health

Department:
Health
PROVINCE OF KWAZULU-NATAL

DISTRICT HEALTH PLAN 2015/2016

UMZINYATHI DISTRICT

KWAZULU-NATAL

STATEMENT BY THE DISTRICT MANAGER

I am pleased to present the Umzinyathi District Health Plan (DHP) for 2015/16. The district will focus on the following areas:

1. On achieving Global, National and Provincial Strategies; to do this the DHP and the Operational Plan are aligned to the; Millennium Development Goals; National Development Plan 2030; Medium Term Strategic Framework 2014-2019; Provincial Growth And Development Plan 2030; KZN DoH Provincial Strategic Goals 2015 -2019; the Annual Performance Plan 2015/16 and the State of the Nation Address 2015/16.

2. Umzinyathi District will focus on, Community Dialogues. The district believes that health solutions lie with the communities, families and individuals, who must take ownership and responsibility of their health. It is for this reason that the district is focusing on a community based approach through Community Dialogues.
The district is modelling the Household Champions Program which aims at having households that are health orientated and self-reliant. Currently there are 200 Household Champions (50 in each of the 4 Sub-Districts) this number will be increased to 400 Household Champions. The concept of using peers (Ground Breakers) by Municipal Ward Based Outreach Teams is being modelled to positively influence sexual & reproductive health especially reducing teenage pregnancy.

3. Umzinyathi being a NHI pilot district will focus on improving; Universal Access, Equity and Quality Service Delivery. Focus on "Operation Phakisa" on Scaling up the Ideal Clinic Initiative is aimed at promoting efficiency, effectiveness and professionalism in clinics.National Core Standards and Ideal Clinic assessments will be intensified. An electronic patient record system will be piloted at hospital and clinic level. The procument of "Square caravans" for MWBOTs is on the NHI business plan. PHC Indabas will be held and District and sub district Health Forum will be established

4. The district will focus on improving it's poor performing indicators, through regular performance reviews, root cause analysis and action planning.

5. The district will focus on equitable resource allocation (Finance, Human Resources, equipment, and capital assets) to improve service delivery.

6. The district commits to work closely with various stakeholders; Local Government, Inter Governmental Departments; Traditional Leaderships; Hospital Boards; Clinic Committees; War Room Structures; NGOs, CBOs, FBOs; Private Doctors, Traditional Healers and the Community to achieve the 4 main outputs (1) Increase Life Expectancy; (2) Decrease Maternal And Child Mortality; (3) Combating HIV and AIDS and Decrease The Burden Of Disease; (4) Strengthen Health Systems Effectiveness.

Lastly, with team work and commitment of all staff, Umzinyathi Vision of being " A leader in providing District Health Services within South Africa and in African countries." can be achieved. As public servants we are here to serve the public.

1. ACKNOWLEDGEMENTS

The District Health Plan has been made possible by the collective efforts of a number of people from various departments and units. We would like to acknowledge in particular

District Manager

Deputy Manager: Planning, Monitoring and Evaluation

Deputy Manager: Planner

Deputy Manager: Finance

Manager: Pharmacy

Deputy Manager: NHI (National Health Insurance)

Hospital Management Teams

Finance and Systems Managers and Team

Human Resource Managers and Team

PHC Coordinators and Team

District Program Managers (Senior Technical Advisors)

District Information Officer and Team

Maintenance Team

District Clinical Specialist Team

Emergency Medical Services Manager and Team

2. OFFICIAL SIGN OFF

It is hereby certified that this District Health Plan:

- Was developed by the district management team of **Umzinyathi 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

J. MNDEBELE
Name
District Manager: DHS

Signature

Date: 2015/03/20

Mr M.M. Zungu
Acting DDG: DHS

Signature

Date: 2015/03/27

Dr S. Zungu
Head of Department

Signature

Date: 31. 03. 2015

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4. LIST OF ACRONYMS

Abbreviations	Description
A	
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
APP	Annual Performance Plan
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
B	
BAS	Basic Accounting System
BLS	Basic Life Support
BUR	Bed Utilisation Rate
C	
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
D	
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
DORA	Division Of Revenue Act
DQPR	District Quarterly Progress Report
E	
EMS	Emergency Medical Services
ESMOE	Essential Steps in the Management of Obstetrics Emergencies
ETB.R	Electronic Tuberculosis Register
ETR.net	Electronic Register for TB
F	
G	
G&S	Goods and Services
H	
HAST	HIV, AIDS, STI and TB
HCT	HIV Counselling and Testing
HIV	Human Immuno Virus
HOD	Head of Department
HPS	Health Promoting Schools

Abbreviations	Description
HPV	Human papillo virus
HR	Human Resources
HTA	High Transmission Area
	I
IDP(s)	Integrated Development Plan(s)
IPT	Ionized Preventive Therapy
ISHP	Integrated School Health Programme
	J
	K
KZN	KwaZulu-Natal
	L
LG	Local Government
	M
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
	N
NDOH	National Department of Health
NCS	National Core Standards
NGO(s)	Non-Governmental Organisation(s)
NHI	National Health Insurance
NIMART	Nurse Initiated and Managed Antiretroviral Therapy
	O
OSD	Occupation Specific Dispensation
OSS	Operation Sukuma Sakhe
	P
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
	R

Abbreviations	Description
RV	Rota Virus Vaccine
S	
SCM	Supply Chain Management
SHS	School Health Services
SLA	Service Level Agreement
Stats SA	Statistics South Africa
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

Umzinyathi District is located in the north central region of KwaZulu Natal. The district has an estimated population of 514,217 distributed as follows; Msinga has the highest population 35% (177,265) followed by Nquthu 32 % (166,215) followed by Umvoti 20% (104,417) and Endumeni 13% (66,320). The population is constituted of 51% females and 49% males.

Umzinyathi has an area of 8,589 square km and has a population density of 59.9 persons per square km. The district is 82% rural, primarily agricultural with no major industries for employment.

According to The South African Multiple Deprivation Index (SAMDI), Districts that fall into Quintile 1 (lowest quintile) are the most deprived districts. Those that fall into Quintile 5 are the least deprived (best-off). Umzinyathi District is classified as Socio-Economic Quintile (SEQ) 1; ranking amongst the poorest districts with Msinga ranked number 1 as the most deprived local municipality in South Africa.

The district has Socio-Economic, Equity, Physical and Infra Structure challenges, Socio-Economic challenges examples: Poverty Index of 93%; Unemployment Rate of 36.6%; only 7% of the population can afford a medical aid scheme, meaning that 93% (478,223) of the population are uninsured and rely heavily on state health services.

Physical and Infra-Structure challenges examples; the mountainous topography, with deep valleys, compounds the challenge of making services accessible. The district is faced with a lack of basic infrastructure like; safe drinking water, sanitation and access to electricity.

Despite the above challenges the district has improved in many indicators, however the performance on the indicators below need attention:

1. PHC Supervisory Rate (47.8%) this is below the national average of 73.3%
2. PHC Utilisation Rate (3.1) The National norm is 3.5 visits per client per annum.
3. The district hospitals expenditure was 57.5% of the total district expenditure - the highest in South Africa. The national average is 37.4%. The emphasis should be on Primary Health Care – it is much cheaper to attend to a client at a clinic(R 348) than at a hospital (R 1,969).
4. Average Length of Stay (6.1 days) the fifth longest in the country. A relatively high Bed Utilisation Rate (BUR) and low Average Length of Stay (ALOS) are indicative of a well-functioning district hospital. The ALOS is a proxy measure of the efficiency of the hospital
5. In Patient Bed Utilisation Rate (63.6%). The national average is 66.3%
6. OPD Headcount not Referred Rate , in Umzinyathi at least 70% of the clients enter OPD without a referral, they bypass the clinics and mobiles
7. Delivery in Facility under 18 Years (Teenage Pregnancy 10%) above the national target of 6.9%
8. In Patient Neonatal Death Rate (9.5/1 000) The district target is 7.5/1 000
9. Immunization Coverage under 1 Year Rate (77.2%) below the national target of 90%
10. Child under 5 Mortality Rate (6.3%/1000) the district target is 6/1000

Below is a summary of the five (5) components of the DHP, namely, Service Delivery, Support Services, Infrastructure, Human Resources and Finances.

1. SERVICE DELIVERY

PRIMARY HEALTH CARE

The district has 50 fixed clinics as follows; 6 clinics in Endumeni serving ± 11 053 population, 18 clinics in Msinga serving ± 9 848 population, 14 clinics in Nquthu serving ± 11 873 population and 12 clinics in Umvoti serving ± 8 032 population.

There are 12 mobile clinics with 241 mobile stopping points. The 12 mobile clinics are as follows; 2 mobiles in Endumeni serving ± 33 160 population, 3 mobiles in Msinga serving ±59 088 population, 4 mobiles in Nquthu serving ± 55 405 population and 3 mobiles in Umvoti serving ± 34 806 population. The following areas in Nquthu sub district have been identified for new mobile points; Qhudeni, Ngqulu, Ntabasbahle, KwaGwija, Ntsingabantu, Masangamnyama.

The district PHC headcount has increased from 1,418,303 (2012/13) to 1,557,375 (2013/14)

"Improved PHC utilisation rates are important in signifying improved equity in the service provisioning and improving access to care." *Bernhard Gaede and Daygan Eagar*

The district PHC utilisation rate has slightly improved from 3 visits (2012/13) to 3.1 visits (2013/14) per patient per annum. The National norm is 3.5 visits per client per annum. Nquthu has increased from 2.4 visits to 2.9 visits per client; Umvoti has increased slightly from 3.3 to 3.4 visits per client; Msinga has increased slightly from 2.4 to 2.8 visits per client while Endumeni has decreased from 3.7 to 3.4 visits per client. This decrease could be due to the correction made; of clinics which were originally placed under Endumeni (Rorkes Drift, Elandskraal, Douglas Clinics) instead of Msinga on DHIS. The increase in the PHC Utilisation Rate could be due firstly to the initiation of HIV positive clients on ARVs being done at PHC level and secondly due to Private GPs contracted to work in the clinics, this could have attracted more clients to the clinics.

The PHC Supervisory Rate has decreased from 77% (2012/13) to 47.8% (2013/14), this is of serious concern. PHC supervisors will have to develop and implement strategies to meet the national average of 73. 3%

Overall the district has a low Professional Nurse (PN) workload; on average one PN sees 26 clients a day, this is below the norm of 35 clients per PN per day. When interpreted this means that the PHC facilities are underutilised and over staffed.

All PHC facilities have been assessed for National Core Standards (NCS) compliance; however none of the PHC facilities are compliant.

Ideal Clinics Concept- initially 22 clinics were identified as piloting sites, this has now expanded to include all the clinics within the district. The Ideal Clinic dashboard tool is used to assess clinics. A Quality Improvement Plan is then developed, implemented and monitored.

HOSPITALS

Umzinyathi has 4 district hospitals and one specialised TB hospital; Dundee Hospital with 224 beds, CJM (Charles Johnson Memorial Hospital) with 349 beds, Church of Scotland Hospital (COSH) with 347 beds, Greytown Hospital with 271 beds and the specialised TB hospital in Greytown with 37 beds.

Of concern is the OPD Headcount Not Referred, it is evident that the Levels of Care Policy has not been fully adhered to. Of the 213,097 (2013/14) clients seen at OPD; 38.25% (83,448) of them entered OPD without referrals from clinics or mobiles. As per district hospital break down; 59% of clients seen at COSH were not referred; followed by CJM – 45%; Greytown - 29% and Dundee hospital 20%. Adherence to the Levels of Care policy will result in lower health care costs and improved utilisation of the PHC services. Hospitals will then be better utilised for more critical cases and in so doing reduce the workload in hospitals. The concern is the high Cost per PDE of R1, 969 as compared to R 348 per PHC headcount. If the Levels of Care Policy was strictly adhered to this would greatly reduce the cost per PDE.

The district hospitals are spending 78.5% of their budget on CoE which is extremely high as compared to the national norm of 65%. The lower level MOs are few, many of the MOs are either Grade 2 or 3 which means that the salary is much higher therefore the increase in COE. Hospitals have had to employ more SCM staff to cope with SCM logistics, Finance has had to employ more finance staff to cope with all the new requirements to obtain clean audits and enhance revenue collection. It is of vital importance that staffs takes into cognisance that treating a patient in hospital who does not warrant hospital / specialised care is a waste of resources. Looking at the OPD patients not referred to hospital, where ± 39% of the patient bypass clinics and mobiles and go straight to the hospital without a referral note, it is obvious that staffs are not taking this seriously. It is now costing the department R 1,969 per patient per day.

The district emergency headcount has decreased from 47,349 (2012/13) to 35,038 (2012/13).

A relatively high Bed Utilisation Rate (BUR) and low Average Length of Stay (ALOS) are indicative of a well-functioning district hospital. The ALOS is a proxy measure of the efficiency of the hospital. The district Bed Utilisation Rate has increased from 57.8 % (2012/13) to 63.5 % (2013/14). The Average Length of Stay has increased from 6.2 (2012/13) to 6.4 (2012/13). Firstly this is due to the high burden of disease where patients need to be hospitalized for longer in order to be effectively cured. Secondly this is due to the admission of TB and Psychiatric patients, because of non-availability of beds in the referral hospitals.

Cost per Patient Day Equivalent measures how the resources available to the hospital are being spent and is a marker of efficiency. The overall Cost per Patient Day Equivalent has increased from R 1 917(2012/13) to R 1 969 (2013/14).

The Caesarian Section Rate has decreased by 1.4% i.e. from 22 %(2012/13) to 20.6 %(2013/14).

NHI – SCHOOL HEALTH PILOT PROJECT

The Integrated School Health Program (ISHP) is one of the 3 streams of PHC re-engineering, through the joint partnership of the European Union and South African Government Umzinyathi received 3 customised and fully equipped vehicles; a truck for Oral Health and a quantum for Eye Care and a School Health Services Truck. Currently the focus is to render services to quintile 1 and 2 schools. The teams also render services to the public during school examinations, school holidays and special events.

TB PROGRAMME

The TB programme in Umzinyathi is doing well. The districts achieved TAT of 93%. All sub-districts are conducting active case finding. The TB incidence (per 100 000 population) has drastically decreased from 816 (2012/13) to 250 (2013/14). The TB (new pulmonary) cure rate has slightly increased from 85.8% to 86.8%. Similarly the TB (new pulmonary) defaulter rate has improved very slightly from 1.8% to 1.6%. Number of patients that started Regimen IV treatment (MDR-TB) has significantly increased by 55% from 44 patients (2013/14) to 98 patients (2013/14) The TB MDR confirmed treatment start rate and TB MDR treatment success rate has improved from 96% to 100%

HIV / AIDS PROGRAMME

Male Condom Distribution Rate has increased from 50 condoms (2012/13) per client to 83 condoms (2013/14). A total of 11 438 182 were distributed in (2013/14).The effectiveness of condom distribution usage would be measured by the sexually transmitted infections (STi) and teenage pregnancy rates.

Medical Male Circumcision increased very slightly by 0.9% from 8,843 (2012/13) to 8,929 (2013/14). All sub districts are struggling to meet the district target of 14278 for MMC.

All PHC facilities within the district have professional nurses trained on NIMART. The CCMDD (Central Chronic Medicine Dispensing and Distribution) Project was launched; Medi-Post pharmacy distributes ART to 20 identified clinics.

Nquthu sub district received a HTA Mobile Vehicle from Head Office. The HTA Mobile provides services to the Nquthu long and short distance Taxi Rank, Mthashana FET College and Sakhisizwe Nursing School. The Sex Worker Programme was launched in the Endumeni Sub-district by Khethimpilo (PEPFAR Funded Partner) they have employed 4 Peer Educators. Sexually Transmitted Infection (STI) partner treatment rate remains very low in the district, and the tracing of these partners remains a challenge.

MATERNAL CHILD AND WOMEN'S HEALTH

Zazi camps targeting school going girls to know their status, teenage pregnancy and about Implanon was conducted in all 4 sub-districts.

Antenatal 1st visits before 20 weeks rate has increased from 50% (2012/13) to 59.6 % (2013/14); the National Target is 60%. Early presentation during pregnancy provides an earlier opportunity to initiate PMTCT services, The Antenatal client initiated on ART rate has increased from 83% (2012/13) to 93.5% (2013/14). The Proportion of mothers visited within 6 days of delivering their babies more than doubled from 38.6 % (2012/13) to 66.9% (2013/14).

Maternal mortality in facility ratio is of serious concern it has increased from 35.7/100K i.e. 4 deaths (2012/13) to 71.5/100k i.e. 8 deaths (2013/14). All 50 clinics have emergency boxes for PPH; Eclampsia and cord prolapse. Antenatal Corticosteroids for preterm labour is available in all 4 sub-districts The Delivery in facility under 18 years rate has increased by 0.3% from 9.7% (2012/13) to 10% (2013/14)

Neonatal mortality in facility rate (annualised) has increased from 6.8% (2012/13) to 9.5 % (2013/14). All 4 district hospitals are now having dedicated, non-rotating doctors in neonatal wards. CPAP machines to enable neonates to breathe are available in all 4 sub-districts.

The Child under 5 years severe acute malnutrition case fatality rate has dramatically dropped from 34.9% (2012/13) to 12.7% (2013/14). The success can be attributed to the following; A

total 54 Phila Mntwana Centres were established since September 2013 to increase assess to a broader community of children under 5 years; in addition 44 out of the 50 clinics have permanent Nutrition Advisors. All crèches are being targeted as service sites for Vitamin A supplementation by Nutritionists, Nutrition Advisors and CCGs. The Vitamin A to 12-59 months children significantly increased from 54% to 74% (beyond the target). Vitamin A Deficiency (VAD) increases child mortality, neonatal infections, diarrhoeal disease and measles. The World Health Organization estimates that vitamin A deficiency is responsible for up to 6% of under-five deaths in sub-Saharan Africa.

3. HUMAN RESOURCES

CJM Hospital appears to be grossly under staffed as far as medical officers are concerned; i.e. 10,664 patients per medical officer per day; followed by COSH with; while Greytown Hospital appears to be better staffed than the other hospitals, followed by Dundee Hospital. There are no medical officers employed full time in the clinics. The hospital medical officers visit the clinics on a regular basis and attend to clients who have been referred to them depending on the availability of doctors. The district is planning to employ doctors on a full time basis at the busy clinics. The contracting of Private GPs in some clinics will also assist with relieving the workload.

The (DCST) District Clinical Specialist team is currently incomplete it comprises of an Advanced PHC Nurse, Advanced Paediatric Nurse and Advanced Midwife ; still to be recruited is a Principal Obstetrician and Gynaecologist; Principal Paediatrician; an Anaesthetist and a Principal Family Physician. These DCST team is recruited by National Department of health.

Umvoti sub district PHC facilities do not have any data capturers. This is being looked into by the district.

4. FINANCE

This section focuses on resource allocation for district health services (DHS), which is the key input to enable the district to render health services to improve health status. Finance includes three main components, namely district hospitals, district management and primary health care.

The PHC expenditure per uninsured capita refers to the total amount of money spent annually, per person without medical scheme coverage, excluding the costs of district hospitals. In 2013/14 the PHC expenditure per uninsured capital was R 348 this was higher than the national average of R 276

The percentage of district health services expenditure by main items includes capital, compensation of employees (CoE), transfers and non-negotiable goods such as blood supplies, vaccines and medical supplies. Of these items CoE accounted for 65% of the budget.

At Umzinyathi's the bulk of the budget is being spent on hospitals. The district hospitals expenditure for 2013/14 was 58.6%, the highest in South Africa. The national average is 37.4%.

The emphasis should be on Primary Health Care – it is much cheaper to attend to a client at a clinic(R 348) than at a hospital (R 1,969). There is slight improvement in the move towards PHC. The Cost per PDE reduced slightly from 62.3% (2012/13) to 58.6% (2013/14)

The DHER average for district hospital proportional expenditure was 39% (2012/13) Despite the improvement noted – much still needs to be done to rectify this.

The DHER average for last year for PHC proportional expenditure was 55%.

The district proportional expenditure for the previous financial year was 2.1% as compared to 2.3% for the current year. The DHER average for 2012/13 was 6%.

OPD headcount not referred also plays a vital role in increasing the hospital expenditure. In Umzinyathi at least 70% of the clients going to OPD without a referral, bypass the clinics and

mobiles – this is of concern especially when comparing the cost per PDE, which is R 1826.30 to the cost per PHC headcount which is only R 115.50. It is therefore of vital importance that the referral pattern / Levels of Care Policy be strictly adhered to in order to reduce costs / expenditure.

Separate Cash flow committees have been established at each sub district for PHC and Hospitals and most Institutions are having weekly cash flow meetings and this action improve the turnaround times on Goods and Services to the wards and to the clinics. Expenditure is monitored monthly and the District expenditure is on par with the budget allocation. 90% Staff linking in District is corrected. All support services – Finance, SCM, Assets for EMRS are now done at District Office level and are fully integrated. Risk toolkits are in place and are completed monthly by the finance managers. A revenue target was set and most institutions have met revenue targets – (timeously follow up patient accounts – rent owing to the Department etc.). Managers are to ensure that post are filled in time as delays effect the next budget allocation as the next year allocation is basically allocated on expenditure trends.

5. INFRASTRUCTURE

In Nquthu sub district two new clinics Thathezake and Zamimpilo were built. Thathezake clinic became functional in July 2013 and Zamimpilo clinic in September 2013. Pomeroy CHC was opened on the 02-02-2015. Ngabayena, Msizini and Mkhuphula clinics in Msinga and Muden clinic in Umvoti are currently under construction. In 2015/16, Umzinyathi Regional Laundry will be temporary shutdown for an R 150 million upgrade. The Charles Johnson Hospital Laundry at Nquthu is already complete.

WATER

Approximately 80% of the PHC fixed facilities are experiencing ongoing problems with the boreholes; many of the boreholes are dry and this is beyond the control of the maintenance team. The mother hospitals are ensuring delivery of fresh water by tanker services. The maintenance plan has been submitted to infrastructure to rectify this issue.

SANITATION

Approximately 50% of the fixed facilities are experiencing ongoing problems with septic tanks which are of old design and regularly overflow; consultants are attending to the problems at Mangeni, Mandleni, Mazabeko, Douglas, Ethembeni, Nondweni, Hlathi Dam, Rorkes Drift, Eshane clinic and Mumbe clinic. The department has come up with a new installation of Lilliput systems, which is also not sufficiently effective.

TELEPHONE

100% of telephones lines are available at clinics but are non-functional. The staff are utilising their cell phones until such time that they are issued with official cell phones. All clinics have VSAT connectivity IT (Information Technology unit). The district is currently involved in MOM Connect the Msinga connectivity project whereby 26 WIFI routers sponsored by USASA and MTN to ensure that the clinics are in a position to send SMS alerts and reminders to patients per month.

ELECTRICITY

All facilities have electricity supply. National Core Standards requires that all facilities have alternative backup generators. Hospitals have backup generators in place, clinics however

do not have any backup generators and remain non-compliant. During electricity interruption clinics experience problems with cold chain.

PHARMACEUTICALS

100% of pharmacies have pharmacists in post. All hospitals have functional PTC committees in place. There has not been any TB or ARV stock outs during the year; while 1.35% of Tracer medicines have been out of stock. All pharmacies were assessed by the Pharmacy Council and 75% of the pharmacies obtaining an "A" grade score.

Experiential learning is being offered to the unemployed youth of Umzinyathi, to career path towards becoming pharmacist assistants.

To improve compliance in taking of chronic medication, the district has embarked on the Central Chronic Medicine and Distribution Project in which Medi- Post Pharmacy will deliver medicines to patients home or collection point. Patients will receive a short message service (SMS) with a tracking number for the parcel, of which a patient will be required to sign for the parcel at the collection point counter.
This process will relieve patients especially the elderly from waking up early each month, getting transport or walking distances the clinic and joining long queues to get their monthly supply of medication. It will also assist in improving compliance with taking medication because no one will skip treatment because they did not have transport fare to collect their treatment. It will also assist in reducing queues and waiting times in our facilities.

PART A - STRATEGIC OVERVIEW

6. SITUATIONAL ANALYSIS

Vision
A leader in providing District Health Services within South Africa and in African countries.

Mission
To provide high quality health care service that is efficient, effective, accessible, economical, equitable and sustainable in order to achieve optimal health care for all persons within Umzinyathi District.

