health

Department:
Health
PROVINCE OF KWAZULU-NATAL

DISTRICT HEALTH PLAN 2015/2016

ETHEKWINI HEALTH DISTRICT

KWAZULU-NATAL

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Martin Gabela (Planning, Monitoring and Evaluation Manger) responsible for the drafting of the DHP 15/16 with input from Nicky Manivasen for the extraction and compilation of the DHIS data tables; the various program managers at the district office that provided strategic input regarding progress and plans for the next financial year. The finance information was compiled by Sandra Moodley. The Human Resource data was compiled by Melanie Dazel and Ronald Dukie. Nkosifikile Ndelu drew the revised map of the sub-districts. Acknowledgement is also extended to Shamim Ganie and Catherine Searle from MatCH (District Support Partner), for valuable assistance with the analysis and write up of the DHP. The support and input of the provincial team under Tracey Hattingh and Ester Snyman is also gratefully acknowledged.

2. OFFICIAL SIGN OFF

It is hereby certified that this District Health Plan:

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

3. TABLE OF CONTENTS

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
DQPR	District Quarterly Progress Report
E	
EMS	Emergency Medical Services
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
HPV	Human papillo virus

Abbreviations	Description
HR	Human Resources
HTA	High Transmission Area
I	
IDP(s)	Integrated Development Plan(s)
IPT	Ionized Preventive Therapy
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	
RV	Rota Virus Vaccine
S	

Abbreviations	Description
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

eThekwini District is a Metropolitan Health District comprising of 103 wards that are urban, rural and peri-rural in nature. The metropolitan area covers a 2, 297 square kilometre area stretching from the Umkomaas in the south, including tribal areas in Umbumbulu, to Tongaat in the north, moving inland to tribal areas in Ndwedwe and ends at Cato Ridge in the west. The district is surrounded by iLembe district to the north, Ugu district to the south, Umgungundlovu district to the west and the Indian Ocean to the east. Despite being highly urbanised and densely populated, pockets of rural communities exist on the outskirts of the west, south and north impacting on access to services and equity. 3 442 361 individuals reside in the district. The data in this DHP is broken down into 8 proposed sub-districts. The South sub-district has been divided into three functional areas: 1) South Central, 2) South West, 3) Umlazi/Engonyameni and 4) Lower South. The North/West is divided into 4 sub-districts namely: 1) North Central, 2) Greater Inanda/Tongaat Sub-District, 3) Inner West; and 4) Outer West Sub-Districts.

eThekwini has a developing population and 62% of the population are below 35 years with high birth rates and infant mortality. Life expectancy remains low as a result of the quadruple burden of disease with HIV, TB, chronic illnesses and deaths due to injury and violence. Maternal and infant mortality and the high TB burden are key challenges that need to be addressed. The district also has the highest number of migrants in the province and the PHC headcount indicates the highest rate of migrant populations using district services. There are also an unknown number of day visitors that make use of services that are not taken into consideration in the budget.

Service Delivery

The service delivery platform consists of one central/academic hospital, 5 regional hospitals, 2 district hospitals (and two previously state aided hospitals yet to be designated), 4 specialised hospitals, 8 CHC and 110 clinics including 57 clinics under local authority. Service delivery challenges in the district include inequitable distribution of CHC and PHC services provide by both Local Authority and Province. South Central has only one CHC (Cato Manor CHC) dually managed by Province and Municipality that does not provide 24 hour services. The lack of PHC facilities in the CBD and surrounds has resulted in an overreliance on regional hospitals for PHC services and most of the PHC clinics are managed by the LG and do not all offer comprehensive services. A large number of mobile service points have been established to increase access to services in the sub-district. The South West sub-district also has no CHC and most PHC are managed by LG with no 24 hour services currently existing. Umlazi and Engonyameni South Sub-District has the largest number of PHC facilities but no CHC. Currently no mobile services are provided in this densely populated area. The Engonyameni Tribal Authority, a rural area on the outskirts of uMlazi has no clinics access to health services is only through Mobile Services from Emaweleni. The Lower South has 9 PHC for a relatively small catchment population. North Central has one CHC and 12 clinics and a large number of mobile service delivery points. Greater Inanda/Tongaat has the highest number of CHC (4) and 14 clinics mostly under LG management. The Inner West has 1 CHC, 14 clinics and a large number of mobile points to increase access to services. The Outer West has one CHC and 9 clinics.

The district is planning to appoint 10 Community Service doctors who will be servicing the PHC clinics in the South Service Area which will result in the termination of the current fee for service doctors, and these posts will be created at PMMH (7) and R.K. Khan hospital (3).

District Hospital Services are currently only provided in two sub-districts. Osindisweni in Greater Inanda/Tongaat is in a sparsely populated rural area with a small uninsured population relatively affecting its utilisation and ability to provide cost effective services. In contrast, Wentworth Hospital in South Central sub-district has a larger catchment population but a low PHC headcount from the Gateway clinic indicating challenges with accessibility of the service and long length of stay as a result of the burden of disease in the area adding to the cost of services. Rationalisation of OPD services will be undertaken and the referral of psychiatric and patients with TB to King Dinuzulu and the utilisation of Clairwood and McCords Hospital for step down services will address this.

HAST

The programme will expand access to medical male circumcision particularly for males over 25 through training and mentoring of doctors and nurses and mobilisation through OSS. In addition, the programme expanded access to HCT through campaigns and increasing PICT, strengthening PEP especially for children at all facilities and through the Thuthuzela Care Centres. It will strive to improve the diagnosis and treatment of TB for adults and children through case finding, IPT and defaulter tracing.

Maternal and Child Health

The MDGs will be addressed through the implementation of the MAF focusing on increasing screening of children for TB, identification of malnourished and HIV exposed children and fast tracking children onto ART. Maternal health will be addressed through HIV and TB screening for all pregnant women, early booking for ANC and increasing contraceptive uptake including through implants.

Environmental Health and Disease Control

Environmental Health renders services for the management of Environmental Health which includes Port Health and Hazardous and plays a big role in health promotion and prevention programmes. Currently the Environmental health functions are rendered by both Provincial and Municipality with some of the functions remaining the responsibility of Province like the inspection of the state buildings. As of 01 July 2015, Environmental Health Services will no longer be managed by the Province but rather will be managed by the eThekwini Municipality.

Infrastructure

Challenges include compliance with National Core Standards and challenges with utilising budgets for maintenance. The budget for maintenance has reduced markedly and will only cover day to day maintenance and servicing of plants and equipment. Support for SCMS is

urgently required and support from partners will be sought. There is a large backlog of equipment requiring repairs that needs to be addressed.

Human Resources (HR)

Effective management of human resources remains a challenge and support for this function is required by the district. HR is not optimally distributed in the district and stronger HR management is therefore needed

Finance

Budget for the district has decreased over the last three years although there has been an increase in spending. Although COE is within the norm, there is still a critical need to fill posts in specific areas to ensure compliance. Compliance with PMFA and Treasury Regulation requires the implementation of SOP in order to improve audit outcomes. Support from partners will be sought to pilot SOPs and monitor implementation.

Conclusion

The division of the District into more manageable sub-districts will improve the functioning of programme areas and the monitoring of implementation and progress more effectively. Facility information meetings will be rolled out to ensure that targets are known and tracked for key programme areas and to improve data quality. This DHP also will allow for the proper tracking and monitoring of the services provided by the School Health and Family Health teams and to report on a wider range of indicators. The Clinical Specialist Team will work on clinical governance to improve compliance with NCS and to support the implementation of the Ideal Clinics. Although the district faces many challenges in service provision this plan makes provision for clear and measurable outputs that if implemented properly will start to improve district outcomes.

