1	1	1

Source: 2010/11 APP

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

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

Table 70 (CHS1 (b): Provincial Strategic Objectives and Annual Targets for IALCH

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
2.8) To implement the National Core Standards in 100% of Central Hospitals for accreditation of 100% facilities by 2010/11[71]	2.8.1) Number of Central Hospitals accredited annually	1 / 1	National Database	New indicator	New indicator	New indicator	Accreditation Body not established	1	1	1
	2.8.2) Number of Central Hospitals conducting Annual Patient Satisfaction Surveys	1 / 1	DQPR	Data not available	1/ 1	1/1	0/1[72]	1	1	1
	2.8.3) Average patient waiting time at OPD	< 1 hour	DQPR	New indicator	New indicator	New indicator	No data	< 4 ½ hrs	< 4 hrs	< 2 hrs
	2.8.4) Average patient waiting time at admissions	< 1 hour	DQPR	New indicator	New indicator	New indicator	No data	< 4 ½ hrs	< 4 hrs	< 2 hrs

Source: 2010/11 APP

[71] Accreditation is dependent on the National processes
[72] Annual indicator that might change during the course of the year

Table 71 (CHS2): Performance Indicators for Central Hospital (IALCH)

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Caesarean section rate	DHIS	%	78%	81.5%	74%	70%	67%	65%	63%	50%
2. Separations - total	DHIS	No	14,405	20,886	20,204	20,248	22,488	24,215	26,015	-
3. Patient day equivalents - total	DHIS	No	190,245	242,334	253,344	248,586	269,014	278,429	279,394	-
4. OPD headcounts - total	DHIS	No	159,459	174,704	182,688	161,244	185,111	197,062	199,033	-
5. Average length of stay	DHIS	Days	9.5 Days	8.8 Days	9.1 Days	9.1 Days	8 Days	7 Days	6 Days	5.5 Days
6. Bed utilisation rate	DHIS	%	42%	62.8%	66.2%	66%	69%	72%	74%	75%
7. Expenditure per patient day equivalent (PDE)	BAS	R	R5 300	R6 307	R8 396	R8 536	R 8 000	R 8 000	R 7 600	-
8. Percentage of complaints of users of Central Hospital services resolved within 25 days	DQPR	%	New indicator	62%	72%	No data available	100%	100%	100%	-
9. Percentage of Central Hospitals with monthly maternal mortality and morbidity meetings	DQPR	%	New indicator	100%	100%	100%	100%	100%	100%	-
10. Percentage of users of Central Hospital services satisfied with services received	DQPR	%	New indicator	New indicator	New indicator	New indicator	Establish Baseline	Based on baseline	Based on baseline	-
11. Number of Central Hospitals assessed for compliance with the 6 Priorities of the core standards	DQPR	No	New indicator	New indicator	New indicator	Routine 1/1	Routine 1	Routine 1	Routine 1	-

Source: 2010/11 APP for 2007/08 and 2008/09; 2009/10 Annual Report for 2009/10

5.3.4. QUARLTERLY TARGETS FOR CENTRAL HOSPITALS 2011/12

Table 72 (CHS3): Quarterly Targets for Central Hospital (IALCH)

Performance Indicators	Annual Target 2011/12	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly					
1. Caesarean section rate	67%	70%	69%	69%	67%
2. Separations - total	22,488	5,622	5,622	5,622	5,622
3. Patient day equivalents - total	269,014	67,253	67,253	67,253	67,255
4. OPD headcounts - total	185,111	46,277	46,277	46,277	46,270
5. Average length of stay	8 Days	Days	Days	Days	8 Days
6. Bed utilisation rate	69%	67%	67%	68%	69%
7. Expenditure per patient day equivalent (PDE)	R 8 000	R 8 500	R 8 450	R 8 200	R 8 000
8. Percentage of complaints of users of Central Hospital services resolved within 25 days	100%	100%	100%	100%	100%
9. Percentage of Central Hospitals with monthly maternal mortality and morbidity meetings	100%	100%	100%	100%	100%
Annual					
10. Percentage of users of Central Hospital services satisfied with services received	Establish baseline				Baseline
11. Number of Central Hospitals assessed for compliance with the 6 Priorities of the core standards	Routine 1				Routine 1
12. Number of CEO's who have signed delegation of authorities	1	1			
13. Number of Central Hospitals accredited annually	1				1[73]
14. Number of Central Hospitals conducting Annual Patient Satisfaction Surveys	1				1
15. Average patient waiting time at OPD	<4 ½ hrs				<4 ½ hrs
16. Average patient waiting time at admissions	<4 ½ hrs				<4 ½ hrs

[73] Achievement of the target is dependent on establishment of National Body

5.3.5. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 73 (CH7 (a): Expenditure Estimates for central and Tertiary Services

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R' thousands	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Central Hospitals	427 508	502 028	506 868	684 786	694 030	705 949	742 612	804 225	819 008
Tertiary Hospitals	980 195	1 319 193	1 552 267	1 460 031	1 584 440	1 512 478	1 731 370	1 937 798	2 121 692
Total	**1407 703**	**1 821,221**	**2 059 135**	**2 144 817**	**2 278 470**	**2 218 427**	**2 473 982**	**2 742 023**	**2 940 700**

Source: BAS

Table 74 (CH7 (b): Summary of Provincial Expenditure Estimates by Economic Classification

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Current payments	**1 259 830**	**1 547 759**	**1 747 573**	**1 910 731**	**2 044 384**	**1 996 433**	**2 193 724**	**2 425 432**	**2 581 782**
Compensation of employees	572 218	717 374	802 490	883 195	1 031 848	1 025 034	1 115 927	1 206 375	1 320 318
Goods and services	**687 612**	**830 385**	**945 083**	**1 027 536**	**1 012 536**	**971 399**	**1 077 797**	**1 219 057**	**1 261 464**
Communication	4 065	3 298	3 398	4 208	3500	3 419	3760	4 136	4 549
Computer Services	1045	299	262	104	299	245	300	350	375
Consultants, Contractors and special services	28 241	56 040	60 403	54 488	48 800	32 878	56983	67 001	78 885
Inventory	312 681	388 967	473 216	548 054	473 400	500 558	532 497	599 029	611 071
Operating leases	1 982	571	512	1010	1 000	471	509	534	550
Travel and subsistence	1 001	1 391	589	1 020	720	740	798	838	863
Interest and rent on land									

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Maintenance , repair and running costs									
Financial transactions in assets and liabilities						32			
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	338 597	379 819	406 703	418 652	484 817	433 088	482 950	547 169	565 171
Transfers and subsidies to	**624**	**8 186**	**2 653**	**3 555**	**3 555**	**4 816**	**3 645**	**3 827**	**3 827**
Provinces and municipalities									
Departmental agencies and accounts									
Universities and Technikons									
Non-profit institutions									
Households	624	8 186	2 653	3 555	3 555	4 816	3 645	3 827	3 827
Payments for capital assets	**147 249**	**265 276**	**3 08 909**	**230 531**	**230 531**	**217 146**	**276 613**	**312 764**	**355 091**
Buildings and other fixed structures									
Machinery and equipment	147 249	265 276	308 909	230 531	230 531	217 146	276 613	312 764	355 091
Software and other intangible assets									
Total economic classification	**1 407 703**	**1 821 221**	**2 059 135**	**2 144 817**	**2 278 470**	**2 218 427**	**2 473 982**	**2 742 023**	**2 940 700**

Data Source: BAS

5.4. PERFORMANCE AND EXPENDITURE TRENDS

The sustained positive growth across Programme 5 from 2008/09 onward is due to the increasing demand for Tertiary and Central Hospital services and the introduction of the initiative for the Modernisation of Tertiary Services in 2007/08, as well as the various OSD's for medical personnel, the annual wage agreements and the related carry-through costs. The significant increases from 2007/08 to 2008/09 and from 2008/09 to 2009/10 relate mainly to the high inflation rate on medicines, medical supplies and medical service costs. The 2011/12 MTEF includes additional funding for capacity building from the 2009/10 MTEF and additional funding provided over the 2011/12 MTEF for national priorities, including OSD, capacity building in personnel and *Goods and Services*, Registrars, improvement of public hospital norms and standards, as well as funding for the previously mentioned general policy adjustment currently being implemented by the Department.

The increasing trend in *Compensation of Employees* includes the higher than anticipated annual wage agreements and the carry-through costs of OSD for medical personnel. The increase over the 2011/12 MTEF includes funding for the improvement of general health capacity, the carry-through costs of the wage agreements and the various categories of OSD, as well as the national priorities for the 2011/12 MTEF mentioned above.

The notable increase in *Goods and Services* from 2007/08 to 2009/10 is due mainly to the high inflation rate on medical supplies, medicines and medical services and the rand/dollar exchange rate. The lower than anticipated figure in the 2010/11 Revised Estimate relates to the reduction in anticipated laboratory costs owing to an agreement between the NHLS and the Department, which is still being finalised, and the lower than anticipated expenditure on medicine and medical supplies, due to lower contract prices. The 2011/12 MTEF includes funding from the 2009/10 MTEF for national priorities for building capacity, improving the standards and norms in public hospitals and funding for the general policy adjustment.

The increase in *Transfers and Subsidies to Households* in 2008/09 and the 2010/11 Revised Estimate relates to medico-legal claims against the Department.

The notable increase in *Machinery and Equipment* in 2009/10 is due to additional funding provided for the Modernisation of Tertiary services. The increase over the 2011/12 MTEF relates mainly to the Modernisation and Expansion of Tertiary services.

5.5. RISK MANAGEMENT

Potential Risks	Mitigating Factors
▪ Delays in infrastructure projects and maintenance backlogs.	▪ Integrated Infrastructure plan has been finalised – Plan will be aligned with transformation plan and make provision for priority projects.
▪ High vacancy rates for Specialists impact on	▪ Review of service delivery platform and classification of

Potential Risks	Mitigating Factors
implementation of package of services and continuum of care – especially relevant to more rural areas.	hospital services – process commenced.
▪ Lack of management competencies and appropriate development programmes.	▪ Establishment of appropriate training and development programmes – part of improved Human Resources Plan for health.

PROGRAMME 6. HEALTH SCIENCES AND TRAINING

6.1. PROGRAMME PURPOSE AND STRUCTURE

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

Sub-Programme 10.1: Nurse Training College

Training of Nurses at both undergraduate and postgraduate level

Sub-Programme 10.2: EMRS Training College

Training of Emergency Care Practitioners

Sub-Programme 10.3: Bursaries

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

Sub-Programme 10.4: PHC Training

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

Sub-Programme 10.5: Training (Other)

Provision of skills development interventions for all occupational categories

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

The Annual Performance Plan only reflects strategic priorities. Other strategies and activities will be incorporated in Operational Plans which will be actively monitored and reported on quarterly as part of the quarterly outcomes-based reviews.

6.2. PRIORITIES

PRIORITY 1: Alignment of training with service delivery requirements.

- Align training and development plans with identified needs and core business of the Department.
- Accreditation of the Nursing College as per requirements of the Higher Education Act.

PRIORITY 2: Establish a Management Training Strategy

- Develop and implement a Management training strategy including succession training, mentoring and team building programmes.

PRIORITY 3: Implement a Mid-Level Worker strategy

- Develop and implement a Mid-level Worker Strategy in line with service delivery needs.

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

STRATEGIC GOAL 1: IMPROVE THE EFFICIENCY AND QUALITY OF HEALTH SERVICES

Table 75 (HST1 (a): Provincial Strategic Objectives and Annual Targets for Health Sciences and Training

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
1.17) To expand and sustain the Registrar training programme to increase the pool of Specialists by retaining 75% of qualified Registrars by 2014/15.	1.17.1) Number of Registrars in training – cumulative.	720	Persal	New indicator	New indicator	272 (2 intakes)	600	620	650	700
	1.17.2) Number of Registrars retained after qualifying.	75%	Persal	New indicator	New indicator	69/87 (79.3%)	50/ 215 (23%)	310/ 620 (50%)	325/ 650 (50%)	525 (75%)

Source: 2007/08 and 2008/09 from the 2010/11 APP; 2009/10 from the 2009/10 Annual report

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

Table 76 (HST1 (b): Provincial Strategic Objectives and Annual Targets for Health Sciences and Training

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
2.9) To implement a Training Strategy aligned with the core functions of the Department	2.9.1) Number of Professional Nurses graduating	560	SANC Persal	725	910	792	901	820	840	800
	2.9.2) Number of Advanced Midwifes graduating per annum	50	SANC Persal	56	42	46	50	106	50	25
	2.9.3) Medical Registrars graduating	80	Persal	38*	34*	87	60	65	70	80
	2.9.4) Number of professional health care workers trained on Provider Initiated Counselling & Testing	647 per annum	Attendance Registers	New indicator	New indicator	New indicator	See Footnote[74]	647 per annum	747 per annum	847 per annum
	2.9.5) Number of Managers accessing the Management Skills Programmes.	120	Internal database	New indicator	New indicator	80	42	100	120	120
	2.9.6) Number of SMS members trained on MIP	20	Internal database	New indicator	New indicator	5	0	20	20	20

Source: HRMS

[74] Moratorium on training during this financial year due to cost-containment

Table 77 (HST2): Performance Indicators for Health Sciences and Training

Indicator	Data Source	Type	Audited/ Actual Performance			Estimate	Medium Term Targets			National Target
			2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014
1. Intake of nurse students	Persal	No	2,485	2,402	2,842	2,500	2,404	383[75]	See Footnote[76]	-
2. Students with bursaries from the province	Bursary Database	No	697	296	896	842	842	860	770	-
3. Basic nurse students graduating	Persal	No	1,170	1,508	1,477	1,500	1,400	1,200	1,000	-

Source: 2009/10 Annual Report

[75] This target is based on the last intake of nurses if the KZNCN does not receive accreditation as an institute of higher education before 2012

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

6.4. QUARTERLY TARGETS FOR HEALTH SCIENCES AND TRAINING

Table 78 (HST3): Quarterly Targets for Health Sciences and Training for 2011/12

Performance Indicators	Annual Targets 2011/12	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly					
1. Number of professional health care workers trained on Provider Initiated Counselling & Testing	647	161	161	164	161
Annual					
2. Intake of nurse students	2,404				2,404
3. Students with bursaries from the province	842				842
4. Basic nurse students graduating	1,400			1,400	
5. Number of Professional Nurses graduating	820				820
6. Number of advanced midwifes graduating per annum	106				106
7. Medical registrars graduating	65				65
8. Number of Registrars in training – cumulative.	620				620
9. Number of Registrars retained after qualifying.	310/ 620 (50%)				310/620
10. Number of Managers accessing the Management Skills Programmes.	100				100
11. Number of SMS members trained on Massification Implementation Plan (MIP)	20				20

