



health

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Department:  
Health  
**PROVINCE OF KWAZULU-NATAL**

# DISTRICT HEALTH PLAN 2015/2016

UGU

KWAZULU-NATAL

## 1. ACKNOWLEDGEMENTS

BRHC – Lynne Footit, Marlien Prins, Mabuyl Mnguni and Nomsa Mtshaka

Ugu Municipality – Nonkululeko Cele – Special Programmes

Local Municipal special programmes

Hospital and CHC Management Teams

District Office Management and team members (DCST, M&E and Programmes)

EMS management and team

Provincial Strategic Planning – T Hattingh

Primary Health Care Coordinators and Clinic Operational Managers

CCG Facilitators

Hospital Board Members

## 2. OFFICIAL SIGN OFF

It is hereby certified that this District Health Plan:

- Was developed by the district management team of **Ugu District** with the technical support from the provincial district development directorate and the strategic planning unit.
- Was prepared in line with the current Strategic Plan and Annual Performance Plan of the Department of Health of KZN

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Date: 2015/03/20

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2015/03/22  
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Date: 31.03.2015

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## 4. LIST OF ACRONYMS

Abbreviations	Description
<b>A</b>	
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
APP	Annual Performance Plan
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
<b>B</b>	
BAS	Basic Accounting System
BUR	Bed Utilisation Rate
<b>C</b>	
CARMMA	Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa
CCG's	Community Care Givers
CEO(s)	Chief Executive Officer(s)
CHC(s)	Community Health Centre(s)
COE	Compensation of Employees
<b>D</b>	
DCST(s)	District Clinical Specialist Team(s)
DHER(s)	District Health Expenditure Review(s)
DHIS	District Health Information System
DHP(s)	District Health Plan(s)
DHS	District Health System
DOH	Department of Health
DQPR	District Quarterly Progress Report
<b>E</b>	
EMS	Emergency Medical Services
ETB.R	Electronic Tuberculosis Register
ETR.net	Electronic Register for TB
<b>F</b>	
<b>G</b>	
<b>H</b>	
HAST	HIV, AIDS, STI and TB
HCT	HIV Counselling and Testing
HIV	Human Immuno Virus
HOD	Head of Department
HPS	Health Promoting Schools
HPV	Human papillo virus
HR	Human Resources
HTA	High Transmission Area
<b>I</b>	

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Abbreviations	Description
IDP(s)	Integrated Development Plan(s)
IPT	Ionized Preventive Therapy
<b>J</b>	
<b>K</b>	
KZN	KwaZulu-Natal
<b>L</b>	
LG	Local Government
<b>M</b>	
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MDR-TB	Multi Drug Resistant Tuberculosis
MEC	Member of the Executive Council
MNC&WH	Maternal, Neonatal, Child & Women's Health
MO	Medical Officers
MOU	Maternity Obstetric Unit
MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework
MUAC	Mid-Upper Arm Circumference
<b>N</b>	
NDOH	National Department of Health
NCS	National Core Standards
NGO(s)	Non-Governmental Organisation(s)
NIMART	Nurse Initiated and Managed Antiretroviral Therapy
<b>O</b>	
OSD	Occupation Specific Dispensation
OSS	Operation Sukuma Sakhe
<b>P</b>	
P1 Calls	Priority 1 calls
PCR	Polymerase Chain Reaction
PCV	Pneumococcal Vaccine
PDE	Patient Day Equivalent
Persal	Personnel and Salaries System
PHC	Primary Health Care
PN	Professional Nurse
<b>R</b>	
RV	Rota Virus Vaccine
<b>S</b>	
SCM	Supply Chain Management
SHS	School Health Services
SLA	Service Level Agreement
Stats SA	Statistics South Africa

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Abbreviations	Description
STI(s)	Sexually Transmitted Infection(s)
T	
TB	Tuberculosis
U	
V	
VCT	Voluntary Counselling and Testing
W	
X	
XDR-TB	Extreme Drug Resistant Tuberculosis
Y and Z	



### 5. EXECUTIVE SUMMARY BY DISTRICT MANAGER

The DHP for 2015/16 has considered the current performance as at 2014/15, DHER 2013/14 findings, District 2014 Annual Report recommendations, Provincial Strategic planning session resolutions, District Health Plan consultative session resolution, facility planning sessions resolutions, Inputs from municipal road shows, inputs arising from sessions with partners and the Operation Sukuma Sakhe forums.

A Summary of the five components of health facilities planning for all 5 components namely service delivery, support services, infrastructure, Human resources and finances of the plan is provided.

Service delivery continues to be hindered by late presentation of clients. In addition, resources are still being used unequally to provide curative as opposed to preventative strategies and high numbers of clients are still seen at the more expensive hospital level rather than at PHC level. The aim to improve outreach PHC services was dealt a blow with the low access to vehicles even in instances where teams have been employed. The high staff turnover at all levels due to the interpretation of the change to the GEPF has also greatly affected the school health teams. HR has been conducting information sessions in an attempt to address and correct staff fears.

The commencement of ICDM/ideal clinics is one of the core strategies to take PHC prioritisation to the next level. The ICDM model is a key factor in improving waiting times, client satisfaction and compliance to treatment. The new ARV guidelines have commenced and have been key in improving access to ARVs.

MDR TB continues to plague the district and nurse initiated MDR TB programme is continuing in the District. The MINE-TB project run together with the Arum institute has been a timely project to improve both facility and community screening. The condom distribution has received a much needed boost with the appointment of condom distributors who are now serving the District.

Implanon insertion which was one of the key strategies to address teenage pregnancies and overall improve women year protection rate faced a stumbling block when the District saw an increase in the numbers of women who presented at the facilities requesting a removal of Implanon either as a result of hearing Messages from religious groups (various sources and areas) or from bleeding that resulted from the contraceptive method.

Poor Infant feeding remains a challenge and the Phila Mntwana sites will continue to function to improve feeding practices through education and early identification of poor growth by routine growth monitoring. PSH will continue to plan for the implementation of a milk bank to serve the District.

#### Support Services

Unavailability of emergency blood continued delayed ambulance response times, inefficient planned patient transport, shortage of storage space for clinic medication and erratic CPS deliveries continue to impact on service delivery.

The emergency medical response times are expected to improve by 5% as replacement vehicles are expected to be received, vacant posts will be filled and the PPT Policy will be finalised and implemented. South Coast Hospice will be working in Hibiscus high volume clinics to reduce waiting times due to pharmacy congestion and delays. The District Pharmacy forum will be re-established with technical support from Broadreach.

### Infrastructure

Overburdened 8 hour clinics will conduct feasibility exercises to explore options regarding the expansion of services to 12 or 24 hours. At PHC facilities lower levels of staff are sometimes occupying accommodation earmarked for the Professional nurses. Operational managers will embark on the exercise of informing all that the policy provides for PNs to be accommodated and give other categories adequate time to vacate (3 months). Dunstan Farrell TB Hospital Infrastructure is unsuitable and much of the building condemned. The building is not belonging to DOH and major repairs are not feasible but minor repairs are being done. The District Infrastructure unit is in discussions with the Provincial Infrastructure unit on obtaining guidance on the matter.

### Human Resources

Accountability remains a challenge and the Operational plans of facilities and programme managers will be linked to EPMDS to further encourage implementation of planned interventions.

### Finances

Capital projects that were put on hold by the Provincial Office were a limiting factor in the spending on the infrastructure budget. The District PHC expenditure per uninsured person ranged from R262 in Vulamehlo to R595 in Hibiscus. The low utilisation in Vulamehlo facilities will be compensated for by the increased focus on outreach interventions/teams in this local municipality. The cost per PDE was similar across all 3 District hospitals. Programme strategies for 2014/15 will be evaluated in terms of value for money in addition to performance against targets.

## PART A - STRATEGIC OVERVIEW

### 6. SITUATIONAL ANALYSIS

#### 6.1 MAJOR DEMOGRAPHIC CHARACTERISTICS

Ugu is situated on the KwaZulu-Natal South coast extending inland. It is bordered by the Eastern Cape to the South, eThekweni Metropolitan to the north, the Indian Ocean to the East, Harry Gwala District to the West and UMgungundlovu to the North West of the District. Eastern Cape Residents are users of the health care system in Ugu. The recently established Cross Border Committee will play a significant role in dealing with issues such as follow ups that impact on providing services between the different provinces.

The District faces challenges in improving the quality of life amidst high levels of poverty and unemployment and low levels of economic growth. The population of Ugu is predominantly rural with 86% of the population living in rural areas. There has been a gradual shift in rural settlement patterns from much dispersed to a concentration around access roads. The decline in agricultural activities and the increase in people seeking wage employment and state grants have also contributed to the change in settlement pattern.

**Table 1 Ugu District and household profile**

Organisation unit	Value
Area per square kilometre	5047
Household head age 10-15 years	0.5
Household head age 16-19 years	1.5
Household head age 20-24 years	5.2
Household head age 25-65 years	74.1
Household head age 66-84 years	17.5
Household head age 85 years and older	1.3
Household head gender – Female	50.5
Household head gender – Male	49.5
Household head population group - Black African	86.5
Household head population group – Coloured	0.8
Household head population group - Indian or Asian	3.9
Household head population group – Other	0.2
Household head population group – White	8.6

Source: DHER REPORT 2013/2014

The majority of the households are headed by females (50.5%) compared to 49.5 % of households being headed by males. The Black African population makes up the majority of the population and 86.5 % of all households are headed by Black Africans. The white population group is the second largest racial group residing in Ugu with 8.6 % of households headed by males and this racial group resides mainly on the coastal strip of the District. Most heads of household are between the age of 25 and 65 years. Child headed households are still a challenge with 0.5% of all households being headed by children between 10 and 15 years.

## UGU DISTRICT HEALTH PLAN 2015/16

**Table 2: District Population 2013/14**

Sub-District	Total Population	% pop uninsured	Uninsured Population
kz Umzumbe Local Municipality	163 376	92.70	151 450
kz Hibiscus Coast Local Municipality	259 059	92.70	240 148
kz Vulamehlo Local Municipality	78 551	92.70	72 817
kz uMuziwabantu Local Municipality	99 138	92.70	91 901
kz Umdoni Local Municipality	79 378	92.54	73 458
kz Ezingoleni Local Municipality	53 726	92.70	49 804
<b>DISTRICT TOTAL</b>	<b>733 228</b>	<b>92.68</b>	<b>679 578</b>

Source: DHER 2012/13

According to the 2013 2014 IDP Review, Ugu makes up 7% of the total population of the KZN province, the fifth highest of 11 districts in the Province. This is a drop of from 7.3% in 2001. The most urbanised Umdoni and Hibiscus Municipalities have the highest densities at 314 and 305 people/ km<sup>2</sup> respectively. Patients from rural areas often seek healthcare in the urban clinics/facilities due to the ease of access due to transport routes to these clinics. It is easier to access a taxi into town. Taxis to nearby clinics are often against the transport flow. Coupled with the ease of travel to the urban clinics is the infrastructure around the urban clinics that is an attractive bonus to visiting a clinic where the client can also couple the trip with shopping and other chores that need to be conducted in urban areas. Vulamehlo (81 people/ km<sup>2</sup>), Umzumbe (128 people/ km<sup>2</sup>), Ezingoleni (81 people/ km<sup>2</sup>) and Umuziwabantu (89 people/ km<sup>2</sup>) municipalities all have lower densities as they are all predominantly rural. The 2014/15 population estimates, similarly shows that Hibiscus and Umzumbe are the subdistricts with the largest populations. The 2 Community health centres (CHCs) that were built in these subdistricts were built with the intention of improving access to the large population of these 2 Local Municipalities (LM). The evidence of this is observed in the increasing PHC utilisation rates in the 2 LMs. Comparing 2010/11 utilisation to 2013/14 utilisation shows that Hibiscus increased from 3.0 to 3.7 and Umzumbe increased from 2.1 to 3.1.

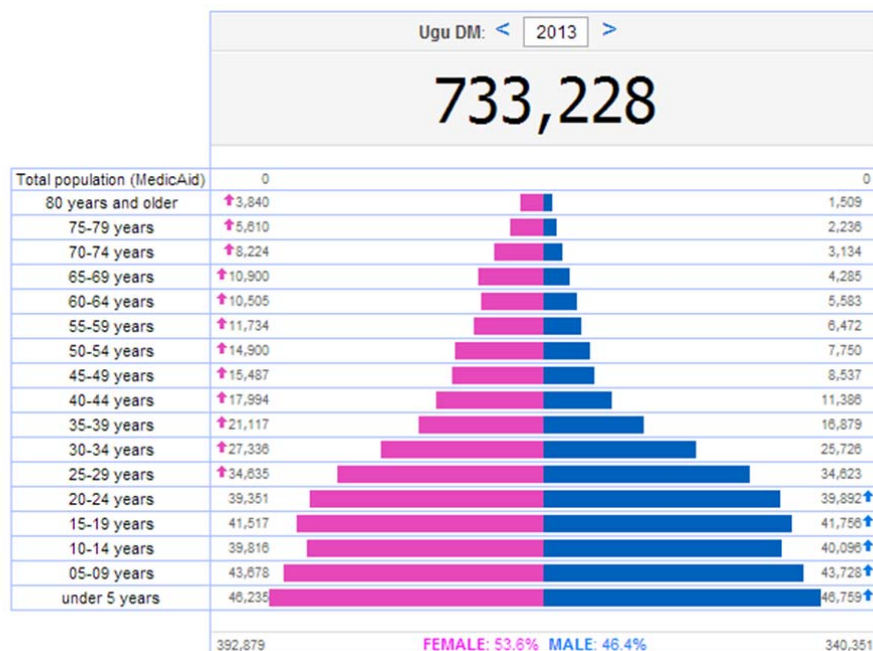
The Uneven distribution of the population has the following implications:

The client movement is often seen to increase at the Urban clinics due to ease of access via the established transport routes/taxis and buses. This results in clinics in the “easy to access” areas often being overburdened because they are serving their own catchment area and the catchment of surrounding rural areas. The trends in headcount in urban clinics needs to be monitored over the coming year and budget allocation should be made based on these trends of where clients are using services.

As stated above, many communities are living in the sparse traditional areas so clinics built in these areas to improve access are often underutilised as there are small catchments. It is necessary to conduct outreach from these clinics to be able to reach the communities.

**Figure 1: Population Pyramid Ugu District 2011 Stats SA**

## UGU DISTRICT HEALTH PLAN 2015/16



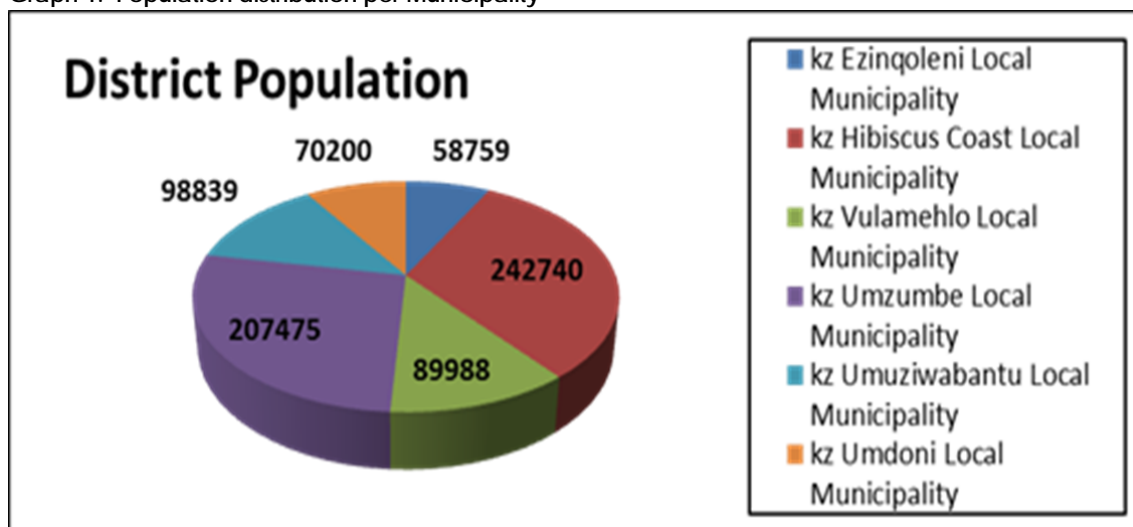
There are 733 228 people in Ugu. This is a drop of 34 771 as a result of the Census data being adopted into DHIS compared to previous years DHIS estimates of the previous year. This drop in population numbers has resulted in budget decrements at a Provincial level. There are 392 879 women and 340 759 men. The age groups under 29 years all show a larger male population size compared to females.

The roll out of the PMTCT programme in 2003/4 has turned around the decline in the under 5 population due to the impact of mother-to-child transmission of HIV. The base of the pyramid is once again increasing in size. The table below shows the improvement in outcomes among babies born to HIV positive women from 2008 to 2013 (DHIS Closed off data)

**Table 3 Mother to child transmission outcomes 2008 – 2013 (DHIS Closed off Data)**

DataElementName	2008	2009	2010	2011	2012	2013
Infant 1st PCR test positive around 6 weeks	589	733	313	195	159	82
Infant rapid HIV test positive around 18 months		299	169	149	177	184
PCR test positive 6 weeks post cessation of breast feeding			34	65	60	29

Graph 1: Population distribution per Municipality



Source: DHIS

Prior to 1994, most of the black population resided in rural areas. Post 1994, there is an increase in urbanisation among the black population. The continued growth of the urban population places a burden on health and other services. Migration is intertwined with urbanisation and split families have become the norm in South Africa as seen in Ugu District. Children left in the care of rural grandparents while parents seek employment in the urban areas is a common practice.

Ezingoleni serves the smallest population of 53 726 which was a drop from the previous year's population of 58 759. According to the Ezingoleni Municipal Manager, the subdistrict is due to combine with Hibiscus Coast in 2016/2017 in terms of demarcation zones. Other sub-districts that experienced a drop in population estimates are Vulamehlo which dropped from 89988 to 78551, Umzumbe which dropped from 207475 to 163376 and Umdoni which dropped from 70200 to 79378.

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### 6.2 SOCIAL DETERMINANTS OF HEALTH

**Table 4 (A1): Social Determinants of Health**

Sub-Districts	Data Source	Total number of households	Unemployment rate	Percentage of population living below poverty line of R200 per month	Number of households in informal dwelling	Number of households in formal dwelling	Percentage of Households with access to sewerage	Households with access to potable water	Percentage of Households with access to electricity	Adult literacy rate
Ezinqoleni	Census 2001	10 684	-	-	2.4	-	-	-	-	-
	Community Survey 2007	10 953	24	28	6.3	55.4	2.8	--	88.3	21
	Census 2011	52 540	41.6		64		3.3 <sup>1</sup>	6.8 <sup>2</sup>		
Hibiscus Coast	Census 2001	51 466	-	-	5.1	-	-	-	-	-
	Community Survey 2007	50 650	24	18	0.6	22.7	37.7	-	44.7	16
	Census 2011	72 175	28		83.3		29.6	40.5		
Umdoni	Census 2001	15 287	-	-	13.8	-	-	-	-	-
	Community Survey 2007	16 384	24	18	5.1	24.4	55.8	-	95.6	16
	Census 2011	22 869	33.3		74.3		34.2	40.6		
Umuziwabantu	Census 2001	19 088	-	-	2.2	-	-	-	-	-
	Community Survey 2007	20 313	20	29	1.7	70.4	15.3	-	59.4	19
	Census 2011	21 619	33		47.7		8.7	10.3		
Umzumbe	Census 2001	38 280	-	-	1.5	-	-	-	-	-
	Community Survey 2007	40 579	24	39	0.4	63.7	1.9	-	39.1	20
	Census 2011	35 171	51.9		47.6		2	5.1		
Vulamehlo	Census 2001	15 806	-	-	1.9	-	-	-	-	-
	Community Survey 2007	12 744	24	39	0.6	71.9	5.8	-	44.7	23
	Census 2011	16 135	52.6		30.5		2.8	5.6		
<b>District Total</b>	<b>Census 2001</b>	<b>150 611</b>	<b>-</b>	<b>-</b>	<b>4.2</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>
	<b>Community Survey 2007</b>	<b>151 621</b>	<b>23</b>	<b>27</b>	<b>1.6</b>	<b>46.7</b>	<b>21.9</b>	<b>19a</b>	<b>67.8</b>	<b>-</b>
	<b>Census 2011</b>									

<sup>1</sup> Flush toilet connected to sewerage

<sup>2</sup> Piped water inside dwelling

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Ezingoleni has seen the highest (164%) increase in percentage of households in informal dwellings between 2001 and 2007. Ezingoleni is bordering Hibiscus which is considered to be the economic hub of the District therefore informal dwellings are common in this subdistrict.

The above social determinants have a direct impact on health outcomes. Mothers who choose formula feeding for their infants often do not meet the AFASS criteria. (Acceptability, feasibility, affordability, sustainability and safety). The water source that they use is often not suitable for preparation of feeds and sanitising of equipment used to feed the babies. Hence, babies are exposed to malnutrition and diarrhoea.

Ugu is an area that has an urban development bias and a large proportion of the population with limited skills and low education levels. Poverty is often defined as the lack of resources to meet basic needs. An important indicator of poverty is the number of households with an income below the Minimum living level (MLL). The MLL is calculated for different racial groups, household sizes etc. and reflects the minimum amount a household needs to earn to meet its basic needs. In terms of South African standards, a household earning less than two old age pension grants is regarded as poor to the extent that it is relieved of paying for municipal services. According to the Water Services Development Plan backlog study (February 2008) used to calculate affordability, household income and people living in poverty, it is evident that 75% of the households in the district earn less than R1600 per month and live below the poverty line (45,160 households). According to Global Insight, the current unemployment rate at Ugu is 44.8%. The economically active population is 29.3% (people able and willing to work between the ages of 15 and 65). Of the 87 807 people who are employed, 67% are formally employed whilst 33% are participating in informal employment.