PART A - STRATEGIC OVERVIEW

6. SITUATIONAL ANALYSIS

The eThekwini District is a Metropolitan Health District comprising of 103 wards in a 2, 297 square kilometre area stretching from Umkomaas in the south to Tongaat in the north and Cato Ridge in the west. This coastal district is bordered by iLembe, Ugu and UMgungundlovu districts. Despite being highly urbanised the district has pockets of rural communities that exist on the outskirts of the west, south and north impacting on access to services and equity.

eThekwini is densely populated (3, 464, 205) with the greatest concentrations of the population settling in the South Region (41%), followed by the North Region (32%) and West Region (27%). For an in-depth evaluation of equity and access to care, eThekwini district has been broken down into 8 proposed sub-districts. The South sub-district has been divided into three functional areas: 1) South Central, 2) South West, 3) Umlazi/Engonyameni and 4) Lower South. The North/West is divided into 4 sub-districts namely: 1) North Central, 2) Greater Inanda/Tongaat Sub-District, 3) Inner West; and 4) Outer West Sub-Districts.

Sub-district 1: South Central
South Central is comprised of S3, S4 and S7 PHC service areas and includes the CBD as well as 15% of the population. There are 4 provincial PHCs and several Regional hospitals - King Edward, Addington, St Aidan's, King Dinuzulu (current designation) and Inkosi Albert. Wentworth is currently the only district hospital in this area. One CHC, Cato Manor managed by the local authority, services the area. Some PHC clinics are poorly distributed and do not all offer comprehensive services resulting in patients bypassing PHC level and using regional services. The provincializsation of Cato Manor CHC, McCord hospital and the full Commissioning of King Dinuzulu hospital will reduce the use of regional services.

Sub-district 2: South West
The S8 PHC Area covering the Chatsworth and Welbedacht areas make up this sub-district. 6% of the population reside in this sub-district. The emergence of informal settlements and low cost houses has seen an unprecedented increase in population densities in an area with very few health facilities. The area is services by 2 local authority clinics, R K Khan Hospital and a small Gateway Clinic. The provision of mobile services for R K Khan Hospital is planned to decongest the hospital and increase access to services.

Sub-district 3: Umlazi and Engonyameni
This sub-district is comprised of S2, S5 and S6 PHC areas. This is the most densely populated part of the South Service Area with uMlazi being the 2nd most densely populated township in the country with 16% of the district's population. Due to previous historical planning along racial lines there is only 1 hospital in this catchment, Prince Mshiyeni Memorial Hospital. This Regional hospital also offers district Level services due to the absence of a District hospital or a Community Health Centre. There are 31 PHC clinics (15 Provincial and 16 Local Authority) referring directly to the hospital. Three (3) clinics provide 24 hour services. The area includes the Engonyameni Tribal Authority, a rural area on the outskirts of uMlazi with no clinics and high reliance on mobile health services from Emaweleni.

Sub-district 4; Lower South
This is made up of the S1 PHC area including Reunion, Isipingo, Folweni, and Philani Valley, Nsimbini area, Kwa-Makhutha, Ezimbokodweni, Illovo, Umbumbulu, Umnini, Danganya, eMagabheni and Umnini. Population densities are high around Folweni, Nsimbini, Illovo and Philani Valley and more human settlement zones are being developed. Although only 4% of

the population live in this sub-district it includes the rural area of Umbumbulu, which is one of the most deprived wards in the District, has very limited access to health services. No CHC services exist in this area.

Sub-district 5: North Central

This is formed by North 1, 2 & 3 PHC areas and is home to 14% of the district population. It includes upper class residential areas like Durban North and Umhlanga and the townships of Kwa-Mashu, Ntuzuma, Lindelani, East and West Newlands and Parlock as well as informal settlements and low cost housing settlements. Ward 35 services a mainly insured population; however services for uninsured people working in this area need to be provided. The townships of Phoenix, Kwa-Mashu, Lindelani, Ntuzuma, Newlands East and Newlands West are each serviced by a CHC. Mahatma Gandhi Hospital provides regional and district services. Sub-optimal usage of Phoenix CHC at the expense of Inanda CHC has been identified as a challenge. Kwa-Mashu CHC acts as a referral CHC for Lindelani, Richmond Farm and Ntuzuma besides being a first level of care for Kwa-Mashu Township. Newlands East Clinic which is currently under the management of Addington Hospital will be delinked to be under the direct Supervision of Kwa-Mashu CHC.

Sub-district 6: Greater Inanda /Tongaat Sub-District

This sub-district is composed of North 4, 5 and 6 PHC Areas. This is the most populous sub-district and 18% of the population live in this sub-district. There are 3 CHC in this sub-District (Inanda C, Newtown A and Tongaat CHC) with 1 district hospital, Osindisweni. The development of new human settlements in the Waterloo, Zwelitsha and up and coming Cornubia necessitates a review in the planning and siting of health facilities.

Sub-district 7: Inner West

This sub-district comprised of West 1 and West 3 PHC Areas. 15% of the population live in this sub-district. This area includes the Pinetown area which is highly industrialised as well as township and informal settlements of KwaDabeka and surrounds. It has one CHC (KwaDabeka) and provincial and local authority clinics. There is one district hospital, St Marys (under sequestration), a TB hospital (Don McKenzie) and a chronic care hospital (Hillcrest). District level services are limited as St Marys but lacks capacity (infrastructure, HR, skills) to service the entire West region. Spill over of patients to R K Khan Hospital needs to be addressed. Proposals for consideration include repurposing Hillcrest hospital as a CHC.

Sub-district 8: Outer West

This is made up of the West 2 and 4 PHC areas and includes semi-rural and deep rural areas such as Mpumalanga Township, Kwa Ximba, Ntshongweni, Ntshanga and the 5 Tribal areas of Kwa-Dedangendlale in the Valley of a Thousand Hills. Twelve percent (12%) of the district population live in this sub-district. There is 1 CHC, Hlengisizwe that serves this population with 6 Provincial clinics and 4 Local Authority clinics.

Forty percent (40%) of the population rely on public transport. Transport routes are not equitably distributed across the district with few options in rural and outlying areas. Routes focus on central areas and hubs rather than providing access to PHC services located in less central locations.

It must be noted that eThekwini district has 2 parallel health systems. One managed by the Local Authority and the other by KZN Province. Most local authority PHCs do not offer the full package of service creating a greater burden for provincial clinics. No information on the local authority clinics and services was available to include in this document.

6.1 MAJOR DEMOGRAPHIC CHARACTERISTICS

EThekwini's demographic information (available in the eThekwini Municipality IDP) reflects that 62% of the population are below the age of 35 years. There are marginally more females (50.4%) than males (49.6%). Majority are Black (71.9%), followed by Indian/ Asian (16.3%) and Coloured (2.2%).

The economically active group represents 64% of the total population. Most households are led by males (60%) and majority of household heads (82.1%) are between the ages of 25-65 years old. Children (<15 years) and the elderly (>60 years) account for 28% and 8% respectively.

Comparison to the 2012/13 population estimates show that there is an overall decrease in the eThekwini population from 3,474,030 to 3,464,205 in 2013/14. The total female population decreased by 2.5% (44, 326) in 1 year from 1,788,948 to 1,744,622, while the overall male population increased by 2% (34,500). Notable decreases were observed in the female 10-39 year categories, with a drop by 9% (83,138) and in the male 10-34 year old categories with a drop by 8% (63,016). This decrease was also noted in the 2011 Census. Increases were in the number of elderly 5% (13,628) and in children (<15years) by 3% (27,054).