Core Values
- Legacy values - Leading in District Health Services
- Foundation Values - Respect, Trust, Honesty and Commitment
- Service Value - Innovation, Efficiency, Economical, Flexibility and Risk Taking
- Resultant Benefit Values - Empowerment, Skills development, Poverty alleviation and Role Model

Table 1: Provincial strategic goals 2009 – 2014

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

Strategic Goal	Goal Statement	Rationale	Expected Outcomes
	province.		• Improved Financial & SCM efficiency and accountability to curb over-expenditure, improve return on investment and value for money, budget aligned with service delivery priorities and needs. • Appropriate response to the burden of disease and consequent health needs. • Improved governance including regulatory framework, policies and delegations to facilitate implementation of the Strategic Plan. • Decentralized delegations, controls and accountability. • Improved information systems, data quality and management and improved performance monitoring and reporting. • Improved infrastructure to improve service delivery.
Goal 2: Improve the efficiency and quality of health services.	Achieving the best possible health outcomes within the funding envelope and available resources.	Improved compliance with legislative/ policy requirements and Core Standards for quality service delivery in order to improve	• Accreditation of health facilities in line with National Core Standards for Quality. • Improved management capacity. • Improved health outcomes and increased life expectancy at birth as a result of improved clinical governance. • Improved performance towards achieving the MDG targets.

Strategic Goal	Goal Statement	Rationale	Expected Outcomes
		clinical/ health outcomes.	• Patient satisfaction.
Goal 3: Reduce morbidity and mortality due to communicable diseases and non-communicable conditions and illnesses.	Implement integrated high impact strategies to improve prevention, detection, management and support of communicable diseases & non-communicable illnesses and conditions at all levels of care.	Reduction of preventable/ modifiable causes of morbidity and mortality at community and facility level contributing to a reduction in morbidity and mortality rates.	• Decrease in morbidity and mortality – with specific reference to preventable causes. • Improved performance towards achievement of MDG targets i.e. - HIV and AIDS; - TB; - Maternal & Child Health; - Malaria. - Change trends of non-communicable disease patterns.

Source: 2010-2014/15 Provincial Strategic Plan

Table 2: National health system 10 point plan and medium strategic framework (MTSF) 2014-2019

National Health System 10 Point Plan	Medium Strategic Framework) 2014-2019
1. Provision of strategic leadership and creation of social compact for better health outcomes. 2. Implementation of National Health Insurance (NHI). 3. Improving the quality of health services. 4. Overhauling the health care system and improving its management. 5. Improved human resources planning, development and management. 6. Revitalization of infrastructure. 7. Accelerated implementation of the HIV and AIDS strategic plan and the increased focus	1. Universal Health coverage achieved through implementation of National Health Insurance Improved quality of health care 2. Re-engineering of Primary Health Care 3. Health care costs reduced 4. Improved human resources for health 5. Improved health management and leadership 6. Improved health facility planning and infrastructure delivery 7. HIV & AIDS and Tuberculosis prevented and successfully managed 8. Maternal, infant and child mortality reduced 9. Efficient Health Management Information

National Health System 10 Point Plan	Medium Strategic Framework) 2014-2019
on TB and other communicable diseases. 8. Mass mobilization for better health for the population. 9. Review of the drug policy. 10. Improving research and development.	System for improved decision making

6.1 MAJOR DEMOGRAPHIC CHARACTERISTICS

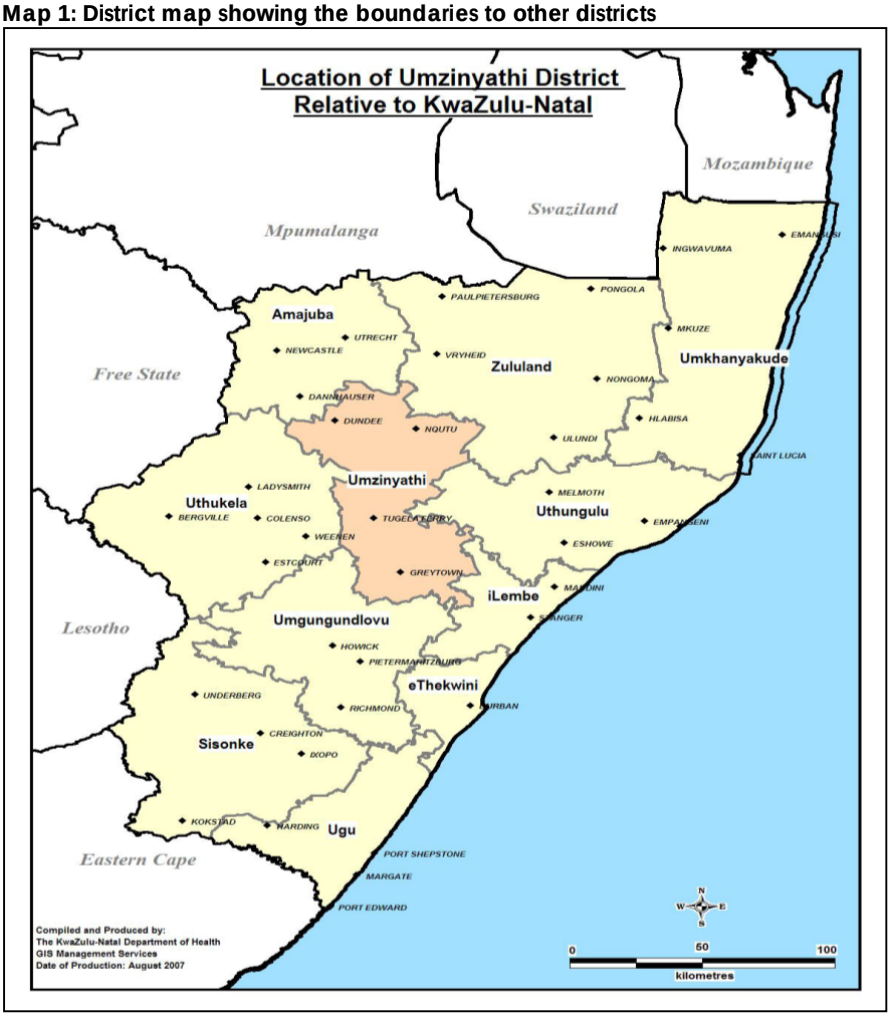
INTRODUCTION

Umzinyathi District is situated in the north central region of KwaZulu-Natal province. Umzinyathi is bordered by the following districts; in the north by Amajuba, north east by Zululand, east by Uthungulu, south east by lLembe, south west by Umgungundlovu and west by Uthukela. Umzinyathi district has four local municipalities; Endumeni, Msinga, Nquthu and Umvoti and 53 wards.

Table 3: Population per sub-district

Sub District	Census 2011	Population 2013/14	Area per Square Km	Population Density
Endumeni	64,862	66,320	1,610	41,2
Msinga	177,577	177,265	2,501	70.1
Nquthu	165,307	166,215	1,962	84.7
Umvoti	103,093	104,417	2,516	41.5
Umzinyathi	**510,839**	**514,217**	**8,589**	**59.9**

Map 1: District map showing the boundaries to other districts



Map 2: Sub-Districts of Umzinyathi

OVERVIEW OF THE LOCAL MUNICIPALITIES (Source Umzinyathi IDP 2013/14)

ENDUMENI

Endumeni is situated in the north-western boundary of Umzinyathi District. Endumeni Local Municipality is home to a population that is predominantly urban, with only 16,8% living in non-urban areas. The towns of Dundee, Glencoe and Wasbank house most of the urban population of Endumeni. Dundee is the main commercial centre; it has the most diversified economy, commercial cattle farming and dairy production and is the centre of the Battlefields tourist region.

NQUTHU

Nquthu municipality is located along the north-eastern boundary of the district, boarded by eMadlangeni and Abaqulusi in the north, Ulundi in the east, Nkandla in the south and Msinga and Endumeni in the west. This municipality is typically rural and largely tribal authority where the population is largely previously disadvantaged and relatively dispersed and where services are scarce and often at rudimentary levels. The main town is Nquthu and subsistence agriculture is the main activity in the area.

MSINGA

Msinga is centrally situated in the district, it is predominantly rural, with 99, 1% of the population living in rural areas. Owing to its rugged terrain; Msinga's population is relatively dispersed and where services exist they are concentrated along road infrastructure and water sources such as the Tugela River. The main towns are Pomeroy and Tugela Ferry; it's a rural region with subsistence farming.

UMVOTI

Named after the Umvoti River, the municipality is situated along the eastern boarder of Umzinyathi District. This local municipality comprises of urban areas, commercial agricultural areas and tribal authority areas all of which exhibit typical characteristics associated with these settlement types. Service levels in urban areas are high except for informal areas, in commercial agricultural areas they are relatively high as farmers provide their own services and in tribal authority areas they are low to moderate. Greytown is the main commercial centre of the sub-district.

Table 4: organisational unit

Organisation unit	Value
Area per square kilometre	8,589
Household head age 10-15 years	0.6%
Household head age 16-19 years	1.9%
Household head age 20-24 years	5.2%
Household head age 25-65 years	74.6%
Household head age 66-84 years	15.9%
Household head age 85 years and older	1.8%
Household head gender - Female	59%
Household head gender - Male	41%
Household head population group - Black African	95.3%
Household head population group - Coloured	0.5%
Household head population group - Indian or Asian	1.7%
Household head population group - Other	0.2%
Household head population group - White	2.2%

Figure 1: Population Pyramid Umzinyathi District 2011 Stats SA

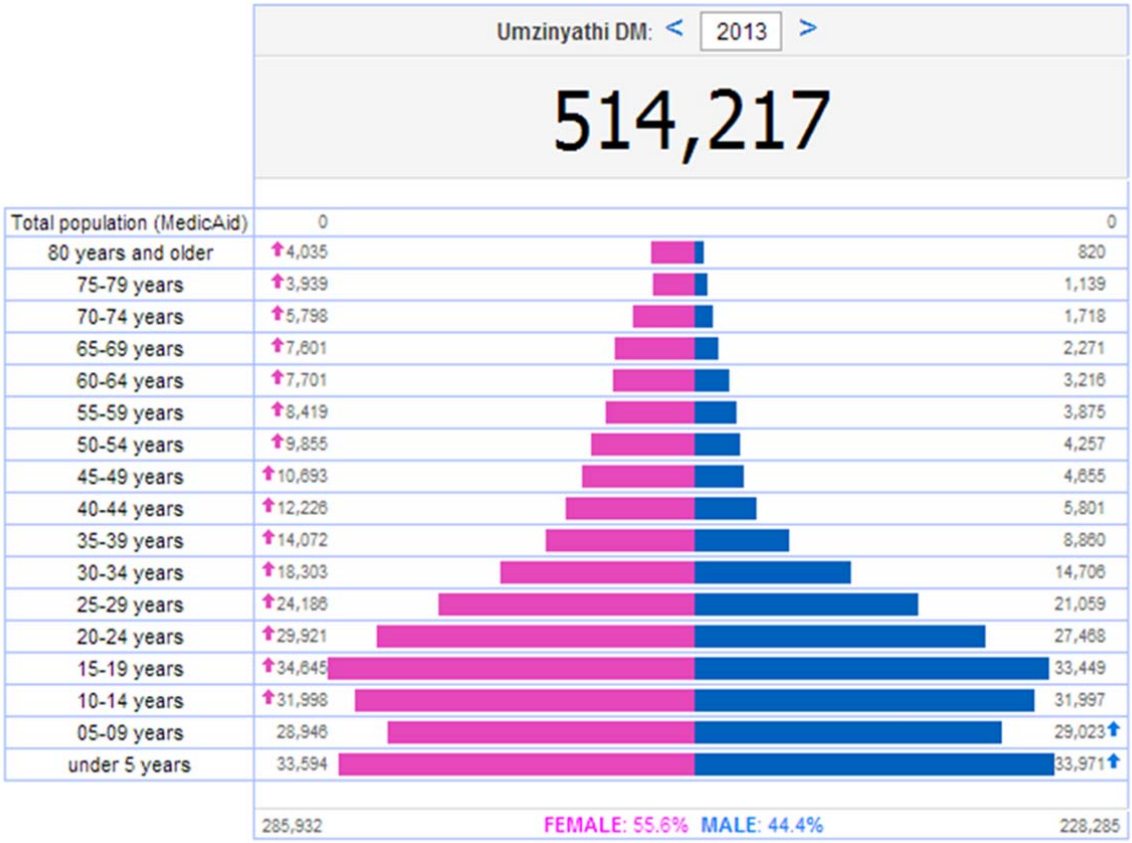


Figure 2: Population Pyramid Umzinyathi District 2011 Stats SA

There remains a sharp decrease of the population between the 20-24 yrs. and 40 to 44 yrs. This could be attributed to HIV and AIDS, TB, injuries and trauma. The distribution is 55.6% (285 932) Females to 44.4% (228 285).

The population under 5 years is a vulnerable population group these children are prone to many communicable diseases and infections i.e. gastro-enteritis and pneumonia. (See *Morbidity Profile 2013/14 table)*

Umzinyathi district has a youth bulge pyramid i.e. the majority (72%) of the population is under 35 years. The youth bulge poses a challenge in relation to the Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS). In South Africa, the actuarial projections and the annual sero-prevalence survey have confirmed that there is a high prevalence rate of HIV in the 15 to 29 years groups, Although the HIV/AIDS prevalence rate of the Umzinyathi district is relatively lower than most districts at 24% as against the KZN prevalence (39.5%), there is still high prevalence in the of HIV/AIDS in the female population.

The district pyramid tapers as it get to the age of 35 years and upwards. This indicates that the district has a high mortality rate; this indicates a short life expectancy. The elderly in Umzinyathi make up 7% of the population.

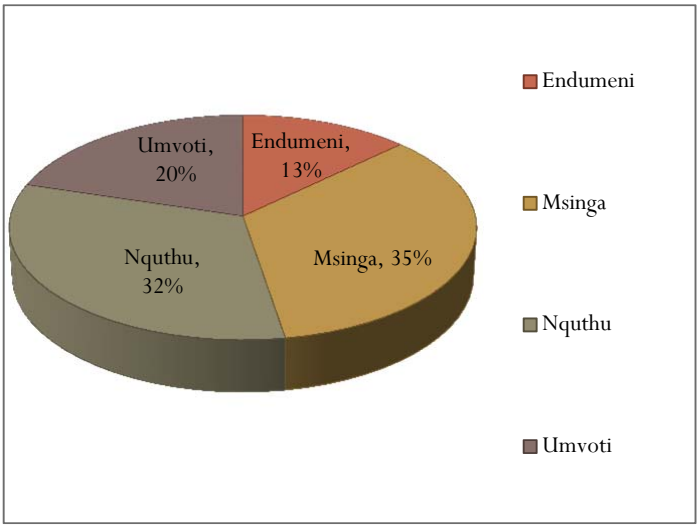
1.1 MAJOR DEMOGRAPHIC CHARACTERISTICS

Table 5: District Population 2013/14

Sub-District	Total Population	% pop uninsured	Uninsured Population
Msinga Local Municipality	177 265	93%	164 857
Nquthu Local Municipality	166 215	93%	154 580
Umvoti Local Municipality	104 417	93%	97 108
Endumeni Local Municipality	66 320	93%	61 678
DISTRICT TOTAL	**514,217**	**93%**	**478 223**

Source: DHER 2012/13

Graph: 1: population per sub-district



Msinga has the highest population in the district; 35% of the total district's population resides in Msinga, followed by Nquthu with 32%, followed by Umvoti with 20%. Endumeni has the lowest population in the district of 13%.

SOCIO-DEMOGRAPHIC INFORMATION

According to the Census 2011, there are 113 469 households within the district.

EMPLOYMENT RATE

According to the census 2011, the unemployment rate in Umzinyathi district, has decreased from 62.6% (2001) to 39.6% (2011)

AVERAGE ANNUAL HOUSEHOLD INCOME

According to the census 2011 the average annual household income has increased from R 21 382 (2001) to R 46 637(2011)

ANNUAL PER CAPITA INCOME

Annual per capita income has also improved during this period from R 3 900.00 in 1996 to just below R 14 208.00 in 2011.

Table 6: Annual capita income

Access to water	KZN241 Endumeni	KZN242 Nqutu	KZN244 Msinga	KZN245 Umvoti	Total	%
Piped water inside the dwelling	7891	1196	227	6933	16247	15.54
Piped water inside the yard	3694	4050	485	6432	14661	14.02
Piped water access outside the yard	1183	16501	6346	4207	28237	27.01
Borehole	198	3006	5706	1667	10577	10.12
Spring	0	2229	2562	1154	5945	5.69
Dam/Pool	93	188	580	202	1063	1.02
River/ Stream	439	4807	16033	4778	26057	24.93
Water vendor	0	0	494	226	720	0.69
Rain water tank	160	58	160	274	652	0.62
Other	96	136	0	148	380	0.36
Total	13754	32171	32593	26021	104539	100.%

Census 2011

Table 7: household electricity

Type of fuel	KZN241 Endumeni	KZN242 Nqutu	KZN244 Msinga	KZN245 Umvoti	Total	%
None	69	183	475	245	972	0.9%
Electricity	13335	16768	9478	15907	55489	48.9%
Gas	47	86	276	119	528	0.5%
Paraffin	111	649	380	169	1308	1.2%
Candles (not a valid option)	3245	13867	25074	10758	52943	46.7%
Solar	45	60	2040	84	2229	2.0%
Unspecified	-	-	-	-	-	
Not applicable	-	-	-	-	-	
Total	16851	31612	37724	27282	113469	100%

Census 2011

Table 8: sanitation

Toilet	KZN241 Endumeni	KZN242 Nqutu	KZN244 Msinga	KZN245 Umvoti	Total	%
None	686	2753	8812	2495	14746	13.00%
Flush toilet (connected to sewerage system)	12820	1607	646	6371	21445	18.90%
Flush toilet (with septic tank)	659	215	594	1242	2710	2.39%
Chemical toilet	129	741	2821	3344	7035	6.20%
Pit toilet with ventilation (VIP)	848	11268	13319	6759	32195	28.37%
Pit toilet without ventilation	1381	13371	9864	5839	30455	26.84%
Bucket toilet	41	301	204	261	807	0.71%
Other	286	1357	1463	969	4076	3.59%
Unspecified	-	-	-	-	-	
Not applicable	-	-	-	-	-	
Total	16851	31612	37724	27282	113469	100.%

Census 2011

6.2 SOCIAL DETERMINANTS OF HEALTH

Table 9 (A1): Social Determinants of Health

Sub-Districts	Data Source	Total number of households	Unemployment rate	Percentage of population living below poverty line of R 283 per month	Number of households in Informal dwelling	Number of households in Formal dwelling	Percentage of Households with access to sanitation	Households with access to potable water	Percentage of Households with access to electricity	Adult literacy rate
Endumeni	Census 2001	12 278	46%	6.6%	612	10 027	59.8%	9 682	14.7%	No data
	Community Survey 2007	No data	No data	No data	6.7%	No data	11116 80.8%	No data	8914/13754 64.8%	No data
	Census 2011	16 851	26.4%	12%	882	14 683	16165/16851 96%	14 287	13335/16851 79%	3146/64862 4.8%
Msinga	Census 2001	32 369	78.7%	15343/ 32369 47%	366	5 784	20%	4 778	2828/168025 1.6%	68%
	Community Survey 2007	No data	No data	No data	0.6%	No data	356/32593 1.1%	No data	2159/104539 6.6%	No data
	Census 2011	37 724	49.5%	4468/37724 12%	139	12 258	28912/37724 77%	12 713	9478/37724 25%	34304/177577 19.3%
Nquthu	Census 2001	29 417	81.6%	16866/294171 57%	544	11 639	29698/168991 1.8%	3 254	4966/168991 0,3%	No data
	Community Survey 2007	No data	No data	No data	1.7%	No data	1204/104519 3.7%	No data	3650/104519 11.3%	No data
	Census 2011	31 612	7 896 44.4%	3914/31612 12%	181	19 947	28859/31612 91.3%	12 824	15907/27282 58%	15226/165307 9.2%
Umvoti	Census 2001	19 669	40.7%	5809/19669 29%	639	8 280	10477/104519 4 0.2%	6 423	7503/104519 8%	No data
	Community Survey 2007	No data	No data	No data	4.7%	No data	22997/114509 2%	No data	8459/114509 0.7%	No data
	Census 2011	27 282	30.4%	3344/27281 12%	1 474	14 587	24787/27282 91%	1 320	15907/27282 58%	15501/103093 15%
District Total	**Census 2001**	**93 733**	**62.6%**	**49.7%**	**2 161**	**35 731**	**22.2%**	**20 783**	**23.8%**	**14.4**
	Community Survey 2007	No data	No data	No data	13.7%	No data	21.9%	No data	22.5%	No data
	Census 2011	**113 469**	**39.6%**	**12%**	**2 677**	**61 474**	**34.4%%**	**45 441**	**48.9%**	**26.5%**

6.3 EPIDEMIOLOGICAL (DISEASE) PROFILE OF THE DISTRICT

Table 10: 10 Major causes of Morbidity and Mortality – adults and children

Morbidity Profile 2013/14		***Mortality Profile 2013/14***	
Top 10 common causes of Adult Morbidity	***Top 10 common causes of Paediatric Morbidity***	***Top 10 common causes of Adult Mortality***	***Top 10 common causes of Paediatric Mortality***
PTB Gastro Enteritis Pneumonia HIV AIDS Abortions Injury/Trauma Epilepsy Hypertension Cardiac Conditions Diabetes	Gastro Enteritis LRTI Epilepsy Malnutrition Poisoning Intestinal Parasites Hypertension Meningitis Preterm Delivery Burns	*PTB* Pneumonia Gastro enteritis Cardiac Conditions CVA Hypertension HIV/AIDS Diabetes Meningitis	*Pneumonia* *Malnutrition* *Gastro Enteritis* *Preterm delivery* *Intra Uterine Death* *Herbal Enema* *Sepsis* *Renal Conditions* *Jaundice* *Meningitis*

Source: Inpatient Discharge registers

Looking at the above morbidity and mortality profile for paediatrics, e.g. gastro enteritis, malnutrition and respiratory conditions, these are preventable conditions. It is therefore of great importance that PHC be prioritised and in so doing; reduce the incidence of these preventable conditions. Unfortunately 58.6% of the total expenditure is for Hospital as compared to 63% in the previous financial year. – Which is curative and more costly whereas only 39% of the total expenditure is for PHC which is prevention driven as compared to 18.7% in the previous financial year. This is a great improvement from the previous financial year. The curative practices require more resources like human resources and equipment.

The utilisation rate for these children is equivalent to 4.8 visits per child to a health facility per annum as compared to 5 visits per child in the previous financial year.
Umzinyathi is National Health Insurance (NHI) pilot site so PHC Re engineering is a priority. Eleven family Health Teams (some still incomplete) and fifteen School Health Teams have been employed, though some teams are incomplete. There is a high attrition rate of these teams due to the unfavourable working conditions, lack of accommodation and transport. There is also an incomplete District Clinical Specialist Team which consists of an Advanced PHC nurse, Advanced Midwife and Paediatric Nurse. These teams go out into the community to identify and treat clients and where the condition warrants further management, the clients are referred to a health facility.

A. Maternal Mortality Ratio –

Total Number of Maternal Deaths in relation to the Total number of Live births (Per 100k) at the Facility

Table 11: Maternal Mortality Ratio

Sub District	2011/12	2012/13	2013/2014
Endumeni	174.9	0	86.1
Msinga	139.1	59.1	130.2
Umvoti	54.1	0	0
SNquthu	83.9	56.6	57.1
District	**113**	**28.93**	**68.35**

Source: DHIS

Reduction in Maternal Mortality Rate

In 2012/13 there were zero maternal deaths both for Endumeni and Umvoti. In 2013/14 there was no maternal death for Umvoti. The Couple year protection rate improved to 59.9% (86 642) the district is working hard to reach all women of bearing age. ANC bookings before 20 weeks has improved to 59.6% (5 456 / 13 503) which assisted in early identification of complications and management thereof. ANC initiated on ART following the 2013 Guidelines irrespective of CD4 count and gestational age.

The Delivery in facility rate improved to 96% (10 813) perhaps the improvement may be attributed by the availability of Obstetric Ambulances. Maternal deaths from preventable causes were avoided except for those who came already complicated and having not booked. Pulmonary embolism was also amongst the causes as a rare cause.

The DCST visited facilities were gaps were identified; personnel were assisted and supported in skills development in their workplace as well attending to issues of resources.