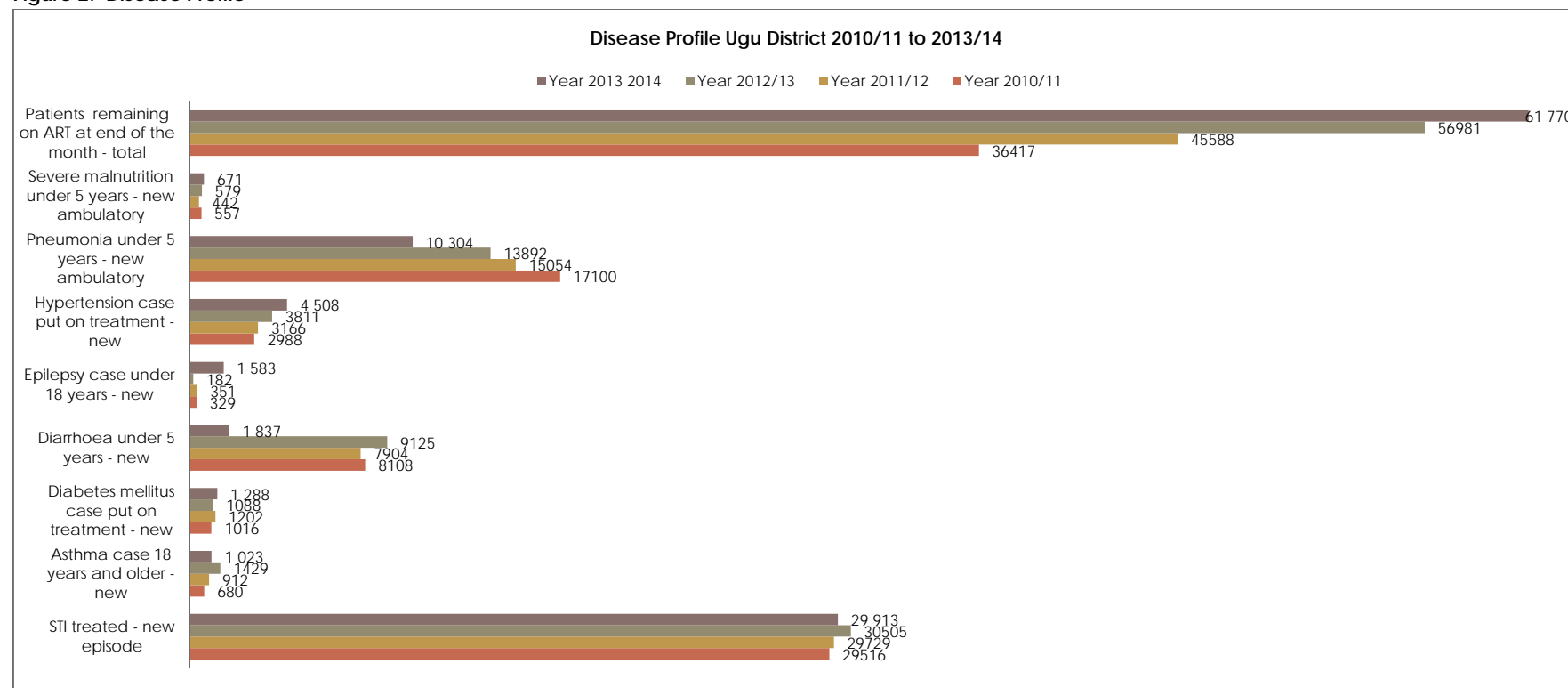
The 4 rural sub districts of Vulamehlo, Umzumbe, Umuziwabantu and Ezingoleni are under developed in terms of physical infrastructure and basic services. The 2 sub districts Umdoni and Hibiscus Coast with high electricity usage are both on the coastal belt of Ugu, with easy access to the N2 and therefore have a highly developed tourism trade influencing employment rates. In comparison, the 4 under developed sub districts do not have access to the N2 and therefore do not have the benefits with this phenomenon. Of the total households within the entire Ugu District, 68 % have access to piped water. The sub districts with the greatest access to piped water namely Umdoni and Hibiscus (in terms of percentage of total households with access to piped water), have the greatest incidence of diarrhoea without dehydration. According to the observations by the clinical and programmes component, Hibiscus and Umdoni have large informal settlements that contribute to the incidence of diarrhoea. While the informal settlements are a long term challenge, the programme manager and DCST continues to monitor the trends for diarrhoea and advocates for and monitor the use of oral rehydration in the management of diarrhoea and prevention messages are included in schools and other outreach projects.



## UGU DISTRICT HEALTH PLAN 2015/16

### 6.3 EPIDEMIOLOGICAL (DISEASE) PROFILE OF THE DISTRICT<sup>3</sup>

Figure 2: Disease Profile



<sup>3</sup> Written by Dr F Olowookorun- District Family Physician

### **STI treated, new episode**

In comparison to what was seen during 2012/13, there was a slight reduction in the STI treated, new episode in 2013/14. This can be attributed to the improved condom distribution, both male and female, as well as the continuous community education.

### **NCD (Asthma, Diabetes, Hypertension)**

There is increased incidence of both diabetes and hypertension in 2013/14. This can be as a result of increased screening at the PHCs and improved community awareness programmes. However, the newly diagnosed need to be properly monitored, healthy lifestyle behaviours advocated and defaulters identified early.

No significant shift noticed in the new cases of asthma diagnosed in comparison to the previous years.

### **Pneumonia (Under 5)**

Significant decrease in reported cases of pneumonia reported in 2013/14 due to improved IMCI classification and reporting at the clinics emanating from the ongoing IMCI Trainings. It had previously been discovered that not all those classified as having pneumonia actually had pneumonia.

### **Severe Acute Malnutrition**

This is still a problem in the district and it cuts across many levels. It does require a multi sectorial approach from DSD regarding grants, Municipality with regards to adequate supply of safe water, proper linkage to the war rooms via the CCGS and full functioning of the PHILA Mntwana Centres. Also the IMAM Training that will be rolled out should improve management of those presenting at the health facilities.

### **ART**

There is steady increase in those remaining in care in the ART Programme. However, the challenges are still proper monitoring of those in care, timeous tracing of defaulters, management of TB/HIV Co-infected, IPT roll out, and early identification of those developing resistance. On-going counselling needs to be strengthened at all levels of care. The New ART guidelines will result in an increase in the number of clients on ARTs in the new financial year.

### **Mortality**

#### Maternal Mortality

For the 2013/14 year, Ugu ranks 14th in the country in terms of the highest number of maternal mortality in facility ratio. When viewing the trends over the last few years, it has dropped since the 2010/11 spike of just under 300 deaths per 100 000 live births. There is an association between districts with a high HIV prevalence and high MMR. There is also an association with high number of C sections and MMR<sup>4</sup>.

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<sup>4</sup> District Health Barometer 2013/14

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### Infant and Child Mortality

At 9.8 per 1000 births, the neonatal mortality in facility was above the target value of 8.5 for the district for 2013/14. District hospitals listed extremely low birth weight as a biggest contributor towards premature death. In terms of late neonatal deaths, SAM, herbal intoxication and mixed feeding were listed as major contributory factors<sup>5</sup>.

### **District HIV and AIDS Profile**

The National Sero-prevalence survey indicated that Ugu had the highest HIV Prevalence among all districts in KZN at 41.7% in 2011. In 2012, the rate dropped to 38.8%. This indicates that there are fewer pregnant women who are HIV positive and impacts favourably on maternal and child survival.

### **District TB Profile**

Incidence of TB: Of all the Districts, Ugu has the highest incidence of TB per 100 000 population at 1096. In terms of infectious TB (pulmonary smear-positive), Ugu ranks 12th at 325 cases per 100 000 population, above the Countries average of 208 cases per 100 000 population.

Smear conversion is a precursor of cure and is often low when facilities do not invest enough effort into recording SCR as they do in treatment outcomes. It is important for all smear positive TB patients to have their sputum taken after 2 months of treatment and have the results recorded. Ugu has a smear conversion rate of 66.3%. TB Cure rate is 73.7%, below the WHO target of 80%. TB successful treatment rate (All TB) is 74.7% and below the targeted 84%.

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<sup>5</sup> DQPR q4 2013/14

<sup>6</sup> 2012 National ANC sentinel HIV Prevalence survey

## UGU DISTRICT HEALTH PLAN 2015/16

### 7. DISTRICT SERVICE DELIVERY ENVIRONMENT

#### 7.1 DISTRICT HEALTH FACILITIES

##### 7.1.1 PRIMARY HEALTH CARE FACILITIES

Table 5 (NDoH 1): PHC facilities (Provincial and LG combined) per Sub-District as at 31 March 2014

Sub-Districts	Health Posts		Mobiles		Satellites		Clinics		Community Day Centre <sup>7</sup>		Community Health Centres (24 x 7) <sup>8</sup>		Standalone MOU <sup>9</sup>		District Hospitals
	LG	P	LG	P	LG	P	LG	P	LG	P	LG	P	LG	P	
Ezinqoleni	0	0	0	2	0	0	0	4	-	-	-	-	-	-	-
Hibiscus	0	0	0	6 <sup>10</sup>	0	0	0	17 <sup>11</sup>	-	-	-	1	-	-	1
Umdoni LM	0	0	0	1	0	0	0	5	-	-	-	-	-	-	1
Umuziwabantu	0	0	0	3	0	0	0	11	-	-	-	-	-	-	1
Umzumbe	1	1	0	3	0	0	0	13	-	-	-	1	-	-	-
Vulamehlo	1	1	0	2	0	0	0	5	-	-	-	-	-	-	-
<b>District</b>	<b>2<sup>12</sup></b>	<b>2</b>	<b>0</b>	<b>16</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>55</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>2</b>	<b>-</b>	<b>-</b>	<b>3</b>

Source: DHIS

The most number of clinics are found in Hibiscus Coast Municipality with 6 and a utilisation rate of 3.7. The utilisation rate in Ezinqoleni is the highest in the district at 3.9. In the previous year, Hibiscus had the highest utilisation at 3.7. There are currently 3 clinics functioning as MOUs within

7 There are no Community Day Centres in KwaZulu-Natal

8 All Community Health Centres (CHC's) in KwaZulu-Natal do not have MOU's according to the definitions used in the DHER 2011/12. All KZN CHC's operate on a 24 hour, 7 day a week basis.

9 Accordingly to the DHER 2011/12 definitions for Stand Alone MOU's, there are no Stand Alone MOU's operational within KwaZulu-Natal

10 This includes HTA Mobile 1

11 Hibiscus wellness was included in the closed off data. IT functions as an HTA, in previous years; it was not included as fixed clinics but will be included due to plans to further increase infrastructure and headcount.

12 Sheepwalk in Umzumbe and Kwalembe in Vulamehlo are identified as health posts but currently function as mobile points and Phila Mntwana sites.

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a clinic (i.e. not a stand-alone) and these are Ntabeni in Hibiscus, Umzinto in Umdoni and Elim in Umuziwabantu. Umzinto is currently functioning as a 24 hour clinic due to the demand of the service in the area (high headcounts and an average of 10 deliveries per month).

**Table 6: Provincial Clinic Facility to Population – 2013/14**

Sub-Districts/ District	Pop per PHC facility ratio - Health Post	pop per PHC Mob provincial	Pop Per PHC facilities ratio – Clinic provincial	Pop Per PHC facilities ratio - CHC provincial
Umzumbe	163 376.00	54 458.70	12 567.40	163 376.00
Hibiscus	NA	43 176.50	16 191.20	259 059.00
Vulamehlo	78 551	39 275.50	15 710.20	
Umuziwabantu	NA	33 046.00	9 913.80	
Umdoni	NA	79 378.00	13 229.70	
Ezinqoleni	NA	26 863.00	13 431.50	

Source: DHER 2012/13 Customised District Report

The table above shows that Hibiscus has the highest population to clinic ratio than any other LM. This ratio will be further compounded by the influx of clients from informal settlements. The clinics in Umuziwabantu have the lowest population to clinic ratio. This table should always be looked at together with the actual headcounts as clients preference does not always result in the nearest clinic being utilised. In Umzumbe and Hibiscus, there are CHCs that can be accessed. Although the mobile population to PHC rate is high in Umdoni, there is a low clinic rate compared to the mobile.

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**Table 7 (NDoH 2): District Hospital Catchment Populations 2013/14**

Name of District Hospital	2012/13			2013/14		
	GJ Crookes	Murchison	St Andrew's	GJ Crookes	Murchison	St Andrew's
Catchment Population of District Hospital	159696	159696	159696	159 788	81 087	100 081

Source: DHER 2013/14 (GIS)

**Note:** District Hospital Catchment Populations are calculated according to the catchment population of referring clinics.

The catchment populations are calculated from the addition of the catchment populations of the referring clinics. Murchison has been most affected in terms of catchment population as Gamalakhe CHC has taken over clinics that were previously attached to Murchison Hospital.

## UGU DISTRICT HEALTH PLAN 2015/16

### 7.2 TRENDS IN KEY DISTRICT HEALTH SERVICE VOLUMES

#### 7.2.1 PRIMARY HEALTH CARE SERVICE VOLUMES AND UTILISATION

Table 8 (NDoH 3): PHC Headcount Trend

Sub-District	2012/13			2013/14			Variation		
	PHC Headcount – Provincial	PHC Total Headcount	PHC Total Utilisation Rate	PHC Headcount – Provincial	PHC Total Headcount	PHC Total Utilisation Rate	PHC Headcount – Provincial	PHC Total Headcount	PHC Total Utilisation Rate
Ezinqoleni	193 665	193 665	3.3	212 189	212 189	3.9	9.6%	9.6%	18.2%
Hibiscus Coast	890 370	890 370	3.7	965 353	965 353	3.7	8.4%	8.4%	0.0%
Umdoni	242 210	242 210	3.4	267 090	267 090	3.4	10.3%	10.3%	0.0%
Umuziwabantu	301 064	301 064	3.0	327 108	327 108	3.3	8.7%	8.7%	10.0%
Umzumbe	480 120	480 120	2.3	513 808	513 808	3.1	7.0%	7.0%	34.8%
Vulamehlo	170 883	170 883	1.9	170 487	170 487	2.2	-0.2%	-0.2%	15.8%
<b>District</b>	<b>2 278 312</b>	<b>2 278 312</b>	<b>3.0</b>	<b>2 456 035</b>	<b>2 456 035</b>	<b>3.3</b>	<b>7.8%</b>	<b>7.8%</b>	<b>2.3%</b>

Source: DHIS downloads

The Utilisation rate and actual headcounts are viewed together. This is done to ensure the change in reference population values resulting from the adoption of Census estimates are taken into account. The table below depicts the change in population. The growth or decline in population according to the estimates will have the following impact:

It may reflect an apparent improved uptake of services in areas where the population dropped and an apparent reduced uptake of services where the population (denominator) has increased. This is seen in Ezinqoleni, Vulamehlo and Umzumbe which have the biggest declines in population estimates and the biggest positive variation in PHC utilisation. Vulamehlo is the only subdistrict with a drop in the headcounts. As proposed in the 2013/2014 DHER, outreach services should be prioritised for Vulamehlo as the population is scattered and additional facilities may not create the desired improvement in clinic utilisation. The actual PHC Headcounts for Ezinqoleni has declined from 18697 in April 2013 to 17329 in March 2014.

## UGU DISTRICT HEALTH PLAN 2015/16

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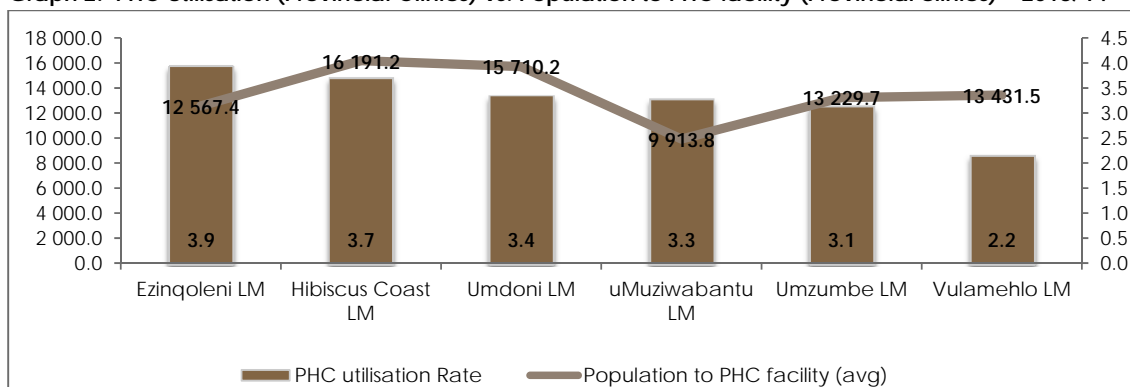
Table 9 Percentage growth/decline in SD and district population estimates 2012/13 to 2013/14

SD population	2012/2013	2013/2014	difference/growth	% growth/decline
Ezinqoleni	58759	53726	-5033	-8.6
Hibiscus	242740	259059	16319	6.7
Vulamehlo	89988	78551	-11437	-12.7
Umzumbe	207475	163376	-44099	-21.3
Umuziwabantu	98839	99138	299	0.3
Umdoni	70200	79378	9178	13.1
	768001	733228	-34773	-4.5



## UGU DISTRICT HEALTH PLAN 2015/16

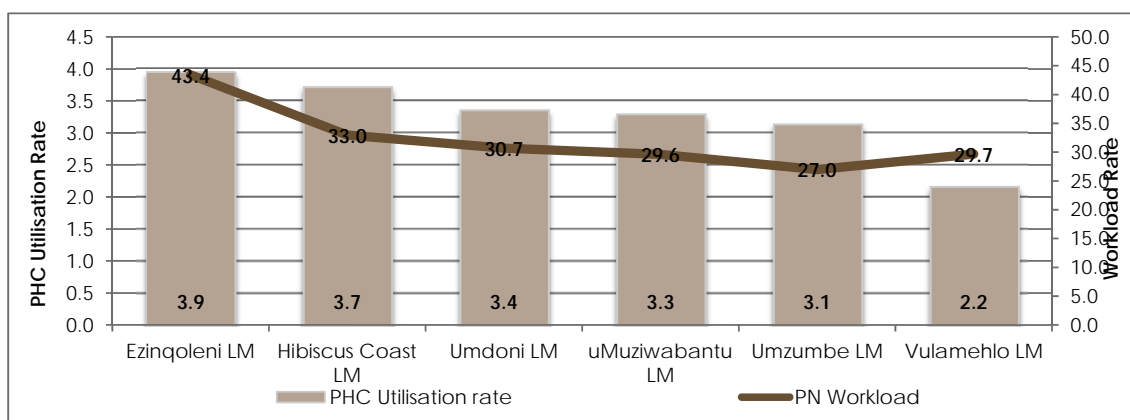
**Graph 2: PHC Utilisation (Provincial Clinics) vs. Population to PHC facility (Provincial clinics) – 2013/14**



Source: DHIS & DHER 2012/13 Customised District Report

The graph above displays the utilisation compared to number of clinics. Umuziwabantu appears to be well covered in terms of clinics to population and the utilisation is also high. Conversely, Vulamehlo, having the 3<sup>rd</sup> highest clinics to population has the lowest utilisation. Therefore, although the STP lists Vulamehlo as the neediest for building of new clinics, the placement of the clinics is crucial as accessibility needs to be factored in. The Vulamehlo municipality IDP states that plans are in place to develop the Dududu area into a town and this could improve Utilisation. Outreach services should be prioritised over fixed facilities in Vulamehlo.

**Graph 3: PHC Utilisation rate in relation to PN Workload Provincial Clinics**



Source: DHIS, DHER

Ezinqoleni has the highest workload and PHC Utilisation. Vulamehlo's workload and utilisation are the lowest in the district. There are not enough clients for the sub-district to function in an economically viable manner.

**Table 10 (NDoH 4): District Hospital activities**

District Hospitals	Year	GJ Crookes	Murchison	St Andrews	District Totals
1. Inpatient Days – total	2012/13	81 372	78 198	44 516	204 086
	2013/14	78 448	83 386	50 322	212 156
	Variation	-3.6%	6.6%	13.0%	4.0%

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District Hospitals		Year	GJ Crookes	Murchison	St Andrews	District Totals
2.	Day patient – total	2012/13	8	85	62	155
		2013/14	13	41	99	153
		Variation	62.5%	-51.8%	59.7%	-1.3%
3.	OPD Headcount not referred new	2012/13	0	1 763	6 740	8 503
		2013/14	0	981	6463	7 444
		Variation	0.0%	-44.4%	-4.1%	-12.5%
4.	Inpatient Separations	2012/13	13 607	11 559	7 785	32 951
		2013/14	13 905	13 851	8 385	36 141
		Variation	2.2%	19.8%	7.7%	9.7%
5.	Inpatient Deaths	2012/13	1 051	888	595	2 534
		2013/14	900	907	612	2 419
		Variation	-14.4%	2.1%	2.9%	-4.5%
6.	OPD Headcount – total	2012/13	109 140	80 174	60 897	250 211
		2013/14	120 563	72 620	50 419	243 602
		Variation	10.5%	-9.4%	-17.2%	-2.6%
7.	Emergency headcount total	2012/13	15 082	13701	11 140	39 923
		2013/14	8 272	13 898	11 234	33 404
		Variation	-45.2%	1.4%	0.8%	-16.3%
8.	Patient Day Equivalent	2012/13	122 369	109 219	68 319	299 908
		2013/14	121 399	112 246	70 922	304568
		Variation	-0.8%	2.8%	3.8%	1.6%
9.	Cost per PDE	2012/13	R 1 580.97	R 1 490.83	R 1 705.87	R 1 660.63
		2013/14	1 745.76	1 898.94	1 808.47	1 816.82
		Variation	10.4%	27.4%	6.0%	9.4%
10.	Delivery by caesarean section rate	2012/13	44%	35%	29.10%	37.10%
		2013/14	37.4	39.3	31.3	36.4
		Variation	-15.0%	12.3%	7.6%	-1.9%
11.	Average length of stay - total	2012/13	6	6.8	5.7	6.2
		2013/14	5.6	6.0	6.0	5.9
		Variation	-6.7%	-11.8%	5.3%	-4.8%
12.	Inpatient bed utilisation rate – total	2012/13	93.40%	71.10%	58.30%	74.60%
		2013/14	72.4	73.9	65.7	71.2
		Variation	-22.5%	3.9%	12.7%	-4.6%
13.	Total Ambulatory	2012/13	124 222	93 875	72 037	290 134
		2013/14	128 835	86 518	61 653	277 006
		Variation	3.7%	-7.8%	-14.4%	-4.5%

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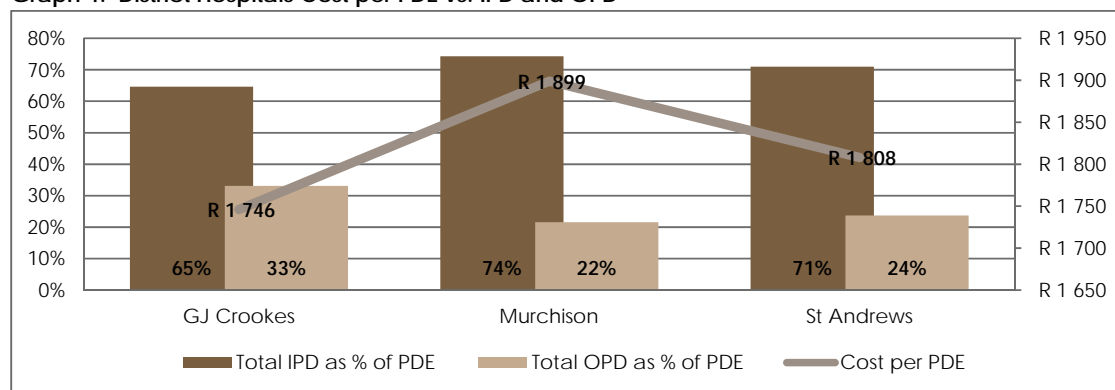
District Hospitals	Year	GJ Crookes	Murchison	St Andrews	District Totals
14. Ratio of Ambulatory to Inpatient Days Total	2012/13	1.5:1	1.2:1	1.6:1	1.4:1
	2013/14	1.6:1	1:1	1.2	1.3
	Variation				

Source: DHIS Downloads 2012/13 & 2013/14

The DHIS system error of 2012/2013 that showed false high bed utilisation has been corrected. Murchison has the highest bed utilisation. The average length of stay (ALOS) norm is 5.5 days. The ALOS at GJ Crookes and Murchison has seen a favourable drop as the Orthopaedic surgery backlog at the Regional Hospital has been alleviated in the 2013/14 financial year. Additional HR and functioning medical equipment were central in the improved turnaround time of the Regional Hospital Orthopaedic ward. Murchison has 80 beds allocated to TB care (MDR TB & TB) the ALOS for MDR-TB is 2 months and TB is 15-20 days. St Andrews Hospital has a 42 bed TB ward and the ALOS has increased from 5.7 to 6. The ratio of ambulatory to inpatient ratio shows that PHC is functioning. The high Not-Referred OPD Headcount in St Andrew's Hospital was explained by SAH M&E as being due to a correction in the recording of maternity clients who come for hospitalisation and eventually delivery without being referred from PHC. Since the data audit in the first quarter of 2013/14, this was corrected. In addition, there are no CHC facilities and no 24 hours and 7 day clinics in Umuziwabantu and many clients with chronic conditions present on weekends and after hours at casualty without referrals. Previously these clients were recorded under casualty but have since been recorded as OPD not referred. Clients attending crisis centre are attending with no referral letters. The hospital plans to improve triaging system and direct clients without referrals to gateway clinic during working hours.