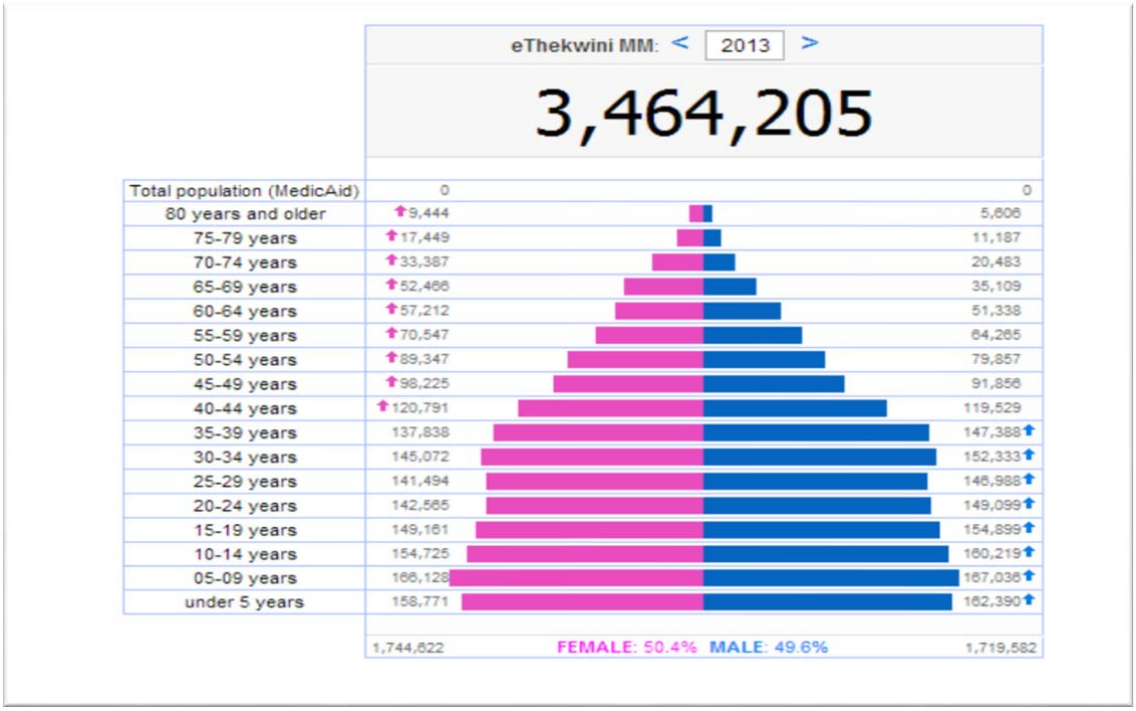
Key considerations in terms of service delivery include cross-border utilisation of services which is seen when one compares total head count (35%) to population (33%). EThekwini also has an unknown number of day visitors that are not accounted for in population estimates. Census 2011 found high numbers of migrants from within KZN, other countries and other provinces (E Cape, Gauteng) come to eThekwini.

Table 1: District Population 2013/14

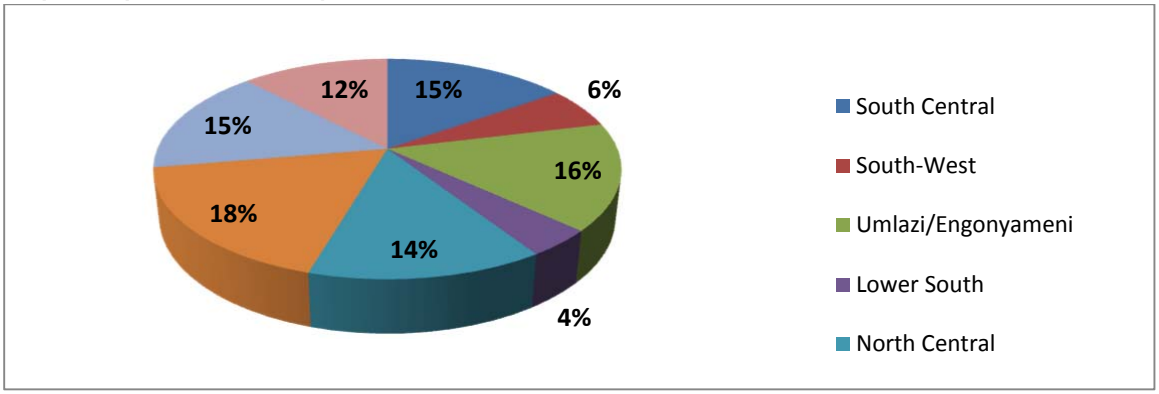
Sub-District	Total Population	% District Population	Uninsured Population
South Central	526 720	15%	421 376
South-West	206 931	6%	165 544
Umlazi/Engonyameni	541 593	16%	433 274
Lower South	138 132	4%	110 506
North Central	476 727	14%	381 382
Greater Inanda/ Tongaat Region	614 568	18%	491 655
Inner West	536 582	15%	429 266
Outer West	422 953	12%	338 362
DISTRICT TOTAL	3 464 205	100%	2 736 722

Source: DHER 2012/13

Figure 1: Population Pyramid eThekwini District 2013 Stats SA



Graph 1: Population distribution per Sub-District



Source: DHIS

The proposed eight sub-districts in order of descending size are Greater Inanda/Tongaat (18%) of population, Umlazi/Engonyameni (16%), Inner West and South Central (15% each), North Central (14%), Outer West (12%), South West (6%) and Lower South (4%). The sub-district with the lowest ratio of clinics per population is the Outer West where 12% of the population have 0.21 clinics per 10,000 populations. Greater Inanda/Tongaat has the highest population and the second lowest ratio of clinics to population with 0.22 clinics per 10,000 populations. Umlazi/Engonyameni has the second highest population and a ratio of 0.3 clinics per 10,000 populations. South Central and Inner West both have 15% of the population and low ratios of 0.29 and 0.25 clinics per 10,000 populations. In contrast, the sub-district with the lowest population is Lower South with only 4% of the population and the highest ratio of clinics per population at 0.63. The second smallest sub-district, South West with 6% of the population has a ratio of clinics per 10,000 (0.33) above the average for the district (0.27).

6.2 SOCIAL DETERMINANTS OF HEALTH

Census 2011 cites an unemployment rate of 30.2% for the district, an improvement from 36% found in the Community Survey of 2007. This excludes discouraged job seekers who are no longer actively looking for work. Many individuals move to eThekwini to look for work either from other districts in KZN or from neighbouring provinces such as the Eastern Cape. Fifty four percent (54%) of the unemployed in the province live in eThekwini. Thirty one percent (31%) of the population lives in poverty. This results in a high reliance on public sector services and increases vulnerability to communicable diseases and non-communicable diseases. Job creation and economic development is a municipal priority across all sub-districts. Opportunities for employment are limited to a few large formal sectors such as the automotive, tourism, agriculture, chemicals, creative industries, construction, textile, and wood, pulp and paper sectors. These industries require occupational health services.

Table 2 (A1): Social Determinants of Health

Sub-Districts	Data Source	Total number of households	Unemployment rate	population living below poverty line of R283 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
District Total	Census 2001		39.4%	2.4%	149 289	40 188	95.9%	74%	81%	
	Community Survey 2007		36.8%	2.2%	786 746	-	97.5%	84%	84%	
	Census 2011		30.2%		317 613	103 715	76%	76%	95.6%	

*Community Survey 2007 Report provides total household, non-classified by type.
* Census 2011 provides electricity figures by use, lighting (859 742), heating (726 166) and cooking (819 513).

Strategic priority areas identified in the IDP for development are found in South Central (the planned Port expansion and the inner city regeneration projects); Greater Inanda/Tongaat area (with Bridge City, Cornubia, Canelands, Dube Trade Port/Inyaninga and Tongaat); Lower South (Umkomaas, Amanzimtoti areas) and Umlazi as well as in the Inner and Outer West (Cato Ridge, Mpumalanga, Hammersdale, KwaXimba, Hillcrest, Shongweni). The planning of service delivery in these areas will need to take this expansion into account.