Family planning- improve access to comprehensive Sexual Reproductive Health services

Maternal mortalities can be avoided with good family planning. Family planning is marketed to women of child bearing age in all facilities. In hospitals it is available in all departments that care for females, including Out Patients department, Casualty, Crisis Centre, CTOP clinic as well as Occupational Health clinic,

Early booking

The district early booking rate was 59.6%; (5 456/13 503). The ANC and Post Natal Care policy is implemented in all facilities. The Revised PMTCT 2013 guidelines are implemented in all facilities successfully with a PCR positive rate of 0.8. The Integration into OSS has assisted with improving the program and in reaching clients more effectively.

Emergency Obstetric Care:

Delays in getting urgent medical attention for obstetric emergencies are a contributory cause of maternal mortality. All 4 sub-districts have obstetric ambulances in readiness to transport obstetric emergencies to facilities to be managed by skilled personnel. The Delivery in facility rate improved to 96% (10 813) the improvement may be attributed to the availability of Obstetric Ambulances.

ESMOE (Essential Steps in the Management of Obstetric Emergencies)

ESMOE 4 days training has been rolled out in all 4 sub districts, targeting clinic and maternity midwives. CJM Nursing College educator was also trained. All hospitals have doctors and nurses trained on ESMOE. Consistency is not maintained in conducting fire drills. This Issue is being addressed during perinatal meetings and referral meetings. Each institution has been tasked to draw a training program that will be followed and monitored. Fire drills will be a joint effort for both Nurses and Doctors include night staff and clinic staff.

CARMMA (Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa)

Waiting mother huts/homes are important so that women don't have to travel far while in labour. Waiting mother huts are available in 3 out of the 4 sub districts Endumeni, Nquthu and Umvoti. Due to construction work at COSH, the waiting mothers' hut at is temporarily being used to accommodate other ward patient. All aspects of CARMMA have been implemented in the district.

B. Infant and Child Mortality

Table 12: Infant and Child Mortality

Indicator Name	Sub District	Indicator Type	2011/12	2012/13	2013/14
Inpatient death under 1 year rate	Endumeni	%	8.7	10.3	11.6
	Msinga	%	6.6	8.9	2.6
	Nquthu	%	11. 0	5.2	13.2
	Umvoti	%	6.6	9.6	12.8
Inpatient death under 5 year rate	Endumeni	%	5.2	6.1	7.3
	Msinga	%	5.0	7.6	2.8
	Nquthu	%	14.0	5.1	7.3
	Umvoti	%	4.9	6.1	7

The above 3 year comparative, show that the inpatient death under 1 year rate has increased, except for Msinga which has decreased from 6.6% (2011/12) to 2.6(2013/14). The inpatient death under 5 year rate has also increased, except for Msinga which has decreased from 5.0 %(2011/12) to 2.8 %(2013/14) and Nquthu which has decreased from 14.0 %(2011/12) to 7.3 %(2013/14

Improve child survival through breastfeeding

Three hospitals; Dundee, CJM and COSH are certified as Baby Friendly. Greytown Hospital is awaiting the breast feeding assessments results. Mixed feeding is being discouraged. Continuous community education is conducted to reduce the vertical transmission of HIV.

KMC (Kangaroo Mother Care)

All four hospitals in the district have KMC facilities. These facilities help neonates gaining weight and survive.

Neonatal and Child Mortality Rate

The following strategies were implemented to reduce neonatal and child mortality rate. Firstly doctors and nurses working in nurseries were trained on Kinc (KwaZulu Natal initiative on neonatal care); an initiative of managing neonates at birth and during admission. Secondly the non-rotation of nursery and paediatric nurses. Thirdly doctors must do the wards rounds on weekends and public holidays, so that nurseries and paediatric are always covered. Fourthly CPAP machines (Continuous Positive Airway Pressure) were purchased to help premature babies' breath. Fifthly, etat (Emergency Triaging Assessment and Treatment) training was conducted for Casualty, OPD and Gateway Clinics frontline staff. The training focused on triaging and stabilising a critically ill child arriving at the facility.

C. District HIV & AIDS Profile

Table 13: District & AIDS Profile

Indicator Name	Indicator Type	2011/12	2012/13	2013/14
Children under 12 years sexually assaulted rate	%	43.1%	34%	48.3%
HIV prevalence among clients tested (excluding antenatal)	%	11.3%	11.1%	6.7%
HIV testing rate (excluding antenatal)	%	97%	95%	98.2%
Inpatient days proportion of ART patients	%	20%	23.3%	23.9%
Male condom distribution rate (annualised)	No	13.1	43.4	85.2
New HIV positive patients screened for TB rate	%	83%	56%	64.5%
Proportion clients HIV pre-test counselled (excluding antenatal)	%	14%	11%	14.3%
HIV positive clients remaining on ARV	No	27 335	36 755	37 054
/Children Under 15 yrs. on ARV	No	1 020	2 426	3 143

The program has grown in strength. HIV prevalence among clients tested (excluding antenatal) has decreased from 11.3% (2011/12) to 6.7% (2013/14).

All facilities are initiating ART (anti-retroviral therapy). Medi-Post Pharmacy currently distributes ART to 20 identified clinics, through the CCMDD (Central Chronic Medicine Dispensing and Distribution) programme. The program has started with ART clients, currently chronic clients still collect their medication at their nearest clinic, but over time these chronic clients will also be assisted.

The condom distribution has drastically improved over the past 3 years, from 6 697 176 in (2012/13) to 11 438 182 in (2013/14).

Table 14: District TB Profile

Indicator	2011/12	2012/13	2013/14
TB Cure Rate	86.3%	86%	86.5%
Defaulter Rate	1.1%	2%	1.9%
Death Rate	6.8%	9%	9.5%
PTB 2 months smear conversion Rate	75.5%	76%	77.5%
MDR TB diagnosed	96	70	77
XDR TB Diagnosed	37	14	29

Source: - ETR.net

TB Cure Rate new positive is at 86.5% and is slightly above the national target of 85%,
The Defaulter Rate has increased from 1.1 %(2011/12) to 1.9 %(2013/14). The death rate has increased from 6.8% (2011/12) to 9.5% (2013/14); this is due to the high TB/HIV co-infection rate above 70%. The Smear conversion rate shows an upward trend from 75.5 %(2011/12) to 77.5 %(2013/14)

7. DISTRICT SERVICE DELIVERY ENVIRONMENT

7.1 DISTRICT HEALTH FACILITIES

7.1.1 PRIMARY HEALTH CARE FACILITIES

Table 15 (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[1]		Community Health Centres (24 x 7)[2]		Standalone MOU[3]		District Hospitals
	LG	P	LG	P	LG	P	LG	P	LG	P	LG	P	LG	P	
Endumeni	-	-	-	2	-	-	-	6	-	-	-	-	-	-	1
Msinga	-	-	-	3	-	-	-	18	-	-	-	-	-	-	1
Nquthu	-	-	-	3	-	-	-	14	-	-	-	-	-	-	1
Umvoti	-	-	-	3	-	-	-	12	-	-	-	-	-	-	1 + 1 specialised TB Hospital attached
District	-	-	-	**11**	-	-	-	**50**	-	-	-	-	-	-	**4**

Source: DHIS

Please note the above reporting period ended on 31-03-2014, Pomeroy CHC was excluded as it only opened on the 02-02-2015. The district has 4 district hospitals; Dundee Hospital, CJM (Charles Johnson Memorial Hospital), Church of Scotland Hospital (COSH) and Greytown Hospital which has a specialized TB hospital attached. There are no local government (municipal) clinics the Department of Health has taken over the municipal clinics. There are 50 clinics; 6 in Endumeni, 18 in Msinga, 14 in Nquthu and 12 in Umvoti. There are 12 mobile clinics; 2 in Endumeni, 3 in Msinga, 4 in Nquthu and 3 in Umvoti.

1 There are no Community Day Centres in KwaZulu-Natal
2 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.
3 Accordingly to the DHER 2011/12 definitions for Stand Alone MOU's, there are no Stand Alone MOU's operational within KwaZulu-Natal

Table 16: Provincial Clinic Facility to Population – 2013/14

Sub-Districts/ District	PHC facility per pop ratio - Health Post	PHC facilities per pop - Mob provincial	PHC facilities per pop ratio - Clinical provincial	PHC facilities per pop ratio - CHC provincial
Nquthu	-	55 405	11 873	-
Umvoti	-	34 806	8 032	-
Msinga	-	59 088	9 848	-
Endumeni	-	33 160	11 053	-
Umzinyathi District	-	**45 614**	**10 201**	-

Source: DHER 2012/13 Customised District Report

Table 17: mobile & fixed clinics

Sub district	Number of mobile to population served	Number of fixed clinics to population served
Msinga	3 mobiles each serving ± 59 088 population	18 fixed clinics and each clinic serving ± 9 848 population
Nquthu	4 mobiles each serving ± 55 405 population	14 fixed clinics and each clinic serving ± 11 873 population
Umvoti	3 mobiles each serving ± 34 806 population	12 fixed clinics and each clinic serving ± 8 032 population
Endumeni	2 mobiles each serving ± 33 160 population	6 fixed clinics and each clinic serving ± 11 053 population

It is evident that more mobiles are required to serve the all the sub districts, however it appears as though there are sufficient clinics within the district, if one abides to the national norm for clinics.- but this does not account for equity or access – only universal coverage.

Three of the Msinga clinics; Douglas, Elandskraal and Rorkesdrift are supervised by Endumeni sub district. The Data for the above mentioned clinics are under Msinga Sub District as they serve the Msinga population. Thathezake clinic became functional in July 2013 and Zamimpilo clinic in September 2013. Manxilli, Ngabayena, Msizini , Muden and Mkhuphula clinics are under construction and will open in 2015/16. Noyibazi clinic will close once the Pomeroy CHC (opened 02/02/2015).

The following areas at Nquthu sub district; Qhudeni, Ngqulu, Ntabasbahle, KwaGwija, Ntsingabantu, Masangamnyama have been identified for new mobile points.

Table 18: No. of mobile points

Sub district	Number of mobile points
Nquthu	57
Endumeni	63
Msinga	43
Umvoti	63
District	226

Table 19 (NDoH 2): District Hospital Catchment Populations 2013/14

Name of District Hospital	2012/13				2013/14			
	Dundee Hospital	CJ M Hospital	COSH Hospital	Greytown Hospital	Dundee Hospital	CJ M Hospital	COSH Hospital	Greytown Hospital
Catchment Population of District Hospital	144 944	83 479	68 292	26 948	169 063	97 366	79 656	31 432
% Uninsured Population	84.5%	84.5%	84.5%	84.5%	93%	93%	93%	93%
Uninsured Catchment Population of District Hospital	122 477	70 539	57 706	22 771	157 229	90 550	74 080	29 231

Source: DHER 2013/14 (GIS) The 2012/13 uninsured population figure was aligned to Province however in 2013/14 it was aligned to the General Household Survey

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

Dundee hospital has the lowest population and the highest catchment population. This is due to the fact that Dundee hospital is situated in town and is easily accessible and the cross border patients as discussed above.

7.2 TRENDS IN KEY DISTRICT HEALTH SERVICE VOLUMES

7.2.1 PRIMARY HEALTH CARE SERVICE VOLUMES AND UTILISATION

Table 20 (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
Nquthu	432,844	432,844	2.4	482,634	482,634	2.9	49,790	49,790	0.5
Umvoti	347,694	347,694	3.3	352,319	352,319	3.4	4,625	4,625	0.1
Msinga	407,095	407,095	2.4	497,054	497,054	2.8	89,959	89,959	0.4
Endumeni	230,670	230,670	3.7	225,368	225,368	3.4	-5,302	-5,302	-0.3
District	**1,418,303**	**1,418,303**	**3.0**	**1,557,375**	**1,557,375**	**3.1**	**1,39,072**	**1,39,072**	**0.1**

Source: DHIS downloads

The district PHC utilisation rate has increased slightly from 3.0 to 3.1 visits per patient per annum. The National norm is 3.5 visits per client per annum. Nquthu has improved from 2.4 visits to 2.9 visits per client; Umvoti has increased slightly from 3.3 to 3.4 visits per client; Msinga has also increased slightly from 2.4 to 2.8 visits per client while Endumeni has decreased from 3.7 to 3.4 visits per client. This could be due to the correction made; of clinics which were originally placed under Endumeni (Rorkes Drift, Elandskraal, Douglas Clinics) instead of Msinga on the DHIS. This has also resulted in an increase in the utilisation rate for Msinga. . The initiation of HIV positive clients on ARVs is now done at PHC level and this may have contributed to the increase in the utilisation rate. Private GPs have also been contracted to work in the clinics and this could have attracted the clients to clinics.

The Outreach teams are also involved in identifying patients in the community who need to be referred to clinics for diagnosis and treatment. The functional War Rooms are also key in this regard.

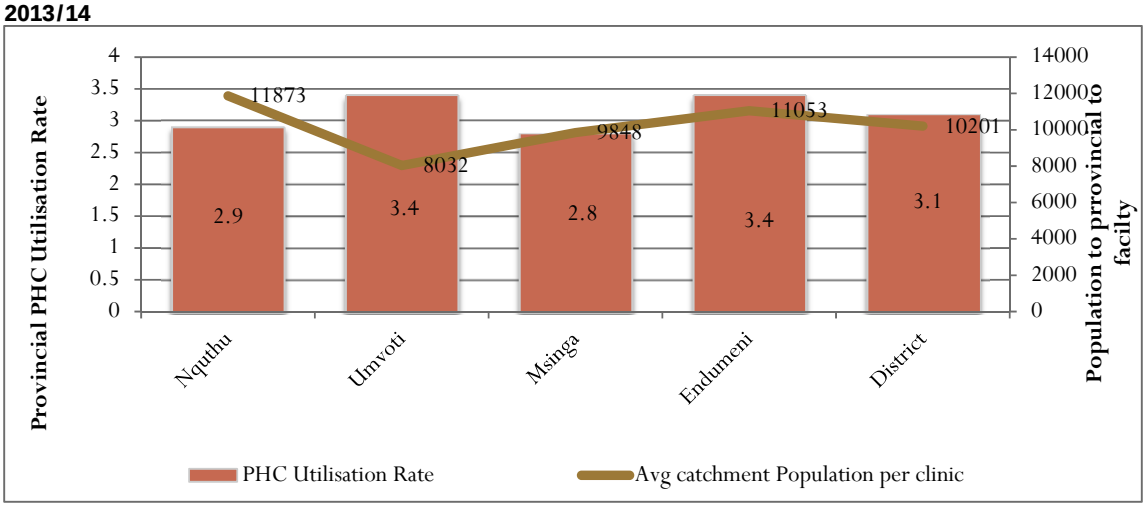
Table 21: Facility linked with WBOT (Ward Based Outreach Teams)

Sub district	Facility linked with WBOT (Ward Based Outreach Teams)	Ward	Number of WBOT Teams
Msinga	Ethembeni Clinic	11	2
	Mandleni Clinic	3	2
	Ncomboshe Clinic	15	2
	Mhlangana Clinic	6	2
Endumeni	Empathe Clinic	2,6,3	2
	Siphimpilo Clinic	3	2
	Douglas Clinic	19	2
Umvoti	Ntembisweni Clinic	3	2
	KwaSenge Clinic	6	2
Nquthu	Nondweni	5	2

Table 22: Contract GPs at Clinics

Sub District	GP's name	Clinic visited	Day of the week	Time
Umvoti	Dr. Dlamini	Amakhabela, Ntembisweni& Kranskop	Tuesday, Wednesday and Friday.	07h30-10h30
	Dr. Mkhize	Pine street & Ukuthula	Monday, Wednesday & Friday	08h00-09h00
	Dr. Zungu	Amatimatolo & Eshane	Monday to Friday	07h00-10h00
Nquthu	Dr. Kubheka	Hlathidam	Wednesday & Friday	08h00-10h00
	Dr. Mgabhi	CJM Gateway	Monday to Friday	07h30-09h30
	Dr. Nkosi	Nkande	Wednesday and Thursday	07h30-09h30
	Dr. Ntuli	Thathezakhe	Wednesday and Thursday	
Msinga	Dr. Hlatshwayo	Noyibazi & Qinelani	Monday, Wednesday & Friday	08h30-11h30
	Dr. Yusouff	Ethembeni	Wednesday	09h00-12h00
Endumeni	Dr. Bodiat	Glenridge	Wednesday	08h30-11h30
	Dr. Mbonani	Siphimpilo	Thursday	08h00-12h00
	Dr. Ramdharee	Wasbank	Wednesday	07h00-12h00

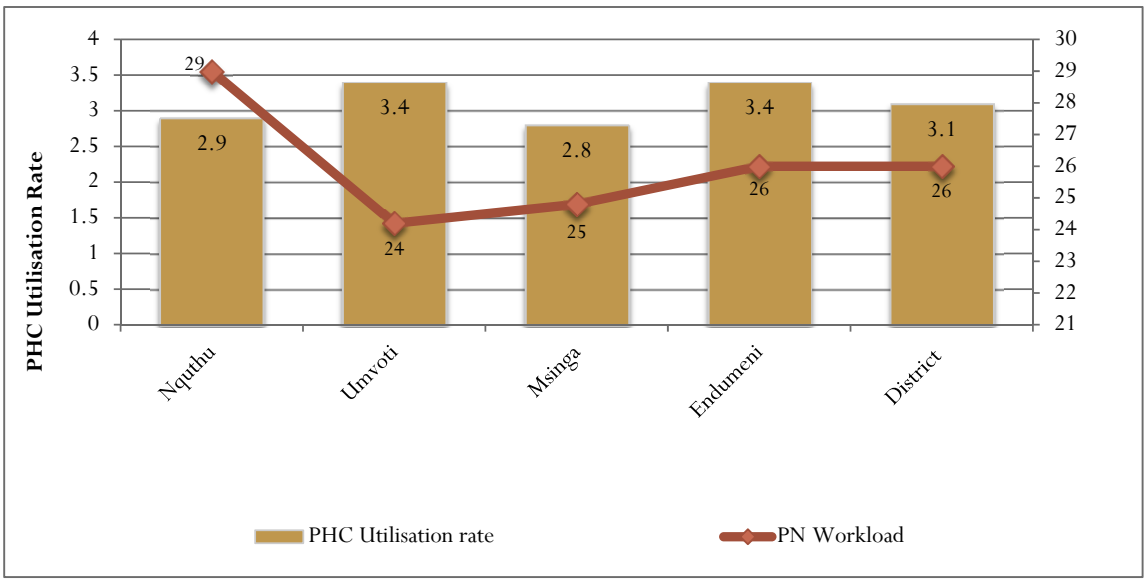
Graph: 2: PHC Utilisation (Provincial Clinics) vs. PHC facilities per 10 000 population (Provincial clinics) – 2013/14



Source: DHIS & DHER 2012/13 Customised District Report

According to the National STP norm – each clinic should serve on average 10,000 population. The PHC utilisation rate for Endumeni (3.4) and Umvoti(3.4) is above 3 visits per client per annum, however they have the lowest PHC facilities per 10 000 population, this is due to the fact that these facilities are situated in and around town and is therefore easily accessible to the clients. On the other hand Msinga and Nquthu have a high population and the lowest PHC utilisation rate – these sub districts are deep rural.

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



Source: DHIS, DHER

Nquthu has the highest PN workload of 29 though and a lower PHC utilisation rate of 2.9. Umvoti sub district has a high PHC utilisation rate of 3.4 and a low PN workload of 24. This is an indication that there might be a high number of actual PN's functional in this sub district. A direct opposite of Nquthu sub district.

Msinga has a low PHC utilisation rate of 2.8 and a low PN workload of 25 and has room for growth

Endumeni has a high PHC utilisation rate of 3.4 and a substantially low PN workload of 26

There is a vast difference in the equity within the district and this, needs to be corrected. The norm for PN workload is 35 clients per PN and looking at the data above it is of concern. The staffing needs to be verified, as well as the linking of staff, which is problematic in the district.

Table 23: (NDoH 4): District Hospital activities

District Hospitals	Year	Dundee Hospital	CJM Hospital	COSH Hospital	Greytown Hospital	District
1. Inpatient Days – total	2012/13	47 631	73 860	72 664	49 088	243 243
	2013/14	45 147	77 455	72 818	54 143	249 563
	Variation	-2 484	3595	154	5 055	6 320
2. Day patient – total	2012/13	57	0	0	2	59
	2013/14	59	0	1	105	165
	Variation	2	0	1	103	106
3. OPD Headcount not referred new	2012/13	13 476	34 689	43 905	8 342	100 412
	2013/14	12 359	33 667	28 986	8 434	83 448
	Variation	-1 117	-1020	-14919	92	-16964
4. OPD Headcount – total	2012/13	76 006	78 750	62 264	41 058	258 078
	2013/14	60 561	74 956	48 488	29 092	213 097
	Variation	-15 445	-3 794	-13 776	-11 966	-44 981
5. Emergency headcount total	2012/13	15 433	12 489	9 928	9 499	47 349
	2013/14	15 596	12 603	4 971	1 868	35 038
	Variation	163	114	-14 957	-7 631	-12 311
6. Total ambulatory [OPD + emergency]	2012/13	91 439	91 239	82 192	9499	305 427
	2013/14	76 157	87 559	53 459	30960	248 135
	Variation	-15 282	-3 680	-28 733	21 461	-57 292
7. Patient Day Equivalent	2012/13	77 834	103 969	96 487	65 773	344 063
	2013/14	70 562	106 641	90 638	64 515	332 356
	Variation	-7 272	2 672	-5 849	-1 258	-11 707
8. Delivery by caesarean section rate	2012/13	19% 452/2373	26.4% 976/3699	18% 630/3521	25% 490/1959	22% 2548/11552
	2013/14	14,5%	22,1%	20,5%	25,4%	20,6%
	Variation	-4,5%	-4,3%	2,5%	0.4%	-1.4%
9. Useable beds-annual	2012/13	224	349	347	271	1 191
	2013/14	224	349	347	271	1 191
	Variation	0	0	0	0	0
10. Average	2012/13	4.4	5.3	8.4	6.9	6.2

District Hospitals	Year	Dundee Hospital	CJM Hospital	COSH Hospital	Greytown Hospital	District
length of stay - total	2013/14	4.7	6.3	6.8	7.7	6.4
	Variation	0.3	1	-1.6	0.8	0.2
11. Inpatient bed utilisation rate – total	2012/13	58.3%	58%	57.4%	57.5%	57.8%
	2013/14	58%	66.6%	73.8%	55.4%	63.5%
	Variation	0%	8%	16%	-2%	5%
12. Emergency headcount as % of Ambulatory	2012/13	16%	13%	24%	100%	15%
	2013/14	20%	14%	9%	6%	14%
	Variation	4%	1%	-15%	-94%	-1%
13. Ratio of ambulatory to inpatient days	2012/13	52%	81%	88%	97%	80%
	2013/14	59%	88%	136%	174%	100%
	Variation	7%	7%	48%	77%	20%
14. Usable beds per 1 000 population	2012/13	4	2	2	3	2.75
	2013/14	4	2	2	3	2.75
	Variation	0	0	0	0	0
15. Inpatient Separations	2012/13	10 794	13 908	8 691	7 113	40 506
	2013/14	9 715	12 227	10 680	7 174	39 796
	Variation	-1 079	-1 681	1 989	61	-710
16. Inpatient Deaths	2012/13	649	813	775	445	2 682
	2013/14	643	816	707	458	2 624
	Variation	-6	3	-68	13	-58
17. Cost per PDE	2012/13	R 1 933	R 1 620	R 1 948	R 2 169	R 1 917
	2013/14	R 2 131	R1 690	R 1 759	R 2 298	R 1 969
	Variation	R 198	R 70	R -189	R 129	R 52

Source: DHIS Downloads 2012/13 & 2013/14

When comparing the 2013/14 OPD headcount to the OPD Headcount not referred new, it is evident that the Levels of Care Policy has not been fully implemented. Of the 213,097 clients seen at OPD; 38.25% (83,448) of them entered OPD without referrals from clinics or mobiles. As per district hospital breakdown COSH saw 59% of clients not referred; followed by CJM – 45%; Greytown - 29% and Dundee hospital 20%. The institutions are requested to adhere to the policy in order to reduce this high and unwarranted number of clients attending OPD without a referral from the PHC facilities.