Inpatient deaths and inpatient bed days increased at St Andrews and Murchison Hospital.

**Graph 4: District Hospitals Cost per PDE vs. IPD and OPD**



Source: DHER 2012/13 Customised District Report

Across all three district hospitals, the IPD far exceeds the OPD portion of the PDE total. The higher cost per PDE at Murchison is in part a result of the cost of running the TB/MDR TB care unit as MDR TB drugs are costly.

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### 8. DISTRICT PROGRESS TOWARDS THE ACHIEVEMENT OF THE MDG'S

**Table 11 (NDoH 5): Review of Progress towards the Health-Related Millennium Development Goals (MDG's) and required progress by 2015**

MDG	Target	Indicator	Provincial progress 2013/14	Source of data	District progress 2013/14	District targeted progress 2014/15
Goal 1: Eradicate Extreme Poverty And Hunger	Halve, between 1990 and 2015, the proportion of people who suffer from hunger	Prevalence of underweight children under 5 years of age	14 per K	DHIS	12.8 PER 1k	10 PER 1 K
		Severe malnutrition under 5 years incidence )	5.6 per 1K	DHIS	7.4 PER 1K	6 per k
Goal 4: Reduce Mortality	Child Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Under-five mortality rate – use proxy "Inpatient death under 5 years rate"	5.5%	DHIS	4.4%	4%
		Infant mortality rate – use proxy "Child under 1 year mortality in facility rate"	6.9%	DHIS	6.0%	5.5%
Goal 4: Reduce Mortality	Child Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Measles 2 <sup>nd</sup> Dose coverage		DHIS	69.6%	72%
		Immunisation coverage under 1 year	85.8%	DHIS	73.7%	100%
Goal 5: Improve Maternal Health	Maternal Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate	Maternal mortality ratio (only facility mortality ratio)	147 per 100K	DHIS	160.5 PER 100k	160 per 100k
		Proportion of births attended by skilled health personnel (Use delivery in facility as proxy indicator)		DHIS	69.6%	72%
Goal 6:	Have halted by 2015,	HIV prevalence among 15- 19-		National HIV Syphilis	38.3	36

## UGU DISTRICT HEALTH PLAN 2015/16

MDG	Target	Indicator	Provincial progress 2013/14	Source of data	District progress 2013/14	District targeted progress 2014/15
Combat HIV and AIDS, malaria and other diseases	and begin to reverse the spread of HIV and AIDS	year-old pregnant women		Prevalence Survey of SA		
		HIV prevalence among 20- 24-year-old pregnant women		National HIV Syphilis Prevalence Survey of SA	38.3	36
		Contraceptive prevalence rate (use Couple year protection rate as proxy)		DHIS	41.9	45
		TB Cure Rate		ETR.Net	82.1% <sup>13</sup>	85%

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<sup>13</sup> Q4 DQPR

## UGU DISTRICT HEALTH PLAN 2015/16

### 9. PROVINCIAL AND DISTRICT CONTRIBUTION TOWARDS THE HEALTH SECTOR

The National Development Plan 2030 was adopted by government as its vision for the health sector. It will be implemented over three electoral cycles of government. The MTSF 2014-2019 therefore finds its mandate from National Development Plan 2030.

**Table 12: (NDoH): Alignment between NDP Goals 2030, Priority interventions proposed by NDP 2030 and Sub-outcomes of MTSF 2014-2019**

NDP Goals 2030	NDP Priorities 2030	Sub-Outcomes 2014-2019 (MTSF)
Average male and female life expectancy at birth increased to 70 years	a. Address the social determinants that affect health and diseases	HIV & AIDS and Tuberculosis prevented and successfully Managed
Tuberculosis (TB) prevention and cure progressively improved;	d. Prevent and reduce the disease burden and promote health	
Maternal, infant and child mortality reduced		Maternal, infant and child mortality reduced
Prevalence of Non-Communicable Diseases reduced by 28%		
Injury, accidents and violence reduced by 50% from 2010 levels		
Health systems reforms completed	b. Strengthen the health system	Improved health facility planning and infrastructure delivery
		Health care costs reduced
	c. Improve health information systems	Efficient Health Management Information System for improved decision making
	h. Improve quality by using evidence	Improved quality of health care
Primary health care teams deployed to provide care to families and communities		Re-engineering of Primary Health Care
Universal health coverage achieved	e. Financing universal healthcare coverage	Universal Health coverage achieved through implementation of National Health Insurance
Posts filled with skilled, committed and competent individuals	f. Improve human resources in the health sector	Improved human resources for health

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NDP Goals 2030	NDP Priorities 2030	Sub-Outcomes 2014-2019 (MTSF)
	g. Review management positions and appointments and strengthen accountability mechanisms	Improved health management and leadership

The NDP 2030, together with the MTSF 2014-2019, forms the umbrella goals for the health sector. These goals are specific but also generic enough to allow District management to develop their own plans in order to achieve the health sector goals but also incorporate priorities, which respond to localised challenges

## 10. SUMMARY OF MAJOR HEALTH SERVICE CHALLENGES AND PROGRESS MADE FOR THE PREVIOUS THREE FINANCIAL YEARS

This section should outline (e.g. imbalance in service delivery platform, staff mix and provision of care, problems in referral chain, district hospital and PHC infra-structure revitalisation, quality of care improvements, public/private interactions).

### 10.1 INTRA DISTRICT EQUITY IN THE PROVISION OF SERVICES

Include information relevant to equity from the DHER Report. This should include plans and strategies for improvement.

Table 13 (NDoH 6): PHC Expenditure

Sub-District	PHC Expenditure / Uninsured Capita	PHC Utilisation Rate	PN to Patient Provincial clinics	% Share of District Population
Ezinqoleni	R411.4	3.9	5195.2	7.3%
Hibiscus	R635.1	3.7	5973.3	35.3%
Umdoni	R433.8	3.4	5425.2	10.8%
Umuziwabantu	R462.3	3.0	4257.9	13.5%
Umzumbe	R693.7	3.1	4380.3	22.3%
Vulamehlo	R282.5	2.2	3412.0	10.7%

Source: DHER 2013/14 Customised District Report, DHIS

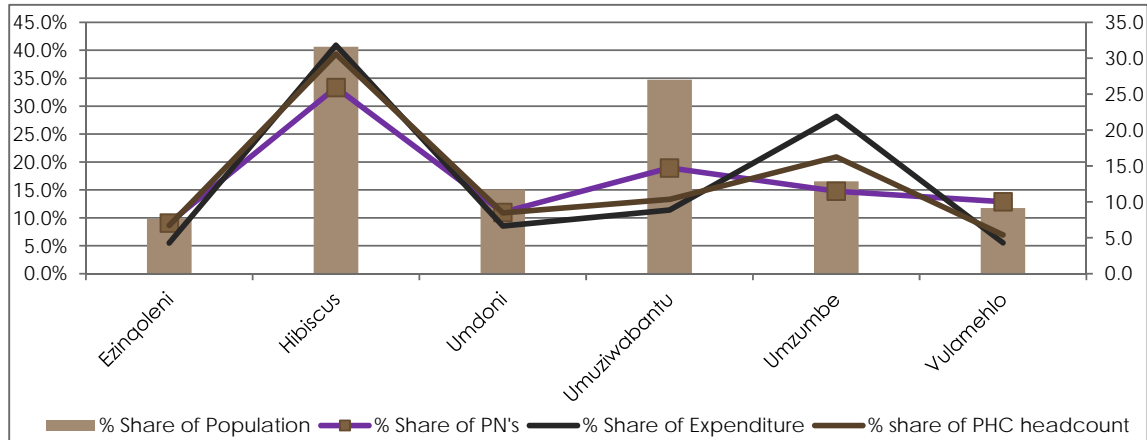
**Note:** The CHC's have been included in the analysis and will affect the balance of equity.

Vulamehlo Sub district has the lowest expenditure per capita, lowest utilisation rate, the highest staff to patient ratio and the second lowest share of the population. Although it has a similar percentage share of the population as Umdoni (which is a hub of economic activity second to Hibiscus coast), Vulamehlo has a much lower PHC headcount than this sub district with which it shares a boundary indicating a likely cross boundary movement of clients from Vulamehlo to Umdoni. This is supported by the expenditure per capita which is higher at Umdoni compared to Vulamehlo.

There are currently 8 hour clinics that are overburdened with very high head counts. The infrastructure challenges do not enable the employment of additional staff. The suggestion is to change these to function for longer hours. The DDM Clinical along with HR and PHCCs to conduct needs analysis and feasibility study for the proposal.



**Graph 5: Equity of resources vs population and headcount – 2013/14**



Source: DHER 2013/14 Customised District Report

The graph above views the resources in relation to the population. It cannot be viewed in isolation as the cross boundary movement of clients away from the rural clinics and towards the clinics in the economic hubs of Hibiscus and Umdoni need to be factored into this matter. Hibiscus has the greatest share of expenditure, population and PN's and is the sub district with the largest number of clinics. Vulamehlo has a low percentage share of expenditure compared to the share of population; however, the cross boundary move of clients out towards the urban clinics needs to be considered here. The share of headcounts is a valuable indicator. The table below shows Ezingqoleni, Hibiscus, Umdoni and Umuziwabantu are seeing clients in excess of their proportionate population share. When allocating new resources, this needs to be taken into consideration as resources should follow the services provided.

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**Table 14 (NDoH 7 (a)): Number of patients to staff type (Sub-District) – PDoH PHC Clinics**

Sub-District	Administrat or	Clinical Staff Other	Counsellor	Data Capturer	General Worker / Cleaner	Medical Officer	Nurse Assistant	Pharmacist Assistant Basic	Pharmacist Assistant Post Basic	Pharmacist	Professional Nurse	Staff Nurse	Specialist
Umzumbe	25 270.8		12 635.4	27 376.8	16 426.1		36 502.3				4 380.3	9 955.2	
Hibiscus	35 555.2		15 555.4	46 666.3	17 777.6		46 666.3				5 973.3	12 240.3	
Vulamehlo	25 931.0		11 786.8	21 609.2	16 206.9		21 609.2				3 412.0	6 174.0	
Umuziwabantu	16 499.4		9 428.3	23 999.2	26 399.1		13 894.3				4 257.9	8 515.8	
Umdoni	49 911.8		19 196.8	41 593.2	41 593.2		27 728.8				5 425.2	12 478.0	
Ezingoleni	36 366.2		18 183.1	45 457.8	30 305.2		36 366.2				5 195.2	8 658.6	

Source: DHER 2013/14 Customised District Report, DHIS

The table above shows the number of patients a type of staff is expected to see during the financial year. Generally, Hibiscus and Umdoni Staff will see the most patients or have the highest workload from the 6 municipalities. Vulamehlo and Umuziwabantu Facilities appear to be well resourced in terms of patients to staff ratio. Vulamehlo Nurses see the smallest amount of clients in a year.

**Table 15 (NDoH 7 (b)): Number of patients to staff type (Sub-District) – CHC's**

Sub-District	Administrat or	Clinical Staff Other	Counsellor	Data Capturer	General Worker / Cleaner	Medical Officer	Nurse Assistant	Pharmacist Assistant Basic	Pharmacist Assistant Post Basic	Pharmacist	Professional Nurse	Staff Nurse	Specialist
kz Umzumbe	4 449.0	10 804.8	18 908.4	30 253.4	50 422.3	18 908.4	21 609.6	75 633.5	75 633.5	3 0253.4	2 801.2	7 961.4	
kz Hibiscus Coast	4 885.9	78 174.0	26 058.0	78 174.0	31 269.6	14 213.5	14 213.5	78 174.0	39 087.0	26 058.0	4 008.9	6 013.4	

Source: DHER 2013/14 Customised District Report, DHIS

Turton CHC in Umzumbe appears to be better resourced in terms of admin, counsellors and data capturers, PNs and Pharmacy assistants basic compared to Gamalakhe CHC in Hibiscus.

**Note:** There are no CDC's operational in KwaZulu-Natal.

**Note:** There are no Stand-Alone MOU's in KwaZulu-Natal.

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**Table 16 (NDoH 8): Population to Staff per sub-district – 2013/14<sup>14</sup>**

Sub-District	Population to Medical Officers		Population to Professional Nurses	
	Total Population	Uninsured Population	Total Population	Uninsured Population
kz Umzumbe Local Municipality	20 422.0	18 931.3	1 266.5	1 174.0
kz Hibiscus Coast Local Municipality	23 550.8	21 831.6	1 579.6	1 464.3
kz Vulamehlo Local Municipality			2 067.1	1 916.2
kz uMuziwabantu Local Municipality			1 599.0	1 482.3
kz Umdoni Local Municipality			1 725.6	1 596.9
kz Ezingolweni Local Municipality			1 535.0	1 423.0

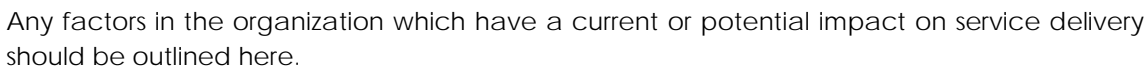
Source: DHER 2013/14 Customised District Report, DHIS

Note: The National Table A12 has been combined to incorporate both Medical Officers and Professional Nurses.

The table above refers to PHC. The CHCs are the only PHC facilities with medical officers linked to them. Turton CHC appears to be better resourced with doctors in terms of number of clients expected to be seen in the year. In addition, the MO visits at Gamalakhe supported clinics is greater than the MO coverage of Turton supported clinics. MOs provide daily support of clinics at Gamalakhe supported clinics. The support ranges between one and two MOs dedicated for clinic support. At Turton, the MO visits are done every second day with only one MO conducting clinic visits.

<sup>14</sup> District hospital plus PHC

## 11.1 ORGANISATIONAL STRUCTURE OF THE DISTRICT MANAGEMENT TEAM



Current organizational structure at District and institutions are not the same as at Head Office and therefore this poses challenges with the development of plans and implementation thereof. An example of this is the person at District filling the health promotion portfolio is also responsible for school health and oral health. Planning for school health, oral health and health promotion is not integrated at Head office level and therefore there is sometimes segmented planning at that level. This would be alleviated if all head office plans were coordinated through the Provincial Planning unit and if all M&E efforts were arranged through the Provincial M&E unit.

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awaiting circular on whether Specialised TB hospitals will be managed by Medical manager only in place of CEO and will proceed accordingly.

The current structure for managing and supporting clinics has a lot of challenges and creates gaps and therefore delays in services to the community. (District to consider implementing sub-district concept or full management and support of clinics by hospitals).

Prioritisation of posts is being done in conjunction with finance to plan for HR within the funding envelope.

PHC supervision negatively affected by the insufficient number of PHC supervisor per clinics i.e. currently certain in one sub-district the ratio is 1:14 instead of accepted norm of 1:6. (District to motivate for additional supervisors if funding permits, alternatively redistribution of the clinics as some subdistricts have more clinics than others.)

The moratorium placed on filling of posts resulted in delays in filling some critical posts and thus vacancy rate.

The district still has a challenge in recruiting and retaining clinical staff to some hospitals due to the rural nature of the district, hence the high turnover of these cadres of staff. This especially applies to St Andrews Hospital with the highest PDE to MO ration of 7068:1 compared to 5400:1 in the other hospitals.

Filling of newly created posts i.e. Nutrition Advisors, TB assistants etc.

Employment of dedicated medical officers at hospitals to support clinics. This has been proven to keep patients out of the hospitals and encouraging the use of PHC facilities.

Bursaries are also offered to communities to study towards medicine both locally and in Cuba. However, these measures do not result in an adequate numbers of doctors and therefore the demand-side of services cannot be provided. This is the reason that medical doctors have to be recruited regionally and internationally.

For pharmaceutical competency, bursaries are offered to communities to study Pharmacology and related fields but there is still a serious shortage as the majority of these graduates leave for the private sector once their Community Service has been completed. Research has shown that in deep rural areas, if bursaries are offered to community members who have family ties to the area and / or another reason for coming back to that area – there is more chance of them returning to the rural areas after completing their studies.

Sick leave may well be abused and appears to be neither managed nor monitored and Supervisors and Managers need to be tasked with the proper management of sick leave and need to take the appropriate action where employees are abusing the sick leave.

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District to motivate for additional family accommodation at our hospitals and clinics as this has been the reason for many professional nurses leaving.

Correct linking of staff has been improved. Only 2 out of adjustment cases are found in Turton CHC and the Head office HR component has been assisting to resolve this.

**Table 17: Staff type to Patient Ratio in Facilities [per 10 000] – Provincial Clinics**

Sub-Districts	MO to Patient Provincial Clinics	PN to Patient Provincial Clinics	EN to Patient Provincial Clinics	ENA to Patient Provincial Clinics	Data Capturer to Patient Provincial Clinics	General Worker to Patient Provincial Clinics
Umzumbe		4 380.3	9 955.2	36 502.3	27 376.8	16 426.1
Hibiscus Coast		5 973.3	12 240.3	46 666.3	46 666.3	17 777.6
Vulamehlo		3 412.0	6 174.0	21 609.2	21 609.2	16 206.9
uMuziwabantu		4 257.9	8 515.8	13 894.3	23 999.2	26 399.1
Umdoni		5 425.2	12 478.0	27 728.8	41 593.2	41 593.2
Ezinqoleni		5 195.2	8 658.6	36 366.2	45 457.8	30 305.2

Source: DHER 2013/14 Customised District Report

**Table 18: Cost per Headcount in relation to Workload**

Sub-Districts and District	Total Staff Cost per PHC Headcount	PN Workload	Staff to Patient ratio at Provincial Clinics - PN
Umzumbe Local Municipality	146.18	27.0	4 380.3
Hibiscus Coast Local Municipality	113.18	33.0	5 973.3
Vulamehlo Local Municipality	85.97	29.7	3 412.0
uMuziwabantu Local Municipality	86.79	29.6	4 257.9
Umdoni Local Municipality	84.56	30.7	5 425.2
Ezinqoleni Local Municipality	65.68	43.4	5 195.2

Source: DHER 2012/13 Customised District Report, DHIS

Ezinqoleni has the lowest total staff cost per PHC headcount and the highest PN workload of 43.4 which exceeds the Provincial target. This could possibly be due to a challenge in the calculation of the PN workload as Ezinqoleni does not have a corresponding high patient staff ratio. At recent review sessions, some PNs were still unsure on the calculation of PN workload. Data management has already begun conducting update sessions for staff on the calculation. Vulamehlo clinics has the lowest patient staff ratio.

**Table 19: District Hospital Staff to PDE Ratio**

District Hospital	Total Medical Staff to PDE ratio	Total Nursing Staff to PDE ratio	Total Pharmacy Staff to PDE ratio	Total Clinical Staff to PDE ratio	Total Support Staff to PDE ratio
kz St Andrew's Hospital	7 067.8	338.2	6 425.3	4 417.4	831.5

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District Hospital	Total Medical Staff to PDE ratio	Total Nursing Staff to PDE ratio	Total Pharmacy Staff to PDE ratio	Total Clinical Staff to PDE ratio	Total Support Staff to PDE ratio
kz GJ Crooke's Hospital	5 278.2	399.3	4 496.3	4 496.3	1 202.0
kz Murchison Hospital	5 345.0	340.1	5 102.1	5 102.1	1 290.2

Source: DHER 2012/13 Customised District Report

This table above shows the number of clients seen by each category of staff at district hospitals during the previous year. At a glance, it appears that St Andrews Hospital Pharmacy and Medical staff components are under resourced. Being the most rural hospital in Ugu (Umuziwabantu SD), staff retention of categories that may be considered scarce as well as those categories that may not be resident in Umuziwabantu may be an issue.

In a bid to improve the medical staff, St Andrew's hospital has stopped using the services of the sessional doctor in favour of creating a permanent post. The district is also prioritising St Andrews Hospital for placement of bursary holders. The challenge remains because bursary holders have the option to pay back their bursary and choose to move out of St Andrews. The district analysis shows that St Andrews Medical staff to patients is the poorest in the district. Currently all bursary holders have an obligation to serve half of their bursary period at the assigned institution. Thereafter, they can apply for specialisation at the Regional Hospital.

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### 12. DISTRICT HEALTH EXPENDITURE

Table 20 (NDoH 9): Summary of District Expenditure

Data element	(Budget, Province)	(Budget, Transfer to LG)	(Budget, LG Own)	(Expenditure, Province)	(Expenditure, Transfer to LG)	(Expenditure, LG Own)
DF - 2.1: District Management	R18 134 000.00	R0.00	R0.00	R18 192 106.00	0.00	0.00
DF - 2.2: Clinics	R264 187 000.00	R0.00	R0.00	R265 318 116.00	0.00	0.00
DF - 2.3: Community Health Centres	R103 279 000.00	R0.00	R0.00	R107 678 072.00	0.00	0.00
DF - 2.4: Community Services	R0.00	R0.00	R0.00	R0.00	0.00	0.00
DF - 2.5: Other Community Services	R62 268 000.00	R0.00	R0.00	R62 355 092.00	0.00	0.00
DF - 2.6: HIV/AIDS	R233 991 000.00	R0.00	R0.00	R232 779 906.00	0.00	0.00
DF - 2.7: Nutrition	R4 071 000.00	R0.00	R0.00	R4 070 981.00	0.00	0.00
DF - 2.9: District Hospitals	R459 733 000.00	R0.00	R0.00	R463 734 426.00	0.00	0.00
DF - 2.12: Donor Funding	R0.00	R0.00	R0.00	R0.00	0.00	0.00

Source: DHER 13/14 District Customised Template

The table above shows the budget and expenditure per sub programmes. The total district budget was R1 145 663 000 and expenditure was R1 154 128 699. The largest bulk was spent on district hospitals with a total expenditure of 40% of total expenditure. The PHC Expenditure increased by 15% compared to the previous year.



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**Table 21 (NDoH 10): Capita PHC expenditure per sub-district – 2013/14**

Sub-Districts and District	Total Expenditure	Population		District		Service Delivery	
		PHC Expenditure / Capita (Total Population)	PHC Expenditure / Uninsured Capita	% Uninsured population compared to District	% Expenditure compared to District	Cost per Uninsured Capita 2012/13	Cost per Uninsured Capita 2013/14
Umzumbe	R105 063 467	R 643.08	R 693.7	22	28	R 350.8	R 693.7
Hibiscus	R152 517 049	R 588.73	R 635.1	35	41	R 595.0	R 635.1
Vulamehlo	R20 568 323	R 261.85	R 282.5	11	6	R 262.9	R 282.5
uMuziwabantu	R42 488 055	R 428.57	R 462.3	14	11	R 499.5	R 462.3
Umdoni	R31 869 180	R 401.49	R 433.8	11	9	R 491.9	R 433.8
Ezinqoleni	R20 489 816	R 381.38	R 411.4	7	5	R 469.4	R 411.4

Source: DHER 2013/14 Customised District Report, DHER 2011/12 and 2012/13

**Note:** The PHC expenditure is inclusive of sub-programmes 2.2 to 2.7

The sub districts with the highest expenditure are Hibiscus and Umzumbe and they are also the sub districts with the largest % population compared to the district. Umzumbe and Hibiscus have the highest cost per capita as the CHC level of care drives the cost per Capita.