Access to water is improving in eThekwini with 865,403 households having access to piped water. Water quality is high (98% on the Municipal Blue Drop Score in 2012). An area identified in need of improvement is Ogunjini water treatment plant which serves the Verulam area.

Table1.2: Access to water

Municipality	Piped water	Borehole	Spring	Rain Water Tank	Dam / Pool / Stagnant Water	River / Stream	Water Vender	Water Tanker	Other
District	865493	14510	3260	3089	4848	4444	14178	20166	26725

In terms of housing, there are 524,582 formal (55%), 103,715 (10.9%) traditional and 317,613 (33.5%) informal households (eThekwini IDP 2012/13). The high proportion of traditional and informal households has implications for communicable disease transmission and diseases relating to hygiene and sanitation. Backlogs in housing delivery and the high proportion of informal settlements make planning and servicing these areas challenging as the necessary infrastructure is not in place (electricity, water, health facilities) and mobile services and home visits have to provide the bulk of services where no health facilities exist. Expanding informal settlements in areas such as Kennedy Road, Cato Manor others are areas of concern. The 12 most deprived wards in the district are found in Greater Inanda/Tongaat (with 3 wards - Ward 53, 55, 56), Umlazi and Engonyameni (wards 96,100), Inner West (2 wards - ward 1, 2), Outer West (2 wards – ward 5, 103) and North Central (2 wards – wards 38, 39). The areas most in need of infrastructure identified in the IDP are in Zones 2, 3 and 10.

Access to sanitation is also improving with 616,152 households with flush toilets and a further 47,006 with septic tanks. 25,758 households still rely on bucket toilets.

Table 1.3: Access to proper sanitation

Municipality	None	Flush toilet (connected to sewerage system)	Flush toilet (connected with septic tank)	Chemical toilet	Pit toilet with ventilation (VIP)	Pit Toilet without ventilation	Bucket Toilet	Other
District	20 256	616 152	47 006	70 879	49 922	108 206	25 758	28 534

However the proximity of informal settlements with poor sanitation to rivers is resulting in the contamination of water sources. E coli rates are high in streams in Mayville/Westridge area, Bellair, New Germany, KwaMashu, Isipingo, Kennedy Road, Umlazi and the area bordering Pietermaritzburg (DWAF Healthy Rivers Report 2011). Informal settlements and other users in contact with these water sources may be vulnerable to disease and diarrhoea outbreaks.

819,513 households have access to electricity (85.6%). Only 1.6% use wood, coal or other sources of fuel for cooking/heating purposes.

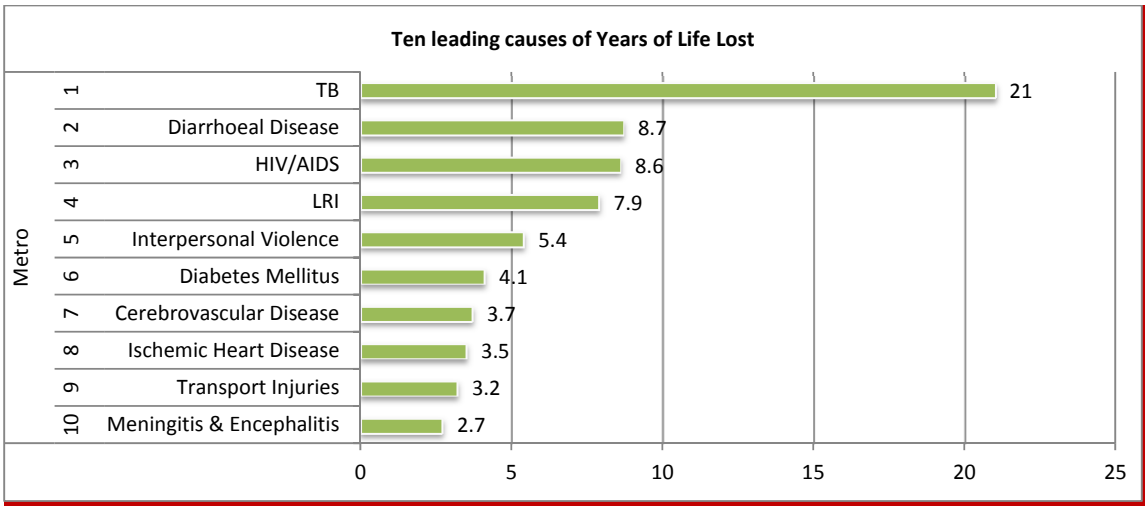
Table 1.4: Access to Electricity

Municipality	Electricity	None	Gas	Paraffin	Wood	Coal	Animal Dung	Solar	Other
District	819513	2403	25831	86839	14272	1261	505	2398	3691

Literacy and education have been improving over the last five years in eThekwini. Forty two 42% of the population aged over 15 have grade 12 education levels. However, eThekwini ranks 5th when compared with other South African metros. Efforts to increase literacy and numeracy and the proportion of adults with grade 12 certification will increase the skills available in the district. Skills development and job creation remain key aims of the eThekwini municipality. The Department of Education has launched the Integrated School Health Policy to address the health needs of learners.

6.3 EPIDEMIOLOGICAL (DISEASE) PROFILE OF THE DISTRICT

The three main causes of Years of Life Lost (YLLs) in the district are due to preventable diseases including TB (21%), diarrhoeal disease (8.7%) and HIV (8.6%). These diseases are also directly linked to social determinants and adversely impact on women and children. The non-communicable diseases and violence related deaths are also a concern for the district.



The table below highlights trend data from 2010 – 2013 on key indicators. Maternal and child health in the district remains a major concern with many of the key indicators showing an increase such as maternal and child mortality rates. Diarrhoea remains a cause for concern in the district, however data is inconsistent. The highest number of deaths occurred in the South West Sub-district (R K Khan Hospital). More cases are found during the rainy season (Oct-Feb) and the rotavirus season (April – August). Sub-districts worst affected by cases of diarrhoea are Greater Inanda/Tongaat (Phoenix, KwaMashu, Inanda), Umlazi (as a result of contamination of water and poor infrastructure), South Sub-district (KwaDabeka and Hlengisizwe) and Qadi in North Central district. Rotavirus remains a concern in subdistricts such as Umlazi and Greater Inanda (Inanda, KwaMashu). Deaths as a result of pneumonia have decreased. This is as a result of the increase in PCV coverage. The number of cases admitted for pneumonia has also decreased in the district. Higher caseloads are anticipated in winter however, data also indicate increased cases in summer. Subdistricts most affected include Umlazi and the South Sub-district (KwaDabeka). Severe and acute malnutrition remains a challenge in the district however data quality is poor. Cases were reported in the Greater Inanda district (Inanda CHC and Osindisweni Hospital).

Maternal deaths were highest in South Central, South West and Umlazi subdistricts as most deaths occur at regional hospitals (King Edward, MGMH, PMMH and RK Khan). Few deliveries are currently being conducted at MOU clinics such as Umlazi D (Umlazi sub-district) and CHC such as KwaMakhutha (Lower South), Halley Stott and KwaNdengezi (Inner West).