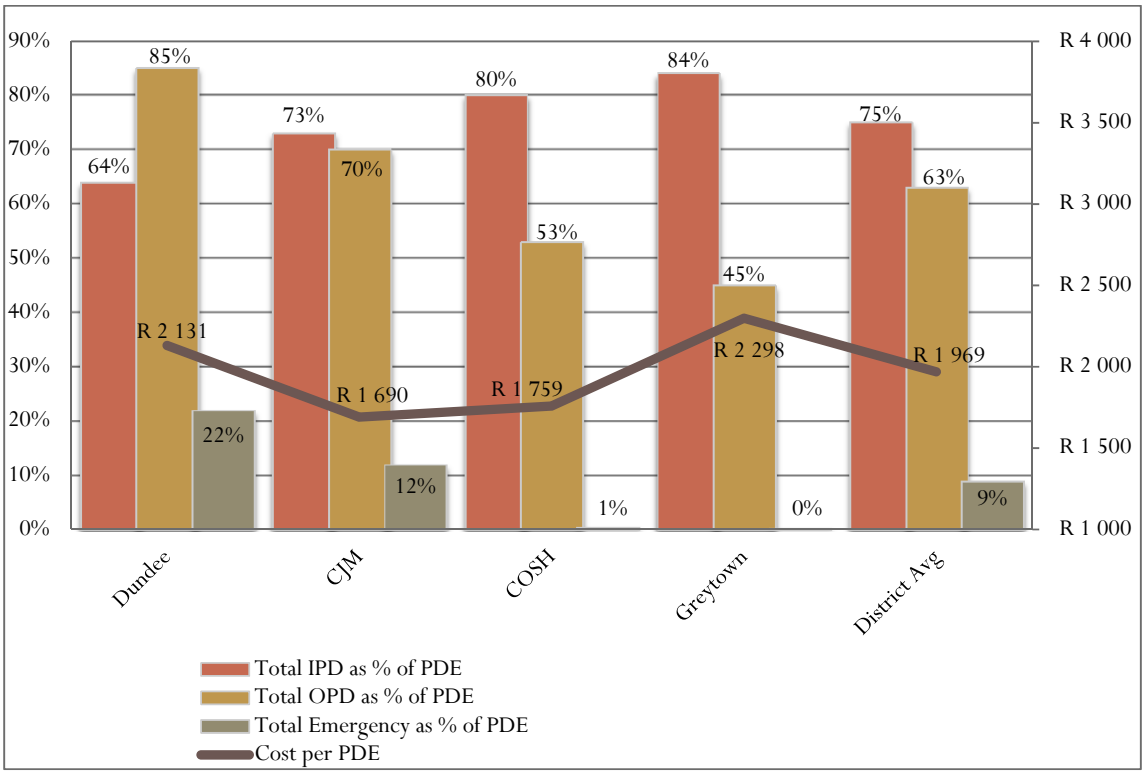
The district emergency headcount has decreased from 47,349 (2012/13) to 35,038 (2012/13).

The district Bed Utilisation Rate has increased from 57.8 % (2012/13) to 63.5 % (2013/14).The ALOS (Average Length of Stay) has increased from 6.2 (2012/13) to 6.4 (2012/13). Firstly this is due to the high burden of disease were patients need to be hospitalized for longer in order to be effectively cured. Secondly this is due to the admission of TB and Psychiatric patients, because of non-availability of beds in the referral hospitals. The overall district PDE (Cost per Patient

Day Equivalent) has increased from R 1 917(2012/13) to R 1 969 (2013/14). Greytown hospital has the highest cost per PDE of R2 2 98 as compared to CJM hospital with R 1 960.

The Caesarian Section Rate has decreased by 1.4% i.e. from 22 %(2012/13) to 20.6 % (2013/14).

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



Source: DHER 2012/13 Customised District Report

With reference to the Total IPD as a percentage of PDE; Greytown Hospital had the highest percentage of 84% followed by COSH at 80% ; followed by CJM Hospital at 73% and Dundee Hospital with the lowest percentage of 64%. The district average was 75%.

With reference to the Total OPD as percentage of PDE ; Dundee Hospital had the highest percentage of 85% followed by CJM Hospital at 70% ; followed by COSH at 53% and Greytown Hospital with the lowest percentage of 45%. The district average was 63%.

With reference to the Total Emergency as percentage of PDE; the above graph indicates that all district hospitals have fewer emergencies as a percentage of PDE. Dundee Hospital had the highest percentage of 22%, followed by CJM Hospital at 12%, followed by COSH at 1% and Greytown Hospital with the lowest percentage of 0%. The district average was 9%.

With reference to the Cost per PDE; Greytown Hospital had the highest Cost per PDE of R 2 298; followed by Dundee Hospital with R 2 131, followed by COSH with R 1 759 and CJM Hospital with R 1 690. The district average was R 1 969

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

Table 24 (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		DHIS	0.4%	0.2%
		Severe malnutrition under 5 years incidence)		DHIS	4.6/1000	4.4/1000
Goal 4: Reduce Child Mortality	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"		DHIS	6.3/1000	6/1000
		Infant mortality rate – use proxy "Child under 1 year mortality in facility rate"		DHIS	9/1000	7.5/1000
Goal 4: Reduce Child Mortality	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Measles 2nd Dose coverage		DHIS	80.1%	90%
		Immunisation coverage under 1 year		DHIS	77.2%	99.5%
Goal 5: Improve Maternal Health	Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate	Maternal mortality ratio (only facility mortality ratio)		DHIS	71.5/100 000	68/100 000
		Proportion of births attended by skilled health personnel (Use delivery in facility as proxy indicator)		DHIS	68.4%	88%
Goal 6: Combat HIV and	Have halted by 2015, and begin to reverse the spread of HIV and	HIV prevalence among 15- 19-year-old pregnant women		National HIV Syphilis Prevalence	24.4%	24%

MDG	Target	Indicator	Provincial progress 2013/14	Source of data	District progress 2013/14	District targeted progress 2014/15
AIDS, malaria and other diseases	AIDS			Survey of SA		
		HIV prevalence among 20- 24-year-old pregnant women		National HIV Syphilis Prevalence Survey of SA	24.6%	30.1%
		Contraceptive prevalence rate (use Couple year protection rate as proxy)		DHIS	59.9%	65%
		TB Cure Rate		ETR.Net	86.8%	87.5%

9. PROVINCIAL AND DISTRICT CONTRIBUTION TOWARDS THE HEALTH SECTOR NEGOTIATED SERVICE DELIVERY AGREEMENT (NSDA)

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 25: (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		

NDP Goals 2030	NDP Priorities 2030	Sub-Outcomes 2014-2019 (MTSF)
Prevalence of Non-Communicable Diseases reduced by 28%		Maternal, infant and child mortality reduced
Injury, accidents and violence reduced by 50% from 2010 levels		
Health systems reforms completed	b. Improve 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
	g. Review management positions and appointments and Improve 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

10.1 INTRA DISTRICT EQUITY IN THE PROVISION OF SERVICES

Table 26 (NDoH 6): PHC Expenditure

Sub-District	PHC Expenditure / Uninsured Capita	PHC Utilisation Rate	PN to Patient Provincial clinics	% Share of District Population
Endumeni	R 372.30	3.4	2.0	12%
Nquthu	R 273.60	2.9	2.0	32%
Msinga	R 344.10	2.8	2.2	36%
Umvoti	R 405.00	3.4	1.5	20%
District	**R 348.75**	**3.1**	**1.9**	**100**

Source: DHER 2013/14 Customised District Report, DHIS

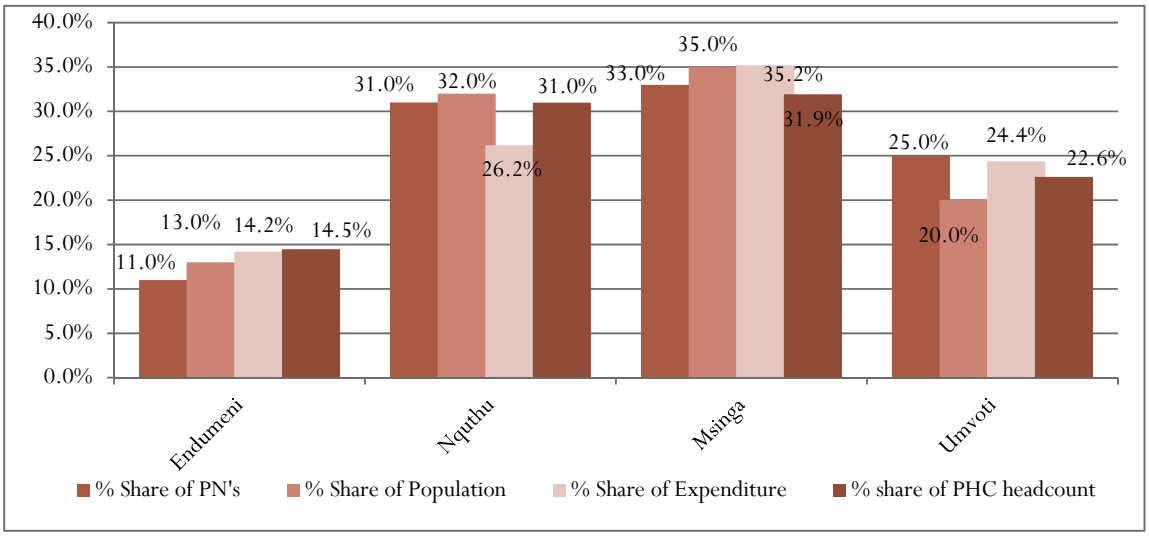
Umvoti has the highest PHC expenditure of R405.40, a high PHC utilisation rate of 3.4 and supports 20% of the district population. Umvoti however has the lowest proportion of professional nurses 1.5 despite the fact that they have the second lowest population and number of PHC facilities.

Endumeni has the second lowest PHC expenditure per capita of R372.30 a high PHC utilisation rate of 3.4 and the smallest share of the district population of 12%

Msinga has the third lowest PHC expenditure per capita of R344.10 and a PHC utilisation rate of 2.8 and the largest share of the district population of 36%

Nquthu has the lowest PHC expenditure per capita of R273.60, the second lowest PHC utilisation rate of 2.9 and supports 32% of the district population

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



Source: DHER 2013/14 Customised District Report

A glance at the graph above is an indication of resource allocation and distribution.

Msinga has the largest population (36%), has the most number of PNs in the district (33%) i.e. 70 PNs, it has the highest PHC headcount-32% and has spent the highest 35.2% of the total expenditure

Nquthu has the second largest population - 32%, the second highest number of PNs- 31% i.e. 67 PNs, has the second highest PHC headcount-31% and has spent the second highest 26.2% of the total expenditure.

Umvoti has the third largest population - 20%, the third highest number of PNs - 25% i.e. 53 PNs, has the third highest PHC headcount-23% and has spent the third highest 24.4% of the total expenditure

Endumeni has the smallest population -12%, the lowest number of PNs -11% i.e. 23 PNs, has the lowest PHC headcount-14.5% and has spent the lowest in the district 14.2% of the total expenditure.

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

Table 27 (NDoH 7 (a)): Number of patients to staff type (Sub-District) – PDoH PHC Clinics

Sub-District	Administrator	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
Endumeni	40,031	100078	16680	66718	20016	0	50039	0	0	0	6065	9098	0
Nquthu	28020	14493	14010	84059	30021	0	210148	0	0	0	5254	9774	0
Msinga	15804	21072	19239	442506	23290	0	23299	0	0	0	5531	5397	0
Umvoti	25423	23468	15254	0	30508	0	152540	0	0	0	4622	8973	0

Source: DHER 2013/14 Customised District Report, DHIS

No Medical Officers have as yet been employed on a full time basis for the PHC clinics. The hospital medical officers visit the clinics when they are available. The Doctor workload for PHC is currently 16 patients per doctor per day. This will increase with the continued employment of private GPs in clinics as Umzinyathi is an NHI site.

There is presently one Clinic Support Officer per clinic in the district who also assists with data management and admin duties. Aurum (NGO) has employed data capturers for the district and are presently being utilised; they will eventually need to be absorbed depending on the availability of posts. These data capturers are assisting with the capturing of TIER.net information. Umzinyathi district decided that the ENAs would be better utilised in the hospitals and this has resulted in fewer ENAs in the clinics.

Table 28 (NDoH 8): Population to Staff per sub-district – 2013/14[4]

Sub-District	Population to Medical Officers		Population to Professional Nurses	
	Total Population	Uninsured Population	Total Population	Uninsured Population
Nquthu	0.0	0.0	2078	1932
Umvoti	0.0	0.0	1582	1471
Msinga	0.0	0.0	2216	2061
Endumeni	0.0	0.0	2010	1869
District	**0.0**	**0.0**	**1971**	**1833**

Source: DHER 2013/14 Customised District Report, DHIS

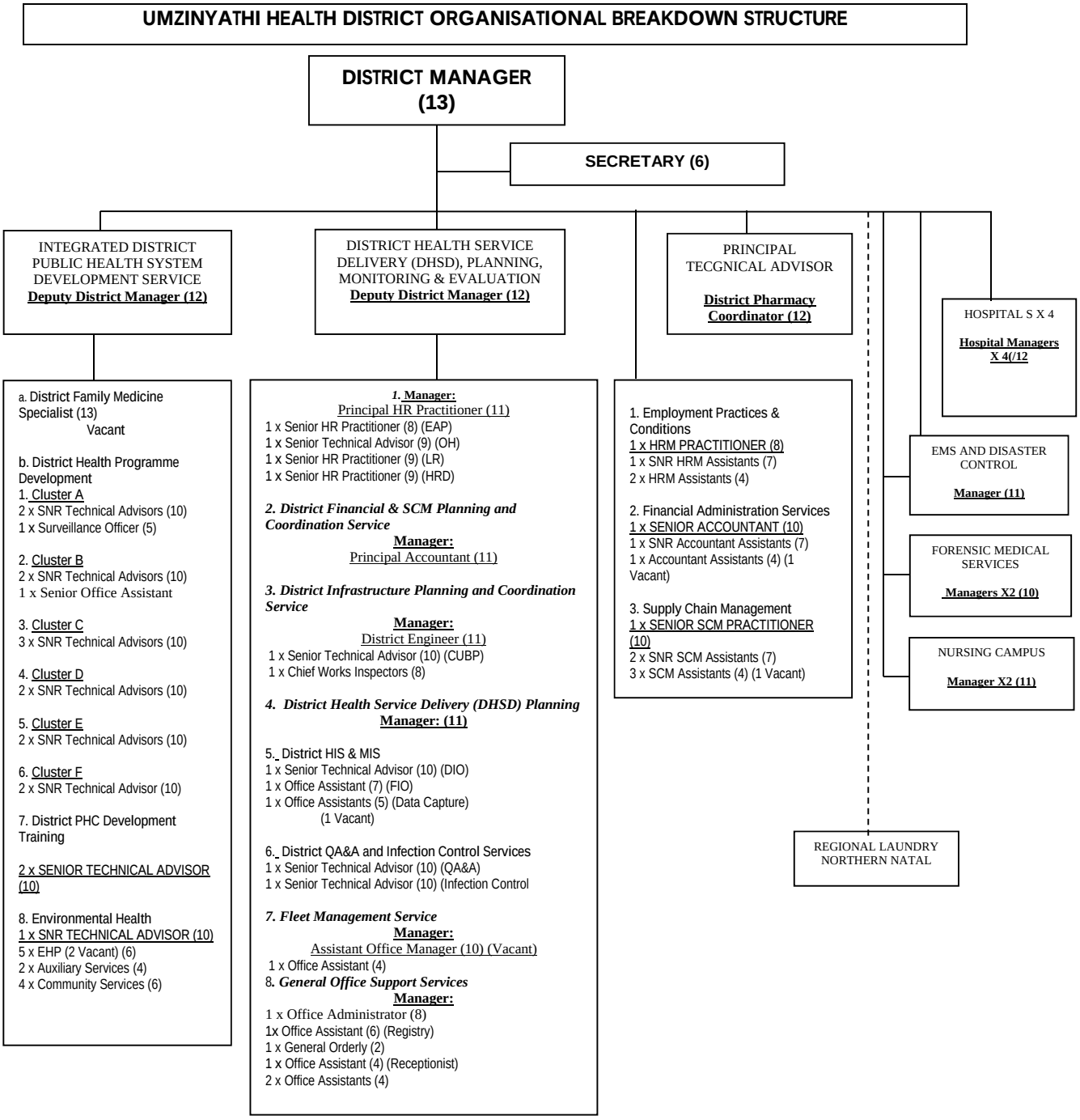
There are no full time Doctors at clinics – they do however visit the clinics on a regular basis if there are sufficient doctors in the hospitals. The medical officer vacancy rate is presently at 20% which is an improvement from previous years. Umzinyathi is deep rural, lack of accommodation and recreational facilities has a negative impact on the staffing within the district.

None of the clinics have a resident doctor. Msinga clinics are not visited by a medical officer as yet due to the shortage of medical officers. However plans have been put in place to commence this service in the next financial year.

Umvoti which is semi-rural, has the lowest number of patients – 1,471 patients per PN per uninsured population, followed by Endumeni which is also semi-rural, with 1,869 patients per PN per uninsured population; Msinga which is deep rural has the highest number of patients at 2,061 patients per PN per uninsured population, followed by Nquthu, which is also deep rural, with 1,932 patients per PN per uninsured population. This is a big different between the rural and semi-rural districts. This tells us that the higher the number of health facilities; the more PN are required to service that community and ultimately the higher the cost per patient.
On average there are 1,833 clients per PN per uninsured population, while there are 1,971 clients per PN per Total population. The average workload per PN per day is 26 clients, whereas the norm is 35 clients per PN per day. This is an indication that some clinics appear to be overstaffed while others appear to be understaffed. The table below indicates the differences between Persal data and the actual physical PN headcount. Umzinyathi currently attends to 6% of the total KZN headcount and spends 6% of the total PHC expenditure.

11. ORGANISATIONAL ENVIRONMENT

11.1 ORGANISATIONAL STRUCTURE OF THE DISTRICT MANAGEMENT TEAM



11.2 HUMAN RESOURCES –

Table 29: 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
Nquthu	0	5,254	9,774	210,148	84,059	30,021
Umvoti	0	4,622	8,973	152,540	0	30,508
Msinga	0	5,531	5,397	23,299	442,506	23,290
Endumeni	0	6,065	9,098	50,039	66,718	20,016

Source: DHER 2013/14 Customised District Report

There are no permanent medical officers employed at provincial clinics. They visit clinics when they are available. Contracted GP'S do however visit clinics (refer to table 6 narrative).

Endumeni PHC facilities has the highest PN patient ratio of 6,065, followed by Msinga – 5,531; followed by Nquthu 5,254 and lastly Umvoti PHC facilities with the lowest PN patient ratio of 4,622. Nquthu PHC facilities have the highest ENA to patient ratio - 210,148 and Msinga PHC facilities have the lowest ENA to patient ratio – 23.299.

Umvoti sub district PHC facilities do not have any data capturers. This is being looked into by the district. Msinga PHC facilities has the highest data capturer to patient ratio – 442,506

Umvoti PHC facilities has the highest general worker to patient ratio 30,508 were as Endumeni PHC facilities has the lowest general worker to patient ratio – 20,016

Table 30: 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
Endumeni	R 101.90	26	2010
Nquthu	R 87.60	29	2078
Msinga	R 114.10	25	2216
Umvoti	R 111.60	24	1582

Source: DHER 2013/14 Customised District Report, DHIS

The increase in headcount will always result in a decrease in cost per headcount. The National average is R201.00 - Umzinyathi is 50% lower than the National average. It is of concern that despite the increase in costs of staffing and commodities, that the cost per headcount is decreasing.

Table 31: 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
COSH	6,474	235	6,043	5,036	1,066
Dundee Hospital	5,040	256	4,410	3,713	603
CJM Hospital	10,664	342	5,332	6,273	903
Greytown Hospital	4,301	214	4,032	3,226	686

Source: DHER 2012/13 Customised District Report

Unfortunately there are no staffing norms for hospitals – it is therefore difficult to identify whether the institution is over / under staffed. We can only compare the workload of one institution to another

Pharmacy assistants from the district hospitals visit the clinics, as there aren't any employed for the clinics.

Pharmacists: Looking at the information above; one can deduct that all the hospital pharmacists appear to be over worked – as they all attend to more than four thousand patient per day; with COSH having the highest workload of 6,043 followed by CJM; Greytown hospital with the lowest workload followed by Dundee hospital. There is dedicated pharmacist work full time in the ARV clinics. There are no community service pharmacists – due to late registrations by council. This affects the employment of these staff and negatively impacts on the hospital and staff themselves. Therefore depriving the rural hospitals of having more staffed as a result the available staff are over worked.

Medical Staff: CJM Hospital appears to be grossly under staffed as far as medical officers are concerned; i.e. 10,664 patients per medical officer per day; followed by COSH; while Greytown Hospital appears to be better staffed that the other hospitals, followed by Dundee Hospital.

Nursing Staff: Greytown Hospital appears to have a lower workload as compared to the other three hospitals (214 patient per nursing staff) while CJM appears to have the highest nursing workload of 342 patients per nurse, followed by Dundee hospital of 256 patient per nurse followed by COSH with 235 patients per nurse per day.

12. DISTRICT HEALTH EXPENDITURE

Table 32 (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	22 434 000	0.00	0.00	23 481 023	0.00	0.00
DF - 2.2: Clinics	161 208 000	0.00	0.00	161 833 697	0.00	0.00
DF - 2.3: Community Health Centres	0.00	0.00	0.00	24 252	0.00	0.00
DF - 2.4: Community Services	0.00	0.00	0.00	0.00	0.00	0.00
DF - 2.5: Other Community Services	81 709 000	0.00	0.00	81 461 690	0.00	0.00
DF - 2.6: HIV/AIDS	147 820 000	0.00	0.00	146 311 610	0.00	0.00
DF - 2.7: Nutrition	2 566 000	0.00	0.00	2 566 121	0.00	0.00
DF - 2.9: District Hospitals	587 644 000	0.00	0.00	589 499 167	0.00	0.00
DF – 2.12: Donor Funding	0.00	0.00	0.00	0.00	0.00	0.00
TOTAL DISTRICT	**1 003 381 000**	**0.00**	**0.00**	**1 005 177 560**	**0.00**	**0.00**

Source: DHER 13/14 District Customised Template

District Management shows a 4.45% over expenditure of the allocated budget. The money allocated under clinics was utilised and show a 0.38% over expenditure of the allocated budget. The expenditure that is shown under Community services though there is no budget allocated. The expenditure for other community Services is also in line with the budget allocation and 99.69% of the budget was spent. The Grant funding HIV/AIDS that was allocated to Umzinyathi shows 98% expenditure. The expenditure for district hospitals was fully utilised and shows an over expenditure of 0.31%.