6.5. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 79 (HST4 (a): Expenditure Estimates for Health Sciences and Training

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised estimate	Medium-Term Estimates		
R' thousands	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Nurse training colleges	278 799	336 812	362 719	373 615	412 480	390 860	424 816	453 386	485 068
EMS training colleges	13 452	16 969	19 338	24 233	16 413	13 246	19 234	20 401	22 063
Bursaries	33 573	44 894	42 454	45 142	53 142	57 757	63 142	66 299	72 688
PHC training	46 892	65 343	76 238	79 373	78 452	77 157	78 945	83 516	85 142
Other training	151 617	212 583	292 437	286 128	332 740	325 073	347 305	375 093	399 120
Total	**524 333**	**676 601**	**793 186**	**808 491**	**893 227**	**864 093**	**933 442**	**998 695**	**1 064 081**

Source: BAS

Table 80 (HST4 (b): Summary of Provincial Expenditure Estimates by Economic Classification

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Current payments	**478 763**	**618 930**	**727 959**	**744 055**	**819 403**	**786 828**	**844 376**	**905 081**	**967 688**
Compensation of employees	409 832	528 940	662 000	664 176	752 875	728 596	779 597	834 169	892 560
Goods and services	**68 931**	**89 990**	**65 959**	**79 879**	**66 528**	**58 232**	**64 779**	**70 912**	**75 128**
Communication	2 243	1 730	1 573	2 017	1 496	1 249	1 373	1 511	1 662
Computer Services	1 007	14 505	14 361	13 359	16 500	9 197	10 117	11 128	12 241
Consultants, Contractors and special services	3 606	1 978	397	1 100	120	46	50	55	60
Inventory	4 204	5 424	4 704	6 594	5 351	4 405	4 858	5 250	5 764

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Operating leases	4 696	9 664	6 570	14 310	10 752	11 048	11 600	12 180	12 789
Travel and subsistence	11 303	13 682	4 880	4 256	5 032	4 809	5049	5 302	5 567
Maintenance , repair and running costs									
Financial transactions in assets and liabilities		16			4	19			
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	41 872	43 007	33 474	38 243	27 277	27 478	31 732	35 486	37 045
Transfers and subsidies	**42 595**	**56 136**	**59 829**	**62 685**	**72 069**	**76 710**	**82 891**	**87 440**	**94 620**
Provinces and municipalities									
Departmental agencies and accounts	4 470	5 827	6 784	7 876	7 637	7 637	8 166	8 963	9 005
Universities and Technikons									
Non-profit institutions	4 809	5 967	11 357	12 377	13 490	13 490	14 298	15 029	15 856
Households	33 316	44 342	41 688	42 432	50 942	55 583	60 427	63 448	69 759
Payments for capital assets	**2 975**	**1 519**	**5 398**	**1 751**	**1 751**	**536**	**6 175**	**6 174**	**1 773**
Buildings and other fixed structures		116							
Machinery and equipment	2 931	1 403	5398	1751	1751	536	6175	6174	1773
Software and other intangible assets	44								
Total economic classification	**524 333**	**676 601**	**793 186**	**808 491**	**893 227**	**864 093**	**933 442**	**998 695**	**1 064 081**

Source: BAS

6.6. PERFORMANCE AND EXPENDITURE TRENDS

Table HST4 (a) and HST4 (b) summarise information relating to Programme 6 for the period 2007/08 to 2013/14. The increasing trend for this Programme can largely be attributed to the training drive, increased bursary allocation and the provision for the intake of medical interns, dentists, pharmacists and other interns. The increases in 2008/09 and 2009/10 are attributed to the carry-through costs of the various OSD's for medical personnel and wage agreements, the introduction of the compulsory two-year internship for medical doctors and the drive to increase the capacity of nursing personnel. The decrease in the 2010/11 Revised Estimate, when compared with the Adjusted Appropriation, relates mainly to the introduction of stipends for student nurses, which are replacing the previously fully funded student nurse posts. The other contributing factor is the under-expenditure related to the EMS Training College, which is not functioning presently as it is in the process of being relocated from Pietermaritzburg to Montebello Hospital.

6.7. RISK MANAGEMENT

Potential Risks	Mitigating Factors
▪ Moratorium on training impede on quality of service delivery.	▪ Review of organisational structure and filling of vacant posts – equitable distribution of available resources.
▪ The retention of Registrars is reliant on availability of posts and filling of these.	▪ The retention of Registrars will improve distribution of Specialists.
▪ The non-alignment of the Workplace Skills Plan with the Human Resource Plan and the Strategic Plan impact on availability of appropriate skills for service delivery.	▪ Aligned training and development programmes including succession training and mentoring programmes.
▪ Delay in accreditation of the KZN College of Nursing as an Institute of Higher education will impact on training of professionals	▪ Speed up accreditation process.

PROGRAMME 7. HEALTH CARE SUPPORT SERVICES (SUP)

7.1. PROGRAMME PURPOSE AND STRUCTURE

Render Pharmaceutical services to the Department.

Sub-Programme 7.1: Pharmaceutical Services (Medicine Trading Account)

Manage the supply of pharmaceuticals and medical sundries to Hospitals, Community Health Centres, Clinics and Local Authorities via the Medicine Trading Account.

There are no changes in this Budget Programme from information presented in the 2010 – 2014 Strategic Plan.

Only strategic priorities are included in the Annual Performance Plan. Other strategies and activities will be included in Operational Plans which will be monitored and reported on quarterly. This will ensure effective outcomes-based monitoring and reporting.

7.2. PRIORITIES

PRIORITY 1: Improve compliance with Pharmaceutical Regulations and legislation.

- Improve the percentage of pharmacies compliant with SAPC standards to 70% by 2012/13.
- PPSD 100% compliant with Good Manufacturing Practice Regulations by 2012/13.

PRIORITY 2: Improve availability of medicines.

- Reduce tracer medicine stock-out rate in bulk store (PPSD and Institutions) to <3% by 2012/13.

PRIORITY 3: Improve quality of Pharmaceutical services.

- Reduce the average patient waiting time at pharmacies to ≤1 hour by 2012/13.

7.3. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR HEALTH CARE SUPPORT SERVICES

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 81 (HCSS1 (a): Provincial Strategic Objectives and Annual Targets for Health Care Support Services

Strategic Objective	Performance Indicator	Strategic Plan Target	Data source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
1.18) Ensure compliance with Pharmaceutical Legislation with 90% pharmacies compliant by 2014/15 and PPSD 100% compliant by 2012/13	1.18.1) Percentage of Pharmacies that obtained A or B grading on inspection[77]	90%	SAPS	New indicator	New indicator	New indicator	50%	60%	70%	80%
	1.18.2) PPSD compliant with Good Manufacturing Practice Regulations	100% compliant	SAPS	New indicator	New indicator	PPSD non-compliant	PPSD non-compliant	Process commence	100% compliant	100% compliant

Source: 2010/11 APP; Pharmaceutical Services Unit

[77] Refers to being compliant with SAPS standards

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

Table 82 (HCSS1 (b): Provincial Strategic Objectives and Annual Targets for Health Care Support Services

Strategic Objective	Performance Indicator	Strategic Plan Target	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14
2.10) To improve medicine supply management systems at PPSD and facility level	2.10.1) Tracer medicine stock-out rate in bulk store (PPSD)	≤ 1%	DQPR PPS	New indicator	New indicator	New indicator	5%	< 4%	< 3%	≤ 2%
	2.10.2) Tracer medicine stock-out rate in bulk store (Institutions)	≤ 1%	DQPR	New indicator	New indicator	New indicator	7%	< 4%	< 3%	≤ 2%
	2.10.3) Average patient waiting time for Pharmacy	< 1 hour for all facilities	DQPR	New indicator	New indicator	New indicator	CHC's: 1.40hr DH: 1.28hr RH: 0.44hr TH: 1 hr CH: No data[78]	< 1 hour	< 1 hour	< 1 hour

Source: 2010/11 APP

[78] CHC's = Community Health Centres; DH = District Hospitals; RH = Regional Hospitals; TH = Tertiary Hospitals; CH = Central Hospitals

7.4. QUARTERLY TARGETS FOR HEALTH CARE SUPPORT SERVICES

Table 83 (HCSS2): Quarterly Targets for Health Care Support Services for 2011/12

Performance Indicators	Annual Targets 2011/12	Quarterly Targets			
		Q1	Q2	Q3	Q4
Quarterly					
1. Tracer medicine stock-out rate in bulk store (PPSD)	<4%	<4%	<4%	<4%	<4%
2. Tracer medicine stock-out rate in bulk store (Institutions)	<4%	<4%	<4%	<4%	<4%
3. Average patient waiting time for Pharmacy	<1 hour	<1 hour	<1 hour	<1 hour	<1 hour
Annual					
4. Percentage of Pharmacies that obtained A or B grading on inspection[79]	60%				60%

[79] Refers to being compliant with SAPS standards

7.5. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 84 (HCSS3 (a): Expenditure Estimates for Health Care Support Services

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R' thousands	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Laundries									
Engineering									
Forensic Services									
Orthotic and prosthetic services									
Medicines trading account	12 649	34 209	27 528	10 764	10 764	10 764	13 971	15 170	16 004
Total	**12 649**	**34 209**	**27 528**	**10 764**	**10 764**	**10 7764**	**13 971**	**15 170**	**16 004**

Source: BAS

Table 85 (HCSS3 (b): Summary of Provincial Expenditure Estimates by Economic Classification

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Current payments		**79**							
Compensation of employees									
Goods and services		**79**							
Communication									
Computer Services									
Consultants, Contractors and special services									

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Inventory									
Operating leases									
Travel and subsistence									
Interest and rent on land									
Maintenance , repair and running costs									
Financial transactions in assets and liabilities									
Specify other									
Transfers and subsidies to	**12 649**	**34 130**	**27 528**	**10 764**	**10 764**	**10 764**	**13 971**	**15 170**	**16 004**
Provinces and municipalities									
Departmental agencies and accounts	12 649	34 130	27 528	10 764	10 764	10 764	13 971	15 170	16 004
Universities and Technikons									
Non-profit institutions									
Households									
Payments for capital assets									
Buildings and other fixed structures									
Machinery and equipment									
Software and other intangible assets									
Total economic classification	**12 649**	**34 209**	**27 528**	**10 764**	**10 764**	**10 764**	**13 971**	**15 170**	**16 004**

Source: BAS

7.6. PERFORMANCE AND EXPENDITURE TRENDS

Tables HCS3 (a) and HCS3 (b) summarise the payments and estimates relating to Programme 7 for the period 2007/08 to 2013/14. The increase in 2008/09 results from an increased stock level to provide for the increased demand for ARV medication and to provide for the increased turn-over of medicines. Funding was provided in 2009/10 to maintain the current level of stock, as well as for the provision of vaccines required for the immunisation campaign and services to reduce vaccine preventable morbidity and mortality. The amounts in 2010/11 were reduced due to limited storage space. Growth over the 2011/12 MTEF is in line with inflation.

7.7. RISK MANAGEMENT

Potential Risks	Mitigating Factors
▪ Infrastructure challenges affecting storage and packing facilities which in turn compromises security and the efficient handling, safety and efficacy of pharmaceuticals.	▪ Alignment with macro plans e.g. Infrastructure Plan to ensure adequate provision of services.
▪ Financial constraints especially relevant to infrastructure requirements.	
▪ Inadequate human resources with very high vacancy rate for Pharmacists.	▪ Recruitment and retention strategy.
	▪ Mid-level worker training – Pharmacy Assistants.

PROGRAMME 8. HEALTH FACILITIES MANAGEMENT

8.1. PROGRAMME PURPOSE AND STRUCTURE

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

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

Sub-Programme 8.2: District Hospitals

Sub-Programme 8.3: Emergency Medical Rescue Services

Sub-Programme 8.4: Provincial Hospital Services

Sub-Programme 8.5: Tertiary and Central Hospital Services

Sub-Programme 8.6: Other Facilities

There are no changes in the purpose of this Budget Programme from information presented in the 2010 – 2014 Strategic Plan.

The strategies and services not specifically identified as priority in the Annual Performance Plan will be included in Operational Plans and monitored and reported on a quarterly basis to ensure effective outcomes-based reporting.

8.2. PRIORITIES

PRIORITY 1: Transform Provincial Health Services through implementation of the aligned Infrastructure Programme Implementation Plan (IPIP)

- Delivery of new clinical infrastructure in line with the approved IPIP aligned with both the STP and the National Department of Health's Shock Treatment Plan.
- Upgrading and renovation of existing infrastructure as per IPIP.

PRIORITY 2: Create an enabling environment to support service delivery

- Creation of office accommodation for Provincial and District Offices

PRIORITY 3: Hospital Revitalisation Programme

PRIORITY 4: Improved management of the Hospital Revitalisation Grant, Coroner Services Grant and Infrastructure Grant to provinces

8.3. PROVINCIAL STRATEGIC OBJECTIVES FOR HFM

STRATEGIC GOAL 1: OVERHAUL PROVINCIAL HEALTH SERVICES

Table 86 (HFM1): Provincial Strategic Objectives and Annual Targets for Health Care Support Services

Strategic Objective	Performance Indicator	Strategic Plan Targets	Data Source	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
1.19) Delivery of new clinical infrastructure in line with the approved IPIP (Infrastructure Programme Implementation Plan)	1.19.1) Construction completed	28	2010:IRM 2010:IPMP 2010:Optimisation Plan 2011/12:U-Amp	New indicator	New indicator	New indicator	19	6	2	28
	1.19.2) Commissioning completed	2	2010:IRM 2010:IPMP 2010:Optimisation Plan 2011/12:U-Amp	New indicator	New indicator	New indicator	17	24	21	2
1.20) Upgrading & renovation of existing clinical infrastructure in line with approved IPIP	1.20.1) Construction completed	67	2010:IRM 2010:IPMP 2010:Optimisation Plan 2011/12:U-Amp	New indicator	New indicator	New indicator	31	14	18	67
	1.20.2) Commissioning completed	18	2010:IRM 2010:IPMP 2010:Optimisation Plan 2011/12:U-Amp	New indicator	New indicator	New indicator	33	54	46	18

Source: 2010/11 APP; Infrastructure Development Database

Table 87 (HFM2): Performance Indicators for Health Facilities Management

Indicator	Data Source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			National Target
			2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Equitable share capital programme as % of total health expenditure	BAS/IP	%	4.9%	3.28%	3%	2,8 %	3%	2%	2%	-
2. Number of Hospitals currently funded on revitalisation programme	PIP	No	7	7	9	9	9	9	8	-
3. Expenditure on facility maintenance as % of total health expenditure	IRM	%	1.6%	1.7%	0.78%	0.71%	0.71%	1.4%	1.4%	-
4. Average backlog of service platform in fixed PHC facilities	Facilities Audit Assessment	R	R 361 900	R2 142	R 302,962 (maintenance) R 2.098,082 (replacement	R 302,962 (maintenance) R 2,307,962 (replacement	R 272 666 (maintenance) R 2 538 679 (replacement)	R 245 399 (maintenance) R 2 792 547 (replacement)	Not available	-