Table 3: Trend data

	2011/12	2012/13	2013/14
Perinatal Mortality	7.2 per 1 000	9.4 per 1 000	9.1 per 1 000

	2011/12	2012/13	2013/14
Neonatal Mortality	8.3 per 1 000	9.5 per 1 000	6.5 per 1 000
Facility Infant Mortality rate (under 1year)	4.6 per1 000	7.7 per 1 000	18.1 per 1 000
Facility Child Mortality rate (under 5 years)	1.3 per 1 000	2.7 per 1 000	5.1 per 1 000
Facility Maternal Mortality	185/100 000	220/100 000	172/100 000
Maternity Deaths (numbers)	127	128	97
Total number of patients (children and adults) on ART	152 149	220 892	275 549
Patients newly diagnosed with TB	33 914	33 655	15 522

Maternal and infant mortality rates remain high and require interventions such as the recently launched Phila Mntwana campaign. Malnutrition is also a concern among children under 5 years. Strategic programmes addressing maternal and child health include the School Health, Family Health and District Specialist Teams. Most wards have CCGs. CCGs are deployed in the most deprived wards – 109 in Umbumbulu, 66 in KwaXimba, 54 in Maphephetheni, 37 in Amaoti, 34 in Ntuzuma, 31 in Mpumalanga and 20 in Inanda. There are 6 full Family Health Teams and 24 partially complete teams linked with CCGs and war rooms. There are 40 school health teams (29 with full complement of staff). District Clinical Specialist Teams have 3 specialised nurses and 3 specialist doctors. They are focusing on training on ESMOE, KINK, IMCI and SRH and CMAM; and will be leading the Ideal Clinic Project. Home visits as part of OSS, are conducted by CCGs. Mobile services and outreach campaigns will be undertaken to increase access to services, particularly in the under-served South. Food security will also be addressed through partnerships with the Department of Agriculture and the 'One Home, One Garden' programme.

HIV prevalence appears to be decreasing in the district. HCT numbers have decreased slightly since 2011/12. More HCT is being done in the Southern sub-districts. HCT numbers are low in the Inner West and Outer West. There seems to be some indication that prevalence is higher in the Northern sub-districts and this will be further investigated. Sub districts with high prevalence rates include Greater Inanda/Tongaat (Verulam and Tongaat), Umlazi, South Sub-district (Pinetown and Hlengisizwe).

TB data needs to be continuously reviewed by sub-district to identify areas with high incidence, high defaulter rates and low cure rates. Incidence of XDR and MDR in the sub-districts also needs to be mapped. Hotspots identified in 2012/2013 were in the Inner West (Qadi, Clermont, Halley Stott, KwaNdengezi and KwaDabeka), Outer West (Mpumalanga, Hlengisizwe, Msunduzi), Greater Inanda (Phoenix, Newtown A, Inanda C, Sivananda, Osindisweni, Tongaat, Amoati, KwaMashu), North Central (Goodwins, Lindelani), Lower South (KwaMakhutha) and Umlazi (Umlazi D, U21, V and K). The management and diagnosis of pediatric TB is another area requiring improvement.

Services for key populations including adolescents, migrants, sex workers and individuals who abuse alcohol and drugs also need to be prioritized. High rates of teen pregnancies (particularly in Umlazi and South sub-district) have been identified. A better understanding of where key populations are located in the district is needed to improve service delivery to these populations.

7. DISTRICT SERVICE DELIVERY ENVIRONMENT

7.1 DISTRICT HEALTH FACILITIES

7.1.1 PRIMARY HEALTH CARE FACILITIES

Table 4 (NDoH 1): PHC facilities (Provincial and LG combined) per Sub-District as at 31 March 2014

Sub-Districts	Health Posts		Mobiles		Satellites		Clinics		Community Health Centres (24 x 7)[1]		District Hospitals
	LG	P	LG	P	LG	P	LG	P	LG	P	
South Central		0	2	0	0	0	12	5	1	0	1
South-West		1	5	1	1	0	6	1	0	0	
Umlazi/Engonyameni		0	0	2	0	0	5	12	0	0	
Lower South		0	0	0	1	0	5	4	0	0	
North Central		0	0	2	0	0	8	4	0	1	
Greater Inanda/ Tongaat Region		0	6	3	0	0	10	4	0	4	1
Inner West		11	1	3	0	0	7	8	0	1	
Outer West		2	8	2	0	0	4	5	0	1	
District		**14**	**22**	**13**	**2**	**0**	**57**	**43**	**1**	**7**	**2**

Source: DHIS

All health posts are concentrated in the West sub-district expect Welbedacht Clinic in the South-west. The latter was re-categorised as a health post in the 13/14 financial year. There are no health posts in the North. The Health Posts found in the Inner West and Outer West do not function as traditional Health Posts but rather as mobile stopping points.

The majority of the mobile points are in the West (44%) and the North (40%) which could be attributed to the low number of clinics and pockets of rural areas in these subdistricts. The South only has 15% of the mobile points but a relatively higher number of clinics.

The largest number of PHC facilities is in the Umlazi/ Engonyameni South Sub-District but there are neither CHCs nor mobile services in this densely populated area. There is a lack of PHC facilities in the CBD and surroundings which have resulted in an overreliance on regional hospitals for PHC services. Most of the PHC clinics are managed by the LG in the CBD but these do not all offer comprehensive services. Hence, a large number of mobile service points have been established to increase access to services in the latter sub-district.

All CHCs are in the North and West subdistricts, with no CHCs in the South (except Cato Manor, which is dually managed). There is a need for CHCs in the South.

1 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.

The Inner West has 1 CHC, 14 clinics and a large number of mobile points to increase access to services. North Central has one CHC and 12 clinics and a large number of mobile service delivery points. Greater Inanda/Tongaat has the highest number of CHC (4) and 14 clinics mostly under LG management. South West sub-district has no CHC and most PHC are managed by LG. No 24 hour services currently exist. Discussions are underway with LG to extend the operating hours of Township Centre Clinic to provide maternity and obstetric services.

There are no Provincial CDCs or Satellite clinics in eThekwini. While there are no Stand Alone MOUs there are 8 MOUs attached to facilities.

Table 5: 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
South Central	0	28 092	105 344	0
South-West	165 544	33 109	165 544	0
Umlazi/Engonyameni	0	0	36 106	0
Lower South	0	0	27 626	0
North Central	0	27 242	95 345	476 727
Greater Inanda/ Tongaat Region	0	13 288	122 914	153 642
Inner West	39,024	11 296	61 324	536 582
Outer West	169 181	17 809	67 672	422 953

Source: DHER 2012/13 Customised District Report

The overall population to PHC facility ratio in table 2.1 above shows that all facilities in eThekwini cater for large populations (well above the approximation of 10 000: 1 ratio).

There is only 1 CHC per sub district in North Central, Inner West and the Outer West. Cumulatively, these sub districts account for 41% of the total population. There is no CHC in the South, while there are 4 CHCs in the Greater Inanda/ Tongaat region.

South Central, South West and the Greater Inanda/ Tongaat Region have the highest number of population to facility ratio. While these facilities do see large volumes of patients, South West data is skewed, as this only represents RK Khan Gateway and does not taken into account the neighbouring local authority clinics. The population data in the South is also questionable and more effort will be made to correct this data.

There is very little equity regarding health posts and mobile points in the district. This system must be reviewed to determine current functionality and should be addressed in the next DHP.

Table 6 (NDoH 2): District Hospital Catchment Populations 2013/14

Name of District Hospital	2012/13		2013/14	
	Osindisweni	Wentworth	Osindisweni	Wentworth
Catchment Population of District Hospital	412 405	409 686	335 951	333 740

Source: DHER 2013/14 (GIS)

District Hospitals render hospital services at general practitioner level as the first line of referral from PHC services. There are currently two designated Level 1 hospitals in the district. eThekwini has 2 districts hospitals; Osindisweni in the Greater Inanda/ Tongaat Region caters to a population of 335 951 and Wentworth Hospital situated in South Central and caters to a population of 333 740.

Osindisweni Hospital is situated in the far North of eThekwini Metropolitan in an area with a sparse rural population which constitutes an uninsured population of only 335 951. The sub-optimal utilization of Osindisweni is reflected in its 114 897 total OPD case (FY 2012/13) compared to that of Wentworth hospital (176 151) and a bed utilization rate of 64.6% (FY 2012/13).

Wentworth Hospital has 217 commissioned beds since October 2013 with a high bed occupancy rate (83% FY 2012/13) due to the changing disease profile such as TB/HIV co-infection, according to report received during an enquiry visit by the district. It is also reported that Psychiatric patients are kept for longer periods while waiting transfers to King Dinuzulu (a designated hospital with psychiatric beds). Downward referral of long term patients occurs at Clairwood hospital which is identified as a step down referral hospital in the district.