Table 33 (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
Endumeni	R 62 219 917	R 22 960 451	R 372.30	93%	17.48%	R 536.90	R 372.30
Nquthu	R 95 308 329	R 42 293 403	R 273.60	93%	26.77%	R 315.60	R 273.60
Msinga	R 115 137 356	R 56 719 712	R 344.10	93%	32.34%	R 346.00	R 344.10
Umvoti	R 83 363 088	R 39 323 973	R 405.00	93%	23.41%	R 482.40	R 405.00
District	**R 356 028 690**	**R 161 297 539**	**R 348.75**	**93%**	**100%**	**R 420.23**	**R 348.75**

Source: DHER 2013/14 Customised District Report

The average National capita PHC expenditure is R 501 as compared to Umzinyathi at R 348.75. The increase in population due to the 2011 census may have been as a result of the decrease in expenditure per capita. In the previous financial year; Umzinyathi's cost per capita per uninsured was R 420.23 as compared to R 348.75 this financial year. Endumeni has decreased from R 536.90 to R 372.30; Msinga decreased from R 346 to R 344.10; Nquthu decreased from R 315.60 to R 273.60 and Umvoti decreased from R 482.40 to R 405

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

Table 34 (NDoH 11): PHC Budget and Expenditure (%) excluding "Other Donor Funding" – 2013/14

	Budget Amount	Budget	Expenditure Amount	Expenditure
District Management (2.1)	22 434 000	2.23%	23 481 023	2.3%
PHC (2.2 – 2.7)	393 303 000	39.19%	392 197 370	39.09%
District Hospitals (2.9)	587 644 000	58.56%	589 499 167	58.6%

Source: DHER 2013/14 Customised District Report

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

Table 35 (NDoH 12): PHC Cost per Headcount– 2013/14

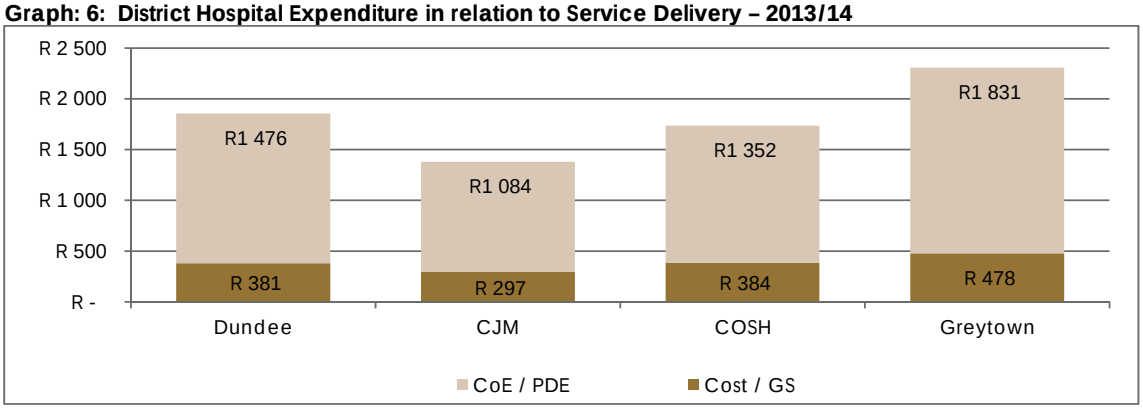
	LG PHC Facilities	Provincial PHC Facilities	Total Staff Cost per PHC Headcount
Umzinyathi District	N/A		64.1

Table 36: District Hospital Expenditure

District Hospital	Expenditure per PDE	ALOS	BUR	Proportion (%) of expenditure spent on staff (CoE)
Dundee hospital	R 2 131	4.6 days	55.3%	R 1 476 (79%)
CJM hospital	R 1 690	6.3 days	60.8%	R 1 084 (78%)
COSH hospital	R 1 759	6.8 days	57.5%	R 1 352 (78%)
Greytown hospital	R 2 298	7.6 days	54.8%	R 1 831 (79%)
District	**R 1 969**	**6.3 days**	**57.1%**	**R 1453 (78.5%)**

Source: DHER 2013/14 Customised District Report

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



Source: DHER 2012/13 Customised District Report

The hospitals are spending 78.5% of their budget on CoE which is extremely high as compared to the norm of 65%. The concern is the high Cost per PDE of R1, 969 as compared to R 348 per PHC headcount. If the Levels of Care Policy was strictly adhered to this would greatly reduce the cost per PDE. The lower level MOs are few, many of the MOs are either Grade 2 or 3 which means that the salary is much higher therefore the increase in COE. Hospitals have had to employ more SCM staff to cope with SCM logistics, Finance has had to employ more finance staff to cope with all the new requirements to obtain clean audits and enhance revenue collection. It is of vital importance that staffs takes into cognisance that treating a patient in hospital who does not warrant hospital / specialised care is a waste of resources. Looking at the OPD patients not referred to hospital, where ± 39% of the patient bypass clinics and mobiles and go straight to the hospital without a referral note, it is obvious that staffs are not taking this seriously. It is now costing the department R R1, 969 per patient per day.

Table 37: Non-Negotiable Expenditure per PDE

Non-Negotiable [Rands per PDE]	COSH	Dundee Hospital	CJM Hospital	Greytown Hospital
Infrastructure Maintenance	0.0	0.0	0.0	0.0
Food Services	51.5	28.2	24.1	32.2
Medicine Expenditure	60.4	79.1	49.6	86.0
Essential Equipment	11.5	10.7	11.4	5.0
Laundry Expenditure	0.0	0.0	0.0	0.0
Vaccination Expenditure	19.2	16.6	5.9	5.3

Non-Negotiable [Rands per PDE]	COSH	Dundee Hospital	CJM Hospital	Greytown Hospital
Blood Support Expenditure	21.0	25.7	14.1	18.8
Infection Control Expenditure	47.1	30.5	38.4	48.9
Medical Sundries (Supplies) Expenditure	51.5	97.0	60.3	73.9
Medical Waste Expenditure	13.6	9.7	8.2	5.8
Laboratory Services Expenditure	0.0	0.0	0.0	0.0
Security Services	25.4	21.7	22.8	25.2

Source: DHER 2013/14 Customised District Report

PART B - COMPONENT PLANS

The main body of the DHP is composed of five inter-related components, namely:
Service delivery;

- Service Delivery
- Support services;
- Infrastructure;
- Human Resources; and
- Finances.

The service delivery component is the core business of District Health Services. It covers the delivery of the full District Health Package of services, the management and supervision of these services, how well the service performs in terms of health outcomes and quality assurance. The other four (4) components in the DHP: support services, human resources, finances and infrastructure – are the resources required to support the core business of District Health service delivery. The five (5) components are inter-related in that an objective in one component will often have implications for other components. For example, if under Service Delivery, you want to improve supervision by employing an additional supervisor, you would need to plan for this in the HR component and plan for the extra expense in the Finance component.

13. SERVICE DELIVERY PLANS FOR DISTRICT HEALTH SERVICES

13.1 SUB-PROGRAMME: DISTRICT HEALTH SERVICES

13.1.1 PHC SUB-PROGRAMME OVERVIEW

PHC PROGRAMME

Achievements

- Increased mobile stopping points at Msinga from 40 to 43 and Umvoti from 56 to 63
- Appointed a PHC Trainer for Msinga Sub-District
- Appointed School Health Teams for Ehlanzeni, Amatimatolo
- Increased PHC Headcount for the District through the WBOT and School Health Teams and the outreach activities planned
- The PHC Re-engineering concept has been introduced to all Local Municipalities
- Created PHC forums to improve the functioning of PHC (Data, QIP teams at Sub-Districts, Risk Management Teams for PHC)
- Contracting of GPs' at facilities to improve medical care for the PHC patients.
- Identification and employment of Household champions at Sub-Districts to improve the health
- Employment of Handyman and Ground-breakers for the District
- Formulation of a District SCM/Finance Committee for PHC

Challenges

- Due to a shortage of staff Msinga cannot extend the mobile services any further.
- Shortage of transport for the employed SHT's.
- No recruits for WBOT's for Ehlanzeni and Amatimatolo
- Lack of support from the OM's and the PHC Supervisors in terms of visiting wards with the teams, providing medical equipment.
- Shortage of transport for WBOT and School Health Teams.
- GP's are not authorized to drive KZN vehicles, GP's therefore rely on PHC for transport
- EPWP programme which means that staff will only be employed for the current financial year.
- Dundee Gateway Clinic has a poor condom distribution rate of 5%.
- Nkande Clinic septic tanks blocked

COMMUNITY CARE GIVERS CCGS

Achievements

- Established 54 Phila Mntwana Centre's manned by CCGs.
- Training of CCGs on integration of both DSD and DOH completed.
- Procurement of 394 cooler bags for CCGs, as well as 500 ice packs for carrying Vitamin A.

Challenges

- Poor ownership of the programme by facilities.
- Poor collection of Home Based Care Kits; some clinics do not have kits.
- Only 39 out of the 59 CCGs recruited. Challenges: applicants gave wrong addresses and local leadership does not understand the recruitment strategy.
- Poor career path for CCGs because they don't have Grade12.
- CCG Facilitators are demotivated because they are acting in the posts.

INTEGRATED SCHOOL HEALTH PROGRAMME

Achievements

- 40 schools introduced into the HPS Programme
- 10 schools were involved in Physical Activity Programme
- 60 schools visited for health assessment.
- 250 schools were given health education on prevention of Oral Health conditions.
- NHI Oral Health and Eye Care vehicles are visiting schools.
- 40 School Health and Family Health Nurses and supervisors were trained on second round HPV campaign immunization

Challenges

- Shortage of transport for School Health Teams.
- Shortage of IEC material.
- Staff shortages: Health Promoters, Dental Therapist for NHI mobile dental truck and Oral Hygienist for COSH, Greytown and Dundee Hospital.
- Consent forms not signed by parents.

Table 38 (NDoH 13): Situation Analysis: Indicators for District Health Services 2013/14 Financial Year

Indicators	Type	Endumeni	Nquthu	Msinga	Umvoti	District Average
1. Percentage of fixed PHC facilities compliant with all extreme measures of the National Core Standards	Quarterly %	0%	0%	0%	0%	0%
Fixed PHC facilities compliant with all the extreme measures of the National Core Standards for health facilities	*No*	*0*	*0*	*0*	*0*	*0*
Fixed PHC clinics plus fixed CHCs / CDCs	*No*	*6*	*14*	*18*	*12*	*50*
2. Patient Experience of Care Survey rate (PHC Facilities)	Quarterly %	100%	100%	100%	100%	100%
Fixed PHC facilities that have conducted Patient Experience of Care Surveys	*No*	*6*	*14*	*15*	*12*	*47*
Fixed PHC clinics plus fixed CHCs / CDCs	*No*	*6*	*14*	*18*	*12*	*50*
3. PHC Patient Experience of Care Survey rate at PHC facilities	Annual %	84%	82%	93%	81%	85%
Patient satisfied with health services	*No*	*202*	*205*	*215*	*203*	*825*
Patients participating in Patient Experience of Care Surveys	*No*	*240*	*250*	*230*	*250*	*970*
4. OHH registration visit coverage	Annual %	Not available	Not available	Not available	Not available	Not available
OHH registration visit	*No*					
OHH in Population	*No*					
5. Number of District Clinical Specialist Teams (DCST's)	Quarterly No	N/A	N/A	N/A	N/A	1 incomplete team
6. PHC utilisation rate	Annual %	3.4	2.9	2.8	3.4	3.1
PHC headcount total	*No*	*225,368*	*482,634*	*497,054*	*352,319*	*1,557,375*
Population Total	*No*	*66,230*	*166,215*	*177,265*	*104,417*	*514,217*
7. *Complaints Resolution Rate*	*Quarterly %*	*91%*	97.4%	97.6%	*91.6%*	*95%*
Complaints resolved	*No*	*21*	*38*	*41*	*33*	*133*
Complaints received	*No*	*23*	*39*	*42*	*36*	*140*
8. Complaint resolution within 25 working days rate	% Quarterly	82.6%	97.4%	97.6%	80.5%	90.7%
Complaint resolved within 25 working days	*No.*	*19*	*38*	*41*	*29*	*127*
Complaint resolved	*No.*	*23*	*39*	*42*	*36*	*140*

Table 39 (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	0%	0%	0%	50%	55%	60%	65%	
Fixed PHC facilities compliant with all the extreme measures of the National Core Standards for health facilities	*QA assessment records*	*No*	*0*	*0*	*0*	*25*	*28*	*33*	*36*	
Fixed PHC clinics plus fixed CHCs / CDCs	*DHIS calculates*	*No*	*47*	*47*	*50*	*50*	*55*	*55*	*55*	
2. Patient Experience of Care Survey rate (PHC Facilities)	QA calculates	% Quarterly	100%	100%	100%	100%	100%	100%	100%	100%
Fixed PHC facilities that have conducted Patient Experience of Care Surveys	*OSS records*	*No*	47	49	*50*	50	55	55	55	
Fixed PHC clinics plus fixed CHCs / CDCs	*DHIS calculates*	*No*	*47*	49	*50*	*50*	*55*	*55*	*55*	
3. PHC Patient Experience of Care Survey rate at PHC facilities	DHIS calculates	% Annual	80%	80%	85%	90%	90%	90%	90%	90%%
Patient satisfied with health services	*PSS results*	*No*	*752*	*752*	*825*	*882*	*940*	*940*	*940*	
Patients participating in Patient Experience of Care Surveys	*PSS records*	*No*	940	940	*970*	*980*	*1040*	*1040*	*1040*	
4. OHH registration visit coverage	DHIS calculates	% Annual	Not available	Not available	Not available	Not available	To establish baseline	Review based on baseline	Review based on baseline	
OHH registration visit	*DHIS/Tick register WBOT*	*No*								
OHH in Population	*District Records*	*No*								
5. Number of District Clinical Specialist Teams (DCST's)	Persal/ District Records	Quarterly No	Not reported	Not reported	1 team incomplete	1	1	1	1	

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
6. PHC utilisation rate	DHIS calculates	Annual %	2.97	3	3.1	3.2	3.25	3.3	3.34	3.5
PHC headcount total	*DHIS/PHC tick register*	*No*	1,423,653	1,447,698	1,557,375	*1,534,037*	*1,595,398*	*1,659,139*	1,831, 115	
Population Total	*DHIS/Stats SA*	*No*	514,840	517,807	*514 217*	*523,195*	*525,472*	*527,587*	548,690	
7. Complaints Resolution Rate	DHIS calculates	*Quarterly %*	Not reported	97%	90.7%	94%	92%	92%	92%	*90%*
Complaints resolved	*DHIS / Complaint records*	*No*	-	141	*127*	*134*	*130*	*131*	*131*	
Complaints received	*DHIS / Complaint records*	*No*	-	145	*140*	*143*	*142*	*143*	*143*	
8. Complaint resolution within 25 working days rate	DHIS calculates	Quarterly %	Not reported	97%	90.7%	94%	92%	92%	92%	90%
Complaint resolved within 25 working days	*DHIS / Complaint records*	*No.*	-	141	*127*	*134*	*130*	*131*	*131*	
Complaint resolved	*DHIS / Complaints record*	*No.*	-	145	*140*	*143*	*142*	*143*	*143*	

Table 40 (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		
				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 %	5.6	6.7	4.5	6.1	5.9	5.7	5.6
	PHC headcount under 5	*DHIS/PHC tick register*	*No*	*340,962*	*343,480*	*303, 980*	303,865	291,710	280,041	345,951
	Population under 5 years	*DHIS/Stats SA*	*No*	*63,606*	*63,086*	*67 205*	*62,356*	*62,017*	*63,606*	*63,086*
	1.2 PHC Total Headcount under 5 years	DHIS/Tick register SHS	No	*340,962*	*343,480*	*303, 980*	303,865	291,710	280,041	345,951
2.	2.1 Expenditure per PHC headcount	DHIS/BAS	Quarterly R	113	118.9	103.80	131	138	144	149
	Total expenditure PHC	BAS (R'000)	R'000	*244,056,879*	*167,721,072*	*161,833,697*	174,497,001	177,986,941	181,546,680	*188,808,547*
	PHC headcount total	DHIS calculates	No	*1,423,653*	*1,418,303*	*1 557 375*	*1,534,037*	*1,595,398*	*1,659,213*	*1,725,518*
3.	3.1 Number of School Health Teams (cumulative)	District Records/ Persal	Quarterly No	2	4	16	22	30	38	40
4.	4.1 Number of accredited Health Promoting Schools (cumulative)	Health Promotion database	Quarterly No	26	34	42	50	61	68	71
5.	5.1 Dental extraction to restoration ratio	DHIS calculates	Quarterly Ratio	934	840	386.9	712	694	675	702
	Tooth extraction	*DHIS/Tick register*	*No*	*18,300*	*17,671*	*18, 959*				
	Tooth restoration	*DHIS/Tick register*	*No*	*131*	*17*	*49*				
6.	6.1 Percentage of PHC facilities conditionally compliant to the National Core Standards	QA assessment records	Annual %	Not reported	0	30%	50%	80%	100%	100%
	Clinics conditionally compliant (50%-75%)to National Core Standards	*QA assessment records*	*No*		*0*	15	25	44	55	55
	CHC's and clinics total	*DHIS calculates*	*No*		*49*	*50*	50	55	55	55

Strategic Objective	Performance Indicators	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
7.	7.1 District PHC expenditure per uninsured person	BAS / Stats SA	R	561	383.32	348.75	394.70	400.85	407.23	407.22
	Total expenditure on PHC services	*BAS*	*R'000*	*244,056,879*	*167,721 072*	*161 833 697*	*174,497,001*	*177,986,941*	*181,546,680*	*188,808,547*
	Number of uninsured people in the Province (Stats SA)	*DHIS / Stats SA*	*No*	*435,039*	*437.546*	*478,223*	*442,099*	*444,023*	*445,811*	*463,643*
8.	8.1 PHC supervisor visit rate (fixed clinic/ CHC/ CDC)	DHIS	%	68%	77%	47.8%	80%	90%	100%	100%
	PHC supervisor visit (fixed clinic/ CHC/ CDC)	*Supervisor checklists*	*No*	32	38	*24*	*40*	*50*	*55*	*55*
	Fixed clinics plus fixed CHCs/CDCs	*DHIS Calculates*	*No*	47	49	*50*	*50*	*55*	*55*	*55*
9.	9.1 Number of functional Ward Based Outreach Teams (Family Health Teams) (cumulative)	District Management / Appointment letters	No	0	11	11	22	25	28	30
10.	10.1 School ISHP coverage (annualised)	DHIS	%	Not reported	Not reported	Not reported	Establish Baseline	To be reviewed	To be reviewed	To be reviewed
	Schools with any learner screened	*DHIS / Tick register SHS*	*No*							
	Schools – total	*DHIS / DoE database*	*No*							
11.	11.1 Number of Primary Health Care Clinics that qualify as Ideal Clinics		No	N/A	N/A	0	22	30	45	55
12.	12.1 Number of Primary Health Care Clinics with functional Clinic Committees		No	47	50	50	50	55	55	55

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

Table 41: PHC Strategies

Strategies	• Activities
PHC re-engineering and innovations to improve universal access an equity	• Fill vacant posts in the existing WBOT's and School Health Teams • Increase the number of WBOT's and School Health Teams • Increase the number of mobile stopping points • Identify CCG's to cover Grey areas within the District and work with WBOT's • Train newly employed School Health Teams and WBOT's within the District
Implementation of integrated quality improvement model - NCS and Ideal Clinics	• Work towards having the identified Ideal Clinics accredited • Ensure the full implementation and the sustainability of the Integrated Chronic Disease Management programme at facilities • Conduct training on the Integrated Chronic Disease Management approach at facilities • Increase distribution sites of chronic medication • Allocate an E/N to distribute chronic medication at distribution sites
Improve on the integrated approach to Non Communicable Diseases	• Link CCG's and WBOT to all chronic patients for easier tracing • Monitor the progress of the Central Chronic Dispensing and Distribution programme (CCMDD) within the District.
Improve Quality of Health Care at PHC	• Formulate PHC Quality Improvement Teams • Employ PHC Quality and Infection Control Managers for PHC. • Co-ordinate annual open days to market quality services offered at PHC facilities • Establish functional Clinical Governance Structures at Sub-District levels where these structures are non-existing. • Initiate the electronic medical recoding system within the District in phases from February 2015 in 10 facilities. • Conducting patient waiting times and patient satisfaction surveys for PHC facilities including Pomeroy CHC. • Conducting staff satisfaction surveys for PHC facilities including Pomeroy CHC. • Monthly itineraries for District Managers to reflect outreach Supervisory Visits. • Sub-Districts to co-ordinate the available transport for outreach teams.

		• Allocation of a PHC driver to transport GP's using the state vehicle
Improve Integrated School Health Programme		• Improve ward based preventative and promotive outreach services in line with the PHC re-engineering strategy. • Employ School Heath Teams consisting of P/N, E/N and ENA's in all 4 sub districts • Accelerate implementation of SHS policy. • Monitor the Primary School coverage from 30 to 40 schools out of a total of 295 Primary schools in quintile 1 and 2 schools. • Monitor the number of grade one learners who receive health assessments according to School Health policy. • Monitor the number of learners in combined grades who receive health assessments. • Monitor the number of Door to Door campaigns conducted in the District. • Monitor the Radio Slots and Media coverage to improve lifestyles of the community.
Improve Oral Health Programme		• Support the Sub-Districts to recruit an Oral Hygienist (Umvoti, Msinga and Endumeni) • Support the Sub-Districts to recruit Dental Therapist for NHI Oral Health Programme

A. SUB-PROGRAM: DISTRICT HOSPITALS

13.2.1 Sub-Programme Overview

Table 42 (NDoH 16): Situational Analysis Indicators for District Hospitals – 2013/14 Financial Year

Indicators	Type	Dundee Hospital	CJM Hospital	COSH Hospital	Greytown Hospital	District Average
1. National Core Standards self-assessment rate	*Quarterly* %	100 %	100%	100%	100%	100%
National Core Standards self-assessment	*No*	*1*	*1*	*1*	*1*	*4*
District Hospitals total	*No*	*1*	*1*	*1*	*1*	*4*
2. Quality Improvement plan after self-assessment rate	Quarterly %	100 %	100%	100%	100%	100%
Quality Improvement plan after self-assessment	*No*	*1*	*1*	*1*	*1*	*4*
District Hospitals total	*No*	*1*	*1*	*1*	*1*	*4*
3. Percentage of District Hospitals compliant to all extreme and vital measures of the National Core Standards	Quarterly %	*0%*	*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	0
District Hospitals total	No	*1*	*1*	*1*	*1*	*4*
4. Patient Experience Of Care Survey Rate		100 %	100%	100%	100%	100%
Number of district hospitals that have conducted patient experience of care surveys	*No*	*1*	*1*	*1*	*1*	*4*
District Hospitals total	*No*	*1*	*1*	*1*	*1*	*4*
5. Patient Experience Of Care Rate	Annual %	83%	85%	80%	82%	82.5%
Number satisfied customers	*No*	*83*	*85*	*80*	*82*	*330*
Number users participated in survey	*No*	*100*	*100*	*100*	*100*	*400*

Indicators	Type	Dundee Hospital	CJM Hospital	COSH Hospital	Greytown Hospital	District Average
6. Average length of stay	Quarterly Days	4.7	6.3	6.8	7.7	6.4
In-patient days	*No*	*45 147*	*77 455*	*72 818*	*54 143*	*249 563*
Day patients	*No*	*59*	*0*	*1*	*105*	*165*
Inpatient separations	*No*	*9 715*	*12 227*	*10 679*	*7 069*	*39 690*
7. Inpatient bed utilisation rate	Quarterly %	58.1%	66.6%	73.8%	52.7%	62.8%
In-patient days	*No*	*45 147*	*77 455*	*72 818*	*54 143*	*249 563*
Day patients	*No*	*59*	*0*	*1*	*105*	*165*
Inpatient bed days available	*No*	*224*	*349*	*347*	*271*	*1 191*
8. Number of District Mental Health Teams	Annual	0	0	0	0	0
9. Expenditure per PDE	Quarterly R	2 216	1 693	2160	2 360	2 107
Expenditure total	*R'000*	*156, 387, 475*	*180, 564, 537*	*195, 859, 418*	*152, 258, 451*	*171,267,470*
Patient day equivalent	*No*	*70 562*	*106 641*	*90 638*	*64 515*	*332 357*
10. Complaint resolution rate	Quarterly %	87%	83%	96%	82%	88%
Complaint resolved	*No*	*13*	*5*	*25*	*28*	*71*
Complaint received	*No*	*15*	*6*	*26*	*34*	*81*
11. Complaint resolution within 25 working days rate	Quarterly %	87%	83%	96%	82%	88%
Complaint resolved within 25 days	*No*	*13*	*5*	*25*	*28*	*71*
Complaint resolved	*No*	*15*	*6*	*26*	*34*	*81*

Table 43 (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	2015/16
1 National Core Standards self-assessment rate	*QA/DHIS calculates*	*Quarterly* %	Not reported	100%	100%	100%	100%	100%	100%	100%
National Core Standards self-assessment	*QA assessment records*	*No*	-	*4*	4	*4*	*4*	*4*	*4*	
District Hospitals total	*DHIS calculates*	*No*	-	*4*	*4*	*4*	*4*	*4*	*4*	
2 Quality Improvement plan after self-assessment rate	*QA/DHIS calculates*	*Quarterly* %	Not reported	100%	100%	100%	100%	100%	100%	*100%*
Quality Improvement plan after self-assessment	*QA assessment records*	*No*	-	*4*	4	*4*	*4*	*4*	*4*	
District Hospitals total	*QA assessment records*	*No*	-	*4*	*4*	*4*	*4*	*4*	*4*	
3 Percentage of District Hospitals compliant to all extreme and vital measures of the National Core Standards	QA/DHIS calculates	Quarterly %	Not reported	0%	0%	50%	100%	100%	100%	
District Hospitals fully compliant (75%-100%) to all extreme and vital measures of National Core Standards	*QA assessment records*	*No*	-	0	*0*	*2*	*4*	*4*	*4*	
District Hospitals total	*DHIS calculates*	*No*	-	4	*4*	*4*	*4*	*4*	*4*	
4 Patient Experience Of Care Survey Rate	QA / DHIS calculates	Quarterly %	100%	100%	100%	100%	100%	100%	100%	100%
Number of district hospitals that have conducted patient experience of care surveys	*QA assessment records*	*No*	*4*	4	*4*	*4*	*4*	*4*	*4*	