Source: 2010/11 APP; Infrastructure Development Unit

8.4. QUARTERLY TARGETS FOR HFM

Table 88 (HFM3): Quarterly Targets for Health Facilities Management for 2011/12

Performance Indicators	Annual Target 2011/12	Quarterly Targets			
		Q1	Q2	Q3	Q4
Annual					
1. Equitable share capital programme as % of total health expenditure	3%				3%
2. Number of Hospitals currently unfunded on revitalisation programme	9				9
3. Expenditure on facility maintenance as % of total health expenditure	0.71%				0.71%
4. Average backlog of service platform in fixed PHC facilities	R 272 666 (maintenance) R 2 538 679 (replacement)				R 272 666 (maintenance) R 2 538 679 (replacement)
5. Construction completed (New infrastructure)	6				6
6. Commissioning completed (New infrastructure)	24				24
7. Construction completed (Upgrading and renovations)	14				14
8. Commissioning completed (Upgrading and renovations)	54				54

8.5. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 89 (HFM4 (a): Expenditure Estimates for Health Facility Management

Sub-Programme	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R' thousands	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Community Health Facilities	240 029	280 625	552 924	432 400	444 154	381 263	459 555	492 267	502 130
District Hospitals	521 236	615 946	482 159	516 573	526 126	516 286	562 308	518 947	632 977
EMS	8 817	4 734	1 201	4 805	4 805	2 391	5 093	5 399	5 696
Provincial Hospitals	158 455	111 763	187 320	419 876	419 876	343 414	449 393	475 700	478 690
Central Hospitals	12 001	15 401	35 161	26 841	26 841	22 391	28 177	29 966	31 614
Other facilities	152 269	75 089	119 484	171 523	170 760	188 666	182 010	188 521	197 001
Total	**1 092 807**	**1 103 558**	**1 378 249**	**1 572 018**	**1 592 562**	**1 454 411**	**1 686 536**	**1 710 800**	**1 8481 08**

Source: BAS

Table 90 (HFM4 (b): Summary of Provincial Expenditure Estimates by Economic Classification

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Current payments	**356 171**	**338 010**	**264 909**	**337 301**	**337 355**	**293 569**	**250 840**	**251 574**	**300 920**
Compensation of employees	1 140	5 510	3 448	5 104	5 158	3 845	5 329	5 025	4 986
Goods and services	**355 031**	**332 500**	**261 461**	**332 197**	**331 197**	**289 724**	**245 511**	**246 549**	**295 934**
Communication	1 179	803	228	1 155	150	91	1 659	1 703	3 500
Computer Services	13 625	12 595	2 872	1 231	1 500	1 212	3 183	3 256	5 779
Consultants, Contractors and special services	201 727	82 122	59 314	65 798	65 527	60 440	33 843	33 984	37 946

	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Inventory	93 950	80 599	52 154	61 127	77 700	56 911	51 186	51 448	78 978
Operating leases	36 657	41 764	59 048	72 161	75 000	52 111	57 797	58 994	63 036
Travel and subsistence	177	787	893	556	1 000	701	611	638	820
Interest and rent on land									
Maintenance , repair and running costs									
Financial transactions in assets and liabilities									
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	7 716	113 830	86 952	130 169	111 320	118 258	97 232	96 526	105 875
Financial transactions in assets and liabilities									
Transfers and subsidies to		**326**							
Provinces and municipalities									
Departmental agencies and accounts									
Households		326							
Payments for capital assets	**736 636**	**765 222**	**1 113 340**	**1 234 717**	**1 255 207**	**1 160 842**	**1 435 696**	**1 459 226**	**1 547 188**
Buildings and other fixed structures	621 725	635 339	1 005 258	1 097 525	1 117 217	916 506	1 357 938	1 295 069	1 436 729
Machinery and equipment	97 783	129 883	108 082	137 192	137 192	243 538	77 758	164 157	110 459
Software and other intangible assets	17 128	-			798	798			
Total economic classification	**1 092 807**	**1 103 558**	**1 378 249**	**1 572 018**	**1 592 562**	**1 454 411**	**1 686 536**	**1 710 800**	**1 848 108**

Source: BAS

8.6. PERFORMANCE AND EXPENDITURE TRENDS

The increasing trend is largely the result of a drive to improve and maintain the infrastructure of the Department. The significant increase over the seven-year period comprises increasing amounts of both Conditional Grant funding, especially the Hospital Revitalisation Grant and the Health Infrastructure Grant (previously IGP), as well as the Department's equitable share. The reduced amount provided for the Hospital Revitalisation Grant in 2008/09 is reflected in the reduced spending under the District Hospital Services Sub-Programme in that year. This is also noted in the negative trend against *Buildings and other fixed structures* in 2008/09. The significant increase in 2009/10 relates to over-expenditure on the Forensic Pathology Services Grant of approximately R143 million for which a roll-over of funding from 2008/09 was not approved, as well as to those projects which were on site and could not be delayed or stopped without further cost to the Department. Also included in 2009/10 is the under-expenditure of approximately R224.909 million against the Hospital Revitalisation Grant for which a roll-over to 2011/12 was requested as the Department was not in a position to spend it in 2010/11. Note that only R63.953 million has been approved for roll-over and is included in the budget for 2011/12.

The increase in the 2010/11 Main Appropriation relates mainly to significant increases in the Health Infrastructure Grant and the Hospital Revitalisation Grant. The 2010/11 Adjusted Appropriation includes a reprioritisation of R10 million to the Forensic Pathology Services Grant from District Health Services Programme 2 to this Programme, to offset over-expenditure against the Grant. The 2010/11 Adjusted Appropriation also includes an amount of R11.307 million from the EPWP Incentive Grant. The decrease in the 2010/11 Revised Estimate results mainly from anticipated under-spending of R117.436 million on the Hospital Revitalisation Grant for which a roll-over will be requested. The allocation for 2011/12 includes an additional R63.953 million, being the roll-over of the Hospital Revitalisation Grant from 2009/10. The increase in this Programme over the 2011/12 MTEF period relates mainly to the significant increases in the Health Infrastructure and Hospital Revitalisation Grants.

8.7. RISK MANAGEMENT

Potential Risks	Mitigating Factors
▪ Failure to improve expenditure on the Infrastructure and Hospital revitalisation Grants	▪ Turn-Around Strategy to improve service delivery
▪ Suspensions and service terminations resulting in lack of capacity	▪ Filling of vacant posts
▪ Failure to manage implementing agents resulting in service backlogs	▪ Implementation of the turn-around strategy
▪ Critical backlogs e.g. SCM, tender appeals, performance of implementing agents, and internal approval processes	

PART C: LINKS TO OTHER PLANS

1. LINKS TO THE LONG-TERM INFRASTRUCTURE AND OTHER CAPITAL PLANS

Table 91 (HFM6): Infrastructure Plan

Programme	Municipality	Outputs	Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimates		
			2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
New and replacement assets (R' thousand)											
Total new and replacement assets			-	**467 254**	**834 950**	**613 925**	**623 925**	**Not available**	**608 404**	**273 400**	**Not available**
Maintenance and repairs (R' thousand)											
Total maintenance and repairs			-	**314 595**	**234 815**	**332 197**	**332 197**	**Not available**	**256 763**	**299 516**	**Not available**
Upgrades and additions (R' thousand)											
Total upgrades and additions			-	**240 709**	**436 832**	**499 751**	**499 751**	**Not available**	**983 720**	**844 549**	**Not available**
Rehabilitation, renovations and refurbishments (R' thousand)											
Total rehabilitation, renovations and refurbishments			-	**75 164**	**148 249**	**121 041**	**131 531**	**Not available**	**98 893**	**13 091**	**Not available**

Source: Infrastructure Unit

2. CONDITIONAL GRANTS

Table 92: Conditional Grants

Conditional Grant	Purpose of the Grant	Performance Indicators	Outputs
Expanded Public Works Programme Grant for the Social Sector	To subsidise Non-Profit Organisations (NPO's) in Home and Community Based Care (HCBC) via the Provincial Departments of Health and Social Development. Provide stipends to previously unpaid volunteers to maximise job creation and skills development in line with the Expanded Public Works Programme (EPWP) Guidelines issued in 2004 and updated in 2005.	Number of HCBC's employed through the EPWP. Number of HCBC's receiving stipends through the EPWP.	Increase number of people employed and FTE's reported through the EPWP reporting system.
Expanded Public Works Programme Incentive Grant to Provinces for the Infrastructure Sector	To increase labour intensive employment through programmes that maximise job creation and skills development in line with the Expanded Public Works (EPWP) guidelines.	Number of people employed through EPWP.	Increased contribution to the objective of halving poverty and unemployment by 2014. Increased number of people employed and receiving income through EPWP. Average duration of work opportunities created. Improved income per EPWP beneficiary.
Infrastructure Grant	To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health; To enhance the application of labour intensive methods in order to maximise job creation and skills development as encapsulated in the Expended Public Works Programme (EPWP) guidelines; To enhance capacity to deliver infrastructure; To assist Provinces to reduce the infrastructure delivery and improvement backlog.	No of projects completed	Quality and quantity of serviceable health infrastructure; Comprehensive 5-10 year Infrastructure Plans and User Asset Management Plans (U-AMPS); Improved employment and skills development in the delivery of infrastructure; Aligned and co-ordinated approach to infrastructure development by Provinces; Improved infrastructure expenditure patterns; Reduced backlogs.
Hospital Revitalisation Grant	To provide funding to enable provinces to plan,	Reduced backlog	Improved hospital infrastructure

Conditional Grant	Purpose of the Grant	Performance Indicators	Outputs
	manage, modernise, rationalise and transform infrastructure, health technology, monitoring and evaluation of hospitals; Transform hospital management and improve quality of care in line with national policy objectives; Revitalisation and modernising of hospitals	No of hospitals on revitalisation programme All hospital projects shall be implemented according to the approved annual Project Implementation Plan.	
Forensic Pathology Services Grant	To continue the development and provision of adequate mortuary services in all provinces; Revitalisation and provision of forensic mortuaries.	Post-mortem coverage ratio Number of Medico-Legal Mortuaries built, refurbished and equipped Number of posts filled against establishment Number of Medico-Legal Mortuaries with operational electronic M&E systems Number of Medico-Legal Mortuaries supplied with appropriate goods and services	New mortuary facilities built, refurbished and equipped Qualified human resources appointed Acceptable productivity levels in mortuaries Progressive rollout of FPS information system Comprehensive Forensic Pathology Services throughout KZN Availability of supplies, consumables and services Reduced backlog
Comprehensive HIV and AIDS Grant	To enable the health sector to develop an effective response to HIV and AIDS To support the implementation of the National Operational Plan for Comprehensive HIV and AIDS treatment and care To subsidise in-part funding for antiretroviral treatment programmes	Number of registered ART patients - total Number of caregivers who received accredited training; all active caregivers who received stipends; HCBC supplies available in all programmes Number of High Transmission Area (HTA) intervention sites; Male and female condoms distribution rate; Number of peer educators trained;	Improved access to ART Adequate staffing for HIV and AIDS service delivery
National Tertiary Services Grant	To compensate tertiary facilities for additional costs associated with rendering of tertiary services	% decrease in patient waiting times No. of hospital boards operational Implementation of IT Master Plan	Provision of designated national tertiary service levels in 22 hospitals/complexes as agreed between the Province and the National Department of Health (NDOH)

Conditional Grant	Purpose of the Grant	Performance Indicators	Outputs
Health Professions Training & Development Grant	Support provinces to fund operational costs associated with training of health professionals; Development and recruitment of medical specialists in under-served provinces; Support and strengthen undergraduate and post graduate teaching and training processes in health facilities	Number and composition of health sciences students by province and training institution Number of students per discipline and per training institution Number of registrars Number of specialists in outreach programmes to all regional and district hospitals to support learning activities	Skill development and improved quality

Source: Forensic Pathology Services Conditional Grant Business Plan 2010/11, Health Professionals Training and Development Conditional Grant Business Plan 2010/11, National Tertiary Services Conditional Grant Business Plan 2010/11 and the Comprehensive HIV and AIDS, STI, TB Integrated Business Plan for 2010/11

3. PUBLIC-PRIVATE PARTNERSHIP (PPP)

Table 93: Public Private Partnerships

Name of PPP	Purpose	Output	Annual Budget (R'000)	Date of Termination	Measures to ensure smooth transfer of responsibilities
Inkosi Albert Luthuli Central Hospital Department of Health in partnership with Impilo Consortium (Pty) Ltd and Cowslip Investments (Pty) Ltd	Subject to, and in accordance with, the provisions of this Agreement, the Project Company shall: 1. Supply Equipment and IM&T systems that are state of the art and replace the Equipment and IM&T systems so as to ensure that they remain state of the art; 2. Supply and replace non-medical equipment; 3. Provide all services necessary to manage the project assets in accordance with best industry practice; 4. Maintain and replace the Department assets in	Schedule 6 output projections	R1 404 849	Year 2017	Termination arrangements are detailed in the project agreement in clauses 35,36,37 and the penalty regime (Schedule 15)

Name of PPP	Purpose	Output	Annual Budget (R'000)	Date of Termination	Measures to ensure smooth transfer of responsibilities
	accordance with Schedules 30 (*FM Output Specifications*) and 24 (*FM Replacement Programme*); 5. Provide or procure utilities and (to the extent provided for in this Agreement) consumables and surgical instruments; and 6. Provide FM services, so as to ensure that the Department is, at all times, able to provide clinical services that achieve and maintain the Hospital Output Specifications.				

Source: Project Agreement

4. CONCLUSION

The Annual Performance Plan presented the priorities, strategic goals, objectives and targets that the KwaZulu-Natal Department of Health will be pursuing during the period 2011 – 2013/14. The Plan is aligned with the National Health System 10 Point Plan and the Negotiated Service Delivery Agreement of the Department of Health.

The Annual Performance Plan only reflects the strategic priorities of the Department while Operational Plans will ensure that systems and processes are in place to ensure that all priorities are operationalised at service delivery level. Great discipline will be exercised to ensure that all health services are provided in line with service obligations and mandates for delivery of health care.

Macro plans, still in the inception stages, will make provision for Implementation Plans to ensure effective monitoring and reporting.

Ongoing performance monitoring at all levels of care will be actioned to ensure pro-active response to service delivery challenges. Quarterly in-depth reviews and outcomes-based reporting and feedback will form an integral part of improved accountability for service delivery and health outcomes.