McCord Hospital was fully taken over by the Province as from the 1st of February 2014, however it has not yet been formally designated. Currently McCord is functioning as a 100 bed step-down hospital while also providing Primary Health Care. No financial information was available for McCord Hospital. This process will run for 18 months and then to be reviewed for a new service package.

In addition the District has five hospitals which offer regional/district health services. Due to the disparities in geographical positions Level 1 hospitals are not always accessible as a result patients requiring Level 1 care are often treated at a higher cost in Level 2 hospitals. In eThekwini the OPD new clients not referred rate is 51.8%, having rapidly improved from 86.5% in 2010/11 (District Health Barometer, 2013). This indicates that approximately more than half of the patients seen at the emergency/OPD units bypass PHC facilities and access district hospital directly.

Strategic challenges for District Hospitals

- District Hospitals are geographically far apart from each other and are few in number compared to large populations requiring services for example the location of Osindisweni Hospital in the far North.
- The West service area has a population 992 427 which is not serviced by a district hospital. This creates a burden for R K Khan Hospital, complicated by the uncertainty of St Mary's.
- King Dinuzulu has a District Service Component but is under-budgeted. It is has 400 beds and its catchment population extends to and includes KwaMashu. Moreover, in order to reduce congestion at Mahatma Gandhi Hospital and most facilities in North Central and South Central are referring clients to King Dinuzulu. The OPD headcount at King Dinuzulu increased from 99 162 (FY 2011/12) to 145 475 (FY 2012/13) (DHIS), an indication of increase for FY 2014/15.
- Five regional hospitals in eThekwini share level-1 services with the district hospitals, with cost implications and compromising the quality of level-2 services. Often low risk patients end up occupying beds in level-2 hospitals. As an interim measure, McCord is being utilized as a step-down facility to decongest beds in acute medical and surgical wards to accommodate critically ill patients.

- Inability to cost the different levels of services within hospitals for better planning and efficiencies
- There are currently no cost centers at hospital level
- There is a lack of strategically placed MOUs to decongest deliveries at the hospital level

7.2 TRENDS IN KEY DISTRICT HEALTH SERVICE VOLUMES

7.2.1 PRIMARY HEALTH CARE SERVICE VOLUMES AND UTILISATION

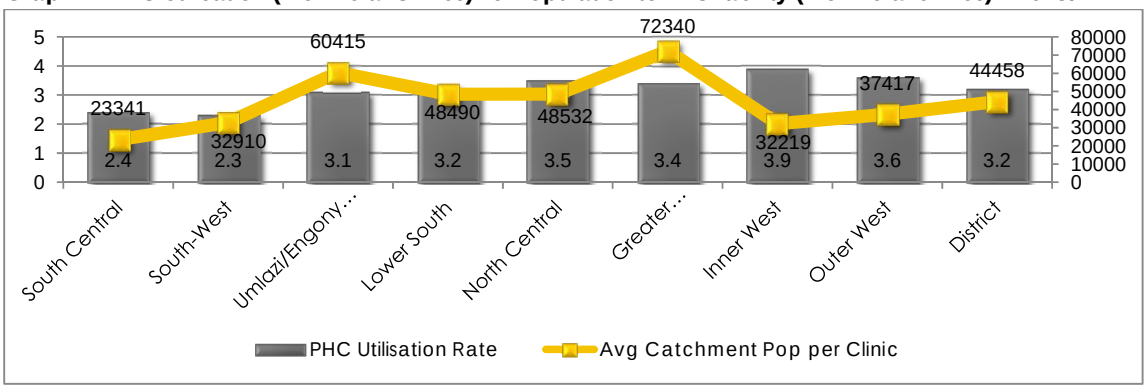
Table 7 (NDoH 3): PHC Headcount Trend

Sub-District	2012/13			2013/14			Variation		
	PHC Headcount – Prov	PHC Total Headcount	PHC Total Utilisation Rate	PHC Headcount – Prov	PHC Total Headcount	PHC Total Utilisation Rate	PHC Headcount – Prov	PHC Total Headcount	PHC Total Utilisation Rate
South Central	266 523	1 024 798	2.3	283 097	1 048 247	2.5	6.2%	2.3%	8.7%
South-West	103 963	405 596	3.1	88 898	416 661	2.3	-14.5%	2.7%	-25.8%
Umlazi/ Engonyameni	2 368 718	2 611 728	3.3	2 275 381	2 549 602	3.1	-3.9%	-2.4%	-6.1%
Lower South	655 367	876 374	3.4	483 460	717 242	3.2	-26.2%	-18.2%	-5.9%
North Central	889 818	1 262 806	3.5	871 099	1 214 402	3.5	-2.1%	-3.8%	0%
Greater Inanda/ Tongaat Region	2 048 729	2 466 877	3.3	2 010 500	2 541 247	3.4	-1.9%	3.0%	3.0%
Inner West	991 263	1 269 100	3.2	1 199 039	1 506 612	3.9	21.0%	18.7%	21.9%
Outer West	810 474	1 116 295	3.5	840 225	1 184 600	3.6	3.7%	6.1%	2.9%
District	8134 855	9 897 574	3.2	8 051 699	11 178 613	3.2	-1.0%	12.9%	0%

Source: DHIS downloads

While the overall district utilisation rate has remained stable at 3.2 since 2012, the PHC headcount has increased by 12.9%. The variation in utilisation in observed in the South West subdistrict with a drop from 3.1 to 2.3, this subdistrict only has 1 facility (RK Khan Gateway) which is flogged by the hospital and neighbouring LG clinics which could account for the drop. A notable increase is observed in the Inner West which could be due to the very busy KwaDakeba CHC as well as Qadi clinics.

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

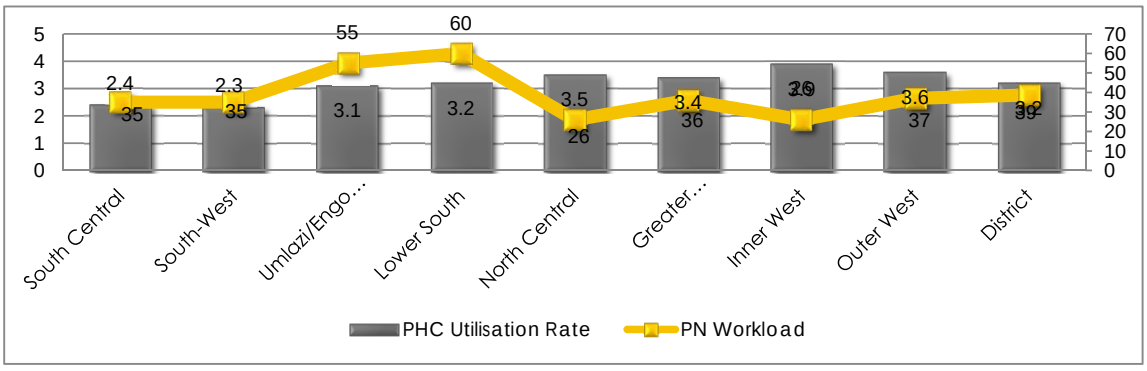


Source: DHIS & DHER 2012/13 Customised District Report

eThekwini has an average of 44 458 catchment population per clinic with an overall utilisation rate of 3.2

- The South West and South Central subdistricts have low utilisation rates and comparatively low catchment population per facility (on average). In total there are 6 clinics in both these sub-districts (5 and 1 respectively), this includes 3 Gateway clinics, 2 clinics that do not provide the full PHC service package which could account for the low utilisation rates. Moreover both these sub-districts are flogged by hospitals and municipality clinics which skews the catchment populations per clinic.
- The Greater Inanda/ Tongaat Region has the highest catchment population and a relatively higher PHC utilisation rate due to the high number of CHCs in the area (4 CHCs).
- The Inner West has a high utilisation rate but low catchment population. The high utilisation rate is attributed to the busy KwaDabeka CHC (4.3) and the high utilisation at Qadi clinic (4.7). There is an obvious error with data in both these facilities as the headcount and expenditure don't correlate.
- Umlazi/ Engonyameni sub-district has a high catchment population and a utilisation rate that is within the norm (3.1). The facility with the highest catchment population is Umlazi U21. This facility has been flagged for very poor reporting on headcount data.