**Table 22 (NDoH 11): PHC Budget and Expenditure (%) excluding “Other Donor Funding” – 2013/14**

	Budget Amount	Budget	Expenditure Amount	Expenditure
District Management (2.1)	R18 134 000.00	2	R18 192 106.00	1.6%
PHC (2.2 – 2.7)	R 667 796 000	58.	R 672 202 167	58.2%
District Hospitals (2.9)	R459 733 000.00	40	R1 154 128 699.00	40.2%

Source: DHER 2013/14 Customised District Report

**Note:** The National Table for District Finance Proportional Expenditure [%] is included in Table A15 above.

The proportion of district funds spent on management slightly declined from 1.7% to 1.6% with the provincial norm of under 2% of total Programme 2 expenditure. There was a favourable shift towards PHC from 57.1 to 58.2 and a decline in Proportion spent on District Hospitals from 41.1 to 40.2. The table below shows that both OPD and OPD not referred have decreased.

**Table 23 (NDoH 12): PHC Cost per Headcount– 2013/14**

	LG PHC Facilities	Provincial PHC Facilities	Total Staff Cost per PHC Headcount
District	N/A	151.87	107.46

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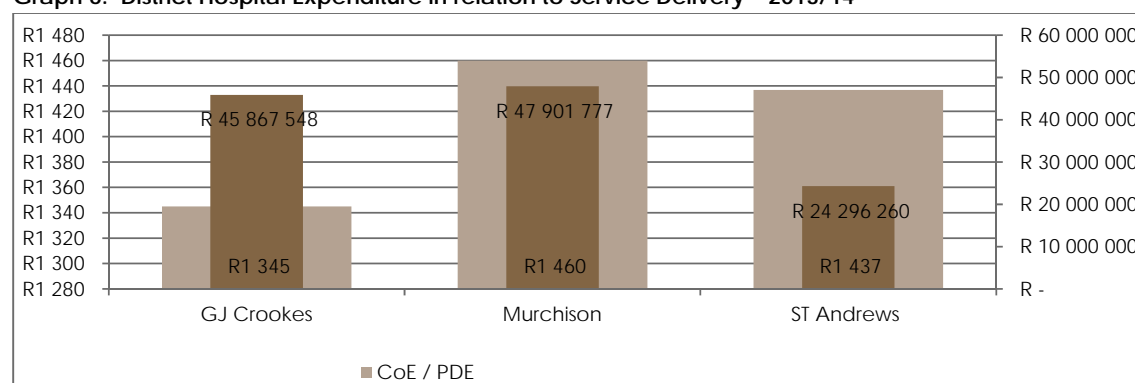
**Table 24: District Hospital Expenditure**

District Hospital	Expenditure per PDE	ALOS	BUR	Proportion (%) of expenditure spent on staff (CoE)
kz St Andrew's Hospital	1 808.47	6.0	65.4	79
kz GJ Crooke's Hospital	1 745.76	5.6	72.4	77
kz Murchison Hospital	1 898.94	6.0	76.2	77
<b>District</b>				

Source: DHER 2013/14 Customised District Report

The average length of stay for St Andrews Hospital was 5.7, the lowest in the district. Murchison Hospital burden of disease of TB clients raised the ALOS to 6.8.

**Graph 6: District Hospital Expenditure in relation to Service Delivery – 2013/14**



Source: DHER 2012/13 Customised District Report

The proportional spend of COE should roughly be 65% of the hospitals budget. All facilities are rural and the rural allowance drives the COE/PDE.

**Table 25: Non-Negotiable Expenditure per PDE (Rand)**

Non-Negotiable [Rands per PDE]	St Andrews	CJ Crookes	Murchison
Infrastructure Maintenance	5.0	0.61	0.0
Food Services	30.8	17.6	23.5
Medicine Expenditure	50.4	67.5	53.4
Medical Sundries (Supplies) Expenditure	55.9	62.1	45.5
Essential Equipment	1.7	6.8	4.4
Laundry Expenditure	0.0	0.0	0.64
Vaccination Expenditure	-1.5	1.9	3.1
Blood Support Expenditure	14.0	20.9	18.1
Infection Control Expenditure	36.2	40.5	27.9
Medical Waste Expenditure	1.4	4.4	3.3
Laboratory Services Expenditure	0.0	0.0	0.0
Security Services	16.2	19.3	6.9

Source: DHER 2013/14 Customised District Report

### ***Food Services***

#### In house catering

The lowest cost was at GJ Crookes at R17.6 per patient compared to St Andrews at R30.8 per patient (R20 in 12/13 financial year). St Andrews is catering for staff meals. Due to the low availability of places from which staff can purchase food, the hospital sells meals to staff members. The fees that are generated from staff meals appear under revenue and not food service.

#### Out-sourced catering

Murchison Hospital providing outsource service at R23.5 per patient.

### ***Infection control & cleaning***

GJ Crookes has the highest cost per patient at R40 per client. This has dropped by R2 per client since last year.

### ***Medical Supplies***

GJ Crookes has seen a big increase from R44 to R62 per patient compared to previous year. This has been thought to be a result of the delay in journals to clinics and will be monitored in subsequent years.

### ***Medical Waste***

Expenditure on medical waste was low at St Andrews and higher at Murchison and GJ Crookes. There was very good recovery of costs from clinics under St Andrews.

### ***Security***

There was no major shift since previous year. As mentioned above, Murchison had low expenditure because Murchison Security is outsourced but staff consists of both outsourced staff and in-house staff. Murchison has a lower outsourced: in-house staff ratio than the other district hospitals. The in-house security staff salaries fall under COE and not under security services. This needs to be taken into account for budgeting for subsequent years.

### ***Medicines***

St Andrews had the lowest cost of R50.4, Murchison at R53.4 and GJ Crookes at R67.50

*In the previous DHER: Expenditure per PDE for medicines ranging from G J Crookes being the highest (59.4) to Murchison (45.6) and St Andrews hospital being the lowest (35.6). The district medicines expenditure has been affected by the shortage of IV fluids across the province (no exp).*

GJ Crookes has a lower number of clients that have been down referred to clinics compared to other hospitals. As at March 2014, GJ Crookes had 2241 Adults on ART at the hospital

compared to Murchison with 1644 clients and St Andrews Hospital with 335 clients on ART at the hospital. GJ Crookes has developed a Down referral plan to monitor and down refer 2900 clients in the subsequent financial year. There is a need for HAST managers to assess the capacity of clinics and provide ongoing support to facilities in terms of the down referral of clients. In some cases the down referral of clients has not been accompanied with the deployment of staff to these levels mostly because of challenges with labour law. Facilities are then encouraged to look into establishing and/or improving outreach teams. Subdistrict HAST meetings are starting in the subsequent year and should include CHCs and Feeder clinics. Mphilonde clubs can further reduce workloads. Viral loads and CD4s are done yearly. With FDC clinics can manage ARV clients better.

Across the district hospitals, the contraceptives expenditure has increased due to the cost of Contraceptive implants.

Another area that deserves attention is the non-medical sites that are dispensing medicines. Data flow of data generated at the sites needs to be monitored. At Murchison Hospital, the pharmacy is planning to undertake a project to monitor data flow from these sites using the pharmacy assistants that support PHC.

### ***Children Vaccines***

St Andrews –appeared to have over-recovered expenses from clinics with a negative "expenses per client".

### ***Blood Supply***

GJ Crookes is the highest at 20.9. Murchison increased from 15.5 in the previous year to 18.1 in the current year. St Andrews increased from 12.5 in the previous year to 14 in the current review year. The blood costs may be affected by Caesars conducted at the hospitals. GJ Crookes has the highest number of Caesars (1272 for 2013/14).

*From the previous year's DHER: Increase in blood and blood products- BUR, CS, rabies (on average 76 dog bites per month at Gamalakhe CHC, 50 dog bites at GJ Crookes and 32 at St Andrews per month receiving Rabigam at a cost of over R593 each.*

After closer look into the issuing of Rabigam to clients who have been bitten by dogs, the adherence to protocol was an issue. Staff were over-issuing to all dog bites in certain cases. This is being monitored as part of the PTC committees and will continue into the 2015/16 year.

Murchison has been monitoring the use of Rabigam and has noted a drop in the Rabigam use from 50 to 10 vials per week. In addition, Murchison has established a team to assess all cases before Rabigam is given, whereas previously, Rabigam was left in Casualty and the Dr. on call would prescribe at his/her discretion. The CDC programme manager is to investigate if this practice should be rolled out to other institutions and to check if PTC includes monitoring of Rabigam at other institutions.

### PART B - COMPONENT PLANS

## 13. SERVICE DELIVERY PLANS FOR DISTRICT HEALTH SERVICES

### 13.1 SUB-PROGRAMME: DISTRICT HEALTH SERVICES

#### *13.1.1 PHC SUB-PROGRAMME OVERVIEW*

The strategic challenges are:

1. Low PHC Supervision rate due to challenges in PHCCs having to attend many forums.
2. PHC supervision with little positive impact
3. Low expenditure per PHC headcount
4. Slow progress/functioning ward based outreach teams. CCG involvement is erratic due to the many roles and responsibilities of CCGs and the many different channels of accountability (CCGs account the OM, CCG supervisors, CCG facilitators and ward based teams). Drop in utilisation of PHC services in Vulamehlo.
5. Low resolution of complaints. Unavailability of or infrequent meetings of clinic committees (No compensation for clinic committees)
6. Complications of Diabetes and other chronic diseases due to poor case identification and lack of emphasis on prevention. Health efforts are still largely curative in nature.  
Congestion and long waiting times at PHC. Chronic repeat patients form a large bulk.
7. Poor performance of NCS – lack of available updated protocols at facility level. Slow implementation of ideal clinics
8. Lack of information sharing of the home-based care programme to relevant stakeholders. No formal monitoring and reporting processes are visible.
9. Low coverage of schools by school health teams. Limited teams. Consent forms for grade 1 learners are sometimes not signed. Bilharzia projects and HPV campaign reduce time available for assessments.
10. Overburdened clinics in urban areas due to clients bypassing clinics near to them based on transport flow.

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**Table 26 (NDoH 13): Situation Analysis: Indicators for District Health Services 2013/14 Financial Year**

Indicators	Type	Umzumbe	Hibiscus	Vulamehlo	Umuziwabantu	Umdoni	Ezingoleni	District Average
1. Percentage of fixed PHC facilities compliant with all extreme measures of the National Core Standards	Quarterly %	0	0	0	0	0	0	0
<i>Fixed PHC facilities compliant with all the extreme measures of the National Core Standards for health facilities</i>	<i>No</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>
<i>Fixed PHC clinics plus fixed CHCs / CDCs</i>	<i>No</i>	<i>14</i>	<i>17</i>	<i>5</i>	<i>11</i>	<i>5</i>	<i>4</i>	<i>56</i>
2. Patient experience of care survey rate (PHC Facilities)	Quarterly %	35.7%	35.3%	0.0%	9.1%	0.0%	0.0%	21.4%
<i>Fixed PHC facilities that have conducted Patient experience of care Surveys</i>	<i>No</i>	<i>5</i>	<i>6</i>	<i>0</i>	<i>1</i>	<i>0</i>	<i>0</i>	<i>12</i>
<i>Fixed PHC clinics plus fixed CHCs / CDCs</i>	<i>No</i>	<i>14</i>	<i>17</i>	<i>5</i>	<i>11</i>	<i>5</i>	<i>4</i>	<i>56</i>
3. PHC patient experience of care rate at PHC facilities	Annual %	New data element	-	-	-	-	-	-
<i>Patient satisfied with health services</i>	<i>No</i>	<i>No Source</i>	-	-	-	-	-	-
<i>Patients participating in PSS</i>	<i>No</i>	<i>No Source</i>	-	-	-	-	-	-
4. OHH registration visit coverage	Annual %	New data element	-	-	-	-	-	-
<i>OHH registration visit</i>	<i>No</i>	<i>No Source</i>	-	-	-	-	-	-
<i>OHH in Population</i>	<i>No</i>	<i>No Source</i>	-	-	-	-	-	-

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Indicators	Type	Umzumbe	Hibiscus	Vulamehlo	Umuziwabantu	Umdoni	Ezinqoleni	District Average
5. Number of District Clinical Specialist Teams (DCST's)	Quarterly No	1 for district	1 for district	1 for district	1 for district	1 for district	1 for district	1
6. PHC utilisation rate	Annual %	3.1	3.7	2.2	3.3	3.4	3.9	3.4
PHC headcount total	No	513 808	965 353	170 487	327 108	327 108	212 189	2 456 035
Population Total	No	163 376	259 059	78 551	99 138	79 378	53 726	733 228
7. Complaints Resolution Rate	Quarterly %	68.4	87	100	84.4	97.8	95.5	83.7
Complaints resolved	No	91	180	24	65	45	21	426
Complaints received	No	133	207	24	77	46	22	509
8. Complaint resolution within 25 working days rate	% Quarterly	84.6	96.7	75	89.2	88.9	90.5	90.6
Complaint resolved within 25 working days	No.	77	174	18	77	40	19	386
Complaint resolved	No.	91	180	24	65	45	21	426

**Table 27 (NDoH 14): District Performance Indicators – District Health Services**

Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Target
			2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
1. Proportion of fixed PHC facilities compliant with all the extreme measures of the National Core Standards	QA assessment records	% Quarterly	New indicator	New indicator	New indicator	New indicator	Establish baseline	-	-	Establish Baseline

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Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Target
			2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
<i>Fixed PHC facilities compliant with all the extreme measures of the National Core Standards for health facilities</i>	<i>QA assessment records</i>	<i>No</i>								
<i>Fixed PHC clinics plus fixed CHCs / CDCs</i>	<i>DHIS calculates</i>	<i>No</i>	54	56	56	56	56	56	56	
2. Patient experience of care survey rate (PHC Facilities)	QA calculates	% Quarterly	Not reported	Not reported	21.4%	30%	100%	100%	100%	100%
<i>Fixed PHC facilities that have conducted Patient Experience of care Surveys</i>	<i>OSS records</i>	<i>No</i>	-	-	<i>Raw data</i>	17	57	57	57	
<i>Fixed PHC clinics plus fixed CHCs / CDCs</i>	<i>DHIS calculates</i>	<i>No</i>	-	-	<i>Raw data</i>	57	57	57	57	
3. PHC patient experience of care rate at PHC facilities	DHIS calculates	% Annual	Not reported	Not reported	QA	26%	29%	32%	35%	75%
<i>Patient satisfied with health services</i>	<i>PSS results</i>	<i>No</i>	-	-	-	-	-	-	-	
<i>Patients participating in PSS</i>	<i>PSS records</i>	<i>No</i>	-	-	-	-	-	-	-	
4. OHH registration visit coverage	DHIS calculates	% Annual	Not reported	Not reported	Not reported	Not reported	Establish baseline	-	-	51.7%
<i>OHH registration visit</i>	<i>DHIS/Tick register WBOT</i>	<i>No</i>	-	-	-					



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Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Target
			2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
<i>OHH in Population</i>	<i>District Records</i>	<i>No</i>	-	-	-					
5. Number of District Clinical Specialist Teams (DCST's)	Persal/ District Records	Quarterly No	Not reported	Not Reported	0	0	1	1	1	
6. PHC utilisation rate	DHIS calculates	Annual %	2.7	3.0	3.4	3.5	3.8	4.1	4.5	3
<i>PHC headcount total</i>	<i>DHIS/PHC tick register</i>	<i>No</i>	<i>2095450</i>	<i>2278312</i>	<i>2456035</i>	<i>2595394</i>	<i>2850817</i>	<i>3112449</i>	<i>3452315</i>	
<i>Population Total</i>	<i>DHIS/Stats SA</i>	<i>No</i>	<i>764 584</i>	<i>768001</i>	<i>733228</i>	<i>741541</i>	<i>750215</i>	<i>759134</i>	<i>767181</i>	
7. Complaints Resolution Rate	DHIS calculates	Quarterly %	Not reported	67.0%	83.7%	84.2%	85.9%	87.6%	89.4%	75%
<i>Complaints resolved</i>	<i>DHIS / Complaint records</i>	<i>No</i>		252	426	263	234	233	233	
<i>Complaints received</i>	<i>DHIS / Complaint records</i>	<i>No</i>		376	509	312	272	266	261	
8. Complaint resolution within 25 working days rate	DHIS calculates	Quarterly %	Not reported	Not reported	90.6%	94%	95%	97%	99%	90%
<i>Complaint resolved within 25 working days</i>	<i>DHIS / Complaint records</i>	<i>No.</i>	-	-	386	247	222	226	231	
<i>Complaint resolved</i>	<i>DHIS / Complaint</i>	<i>No.</i>	-	-	426	263	234	233	233	

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Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Target
			2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
	<i>s record</i>									

**Table 28 (Table 15): District Specific Objectives and Performance Indicators – District Health Services**

Strategic Objective	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial target
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	
1.	1.1 PHC utilisation rate under 5 years (annualised)	DHIS calculates	Quarterly %	4.4%	4.7%	4.3%	4.4%	4.5%	4.6%	4.7%	4.5%
	<i>PHC headcount under 5</i>	<i>DHIS/PHC tick register</i>	<i>No</i>	<i>355 425</i>	<i>366 265</i>	<i>398 849</i>	<i>408 876</i>	<i>408 645</i>	<i>411 346</i>	<i>412 552</i>	
	<i>Population under 5 years</i>	<i>DHIS/Stats SA</i>	<i>No</i>	<i>81 006</i>	<i>78 518</i>	<i>92 994<sup>15</sup></i>	<i>92 114</i>	<i>90 810</i>	<i>89 423</i>	<i>87 777</i>	
	1.2 PHC Total Headcount under 5 years	DHIS/Tick register SHS	No	355 425	366 265	398849	408876	408645	411346	412552	
2.	2.1 Expenditure per PHC headcount	DHIS/BAS	Quarterly R	R125	R115	R152	R250	R260	R280	R300	R300
	<i>Total expenditure PHC</i>	<i>BAS (R'000)</i>	<i>R'000</i>	<i>R236 218 079</i>	<i>R315 593 530</i>	<i>R268 852 833</i>	<i>R309 492 229</i>	<i>R349 401 141</i>	<i>R398 317 301</i>	<i>R401 000 000</i>	
	<i>PHC headcount total</i>	<i>DHIS calculates</i>	<i>No</i>	<i>2 095 450</i>	<i>2 278 312</i>	<i>2 456 035</i>	<i>2 595 394</i>	<i>2 850 817</i>	<i>3 112 449</i>	<i>3 452 315</i>	
3.	3.1 Number of School Health Teams (cumulative)	District Records/ Persal	Quarterly No	6	11	13	23	25	28	30	

<sup>15</sup> DHIS

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Strategic Objective	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial target
				2011/12	2012/13	2013/14		2014/15	2015/16	2016/17	
4.	4.1 Number of accredited Health Promoting Schools (cumulative)	Health Promotion database	Quarterly No	6	11	12	26	30	34	40	
5.	5.1 Dental extraction to restoration ratio	DHIS calculates	Quarterly Ratio	5.5	4:1	3:1	3.6:1	3:1	2.5:1	2:1	15:1
	<i>Tooth extraction</i>	<i>DHIS/Tick register</i>	<i>No</i>	<i>37 286</i>	<i>36 636</i>	<i>40 375</i>	<i>43 999</i>	<i>37 398</i>	<i>31 788</i>	<i>25 940</i>	
	<i>Tooth restoration</i>	<i>DHIS/Tick register</i>	<i>No</i>	<i>6 801</i>	<i>11 793</i>	<i>12 067</i>	<i>12 222</i>	<i>12 466</i>	<i>12 715</i>	<i>12 970</i>	
6.	6.1 Percentage of PHC facilities conditionally compliant to the National Core Standards	QA assessment records	Annual %	New indicator	New indicator	New indicator	New indicator	Baseline to be established	-	-	
	<i>Clinics conditionally compliant (50%-75%)to National Core Standards</i>	<i>QA assessment records</i>	<i>No</i>	-	-	-	-	-	-	-	
	<i>CHC's and clinics total</i>	<i>DHIS calculates</i>	<i>No</i>	-	-	-	-	-	-	-	
7.	7.1 District PHC expenditure per uninsured person	BAS / Stats SA	R	352	444	487	450	502	566	564	
	<i>Total expenditure on PHC services</i>	<i>BAS</i>	<i>R'000</i>	<i>R 236 218 079</i>	<i>R 315 593,530</i>	<i>R268 852 833</i>	<i>R309 492 229</i>	<i>R349 401 141</i>	<i>R398 317 301</i>	<i>R401 000 000</i>	
	<i>Number of uninsured people in the Province (Stats SA)</i>	<i>DHIS / Stats SA</i>	<i>No</i>	<i>646 073</i>	<i>648 961</i>	<i>679 702</i>	<i>687 409</i>	<i>695 449</i>	<i>703 717</i>	<i>711 177</i>	
8.	8.1 PHC supervisor visit rate (fixed clinic/ CHC/ CDC)	DHIS	%	59%	66.8%	65.9%	67%	69%	72%	76%	
	<i>PHC supervisor visit (fixed clinic/ CHC/ CDC)</i>	<i>Supervisor checklists</i>	<i>No</i>	<i>382</i>	<i>457</i>	<i>451</i>	<i>451</i>	<i>472</i>	<i>492</i>	<i>520</i>	

## UGU DISTRICT HEALTH PLAN 2015/16

Strategic Objective	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial target
				2011/12	2012/13	2013/14		2014/15	2015/16	2016/17	
	<i>Fixed clinics plus fixed CHCs/CDCs</i>	<i>DHIS Calculates</i>	<i>No</i>	<i>54x12</i>	<i>56<sup>16</sup>x12</i>	<i>57 x 12</i>	<i>57x12</i>	<i>57x12</i>	<i>57x12</i>	<i>57x12</i>	
9.	9.1 Number of functional Ward Based Outreach Teams (Family Health Teams) (cumulative)	District Manage-ment / Appointment letters	No	Not Reported	Not Reported	5	5	5	5	10	
10.	10.1 School ISHP coverage (annualised)	DHIS	%	58%	<20%	Data	20%	30%	40%	50%	
	<i>Schools with any learner screened</i>	<i>DHIS / Tick register SHS</i>	<i>No</i>	<i>-</i>	<i>-</i>	<i>Data</i>	<i>100</i>	<i>150</i>	<i>200</i>	<i>251</i>	
	<i>Schools – total</i>	<i>DHIS / DoE database</i>	<i>No</i>	<i>-</i>	<i>-</i>	<i>Data</i>	<i>502</i>	<i>502</i>	<i>502</i>	<i>502</i>	
11.	11.1 Number of Primary Health Care Clinics that qualify as Ideal Clinics		No	New indicator	New indicator	New indicator	New indicator	10	10	20	
12.	12.1 Number of Primary Health Care Clinics with functional Clinic Committees		No	No data available	No data available	46	56	56	56	56	

<sup>16</sup> Excludes Hibiscus Wellness And Umzinto North.