ABBREVIATIONS & ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ALOS	Average Length of Stay
ALS	Advanced Life Support.
ANC	Ante Natal Care
APP	Annual Performance Plan
ART	Anti Retroviral Therapy
ARV	Anti Retroviral
BANC	Basic Ante Natal Care
BAS	Basic Accounting System
BLS	Basic Life Support
BOD	Burden of Disease
BOR	Bed Occupancy Rate
CCG's	Community Care Givers
CCMDU	Central Chronic Medication Dispensing Unit
CCMT	Comprehensive Care Management & Treatment
CDC	Communicable Disease Control
CEO	Chief Executive Officer
CHC	Community Health Centre
Child PIP	Child Problem Identification Programme
CHW	Community Health Worker
COE	Compensation of Employees
COEC	College of Emergency Care.
CPSS	Central Pharmaceutical Supply Store
CRH	Centre for Rural Health
CTOP	Choice on Termination of Pregnancy
DHER	District Health Expenditure Review
DHIS	District Health Information System
DHP's	District Health Plans
DHS	District Health System
DOE	Department of Education
DOH	Department of Health
DOTS	Directly Observed Treatment Short Course
ECP	Emergency Care Practitioner
EH	Environmental Health

EHP	Environmental Health Practitioner
EMS	Emergency Medical Services
EPI	Expanded Programme on Immunisation
EPT	Emergency Patient Transport
ESV	Emergency Services Vehicle
ETBR	Electronic Tuberculosis Register
ETR.net	Electronic Register for TB
GIS	Geographic Information System
HAART	Highly Active Ante-Retroviral Therapy
HAST	HIV, AIDS, STI and TB
HBC	Home Based Carer
HCBC	Home & Community Based Carers
HIV	Human Immuno Virus
HOD	Head of Department
HP	Health Promotion
HPS	Health Promoting Schools
HR	Human Resources
HRD	Human Resource Development
HRKM	Health Research & Knowledge Management
HRP	Human Resource Plan
HST	Health Systems Trust.
HTA's	High Transmission Areas
IALCH	Inkosi Albert Luthuli Central Hospital
IGR	Inter-Governmental Relations
ILS	Intermediate Life Support
IMCI	Integrated Management of Childhood Illnesses
INDS	Integrated National Disability Strategy
IPC	Infection Prevention & Control
IT	Information Technology
KZN	KwaZulu-Natal
M&E	Monitoring and Evaluation
MC&WH	Maternal Child & Women's Health
MDG	Millennium Development Goals
MDR TB	Multi Drug Resistant Tuberculosis
MEC	Member of the Executive Council
MHCA	Mental Health Care Act.
MO	Medical Officer

MRC	Medical Research Council
MSP	Master Systems Plan
MTEF	Medium Term Expenditure Framework
MTS	Modernisation of Tertiary Services
MTSF	Medium Term Strategic Framework
NGO's	Non Governmental Organisations
NHC	National Health Council
NHI	National Health Insurance
NHIS	National Health Information System.
NHS	National Health System.
NIP	National Integrated Nutrition Programme.
NSP	National Strategic Plan.
NVP	Nevirapine
OPD	Out-Patient Department.
OSD	Occupation Specific Dispensation.
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis.
Persal	Personnel and Salaries System.
PFMA	Public Finance Management Act
PHC	Primary Health Care
PITC	Patient Initiated Testing & Counselling
PMDS	Performance Management and Development System
PMO's	Principal Medical Officers
PMR	Peri-natal Mortality Rate
PMSC	Provincial Medical Supply Centre
PMTCT	Prevention of Mother to Child Transmission
PN	Professional Nurse
PNC	Post Natal Care
PPIP	Peri-Natal Problem Identification Programme
PPSD	Provincial Pharmaceutical Supply Depot
PPT	Planned Patient Transport
PTB	Pulmonary Tuberculosis
SADHS	South African Demographic & Health Survey
SCM	Supply Chain Management.
SHS	School Health Services
SMS	Senior Management Service
Stats SA	Statistics South Africa

STI's	Sexually Transmitted Infections
STP	Service Transformation Plan
TB	Tuberculosis
TOP	Termination of Pregnancy
UKZN	University of KwaZulu-Natal
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation
XDR TB	Extreme Drug Resistant Tuberculosis

ANNEXURE E - INDICATORS AND DATA ELEMENTS

Table 94: Trends in Key Provincial Service Volumes

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Total PHC headcount in PHC facilities	Number of PHC patients seen during the reporting period in PHC facilities (Clinics and CHCs). Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen	Tracks the uptake of PHC services at each PHC facility for the purposes of allocating staff and other resources.	DHIS	PHC total headcount	Accuracy of headcount depends on the reliability of PHC record management at facility level	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	Programme Manager
OPD general clinic new case not referred rate	Number of general OPD clinic new cases (seeking medical attention for a condition for the first time) that report to the general OPD without being referred from a PHC facility or doctor during the reporting period in all Hospitals (district, regional, tertiary and central) as a percentage of the OPD general headcount new visits total. Patients with general OPD follow-up visits, visiting specialised OPD clinics and emergency patients are not counted in denominator, because this is not regarded as PHC level of care.	Tracks the utilisation of hospitals by patients to access PHC services, which in fact should be accessed at PHC services. This could also points to the needs for PHC services or gaps in PHC service delivery	DHIS	**Numerator**: OPD general clinic headcount - new case not referred. **Denominator**: OPD general clinic headcount new case - total Sum of : • OPD general clinic headcount - new case referred • OPD general clinic headcount - new case not referred	Accuracy of headcount depends on the reliability of hospital record management at facility level	Output	Percentage	Quarterly	Yes	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	Programme Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Total separations in District/ Regional/ Tertiary/ Central Hospitals	Recorded completion of treatment and/or accommodation of patients in hospitals. Separations include inpatients who were discharged, transferred out to other hospitals or who died and includes day patients.	Monitoring the service volumes	DHIS	**Sum of**: • Inpatient deaths • Inpatient discharges • Inpatient transfer out • Day patient Relevant to all hospitals	Accuracy dependant on quality of data from reporting facility	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	District Health Services

Table 95: Millennium Development Goals

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Prevalence of underweight (children under 5)	A child under 5 years identified as being BELOW the third centile but EQUAL TO or OVER 60% of Estimated Weight for Age (EWA) on the Road-to-Health chart. Include any such child irrespective of the reason for the underweight - malnourishment, premature birth, genetic disorders etc.	Essential for growth monitoring in children	DHIS	**Numerator** Number of children underweight for age during the reporting period **Denominator** Number of children weighed during the reporting period	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Quarterly	No	Lower levels of prevalence of underweight (children under 5) are desired	Health Information, Epidemiology and Research Programme Nutrition Programme Maternal, Child and Women's Health Programme
Incidence of severe malnutrition in children (under 5 years of age)	The number of children who weigh below 60% Expected Weight for Age (new cases per month) per 1000 children in the target population	Essential for growth monitoring in children	DHIS	**Numerator** The number of children who weigh below 60% Expected Weight for Age during the reporting period **Denominator** Children under 5 years x 1000	Accuracy dependent on quality of data from reporting facility	Outcome	Number per 1000	Quarterly (Indicator must be annualised)	No	Lower levels of prevalence of underweight (children under 5) are desired	Health Information, Epidemiology and Research Programme Nutrition Programme Maternal, Child and Women's Health Programme
Under-5 mortality rate	Number of children less than five years old who die in one year, per 1000 live births during that year	Monitors trends in under 5 mortality	South African Demographic and Health Survey (SADHS)	**Numerator** Number of children less than one year old who die in one year **Denominator** Total number of live births during that year x 1000	Data are not frequently available. Empirical data are available from the SADHS, which is conducted every 5 years	Outcome	Number per 1000 (rate)	Empirical data are provided by the SADHS every 5 years	No	Lower Infant Mortality Rates are desired	Maternal, Child and Women's Health Programme
Infant mortality rate	Number of children less than one year old who die in one year, per 1000 live births during that year	Monitors trends in infant mortality	South African Demographic and Health Survey (SADHS)	**Numerator:** Number of children less than one year old who die in one year **Denominator** Total number of live births during that year x 1000	Data are not frequently available. Empirical data are available from the SADHS, which is conducted every 5 years	Outcome	Number per 1000 (rate)	Empirical data are provided by the SADHS every 5 years	No	Lower Infant Mortality Rates are desired	Maternal, Child and Women's Health Programme

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Proportion of one-year-old children immunised against measles	Percentage of children under 1 year who received their first measles dose	Monitors measles coverage	DHIS	**Numerator:** Measles 1st dose before 1 year **Denominator:** Population under 1 year	Reliant on under 1 population estimates from Stats SA	Output	Percentage	Quarterly	No	Higher proportions of children immunised against measles are desired.	Expanded Programme on Immunisation (EPI) Manager
Maternal mortality ratio	Number of women who die as a result of childbearing, during pregnancy or within 42 days of delivery or termination of pregnancy in one year, per 100,000 live births during that year	Monitors trends in maternal mortality	SADHS	**Numerator** Number of women who die as a result of childbearing, during pregnancy or within 42 days of delivery or termination of pregnancy in one year **Denominator** Total number of live births during that year x 100,000	Data is not frequently available. Empirical data are available from the SADHS, which is conducted every 5 years	Outcome	Number per 100,000	Empirical data are provided by the SADHS every 5 years	No	Lower Maternal Mortality Ratios are desired Lower	Health Information, Epidemiology and Research Programme MCWH Programme
Proportion of births attended by skilled health personnel	Percentage of women who gave birth in the 5 years preceding the South African Demographic Survey (SADHS) who reported that medical assistance at delivery from either a doctor, nurse or midwife	Monitors trends in maternal mortality	SADHS	**Numerator** Number of women who gave birth in the 5 years preceding the survey who reported that medical assistance at delivery from either a doctor, nurse or midwife **Denominator** Total number of women who gave birth in the 5 years preceding the survey	Data are not frequently available. Empirical data are available from the SADHS, which is conducted every 5 years	Output	Percentage	Empirical data are provided by the SADHS every 5 years	No	Higher levels of skilled births attended by skilled health personnel are desired	Health Information, Epidemiology and Research Programme MCWH Programme
HIV prevalence among 15- to 24-year-old pregnant women	Percentage of women aged 15-19 years surveyed testing positive for HIV	Tracks prevalence of HIV and AIDs in younger women of reproductive age, and the success of efforts to combat HIV and AIDS in South Africa	Annual Antenatal and HIV Survey	**Numerator:** Women aged 15 – 19 years who tested HIV positive during the survey **Denominator:** Women aged 15 – 19 years who were tested for HIV during the survey	Reflects prevalence in surveyed women, not entire population.	Outcome	Percentage	Annual	No	Lower levels of HIV and AIDS prevalence are desired	Health Information, Epidemiology and Research Programme HIV and AIDS Programme
	Percentage of women aged 20-24 years surveyed testing positive for HIV	Tracks prevalence of HIV and AIDs in young adult women of reproductive age, and the success of efforts to combat HIV and AIDS in	Annual Antenatal and HIV Survey	**Numerator:** Women aged 20– 24 years who tested HIV positive during the survey **Denominator:** Women aged 20 – 24 years who were	Reflects prevalence in surveyed women, not entire population	Outcome	Percentage	Annual	No	Lower levels of HIV and AIDS prevalence are desired	Health Information, Epidemiology and Research Programme HIV and AIDS

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
		South Africa		tested for HIV during the survey.							Programme
Contraceptive prevalence rate	Percentage of women of reproductive age (15-44) who are using (or whose partner is using) a modern contraceptive method. Contraceptive methods include female and male sterilisation, injectable and oral hormones, intrauterine devices, diaphragms, spermicides and condoms, natural family planning lactational amenorrhoea.	Track the extent of the use of contraception (any method) amongst women of child bearing age	SADHS	Data available from the 5-year SADHS. The indicator is not monitored routinely.	Data is not frequently available. Empirical data are available from the SADHS, which is conducted every 5 years	Output	Percentage	Empirical data are provided by the SADHS every 5 years	No	Higher Contraceptive prevalence levels are desired	Health Information, Epidemiology and Research Programme MCWH&N Programme

PROGRAMME 1: ADMINISTRATION

Table 96: Human Resources

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Medical officers per 100,000 people	Medical officers in posts on last day of March per 100 000 people.	Tracks the number of filled Medical officer's posts as part of monitoring availability of Human Resources for Health	Persal	**Numerator:** Medical Officers in posts **Denominator:** Total population X 100 000	Dependant on accuracy of Persal system.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of medical officers contributes to improving access to and quality of clinical care	HRM
Medical officers per 100,000 people in rural districts	Medical officers in posts employed in the Rural districts on last day of March per 100 000 people.	Tracks the number of filled Medical officer employed in the rural districts, as part of monitoring availability of Human Resources for Health in Rural Districts. This indicator also assists in assessing urban /rural equity.	Persal	**Numerator:** Medical Officers in posts- Rural **Denominator:** Total population in Rural Districts X 100 000	Dependant on accuracy of Persal system.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of medical officers in rural districts i contributes to improving access to and quality of clinical care n rural district.	HRM
Professional nurses per 100,000 people	Professional Nurses in posts on last day of March per 100 000 people.	Tracks the number of filled Professional Nurses posts , as part of monitoring availability of Human Resources for Health	Persal	**Numerator:** Professional Nurses in posts **Denominator:** Total population X 100 000	Dependant on accuracy of Persal system.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of professional nurses contributes to improving access to and quality of health services	HRM
Professional nurses per 100,000 people in rural districts	Professional Nurses in posts employed in rural districts on last day of March per 100 000 people.	Tracks the number Professional Nurses posts filled in rural districts, as part of monitoring availability of Human Resources for Health in Rural Districts. This indicator also assists in assessing urban /rural equity.	Persal	**Numerator:** Professional Nurses in posts- Rural **Denominator:** Total population in Rural Districts X 100 000	Dependant on accuracy of Persal system.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of professional nurses in rural districts contributes to improving access to and quality of health services rural districts	HRD
Pharmacists per 100,000 people	Pharmacists in posts on last day of March per 100 000 people.	Tracks the number of filled Pharmacists posts to monitor availability of Human Resources	Persal	**Numerator:** Pharmacists in posts **Denominator:** Total population	Dependant on accuracy of Persal system.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of Pharmacists lead to better quality of care	HRD