	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
	District Hospitals total	*DHIS calculates*	*No*	*4*	*4*	*4*	*4*	*4*	*4*	*4*	
5	Patient Experience Of Care Rate	DHIS calculates	Annual %	78.5%	78%	82.5%	85%	90%	90%	90%	90%
	Number satisfied customers	*PSS*	*No*	*503*	*505*	*330*	*340*	*360*	*360*	*360*	
	Number users participated in survey	*PSS*	*No*	*640*	*640*	*400*	*400*	*400*	*400*	*400*	
6	Average length of stay	DHIS calculates	Quarterly Days	5.6	6.1	6.1	6	5.7	5.5	5.7	5.7
	In-patient days	*Midnight census*	*No*	*244,277*	*251,442*	*249563*	*271,959*	*282,837*	*294,151*	*305,917*	
	Day patients	*Midnight census*	*No*	*84*	*59*	*165*	*65*	*69*	*75*	*78*	
	Inpatient separations	*DHIS calculates*	*No*	*41,540*	*40,692*	*39,690*	*44,750*	*47,603*	*53,123*	*55,247*	
7	Inpatient bed utilisation rate	DHIS calculates	Quarterly %	55.7%	57.8%	62.8%	60.4%	62%	65%	66%	75%
	In-patient days	*Midnight census*	*No*	*244,277*	*251,442*	*249,563*	*271,959*	*282,837*	*294,151*	*305,917*	
	Day patients	*Midnight census*	*No*	*84*	*59*	*165*	*65*	*69*	*75*	*78*	
	Inpatient bed days available	*Management*	*No*	*1191*	*1191*	*1191*	*1191*	*1191*	*1191*	*1191*	
8	Number of District Mental Health Teams	Appointment letters	Annual	0	0	0	0	0	0	0	1
9	Expenditure per PDE	BAS/DHIS	Quarterly R	R 1 095	R 1 835	*R 1 829*	R 1 985	R 2 064	R 2 146	R 2 231	
	Expenditure total	*BAS*	*R'000*	398,852,655	649,428,520	594 015 000	745,298,025	798,208,656	854,818,326	889,011,059	
	Patient day equivalent	*DHIS calculates*	*No*	364,249	353,912	332,357	375,465	386,729	398,331	398,331	
10	Complaint resolution rate	DHIS	Quarterly %	Not reported	72.7%	87%	88%	90%	92%	95%	90%

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
Complaint resolved	*PSS*	*No*		*145*	*71*					
Complaint received	*PSS*	*No*		*205*	*81*					
11 Complaint resolution within 25 working days rate	DHIS	Quarterly %	Not reported	72.7%	87%	88%	90%	92%	95%	90%
Complaint resolved within 25 days	*PSS*	*No*		*145*	*71*					
Complaint resolved	*PSS*	*No*								

Table 44 (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		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	1. Delivery by caesarean section rate	DHIS calculates	Quarterly %	*21.4%*	*22%*	19.7%	21%	20.5%	20%	19.7%
	Delivery by caesarean section	*Delivery register*	*No*	*2,467*	*2,548*	*2,226*	*2,756*	*2,866*	*2,980*	*2,860*
	Delivery in facility total	*Delivery register*	*No*	*11,508*	*11,552*	*11, 278*	*12,857*	*13,756*	*14,719*	*14,500*
	2. OPD headcount- total	DHIS/OPD tick register	Quarterly No	313,609	259,972	212, 950	239,590	230,006	220,806	211,973
	3. OPD headcount not referred new	DHIS/OPD tick register	Quarterly No	114,846	100,415	83,444	92,542	88,840	85,287	81,875
	4. Number of District Hospitals with functional boards			4	4	4	4	4	4	4
	5. Proportion of District Hospitals conditionally compliant to National Core Standards	QA / DHIS calculates	Quarterly %	Not reported	0%	0%	50%	100%	100%	100%

Strategic Objective Statement	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	District Hospitals conditionally compliant	*QA assessment records*	*No*	*-*	*0*	*0*	*2*	*4*	*4*	*4*
	District Hospitals Total	*DHIS calculates*	*No*	*-*	*4*	*4*	*4*	*4*	*4*	*4*

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

Table 45: District Hospitals Strategies

Strategies	Activities
Improve hospital efficiency and governance	• Functional clinic committees and hospital boards • Establish clinical governance committees and conduct meetings
Improve quality and efficiency	• Conduct National Core Standard assessments and monitor Quality Improvement Plan quarterly • Conduct ideal clinic assessments • Conduct Batho Pele workshop to improve the staff attitude • Conduct Waiting and service Times surveys • Conduct Patient satisfaction surveys • Each Sub district to submit staffing needs. • Facility Management to do walk about
Improved financial management including Supply Chain Management (SCM)	• Discuss budget & expenditure in every meetings including the relevant stakeholders • Implement the SCM recommendations from the KPMG external assessment Report.

SPECIALISED TB HOSPITAL GREYTOWN

Table 46: National Performance Indicators for Specialised TB Hospitals

Indicator	Data Source	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. Inpatient bed utilisation rate – total	DHIS	Rate	64.7%	60.7%	72%	65%	68%	70%	65%	75%
Inpatient days-total	*DHIS/ Midnight Census*	*No*	*7 111*	*8 199*	*9 732*					
Day Patients	*DHIS/ Midnight Census*	*No*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	
Number of usable beds	*DHIS/ FIO*	*No*	*37*	*37*	*37*	*37*	*37*	*37*	*37*	
2. Expenditure per patient day equivalent (PDE)[5]	BAS/DHIS	R	308	1,339	1,392	1,448	1,506	1,566	1,448	
Total expenditure Specialised TB Hospital	*BAS*	*R*	*4,939,412*	11,818,403						
Patient day equivalents	*DHIS calculates*	*No*	*16,054*	*8,824*	*11 566*					
3. Complaint resolution within 25 working days rate	DHIS	%	100%	100%	100%	100%	100%	100%	100%	90%
Total number of complaints resolved within 25 days in reporting period	*Complaints register*	*No*	*8*	*6*	*0*					
Total number of complaints received during the same reporting period	*Complaints register*	*No*	*8*	*6*	*0*					
4. Number of District Mental Health Teams established	Appointment letters	No	0	0	0	0	1	1	1	1

[5] For planning purposes, budget for NPI's, Fleet, NHLS, registrars, radiological services, HTS, JME and Flying Doctors has been included in the budget projections

Indicator	Data Source	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
5. Patient satisfaction rate (Annual)	DHIS calculates	%	Not Reported	Not reported	Not reported	85%	90%	90%	90%	90%
Total number of users that were satisfied with the services they received	*PSS results*	*No*								
The total number of users that participated in Client Satisfaction Survey	*PSS results*	*No*								
6. Proportion of Specialised TB Hospitals self-assessed for compliance against the National Core Standards	QA database	%	Not reported	Not reported	100%	100%	100%	100%	100%	100%
Specialised TB Hospitals self-assessed for compliance	*QA assessment records*	*No*	-	-	*1*	*1*	*1*	*1*	*1*	
Specialised TB Hospitals total	*DHIS calculates*	*No*	-	-	*1*	*1*	*1*	*1*	*1*	
7. Proportion of Specialised TB Hospitals compliant to all Extreme Measures of National Core Standards	QA database	%	Not reported	Not reported	Not reported	0%	100%	100%	100%	100%
Specialised TB Hospitals fully compliant (75%-100%) to all extreme measures of National Core Standards	*QA assessment records*	*No*	-	-	-	1	1	1	1	
Specialised TB Hospitals total	*DHIS calculates*	*No*	-	-	-	1	1	1	1	

Table 47: Provincial Performance Indicators for Specialised TB Hospitals

Strategic Objective Statements	Indicator	Data Source	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. Delivery by caesarean section rate	DHIS calculates	%	0%	0%	0%	0%	0%	0%	0%	0%
	Number of caesarean sections performed	*DHIS/Delivery Register*	*No*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	
	Total number of deliveries in the facility	*DHIS/Delivery Register*	*No*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	
	2. Average length of stay – total	DHIS	Days	*4.9*	*5.26*	*4.72*	*5.7*	*5.7*	*5.7*	*5.7*	*5.7*
	Inpatient days-total	*DHIS/ Midnight Census*	*No*	*7111*	*8199*	*9 732*					
	Day Patients	*DHIS/ Midnight Census*	*No*	*0*	*0*	*0*					
	Inpatient Separations	*DHIS calculates*	*No*	*191*	*156*	*206*					
	3. OPD headcount - total	*DHIS/OPD tick register*	No		1771	1 047	1915	1992	2072		
	4. Proportion of Specialised TB Hospitals conditionally compliant to National Core Standards	QA/DHIS calculates	%	Not reported	Not reported	Not reported	100%	100%	100%		100%
	Specialised TB Hospitals conditionally compliant	*QA assessment records*	*No*	-	-	-	*1*	*1*	*1*		
	Specialised TB Hospitals total	*DHIS calculates*	*No*	-	-	-	*1*	*1*	*1*		

14. HIV & AIDS & TB CONTROL (HAST)

14.1 PROGRAMME OVERVIEW

HIV/AIDS PROGRAMME

Achievements

- All PHC facilities within the district have professional nurses trained on NIMART.
- CCMDD (Central Chronic Medicine Dispensing and Distribution) Project was launched; Medi-Post pharmacy distributes ART to 20 identified clinics.
- Nurses were employed for the High Transmission Area (HTA) programme in Nquthu Sub-district.
- HTA Mobile Vehicle received from Head Office. HTA Mobile provides services to the Nquthu Long Distance Taxi Rank, Nquthu Short Distance Taxi Rank, Greys Taxi Rank, Mthashana FET College and Sakhisizwe Nursing School.
- Sex Worker Programme was launched in the Endumeni Sub-district by Khethimpilo (PEPFAR Funded Partner) they have employed 4 Peer Educators.
- Distributed 11 438 182 Condoms 85.2% achievement.
- Umzinyathi Municipality has assisted the district by providing a storage area for condoms.

Challenges:

- Tracing of clients who are identified as loss to follow up and defaulters on the ART Programme.
- Shortage of vehicles for providing more HTA services in other sub-district.
- Sexually Transmitted Infection (STI) partner treatment rate remains very low in the district, the tracing of partners remains a challenge.

PMTCT PROGRAMME

Achievements

- There was a decline in the number of infants testing positive for HIV during the first 6 weeks of life.
- The initiation of pregnant women on ART improved drastically to 96%.
- The retesting rate of pregnant women improved due to the correct implementation of the PMTCT Guidelines.

Challenges

- Poor quality data.
- Poor quality PCR tests, due to the poor technic for collection of PCR specimen resulting in some specimen being rejected by the NHLS laboratory services.
-

- Some clients do not adhere to the PMTCT Programme resulting in infants testing positive for HIV.
- Low Mom Connect Project enrolment.

TB CURE AND SMEAR CONVERSION RATE

Achievements:

- Cure rate of remains above the Provincial and National targets. The district has improved from 87.9 % to 89.4%.
- Death rate decreased from 10.3% in quarter 2 of 2013/2014 to 7.1% in Quarter 3 of 2013/2014.
- Defaulter rate remains below 2 %.

Challenges:

- Migration from version 1 of the electronic TB register to version 2 makes it difficult to monitor the smear conversion rate for the district.
- Previously the smear conversion rate remained just below 80 % which is below the target of 85%.

BACTERIOLOGICAL COVERAGE

Achievements:

- Bacteriological coverage remains above 85% to 90% for 3 sub-districts.

Challenges:

- Msinga sub-district bacteriological coverage has dropped to 74.3% in Q3/2014 due to some challenges within NHLS.
- Monitoring indicators and reporting findings to district health management and provincial office

TB/MDR and XDR TB SURVEILLANCE AND MANAGEMENT.

Achievements:

- Newly diagnosed MDR TB patients are initiated on treatment within 7 days.
- Injection teams do daily injections for the clients in the community
- All MDR TB patients are tested for HIV and initiated on ART's.
- MDR TB cure rate increased from 58.8% in Q2/2012 reported in Q2/2014 to 62.5 % in Q2/2012 reported in Q3/2014.

Challenges:

- Many MDR TB patients remain non-confirmed for a long time.
- Clients do not come for their clinic appointments during the festive season hence a high number of results not available for culture conversion.

Table 48 (NDoH 19): Situational Analysis Indicators for HIV & AIDS, STI's and TB Control - 2013/14 Financial Year

Indicator	Type	Endumeni	Nquthu	Msinga	Umvoti	District Average
1. Total clients remaining on ART month	Quarterly No	6 610	11 282	12 375	11 427	41 694
2. Clients tested for HIV (incl ANC)	Quarterly No	17 946	48 170	45 644	34 604	146 364
3. TB symptom 5 years and older screened rate	Quarterly %	2.1%	3.73%	3.6%	4.2%	3.55%
Client 5 years and older screened for TB symptoms	*No.*	*4 001*	*14 191*	*13 838*	*12 502*	*44 532*
PHC headcount 5 years and older	*No.*	*192 143*	*380 691*	*382 676*	*297 885*	*1 253 395*
4. Male condom distribution Rate	Quarterly Rate per male	76 condoms/male	80 condoms/male	63 condoms/male	123 condoms/male	83 condom/male
Male condoms distributed	*No*	*1 795 189*	*3 247 181*	*2 721 109*	*3 674 703*	*11 438 182*
Population 15 years and older male	*Population*	*23 671*	*40 628*	*43 061*	*29 678*	*137 038*
5. Female condom distribution Rate	Quarterly Rate per female	3	2	0.5	1	1.3
Female condoms distributed	*No*	*79 804*	*100 979*	*33 167*	*45 529*	*259 479*
Population 15 years and older female	*Population*	*25 244*	*68 655*	*61 608*	*42 941*	*198 448*
6. Medical male circumcision performed – Total	Quarterly No	1 548	2 245	2 589	2 547	8 929
7. TB client treatment success rate	Quarterly %	*85.8%*	*85.1%*	*90.1%*	*84.9%*	86.8%
TB client successfully completed treatment	*No*	298	276	335	*193*	1107
TB client start on treatment	*No*	*347*	*313*	*385*	*216*	*1289*
8. TB client lost to follow up rate	Quarterly %	14.2%	14.9%	9.9%	15%	13%
TB client lost to follow up	*No*	*49*	*46*	*38*	*29*	*162*
TB client start on treatment	*No*	*347*	*313*	*385*	*193*	*1 238*

Indicator	Type	Endumeni	Nquthu	Msinga	Umvoti	District Average
9. TB client death Rate	Annual %	11.2%	11.1%	6.8%	13.4%	10.6%
TB client died during treatment	*No*	*39*	*35*	*26*	*29*	*129*
TB client start on treatment	*No*	*347*	*313*	*385*	*216*	*1289*
10. TB MDR confirmed treatment start rate	Annual %	100%	100%	100%	100%	100%
TB MDR confirmed client start on treatment	*No*	*-*	*-*	*-*	*-*	*93*
TB MDR confirmed client	*No*	*-*	*-*	*-*	*-*	*93*
11. TB MDR treatment success rate	Annual %	*OUTCOME*	*NOT*	*CAPTURED PER*	*SUB DISTRICT*	*63.1%*
TB MDR client successfully treated	*No.*					
TB MDR confirmed client start on treatment	*No.*					

Table 49 (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	27,704	37,071	41, 694	40,870	42,914	45,600	47,424	
2. Clients tested for HIV (incl ANC)	DHIS calculates	Quarterly No	Not reported	Not reported	146 364	152 218	158 307	164 639	171 225	
3. TB symptom 5 yrs and older screened rate	DHIS	Quarterly %	Not reported	2.9%	3.55%	3.7%	3.8%	4%	4.2%	

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
Client 5 years and older screened for TB symptoms	*TB Register*	*No.*		*33 485*	*44 532*					
PHC headcount 5 years and older	*DHIS calculates*	*No.*		*1 135 932*	*1 253 395*					
4. Male condom distribution Rate	DHIS calculates	Quarterly Rate per male	15	50	83	85	88	92	95	88%
Male condoms distributed	*DHIS/Stock cards*	*No*	*2,012,256*	6,697,176	11 438 182	11 895 709				
Population 15 years and older male	*DHIS/Stats SA*	*Population*	*131 228*	134 112	*137 038*	139 905				
5. Female condom distribution Rate	DHIS calculates	Quarterly Rate per female	*1.2*	0.5	1.3	1.33	1.38	1.43	1.48	1.38
Female condoms distributed	*DHIS/Stock cards*	*No*	239 658	106 567	259 479	269 858				
Population 15 years and older female	*DHIS/Stats SA*	*Population*	192 495	195 423	198 448	201 410				
6. Medical male circumcision performed – Total	DHIS / MMC register	Quarterly No	6 510	8 843	8 929	9 880	10,275	10,686	11, 11 3	
7. TB client treatment success rate	ETR.Net calculates	%	85.4%	86.9%	86.8%	87.5%	87.8%	88%	*90%*	*90%*
TB client successfully completed treatment	*TB Register*	*No*	*495*	*1125*	*1 107*	*1 450*				
TB client start on treatment	*TB Register*	*No*	*580*	*1 295*	*1 289*	1 650				
8. TB client lost to follow-up rate	ETR.Net calculates	Quarterly%	*14.65%*	*13%*	*14%*	*12%*	*11%*	*10%*	*8%*	
TB client lost to follow up	*TB Register*	*No*	*85*	*170*	*182*	*200*				

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
TB client start on treatment	*TB Register*	*No*	*580*	*1 295*	*1 289*	1 650				
9. TB client death Rate	ETR.Net calculates	Annual %	10.7%	7.7%	10.6%	9.6%	9.2%	8.8%	*8.4%*	
TB client died during treatment	*TB Register*	*No*	*34*	*28*	*129*					
TB client start on treatment	*TB register*	*No*	*319*	*365*	*1289*					
10. TB MDR confirmed treatment start rate	ETR.Net calculates	Annual %	92%	96%	100%	100%	100%	100%	100%	
TB MDR confirmed client start on treatment	*TB Register*	*No*	*57*	*45*	*93*					
TB MDR confirmed client	*TB Register*	*No*	*67*	*47*	*93*					
11. TB MDR treatment success rate	EDR calculates	*Annual %*	92%	96%	100%	100%	100%	100%	100%	
TB MDR client successfully treated	*EDR Register*	*No*	*57*	*45*	*93*					
TB MDR confirmed client start on treatment	*EDR Register*	*No*	*67*	*47*	*93*					

Table 50 (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		
				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	57	44	98	100%	100%	100%	100%
	2. MDR-TB Six month interim outcome	EDR.Net calculates	Annual %	72%	68%	56%				
	Number of clients with a negative culture at 6 months who started treatment for 9 months	*EDR Register*	*No*	-	-	*34*				
	Total patients who started treatment in the same period	*EDR Register*	*No*	-	-	*61*				
	3. Number of patients that started XDR-TB treatment	ETR.Net calculates	Annual No	Not reported	Not reported	Not reported				
	4. XDR-TB Six month interim outcome	EDR.Net calculates	Annual %	Not reported	Not reported	Not reported				
	Number of clients with a negative culture at 6 months who started treatment for 9 months	*EDR Register*	*No*	-						
	Total patients who started treatment in the same period	*EDR Register*	*No*	-						
	5. TB incidence (per 100 000 population)	ETR.Net	Annual No per 100,000	993	816	250	200	150	100	90/100 000
	New TB infections	*ETR.Net*	*No*	*5,116*	*4,226*	*1 289*				
	Total population in KZN	*DHIS/Stats SA*	*Population*	514,840	517,807	514 217	523,195	525,472	527,587	
	6. HIV incidence (annual)	ASSA2008	Annual %	29%	24.6%	30.1%	18%	16%	15%	14%

Strategic Objective	Performance Indicator	Data Source	Frequency Type	Audited/ Actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	7. STI treated new episode incidence (annualised)	DHIS calculates	Quarterly No per 1000	63	63	59.1	55	52	50	48
	STI treated new episode	*DHIS/Tick register PHC/ casualty*	*No*	20,086	20,149	18 099				
	Population 15 years and older	*DHIS/Stats SA*	*Population*	317,149	322,702	330, 534	331,983	335,990	340,126	
	8. TB (new pulmonary) defaulter rate	ETR.Net calculates	%	1.7%	1.8%	1.6%	1.2%	1.1%	1%	*0.9%*
	TB(new pulmonary)treatment defaulter	*TB Register*	*No*	*32*	*34*	*20*				
	TB(new pulmonary)client initiated on treatment	*TB Register*	*No*	*1 888*	*1 933*	*1 289*				
	9. TB AFB sputum result turn-around time under 48 hours rate	ETR.Net calculates	%	88%	89.6%	93%	80%	80.3%	85%	*88%*
	TB AFB sputum result received within 48 hours	*TB Register*	*No*	*58,946*	*71,187*	*69,069*				
	TB AFB sputum sample sent	*TB Register*	*No*	*67,177*	*79,404*	*74,406*				
	10. TB (new pulmonary) cure rate	ETR.Net calculates	%	85.4%	85.8%	86.8%	87.5%	87.7%	87.9%	*91%*
	TB (new pulmonary) client cured	*TB Register*	*No*	*292*	*296*	*1 107*				
	TB (new pulmonary) client initiated on treatment	*TB Register*	*No*	*432*	*345*	*1 289*				

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

Table 51: HAST Strategies

Strategies	Activities
To reduce the transmission of HIV, TB and STIs	• Strengthen the tracing of clients that are loss to follow up by increasing the number of available tracing teams. • Ensuring that all facilities are on Tier.net phase six to assist with the generation of reports that will assist in tracing of clients. • Employ personnel and procure vehicles for the HTA programme to provide services to our key population. • Conduct a study to identify the challenges as to why our partner treatment rate remains very low as a district and device strategies that will help improve the partner treatment rate. • Conduct training on quality data. • Conduct onsite training for the professional Nurses on PCR testing. • Conduct Kick TB activities at schools throughout the district. • Conduct a week long Hlolamanje campaigns at all sub-districts to improve case finding. • Conduct intensified case finding at all sub-districts to decrease the infectious pool in the community. • Sustain and increase the number of injection and tracer teams at facilities • Sustain and improve the sputum turnaround time under 48hrs to 85% at all sub-districts. • Supply all sub-districts with the tracking tools (treatment calendar, TB diaries). • Train Health care workers on Basic TB/HIV management at all sub-districts. • Fast track integration of TB/HIV management at all sub-districts.Increase the number of TB MDR patients initiated on treatment within 7 days of diagnosis. • Decrease the MDR TB death rate to below 15%.

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

15.1 PROGRAMME OVERVIEW

MNCWH ACHIEVEMENTS

16 + 2 Key Intervention Implemented

Family Planning

- Zazi camps was conducted in all 4 sub-districts
- Zazi toolkit is being utilized at PHC facility level for group education information

Labour and Delivery Management

- ESMOE 4 days training was conducted in all sub districts
- Interventions for complicated emergency cases are done through communication between the PHC and the DCST to prevent unnecessary mortalities

TB/HIV

Early Detection and Treatment of HIV Training was conducted on in all 4 sub-districts.

Magnesium Salphate For Pre-Eclampsia

All (50) clinics have emergency boxes which includes Eclampsia box with Magnesium Sulphate, Obstetric hemorrhage and cord prolapse

Clean Birth Practices

Traditional Birth attendants were identified and orientated:

- Umvoti = 12
- Msinga = 09
- Nquthu = 10
- Endumeni = 11

Hypertensive Disease Case Management

- ESMOE trainings were conducted, covering the importance of early identification, management and proper referral.
- Labetalol is available in all 50 clinics. Algorithms on proper use are available.
- Cases are referred to High Risk Clinic, which is run by an ADM and doctor.

Promotion of Breastfeeding

- Support groups are established working together with nutritionists. Promotion of breast feeding is monitored at the Child Health Forum and is a standing item on the agenda.

Hand washing with soap

- IPC Managers conduct monthly hand washing audits in all 4 sub-districts. Compliance rates: Umvoti 91%; Msinga 80%; CJM 80%; Dundee 80%

Antenatal Corticosteroids for preterm labor is available in all 4 sub-districts

KMC- Kangaroo mother care is practiced in all hospitals

PMTCT - Positivity rate 0.8%.

Case Management of Severe Neonatal Infections

- All 4 hospitals have dedicated, non-rotating doctors in neonatal wards.
- Staff trained on SAINC:
  - Doctors : 04
  - Prof nurses : 08
  - Enrolled nurses : 10

Oral Antibiotics: Case Management of Pneumonia in Children

- IMCI approach implemented in all clinics.
- Mechanism in place for monitoring constant availability of antibiotics

Neonatal Resuscitation

- Neonatal Resuscitation training conducted: 3 doctors and 20 nurses.
- Staff trained on HBB
  - Doctors : 02
  - Prof Nurses : 05

KINC - training conducted for all hospitals.