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



Source: DHIS, DHER

The overall district PN workload is 39 and the PHC utilisation rate is 3.2. Both these indicators are within the norm. However there is much sub district variation

- Umlazi/ Engonyameni and Lower South have the highest PN Workloads of 55 and 60 respectively. This data is skewed by the very high headcounts in the Umlazi clinics with 7/12 (58%) of those clinics having a PN Workload >50. In the Lower South, 2/4 facilities rank within the top 10 highest headcounts in the district. Headcount data must be verified in these 2 sub districts
- In the Inner West, there is much variation in the PN workload per facility ranging from 14 in Maphephetheni PHC to 39 in Cleremont PHC. From the 8 facilities in this sub district, 4 (50%) have a PN workload <25
- North central has low workload of 26. This is contributed by 60% of the facilities in that sub district (3/5) with PN workloads <25.

Overall the district is showing an increase in the utilisation rate, an increase in the PHC Headcount which is accompanied by the stabilisation of the ART program with high numbers of patients retained in ART throughout the District. The average PN workload in eThekwini remains high at 39 with very dense catchment populations per facility (avg >44 000 per clinic) and the cost per headcount remains low at R97.95 (range: R55.94 – R133.33).

Furthermore reflection on the data shows inequity amongst facilities and sub districts.

The Inner West is showing the highest utilisation rate but relatively low catchment population per facility with high headcounts and low PN workloads. A large proportion of this sub district is rural with a high percentage of the overall district population (15%). Access to care is not a major challenge as this sub district has the second highest number of facilities (9) and has the highest number of Mobile Points and Health Posts. However, the data is conflicting implying a problem with the headcount or with staff linkages in some of the facilities

The Lower South has an utilisation rate of 3.2, a PN workload of 60 and an average catchment population per facility of >48 000. The facilities that require urgent attention are Magabheni and Danganya with PN workloads of 74 and 77 and costs per headcount is R41.02 and R32.63 respectively. Analysis of the raw data (particularly for headcount and PN workload), there is an obvious error with data collection and collation.

The Umlazi/ Engonyameni sub-district also has utilisation rate 3.1, very high PN workload of 55 with an average catchment population per clinic >60 000. The outliers are U21 (PN workload of 90 and cost per headcount R24.22), Umlazi L (PN workload of 76 and cost per headcount of R33.98) and Umlazi D (PN workload of 70 and cost per headcount of R28.76). The data here is highly questionable but the clinics are overcrowded and there is a need for more nurses. This could also imply that there are poor linkages with PERSAL.

Table 8 (NDoH 4): District Hospital activities

District Hospitals		Year	Osindisweni	Wentworth	District Totals
1.	Inpatient Days – total	2012/13	57 033	66 040	123 073
		2013/14	59 876	70 883	130 759
		Variation	5.0%	7.3%	6.2%
2.	Day patient – total	2012/13	0	2 164	2 164

District Hospitals	Year	Osindisweni	Wentworth	District Totals
	2013/14	0	414	414
	Variation	0%	-80.9%	-80.9%
3. OPD Headcount not referred new	2012/13	9 966	4 737	14 703
	2013/14	19 734	10 955	30 689
	Variation	98.0%	131.3%	108.7%
4. Inpatient Separations	2012/13	9 862	9 640	19 502
	2013/14	9122	9499	18621
	Variation	-7.5%	-1.5%	-4.5%
5. Inpatient Deaths	2012/13	737	708	1445
	2013/14	726	684	1410
	Variation	-1.5%	-3.4%	-2.4%
6. OPD Headcount – total	2012/13	114 897	176 153	291 050
	2013/14	88 404	143 343	231 747
	Variation	-23.1%	-18.6%	-20.4%
7. Emergency headcount total	2012/13	23 457	31 786	55 243
	2013/14	13 901	32 417	46 318
	Variation	-40.7%	2.0%	-16.2%
8. Patient Day Equivalent	2012/13	95 332	125 839	221 171
	2013/14	93 978	129 677	223 655
	Variation	1.4%	3.0%	1.1%
9. Cost per PDE	2012/13	R1 394	R1 501	R1 448
	2013/14	R1 053	R1 122	R1 087
	Variation	-24.5%	-25.2%	-24.9%
10. Delivery by caesarean section rate	2012/13	30%	38%	34%
	2013/14	33%	44%	38%
	Variation	10%	1.6%	11.8%
11. Average length of stay - total	2012/13	5.8	5.7	5.8
	2013/14	6.6	7.5	7.1
	Variation	13.8%	31.6%	22.4%
12. Inpatient bed utilisation rate – total	2012/13	65%	84%	75%
	2013/14	68%	90%	79%
	Variation	4.6%	7.1%	5.3%
13. Total Ambulatory (OPD Headcount Total + Emergency Headcount total)	2012/13	138 354	207 939	346 293
	2013/14	102 305	175 760	278 065
	Variation	-26.1%	-15.5%	-19.7%
14. Ratio of Ambulatory to	2012/13	2.4	3.1	2.8

District Hospitals	Year	Osindisweni	Wentworth	District Totals
Inpatient Days Total	2013/14	1.7	2.5	2.1
	Variation	-29.2	-19.4%	-25.0%

Source: DHIS Downloads 2012/13 & 2013/14

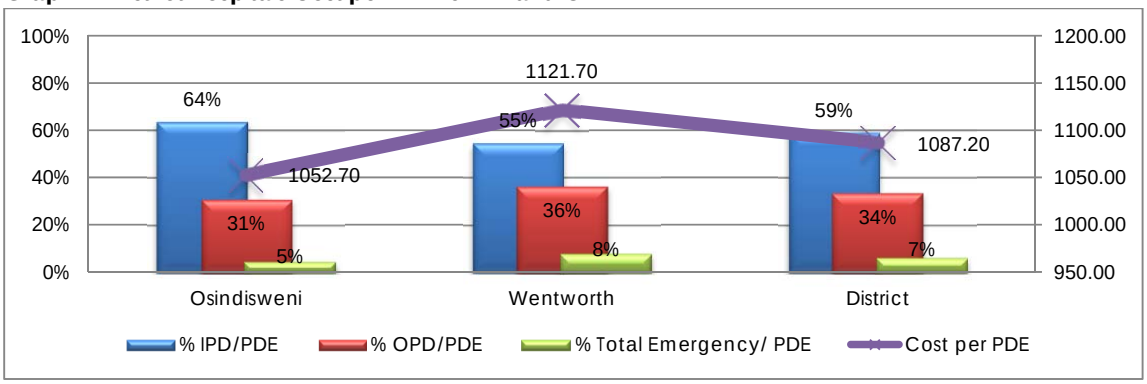
The DH bed status for Wentworth Hospital (WWH) increased from 205 in 2012/13 to 217 in 2013/14, and will increase to 268 in the next financial year. Wentworth Hospital has fewer beds than Osindisweni but a higher PDE. This can be attributed to the higher Inpatient days in WWH (70883) compared to Osindisweni (59878) as well as the higher BUR at WWH (90%), OPD headcount (143 343) and an increased number of Day Patients (404) whereas Osindisweni has a BUR of 68%, an OPD headcount of 88 404 and no day patient data.