## UGU DISTRICT HEALTH PLAN 2015/16

### 13.1.2 District Health Services: Strategies /Activities to be implemented 2015/16

Strategies	Activities
1. Improve Supervision rate by reducing meetings and improving monitoring of supervision rate	Sub district Meetings to be revived in all Sub districts and used as platform for programme managers to interact with PHCCs (Minimal meetings called at District) and combined programme meetings. PHCCs to submit weekly plans. Use sub district forum to discuss workloads, utilization and access especially among PHC facilities.
2. Improve supervision and coordination of PHCCs and quality of supervision visit outcomes	Delinking of PHC from District to Hospital. Clarification of roles on programme managers and PHCCs and outcomes based support visits to facilities (Informed largely by data). Oms to cascade feedback to staff after supervisor visit and keep record of visit feedback and dissemination of information.
3. Improved support and monitoring of PHC financial performance	Finance manager addressing poor performing facilities on PHC financial performance through presentations and corrective actions as part of DMT meetings
4. Scale up outreach services within the district with additional WBOTs and improved functioning of existing outreach teams	Linking of CCGs to ward based teams and developing operational plan with key deliverables of each team. Clarify roles and responsibilities of the WBOT teams. Monitor the provision of outreach services in Vulamehlo SD in an attempt to improve utilisation of PHC services within the subdistrict. Province to assist in defining roles of members. Proper communication of roles and responsibilities within WBOTs. District to motivate for additional CCG posts.
5. PHCC to Monitor complaints resolution within 25 days	Support and monitor clinics with poor functioning committees. CuBP coordinator to assist the PHCCs with formation of clinic committees - Using local community members for committees – no need for transport. OM training on complaints management.
6. Improve management of chronic diseases	Implement ICDM at 10 facilities Assessment of preparedness. Monitoring and support at 10 selected sites
7. Integration of Ideal clinic, NCS and ICDM	Implementation plans to be integrated. Linking Performance to EPMDS of OMs and PHC Monthly monitoring of the 10 colour coded domains accessing clinic readiness and include domains in the PHC Operational plans Formation of district Operation Phakisa steering committee.
8. Improve monitoring and reporting on progress of Home based care programme	Quarterly reporting of performance of Home-based care by programme manager in collaboration with district family physician and presentation to the quarterly partner's forum.
9. Capacitate stakeholders on school health programme. Increase functioning of school health teams	Conduct orientation sessions for school principals, SGB, parents with assistance from OSS structures. Improve recruitment (motivation/creation/filling) School health teams linked to OMs, with support and mentoring by PHCC and programme manager Advertisement of EN post at grade 2 Formalise the data flow of school health teams for every school visited. I.e. under which clinic to report the data.
10. Improve hours of service at overburdened clinics	Conduct feasibility assessment of proposed 24 hour clinics. <sup>17</sup>

<sup>17</sup> DHER 2013/14, DHP consultative session

## UGU DISTRICT HEALTH PLAN 2015/16

### SUB-PROGRAM: DISTRICT HOSPITALS

#### 13.2.1 Sub-Programme Overview

Strategic challenges for the sub-program.

1. Delays in District Hospital Expenditure resulting in fluctuations in expenditure per PDE. Poor Financial Management Capacity. Incorrect allocation of expenses due to poor recovery of expenditure from clinics
2. Patients bypassing rural clinics in favour of urban clinics and district hospitals. High OPD headcount at GJ Crookes. High OPD headcount not-referred at St Andrews Hospital
3. Average length of stay is still above the Provincial Target of 5.5 days (estimated 6 days for 2014/15)
4. High Caesar Rates –above Provincial target.

**Table 29 (NDoH 16): Situational Analysis Indicators for District Hospitals – 2013/14 Financial Year**

Indicators	Type	GJ Crookes	Murchison	St Andrew's	District Average
1. National Core Standards self-assessment rate	Quarterly %	100%	100%	100%	100%
<i>National Core Standards self-assessment</i>	No	1	1	1	3
<i>District Hospitals total</i>	No	1	1	1	3
2. Quality Improvement plan after self-assessment rate	Quarterly %	100%	100%	100%	100%
<i>Quality Improvement plan after self-assessment</i>	No	1	1	1	3
<i>District Hospitals total</i>	No	1	1	1	3
3. Percentage of District Hospitals compliant to all extreme and vital measures of the National Core Standards	Quarterly %	0	0	0	0
District Hospitals fully compliant (75%-100%) to all extreme and vital measures of National Core Standards	No	0	0	0	0
<i>District Hospitals total</i>	No	1	1	1	3
4. Patient experience of care survey rate		100%	100%	100%	100%
<i>Number of district hospitals that have conducted patient experience of care surveys</i>	No	1	1	1	3

## UGU DISTRICT HEALTH PLAN 2015/16

Indicators	Type	GJ Crookes	Murchison	St Andrew's	District Average
<i>District Hospitals total</i>	<i>No</i>	<i>1</i>	<i>1</i>	<i>1</i>	<i>3</i>
5. Patient experience of care rate	Annual %	<i>New Data Element</i>		90	
<i>Number satisfied customers</i>	<i>No</i>				
<i>Number users participated in survey</i>	<i>No</i>				
6. Average length of stay	Quarterly Days	5.6 days	6.0 days	6.0 days	5.9 days
<i>In-patient days</i>	<i>No</i>	78 448	83 386	50 322	212 156
<i>Day patients</i>	<i>No</i>	13	41	99	153
<i>Inpatient separations</i>	<i>No</i>	13 905	13 851	8 385	36 141
7. Inpatient bed utilisation rate	Quarterly %	72.4%	73.9%	65.7%	71.2
<i>In-patient days</i>	<i>No</i>	78 448	83 386	50 322	212 156
<i>Day patients</i>	<i>No</i>	13	41	99	153
<i>Inpatient bed days available</i>	<i>No</i>	108405	109500	76650	294555
8. Expenditure per PDE	Quarterly R	R1 746	R1 899	R1808	R1817
<i>Expenditure total</i>	<i>R'000</i>	211 933 759	213 148 440	128 260 137	553 342 336
<i>Patient day equivalent</i>	<i>No</i>	121 399	112 246	70 922	304568
9. Complaint resolution rate	Quarterly %	71.4%	16.6%	55.9%	38.4%
<i>Complaint resolved</i>	<i>No</i>	70	29	19	118
<i>Complaint received</i>	<i>No</i>	98	175	34	308
10. Complaint resolution within 25 working days rate	Quarterly %	100%	0%	100%	75.4%
<i>Complaint resolved within 25 days</i>	<i>No</i>	70	0	19	89
<i>Complaint resolved</i>	<i>No</i>	70	29	19	118

**Note:** Indicator 9, [data element Expenditure total]: Expenditure should be for all hospital expenditure that occurs at a hospital level, not only sub-programme 2.9. Expenditure at community level is not included in this figure.

## UGU DISTRICT HEALTH PLAN 2015/16

**Table 30 (NDoH 17): Performance Indicators for District Hospitals**

Indicator	Data Source	Frequency Type	Audited/ Actual Performance				Estimated Performance	Medium Term Targets			Provincial Target
			2011/12	2012/13	2013/14	2014/15		2015/16	2016/17	2017/18	
1 National Core Standards self-assessment rate	QA/DHIS calculates	Quarterly %	Not available	Not available	100%	100%		100%	100%	100%	100%
National Core Standards self-assessment	QA assessment records	No			3	3		3	3	3	
District Hospitals total	DHIS calculates	No	3	3	3	3		3	3	3	
2 Quality Improvement plan after self-assessment rate	QA/DHIS calculates	Quarterly %	Not available	Not available	100%	100%		100%	100%	100%	100%
Quality Improvement plan after self-assessment	QA assessment records	No			3	3		3	3	3	
District Hospitals total	QA assessment records	No	3	3	3	3		3	3	3	
3 Percentage of District Hospitals compliant to all extreme and vital measures of the National Core Standards	QA/DHIS calculates	Quarterly %	Not reported	Not reported	0%	0%		33%	67%	100%	14%
District Hospitals fully compliant (75%-100%) to all extreme and vital measures of National Core Standards	QA assessment records	No	-	-	0	0		1	2	3	
District Hospitals total	DHIS calculates	No	3	3	3	3		3	3	3	
4 Patient experience of care survey rate	QA / DHIS calculates	Quarterly %			100%	100%		100%	100%	100%	100%



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Indicator	Data Source	Frequency Type	Audited/ Actual Performance				Estimated Performance	Medium Term Targets			Provincial Target
			2011/12	2012/13	2013/14	2014/15		2015/16	2016/17	2017/18	
<i>Number of district hospitals that have conducted patient experience of care surveys</i>	<i>QA assessment records</i>	<i>No</i>			3	3		3	3	3	
<i>District Hospitals total</i>	<i>DHIS calculates</i>	<i>No</i>	3	3	3	3		3	3	3	
5 Patient experience of care rate	DHIS calculates	Annual %	100%	84%	90 <sup>18</sup> %	91%		92%	94%	96%	90%
<i>Number satisfied customers</i>	<i>PSS</i>	<i>No</i>	-	210	-	-		-	-	-	-
<i>Number users participated in survey</i>	<i>PSS</i>	<i>No</i>	-	249	-	-		-	-	-	-
6 Average length of stay	DHIS calculates	Quarterly Days	6.3 days	6.2 days	5.9 days	5.8 days		5.6 days	5.4 days	5.2 days	5.8
<i>In-patient days</i>	<i>Midnight census</i>	<i>No</i>	213 211	204 086	212 156	211 020		215 240	219 545	223 936	
<i>Day patients</i>	<i>Midnight census</i>	<i>No</i>	157	155	153	150		149	145	143	
<i>Inpatient separations</i>	<i>DHIS calculates</i>	<i>No</i>	33 721	32 951	36 141	36 490		38 496	40 614	42 848	
7 Inpatient bed utilisation rate	DHIS calculates	Quarterly %	71.4%	74.6%	71.2%	71.8%		73.1%	74.6%	76.1%	64.7%
<i>In-patient days</i>	<i>Midnight census</i>	<i>No</i>	213 211	204 086	212 156	211 020		215 240	219 545	223 936	
<i>Day patients</i>	<i>Midnight census</i>	<i>No</i>	157	155	153	150		149	145	143	
<i>Inpatient bed days available</i>	<i>Manageme</i>	<i>No</i>	292 000	294 920	294 555	294 555		294 555	294 555	294 555	

<sup>18</sup> Average of 3 district hospitals DQPR q4

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Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Target
			2011/12	2012/13	2013/14		2015/16	2016/17	2017/18	
	<i>nt</i>									
8 Expenditure per PDE	BAS/DHIS	Quarterly R	R1 049	R1 588	R1 817	R1 508	R1 643	R1 791	R1 952	R1 808
<i>Expenditure total</i>	<i>BAS</i>	<i>R'000</i>		R432 069 028	R553 342 336	R457 718 716	R496 711 623	R532 765 188	R574 885 472	-
<i>Patient day equivalent</i>	<i>DHIS calculates</i>	<i>No</i>	304910	299 908	304 568	303 527	300 491	297 468	294 511	-
9 Complaint resolution rate	DHIS	Quarterly %		55.5%	38.4%	103.2 %	100%	100%	100%	75%
<i>Complaint resolved</i>	<i>PSS</i>	<i>No</i>		252	118	316	315	318	321	
<i>Complaint received</i>	<i>PSS</i>	<i>No</i>		454	308	312	315	318	321	
10 Complaint resolution within 25 working days rate	DHIS	Quarterly %	47%	55.5%	75.4%	70%	91.9%	92%	93%	85%
<i>Complaint resolved within 25 days</i>	<i>PSS</i>	<i>No</i>	-	252	89	290	289	292	299	-
<i>Complaint resolved</i>	<i>PSS</i>	<i>No</i>	-	454	118	316	315	318	321	-

**Table 31 (NDoH 18): District Strategic Objectives and Annual Targets for District Hospitals**

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial target
				2011/12	2012/13	2013/14		2015/16	2016/17	2017/18	
	1. Delivery by caesarean section rate	DHIS calculates	Quarterly %	33.9%	37.1%	36.4%	36.9%	35%	33.3%	31.6%	27.6%
	<i>Delivery by caesarean section</i>	<i>Delivery register</i>	<i>No</i>	2 813	4 887	4 610	3 440	4 460	4 326	4 196	

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Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial target
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
	<i>Delivery in facility total</i>	<i>Delivery register</i>	<i>No</i>	12 494	13 469	1 3710	9 322 <sup>19</sup>	15 100	15 704	16 333	
	2. OPD headcount- total	DHIS/OPD tick register	Quarterly No	243 925	250 211	243 602	240 000	235 200	230 496	225 886	
	3. OPD headcount not referred new	DHIS/OPD tick register	Quarterly No	11 552	8 503	7 444	1 2614 <sup>20</sup>	11 352	10 207	9 195	
	4. Number of District Hospitals with functional boards	Minutes of Board meetings	Quarterly No	3	3	3	3	3	3	3	
	5. Proportion of District Hospitals conditionally compliant to National Core Standards	QA / DHIS calculates	Quarterly %	Not reported	Not reported	67%	100%	100%	100%	100%	
	<i>District Hospitals conditionally compliant</i>	<i>QA assessment records</i>	<i>No</i>	-	-	2	3	3	3	3	
	<i>District Hospitals Total</i>	<i>DHIS calculates</i>	<i>No</i>	3	3	3	3	3	3	3	

<sup>19</sup> Previously we erroneously used all hospitals Caesar rate, number of caesars and number of deliveries and this resulted in jumps in the data. Corrected from here onwards.

<sup>20</sup> The huge spike was as a result of correction in the collection of data of OPD not referred from SAH-previously underreporting by not adding walk ins to maternity and have commenced in previous fin year.

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### 13.2.2 District Hospitals: Strategies /Activities to be implemented 2015/16

Strategies	Activities
1. Continuous monitoring of expenditure trends and reduce HR delays that result in under expenditure, Build capacity among hospital finance staff	<p>Quarterly feedback at DMT by Finance manager</p> <p>Hospital management and sub district teams to establishing quarterly mini DHER sessions<sup>21</sup></p> <p>Implement new SCM structure for segregation of processes (Demand, Acquisition, Log)</p> <p>Long HR verification delays expenditure</p> <p>Share verification results for qualifications. Decentralize criminal verification process from security services to HR Managers.</p> <p>Address delays in HO approval of prohibited items-Finance manager to consult with budget manager</p> <p>District Finance Manager to build capacity and quarterly sessions in conjunction with the Provincial budget Office</p> <p>Hospital plans to include budget estimates for staff who are retiring, reaching retirement age in 2015/16.</p> <p>Consult HO Budget manager on performance based budgeting.</p> <p>Monthly recovery of costs for efficient recovery.</p>
2. Encourage clients to access the correct level of health services	<p>Additional staff to be recruited at Umzinto clinic to assist to decongest GJ Crookes. At St Andrews, Improve compliance to the triaging system by close monitoring by unit managers. Referring clients to gateway during operating hours. Increase medical officer coverage to clinics where feasible.</p>
3. Reduced ALOS at District hospitals by efficient use of step down facilities	<p>Monitoring of performance and improved communication between step down and referring institutions.</p> <p>Infrastructure to assess facilities for the creation of further step-down facilities.</p> <p>Increase the number of orthopedic doctors and beds in Regional Hospital to reduce ALOS of orthopedic patients in District Hospitals.</p>
4. Increase number of medical officers at St Andrews Hospital	<p>Allocation of bursary holders to St Andrews Hospital especially for medical officers. District HR Manager to monitor placement<sup>22</sup>.</p>
5. Reduce Caesar rate with greatest emphasis on GJ Crookes and Murchison Hospital.	<p>Audits on every Caesar rate to continue in the new financial year as a control and accountability mechanism for the number and outcomes of deliveries being conducted by Caesarian section.</p>

<sup>21</sup> DHER 2013 2014

<sup>22</sup> DHER 2013/14

### 14. HIV & AIDS & TB CONTROL (HAST)

#### 14.1 PROGRAMME OVERVIEW

The strategic challenges are:

1. Ineffective monitoring and evaluation systems. Slow capturing on TIER at some facilities due to high turnover of data capturers (staffing challenge). Difficulty in recruiting from 3535 pool.
2. Slow progress on prevention programmes including slow condom distribution and uptake and coordination of MMC. Poor screening coverage at 3 of the inland sub-districts namely Ezinqoleni, Umzumbe and Vulamehlo.
3. Slow TB/HIV integration due to process and infrastructure challenges.
4. High number of TB defaulters slows down cure rate. The TB Screening efforts are not intensive in the form of outreach screening.
5. Slow Paediatric ARV initiation and slow down referral of clients under GJ Crookes catchment due to delayed capacity development at PHC.
6. Poor data quality from poor recording and record keeping. No accountability for poor quality data. Inefficient use of tally sheets. Too many registers at PHC level.  
Loss to follow up

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**Table 32 (NDoH 19): Situational Analysis Indicators for HIV & AIDS, STI's and TB Control - 2013/14 Financial Year**

Indicator	Type	Ezingoleni	Hibiscus	Umdoni	Umuziwabantu	Umzumbe	Vulamehlo
1. Total clients remaining on ART month	Quarterly No	3581	25 642	8 308	7 519	8 894	2 597
2. Clients tested for HIV (incl ANC)	Quarterly No	18 436	71 452	22 941	37 957	39 288	20 958
3. TB symptom 5 years and older screened rate	Quarterly %	1.4%	3.1%	3.2%	2.6%	1.6%	1.8%
<i>Client 5 years and older screened for TB symptoms</i>	<i>No.<sup>23</sup></i>	<i>2 463</i>	<i>25 930</i>	<i>7 345</i>	<i>6 628</i>	<i>7 034</i>	<i>2 578</i>
<i>PHC headcount 5 years and older</i>	<i>No.</i>	<i>177 610</i>	<i>826 544</i>	<i>226 230</i>	<i>258 393</i>	<i>427 987</i>	<i>140 422</i>
4. Male condom distribution Rate	Quarterly Rate per male	37	49.1	18.8	31.1	23.7	20
<i>Male condoms distributed</i>	<i>No</i>	<i>511 283</i>	<i>4 031 495</i>	<i>501 405</i>	<i>756 802</i>	<i>1 019 340</i>	<i>413 899</i>
<i>Population 15 years and older male</i>	<i>Population</i>	<i>13 783</i>	<i>81 783</i>	<i>26 493</i>	<i>24 246</i>	<i>42 816</i>	<i>20 637</i>
5. Female condom distribution Rate	Quarterly Rate per female	2.5	1.4	0.6	1.2	1.5	0.7
<i>Female condoms distributed</i>	<i>No</i>	<i>46 801</i>	<i>136 669</i>	<i>18 941</i>	<i>38 237</i>	<i>84 047</i>	<i>18 326</i>
<i>Population 15 years and older female</i>	<i>Population</i>	<i>18 529</i>	<i>99 094</i>	<i>30 012</i>	<i>32 603</i>	<i>55 880</i>	<i>27 028</i>
6. Medical male circumcision performed – Total	Quarterly No	459	1 874	733	654	9 744	304
7. TB client treatment success rate	Quarterly %	81.1%	73.1%	76.5%	77%	88.2%	92.5%
<i>TB client successfully completed treatment</i>	<i>No</i>	<i>99</i>	<i>626</i>	<i>186</i>	<i>207</i>	<i>277</i>	<i>74</i>
<i>TB client start on treatment</i>	<i>No</i>	<i>122</i>	<i>856</i>	<i>243</i>	<i>269</i>	<i>314</i>	<i>80</i>
8. TB client lost to follow up rate	Quarterly %	2%	3.9%	7%	0%	6%	5%

<sup>23</sup> Used Adult screened for TB at start of ART, ART patient screened for TB and HIV positive client screened for TB. No other screening data on DHIS.

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Indicator	Type	Ezinqoleni	Hibiscus	Umdoni	Umuziwabantu	Umzumbe	Vulamehlo
<i>TB client lost to follow up</i>	<i>No</i>	<i>0</i>	<i>11</i>	<i>91</i>	<i>0</i>	<i>64</i>	<i>15</i>
<i>TB client start on treatment</i>	<i>No</i>	<i>94</i>	<i>1381</i>	<i>1763</i>	<i>339</i>	<i>727</i>	<i>193</i>
9. TB client death Rate	Annual %	10%	3.9%	3%	7%	0%	12%
<i>TB client died during treatment</i>	<i>No</i>	<i>9</i>	<i>15</i>	<i>3</i>	<i>9</i>	<i>0</i>	<i>4</i>
<i>TB client start on treatment</i>	<i>No</i>	<i>88</i>	<i>381</i>	<i>94</i>	<i>129</i>	<i>85</i>	<i>33</i>
10. TB MDR confirmed treatment start rate	Annual %	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
<i>TB MDR confirmed client start on treatment</i>	<i>No</i>						
<i>TB MDR confirmed client</i>	<i>No</i>						
11. TB MDR treatment success rate	Annual %	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
<i>TB MDR client successfully treated</i>	<i>No.</i>						
<i>TB MDR confirmed client start on treatment</i>	<i>No.</i>						

**Table 33 (NDoH 20): Performance Indicators for HIV & AIDS and TB Control**

Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Target
			2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
1. Total clients remaining on ART month	DHIS calculates	Quarterly No	39 312	45 588	56 541	74 911	80 895 <sup>24</sup>	95 456	112 638	1 276 200
2. Clients tested for HIV (incl ANC)	DHIS calculates	Quarterly No		184 762	211 034 <sup>25</sup>	207 718	250 000 <sup>26</sup>	287 500	330 625	

<sup>24</sup> HAST Plan

<sup>25</sup> DQPR q4 (Total tested),

<sup>26</sup> From HAST Plan

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Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Target
			2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
3. TB symptom 5 yrs. and older screened rate	DHIS	Quarterly %		4.1%	2.3%	3.2%	3.3%	3.4%	3.5%	20
<i>Client 5 years and older screened for TB symptom<sup>27</sup>s</i>	<i>TB Register</i>	<i>No.</i>		<i>79 952</i>	<i>51 978</i>	<i>70 264</i>	<i>77 290</i>	<i>85 019</i>	<i>93 521</i>	
<i>PHC headcount 5 years and older</i>	<i>DHIS calculates</i>	<i>No.</i>		<i>1 917 184</i>	<i>2 057 186</i>	<i>2 183 934</i>	<i>2 336 809</i>	<i>2 500 386</i>	<i>2 675 413</i>	
4. Male condom distribution Rate	DHIS calculates	Quarterly Rate per male	7.2	16.9	34.4	66.4	69.7	73.2	76.9	62.9
<i>Male condoms distributed</i>	<i>DHIS/Stock cards</i>	<i>No</i>	<i>1 911 220</i>	<i>4 206 125</i>	<i>7 234 224</i>	<i>13 635 136</i>	<i>15 087 680</i>	<i>16 116 224</i>	<i>17 224 062</i>	
<i>Population 15 years and older male</i>	<i>DHIS/Stats SA</i>	<i>Population</i>	<i>245 442</i>	<i>248 980</i>	<i>209 769</i>	<i>213 049</i>	<i>216 466</i>	<i>220 167</i>	<i>223 980</i>	
5. Female condom distribution Rate	DHIS calculates	Quarterly Rate per female	Not available	Not available	1.3	1.5	1.6	1.65	1.7	0.9
<i>Female condoms distributed</i>	<i>DHIS/Stock cards</i>	<i>No</i>	<i>Not available</i>	<i>Not available</i>	<i>343 021</i>	<i>604 192</i>	<i>785 449</i>	<i>1 021 084</i>	<i>1 327 409</i>	
<i>Population 15 years and older female</i>	<i>DHIS/Stats SA</i>	<i>Population</i>			<i>263 146</i>	<i>266 260</i>	<i>269 530</i>	<i>273 103</i>	<i>276 927</i>	
6. Medical male circumcision performed – Total	DHIS / MMC register	Quarterly No	6 456	6 439	13 768	13 000	38 000 <sup>28</sup> (14300) <sup>29</sup>	41 800	45 980	
7. TB client treatment success	ETR.Net	%	70.6%	72%	81.8 <sup>30</sup>	83%	86%	89%	93%	85%