CPAP machines are available in all 4 sub-districts. Greytown Hospital has no medical air.

MNCWH CHALLENGES

- Poor growth monitoring
- Poor utilization of RTH booklet
- Few dedicated child health nurses
- Neonates still nursed in children's ward.
- Poor triaging and stabilising of critically ill children both hospital and clinic level. Due to high staff turnover and staff rotation new staff were not familiar with Emergency Triaging Assessment and Treatment (ETAT) guidelines
-

NUTRITION PROGRAMME

Achievements

- Established 54 Phila Mntwana Centres since September 2013, which increase assess to a broader community of children under 5 years.
- All crèches are being targeted as service site for Vitamin A supplementation by Nutritionists, Nutrition Advisors and CCGs
- Vitamin A to 12-59 months children increased from 54% to 74% (beyond the target)
- SAM (severe acute malnutrition) case fatality rate has decreased from 31% (2012) to 7.5% (2014).
- Exclusive breastfeeding at HepB 3rd dose increase from 69.9% (2013) to 81.8% (2014)
- Identification of Child Health IMCI trained Professional Nurse to attend to all children presenting at each facility
- Establishment of District Child Health Forum Quarterly meetings
- 44 out of the 50 clinics have permanent Nutritional Advisors

Challenges

- Poor sustainability of the established centres
- Shortage of transport on some days
- Poor data quality
- The Admissions, discharge and death register is poorly completed
- Linkage between hospitals and PHC facilities to ensure that referred cases are being follow-up is still a challenge in some facilities. Early introduction of solids to infants

Table 52 (NDoH 22): Situational Analysis Indicators for MCNWH & N – 2013/14 Financial Year

Indicator	Type	Endumeni	Nquthu	Msinga	Umvoti	District Average
1. Antenatal 1st visit before 20 weeks rate	Quarterly %	62.2%	53.6%	60.7%	64.8%	59.6%
Antenatal 1st visit before 20 weeks	*No*	*5 92*	*1 857*	*2 088*	*919*	*5 456*
Antenatal 1st visit total	*No*	*1 568*	*4 005*	*5 317*	*2 613*	*13 503*
2. Proportion of mothers visited within 6 days of delivering their babies	Quarterly %	49%	63.8%	79.27%	68%	66.9%
Mother postnatal visit within 6 days after delivery	*No*	*1 071*	*2 241*	*2 969*	*1 260*	*7 542*
Delivery in facility total	*No*	*2 186*	*3 511*	*3 726*	*1 855*	*11 278*
3. Antenatal client initiated on ART rate	Annual %	94.4%	108.3%	83.3%	88.4%	93.5%
ANC client started on ART	*ART Register*	*375*	*795*	*891*	*596*	*2657*
ANC client eligible for ART initiation	*ART Register*	*396*	*736*	*1 069*	*674*	*2 841*
4. Infant 1st PCR test positive around 6 weeks rate	Quarterly %	1.5%	1%	1.2%	1.9%	1.3%
Infant 1st PCR test positive around 6 weeks	*No*	*7*	*15*	*14*	*15*	*51*
Infant 1st PCR test around 6 weeks	*No*	*474*	*1 453*	*1 217*	*801*	*3 945*
5. Immunisation coverage under 1 year (annualised)	Quarterly %	90%	70%	70%	77%	73%
Immunised fully under 1 year new	*No*	*1 187*	*3 501*	*3 975*	*2 161*	*10 824*
Population under 1 year	*No*	*1 314*	*4 969*	*5 656*	*2 803*	*14 742*
6. Measles 2nd dose coverage	Quarterly %	94.8%	76.2%	77.7%	85%	80.1%
Measles 2nd dose	*No*	*1 155*	*3 338*	*3 832*	*2 037*	*10 362*
Population 1 year	*No*	*1 314*	*4 969*	*5 656*	*2 803*	*14 742*

Indicator	Type	Endumeni	Nquthu	Msinga	Umvoti	District Average
7. DTaP-IPV-HepB-Hib 3 - Measles 1st dose drop-out rate	Quarterly %	8.4%	2%	3.7%	0.42%	1.5%
DTaP-IPV-HepB-Hib 3 to Measles1st dose drop-out	*No*	*103*	*101*	*165*	*12*	*155*
DTaP-IPV-HepB-Hib 3rd dose	*No*	*1 314*	*4 969*	*5 656*	*2 803*	*14 742*
8. Child under 5 years diarrhoea case fatality rate	Quarterly %	4.4%	4.3%	8.4%	4.8%	5.6%
Child under 5 years with diarrhoea death	*No*	*6*	*8*	*18*	*8*	*40*
Child under 5 years with diarrhoea admitted	*No*	*125*	*190*	*190*	*159*	*664*
9. Child under 5 years pneumonia case fatality rate	Quarterly %	6.9%	5.8%	6.6%	3.8%	6.1%
Child under 5 years pneumonia death	*No*	*13*	*9*	*8*	*3*	*33*
Child under 5 years pneumonia admitted	*No*	*186*	*170*	*128*	*60*	*544*
10. Child under 5 years severe acute malnutrition case fatality rate	Quarterly %	7.5%	14.3%	18.3%	10.1%	12.7%
Child under 5 years severe acute malnutrition death	*No*	*2*	*4*	*12*	*7*	*25*
Child under 5 years severe acute malnutrition admitted	*No*	*50*	*36*	*57*	*77*	*220*
11. School Grade R screening coverage	Quarterly %	Not reported	Not reported	Not reported	Not reported	
School Grade R learners screened	*No.*					
School Grade R learners - total	*No.*					
12. School Grade 1 screening coverage	Quarterly %	Not reported	Not reported	Not reported	Not reported	
School Grade 1 learners screened	*No.*					
School Grade 1 learners - total	*No.*					

Indicator	Type	Endumeni	Nquthu	Msinga	Umvoti	District Average
13. School Grade 8 screening coverage	Quarterly %	Not reported	Not reported	Not reported	Not reported	
School Grade 8 learners screened	*No.*					
School Grade 8 learners - total	*No.*					
14. Couple year protection rate	Quarterly %	72.7%	57%	43.5%	82.1%	59.9%
Contraceptive years dispensed	*No*	*13 874*	*25 616*	*21 327*	*25 826*	*86 642*
Population 15-49 years female	*No*	*17 780*	*42 437*	*46 154*	*29 323*	*135 694*
15. Cervical cancer screening coverage (amongst women)	*Quarterly %*	63%	71%	56%	69%	64%
Cervical cancer screening in women 30 years and older	*No*	*1327*	*3 509*	*3199*	*2 516*	*10,551*
Population 30 years and older female/10	*No*	*2 108*	*4 926*	*5 684*	*3 630*	*16 349*
16. Human Papilloma Virus Vaccine 1st Dose coverage	Annual %	Not collected	Not collected	Not collected	Not collected	
Numerator	*No*					
Denominator	*No*					
17. Vitamin A dose12 – 59 months coverage	Quarterly %	67.9%	48.8%	45.8%	59.7%	51.4%
Vitamin A dose 12 - 59 months	*No*	*6 326*	*16 157*	*16 778*	*10 315*	*49 576*
Population 12-59 months (multiplied by 2)	*No*	*12 484*	*44 156*	*49 454*	*23 004*	*129 098*
18. Maternal mortality in facility ratio	Annual No per 100K	92.1	57.4	109.6	0	71.5
Maternal death in facility	*No*	*2*	*2*	*4*	*0*	*8*
Live birth in facility	*No*	*2 171*	*3 482*	*3 649*	*1 893*	*11 195*

Indicator	Type	Endumeni	Nquthu	Msinga	Umvoti	District Average
19. Early neonatal death in facility rate	Annual Per 1 000	9/1k	19.8/1k	2.4/1k	14.2/1k	11/1k
Death in facility 0-7 days	*No*	*20*	*69*	*9*	*27*	*125*
Live birth in facility	*No*	*2 171*	*3 482*	*3 649*	*1 893*	*11 195*

Table 53 (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 1st visits before 20 weeks rate	DHIS	Quarterly %	44%	50%	59.6%	70%	80%	90%	94%	65%
Antenatal 1st visit before 20 weeks	*DHIS / Tick register PHC*	*No*	*5,869*	*6,544*	*5,456*					
Antenatal 1st visit total	*DHIS calculates*	*No*	*13,335*	*13,131*	*13,503*					
2. Proportion of mothers visited within 6 days of delivering their babies	DHIS	Quarterly %	60.3%	38.6	66.9%	70%	75%	78%	82%	
Mother postnatal visit within 6 days after delivery	*DHIS / Tick Register PHC*	*No*	*6,903*	*4,267*	*7,542*					
Delivery in facility total	*DHIS / Delivery register*	*No*	*11,508*	*11,552*	*11278*					
3. Antenatal client initiated on ART rate	DHIS calculates	Annual %	32%	83%	93.5%	98%	100%	100%	100%	100%
ANC client started on ART	*ART Register*	*No*	*276*	*674*	*2657*					
ANC client eligible for ART initiation	*ART Register*	*No*	*831*	*807*	*2 841*					
4. Infant 1st PCR test positive around 6 weeks rate	DHIS	Quarterly %	3.5%	1.6%	1.3%	1.3%	1%	0.8%	0.5%	1%

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
Infant 1st PCR test positive around 6 weeks	*DHIS / Tick register PHC*	*No*	*123*	*65*	*51*					
Infant 1st PCR test around 6 weeks	*DHS / Tick Register PHC*	*No*	*3 450*	*4 285*	*3 945*					
5. Immunisation coverage under 1 year	DHIS	Quarterly %	91%	83.7%	72.2%	80%	85%	90%	95%	98%
Immunised fully under 1 year new	*DHIS / Tick register PHC*	*No*	*13,082*	*12,491*	*10,824*	*11 503*	*11 355*	*11 143*	*11 256*	*13 996*
Population under 1 year	*DHIS / Stats SA*	*No*	*14 282*	*14 917*	*14 980*	*14 379*	*13 359*	*12 382*	*11 849*	*14 282*
6. Measles 2nd dose coverage	DHIS	Quarterly %	44%	75%	69%	80%	85%	90%	95%	98%
Measles 2nd dose	*DHIS / Tick register PHC*	*No*	*6 310*	*11 227*	*10 362*	*11 503*	*11 355*	*11 143*	*11 256*	*13 996*
Population 1 year	*DHIS / Stats SA*	*No*	*14 282*	*14 917*	*14 980*	*14 379*	*13 359*	*12 382*	*11 849*	*14 282*
7. DTaP-IPV-HepB-Hib 3 - Measles 1st Dose drop-out rate	DHIS	Quarterly %			1.5%	1.3%	1%	0.5%	0.2%	1%
DTaP-IPV-HepB-Hib 3 to Measles1st dose drop-out	*DHIS / Tick register PHC*	*No*	------	-----	155					
DTaP-IPV-HepB-Hib 3rd dose	*DHIS / Tick register PHC*	*No*			14,742					
8. Child under 5 years diarrhoea case fatality rate	DHIS	Quarterly %	9.9%	4.6%	5.6%	4.3%	4%	3.5%	3%	4.3%
Child under 5 years with diarrhoea death	*DHIS / Tick register*	*No*	21	19	40					
Child under 5 years with diarrhoea admitted	*Admission Records*	*No*	280	440	664					
9. Child under 5 years pneumonia case fatality rate	DHIS	Quarterly %	4.4%	4.2%	6.1%	3.5%	3%	2.5%	2%	3.5%

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
Child under 5 years pneumonia death	*DHIS / Tick register*	*No*	24	17	33					
Child under 5 years pneumonia admitted	*Admission records*	*No*	569	414	544					
10. Child under 5 years severe acute malnutrition case fatality rate	DHIS	Quarterly %	45.5%	34.9%	12.7%	25%	20%	15%	10%	<10%
Child under 5 years severe acute malnutrition death	*DHIS / Tick register*	*No*	26	58	25					
Child under 5 years severe acute malnutrition admitted	*Admission records*	*No*	76	190	220					
11. School Grade R screening coverage	DHIS	Quarterly %	Not reported	Not reported	Not reported					
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 %	Not reported	Not reported	Not reported					
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 %	Not reported	Not reported	Not reported					
School Grade 8 learners screened	*DHIS / Tick register SHS*	*No.*								
School Grade 8 learners - total	*DHIS / DoE database*	*No.*								

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
14. Couple year protection rate	DHIS	Quarterly %	24.4%	42.8%	59.3%	55%	60%	65%	70%	60%
Contraceptive years dispensed	*DHIS calculates*	*No*	*34,737*	*61,642*	*86,642*	*81 583*	*9 0273*	*99 050*	*10 7837*	*8 5153*
Population 15-49 years female	*DHIS/Stats SA*	*No*	*141 922*	*144 044*	*146 209*	*148 333*	*150 456*	*152 386*	*154 053*	*141 922*
15. Cervical cancer screening coverage (amongst women)	DHIS	*Quarterly %*	71%	71%	64%	70%	73%	76%	79%	
Cervical cancer screening in women 30 years and older	*DHS / Tick register PHC / Hospital register*	*No*	*11,174*	*11,444*	*10,551*					
Population 30 years and older female/10	*DHIS / Stats SA*	*No*	*15 822*	*16 069*	*16 349*	*8,621*	*8,814*	*9,166*		
16. Human Papilloma Virus vaccine 1st Dose coverage	DHIS	Annual %	Not reported	Not reported	Not collected	To establish Baseline	To be reviewed	To be reviewed		
Numerator	*DHIS / Tick register SHS*	*No*								
Denominator	*DHIS / DoE enrolment*	*No*								
17. Vitamin A dose12 – 59 months coverage	DHIS	Quarterly %	47%	43.4%	51.4%	50.4%	50.4%	50.4%	52%	50.4%
Vitamin A dose 12 - 59 months	*DHIS / Tick register PHC*	*No*	*48,241*	*43,995*	*49,576*					
Population 12-59 months (multiplied by 2)	*DHIS / Stats SA*	*No*	*102,430*	*101,298*	*99,152*					
18. Maternal mortality in facility ratio	DHIS	Annual No per 100 000	100.7	35.7	71.5	68	65	62	60	65/100 000
Maternal death in facility	*DHIS / Midnight census*	*No*	11	4	8					

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
Live birth in facility	*DHIS / Delivery register*	*No*	11,426	11,519	11,195					
19. Early neonatal death in facility rate	DHIS	Annual %			11/1000					9/1000
Death in facility 0-7 days		*No*			*125*					
Live birth in facility		*No*			*11 195*					

Table 54 (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		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Strategic Objective 2.5: Reduce the infant mortality										
2.5.1) Reduce the infant mortality rate to 29 per 1000 live births by March 2020	1. Infant mortality rate	ASSA2008 (2011) StatsSA and RMS[6] (2012 onwards)	Annual/ No per 1000 pop	43/ 1000*	32.1/ 1000	32/ 1000	31.4/1000	30.5/ 1000	30/ 1000	29.5/ 1000
Strategic Objective 2.6: Reduce under 5 mortality										
2.6.1) Reduce the under 5 mortality rate to 40 per 1000 live births by March 2020	2. Under 5 mortality rate	ASSA2008 (2011) StatsSA and RMS (2012 onwards)	Annual/ No per 1000 pop	63/ 1000*	43.4/ 1000	43/ 1000	42.6/ 1000	42/ 1000	41.5/ 1000	41/ 1000

[6] Rapid Mortality Surveillance

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
2.6.10) Reduce under-5 diarrhoea with dehydration incidence to 10.9 per 1000 by March 2018	3. Child under 5 years diarrhoea with dehydration incidence (annualised)	DHIS	Annual/ No per 1000	6.2/ 1000	8.5/ 1000	5.8/ 1000	5.8/ 1000	4.8/ 1000	3.9/ 1000	3.1 / 1000
	Child under 5 years diarrhoea with dehydration new	*PHC Tick Register*	*No*	*394*	*534*	*387*	*367*	*300*	*250*	*200*
	Population under 5 years	*DHIS/Stats SA*	*No*	*63,606*	*63,086*	*67 205*	*62,356*	*62,017*	*63,606*	*63,086*
2.6.11) Reduce the under-5 pneumonia incidence to 86 per 1000 by March 2018	4. Child under 5 years pneumonia incidence (annualised)	DHIS	Annual/ No per 1000	20/ 1000	71.8/ 1000	54.7/ 1000	47.8/ 1000	40/ 1000	31.4/ 1000	28.5/ 10000
	Child under 5 years with pneumonia new	*PHC Tick Register*	*No*	*1 278*	*4 534*	*3 677*	*2 984*	*2 500*	*2 000*	*1 800*
	Population under 5 years	*DHIS/Stats SA*	*No*	*63,606*	*63,086*	*67 205*	*62,356*	*62,017*	*63,606*	*63,086*
2.6.2) Reduce severe acute malnutrition incidence under 5 years to 4.6 per 1000 by March 2020	5. Child under 5 years severe acute malnutrition incidence (annualised)	DHIS	Annual/ No per 1000	0.95/1000	6.2/1000	4.64/ 1000	3.5/ 1000	3.2/1000	2.3/1000	1.5/1000
	Child under 5 years with severe acute malnutrition new	*DHIS/Tick register PHC*	*No*	*61*	*393*	*312*	*221*	*200*	*150*	*100*
	Population under 5 years	*DHIS/Stats SA*	*No*	*63,606*	*63,086*	*67 205*	*62,356*	*62,017*	*63,606*	*63,086*
2.6.12) Reduce the child under 1 year mortality in facility rate to less than 5.5% by March 2020	6. Child under 1 year mortality in facility rate (annualised)	DHIS	Annual/ %		7%	8.1%	7.6%	6.5%	6.3%	6.1%
	Inpatient death under 1 year	*DHIS calculates*	*No*	*220*	*214*	*201*	*139*	*119*	*116*	*113*

Strategic Objective Statement	Performance Indicators	Data Source	Frequency Type	Audited/actual Performance			Estimated Performance	Medium Term Targets		
				2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	Inpatient separations under 1 year	*DHIS calculates*	*No*	_____	*3 034*	*2 468*	*1 818*	*1 832*	*1 846*	*1 860*
2.6.13) Reduce the inpatient death under-5 rate to less than 4.5% by March 2020	7. Inpatient death under 5 year rate	DHIS	Annual/ %		10.7%	9.8%	5.6%	5.5%	5.4%	5.3%
	Inpatient death under 5 years	*DHIS calculates*	*No*	*267*	*347*	*275*	*174*	*171*	*170*	*168*
	Inpatient separations under 5 years	*DHIS calculates*	*No*	_____	*3 226*	*2 787*	*3 102*	*3 126*	*3 151*	*3 176*

15.2 STRATEGIES/ ACTIVITIES TO BE IMPLEMENTED 2015/16

Table 55: MCWH Strategies

Strategies	Activities
Decrease Maternal and Child Mortality	• Conduct ongoing ESMOE trainings • Increase Ante-natal care visits< 20 weeks. • Provide quality post -natal mother and baby care services within six days post delivery • Provide and improve the referral system for pregnant women, new-borns and children requiring specialised services • Reduce the number of BBAs which negatively impact on neonatal mortality • Provide ART to all HIV positive pregnant women irrespective of gestational age and CD4 count. • Empower women of child bearing age on family planning and contraception and offer the service • Re-test all HIV negative pregnant women after every three months visit to put those who have seroconverted on treatment. • Reduce teenage pregnancy rate which increases maternal mortality rate in Umzinyathi
Increase Child Survival	• Community level: CIMCI; Phila Mntwana. • PHC Clinic: Well child services (includes <12 year old children); IMCI case management; Paediatric HAART initiation; Management of diarrhoea, pneumonia and malnutrition • Improving Emergency neonatal and child care; Piloting of retrieval teams with EMS and High Care / Intensive Care • Increase TB and initiation of screening of TB in children under-5. • Increase immunization coverage through performance of mini campaigns in the areas with low coverage below 90% • Conduct monthly Child Health Forum Meetings • Ensure sustainability of the district resolution that every PHC clinic must have an IMCI trained nurse to attend to all children presenting the facility
Improve Nutrition Programme	• Improve community interventions on early detection of acute malnutrition through CIMCI and effective use of Phila Mntwana Centres. • Improve hospital management of children with severe acute malnutrition through proper implementation of the WHO ten steps protocol • Nutritionist, Nutrition Advisors and CCGs to conduct household support visits to all mothers of children 6 months and below

	• Improve the community administration of Vitamin A dose to 12-59 months children by CCGs • All clinics to have at least a monthly vitamin A campaign at a community level targeted at grey areas. • Continuous trainings on IMAM, IYCF policy, PEM and GMP are crucial at PHC level. • Facilitate the establishment of the b/feeding support group in 60% of the facilities

16. DISEASE PREVENTION AND CONTROL (ENVIRONMENTAL HEALTH INDICATORS)

16.1 PROGRAMME OVERVIEW

MENTAL HEALTH, SUBSTANCE ABUSE AND CHRONIC DISEASES GERIATRICS

Achievements

- All 4 District hospitals provide 72 hours assessment and monitoring tool.
- 40 Substance Abuse Awareness Campaigns conducted targeting youth and the community
- 64 Chronic Disease Awareness at clinics
- 11 Community Awareness Campaigns on chronic diseases conducted
- 6 Community Chronic distribution site established
- 38 functional Chronic Support Groups
- MHC are done HCT and Pap Smear

Challenges

- COSH Mental Health team does not have dedicated outreach vehicle, to trace Mental Health Care Users
- COSH seclusion not according to specifications
- Old Age Homes not visited by Doctors. No clear policy available

EYE HEALTH (NCD)

Achievements

- Increase in screening service due to the utilization of the NHI Eye Health mobile clinic.
- 32 Family and school Health nurses were trained on Primary eye Health.
- Increase in the number of refractions conducted & corrected

Challenges

- Staff shortage; 2 Optometrist required for the NHI Mobile Unit.
- Unavailability of flying doctors for cataract surgery
- Poor referral lists from School Health Nurses.