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
				X 100 000							
Pharmacists per 100,000 people in rural districts	Pharmacists in posts employed in rural districts on last day of March per 100 000 people.	Tracks the number Pharmacists posts filled in rural districts, as part of monitoring availability of Human Resources for Health in Rural Districts. This indicator also assists in assessing urban /rural equity	Persal	**Numerator:** Pharmacists in posts - Rural **Denominator:** Total population in Rural Districts X 100 000	Dependant on accuracy of Persal system.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of Pharmacists in rural districts lead to better quality of care in these rural districts	HRD
Vacancy rate for professional nurses	Percentage of **funded** vacant professional Nurses posts on the last day of the reporting period	Tracks the number of **funded** vacant Professional Nurses posts to monitor availability of Human Resources	Persal	**Numerator:** Total Number of **funded** vacant Professional Nurses posts **Denominator:** Total number of **funded** professional nurse posts in the province	Dependant on accuracy of Persal data	Process	Ratio per 100 000 population	Quarterly	No	Increase in the number of professional nurses lead to better quality of care	HRD
Vacancy rate for doctors	Percentage of **funded** vacant doctors posts on the last day of the reporting period	Tracks the number of **funded** vacant Doctors posts to monitor availability of Human Resources	Persal	**Numerator:** Total Number of **funded** vacant Doctors posts on the last day of the reporting period **Denominator:** Total number of doctors **funded** posts in the province	Dependant on accuracy of Persal data	Process	Percentage	Quarterly	No	Decrease in the vacancy rate lead to better quality of care	Human Resources Management
Vacancy rate for medical specialists	Percentage of **funded** vacant medical specialists posts on the last day of the reporting period	Tracks the number of **funded** vacant medical specialists posts to monitor availability of Human Resources	Persal	**Numerator:** Total Number of **funded** vacant medical specialists posts on the last day of the reporting period **Denominator:** Total number of medical specialists **funded** posts in the province	Dependant on accuracy of Persal data	Process	Percentage	Quarterly	No	Decrease in the vacancy rate lead to better quality of care	Human Resources Management

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Vacancy rate for pharmacists	Percentage of **funded** vacant pharmacists posts on the last day of the reporting period	Tracks the number of **funded** vacant pharmacists posts to monitor availability of Human Resources	Persal	**Numerator:** Total Number of **funded** vacant Pharmacists posts on the last day of the reporting period **Denominator:** Total number of **funded** pharmacists posts in the province	Dependant on accuracy of Persal data	Process	Percentage	Quarterly	No	Decrease in the vacancy rate lead to better quality of care	Human Resources Management

Table 97: Administration

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Tabled 2011/12 – 2013/14 Annual Performance Plan (APP)	Annual APP aligned with Strategic Plan, NHS 10-Point Plan and MTSF Priorities signed off and tabled annually as per National Health Act 2003 and Treasury Regulations.	Monitor compliance with National Health Act 2003 and Treasury Regulations.	APP	Approved annual APP tabled as per Treasury Regulations.	None.	Process	Yes/ No	Annual (Quarter 1)	No	Provide necessary leadership in implementation and monitoring of national and provincial priorities based on evidence-based needs.	Strategic Planning Manager.
Number approved 2011/12 District Health Plans	Annual DHP's developed and approved in line with National Health Act 2003 requirements and incorporating Provincial priorities as per APP.	Monitor compliance with National Health Act 2003 and National DOH requirements.	DHP's	Approved annual DHP's as per National Health Act 2003 requirements and National DOH submission dates.	None.	Process	Yes/ No	Annual (Quarter 1)	No	Unified action in addressing health priorities and needs.	Strategic Planning & District Managers.
Approved STP implemented as per Implementation Plan	Long-term transformation plan for Provincial health services, aligned with the NHS 10-Point Plan, to improve effectiveness and efficiency of public health services in the Province.	To provide long-term strategic leadership for transformation of Provincial health services.	Quarterly Reports	Approved and published STP.	Financial resource limitations (due to over-expenditure and current cost saving measures) may impact on intended implementation schedule.	Process	Yes/ No	Annual 2010/11	No	Improved equity, effectiveness and efficiency of public health services in response to health needs in the Province.	Strategic Planning Manager.

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of District Managers who have signed delegations of authorities.	Delegations make provision for a decentralised operation model to improve service delivery, reduce bottlenecks and improve accountability.	Monitor compliance with management practices.	Signed delegations	Number of District Managers who formally signed delegation of authorities.	Delays in approval of reviewed delegations (National Health Council – National DOH process).	Input	Number	Annual	No	Reduce bottlenecks in service delivery and improve accountability.	HRMS and District Managers.
Number of Hospital Managers who have signed Performance Agreements (PA's).	Hospital Managers sign Performance Agreements aligned with the APP priorities.	Monitor compliance.	Signed PA's (HRMS)	Number of Hospital Managers with signed Performance Agreements.	None.	Input	Number	Annual	No	Improve accountability for service delivery outcomes as per Performance Agreements at operational level.	HRMS & Hospital Managers.
Number of District Managers who have signed PA's.	District Managers sign Performance Agreements aligned with the APP priorities.	Monitor compliance.	Signed PA's (HRMS)	Number of District Managers with signed Performance Agreements.	None.	Input	Number	Annual	No	Improve accountability for service delivery outcomes as per Performance Agreements at operational level.	HRMS & District Managers.
Number of Head Office Managers (Level 13 and above) who have signed PA's.	Managers sign Performance Agreements aligned with priorities referred to in the Annual Performance Plan.	Monitor compliance.	Signed PA's (HRMS)	Number of Head Office Managers with signed Performance Agreements.	None.	Input	Number	Annual	No	Improve accountability for service delivery outcomes as per Performance Agreements.	HRMS Manager.
Annual unqualified audit opinion for financial statements.	The Auditor General of South Africa (AGSA) declares the Annual Financial Statements compliant with the PFMA and Treasury Regulations.	Monitor improved financial management and compliance with the PFMA.	Auditor-General's Report	Unqualified audit opinion by the AGSA.	Accuracy of financial data (especially at district/ facility level).	Outcome	Audit opinion	Annual	No	Improved financial management and compliance with PFMA.	CFO & Finance Manager.
Zero over-expenditure.	Expenditure within allocated budget.	Monitor expenditure trends.	BAS - Annual Financial Statements	**Numerator** Expenditure. **Denominator** Allocated budget.	Accuracy of financial data (especially capturing at district/ facility level).	Outcome	Rand	Annual	No	Expenditure within budget in compliance with PFMA and Treasury Regulations.	CFO & Finance Manager.
Approved District Health Expenditure Reviews.	Analysis and review of expenditure trends at district/ facility level in compliance with the National Health Act	Monitor compliance with the National Health Act 2003 and PFMA imperatives in respect of DHER	Approved DHER's	Number of approved DHER's submitted.	Limited technical support at Provincial level. Being addressed by partnership with Health Systems Trust (HST).	Input	Number	Annual	No	Annual review and analysis of expenditure trends at district & facility levels.	CFO & District, Facility Managers.

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
	2003 and PFMA imperatives.	submissions.									
Accurate financial disclosure of inventory and assets in Annual Financial Statement.	Financial disclosure of assets based on actual.	Monitor financial disclosure for Annual Financial Statements.	Annual Financial Statements	Financial disclosure based on assets in Asset Register.	Accuracy of Asset Registers.	Output	Yes/ No	Annual	No	Unqualified audit opinion.	Supply Chain Manager.
Annual Departmental Risk Profile (Operational and Strategic).	Identify strategic and operational risks in the Department and monitor interventions to mitigate identified risks.	Monitor strategic & operational risks.	Audit & Risk records	Risk Profile.	Appropriate systems and processes to identify risks.	Output	Yes/ No	Annual	No	Timeous identification and response to strategic and operational risks.	Audit & Risk Manager.
Persal data verified.	All personnel records verified in the Persal system.	Verify Persal data to ensure accurate account of employees in the Department.	Persal	Persal system aligned with actual personnel records.	Persal data.	Output	Yes/ No	Annual	No	Verified records to reduce wasteful expenditure.	HRMS Manager
Annual unqualified audit opinion on performance information.	The AGSA declare the performance information in published reports accurate and a true reflection of performance.	Monitor quality and accuracy of performance information.	Annual Report	Unqualified audit opinion by the AGSA.	Effective systems and processes to ensure data completeness and quality at all levels of service delivery.	Outcome	Audit opinion	Annual		Improved information management and reporting.	Data Management Manager.
Master System Plan implemented	A comprehensive plan to coordinate implementation of information systems and processes to ensure effective utilisation of resources and improved data quality and utilisation.	Monitor implementation of the MSP as per approved Implementation Plan.	Master Systems Plan	Master Systems Plan (MSP).	Funding to implement MSP.	Output	Yes/ No	Annual	No	Effective utilisation of resources.	Information Technology Manager.
Table 2010/11 Annual Report.	Annual Report as per National Health Act 2003 to report on performance information relevant to the strategic goals, objectives and targets set in the Provincial Strategic Plan and APP.	Monitor compliance with the National Health Act of 2003.	Tabled Annual Report	Approved and tabled Annual Report.	None.	Output	Yes/ No	Annual	No	Compliance with National Health Act 2003 and Treasury timelines for submission of reports.	Strategic Planning Manager.

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Four (4) Quarterly Progress Reports on the 10-Point Plan.	Results-based performance monitoring as per M&E Framework to track performance against targets set in the Strategic Plan and APP (aligned with the NHS 10-Point Plan).	Monitor submission of performance reports to track progress towards targets in APP (aligned with NHS 10-Point Plan).	Quarterly Reports	Quarterly Reports.	Recording and reporting from Programmes, Districts and Facilities.	Output	Number	Quarterly	No	Improved performance monitoring.	Monitoring & Evaluation Manager.
Provincial Consultative Health Forum convened annually.	Provincial governance structure convened as per National Health Act 2003 to improve social compact for health through participation and consultation.	Monitor meetings with Provincial Health Council as per KZN Health Act (1 of 2009).	Corporate Services database	Provincial Health Council convened.	None.	Output	Yes/ No	Annual	No	Improved social compact for better health outcomes.	Corporate Services Manager.
Number of District Health Councils convened annually.	District governance structure convened as per National Health Act 2003 to improve social compact for health through participation and consultation.	Monitor meetings with District Health Councils as per KZN Health Act (1 of 2009).	Corporate Services database	Number of District health Forums convened.	None.	Output	Number cumulative	Annual	No	Improved social compact for better health outcomes.	Corporate Services Manager.

PROGRAMME 2: DISTRICT HEALTH SERVICES

Table 98: Primary Health Care Services

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Provincial PHC expenditure per uninsured person	Total expenditure by the Provincial DoH on PHC services	To monitor adequacy of funding levels for PHC services	BAS	**Numerator** Total expenditure of the Province on PHC services (Programme 2) **Denominator** Number of uninsured people in the Provinces as indicated in STATSSA or Council for Medical Scheme data	Accuracy of data	Input	Annual	Annual	No	Higher levels of expenditure reflect prioritisation of PHC services	DHS Programme Manager Financial Management Officials
PHC total headcount	Number of PHC patients seen during the reporting period. Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen	Tracks the uptake of PHC services at each PHC site for the purposes of allocating staff and other resources.	DHIS	Sum total of PHC headcounts during the reporting period	Accuracy of headcount depends on the reliability of PHC record management at facility level	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	DHS Programme Manager
PHC total headcount – under 5 years	Number of PHC patients under the age of 5 years seen during the reporting period. Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen	Tracks the children under 5 uptake of PHC services at each PHC site for the purposes of allocating staff and other resources.	DHIS	Sum of PHC headcount under 5 years during the reporting period	Accuracy of headcount depends on the reliability of PHC record management at facility level	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease amongst children, or greater reliance on public health system	DHS Programme Manager
Utilisation rate - PHC	Rate at which services are utilised by the target population, represented as the average number of visits per person per period in the target population.	Tracks the uptake of PHC services at each PHC site for the purposes of allocating staff and other resources.	DHIS - PHC Total Headcount StatsSA - Total Population	**Numerator:** PHC total headcount **Denominator:** Total Population	Dependant on the accuracy of estimated total population from StatsSA	Output	Annualised rate	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	Programme Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Utilisation rate - PHC under 5 years	Rate at which services are utilised by the target population under 5 years, represented as the average number of visits per person per period in the target population.	Tracks the uptake of PHC services at each PHC site for the purposes of allocating staff and other resources.	DHIS - PHC headcount under 5 years StatsSA - Population under 5 years	**Numerator:** PHC headcount under 5 years **Denominator:** Population under 5 years	Dependant on the accuracy of estimated population 5 years an under from StatsSA	Output	Annualised rate	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	Programme Manager
Percentage of fixed PHC facilities that were visited by a supervisor at least once every month	Percentage of fixed PHC facilities that were visited by a supervisor at least once every month (official supervisor report completed)	Tracks the supervision rate of all PHC facilities.	DHIS	**Numerator:** Number of fixed PHC facilities that were visited by a supervisor **Denominator:** Total number of fixed PHC facilities	Dependant on the reporting the purpose of the visit by the supervisor to the PHC facility.	Quality	Percentage	Quarterly	No	Higher levels indicate better support to the PHC facility	QA Programme Manager
Expenditure per PHC Headcount	Expenditure per PHC headcount by provincial DoH at provincial PHC facilities.	Tracks the cost to provincial DoH for every visit to provincial PHC facility.	DHIS – PHC Total Headcount BAS – Expenditure on PHC by provincial DoH	**Numerator:** Expenditure on PHC by provincial DoH **Denominator:** PHC Total Headcount	Accuracy of headcount depends on the reliability of PHC record management at facility level and accuracy of expenditure depends on the accuracy of correct expenditure allocation	Efficiency	Rate	Quarterly	No	Lower expenditure could indicate efficient use of financial resources, or incomplete provision of the comprehensive PHC package	DHS Programme Manager
Community Health Centres (CHCs) and Community Day Centres (CDCs) with resident doctor rate	Percentage of CHCs and CDCs with at least one resident Doctor.	Tracks the national norms of the PHC package	QA	**Numerator:** Total number of CHCs and CDCs with at least one resident Doctor. **Denominator:** Total number of CHCs and CDCs in the province	Accuracy dependant on the quality of data from the reporting facility	Input	Percentage	Quarterly	Yes	Higher percentage indicates better compliance to the national norms	Human Resources Management Districts and Development
Percentage of complaints of users of PHC services resolved within 25 days	Percentage of complaints of users of PHC Services resolved within 25 days	To monitor the management of the complaints in the PHC services	Quality Assurance	**Numerator:** Total number of complaints resolved within 25 days during the quarter **Denominator:** Total number of complaints during the quarter	Accuracy of information is dependant on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	Yes	Higher percentage suggest better management of complaints in PHC Services	Quality Assurance
Number of PHC facilities assessed for compliance	Total number of PHC facilities assessed for compliance against the	Tracks the levels of compliance against the	Quality Assurance	Total number of PHC facilities assessed against the core		Process	Sum	Annual	Yes	Higher number indicates better compliance with the	Quality Assurance