<sup>27</sup> Used Adult screened for TB at start of ART, ART clients screened for TB and HIV positive client screened for TB

<sup>28</sup> HAST Plan-prescribed target from Province

<sup>29</sup> Expected-Using target setting tool

<sup>30</sup> ETR District TB unit



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Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Target
			2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
rate	calculates									
<i>TB client successfully completed treatment</i>	<i>TB Register</i>	<i>No</i>	-	-	-	-	-	-	-	-
<i>TB client start on treatment</i>	<i>TB Register</i>	<i>No</i>	-	-	-	-	-	-	-	-
8. TB client lost to follow-up rate	ETR.Net calculates	Quarterly %	4.4%	4.7%	4.95 <sup>31</sup> %	4.5%	4.41%	4.3%	4.2%	3.9%
<i>TB client lost to follow up</i>	<i>TB Register</i>	<i>No</i>	137	108	<i>Not available</i>	<i>Not available</i>	-	-	-	-
<i>TB client start on treatment</i>	<i>TB Register</i>	<i>No</i>	2 893	2 308			-	-	-	-
9. TB client death Rate	ETR.Net calculates	Annual %	5.9%	5.7%	7.1%	4.5%	4.3%	4.1%	3.9%	4%
<i>TB client died during treatment</i>	<i>TB Register</i>	<i>No</i>	182	126	<i>Not available</i>	<i>Not available</i>	-	-	-	-
<i>TB client start on treatment</i>	<i>TB register</i>	<i>No</i>	2893	2308			-	-	-	-
10. TB MDR confirmed treatment start rate	ETR.Net calculates	Annual %	Not reported	Not reported	53%	100 <sup>32</sup> %	100%	100%	100%	60%
<i>TB MDR confirmed client start on treatment</i>	<i>TB Register</i>	<i>No</i>	-	-	<i>Not available</i>	<i>Not available</i>	-	-	-	-
<i>TB MDR confirmed client</i>	<i>TB Register</i>	<i>No</i>	-	-			-	-	-	-
11. TB MDR treatment success rate	EDR calculates	Annual %			60% <sup>33</sup>	62%	64%	66%	68%	60.9%
<i>TB MDR client successfully treated</i>	<i>EDR Register</i>	<i>No</i>			<i>Not available</i>	<i>Not available</i>	-	-	-	-
<i>TB MDR confirmed client start</i>	<i>EDR Register</i>	<i>No</i>					-	-	-	-

<sup>31</sup> DQPR q4

<sup>32</sup> DQPR q2

<sup>33</sup> DQPR q4

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Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Target
			2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
<i>on treatment</i>										

**Table 34 (NDoH 21): District Strategic Objectives and Annual Targets for HIV & AIDS**

Strategic Objective	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Target
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	
	1. Number of patients that started regimen iv treatment (MDR-TB)	EDR.Net calculates	Annual No	Not reported	Not reported	80	Not available	-	-	-	
	2. MDR-TB Six month interim outcome	EDR.Net calculates	Annual %	Not reported	Not reported	60%	Not available	-	-	-	75%
	<i>Number of clients with a negative culture at 6 months who started treatment for 9 months</i>	EDR Register	No	--	-	-	-	-	-	-	
	<i>Total patients who started treatment in the same period</i>	EDR Register	No	-	-	-	-	-	-	-	
	3. Number of patients that started XDR-TB treatment	ETR.Net calculates	Annual No	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	
	4. XDR-TB Six month interim outcome	EDR.Net calculates	Annual %	Not reported	Not reported	Not reported	Not applicable	Not applicable	Not applicable	Not applicable	60
	<i>Number of clients with a negative culture at 6 months who started treatment for 9 months</i>	EDR Register	No	-	-	-	-	-	-	-	
	<i>Total patients who started treatment in the same period</i>	EDR Register	No	-	-	-	-	-	-	-	
	5. TB incidence (per 100 000 population)	ETR.Net	Annual No per	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	700

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Strategic Objective	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Target
				2011/12	2012/13	2013/14		2015/16	2016/17	2017/18	
	<i>New TB infections</i>	<i>ETR.Net</i>	100,000 <i>No</i>	-	-	-	-	-	-	-	
	<i>Total population in KZN</i>	<i>DHIS/Stats SA</i>	<i>Population</i>	-	-	-	-	-	-	-	
	6. HIV incidence (annual)	ASSA2008	Annual %	Not reported at District	Not reported at District	Not reported at District	Not reported at District	Not reported at District	Not reported at District	Not reported at District	1.01 %
	7. STI treated new episode incidence (annualized)	DHIS calculates	Quarterly No per 1000	55%	60%	63%	66.4%	62%	61%	60%	14.9/1000
	<i>STI treated new episode</i>	<i>DHIS/Tick register PHC/ casualty</i>	<i>No</i>	<i>29 729</i>	<i>30 397</i>	<i>29 900</i>	<i>301 965</i>	<i>306 178</i>	<i>310 760</i>	<i>315 571</i>	
	<i>Population 15 years and older</i>	<i>DHIS/Stats SA</i>	<i>Population</i>	<i>45 6857</i>	<i>466 564</i>	<i>472 914</i>	<i>479 309</i>	<i>485 996</i>	<i>493 269</i>	<i>500 907</i>	
	8. TB (new pulmonary) defaulter rate	ETR.Net calculates	%	4.4%	4.7%	4.95 <sup>34</sup> %	4.5%	4.45%	4.4%	4.3%	
	<i>TB(new pulmonary)treatment defaulter</i>	<i>TB Register</i>	<i>No</i>	<i>137</i>	<i>108</i>	<i>Not available</i>	<i>Not available</i>	-	-	-	
	<i>TB(new pulmonary)client initiated on treatment</i>	<i>TB Register</i>	<i>No</i>	<i>2 893</i>	<i>2 308</i>						
	9. TB AFB sputum result turn-around time under 48 hours rate	ETR.Net calculates	%	Data not available	Data not available	56 <sup>35</sup> %	80%	88%	96%	100%	85%
	<i>TB AFB sputum result received</i>	<i>TB</i>	<i>No</i>	-	-	-	-	-	-	-	

<sup>34</sup> DQPR q4

<sup>35</sup> DQPR q4

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Strategic Objective	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Target
				2011/12	2012/13	2013/14		2015/16	2016/17	2017/18	
	<i>within 48 hours</i>	<i>Register</i>									
	<i>TB AFB sputum sample sent</i>	<i>TB Register</i>	<i>No</i>	-	-	-	-	-	-	-	
	10. TB (new pulmonary) cure rate	ETR.Net calculates	%	70.6%	72.8%	74.9 <sup>36</sup> %	85%	87%	90%	92%	85%
	<i>TB (new pulmonary) client cured</i>	<i>TB Register</i>	<i>No</i>	<i>Not available</i>	2183	<i>Not available</i>	<i>Not available</i>	-	-	-	
	<i>TB (new pulmonary) client initiated on treatment</i>	<i>TB Register</i>	<i>No</i>	-	2 998			-	-	-	

### 14.2 HIV & AIDS, STI & TB CONTROL (HAST): STRATEGIES/ ACTIVITIES TO BE IMPLEMENTED 2015/16

List in a point form key strategies/activities that would be implemented by the district to reach the 2015/16 targets set for the Sub-program HIV & AIDS, STI & TB CONTROL (HAST)

<i>Strategies</i>	<i>Activities</i>
1. Improve recruitment of data capturers	Follow up on motivation to employ from outside the 3535 pool of data capturers. Decentralise recruitment of data capturers to institutions to fast track recruitment processes. Facilities to recruit and supervise their own data capturers. IT specialists to be requested to check the server weekly.
2. Improve HIV prevention efforts	<p>Improve condom distribution by allocation of targets to CCGs. Follow up on SCM procedures for Condom distribution service provider.</p> <p>Improve MMC recruitment of candidates - Programme manager to monitor cost benefit relationship of MMC team at Umzumbe (Number of MMCs vs COE). Use of development partners to transport candidates. Use MMC mobilisers with the existing transport systems like TB tracers and family health teams.</p> <p>Work with the Provincial unit to improve demand for MMC services.</p> <p>Programme manager to monitor performance of traditional MMC coordinators (Number of candidates per coordinator per year)</p> <p>Weekly nerve centre meetings to continue as a method of monitoring facility performance in meeting district targets most especially the</p>

<sup>36</sup> DQPR q4

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<i>Strategies</i>	<i>Activities</i>
	screening for TB and HIV in Umzumbe, Vulamehlo and Ezinqoleni. Initiate one youth friendly programme in each LM to address the recreational crisis among youth (Part of OSS).
3. Cultivate integration of TB and HIV by restructuring operations of TB programmes at facilities. Improve CPT initiation	Allocate PN to TB in every facility. Improve screening among children and pregnant women by using the relevant screening tools. Implement guidelines regarding CPT initiation.
4. Improve tracing of TB defaulters and improve TB prevention, diagnosis and treatment via outreach efforts	Engage district partners and strengthen relationship with Eastern Cape DOH in developing working solutions to trace cross border defaulters. Appointment of additional TB tracers. Improve collection of TB specimens from community level. Conduct TB screening outreach and establish routine screening at correctional services facilities. Conduct community awareness on TB on local radio station. Collaboration with Aurum institute to increase facility and community based screening in the MINE-TB project run at 14 sites within the district ( 4 hospitals and 2 CHCs, Izing, Mbunde, Marburg, Borough, Ntabeni, Margate, Umzinto and Dududu)
5. Improve uptake of eligible clients especially paediatric clients on ART	Implementation of new ARV guidelines. Capacitate clinicians. Monitor paediatric availability on a quarterly basis. Improve follow up and filling in of investigations at facility level. Implement and Monitor GJ Crookes plan to down refer 2900 ARV clients to PHC. Establish new and sustain existing Mphilonde Clubs. Implement new Policy on initiating ARVs for clients with CD4 of 500. GJ Crookes Hospital HAST Managers to conduct readiness assessment of clinics in terms of down referral of clients. All hospital HAST Managers to provide ongoing support for PHC facilities in the management of clients on ARVs. District to conduct sub-district HAST meetings including all levels of client care.
6. Improve management of clients lost to follow up	Monitor source documents and follow up on TIER.net. Monthly review of TIER reports and interpretation by Oms and PHCC. PHCCs to monitor if there is weekly monitoring of missed opportunities at facility level. Implementation of Rationalisation of Registers.

## 15. MATERNAL, NEONATAL, CHILD AND WOMEN'S HEALTH AND NUTRITION

### 15.1 PROGRAMME OVERVIEW

#### Strategic Challenges:

1. Poor identification and interpretation of growth challenges at PHC level resulting in high severe malnutrition at facility in comparison to PHC.
2. High Severe Acute Malnutrition case fatality. Unsafe feeding practices (unsafe water source)
3. High number of neonatal and child deaths
4. Low immunisation coverage. Partly due to data challenges – not adding catch up data
5. High number of maternal deaths
6. Vitamin A Coverage low for 12 to 59 months
7. Slow progress on contraception despite Implanon (Community perceptions and mistrust of the nature of implants)
8. Large number of deliveries still taking place at hospitals rather than PHC level. One specific cause is referral based on catchment area is not always implemented by all role-players. E.g. pregnant women from Mabheleni, when collected by EMS, request to go to a district hospital rather than to Turton CHC due to higher cost of transport from Turton to Mabheleni (Against the flow of traffic).

**Table 35 (NDoH 22): Situational Analysis Indicators for MCNWH & N – 2013/14 Financial Year**

Indicator	Type	Ezinqoleni	Hibiscus	Umdoni	Umuziwabantu	Umkhumbi	Vulamehlo	District Average
1. Antenatal 1 <sup>st</sup> visit before 20 weeks rate	Quarterly %	54.6%	60.2%	60.6%	55.9%	58.3%	55.4%	58.5%
<i>Antenatal 1<sup>st</sup> visit before 20 weeks</i>	<i>No</i>	<i>599</i>	<i>3 898</i>	<i>1 329</i>	<i>1 579</i>	<i>1 577</i>	<i>510</i>	<i>9 492</i>
<i>Antenatal 1<sup>st</sup> visit total</i>	<i>No</i>	<i>1 097</i>	<i>6 482</i>	<i>2 192</i>	<i>2 805</i>	<i>2 640</i>	<i>920</i>	<i>16 136</i>
2. Proportion of mothers visited within 6 days of delivering their babies	Quarterly %	267.1%	39.3%	30.2%	69.4%	308.3%	698.4%	60.0%
<i>Mother postnatal visit within 6 days after delivery</i>	<i>No</i>	<i>577</i>	<i>2 730</i>	<i>1 052</i>	<i>1 694</i>	<i>1 739</i>	<i>440</i>	<i>8 232</i>

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Indicator	Type	Ezinqoleni	Hibiscus	Umdoni	Umuziwabantu	Umzumbe	Vulamehlo	District Average
<i>Delivery in facility total</i>	<i>No</i>	<i>223</i>	<i>6 896</i>	<i>3 468</i>	<i>2 489</i>	<i>566</i>	<i>66</i>	<i>13 710</i>
3. Antenatal client initiated on ART rate	Annual %	83.8%	93.0%	97.4%	78.6%	94.7%	98.1%	91.3%
<i>ANC client started on ART</i>	<i>ART Register</i>	<i>268</i>	<i>1 798</i>	<i>709</i>	<i>539</i>	<i>642</i>	<i>203</i>	<i>4 159</i>
<i>ANC client eligible for ART initiation</i>	<i>ART Register</i>	<i>320</i>	<i>1 934</i>	<i>728</i>	<i>686</i>	<i>678</i>	<i>207</i>	<i>4 553</i>
4. Infant 1 <sup>st</sup> PCR test positive around 6 weeks rate	Quarterly %	1.8%	2.5%	1.8%	2.1%	1.8%	1.6%	2.1%
<i>Infant 1<sup>st</sup> PCR test positive around 6 weeks</i>	<i>No</i>	<i>8</i>	<i>54</i>	<i>13</i>	<i>20</i>	<i>17</i>	<i>4</i>	<i>116</i>
<i>Infant 1<sup>st</sup> PCR test around 6 weeks</i>	<i>No</i>	<i>450</i>	<i>2187</i>	<i>718</i>	<i>972</i>	<i>921</i>	<i>250</i>	<i>5 498</i>
5. Immunisation coverage under 1 year (annualised)	Quarterly %	77.1%	74.6%	105.7%	79.4%	68.4%	47.0%	73.7%
<i>Immunised fully under 1 year new</i>	<i>No</i>	<i>1161</i>	<i>4358</i>	<i>1754</i>	<i>2315</i>	<i>2949</i>	<i>1017</i>	<i>73.7</i>
<i>Population under 1 year</i>	<i>No</i>	<i>1 516</i>	<i>5 880</i>	<i>1 671</i>	<i>2 939</i>	<i>4 341</i>	<i>2 180</i>	<i>18 527</i>
6. Measles 2 <sup>nd</sup> dose coverage	Quarterly %	70.8%	71.7%	89.7%	74.6%	66.5%	47.5%	69.6%
<i>Measles 2nd dose</i>	<i>No</i>	<i>1 091</i>	<i>4 148</i>	<i>1 491</i>	<i>2 216</i>	<i>2 968</i>	<i>1 037</i>	<i>12 951</i>
<i>Population 1 year</i>	<i>No</i>	<i>1 546</i>	<i>5 810</i>	<i>1 669</i>	<i>2 983</i>	<i>4 486</i>	<i>2 193</i>	<i>18 687</i>
7. DTaP-IPV-HepB-Hib 3 - Measles 1st dose drop-out rate	Quarterly %	-2.5%	6.2%	8.9%	5.1%	0.6%	3.8%	4.3%
<i>DTaP-IPV-HepB-Hib 3 to Measles 1st dose drop-out</i>	<i>No</i>	<i>-28</i>	<i>288</i>	<i>172</i>	<i>125</i>	<i>18</i>	<i>40</i>	<i>615</i>
<i>DTaP-IPV-HepB-Hib 3rd dose</i>	<i>No</i>							
8. Child under 5 years diarrhoea case fatality rate	Quarterly %	Not applicable (NA)	3.0%	3.7%	7.3%	Not applicable	Not applicable	4.3%
<i>Child under 5 years with diarrhoea death</i>	<i>No</i>		<i>14</i>	<i>9</i>	<i>18</i>			<i>41</i>

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Indicator	Type	Ezingoleni	Hibiscus	Umdoni	Umuziwabantu	Umzumbe	Vulamehlo	District Average
<i>Child under 5 years with diarrhoea admitted</i>	No		469	241	245			955
9. Child under 5 years pneumonia case fatality rate	Quarterly %	Not applicable	1.4%	3.4%	6.1%	Not applicable	Not applicable	3.0%
<i>Child under 5 years pneumonia death</i>	No	-	8	11	16	-	-	35
<i>Child under 5 years pneumonia admitted</i>	No	-	570	328	264	-	-	1 162
10. Child under 5 years severe acute malnutrition case fatality rate	Quarterly %	Not applicable	9.1%	15.7%	12.0%	Not applicable	Not applicable	12.5%
<i>Child under 5 years severe acute malnutrition death</i>	No	-	15	19	10	-	-	46
<i>Child under 5 years severe acute malnutrition admitted</i>	No	-	165	121	83	-	-	369
11. School Grade R screening coverage	Quarterly %	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
School Grade R learners screened	No.	-	-	-	-	-	-	-
School Grade R learners - total	No.	-	-	-	-	-	-	-
12. School Grade 1 screening coverage	Quarterly %	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
School Grade 1 learners screened	No.	-	-	-	-	-	-	-
School Grade 1 learners - total	No.	-	-	-	-	-	-	-
13. School Grade 8 screening coverage	Quarterly %	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
School Grade 8 learners	No.	-	-	-	-	-	-	-



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Indicator	Type	Ezinqoleni	Hibiscus	Umdoni	Umuziwabantu	Umzumbe	Vulamehlo	District Average
<i>screened</i>								
<i>School Grade 8 learners - total</i>	<i>No.</i>	-	-	-	-	-	-	-
14. Couple year protection rate	Quarterly %	36.9%	54.1%	44.8%	42.5%	28.9%	22.6%	41.9%
<i>Contraceptive years dispensed</i>	<i>No</i>	<i>5 151</i>	<i>40 650</i>	<i>10 063</i>	<i>10 800</i>	<i>11 816</i>	<i>4 526</i>	<i>83 004</i>
<i>Population 15-49 years female</i>	<i>No</i>	<i>12 846</i>	<i>69 304</i>	<i>20 608</i>	<i>23 450</i>	<i>37 378</i>	<i>18 358</i>	<i>181 944</i>
15. Cervical cancer screening coverage (amongst women)	Quarterly %	105.3%	68.6%	70.5%	128.3%	82.9%	132.4%	87.8% <sup>37</sup>
<i>Cervical cancer screening in women 30 years and older</i>	<i>No</i>	<i>1 086</i>	<i>3 906</i>	<i>1 246</i>	<i>2 215</i>	<i>2 594</i>	<i>1 992</i>	<i>13 039</i>
<i>Population 30 years and older female/10</i>	<i>No</i>	<i>10 251</i>	<i>56 591</i>	<i>17 577</i>	<i>17 170</i>	<i>31 104</i>	<i>14 957</i>	<i>147 650</i>
16. Human Papilloma Virus Vaccine 1 <sup>st</sup> Dose coverage	Annual %	New Indicator	New Indicator	New Indicator	New Indicator	New Indicator	New Indicator	New Indicator
<i>Numerator</i>	<i>No</i>	-	-	-	-	-	-	-
<i>Denominator</i>	<i>No</i>	-	-	-	-	-	-	-
17. Vitamin A dose12 – 59 months coverage	Quarterly %	43.2%	42.8%	49.5%	42.0%	41.2%	34%	41.9%
<i>Vitamin A dose 12 - 59 months</i>	<i>No</i>	<i>5 368</i>	<i>19 344</i>	<i>6 521</i>	<i>10 069</i>	<i>15 064</i>	<i>5 929</i>	<i>62 295</i>
<i>Population 12-59 months (multiplied by 2)</i>	<i>No</i>	<i>12 452</i>	<i>45 276</i>	<i>13 178</i>	<i>23 970</i>	<i>36 580</i>	<i>17 464</i>	<i>1 489 320</i>
18. Maternal mortality in facility ratio	Annual No per 100K	0.0	174.0	201.8	80.4	176.7	0.0	160.5
<i>Maternal death in facility</i>	<i>No</i>	<i>0</i>	<i>12</i>	<i>7</i>	<i>2</i>	<i>1</i>	<i>0</i>	<i>22</i>
<i>Live birth in facility</i>	<i>No</i>	<i>223</i>	<i>6 896</i>	<i>3 468</i>	<i>2 489</i>	<i>566</i>	<i>66</i>	<i>13 708</i>

<sup>37</sup> The data element was incorrectly interpreted and in some facilities, ALL women who underwent cancer screening were recorded against the age group 30 years and older.