Table 56 (NDoH 25): Situational Analysis for Disease Prevention and Control - 2013/14 Financial Year

Indicator	Type	Endumeni Sub-District	Nquthu Sub-District	Msinga Sub-District	Umvoti Sub-District	District Avg
1. Clients screened for hypertension	Quarterly No	Not collected	Not collected	Not collected	Not collected	
2. Clients screened for diabetes	Quarterly No	Not collected	Not collected	Not collected	Not collected	
3. Percentage of people screened for mental disorders	Quarterly %	Not collected	Not collected	Not collected	Not collected	
PHC Client screened for mental disorders	*No*					
PHC headcount total	*No*					
4. Percentage of people treated for mental disorders	Quarterly %	Not collected	Not collected	Not collected	Not collected	
Client treated for mental disorders at PHC level	*No*					
Clients screened for mental disorders at PHC level	*No*					
5. Cataract surgery rate	No per million uninsured population	422.38/million	Only Endumeni does cataract surgery	Only Endumeni does cataract surgery	Only Endumeni does cataract surgery	422.38/million
Cataract surgery total	*No*	202	*0*	*0*	*0*	*202*
Population uninsured total	*No*	*61 678*	*154 580*	*164 857*	*97 108*	*478 223*
6. Malaria case fatality rate	%	*0%*	*0%*	*0%*	*0%*	*0%*
Malaria death reported	*No*	*0*	*0*	*0*	*0*	*0*
Number of malaria cases (new)	*No*	*0*	*0*	*0*	*0*	*0*

Table 57 (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 collected	Not collected	Not collected					
2. Clients screened for diabetes	DHIS / Tick register	Quarterly No	Not collected	Not collected	Not collected					
3. Percentage of people screened for mental disorders	DHIS calculates	Quarterly %	Not collected	Not collected	Not collected					
PHC Client screened for mental disorders	*DHIS / Tick register*	*No*								
PHC headcount total	*DHIS / Tick Register*	*No*								
4. Percentage of people treated for mental disorders	DHIS Calculates	Quarterly %	Not collected	Not collected	Not collected					
Client treated for mental disorders at PHC level	*DHIS / Tick register*	*No*								
Clients screened for mental disorders at PHC level	*DHIS / Tick register*	*No*								
5. Cataract surgery rate	DHIS	Quarterly No per 1 mil uninsured population	376	466	422.38/million					
Cataract surgery total	*DHIS / Theatre register*	*No*	185	*204*	*202*	*220*	*229*	*239*		
Population uninsured total	*DHIS / Stats SA*	*No*	*491 916*	*517 807*	*478 223*					

	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
6. Malaria case fatality rate	Malaria Register	Annual %	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*
Malaria death reported	*Malaria register / Tick register PHC*	*No*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Number of malaria cases (new)	*Malaria register / Tick register PHC*	*No*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*

Table 58 (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		
				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	0	0	0	0	0	0	0
	Number of malaria cases (new)	*Malaria register/Tick register PHC*	*No*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Population Umzinyathi	*DHIS/Stats SA*	*Population*	*506 445*	*510 222*	*514 217*	*518 409*	*522 808*		
2.	Hypertension incidence (annualised)	DHIS	Quarterly No per 100	Not reported	Not reported					
	Hypertension client treatment new	*DHIS / PHC tick registers*	*No*							
	Population 40 years and older	*DHIS / Stats SA*	*No*							
3.	Diabetes incidence (annualised)	DHIS	Quarterly No per 100	Not reported	Not reported					
	Diabetes client treatment new	*DHIS / PHC tick registers*	*No*							
	Population total	*DHIS / Stats SA*	*No*							

16.2 STRATEGIES/ ACTIVITIES TO BE IMPLEMENTED 2015/16

Strategies	Activities
Improve Occupational Health and Safety	• Conduct Health Promotion Programmes • Improve Medical Surveillance – periodicals • Establish Health Clubs and Sport Codes • Improve awareness strategies for MMC • Screening of monitoring of PHC staff • Improve the ex-miners programme
Reduce morbidity and mortality due to non-communicable diseases and illnesses	• Implement an integrated inter sectorial health lifestyle strategy as part of PHC Re engineering and staff wellness • Establish health lifestyle clubs in war rooms. • Establish integrated support groups • Establish integrated disease management programme within the facilities
Decrease hypertension and diabetes by 20% per annum	• Screen for NCDs/, BP, HCT, DM, TB, in all household profiled community events & facilities. • Create community awareness on NCDs • Increase distribution of Chronic medication to community sites
Improve EYE CARE PROGRAMME	• Employ two full time optometrists to work on a NHI mobile. • Employ a private Ophthalmologist to do cataract surgery on session basis. • To have a follow up meeting with School Health Nurses to improve referral lists • Integrate eye care services with PHC re-engineering • Ensure administration of vitamin A to all under 5 years • Screening of learners in school using NHI eye care mobile unit • Screening of all clients at pension points for cataracts • Increase the number of cataracts surgery rate

17. INFRASTRUCTURE, EQUIPMENT AND OTHER SUPPORT SERVICES

Table 59 (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	%								
Numerator									
Denominator									
2. Number of facilities that have undergone major and minor refurbishment		100%	100%	100%	100%				
3. Fixed PHC facilities with access to continuous supply of clean portable water	%	100%	100%	100%	100%				
Numerator		*47*	*47*	*50*	*54*				
Denominator		*47*	*47*	*50*	*54*				
4. Fixed PHC facilities with access to continuous supply of electricity	%	100%	100%	100%	100%				
Numerator		*47*	*47*	*50*	*54*				
Denominator		*47*	*47*	*50*	*54*				
5. Fixed PHC facilities with access to sanitation		100%	100%	100%	100%				
Numerator		*47*	*47*	*50*	*54*				
Denominator		*47*	*47*	*50*	*54*				
6. Fixed PHC facilities with access to fixed telephone line	%	100%	100%	100%	100%				
Numerator		*47*	*47*	*50*	*54*				
Denominator		*47*	*47*	*50*	*54*				
7. Percentage of PHC facilities with network access		100%	100%	100%	100%				
Numerator		*47*	*47*	*50*	*54*				
Denominator		*47*	*47*	*50*	*54*				
8. Number of additional clinics and community health centres constructed		0	0	0	4	2			

INFRA-STRUCTURE

Achievements

- Painting of Ideal Clinics
- Servicing of Plant and Equipment in the Hospitals and clinics
- Installation of directional signage's in the Ideal clinics
- 98% of clinics are paved
- Handover of Greytown Mortuary

Challenges:

- Overflowing of Septic tanks with the clinic
- Bore failure to supply water to clinics
- Backup of energy in the clinics
- Poor Directional signage's to the clinics with the district
- Aged infrastructure
- Waste storage areas and hand washing facilities not complaint to IPC guidelines

INFRA-STRUCTURE STRATEGIES 2015-16

Maintenance of existing Community Health Centers, Primary Health Care clinics and facilities

- Install bigger capacity Septic Tanks and empty septic tanks on regular basis
- Conduct engineering study to locate new sources of borehole water for the clinics
- Install solar panels, UPS and generators in clinics
- Install directional signage to clinics
- Ongoing major and minor maintenance to maintain aged infra-structure
- Construct Waste storage areas and install Hand wash facilities in all clinical areas compliant with IPC guidelines

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

ACHIEVEMENTS

- 75% of pharmacies obtaining an "A" grade after being inspected by the pharmacy council
- Providing experiential learning to the unemployed youth of Umzinyathi , to learn towards becoming pharmacist assistants
- Establishing a district pharmaceutical-finance forum where integrated pharmacy-finance issues are discussed and challenges resolved.
- Retention of 1 PHC pharmacist assistant per sub-district (except in Msinga sub-district where there was none).

CHALLENGES

- Infrastructure is a challenge due to legacy pharmacies that are not aligned to the current workload and disease burden.
- Unavailability of tutors to mentor and increase the pool of experiential learners.
- Lack of dedicated pharmacy transport, which makes it difficult to perform all pharmaceutical competences.
- Rural nature of the district makes it difficult to retain recruited personnel

STRATEGIES

- Put all necessary requirements according to Good Pharmacy Practice and all other legislature that relates to pharmaceutical services on the 2014/15 and MTEF Business plans.
- Recruit more pharmacists. Register community service pharmacists as tutors in the month that they assume duty.
- Enforce quarterly meetings, or at least analyze pharmacy-finance indicators and communicate with all relevant stakeholders quarterly.
- Transport section to allocate at least 1 dedicated pharmacy vehicle per sub-district.
- Re-introduce automatic rural allowance in all facilities in the rural node districts including in Umzinyathi district as per resolutions taken in the Bargaining Chamber.

Table 60 (NDoH 39): Pharmaceutical Services Performance Indicators

Indicators	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. Percentage of institutions (District Hospitals and CHC's) with functional of Pharmaceutical and Therapeutics Committees (PTC's)	%	75%	75%	75%	100%	100	100	100	100%
Number of CHC's and District Hospitals with functional Pharmaceutical and Therapeutic Committees		*3*	*3*	*3*	*4*	*4*	*4*	*5*	
Number of District Hospitals and CHC's		*4*	*4*	*4*	*4*	*4*	*4*	*4*	
2. Any ARV Drug Stock Out Rate	%	0%	0%	0%	0%	0%	0%	0%	0%
Number of ARV drug's out of stock		*0*	*0*	*0*					
Number of ARV's drugs		*12*	*12*	*12*					
3. Any TB Stock Out Rate	%	0%	0%	0%	0%	0%	0%	0%	0%
Number of TB drugs out of stock		*0*	*0*	*0*					
Number of TB drugs		*7*	*7*	*7*					
4. Percentage of Hospitals with Pharmacists	%	100%	100%	100%	100%	100%	100%	100%	100%
Number of District Hospitals with Pharmacists		*4*	*4*	*4*	*4*	*4*	*4*	*4*	
Number of District Hospitals		*4*	*4*	*4*	*4*	*4*	*4*	*4*	
5. Percentage of CHC's with Pharmacists	%	N/A	N/A	N/A	100%	100%	100%	100%	100%
Number of CHC's with pharmacists		*0*	*0*	*0*	*1*	*1*	*1*	*1*	
Number of CHC's		*0*	*0*	*0*	*1*	*1*	*1*	*1*	

Table 61 (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	2014/15	2015/16	2016/17	2017/18
1.	1. Percentage of Pharmacies that obtained A and B grading on inspection	Pharmacy records	Annual %	100%	100%	100%	100%	100%	100%	100%
	Pharmacies with A or B Grading	*Pharmacy records*	*No*	*4*	*4*	*4*	*4*	*4*	*4*	*4*
	Number of pharmacies	*Pharmacy records*	*No*	*4*	*4*	*4*	*4*	*4*	*4*	*4*
	2. Tracer medicine stock-out rate (PPSD)	Pharmacy records	Quarterly %	This is a PPSD indicator,	This is a PPSD indicator,	This is a PPSD indicator,	This is a PPSD indicator,			
	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 %	3.3%	2.88%	1.35%	1%			
	Number of tracer medicines stock out in bulk store	*Pharmacy records*	No	*22*	*19*	*8*	*6*			
	Number of tracer medicines expected to be stocked in the bulk store	*Pharmacy records*	No	*660*	*660*	*600*	*600*			
2.	4. Number of mortuaries rationalised	Management	Annual No	Nil	Nil	Nil				

18.2 EQUIPMENT AND MAINTENANCE

See annexure 3 and 4 attached

Table 62: 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. Percentage of maintenance budget spent	Annual %	94%	95%						
Expenditure on maintenance (preventive and scheduled)	*No*	21,795,593	15,555,000						
Maintenance budget	*No*	23,204,000	16,252,132						
2. Proportion of Programme 8 (infrastructure budget) spent on all maintenance (preventative and scheduled)	Annual %	21,795,593	16,252,132						
Expenditure on maintenance (preventive and scheduled)	*No*								
Infrastructure budget	*No*								
3. Number of health facilities that have undergone major and minor refurbishments	Annual No.	47	47	50					

18.3 EMERGENCY MEDICAL SERVICES (EMS)

Table 63 (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
Nqutu	No	4	4	5	6	7	8	13	
Msinga	No	5	5	6	7	8	9	13	
Endumeni	No	3	3	3	4	5	6	11	
Umvoti	No	5	4	6	7	8	9	13	

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
District Average	No	17	16	20	24	28	32	50	

Table 64 (NDoH 31 (b)): Ambulance Response Time Rural under 40 minutes (Inclusive of LG)

	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	
Nqutu	%	-	-	-	-	-	-	-	
Msinga	%	-	-	-	-	-	-	_	
Endumeni	%	82%	67%	71%	75%	80%	82%	85%	
Umvoti	%	42%	33%	36%	40%	47%	52%	70%	
District Average	%	80%	53%	59%	64%	70%	75%	80%	

Table 65 (NDoH 31(c)): Ambulance Response Times Urban under 15 minutes (Inclusive of LG)

Ambulance Response Time: Urban	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
Nqutu	%	-	-	-	-	-	-	-	
Msinga	%	-	-	-	-	-	-	_	
Endumeni	%	82%	67%	71%	75%	80%	82%	85%	
Umvoti	%	42%	33%	36%	40%	47%	52%	70%	
District Average	%	80%	53%	59%	64%	70%	75%	80%	

Table 66 (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

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
	%								
	%			No data					
	%								
	%								
District	%								

19. HUMAN RESOURCES

Table 67 (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
Health district	Personnel category							
Endumeni	**PHC facilities**							
	Medical officers	0	0	1	1	1	2	2
	Professional nurses	50	50	55	49	55	60	65
	Pharmacists	0	0	0	0	0	0	0
	Dundee Hospital							
	Medical officers	12	15	10	7	10	13	16
	Professional nurses	120	130	108	116	130	135	140
	Pharmacists	4	4	4	4	5	6	6
	Radiographers	3	4	5	5	5	5	5
Msinga	**PHC facilities**							
	Medical officers	0	0	0	0	0	1	3
	Professional nurses	55	65	56	64	70	75	80
	Pharmacists	0	0	0	0	0	0	0
	Church of Scotland Hospital (COSH)							
	Medical officers	22	25	15	13	15	20	25
	Professional nurses	128	138	128	109	120	130	140

	TOTAL POSTS FILLED	Audited/ Actual performance			Estimate	MTEF Projection		
		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	Pharmacists	4	5	3	3	4	6	8
	Radiographers	3	4	3	3	4	5	6
Nquthu	**PHC facilities**							
	Medical officers	0	0	0	0	0	2	3
	Professional nurses	59	68	74	79	85	90	95
	Pharmacists	0	0	0	0	0	0	0
	Charles Johnson Memorial Hospital (CJM)							
	Medical officers	5	8	9	10	14	16	20
	Professional nurses	107	112	138	137	140	150	160
	Pharmacists	1	3	3	3	4	6	8
	Radiographers	2	1	4	2	4	5	5
Umvoti	**PHC facilities**							
	Medical officers	0	0	0	0	0	1	2
	Professional nurses	60	65	75	72	75	80	90
	Pharmacists	0	0	0	0	0	0	0
	Greytown Hospital							
	Medical officers	9	10	6	7	10	14	18
	Professional nurses	120	120	127	119	125	130	135
	Pharmacists	3	3	4	5	5	5	5

	TOTAL POSTS FILLED	Audited/ Actual performance			Estimate	MTEF Projection		
		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	Radiographers	4	4	4	4	4	4	4
District	**PHC facilities**							
	Medical officers	0	0	1	1	1	6	10
	Professional nurses	224	248	260	264	285	305	330
	Pharmacists	0	0	0	0	0	0	0
	District hospitals							
	Medical officers	48	58	40	37	49	63	79
	Professional nurses	475	500	501	481	515	545	575
	Pharmacists	12	16	14	15	18	23	27
	Radiographers	13	16	16	14	17	19	20

Table 68 (NDoH 33): Plans for Health Science and Training

CONTINUOUS PROFESSIONAL CAPACITY BUILDING / TRAINING [7]	INDICATORS	Estimated performance	Medium term targets		
		2014/15	2015/16	2016/17	2017/18
Basic Life support	220	80	60	60	60
Advanced Cardiac Life Support	40	15	24	24	24
Paediatric Advanced Life Support	15	15	0	0	0
BLS Instructor Training	10	10	0	0	0

[7] This would include formal and informal (short courses, refreshers, etc.) courses.

CONTINUOUS PROFESSIONAL CAPACITY BUILDING / TRAINING 7	INDICATORS	Estimated performance	Medium term targets		
		2014/15	2015/16	2016/17	2017/18
Advanced Trauma Life Support	57	0	19	19	19
Adherence Counselling	21	0	0	0	0
Death Certification	4	3	0	0	0
Dry Needling	9	0	0	0	0
Management of Drug Resistance	4	0	0	0	0
Midwifery	5	12	8	8	8
Pharmacovigilence	4	0	0	0	0
Hand Rehabilitation	9	0	0	0	0
Dispensing	25	0	12	13	0
Diploma in Clinical Nursing Science	50	25	25	25	25
Pharmacy Assistants (Basic & Post Basic)	12	7	8	8	8

20. DISTRICT FINANCE PLAN

Table 69 (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	11,865,000	12,458,250	21,960,000	24,236,000			26,150,644	28,190,394	30,417,435
Clinics	187,870,000	197,263,500	172,976,800	181,208,000			195,523,432	210,774,260	227,425,426
Community Health Centres	-	-	-	-			-	-	-
Community Services	882,000	886,410	-	-			-	-	-
Other Community	41,556,768	43,634,606	84,103,000	87,711,000			92,447,394	97,347,106	103,479,974
Coroner Services	9,315,000	9,361,575	10,936,000	10,998,000			11,591,892	12,206,262	12,975,257
HIV and AIDS	84,741,000	85,1647,05	134,431,000	155,688,000			164,095,152	172,792,195	183,678,103
Nutrition	2,189,000	2,199,945	2,566,000	2,551,000			2,688,754	2,831,258	3,009,627
District Hospitals	432,612,232	449,916,721	594,015,000	601,154,000			633,616,316	667,197,981	709,231,454
Environmental Health Services	5,244,000	5,283,330	2,737,000	-			-	-	-
TOTAL	**776,275,000**	**806,169,042**	**1,023724,800**	**1,063,546,000**			**1.126,113,584**	**1,191,339,456**	**1,270,217,276**

Table 70 (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	920,086,000	920,086,000	1 127 143 000	1 219 252 000			1 307 510 933	1 400 999 464	1 505 951 907
Compensation of employees	689,879,000	741,619,000	824 116 000	896 773 000			967 618 067	1 043 092 276	1 125 496 566
Goods and services	230,207,000	248,623,000	303 027 000	322 479 000			339 892 866	357 907 188	308 455 341
Transfers and subsidies to	11,579,000	12,215,000	6 296 000	5 258 000			5 541 932	5 835 654	6 203 301
Payments for capital assets	8,398,000	8,902,000	14 601 000	5 564 000			5 864456	6 175 272	6 564 314
Total economic classification	**940,081,000**	**1,011,359,000**	**1 148 040 000**	**1 230 074 000**			**1 318 917 321**	**1 413 010 391**	**1 518 719 522**

FINANCE

ACHIEVEMENTS

- 90% of the payments are done within 30 days Backlog Debt files handed over to Head Office for record keeping. Umzinyathi District updated the backlog.
- Budget was placed on the system in the beginning of the financial year.
- 100% journal batches timeously handed over to Head Office and backlog was completed. All the journals are compliant with policies and procedures and relevant attachments are filed on the journal.
- 100% journal batches timeously handed over to Head Office and backlog was completed. All the journals are compliant with policies and procedures and relevant attachments are filed on the journal.
- Suspense accounts up to date and are now cleared on a monthly basis.
- Separate Cash flow committees have been established at each sub district for PHC and Hospitals and most Institutions are having weekly cash flow meetings and this action improve the turnaround times on Goods and Services to the wards and to the clinics.
- Expenditure is monitored monthly and the District expenditure is on par with the budget allocation.
- Finance Managers were all trained on Vulendlela and are using this system to get updated reports daily for cash flow purposes and also to monitor expenditure and to detect incorrect expenditure.
- Finance Managers no longer have to rely on one system to obtain necessary information.

- 90% Staff linking in District is corrected.
- All support services – Finance, SCM, Assets for EMRS are now done at District Office level and are fully integrated.
- Risk toolkits are in place and are completed monthly by the finance managers.
- A revenue target was set and most institutions have met revenue targets – (timeously follow up patient accounts – rent owing to the Department etc.).

CHALLENGES

- SCM Managers and Finance Managers do not do follow ups on outstanding orders weekly.
- Cash flow plans not in place in the beginning of the financial year and copy not on file at clinic level
- PHC supervisors are not involved in budget planning there is no evidence such as minutes of budget planning committees at sub district level and district office not available.
- Posts not filled in time effect the next budget allocation as the next year allocation is basically allocated on expenditure trends.
- 10% incorrect expenditure on reports – causes unnecessary work in Finance to process journals to correct expenditure where there is no budget allocation.
- Regional Laundry not working and contract not in place delay service delivery due to fact that authority to continue must first be obtained from CFO.

PART C: LINKS TO OTHER PLANS

CONDITIONAL GRANTS

Table 71 (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
COMPREHENSIVE HIV AIDS CONDITIONAL GRANT (*Applicable to all Districts*)	• To enable the health sector to develop an effective response to HIV and AIDS including universal access to HIV Counselling and Testing • To support the implements of the National operational plan for comprehensive HIV and AIDS treatment and care • To subsidise in-part funding for the antiretroviral treatment plan	Total Number of fixed public health facilities offering ART Services	**57**
		Number of new patients that started on ART	**18 181**
		Total number of patients on ART remaining in care.	**67 955**
		Number of beneficiaries served by home-based categories	**462 375**
		Number of active home-based careers receiving stipends	**650**
		Number of male and female condoms distributed	**11 830 000**
		Number of High Transmission Areas (HTA) intervention sites	**10**
		Number of Antenatal Care (ANC) clients initiated on lifelong ART	**2 642**
		Number of babies Polymerase Chain Reaction (PCR) tested at 6 weeks	**4 773**
		Number of HIV positive clients screened for TB	**14 483**
		Number of HIV positive patients that started on IPT	**10 138**
		Number of active lay counselors on stipends	**0**
		Number of clients pre-test counselled on HIV testing (including Antenatal)	**156 789**

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
		Number of HIV tests done	**156 789**
		Number of health facilities offering MMC services	**4**
		Number of Medical Male Circumcisions performed	**19 614**
		Sexual assault cases offered ARV prophylaxis	**80%**
		Step down care (SDC) facilities/units	**1**
		Doctors and professional nurses training on HIV/AIDS, STIs, TB and chronic diseases	**±200**
NHI Business plan for 2015/16	See Annexure 6 attached		
Health Professionals Training & Development Grant	Training and Development of Health Professionals	To Train Medical Officers	
Forensic Pathology Grant	Forensic Pathology Services	Total Number of admissions	**266**

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

N/A to Umzinyathi

Table 72 (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.					
2.					

Partners 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.

VEHICLE PROCUREMENT PLAN 2015/2016 - ADDITIONAL VEHICLES

Table 73: CHARLES JOHNSON HOSPITAL

	Make	Type	Allocation	Estimated Price
1	Ford	Ranger 2.2 XL 4X4 6MT S/C diesel (To be converted to Mobile Clinic)	PHC Mobile Clinic	R 500 000.00
2	Ford	Ranger 2.4 Diesel D/C	Pharmacy	R 289 204.00
3	Ford	Ranger 2.4 Diesel D/C	TB	R 289 204.00
4	Ford	Ranger 2.4 Diesel D/C	TB	R 289 204.00
				R 1 367 612.00

Table 74: CHURCH OF SCOTLAND HOSPITAL

	Make	Type	Allocation	Estimated Price
1	Toyota	Hilux 2.5 diesel S/C LWB	Maintenance	R 208 986.00
2	Toyota	Hilux 2.5 diesel D/C	Psychiatric Programme	R 275 251.00
3	Toyota	Hilux D/C	MMC	R 275 251.00
4	VW	Transporter T5	PHC Mobile Staff	R 392 900.00

				R 1 152 388.00

Table 75: DUNDEE HOSPITAL

	Make	Type	Allocation	Estimated Price
1	Toyota	Hilux 2.5 diesel D/C with canopy	Maintenance	R 280 000.00
2	Toyota	Hilux 2.5 diesel D/C with canopy	PHC	R 280 000.00
3	Toyota	Hilux 2.5 diesel D/C with canopy	Delivery to all clinics	R 280 000.00
4	Toyota	Hilux 2.5 diesel D/C	Dental Clinic	R 275 251.00
5	Toyota	Hilux 2.5 diesel D/C	Rorkesdrift Clinic	R 275 251.00
				R 1 390 502.00

Table 76: GREYTOWN HOSPITAL

	Make	Type	Allocation	Estimated Price
1	Ford	Ranger 2.2 5mt S/C	TB	R 139 000.00
2	Ford	Ranger 2.2 5mt S/C	Maintenance	R 139 000.00
3	Nissan	NP200	Mental Health	R 118 000.00
4	Toyota	Quantum	Pool	R 379 000.00
5	Toyota	Hilux 4X4 SRX D/C with Canopy	Pool	R 275 251.00
6	Toyota	Corolla 1.8	Pool	R 211 939.00
				R 1 262 190.00

Table 77: POMEROY CHC

	Make	Type	Allocation	Estimated Price
1.	Toyota	Hilux 2.5 Diesel D/C with canopy	Pharmacy	R 275 251.00
2.	Toyota	Hilux 2.5 Diesel D/C	Outreach Teams	R 275 251.00
3	Toyota	Hilux 2.5 Diesel D/C	Outreach Teams	R 275 251.00
4	Ford	Ranger 2.2 S/C petrol	Stores	R 139 000.00
5	Ford	Ranger 2.2 S/C petrol	Maintenance	R 139.000.00
6	Toyota	Quantum	Administration	R 379 000.00
7	Toyota	Corolla 1.8	Pool	R 211 939.00
8	Ford	Ranger 2.2XL 4X4 6MT diesel (Converted to Mobile Clinic)	PHC	R 500 000.00
9	Ford	Ranger 2.2XL 4X4 6MT diesel (Converted to Mobile Clinic)	PHC	R 500 000.00

10	Ford	Ranger 2.2XL 4X4 6MT diesel (Converted to Mobile Clinic	PHC	R 500 000.00
11	Toyota	Avanza 1.5SX Panel Van(Separate compartments)	Waste Management	R 153 020.00
				R 3 694 692.00

Table 78: DISTRICT OFFICE

	Make	Type	Allocation	Estimated Price
1	Toyota	Quantum	Pool	R 379 000.00
2	Toyota	Hilux 2.5 Diesel D/C	Pool	R 275 251.00
				R 654 251.00

The Total Budget is **R 5 826 943.00**

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.