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
against the 6 priorities of the core standards	core standards	core standards		standards.						core standards	
Number of Clinic Committees (PHC) appointed (cumulative - 10% per annum).	Clinic Committees established as per KZN Health Act (1 of 2009).	Track appointment of Clinic Committees as per KZN Health Act (1 of 2009) imperatives.	DQPR / Corporate Governance database	Number of Clinic Committees appointed.	None.	Output	Number cumulative (at 10% per annum)	Annual	No	Improved compliance with legislation to improve community consultation and participation at clinic level.	Corporate Services & District Managers.
Number of Clinic Committees (CHC) appointed (cumulative per annum).	Clinic Committees established as per KZN Health Act (1 of 2009).	Track appointment of Clinic Committees as per KZN Health Act (1 of 2009) imperatives.	DQPR / Corporate Governance database	Number of Clinic Committees (CHC) appointed.	None.	Output	Number cumulative	Annual	No	Improved compliance with legislation to improve community consultation and participation at clinic level.	Corporate Services & District Managers.
Number of Hospital Boards appointed (cumulative per annum).	Hospital Boards established as per KZN Health Act (1 of 2009).	Track appointment of Hospital Boards as per KZN Health Act (1 of 2009) imperatives.	Corporate Governance database	Number of Hospital Boards appointed.	None.	Output	Number cumulative	Annual	No	Improved compliance with legislation to improve community consultation and participation at hospital level.	Corporate Services & Hospital Managers.
Number of accredited Health Promoting Schools	The number of schools that are formally accredited by an external Assessment Team as fully compliant with the national norms and standards for HPS.	Monitor implementation of HPS in line with the Ottawa Charter's 5 Action Areas to expand the role of learners as partners in health and improve accountability for health at household level.	DQPR	Sum of the total number of schools formally accredited by an external assessment team as HPS.	Accuracy of database.	Output	Number cumulative	Quarterly	No	Increase community participation in health programmes through partnerships and active community involvement.	DHS, District and Health Promotion Managers.
School Health Services coverage	The total number of schools (out of total number of schools) visited by a School Health Team for basic screening services and health promoting/ education during the reporting period.	Track the total number of schools that receive at least one SHS visit per year from an integrated School Health Team to render services as per Provincial School Health Services Policy.	DQPR	**Numerator** Number of schools visited. **Denominator** Total number of schools.	Accurate reporting at district level.	Output	% cumulative	Quarterly	No	Improved school health coverage as per Provincial School Health Services Policy Implementation Plan.	DHS, District & MC&WH Managers.
Number of PHC clinics/ CHC's/ Hospitals	The total number of PHC clinics accredited (out of the total number) by the	Monitor implementation of Quality Improvement Plans towards	Accreditation body database	Number of PHC clinics accredited by National Accreditation Authority.	Accuracy of National & Provincial database.	Outcome	Number cumulative	Annual		All PHC clinics implement the National Core Standards	DHS, District & Quality Assurance Managers.

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
accredited	National Accreditation Body as being compliant with the National Core Standards for Quality.	compliance with National Core Standards to improve quality and deficiency of health services.		The indicator is the same for all facilities – not repeated elsewhere						towards accreditation.	
Number of CHC's/ Hospitals conducting annual Patient Satisfaction Survey's	The number of CHC's that conducted a Patient Satisfaction Survey (using the standard national template) in the last 12 months.	Measure patient satisfaction with health services.	DQPR	Number CHC's that conducted a Patient Satisfaction Survey the last 12 months. The indicator is the same for all facilities conducting surveys – not repeated elsewhere	Limitation not related to number of surveys conducted – rather the response to surveys and monitoring of outcomes.	Output	Number	Annual	No	Annual surveys inform Quality Improvement Plans and track performance towards improved quality and patient satisfaction.	Quality Assurance Managers.
Average patient waiting time in CHC's	The average time that clients spent in CHC's from the time of arrival to the time that they receive the appropriate service.	Monitor average patient waiting time to determine the efficiency and effectiveness of health services in direct relation to patient numbers and delivery of appropriate package of services.	DQPR	**Numerator** Waiting time (in minutes/ hours) during reporting period. **Denominator** Total patients visiting CHC during reporting period.	Reporting on regular surveys.	Output	Hours	Annual	No	Shorter waiting times (under 1 hour) considered an indication of efficient and effective health services. This is however directly related to appropriate placement of staff, skills mix and availability of appropriate resources to render services as per service delivery package.	District & CHC Managers.

PROGRAMMES 2/ 4/ 5: HOSPITAL SERVICES

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Caesarean section rate The same for all levels of care (district/ regional/ tertiary and central hospitals)	Caesarean section deliveries in hospitals expressed as a percentage of all deliveries in hospitals.	Track the performance of obstetric care of the hospitals	DHIS	**Numerator:** Number of Caesarean sections performed **Denominator:** Total number of deliveries in facility	Accuracy dependant on quality of data from reporting facility	Output	Percentage	Quarterly	No	Higher percentage of Caesarean section indicates higher burden of disease, and/or poorer quality of antenatal care.	MCWH&N Programme Manager
Total separations The same in all hospitals	Recorded completion of treatment and/or the accommodation of a patient in hospitals. Separations include inpatients who were discharged, transferred out to other hospitals or who died and includes Day Patients.	Monitoring the service volumes	DHIS	**Sum of:** • Inpatient deaths • Inpatient discharges • Inpatient transfer out • Day patient	Accuracy dependant on quality of data from reporting facility	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	District Health Services
Patient Day Equivalent The same in all hospitals	Patient day equivalent is weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All hospital activity expressed as a equivalent to one inpatient day	Monitoring the service volumes	DHIS	**Sum of:** • Inpatient days -total • 1/2 Day patients • 1/3 OPD headcount - total • 1/3 Emergency Headcount **OPD Headcount total = sum of:** • OPD specialist clinic headcount + • OPD general clinic headcount	Accuracy dependant on quality of data from reporting facility	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	District Health Services

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
OPD Headcount – Total The same in all hospitals	A headcount of all outpatients attending an outpatient clinic.	Monitoring the service volumes	DHIS	**Sum of:** • OPD specialist clinic headcount • OPD general clinic headcount	Accuracy dependant on quality of data from reporting facility	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	District Health Services
Average length of stay The same in all hospitals	Average number of patient days that an admitted patient in the hospital stays before separation.	To monitor the efficiency of the hospital	DHIS	**Numerator:** Inpatient days + 1/2 Day patients **Denominator:** Separations	High levels of efficiency could hide poor quality	Efficiency	Ratio	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care	District Health Services
Bed utilisation rate (based on usable beds) The same in all hospitals	Patient days during the reporting period, expressed as a percentage of the sum of the daily number of usable beds.	Track the over/under utilisation of hospital beds	DHIS	**Numerator:** Inpatient days + 1/2 Day patients **Denominator:** Number of usable bed days	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels	District Health Services
Expenditure per patient day equivalent (PDE) The same in all hospitals	Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All hospital activity expressed as a equivalent to one inpatient day	Track the expenditure per PDE in hospitals in the province	BAS / DHIS	**Numerator:** Total Expenditure in hospitals **Denominator:** Patient Day Equivalent (PDE)*		Efficiency	Rate	Quarterly	No	Lower rate indicating efficient use of financial resources.	District Health Services.
Percentage of complaints of users of 'District' Hospital Services resolved within 25 days The same for all hospitals	Percentage of complaints of users of 'District' Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	Quality Assurance	**Numerator:** Total number of complaints resolved within 25 days during the quarter **Denominator:** Total number of complaints during the quarter	Accuracy of information is dependant on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	Yes	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
'District' hospitals with monthly Maternal Mortality and Morbidity Meetings The same in all hospitals	Percentage of 'district' hospitals having monthly Maternal Mortality and Morbidity Meetings (3 per quarter)	To monitor the quality of hospital services, as reflected in levels of diseases adverse events; and proportion of deaths	Quality Assurance (QA)	**Numerator:** Number of 'district' hospitals having Maternal Mortality and Morbidity every month **Denominator:** Total number of 'district' hospitals	Accuracy dependant on quality of data from reporting facility	Quality	Percentage	Quarterly	No	Higher percentage suggests better clinical governance	Quality Assurance (QA)
Percentage of users of 'District' Hospital Services satisfied with the services received The same for all hospitals	The percentage of users that participated in the 'District 'Hospital Services survey that were satisfied with the services	Tracks the service satisfaction of the Hospital users	QA	**Numerator:** Total number of users that were satisfied with the services rendered in 'District' Hospitals **Denominator:** Total number of users that participated in the Client Satisfaction Survey (in 'District' Hospitals)	Generalised - depends on the number of users participating in the survey.	Output	Percentage	Annual	Yes	Higher percentage indicates better levels of satisfaction in Hospital services	Quality Assurance
Percentage of 'District 'Hospitals facilities assessed for compliance against the 6 priorities of the core standards The same in all hospitals	Percentage of 'District' Hospitals assessed for compliance against the core standards	Tracks the levels of compliance against the core standards	QA	**Numerator:** Total number of 'District' Hospitals assessed against the 6 priority areas of the core standards. **Denominator:** Total number of 'District 'hospitals in the province.	Availability of records	Process	Sum	Annual	Yes	Higher number indicates better compliance with the core standards in Hospitals	Quality Assurance
Number of CEO's who have signed delegation of authorities Relevant to all hospitals	The number of Hospital Managers who signed the reviewed delegation of authorities in support of a decentralised operational model.	Track the number of Hospital Managers who officially signed the national delegation of authorities.	Signed delegations	Number of Hospital Managers who signed the national delegation of authorities.	None.	Input	Number cumulative	Annual	No	Improved accountability and reduction of bottlenecks in service delivery by implementing the decentralised operational model.	HRMS & District Managers.
Number of 'District' Hospitals accredited Relevant to all hospitals	The total number of 'District' Hospitals accredited as compliant with the National Core Standards for Quality by the National Accreditation Body.	The total number of 'District' Hospitals accredited as compliant with the National Core Standards for Quality by the National Accreditation Body.	Accreditation body database	Number of 'District' Hospitals accredited.	Accuracy of National & Provincial database.	Outcome	Number cumulative	Annual	Yes	All Hospitals implement the National Core Standards towards accreditation as per identified targets.	District & Facility Managers.

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of 'District' Hospitals conducting annual Patient Satisfaction Surveys Relevant to all hospitals	Number 'District' Hospitals with a published Patient Satisfaction Survey in the last 12 months.	Number 'District' Hospitals with a published Patient Satisfaction Survey in the last 12 months.	DQPR	'District 'Hospitals with a published Patient Satisfaction Survey in the last 12 months.	Accuracy dependant on quality of data from reporting facility.	Output	Number cumulative	Annual	No	Improved patient satisfaction and quality in compliance with Batho Pele and Patient Rights Principles.	Quality Assurance, Hospital & District Managers.
Average patient waiting time at OPD Relevant to all hospitals	The average time that clients spent in OPD from the time they arrive to the time that they receive the appropriate health service.	The average time that clients spent in OPD from the time they arrive to the time that they receive the appropriate health service.	DQPR	**Numerator** Waiting time (in minutes/ hours) during reporting period. **Denominator** Total patients during reporting period.	Reporting on regular surveys.	Outcome	Minutes/ Hours	Annual	No	Shorter waiting times (under 1 hour) considered an indication of efficient and effective health services.	District & CHC Managers.
Average patient waiting time at admissions Relevant to all hospitals	The average time that clients spent in admissions from the time they arrive to the time that they are admitted.	The average time that clients spent in admissions from the time they arrive to the time that they are admitted.	DQPR	**Numerator** Waiting time (in minutes/ hours) during reporting period. **Denominator** Total patients during reporting period.	Reporting on regular surveys.	Outcome	Minutes/ Hours	Annual	No	Shorter waiting times (under 1 hour) considered an indication of efficient and effective health services.	District & CHC Managers.

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

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Total number of patients (Children and Adults) on ART	Number of patients on an ARV regimen	Track the number of patients on ARV Treatment	CCMT	Cumulative total of Number of patients on an ARV regimen	Accuracy of data – vertical systems (some paper based)	Input	Cumulative total	Quarterly	No	Higher total indicates a larger population on ART treatment	HIV/AIDS Programme Manager
Male condom distribution rate	Number of male condoms distributed within the province at public health facilities per male population 15 years and over	Track the contraceptive measures	DHIS	**Numerator:** Male condoms distributed within province **Denominator:** Male population 15 and over	Indicator reliant on accuracy of population estimates from StatsSA	Process	rate	Quarterly	No	Higher rate indicates better contraceptive measures which should lead to decrease in HIV/AIDS incidence.	HIV/AIDS Programme manager
New smear positive PTB defaulter rate	Percentage of smear positive PTB cases who interrupted (defaulted) treatment		ETR.Net	**Numerator:** All smear positive defaulted **Denominator:** All smear positive newly registered	Accuracy of data	Output	Percentage	Quarterly	No	Lower levels of interruption reflect improved case holding, which is important for facilitating successful TB treatment	
PTB two month smear conversion rate	The percentage of new smear positive PTB clients who converted to smear negative after being on treatment for 2 months.	Track the morbidity and mortality due to TB and the routine sputum collection in all TB patients at 2 months.	ETBR	**Numerator** New smear positive PTB clients who converted to smear negative at 2 months. **Denominator** New smear positive PTB clients registered.	Accuracy is dependent on accurate completion of the ETBR at facility level.	Outcome	%	Quarterly	No	Higher smear conversion rates will lead to better TB outcomes.	TB Manager.
Percentage of HIV-TB Co-infected patients placed on ART	Percentage of HIV and TB co-infected patients placed on Ante retrovirus Treatment (ART)	Monitors the coverage of ART among co-infected population	ETR. Net	**Numerator:** Total number of HIV and TB co-infected people placed on ART **Denominator:** Total number of co-infected people with a CD4 count of 350 or less.	Dependant on the accuracy of the Electronic TB Register.	Output	Percentage	Quarterly	Yes	Higher percentage indicate better coverage	TB Programme Manager
HCT testing rate	Percentage of clients tested to those counselled.	Monitors the number of people convinced for testing	DHIS	**Numerator:** Total number clients of HCT clients tested for HIV **Denominator:** Total number of HCT clients pre-test counselled	Dependant on the accuracy of tick and tally sheets	Process	Percentage	Quarterly	Yes	Higher percentage indicates increased population knowing their HIV status.	HIV/AIDS Programme Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
New smear positive PTB cure rate	Percentage of new smear positive PTB cases cured at first attempt	Monitor the TB Cure rate	ETR	**Numerator:** New smear positive cured **Denominator:** New smear positive newly registered	Accuracy dependant on quality of data from reporting facility	Outcome	Percentage	Annual	No	Higher percentage indicate better cure rate for the province	TB Programme Manager
HIV incidence	New HIV infections.	Monitor the impact of HIV & AIDS Programmes on HIV incidence.	Scientific Community	**Numerator** New HIV infections. **Denominator** Total population.	Dependence on external data sources for information.	Impact	%	Annual projections	No	Reduction in HIV incidence will indicate positive behaviour change.	HAST Manager.
Percentage qualifying HIV-positive patients on ART	The proportion of HIV-positive clients who qualify for ART based on the HIV policy (including new changes announced on the 1st of December 2009) on the appropriate treatment regime.	Track performance against the National Strategic Plan targets and monitor the effectiveness of the HIV & AIDS Programme.	HIV database[80]	**Numerator** The number of HIV-positive qualifying patients on a treatment regime. **Denominator** The total number of HIV-positive clients qualifying for treatment.	Data quality and completeness from reporting facilities.	Output	%	Annual	No	HIV-positive qualifying patients have access to appropriate treatment.	District & HAST Managers.
Percentage of people with HIV-TB co-morbidity initiated on ART at a CD4 count of 350 or less	The proportion of HIV-TB co-infected clients initiated on ART at a CD4 count of 350 or less.	Track implementation of the HIV & AIDS policy and monitor management of integrated HIV and TB programmes.	HIV database	**Numerator** HIV-TB co-infected clients with a CD4 count of 350 or less on ART. **Denominator** Total HIV-TB co-infected clients.	Data quality and completeness from reporting facilities.	Output	%	Quarterly	Yes	All HIV-TB co-infected patients receive treatment and care as per policy guidelines.	District, HAST and TB Managers.
Number of neo-natal males circumcised[81]	The number of male newborns circumcised as proportion of total male live births.	Monitor male medical circumcision strategy to reduce HIV incidence.	DHIS	**Numerator** Number of neonates circumcised. **Denominator** Number of male live births.	Data quality and completeness from reporting facilities.	Output	Total cumulative	Quarterly	No	Reduce HIV incidence.	HAST and MC&WH Managers.