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Indicator	Type	Ezingoleni	Hibiscus	Umdoni	Umuziwabantu	Umzumbe	Vulamehlo	District Average
19. Early neonatal death in facility rate	Annual Per 1 000	4.5	15.1	8.1	8.0	1.8	0	11.2
<i>Death in facility 0-7 days</i>	<i>No</i>	<i>1</i>	<i>85</i>	<i>28</i>	<i>20</i>	<i>1</i>	<i>0</i>	<i>135</i>
<i>Live birth in facility</i>	<i>No</i>	<i>223</i>	<i>6 896</i>	<i>3 468</i>	<i>24 89</i>	<i>566</i>	<i>66</i>	<i>13 708</i>

**Table 36 (NDoH 23): Performance Indicators for MCWH&N**

Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Target
			2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
1. Antenatal 1 <sup>st</sup> visits before 20 weeks rate	DHIS	Quarterly %	35.1%	49.3%	58.5%	59.9%	65%	72%	79.5%	60%
<i>Antenatal 1<sup>st</sup> visit before 20 weeks</i>	<i>DHIS / Tick register PHC</i>	<i>No</i>	<i>5 354</i>	<i>6 791</i>	<i>9 492</i>	<i>9 396</i>	<i>11 181</i>	<i>13 305</i>	<i>15 833</i>	
<i>Antenatal 1<sup>st</sup> visit total</i>	<i>DHIS calculates</i>	<i>No</i>	<i>14 942</i>	<i>13 770</i>	<i>16 136</i>	<i>15 678</i>	<i>16 979</i>	<i>18 388</i>	<i>19 914</i>	
2. Proportion of mothers visited within 6 days of delivering their babies	DHIS	Quarterly %	38.9%	76.6%	60.0%	59.3%	63%	65%	67%	74.4%
<i>Mother postnatal visit within 6 days after delivery</i>	<i>DHIS / Tick Register PHC</i>	<i>No</i>	<i>5 660</i>	<i>10 242</i>	<i>8 232</i>	<i>9 072</i>	<i>9 513</i>	<i>10 207</i>	<i>10 943</i>	
<i>Delivery in facility total</i>	<i>DHIS / Delivery register</i>	<i>No</i>	<i>12 494</i>	<i>13 469</i>	<i>13 710</i>	<i>14 520</i>	<i>15 100</i>	<i>15 704</i>	<i>16 333</i>	
3. Antenatal client initiated on ART rate	DHIS calculates	Annual %	Not available	Not available	91.3%	91.2%	98%	100%	100%	95%
<i>ANC client started on ART</i>	<i>ART Register</i>	<i>No</i>	<i>-</i>	<i>-</i>	<i>4 159</i>	<i>4 000</i>	<i>4 000</i>	<i>3 987</i>	<i>3 867</i>	
<i>ANC client eligible for ART initiation</i>	<i>ART Register</i>	<i>No</i>	<i>-</i>	<i>-</i>	<i>4 553</i>	<i>4 238</i>	<i>4 110</i>	<i>3 987</i>	<i>3 867</i>	
4. Infant 1 <sup>st</sup> PCR test positive	DHIS	Quarterly	3.2%	2.6%	2.1%	1.8%	1.4%	1.1%	0.9%	<1%

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Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Target
			2011/12	2012/13	2013/14		2015/16	2016/17	2017/18	
around 6 weeks rate		%								
<i>Infant 1<sup>st</sup> PCR test positive around 6 weeks</i>	<i>DHIS / Tick register PHC</i>	<i>No</i>	<i>192</i>	<i>150</i>	<i>116</i>	<i>108</i>	<i>89</i>	<i>74</i>	<i>62</i>	
<i>Infant 1<sup>st</sup> PCR test around 6 weeks</i>	<i>DHS / Tick Register PHC</i>	<i>No</i>	<i>6 324</i>	<i>5 772</i>	<i>5 498</i>	<i>5 994</i>	<i>6 251</i>	<i>6 520</i>	<i>6 800</i>	
5. Immunisation coverage under 1 year	DHIS	Quarterly %	95.9%	98.7%	73.7%	74.7%	80%	85%	90%	90%
<i>Immunised fully under 1 year new</i>	<i>DHIS / Tick register PHC</i>	<i>No</i>	<i>13 885</i>	<i>13 662</i>	<i>13 554</i>	<i>13 394</i>	<i>13 795</i>	<i>14 209</i>	<i>14 635</i>	
<i>Population under 1 year</i>	<i>DHIS / Stats SA</i>	<i>No</i>	<i>14680</i>	<i>13876</i>	<i>18525</i>	<i>18008</i>	<i>17353</i>	<i>16718</i>	<i>16096</i>	
6. Measles 2 <sup>nd</sup> dose coverage	DHIS	Quarterly %	Not available	69.8%	69.6%	70.5%	70%	73%	77%	85%
<i>Measles 2<sup>nd</sup> dose</i>	<i>DHIS / Tick register PHC</i>	<i>No</i>	<i>-</i>	<i>13 173</i>	<i>12 951</i>	<i>12 340</i>	<i>12 587</i>	<i>12 839</i>	<i>13 095</i>	
<i>Population 1 year</i>	<i>DHIS / Stats SA</i>	<i>No</i>	<i>-</i>	<i>18 864</i>	<i>18 688</i>	<i>18 367</i>	<i>17 932</i>	<i>17 499</i>	<i>17 041</i>	
7. DTaP-IPV-HepB-Hib 3 - Measles 1 <sup>st</sup> Dose drop-out rate	DHIS	Quarterly %	Not available	0.6%	4.3%	6.8%	6.1%	5.5%	5%	7%
<i>DTaP-IPV-HepB-Hib 3 to Measles1st dose drop-out</i>	<i>DHIS / Tick register PHC</i>	<i>No</i>	<i>-</i>	<i>-</i>	<i>615</i>	<i>1 000</i>	<i>1 000</i>	<i>-</i>	<i>-</i>	
<i>DTaP-IPV-HepB-Hib 3rd dose</i>	<i>DHIS / Tick register PHC</i>	<i>No</i>	<i>-</i>	<i>-</i>	<i>14 157</i>	<i>14 598</i>	<i>14 600</i>	<i>-</i>	<i>-</i>	
8. Child under 5 years diarrhoea case fatality rate	DHIS	Quarterly %	3.4%	5.0%	4.3%	2.8%	2%	1.5%	1.1%	3.2%
<i>Child under 5 years with diarrhoea death</i>	<i>DHIS / Tick register</i>	<i>No</i>	<i>15</i>	<i>34</i>	<i>41</i>	<i>26</i>	<i>20</i>	<i>16</i>	<i>13</i>	
<i>Child under 5 years with diarrhoea admitted</i>	<i>Admission Records</i>	<i>No</i>	<i>443</i>	<i>682</i>	<i>955</i>	<i>950</i>	<i>997</i>	<i>1 047</i>	<i>1 099</i>	

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Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Target
			2011/12	2012/13	2013/14		2014/15	2015/16	2016/17	
9. Child under 5 years pneumonia case fatality rate	DHIS	Quarterly %	3.3%	1.8%	3.0%	3.5%	2.8%	2.0%	1.8%	2.4%
Child under 5 years pneumonia death	DHIS / Tick register	No	19	16	35	50	50	50	50	
Child under 5 years pneumonia admitted	Admission records	No	569	875	1162	1 138	1 308	1 505	1 730	
10. Child under 5 years severe acute malnutrition case fatality rate	DHIS	Quarterly %	14.5%	10.9%	12.5%	10%	9%	8%	8.5%	8%
Child under 5 years severe acute malnutrition death	DHIS / Tick register	No	32	32	46	Not available	-	-	-	
Child under 5 years severe acute malnutrition admitted	Admission records	No	220	294	369	-	-	-	-	
11. School Grade R screening coverage	DHIS	Quarterly %	New indicator	New indicator	New indicator	New indicator	Baseline to be established	-	-	40%
School Grade R learners screened	DHIS / Tick register SHS	No.	-	-	-	-	-	-	-	
School Grade R learners - total	DHIS / DoE database	No.	-	-	-	-	-	-	-	
12. School Grade 1 screening coverage	DHIS	Quarterly %	New indicator	New indicator	New indicator	New indicator	Baseline to be established	-	-	55%
School Grade 1 learners screened	DHIS / Tick register SHS	No.	-	-	-	-	-	-	-	
School Grade 1 learners - total	DHIS / DoE database	No.	-	-	-	-	-	-	-	
13. School Grade 8 screening coverage	DHIS	Quarterly %	New indicator	New indicator	New indicator	New indicator	Baseline to be established	-	-	40%

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Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Target
			2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
<i>School Grade 8 learners screened</i>	<i>DHIS / Tick register SHS</i>	<i>No.</i>	-	-	-	-	-	-	-	
<i>School Grade 8 learners - total</i>	<i>DHIS / DoE database</i>	<i>No.</i>	-	-	-	-	-	-	-	
14. Couple year protection rate	DHIS	Quarterly %	27%	32.3%	41.9%	45%	50%	52%	54%	55%
<i>Contraceptive years dispensed</i>	<i>DHIS calculates</i>	<i>No</i>	<i>Not available</i>	<i>Not available</i>	<i>83004</i>	<i>89775</i>	<i>100888</i>	<i>106332</i>	<i>112199</i>	
<i>Population 15-49 years female</i>	<i>DHIS/Stats SA</i>	<i>No</i>	-	-	<i>197433</i>	<i>199499</i>	<i>201776</i>	<i>204485</i>	<i>207775</i>	
15. Cervical cancer screening coverage (amongst women)	DHIS	Quarterly %	71.5%	84.1%	87.8%	90%	92%	94%	96%	75%
<i>Cervical cancer screening in women 30 years and older</i>	<i>DHS / Tick register PHC / Hospital register</i>	<i>No</i>	<i>11 062</i>	<i>10 799</i>	<i>13 039</i>	<i>135 960</i>	<i>142 280</i>	<i>148 488</i>	<i>154 881</i>	
<i>Population 30 years and older female/10</i>	<i>DHIS / Stats SA</i>	<i>No</i>	<i>138 827</i>	<i>144 570</i>	<i>147 647</i>	<i>151 067</i>	<i>154 652</i>	<i>157 966</i>	<i>161 334</i>	
16. Human Papilloma Virus vaccine 1 <sup>st</sup> Dose coverage	DHIS	Annual %	Not reported	Not reported	Not reported	87%	89%	92%	94%	85%
<i>Numerator</i>	<i>DHIS / Tick register SHS</i>	<i>No</i>	-	-	-	<i>Not available</i>	-	-	-	
<i>Denominator</i>	<i>DHIS / DoE enrolment</i>	<i>No</i>	-	-	-		-	-	-	
17. Vitamin A dose 12 – 59 months coverage	DHIS	Quarterly %	45.3%	44.1%	41.9%	50.2%	53%	56%	60%	60%
<i>Vitamin A dose 12 - 59 months</i>	<i>DHIS / Tick register PHC</i>	<i>No</i>	<i>59 676</i>	<i>56 709</i>	<i>62 295</i>	<i>Not available</i>	<i>77 864</i>	<i>81 430</i>	<i>86 017</i>	
<i>Population 12-59 months (multiplied by 2)</i>	<i>DHIS / Stats SA</i>	<i>No</i>	<i>35 476</i>		<i>148 938</i>	<i>148 212</i>	<i>146 914</i>	<i>145 410</i>	<i>143 362</i>	

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Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Target
			2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
18. Maternal mortality in facility ratio	DHIS	Annual No per 100K	177.9	155.9	160.5	133.5	130	120	110	120
Maternal death in facility	DHIS / Midnight census	No	13	21	22	Not available	-	-	-	
Live birth in facility	DHIS / Delivery register	No	12 461	13 468	13 708	14 520	15 100	15 704	16 333	
19. Early neonatal death in facility rate	DHIS	Annual %	Not available	Not available	11.2%	10%	<10%	<8.5%	<7%	
Death in facility 0-7 days		No	-	-	135	Not available	<151	<133	<114	
Live birth in facility		No	-	-	13 708	14 520	15 100	15 704	16 333	

## UGU DISTRICT HEALTH PLAN 2015/16

**Table 37 (NDoH 24): District Objectives and Annual Targets for MCWH & N**

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/actual Performance			Estimated Performance	Medium Term Targets			Provincial target
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	
1. Reduce the infant mortality rate to 29 per 1000 live births by March 2020	Infant mortality rate	ASSA2008	Annual Rate per 1000	8.9	7.6	12	7.8	6.5	6	5.5	30.5
2. Reduce the under 5 mortality rate to 40 per 1000 live births by March 2020	Under 5 mortality rate	ASSA2008	Annual Rate per 1000	6.1	5.4	4.4	4.7	4.4	4	3.8	42
3. Reduce under 5 diarrhoea with dehydration incidence to less than 9.5 per 1000 by March 2020	6.1 Child under 5 years diarrhoea with dehydration incidence (annualised)	DHIS calculates	Annual No per 1000	14	16	17.1	12.2	11.8	11.4	11	12.9
	<i>Child under 5 years diarrhoea with dehydration new</i>	<i>PHC Tick Register</i>	<i>No</i>	<i>1 165</i>	<i>1 304</i>	<i>1 583</i>	<i>1 134</i>	<i>1 077</i>	<i>1 023</i>	<i>972</i>	
	<i>Population under 5 years</i>	<i>DHIS/Stats SA</i>	<i>No</i>	<i>81 006</i>	<i>78 518</i>	<i>92 994<sup>38</sup></i>	<i>92 114</i>	<i>90 810</i>	<i>89 423</i>	<i>87 777</i>	
4. Reduce the under-5 pneumonia incidence to less than 80 per 1000 by March 2020	7.1 Child under 5 years pneumonia incidence (annualised)	DHIS calculates	Annual No per 1000	187	177.9	110.5	108.5	89	73	61	88.9
	<i>Child under 5 years with pneumonia new</i>	<i>PHC Tick Register</i>	<i>No</i>	<i>15 054</i>	<i>13 892</i>	<i>10 254</i>	<i>10 000</i>	<i>8 100</i>	<i>6 561</i>	<i>5 314</i>	
	<i>Population under 5 years</i>	<i>DHIS/Stats SA</i>	<i>No</i>	<i>81 006</i>	<i>78 518</i>	<i>92 994<sup>39</sup></i>	<i>92 114</i>	<i>90 810</i>	<i>89 423</i>	<i>87 777</i>	

<sup>38</sup> DHIS  
<sup>3939</sup> DHIS

## UGU DISTRICT HEALTH PLAN 2015/16

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/actual Performance			Estimated Performance	Medium Term Targets			Provincial target
				2011/12	2012/13	2013/14		2015/16	2016/17	2017/18	
5. Reduce severe acute malnutrition incidence under 5 years to 4.6 per 1000 by March 2020	8.1 Child under 5 years severe acute malnutrition incidence (annualised)	DHIS calculates	Annual No per 1000	5.5	7.4	7.4	7.3	6.8	6.3	6.4	5.5
	<i>Child under 5 years with severe acute malnutrition new</i>	<i>DHIS/Tick register PHC</i>	<i>No</i>	442	295	684	658	625	593	564	
	<i>Population under 5 years</i>	<i>DHIS/Stats SA</i>	<i>No</i>	81 006	78 518	92 994 <sup>40</sup>	92 114	90 810	89 423	87 777	
6. Reduce the child under 1 year mortality in facility rate to less than 4% by March 2020	Child under 1 year mortality in facility rate (annualised)	DHIS	Annual %	8.5%	7.6%	12%	14.8%	13.3%	12.0%	10.8%	
	<i>Inpatient death under 1 year</i>	<i>DHIS calculates</i>	<i>No</i>	263	252	227	274	246	221	199	
	<i>Inpatient separations under 1 year</i>	<i>DHS calculates</i>	<i>No</i>	<i>Not available</i>	<i>Not available</i>	3 834	3 930	1 849	1 874	1 842	
7. Reduce the inpatient death under-5 rate to less than 4% by March 2020	5.1 Inpatient death under 5 years rate	DHIS	Annual Per 1 K	5.4	5.4	4.4	5.7	4.76	4.56	4.31	
	<i>Inpatient death under 5 years</i>	<i>DHIS calculates</i>	<i>No</i>	300	311	275	300	297	294	291	
	<i>Inpatient separations under 5 years</i>	<i>DHS calculates</i>	<i>No</i>	4 889	5 722	6 247	6 000	6 240	6 489	6 749	

<sup>40</sup> DHIS



## UGU DISTRICT HEALTH PLAN 2015/16

### 15.2 STRATEGIES/ ACTIVITIES TO BE IMPLEMENTED 2015/16

<i>Strategies</i>	<i>Activities</i>
1. Phila Mntwana project sustained in district to scale up screening for the big 5 namely TB, HIV, Pneumonia, Diarrhoeal diseases and malnutrition	Sustain existing Phila Mntwana. Set weekly or daily targets for CCGs for distribution of Vitamin A. Routing monitoring of data by Programme manager and PHCC. Continue to link CCG to baby post-delivery. Re-launch and realign Phila Mntwana Sites via OSS war rooms and clarification of roles-led by CCG facilitator and supported by programme manager. Discuss PM progress reports at DMT and feedback at war rooms. WBOTS supporting PMC. Local clinic to visit PMC to conduct deworming on certain days.
2. Improve identification and management of neonatal and child deaths	Implement KINC, Countdown to 2015, ESMOE, HBB, ETAT and new PMTCT/ART Policy guideline. Enhance the neonatal/paeds sections in referral policy. Hospitals to develop a plan for support from Province to district and District to PHC. Formal investigations of neonatal deaths using multisectoral teams. Improve outreach and support of Child PIPP meetings from Provincial to District hospitals. Enhance 4 hourly monitoring of children admitted with diarrhoea and vomiting. ORT corners at Clinics.  Implementing ESMOE operational plan and monitoring implementation at child Pip meetings which will be attended by stakeholders at all levels of care. Weekly radio slots on malnutrition/dietary diversity.  Training CCGs to conduct skin pinch test.  Maintain Mother and baby friendly status of health facilities and commence roll out to PHC to improve Breastfeeding practices. PSH to conduct feasibility assessment of milk bank.
3. Improve in-hospital management of SAM cases	Every SAM case audited by multi-disciplinary team and followed up by PHC, linked to nutrition advisor and CCG. Discuss cases at OSS LIT level-PHC to provide summary of closed cases.  Have a dedicated paed's corner in casualty for triaging and feeds. Develop a protocol for the linking of children to the CCG. Feedback to be provided to management at the monthly CHIPPP meetings.
4. Improve immunization coverage at low performing sites	Implement action plans that have been developed to improve handling of catch up data.  Catch up via outreach to crèches <sup>41</sup>
5. Prioritise maternal health performance	Implementation and scaling up of CARMMA. Implementation of mom-connect to empower pregnant women to lodge complaints, submit complements and received health messages. Monitoring the deployment of obstetric ambulances at the facility obstetric meetings (Involving programmes, EMS and facility).  Explore CCGs administering home pregnancy kits and implement SIYANQOBA QIP to link all ANC and Post-delivery women to CCGs.  Train Traditional Birth Attendants on early referral of pregnancy.  Conducting Zazi camps to address adolescent health education needs.
6. Improve handling of Vitamin A issued by CCGs	Weekly monitoring of CCG targets for Vitamin A distribution by clinics and PHCC
7. Improve contraceptive uptake and	Health education sessions and monthly monitoring of Implanon performance against targets at facility subdistrict and district levels. Staff training

<sup>41</sup> Resolution from DMT Oct 2014

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<i>Strategies</i>			<i>Activities</i>
address	misconceptions	around	and intensive marketing on all contraceptive methods. PHCCs to set and monitor facility targets
8.	Improve referral pattern adherence by all role-players		Recirculate referral pattern to all stakeholders, Explore if Turton can use PPT to transport women back to the clinic from where they were collected. EMS Harmonisation High volume MOUs- allocation of resources accordingly. Recirculate referral policy to all stakeholders including private ambulance services.

## 16. DISEASE PREVENTION AND CONTROL (ENVIRONMENTAL HEALTH INDICATORS)

### 16.1 PROGRAMME OVERVIEW

#### Strategic Challenges

1. Cataracts are being conducted but at a low rate
2. Poor prevention strategies resulting in a high rate of Diabetes and HPT. HPT is being noted commonly among younger HIV positive clients
3. The social determinants of health compound the prevalence of NCDs
4. Access to disability and rehab services is still a challenge
5. Mental health patient defaulter rate driven by multiple societal factors including substance abuse
6. High rate of trauma incidence within the District. Contributing factors include alcohol abuse, substance abuse, Motor Vehicle accidents and violence.
7. Dog bites are still a challenge within the district. Contributing factors include stray dogs and properties not having perimeter fencing<sup>42</sup>. In addition the management of rabies vaccine administration has been identified as a challenge.
8. Unemployment, poverty, peer pressure, substance abuse and depression resulting in para-suicides<sup>44</sup>. Asthma, COPD and Epilepsy not well managed

**Table 38 (NDoH 25): Situational Analysis for Disease Prevention and Control - 2013/14 Financial Year**

Indicator	Type	Ezinqoleni	Hibiscus	Umdoni	Umuziwabantu	Umkumbe	Vulamehlo	District Avg
1. Clients screened for hypertension	Quarterly No	Not available	Not available	Not available	Not available	Not available	Not available	Not available
2. Clients screened for diabetes	Quarterly No	Not available	Not available	Not available	Not available	Not available	Not available	Not available
3. Percentage of people screened for mental disorders	Quarterly %	Not available	Not available	Not available	Not available	Not available	Not available	Not available
<i>PHC Client screened for mental disorders</i>	No							
<i>PHC headcount total</i>	No							

<sup>42</sup> DHP session-Community disease prevention commission

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Indicator	Type	Ezingoleni	Hibiscus	Umdoni	Umuziwabantu	Umzumbe	Vulamehlo	District Avg
4. Percentage of people treated for mental disorders	Quarterly %	Not available	Not available	Not available	Not available	Not available	Not available	Not available
<i>Client treated for mental disorders at PHC level</i>	<i>No</i>	-	-	-	-	-	-	-
<i>Clients screened for mental disorders at PHC level</i>	<i>No</i>	-	-	-	-	-	-	-
5. Cataract surgery rate	No per million uninsured population	0	734.9	1870.7	1036.5	0	0	602.5
<i>Cataract surgery total</i>	<i>No</i>	-	191	149	103	-	-	443
<i>Population uninsured total</i>	<i>No</i>	-	-	-	-	-	-	-
6. Malaria case fatality rate	%	0	0	0	0	0	0	0
<i>Malaria death reported</i>	<i>No</i>	-	-	-	-	-	-	-
<i>Number of malaria cases (new)</i>	<i>No</i>	-	-	-	-	-	-	-

**Table 39 (NDoH 26): Performance Indicators for Environmental Health Services**

	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Targets
			2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
1. Clients screened for hypertension	DHIS / Tick register	Quarterly No	Not available	Not available	Not available	Not available	Baseline to be established	-	-	
2. Clients screened for diabetes	DHIS / Tick register	Quarterly No	Not available	Not available	Not available	Not available	Baseline to be established	-	-	
3. Percentage of people screened for mental disorders	DHIS calculates	Quarterly %	Not available	Not available	Not available	Not available	Baseline to be established	-	-	
<i>PHC Client screened for mental disorders</i>	<i>DHIS / Tick register</i>	<i>No</i>	-	-	-	-	-	-	-	

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	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial Targets
			2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
<i>PHC headcount total</i>	<i>DHIS / Tick Register</i>	<i>No</i>	-	-	-	-	-	-	-	
4. Percentage of people treated for mental disorders	DHIS Calculates	Quarterly %	Not available	Not available	Not available	Not available	Baseline to be established	-	-	
<i>Client treated for mental disorders at PHC level</i>	<i>DHIS / Tick register</i>	<i>No</i>	-	-	-	-	-	-	-	
<i>Clients screened for mental disorders at PHC level</i>	<i>DHIS / Tick register</i>	<i>No</i>	-	-	-	-	-	-	-	
5. Cataract surgery rate	DHIS	Quarterly No per 1 mil uninsured population	247.3	678.9	602.5	1038.4	1089	1144	1201	930
<i>Cataract surgery total</i>	<i>DHIS / Theatre register</i>	<i>No</i>	150	522	443	1 096	757	805	854	
<i>Population uninsured total</i>	<i>DHIS / Stats SA</i>	<i>No</i>	606 566	612 913	679 578	687 408	695 449	703 717	711 176	
6. Malaria case fatality rate	Malaria Register	Annual %	0	0	0	0	0	0	0	<0.5
<i>Malaria death reported</i>	<i>Malaria register / Tick register PHC</i>	<i>No</i>	0	0	0	0	0	0	0	
<i>Number of malaria cases (new)</i>	<i>Malaria register / Tick register PHC</i>	<i>No</i>	0	0	0	0	0	0	0	

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**Note:** Where targets and performance are indicated as a percentage, the district should also include the numerator and denominator.

- This table makes provision for district indicators to monitor implementation of your strategies. This must be ultimately aligned with the APP (although the district indicators will be more comprehensive and district-specific).

**Table 40 (NDoH 27): District Objectives and Annual Targets for Environmental Health Services**

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets			Provincial target
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	
1.	Malaria incidence per 1000 population at risk	Malaria register	Annual Per 1000 population at risk	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	
	<i>Number of malaria cases (new)</i>	<i>Malaria register/Tick register PHC</i>	<i>No</i>	-	-	-	-	-	-	-	
	<i>Ugu</i>	<i>DHIS/Stats SA</i>	<i>Population</i>	-	-	-	-	-	-	-	
2.	Hypertension incidence (annualised)	DHIS	Quarterly No per 100	21.5	23.3	21.5	24.9	24	23	22	18.9
	<i>Hypertension client treatment new</i>	<i>DHIS / PHC tick registers</i>	<i>No</i>	<i>3 166</i>	<i>3 823</i>	<i>4 530</i>	<i>4 690</i>	<i>3 589</i>	<i>3 475</i>	<i>3 359</i>	
	<i>Population 40 years and older</i>	<i>DHIS / Stats SA</i>	<i>No</i>	<i>147 109</i>	<i>164 385</i>	<i>147 109</i>	<i>148 284</i>	<i>149 572</i>	<i>151 091</i>	<i>152 726</i>	
3.	Diabetes incidence (annualised)	DHIS	Quarterly No per 100	1.6	1.4	1.8	1.5	1.5	1.5	1.5	1.5
	<i>Diabetes client treatment new</i>	<i>DHIS / PHC tick registers</i>	<i>No</i>	<i>1 202</i>	<i>1 079</i>	<i>1 288</i>	<i>1 176</i>	<i>1 125</i>	<i>1 138</i>	<i>1 150</i>	
	<i>Population total</i>	<i>DHIS / Stats SA</i>	<i>No</i>	<i>764 584</i>	<i>768 001</i>	<i>733 228</i>	<i>741 541</i>	<i>750 215</i>	<i>759 134</i>	<i>767 181</i>	

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### 16.2 STRATEGIES/ ACTIVITIES TO BE IMPLEMENTED 2015/16

Strategies	Activities
1. Close monitoring of implementation of eye health services relative to targets	Continue quarterly eye health meetings and address challenges with cataracts at this forum
2. Improve prevention and early detection of chronic diseases	Roll out of ICDM and PC101 in the District Increase number of schools accredited as health promoting schools- 1 per LM for new Financial year
3. Integrated ward based services	Turton to revisit the functioning of the substance abuse/mental health management package within Umzumbe <sup>43</sup>
4. Improve access to disability and rehab services by the framework and model for rehab.	Programme manager to establish rehab forum within the district. Develop operational plan for implementing rehab framework and monitor at quarterly rehab forum meetings. School health to screen learners for substance abuse.
5. Improve comprehensive management of mental health clients and strengthen discharge plan	Involve DSD and social workers in social assessment of all mental health clients via OSS as referrals to the war room/LTI by OMs and hospital OSS reps. Re-establish community psychiatric services. Psychiatric team to conduct tracing of defaulters. Intensified screening by planned outreach campaigns per Subdistrict. Initiate District substance abuse forum with DSD and other stakeholders. Initiate screening of substance abuse at schools. Re-establish community psychiatric services within the district.
6. Reduce incidence of trauma with intersectoral collaboration with stakeholders including SAPS, DSD, DOE, RTI, DOT	Involve Hospital board and clinic committee members in planning awareness activities- 1 awareness in high incident facilities.
7. Limit the complications arising from dog bites	Reinforce the by-laws for dog licencing-address via OSS in areas with high incidence of dog bites. Improve inoculation of dogs- Rabies campaign. Monitor the use cost of treatment of dog bites and monitor for compliance to policy (pharmacy).
8. Early identification and management of potential para-suicide. Improve early identification, prevention and management of asthma, COPD and epilepsy	Awareness campaigns via OSS. Linking patients to CCGs. Re-establish community psychiatric services within the district. Formation of support groups in poor performing areas.

<sup>43</sup> Resolution from Oct 2014 DMT

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### 17. INFRASTRUCTURE, EQUIPMENT AND OTHER SUPPORT SERVICES

Table 41 (NDoH 38): Performance Indicators for Health Facilities Management

Indicator	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
1. Expenditure on facility maintenance as % of total district health expenditure	%	1	2	1	2	2	2	2	
<i>Numerator</i>									
<i>Denominator</i>									
2. Number of facilities that have undergone major and minor refurbishment									
3. Fixed PHC facilities with access to continuous supply of clean portable water	%	100%	100%	100%	100%	100%	100%	100%	
<i>Numerator</i>		54	54	54	54	54	54	54	
<i>Denominator</i>		54	54	54	54	54	54	54	
4. Fixed PHC facilities with access to continuous supply of electricity	%	100%	100%	100%	100%	100%	100%	100%	
<i>Numerator</i>		54	54	54	54	54	54	54	
<i>Denominator</i>		54	54	54	54	54	54	54	
5. Fixed PHC facilities with access to sanitation		100%	100%	100%	100%	100%	100%	100%	
<i>Numerator</i>		54	54	54	54	54	54	54	
<i>Denominator</i>		54	54	54	54	54	54	54	
6. Fixed PHC facilities with access to fixed telephone line	%	100	100%	100%	100%	100%	100%	100%	



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Indicator	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
	Numerator	54	54	54	54	54	54	54	
	Denominator	54	54	54	54	54	54	54	
7. Percentage of PHC facilities with network access		New indicator	New indicator	New indicator	New indicator	Baseline to be established	-	-	
	Numerator								
	Denominator								
8. Number of additional clinics and community health centres constructed		2	0	0	0	1	0	0	

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### 18. SUPPORT SERVICES

This section of the DHP addresses the support services, which enable health workers to operate and provide the actual health services, namely:

- Pharmaceutical services;
- Equipment and Maintenance; and
- Transport and EMRS.

#### 18.1 PHARMACEUTICAL SERVICES

**Table 42 (NDoH 39): Pharmaceutical Services Performance Indicators**

Indicators	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2011/12	2012/13	2013/14		2015/16	2016/17	2017/18	
1. Percentage of institutions (District Hospitals and CHC's) with functional of Pharmaceutical and Therapeutics Committees (PTC's)	%	Not available	Not available	<i>Not available</i>	100%	100%	100%	100%	100%
<i>Number of CHC's and District Hospitals with functional Pharmaceutical and Therapeutic Committees</i>	<i>No</i>	-	-	-	5	5	5	5	5
<i>Number of District Hospitals and CHC's</i>	<i>No</i>	-	-	-	5	5	5	5	5
2. Any ARV Drug Stock Out Rate	%	Not available	Not available	Not available	0%	0%	0%	0%	
<i>Number of ARV drug's out of stock</i>	<i>No</i>	-	-	-	-	-	-	-	
<i>Number of ARV's drugs</i>	<i>No</i>	-	-	-	-	-	-	-	

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Indicators	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2011/12	2012/13	2013/14		2015/16	2016/17	2017/18	
3. Any TB Stock Out Rate <i>Number of TB drugs out of stock</i> <i>Number of TB drugs</i>	%					0	0	0	
4. Percentage of Hospitals with Pharmacists <i>Number of District Hospitals with Pharmacists</i> <i>Number of District Hospitals</i>	%	100%	100%	100%	100%	100%	100%	100%	100%
		3	3	3	3	3	3	3	
		3	3	3	3	3	3	3	
5. Percentage of CHC's with Pharmacists <i>Number of CHC's with pharmacists</i> <i>Number of CHC's</i>	%	N/A	100%	100%	100%	100%	100%	100%	100%
		0	2	2	2	2	2	2	2
		0	2	2	2	2	2	2	2

**Table 43 (NDoH 30): Pharmaceutical Services**

Strategic Objective	Performance Indicator	Data source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14		2015/16	2016/17	2017/18
	1. Percentage of Pharmacies that obtained A and B grading on inspection <i>Pharmacies with A or B Grading</i> <i>Number of pharmacies</i>	Pharmacy records  <i>Pharmacy records</i>  <i>Pharmacy records</i>	Annual %  <i>No</i>  <i>No</i>	100%	100%	100%	100%	100%	100%	100%
						6	6	6	6	6
				6	6	6	6	6	6	6

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Strategic Objective	Performance Indicator	Data source	Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14		2014/15	2015/16	2016/17
	2. Tracer medicine stock-out rate (PPSD)	Pharmacy records	Quarterly %	11%	7%	1.23%	1%	<1%	<1%	0
	Number of tracer medicine out of stock	Pharmacy records	No	-	-	-	-	-	-	-
	Total number of tracer medicine expected to be in stock	Pharmacy records	No	-	-	-	-	-	-	-
	3. Tracer medicine stock-out rate (Institutions)	Pharmacy records	Quarterly %	33%	6.7%	2%	1%	<1%	<1%	0
	Number of tracer medicines stock out in bulk store	Pharmacy records	No	-	-	-	-	-	-	-
	Number of tracer medicines expected to be stocked in the bulk store	Pharmacy records	No	-	-	-	-	-	-	-
	4. Number of mortuaries rationalised	Management	Annual No	Not reported	Not reported	-	-	-	-	-

### STRATEGIES/ACTIVITIES FOR PHARMACY MANAGEMENT

Strategies	Activities
1. Monitor the data flow at Non medical sites	District DIO to consult with All FIOs and Pharmacy managers to develop a system of monitoring data for medicines dispensed at non-medical sites.
2. Sustain PTC Committee meetings in the district	District Pharmacy Manager to establish/Sustain PTC committee on a quarterly basis. Monitor the pharmaceutical management of dog bites within the district in collaboration with District CDC manager.

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### 18.2 EQUIPMENT AND MAINTENANCE

**Table 44: District Equipment and Maintenance**

Indicators	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target 2015/16
		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	
1. Number of districts spending more than 90% of maintenance budget		1	1	1	1	1	1	1	11
2. Proportion of infrastructure budget allocated to maintenance		1.39%	1.64%	1.72%	2%	2.1%	2.2%	2.3%	
<i>Numerator</i>									
<i>Denominator</i>									
3. Proportion of Programme 8 ( infrastructure budget) spent on all maintenance (preventative and scheduled)			10	11	12	13	15	16	
<i>Numerator</i>									
<i>Denominator</i>									

### 18.3 EMERGENCY MEDICAL SERVICES (EMS)

Figures on the table below are calculated based on the schedule status and population of each Local municipality. Out of the 15 scheduled vehicles for Ugu District none are allocated to Ezinqoleni & Vulamehlo. Umuziwabantu = 3. Umzumbe = 2. Umdoni = 4. Hibiscus Coast = 6. Estimates & projections will be the same as 2013/2014 unless there is a change in the schedule or a change of over 10000 in the population.

**Table 45 (NDoH 31 (a)): Operational Ambulances per 10,000 Population Coverage (inclusive of LG)**

District	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
Hibiscus Coast		0.14(7)	02(5)	0.24(6)	0.24(6)	0.24(6)	0.28(7)	0.32(8)	1(25)

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District	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
Ezinqoleni			n/a	n/a	n/a	n/a	n/a	n/a	1(5)
Umzumbe			0.1(2)	0.1(2)	0.1(2)	0.1(2)	0.18(3)	0.25(4)	1(16)
Umdoni		0.2(4)	0.5(4)	0.5(4)	0.5(4)	0.5(4)	0.62(5)	0.75(6)	1(8)
Vulamehlo			n/a	n/a	n/a	n/a	n/a	n/a	1(8)
Umuziwabantu		0.4(4)	0.4(4)	0.3(3)	0.3(3)	0.3(3)	0.4(4)	0.5(5)	1(10)

**Table 46 (NDoH 31 (b)): Ambulance Response Time Rural under 40 minutes (Inclusive of LG)**

	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
Hibiscus Coast	26%	31.5%	36.5%	38.5%	40.5%	42.5%	44.5%	40%
Ezinqoleni	14%	13.4%	12.9%	14.9%	16.9%	18.9%	20.9%	40%
Umzumbe	11%	15.1%	19.1%	21.1%	23.1%	25.1%	27.1%	40%
Umdoni	35%	31.7%	39.8%	41.8%	43.8%	45.8%	47.8%	40%
Vulamehlo	12%	9.2%	11.2%	13.2%	15.2%	17.2%	19.2%	40%
Umuziwabantu	11%	12.1%	12.4%	14.4%	16.4%	18.4%	20.4%	40%

**Table 47 (NDoH 31(c)): Ambulance Response Times Urban under 15 minutes (Inclusive of LG)**

Ambulance Response Time: Urban	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16

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Ambulance Response Time: Urban	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
Hibiscus Coast	8%	7.8%	7.2%	9.2%	11.2%	13.2%	15.2%	15%
Ezinqoleni	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Umzumbe	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Umdoni	6%	7.3%	6.7%	8.7%	10.7%	12.7%	14.7%	15%
Vulamehlo	3%	2.7%	3.3%	5.3%	7.3%	9.3%	11.3%	15%
Umuziwabantu	3%	4.0%	2.6%	4.6%	6.6%	8.6%	10.6%	15%
District Average								

**Ezinqoleni & Umzumbe are completely rural.**

**Table 48 (NDoH 31 (d)): EMS Inter-facility Transfer Rate**

District	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
Inter-facility Transfer Rate – UGU	%	23%	34%	34%	37%	38%	39%	40%	34%

During the DHER discussions at the CHC session, there was some discussion over the EMS bypassing Turton if clients are collected from the Mabheleni area (close to Hibiscus). This will be pursued by follow up with EMS and recirculating the facility catchment clinics.

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### 19. HUMAN RESOURCES

**Table 49 (NDoH 32): Performance for Human Resources**

	TOTAL POSTS FILLED	Audited/ Actual performance			Estimate	MTEF Projection		
		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
<b>Health district</b>	<b>Personnel category1</b>							
<b>Ezingoleni</b>	<b>PHC facilities</b>							
	Medical officers							
	Professional nurses	23	25	27				
	Pharmacists							
	<b>District hospitals</b>							
	Medical officers							
	Professional nurses							
	Pharmacists							
	Radiographers							
<b>Hibiscus</b>	<b>PHC facilities</b>							
	Medical officers	3	6	8				
	Professional nurses	111	144	147				
	Pharmacists	1	1	2				
	<b>District hospitals</b>							
	Medical officers	11	15	14				
	Professional nurses	87	115	118				
	Pharmacists	4	5	5				
	Radiographers	3	3	3				
<b>Umdoni</b>	<b>PHC facilities</b>							



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	TOTAL POSTS FILLED	Audited/ Actual performance			Estimate	MTEF Projection		
		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	Medical officers							
	Professional nurses	27	43	41				
	Pharmacists							
	<b>District hospitals</b>							
	Medical officers	20	21	20				
	Professional nurses	113	123	125				
	Pharmacists	8	10	10				
	Radiographers	4	3	3				
Umuziwabantu	<b>PHC facilities</b>							
	Medical officers							
	Professional nurses	25	43	46				
	Pharmacists							
	<b>District hospitals</b>							
	Medical officers	6	6	8				
	Professional nurses	52	71	68				
	Pharmacists	1	2	2				
Umzumbe	Radiographers	0	0	1				
	<b>PHC facilities</b>							
	Medical officers	1	6	7				
	Professional nurses	73	90	91				
	Pharmacists	0	2	3				
	<b>District hospitals</b>							
	Medical officers							

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	TOTAL POSTS FILLED	Audited/ Actual performance			Estimate	MTEF Projection		
		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Vulamehlo	Professional nurses							
	Pharmacists							
	Radiographers							
	<b>PHC facilities</b>							
	Medical officers							
	Professional nurses	21	21					
	Pharmacists							
	<b>District hospitals</b>							
	Medical officers							
	Professional nurses							
District	Pharmacists							
	Radiographers							
	<b>PHC facilities</b>							
	Medical officers	4	12					
	Professional nurses	280	366					
	Pharmacists	1	3					
	<b>District hospitals</b>							
	Medical officers	37	42					
	Professional nurses	252	309					
	Pharmacists	13	17					
	Radiographers	7	6					

Table 50 (NDoH 33): Plans for Health Science and Training

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	INDICATORS	Estimated performance	Medium term targets		
		2014/15	2015/16	2016/17	2017/18

### STRATEGIES /ACTIVITIES FOR HR

Motivating for family accommodation at clinics and hospitals with the highest staff turnovers.

Proper management of sick leave and taking appropriate action.

All managers are responsible to link operational plans to EPMDS- work plans.

District to motivate for additional supervisors if funding permits, alternatively redistribution of the clinics as some sub districts have more clinics than others.)

Prioritise St Andrews Hospital for placement of bursary holders.

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### 20. DISTRICT FINANCE PLAN

**Table 51 (NDoH 34): District Health MTEF Projections**

Sub-programme	Audited outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
R' thousand	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
District Management	12 091 253	16 187 634	18 192 106	17 820 000			18 711 000	19 647 000	20 629 000
Clinics	208 904 413	231 153 594	265 318 116	284 337 000			298 554 000	313 482 000	329 156 000
Community Health Centres	27 688 151	84 817 424	107 678 0712	117 053 000			122 906 000	129 051 000	135 504 000
Community Services	4 026 000	-		0			0	0	0
Other Community	39 502 886	45 404 141	56 199 057	69 499 000			74 744 250	78 482 000	82 406 000
Coroner Services	12 721 622	13 466 169	13 771 216	14 444 000			15 167 000	15 925 000	16 721 000
HIV and AIDS	135 949 499	189 349 936	232 779 906	215 789 000			226 579 000	237 908 000	249 803 000
Nutrition	5 169 668	3 197 379	4 070 981	3 591 000			3 771 000	3 960 000	4 158 000
District Hospitals	330 375 005	402 699 773	463 734 426	503 106 000			528 262 000	554 675 000	582 409 000
Environmental Health Services	6 767 872	6 480 865	6 156 034	1 686 000			0	0	0
<b>TOTAL</b>	<b>783 196 369</b>	<b>992 756 917</b>	<b>1 167 899 915</b>	<b>1 220 588 000</b>			<b>1 288 692 000</b>	<b>1 353 126 000</b>	<b>1 420 783 000</b>

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**Table 52 (NDoH 35): District Health MTEF Projections per Economic Classification**

R' Thousands	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Current payments	759 253 761	965 210 582	1 151 200 064	1 227 325 000			1 281 618 000	1 345 699 000	1 412 984 000
Compensation of employees	563 704 246	719 319 334	847 419 149	904 877 000			950 121 000	997 627 000	1 047 509 000
Goods and services	195 549 515	245 891 248	303 780 914	315 711 000			331 497 000	348 072 000	365 475 000
Transfers and subsidies to	11 246 294	15 774 167	4 396 953	4 866 000			5 109 000	5 366 000	5 634 000
Payments for capital assets	12 696 315	11 772 167	12 302 897	1 871 000			1 964 000	2 063 000	2 166 000
Total economic classification	783 196 370	992 756 917	1 167 899 915	1 227 325 000			1 288 692 000	1 3 53 126 000	1 420 783 000

### STRATEGIES /ACTIVITIES FOR FINANCE

Murchison Hospital Security expenditure falls under COE and not security services. Murchison hospital to allocate larger budget to COE and less to security services.

Monthly journals/recovery of expenses for PHC to be done by facility finance managers.

## UGU DISTRICT HEALTH PLAN 2015/16

### PART C: LINKS TO OTHER PLANS

#### 21. CONDITIONAL GRANTS (WHERE APPLICABLE)

**Table 53 (NDOH 36): Outputs of a result of Conditional Grants**

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Case prepared for each Conditional Grant)	Indicator targets for 2015/16
<b>COMPREHENSIVE HIV AIDS CONDITIONAL GRANT</b> ( <i>Applicable to all Districts</i> )	• To enable the health sector to develop an effective response to HIV and AIDS including universal access to HIV Counselling and Testing	1. Total Number of fixed public health facilities offering ART Services	61
	• To support the implements of the National operational plan for comprehensive HIV and AIDS treatment and care	2. Number of new patients that started on ART	19694 <sup>44</sup>
	To subsidise in-part funding for the antiretroviral treatment plan	3. Total number of patients on ART remaining in care.	80895
		4. Number of beneficiaries served by home-based categories	1000000
		5. Number of active home-based carers receiving stipends	1500
		6. Number of male and female condoms distributed	20 000 000 male 500 000 female
		7. Number of High Transmission Areas (HTA) intervention sites	6
		8. Number of Antenatal Care (ANC) clients initiated on lifelong ART	4000
		9. Number of babies Polymerase Chain Reaction (PCR) tested at 6 weeks	6251 <sup>45</sup>

<sup>44</sup> HAST Business plan

<sup>45</sup> Target setting tool

## UGU DISTRICT HEALTH PLAN 2015/16

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Case prepared for each Conditional Grant)	Indicator targets for 2015/16
		10. Number of HIV positive clients screened for TB	45000
		11. Number of HIV positive patients that started on IPT	
		12. Number of active lay counselors on stipends	0
		13. Number of clients pre-test counselled on HIV testing (including Antenatal)	260 000
		14. Number of HIV tests done	250 000
		15. Number of health facilities offering MMC services	Roving team offering at all facilities
		16. Number of Medical Male Circumcisions performed	38000
		17. Sexual assault cases offered ARV prophylaxis	400
		18. Step down care (SDC) facilities/units	1
		19. Doctors and professional nurses training on HIV/AIDS, STIs, TB and chronic diseases	800

## 22. PUBLIC-PRIVATE PARTNERSHIPS (PPPS) AND PUBLIC PRIVATE MIX (PPM)

Districts are required to indicate which of their PPPs will be ending during the planning period, and outline steps being put in place to ensure a smooth transfer of responsibilities. National Treasury also requires an outline of outputs to be achieved through PPPs.

**Table 54 (NDoH 38): Outputs as a result of PPP and PPM**

Name of PPP or PPM	Purpose	Outputs	Current Annual Budget (R'Thousand)	Date of Termination	Measures to ensure smooth transfer of responsibilities
1. Genesis Care Centre	Step down unit	Reduce average length of	3 095 000	Renewable annually	Not applicable at present

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Name of PPP or PPM	Purpose	Outputs	Current Annual Budget (R'Thousand)	Date of Termination	Measures to ensure smooth transfer of responsibilities
		stay at district hospitals			time
2. Happy hours Nyangwini Home	Caring for mentally challenged children. Day care facility. Therapists from Turton CHC and GJC as well as mental health programme coordinator conduct monthly visit.	Referral site for stable children in Umzumbe	21 children 273 000	Renewable Annually	Not applicable at present

Partner's forum revived and quarterly meetings have been set. Memorandums of agreement will be sought from all and reporting will improve by the development of partner data collection tools to all partners working in Ugu.



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### PART E: INDICATOR DEFINITIONS

Indicator	Short Definition	Purpose of Indicator	Primary Source	APP Source	Method of Calculation	Calculation Type	Type of Indicator	Reporting Cycle	Data Limitations	Desired Performance	Indicator Responsibility

Use this template if district has added any indicators throughout the document.

### STRATEGIES/ACTIVITIES FOR DATA MANAGEMENT

1.	Improve data management within the district	Capacitate Oms on use and ownership of information. Include data management (validation and verification) in EPMDs of Oms. Pilot DHIS project at clinic level.
2.	Monitor the data flow at Non medical sites	District DIO to consult with All FIOs and Pharmacy managers to develop a system of monitoring data for medicines dispensed at non-medical sites.