[80] All HIV indicators will be incorporated into DHIS and the web-based reporting system
[81] Targets for circumcision were taken from a formal presentation by the Senior Manager for Priority Programmes

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of adult males circumcised	The number of males circumcised (male medical circumcision) as proportion of males between 15 – 49 years old – assuming an acceptance rate of 80%.	Strategy to reduce HIV incidence and transmission.	DHIS	**Numerator** The number of males 15 – 49 years circumcised. **Denominator** Number of males 15 – 49 years.	Data quality and completeness from reporting facilities. Accurate population estimates by Stats SA.	Output	Total cumulative	Quarterly	No	Reduce HIV incidence and transmission.	HAST Manager.

SUB-PROGRAMME: MATERNAL, CHILD AND WOMAN HEALTH

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Immunisation coverage under 1 year	Percentage of all children in the target area under one year who complete their primary course of immunisation during the month (annualised). A Primary Course includes BCG, OPV 1,2 & 3, DTP-Hib 1,2 & 3, HepB 1,2 & 3, and 1st measles at 9 month.	Monitor the implementation of Extended Programme in Immunisation (EPI)	DHIS	**Numerator:** Immunised fully under 1 year **Denominator:** Population under 1-year	Reliant on under 1 population estimates from StatsSA	Output	Percentage Annualised	Quarterly	No	Higher percentage indicate better immunisation coverage	EPI Programme manager
Vitamin A coverage under 12 – 59 months	Percentage of children 12-59 months receiving vitamin A 200,000 units twice a year.(The denominator is therefore the target population 1-4 years multiplied by 2.)	Monitor the Vitamin A coverage of children	DHIS	**Numerator:** Vitamin A supplement to 12-59 months child **Denominator:** Target population 1-4 years x 2	Reliant on Child population estimates from StatsSA	Output	Percentage Annualised	Quarterly	No	Higher percentage indicate better Vitamin A coverage, and better nutritional support to children	Nutrition Programme manager
Measles coverage under 1 year	Percentage of children under 1 year who received measles dose	Monitor the measles coverage	DHIS	**Numerator:** Measles 1st dose before 1 year **Denominator:** Population under 1 year	Reliant on under 1 population estimates from StatsSA	Output	Percentage Annualised	Quarterly	No	Higher percentage indicate better Measles coverage	EPI Programme manager
Pneumococcal 3st dose coverage under 1 year	Percentage of children under 1 year who received Pneumococcal 3st dose	Monitor the Pneumococcal coverage	DHIS	**Numerator:** Pneumococcal 3rd doses before 1 year **Denominator:** Population under 1 year	Reliant on under 1 population estimates from StatsSA	Output	Percentage Annualised	Quarterly	No	Higher percentage indicate better Pneumococcal coverage	EPI Programme manager
Rota Virus 2nd dose coverage under 1 year	Percentage of children under 1 year who received Rota Virus 2nd dose	Monitor the Rota Virus coverage	DHIS	**Numerator:** Rota Virus 2nd doses before 1 year **Denominator:** Population under 1 year	Reliant on under 1 population estimates from StatsSA	Output	Percentage	Quarterly	No	Higher percentage indicate better Rota Virus coverage	EPI Programme manager
Cervical cancer	Percentage of women	Monitor cervical cancer	DHIS	**Numerator:**	Reliant on population	Output	Percentage	Quarterly	No	Higher percentage	MNCWH

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
screening coverage	from 30 years and older who were screened for cervical cancer	screening coverage		Cervical smear in woman 30-years and older screened for cervical cancer **Denominator:** Female population 30-59 years	estimates from StatsSA for women in age category 30-59 years		Annualised			indicate better cervical cancer coverage	Programme Manager
Antenatal visits before 20 weeks rate	The percentage of women who have a booking visit (first visit) before they are 20 weeks (about half way) into their pregnancy.	Utilisation of ANC services	DHIS	**Numerator:** Antenatal 1st visits before 20 weeks **Denominator:** Antenatal 1st visits	Reliant on accuracy of number of weeks the client is pregnant	Process	Percentage	Quarterly	No	Higher percentage indicates better access to antenatal care.	MNCWH programme Manager
Baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks	The number of babies who test positive for HIV at 6 weeks as a proportion of the total number tested at 6 weeks	Track mother to child transmission of HIV	DHIS	**Numerator:** Number of babies who tested PCR positive at 6 weeks after birth **Denominator:** Total number of babies tested at 6 weeks after birth	Quality of data – poor reporting/ recording	Outcome	Percentage	Quarterly	No	Lower % indicates that PMTCT programme is working	MC&WH Manager
Couple Year Protection Rate	Percentage of women of reproductive age (15-44) who are using (or whose partner is using) a modern contraceptive method. Contraceptive methods include female and male sterilisation , injectable, and oral hormones, intrauterine devices, diaphragms, spermicides and condoms	Track the extent of the use of contraception (any method) amongst women of child bearing age	DHIS SADHS	**Numerator** Contraceptive years equivalent = Sum: • Male sterilisations x 20 • Female sterilisations x10 • Medroxyprogesterone injection /4 • Norethisterone enanthate injection /6 • Oral pill cycles /13 • IUCD x 4 • Male condoms /500 **Denominator**: Female target population 15-44 years	Reliant on accuracy of data collection	Output	Percentage	Annual	No	Higher protection levels are desired	Health Information, Epidemiology and Research Programme MCWH&N Programme
Facility Maternal Mortality Ratio (MMR)	Number of maternal deaths in facility expressed per 100 000 live births. . A maternal death is the death of a woman while pregnant or within 42 days of	Confidential enquiry into maternal deaths report only released every 3-5 years, so monitoring of maternal deaths on a routine basis is very important	DHIS	**Numerator:** Maternal death in facility **Denominator:** Live births in facility	Reliant on accuracy of classification of inpatient death	Outcome	Ratio per 100 000 live births	Annual	No	Lower institutional rate indicate fewer avoidable deaths.	MNCWH programme manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
	termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (as cited in ICD 10).	to monitor progress towards MDG target. Mortality and causes of death report does not give exact figures for maternal deaths.									
Delivery rate for women under 18 years	Percentage of deliveries where the mother is under 18 years on the day of delivery.	Monitor the percentage of deliveries among teenagers	DHIS	**Numerator:** Total number of Deliveries in province to woman under 18 years **Denominator:** Total Deliveries in province	Data quality and accuracy	Outcome	Percentage	Annual	No	Higher percentage indicates increase in the number of deliveries among teenagers.	MCWH Programme manager
Facility Infant mortality (under 1 years) rate	The number of children who have died in a health facility between birth and their first birthday, expressed per thousand live births in facility	Monitoring of infant deaths on a routine basis is very important to monitor progress towards MDG.	DHIS	**Numerator:** Total number of inpatient death under one year **Denominator:** Inpatients separations under 1 year (Sum of Inpatient discharge < 1 year and Inpatient transfer out < 1)	Reliant on accuracy of in facility live births reporting	Outcome	Rate	Annual	No	Lower infant mortality rate	MC&WH Manager
Facility child mortality (under 5 years) rate	The number of children who have died in a health facility between birth and their fifth birthday, expressed per thousand live births in facility	Monitoring of children deaths on a routine basis is very important to monitor progress towards MDG.	DHIS	**Numerator:** Total number of inpatient deaths under 5 years **Denominator:** Inpatients separations under 5 year (Sum of Inpatient discharge < 5 year and Inpatient transfer out < 5)	Reliant on accuracy of in facility live births reporting	Outcome	Rate	Annual	No	Lower children mortality rate	MC&WH Manager
% of pregnant women tested for HIV	The proportion of pregnant women who are tested for HIV during the ANC period.	Track the number of ANC clients tested for HIV in support of improved PMTCT Programme and reduction of maternal mortality.	DHIS	**Numerator** Number of ANC clients tested for HIV. **Denominator** Total number of ANC clients	Data quality and completeness from reporting facilities.	Output	%	Quarterly	No	Increased testing will have an impact on the success of the PMTCT and HIV Programme.	MC&WH, PMTCT & HAST Managers.

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
% of eligible pregnant women placed on HAART	HIV-positive antenatal (ANC) clients initiated on HAART as a proportion of HIV-positive antenatal clients with CD4 count under the specified threshold and/or WHO staging of 4.	Monitor the effective implementation of the PMTCT Programme.	DHIS	**Numerator** Number of HIV-positive ANC clients initiated on HAART during current pregnancy. **Denominator** Number of HIV-positive ANC clients with a CD4 count under the specified threshold and/or a WHO staging of 4.	Data quality and completeness from reporting facilities.	Output	%	Quarterly	No	All pregnant HIV-positive or exposed women receive appropriate treatment as per PMTCT Policy & Protocol.	MC&WH and PMTCT Managers.
Number of diarrhoea cases – children under-5 years[82]	The total number of diarrhoea cases (children under 5 years) seen in public health facilities.	Monitor the trend in diarrhoea cases – link with rotavirus vaccine coverage and child mortality (MDG 4).	DHIS	**Sum** Number of children under 5 years reporting with diarrhoea during reporting period.	Quality of data from reporting facility and effective reporting system.	Outcome	Number	Quarterly	No	Track progress towards MDG's.	MC&WH Manager.
Number of pneumonia cases – children under-5 years	The total number of pneumonia cases (children under 5 years) seen in public health facilities.	Monitor the trend in pneumonia cases – link with pneumococcal vaccine coverage and child mortality (MDG 4).	DHIS	**Sum** Number of children under 5 years reporting with pneumonia in reporting period.	Quality of data from reporting facility and effective reporting system.	Outcome	Number	Quarterly	No	Track progress towards MDG's.	MC&WH Manager.
% of mothers and newborn babies who received post partum care within 6 days after delivery	The proportion of mothers and babies, compared to total deliveries that receive a follow-up visit at a health facility within 6 days of delivery.	Monitor the effectiveness and utilisation of postpartum health services as part of effective maternal health care.	DHIS	**Numerator** Percentage mothers and babies receiving postpartum care within 6 days after delivery. **Denominator** Total deliveries in facilities.	Reliant on accuracy of gestation period as well as reporting from facilities and reliable information systems.	Output	%	Quarterly	No	Increased utilisation of postpartum services will improve maternal & infant health outcomes (MDG 4 and 5).	MC&WH Manager.
Number of maternity care units that review Maternal and Peri-Natal deaths and address identified deficiencies[83]	Number of maternity units that conduct monthly maternal & perinatal morbidity and mortality meetings and have quality improvement plans to address identified challenges.	Monitor the quality of services specifically related to preventable causes of neonatal, child and maternal deaths.	District Quarterly Reports Web-based system	**Sum** Number of maternity units that conduct monthly morbidity and mortality meetings and implement quality improvement plans to address deficiencies.	Accuracy dependant on quality of data from reporting facilities and effective information system.	Quality	Number	Quarterly	No	Higher number suggests better clinical governance and compliance with National Core Standards and best practice models.	Hospital & MC&WH Manager.

[82] Re-consider indicators – monitor the same for national (performance) indicators
[83] This includes only hospitals. No CHC's or PHC Clinics have been included in the totals for this indicator

SUB-PROGRAMME: DISEASE CONTROL AND PREVENTION

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Malaria fatality rate (annual)	Deaths from malaria as a percentage of the number of cases reported	Monitor the number deaths caused by Malaria	DHIS	**Numerator:** Deaths from malaria **Denominator:** Total number of Malaria cases reported	Accuracy dependant on quality of data from health facilities	Outcome	Rate	Annual	No	Lower percentage indicates a decreasing burden of malaria	Communicable Diseases
Cholera fatality rate (annual)	Deaths from cholera as a percentage of the number of cases reported	Monitor the number deaths caused by Cholera	CDC	**Numerator:** Deaths from Cholera **Denominator:** Total number of cholera cases reported	Accuracy dependant on quality of data from health facilities	Outcome	Rate	Annual	No	Lower percentage indicates a decreasing burden of cholera	Communicable Diseases
Cataract surgery rate (annual)	Cataract operations completed per 1,000,000 population	Monitor the number of cataract surgery	DHIS	**Numerator:** Cataract operations completed **Denominator:** Total population	Accuracy dependant on quality of data from health facilities	Outcome	Rate per 1mil population	Annual	No	Higher levels reflects a good contribution to sight restoration, especially amongst the elderly population	Non communicable Diseases
Malaria incidence per 1000 population at risk.	New malaria cases as proportion of 1000 population at risk.	Monitor the new malaria cases as proportion of the population at risk to monitor performance in relation to MDG 6.	DQPR	**Numerator** Number of new malaria cases reported. **Denominator** Population at risk.	Accuracy dependant on quality of data and effective information systems.	Outcome	% per 1000 population	Annual	No	Reduced incidence indicates improved prevention strategies.	CDC & Environmental Health Managers.

PROGRAMME 3: EMERGENCY MEDICAL & PATIENT TRANSPORT SERVICES

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Rostered ambulances per 10 000 population	Number of all rostered ambulances per 10 000 people in the province	Track the availability of rostered ambulances	EMS Information Systems	**Numerator:** Total number of roistered ambulances **Denominator:** Total population in the province (divided by 10 000)	Data quality	Input	Sum	Quarterly	No	Higher number of roistered ambulances may lead to faster response time her	EMS Manager
P1 calls with a response of time <15 minutes in an urban area	Percentage of P1 call outs to urban locations with response times within national urban target (15 min)	Monitor Response times within national urban target	EMS Information Systems	**Numerator:** No priority 1 urban calls where Response times within national urban target **Denominator:** All priority 1 urban Call outs	Accuracy dependant on quality of data from reporting EMS station	Quality	Percentage	Quarterly	No	Higher percentage indicate better response times in the urban area	EMS Manager
P1 calls with a response time of <40 minutes in a rural area	Percentage of P1 call outs to rural locations with response times within national rural target (40 min)	Monitor Response times within national rural target	EMS Information Systems	**Numerator:** No priority 1 rural calls where Response times within national rural target **Denominator:** All priority 1 rural Call outs	Accuracy dependant on quality of data from reporting EMS station	Quality	Percentage	Quarterly	No	Higher percentage indicate better response times in the rural areas	EMS Manager
All calls with response time within 60 minutes	Percentage of all call outs with response times within 60min	Monitor Response times	EMS Information Systems	**Numerator:** No of calls where Response times within 60min **Denominator:** All Call outs	Accuracy dependant on quality of data from reporting EMS station	Quality	Percentage	Quarterly	No	Higher percentage indicate better response times	EMS Manager
Rostered ambulances per 10,000 people[84]	Number of rostered ambulances per 10 000 population.	Track the proportion of rostered ambulances per 10 000 population against the national norm.	EMS Information System Stats SA	**Numerator** Total number of rostered ambulances. **Denominator** Total population.	Reliant on accuracy of population estimates by Stats SA.	Input	Rate per 10 000 population	Annual	No	Higher number of rostered ambulances will improve efficiency and effectiveness of EMS.	EMS Manager.

[84] Indicator incorrectly calculated previously, is now corrected. Uninsured population utilised in calculation

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Total number of EMS emergency cases	Number of patients transported by ambulance.	Monitor the service volumes and capacity.	EMS Information System	Number of patients transported by ambulance.	Accuracy dependant on quality of data from reporting EMS stations.	Output	Number cumulative	Quarterly	No	Increasing numbers may indicate increased dependence on public health services or more efficient EMS.	EMS Manager.
Total number of inter facility transfers	Patients transferred between facilities by appointment	Track patient activity between facilities – relevant to transport availability	EMS Database	**Sum** Number of patients transported by appointment between facilities	Quality of data	Output	Number	Quarterly	No	Increasing number might be indication of effective referral system or increasing burden of disease	EMS & Hospital Manager
Locally based staff with training in BLS (BAA)	The number of Emergency Medical Services (EMS) staff that completed an accredited training course for BLS.	Annual	HPCSA	**Sum** EMS staff with BLS qualification.	Data quality depends on record keeping of training college.	Input	Number	Annual	No	Higher number of EMS staff with BLS qualification will improve efficiency of emergency services.	HRD & EMS Managers.
Locally based staff with training in ILS (AEA)	The number of Emergency Medical Services (EMS) staff that completed accredited an accredited training course for ILS.	Annual	HPCSA	**Sum** EMS staff with ILS qualification.	Data quality depends on record keeping of training college.	Input	Number	Annual	No	Higher number of EMS staff with BLS qualification will improve efficiency of emergency services.	HRD & EMS Managers.
Locally based staff with training in ALS (Paramedics)	The number of Emergency Medical Services (EMS) staff that completed an accredited training course for ALS.	Annual	HPCSA	**Sum** EMS staff with ALS qualification.	Data quality depends on record keeping of training college.	Input	Number	Annual	No	Higher number of EMS staff with BLS qualification will improve efficiency of emergency services.	HRD & EMS Managers.

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of Registrars in training – cumulative.	Number of registrars who are in training with the DoH.	Track number of registrar's in training	Persal	Number of registrar's in training	Data quality depends on good record keeping of the DoH.	Input	Number	Annual	Yes	Increased number of medical registrars in training.	HRMS
Number of Registrars retained after qualifying.	Number of Medical Specialists that stays in the public health service after graduation.	Track retention of Registrars after graduation.	Persal	**Numerator** Number of Registrars retained after graduation. **Denominator** Total number of Registrars graduating.	Records of students and retention.	Outcome	% cumulative	Annual	No	Increased pool of Medical Specialists.	HRMS
Number of Professional Nurses graduating	Number of Professional Nurses who graduate from the basic nursing course.	Number cumulative	SANC / Persal	Professional Nurses graduating.	Data quality depends on good record keeping by both the Provincial DoH and nursing colleges.	Output	Number cumulative	Annual	No	Desired performance level is that the number of student nurses graduating should be in direct response to Provincial needs.	HRMS Manager & Nursing College.
Number of advanced midwifes graduating per annum	Number of Advanced Midwifes who graduate with a post basic nursing qualification in Advanced Midwifery.	Number cumulative	SANC / Persal	Advanced Midwifes graduating.	Data quality depends on good record keeping by the Provincial DoH and Training College.	Output	Number cumulative	Annual	No	Training more Advanced Midwifes in response to MC&WH Strategy to improve maternal health.	HRMS, Nursing College and MC&WH Managers.
Students with bursaries from the Province	Number of students provided with bursaries by the Provincial Department of Health.	Number	Internal database	Number of students with bursaries from the Province.	Data quality depends on good record keeping by both the Provincial DOH and Health Science Training institutions.	Input	Number	Annual	No	Higher numbers of students provided with bursaries will increase the potential pool of health care providers.	HRMS Manager.
Medical registrars graduating	Number of Medical Registrars who graduate from post-graduate training	Track the production of new Medical Specialists.	Persal	Number of Medical Registrars graduating.	Data quality depends on good record keeping by both the Provincial DOH and training institutions	Output	Number	Annual	No	Increase in the potential pool of Medical Specialists for public health services.	HRMS
Number of professional health care workers trained on Provider Initiated Counselling & Testing	Training of professional health workers in Provider Initiated Counselling & Testing in response to the forthcoming national HCT campaign.	Track the progress with training of health care providers.	Attendance Registers	Number of professional health care workers trained in Provider Initiated Counselling & Testing.	Accuracy of training records.	Input	Number cumulative	Quarterly	No	All providers trained in Provider Initiated Counselling & Testing to ensure effective implementation of the HCT campaign.	HRMS & HAST Managers.

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of Managers accessing the Management Skills Programmes.	Managers attending Leadership & Management training programmes.	Track the number of Managers that attend Leadership & Management training programmes.	Internal database	Managers attending Leadership & Management training programmes.	Data quality depends on record keeping by HRD and external service providers.	Output	Total cumulative	Quarterly	No	Training will improve governance and management competencies.	HRD Manager.
Number of SMS members trained on Massification Implementation Plan (MIP)	SMS members attending the MIP for Senior Managers.	Track the number of Senior Managers attending the MIP.	Internal database	SMS members attending MIP.	Data quality depends on record keeping by HRD and the external training provider.	Output	Total cumulative	Annual	No	Higher attendance will improve service delivery.	HRD Manager.
Intake of nurse students	Number of nurses entering the first year of nursing college	Tracks the training of nurses	Human Resources Development	Total intake	Data quality depends on good record keeping by both the Provincial DoH and nursing colleges	Input	Sum total	Annual	No	Higher levels of intake are desired, to increase the availability of nurses in future	Human Resources Development Programme
Students with bursaries from the province	Number of students provided with bursaries by the provincial department of health	Tracks the numbers of health science students sponsored by the Province to undergo training as future health care providers	Human Resources Development	Number of students with bursaries	Data quality depends on good record keeping by both the Provincial DoH and Health Science Training institutions	Input	Sum total	Annual	No	Higher numbers of students provided with bursaries are desired, as this has the potential to increase future health care providers	Human Resources Development
Basic nurse students graduating	Number of students who graduate from the basic nursing course	Tracks the production of nurses	Human Resources Development	Number of students graduating	Data quality depends on good record keeping by both the Provincial DoH and nursing colleges	Output	Sum total	Annual	No	Desired performance level is that higher numbers of nursing students should be graduating	All Managers

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Percentage of Pharmacies that obtained A or B grading on inspection[85]	The number of Pharmacies (out of the total number of Pharmacies) that comply with Pharmaceutical prescripts on inspection.	Track compliance with Pharmaceutical prescripts.	Pharmacy database	**Numerator** Number of Pharmacies with A or B grading on inspection. **Denominator** Total number of Pharmacies.	Accurate records of inspections conducted.	Quality	% cumulative	Annual	No	Improved compliance will improve quality and efficiency of Pharmaceutical services.	Pharmacy Manager.
PPSD compliant with Good Manufacturing Practice Regulations	PPSD (including infrastructure) compliant with Good Manufacturing Practice Regulations.	Track progress towards compliance.	Pharmacy reports	PPSD compliant with prescripts of Good Manufacturing Practice Regulations.	None.	Output	Yes/ No	Annual progress	No	PPSD compliant with prescripts.	Pharmacy Manager.
Tracer medicine stock-out rate in bulk store (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	Any tracer medicine stock-out in bulk store (PPSD).	Accuracy dependant on quality of data from reporting facility.	Efficiency	%	Quarterly	No	Targeting zero stock-out.	Pharmacy Manager.
Tracer medicine stock-out rate in bulk store (Institutions)	Any item on the Tracer Medicine List that had a zero balance in Bulk Store (facilities) on the Stock Control System. Percentage of fixed facilities with tracer medicine stock-outs (>0) during the reporting period. A facility should be counted once as having a stock-out during the reporting period.	Monitor shortages in Tracer medicines.	DHIS	**Numerator** Any tracer medicine stock-out in facilities. **Denominator** Number of fixed facilities.	Accuracy dependant on quality of data from reporting facilities.	Efficiency	%	Quarterly		Targeting zero stock-out of all tracer medicines.	District & Pharmacy Managers.

[85] Refers to being compliant with SAPS standards

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Average patient waiting time for Pharmacy	The average time that clients have to wait for medicines from Pharmacy calculated from the time of arrival to the time they receive their medicines.	Monitor average waiting time as proxy of quality and efficiency of Pharmaceutical services.	Waiting Time Surveys	**Numerator** Waiting time (in minutes/ hours) per sample patients in Pharmacy. **Denominator** Total sample patients.	Reporting on regular surveys and identified challenges - monitoring of interventions to address challenges.	Outcome	Minutes/ Hours	Annual		Shorter waiting times (under 1 hour) considered an indication of efficient and effective health services.	District & Pharmacy Managers.

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
New infrastructure construction completed	The number of new clinical infrastructure (clinics, etc.) completed.	Monitor progress with projects for new clinical infrastructure.	2010:IRM 2010:IPMP 2010:Optimisation Plan 2011/12:U-Amp	Number of projects, construction.	Recording of progress.	Process	Number	Quarterly	No	Effective monitoring of performance and progress.	Health Facility Maintenance Programme.
New infrastructure Commissioning completed	The number of new clinical infrastructure (clinics, etc.) fully commissioned.	Monitor progress with projects for new clinical infrastructure.	2010:IRM 2010:IPMP 2010:Optimisation Plan 2011/12:U-Amp	Number of projects commissioned.	Recording of progress.	Process	Number	Quarterly	No	Effective monitoring of performance and progress.	Health Facility Maintenance Programme.
Upgrading and renovation construction completed	The number of upgrading and renovation projects constructed.	Monitor progress with upgrading and renovation projects.	2010:IRM 2010:IPMP 2010:Optimisation Plan 2011/12:U-Amp	Number of projects construction.	Recording of progress.	Process	Number	Quarterly	No	Effective monitoring of performance and progress.	Health Facility Maintenance Programme.
Upgrading and renovation commissioning completed	The number of upgrading and renovation projects fully commissioned.	Monitor progress with upgrading and renovation projects.	2010:IRM 2010:IPMP 2010:Optimisation Plan 2011/12:U-Amp	Number of projects commissioned.	Recording of progress.	Process	Number	Quarterly	No	Effective monitoring of performance and progress.	Health Facility Maintenance Programme.
Equitable share capital programme as % of total health expenditure	Expenditure on buildings and equipment from the provincial equitable share allocation (I.e. excluding conditional grants) as a percentage of total provincial health expenditure	Tracks expenditure on health infrastructure and equipment	Health Facility Maintenance Programme BAS	**Numerator** Expenditure on buildings upgrade renovation and construction **Denominator** Total Expenditure by provincial DoH (equitable share)	Data quality is reliant on accurate costing and assessment of the condition of health facilities	Quality	Expenditure in Rand	Annual	No	Higher average backlog of service platform reflects poor condition of health facilities. In some instances, it might even be more cost-effective to replace than to repair the facility	Health Facility Maintenance Programme
Number of Hospitals funded from the revitalisation programme	Number of hospitals with funding from the Revitalisation Grant from 2003	Tracks progress with the revitalisation of hospitals to improve service delivery	Health Facility Maintenance Programme	Number of hospitals on Revitalisation Grant	Focus should be on hospitals that have been actually funded for planning or construction, or both, but not on approved business cases that have not been funded	Input	Sum	Annual	No	Higher percentages of hospitals funded reflect progress with the revitalisation of hospitals	Health Facility Maintenance Programme
Expenditure on	Expenditure on health	Tracks expenditure on	Health Facility	**Numerator**	Data quality is reliant	Input	Expenditure	Annual	No	Expenditure on facility	Health Facility

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
facility maintenance as % of total health expenditure	buildings maintenance in the Province as a percentage of total provincial health expenditure	the maintenance of health facilities	Maintenance Programme	Expenditure on Buildings maintenance expenditure **Denominator** Total expenditure by Provincial DoH	on accurate costing of maintenance expenditure		in Rand			maintenance is desired to be about 4% of total health expenditure, but no Province has reached this target	Maintenance Programme
Average backlog of service platform in fixed PHC facilities	Expenditure required to bring all fixed provincial health clinics and CHCs up to a standard requiring routine maintenance (NHFA condition 4 - that is all systems and components fully operational and fit for purpose) as a percentage of total	Tracks the quality (condition) of health facilities and expenditure required to render them 'fit for purpose'	Health Facility Maintenance Programme BAS	**Numerator** Expenditure required for fixed PHC facilities to reach maintenance standard **Denominator** Replacement cost for all PHC facilities	Data quality is reliant on accuracy of costing and assessment of the condition of health facilities	Quality	Expenditure in Rand	Annual	No	Higher average backlog of service platform reflects poor condition of health facilities. In some instances, it might even be more cost-effective to replace than to repair the facility	Health Facility Maintenance Programme District Health Services