A current challenge remains at the Osindisweni Hospital is that day patient as well as inpatient information is not correctly reported which could skew the data. Mechanisms are in place to strengthen data collection and collation processes for a more accurate reflection on facility performance.

Review of the district hospital data reflects that both facilities have high ALOS of 6.6 days at Osindisweni hospital and 7.5 days WWH. This is higher than the 2013/2014 Provincial target of 5.4 days. At WWH, the longer stays were contributed by psychiatry patients (ALOS = 19.1 day), TB/ HIV patients (ALOS = 13.6 days), Paediatrics (ALOS = 6.5 days), Surgical patients (ALOS = 9.2 days) and medical patients (ALOS = 10.2 days). WWH also has high BUR, possibly due to the down-referred patients from King Dinizulu and Addington Hospitals. The additional beds in the new financial year will assist in lowering the BUR. Addressing the ALOS will also assist with this.

At Osindisweni Hospital, the high ALOS is contributed to by the psychiatric patients (ALOS = 26.6 days) and orthopaedic patients (ALOS = 42.8), Paediatric patients (ALOS = 6.2). It is recommended that the orthopaedic patients at Osindisweni Hospital be moved to the Regional Hospitals. Osindisweni has a low BUR of 68%. The low BUR and high ALOS raises issues of poor management and low efficiency. This has been raised with the hospital management.

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



Source: DHER 2012/13 Customised District Report

In eThekwini, the overall IPD/PDE increased from 52% to 59% as a result of both hospitals increasing their IPD/PDE. This could be attributed to the increase in the number of beds in Wentworth hospital as well as the increase of the BUR in Osindisweni.

The OPD/PDE has decreased from 40% in 2012/13 to 34% in this financial year. The OPD headcount decreased in both hospitals. Osindisweni OPD/PDE decreased from 37% to 31% and Wentworth decreased from 43% to 36%. More efforts are being made this year to shift services to the Gateway clinic.

The Emergency Headcount/ PDE remained fairly stable from 8% in 2012/13 to 7% in 2013/14. Osindisweni Emergency headcount decreased from 8% to 5%.

The cost/PDE decreased from R1448 in 2012/13 to R1087 in 2013/14. Osindisweni decreased from R1394 to R1052 and Wentworth decreased from R1501 to R1121. All costs were not processed timeously to be included in the DHER hence it is lower than expected.

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

Table 9 (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	8.5 per 1K	5.5 per 1K
		Severe malnutrition under 5 years incidence)		DHIS	3.1 per 1K	3.0 per 1K
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	5.1 per 1K	5.0 per 1K
		Infant mortality rate – use proxy "Child under 1 year mortality in facility rate"		DHIS	18 per 1K	15 per 1K
Goal 4: Reduce Child Mortality	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Measles 2nd Dose coverage		DHIS	85%	88%
		Immunisation coverage under 1 year		DHIS	92%	95%
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	172 per 100K	150 per 100K
		Proportion of births attended by skilled health personnel (Use delivery in facility as proxy indicator)		DHIS	98%	98%
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	-	-

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	-	-
		Contraceptive prevalence rate (use Couple year protection rate as proxy)		DHIS	32%	35%
		TB Cure Rate		ETR.Net	71%	75%

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 10: (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 d. Prevent and reduce the disease burden and promote health	HIV & AIDS and Tuberculosis prevented and successfully Managed
Tuberculosis (TB) prevention and cure progressively improved;		
Maternal, infant and child mortality reduced		
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. Strengthen the health system	Improved health facility planning and infrastructure delivery
		Health care costs reduced
	c. Improve health information systems	Efficient Health Management Information System for improved decision making
	h. Improve quality by using evidence	Improved quality of health care
Primary health care teams deployed to provide care to families and communities		Re-engineering of Primary Health Care
Universal health coverage achieved	e. Financing universal healthcare coverage	Universal Health coverage achieved through implementation of National Health Insurance

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

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

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

10.1 INTRA DISTRICT EQUITY IN THE PROVISION OF SERVICES

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

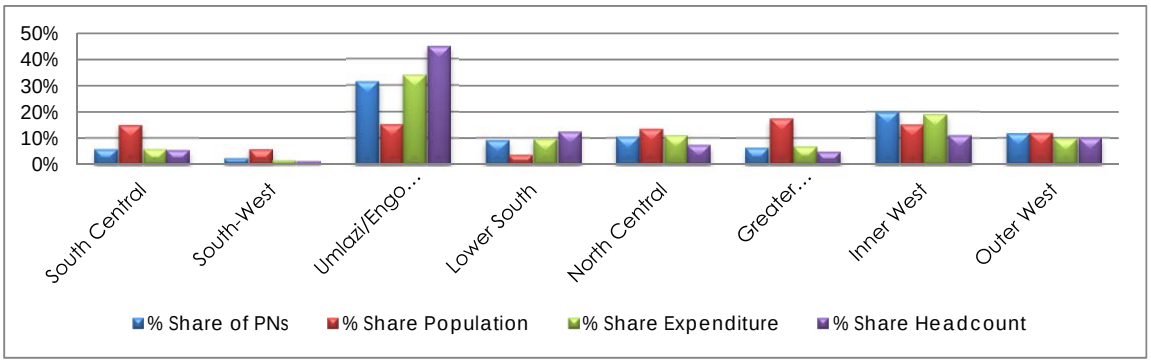
Table 11 (NDoH 6): PHC Expenditure

Sub-District	PHC Expenditure / Uninsured Capita	PHC Utilisation Rate	PN to Patient Provincial clinics	% Share of District Population
South Central	53.06	2.4	1: 35	15%
South-West	39.93	2.3	1: 35	6%
Umlazi/Engonyameni	288.12	3.1	1: 55	16%
Lower South	326.19	3.2	1: 60	4%
North Central	107.89	3.5	1: 26	14%
Greater Inanda/ Tongaat Region	52.77	3.4	1: 36	18%
Inner West	163.81	3.9	1: 26	15%
Outer West	107.77	3.6	1: 37	12%
District	132.90	3.2	1: 39	100%

Source: DHER 2013/14 Customised District Report, DHIS

There are challenges in the South subdistricts, Umlazi/ Engonyameni and Lower South have relatively high PHC Expenditure/ Uninsured Capita while South Central and South West have very low expenditure per uninsured capita. The high expenditure in the Umlazi/ Engonyameni subdistrict is due to the highest nurses allocated there. The PN to Patient ratio is still high, due to the possible need of additional staff or poor recording. Expenditure is also high in the Lower South due the large number allocated to KwaMakhutha PHC which is a 24 hour facility. However, there may be a problem with the HR linkages here which will be investigated. South West and South Central have few nurses but a PN to patient ratio that is within the norm. These sub-districts are surrounded by LG clinics and hospitals that also serve the population.

Graph 5: Equity of Resources vs. Population and Headcount – 2013/14



Source: DHER 2013/14 Customised District Report

CHC cost per headcount data was not included in graph 5 above as it would have skewed the comparison. Not all sub districts have CHCs and CHCs have a much higher Cost per headcount which hides the performance of the PHCs within the same sub district. No Municipal data was available.

As shown in graph 5, North Central, Outer West and Inner West show an equitable distribution of resources. The headcount is proportionally lower in these subdistricts due to the presence of the CHCs. The South West has a high population, but this subdistrict only has 1 provincial facility (RK Khan Gateway) and is mainly serviced by the local government facilities.

The Lower South has the lowest share of the population and a relatively high share of the PNs, Expenditure and headcount. The outlying facilities are Danganya and Magabheni which have high PN workloads (74 and 77 respectively). The headcount data needs to be reviewed.

The Umlazi/Engonyameni sub-district has a higher share of the expenditure and share of nurses compared to the population. This subdistrict has a large number of PHCs (12) accompanied by many staff which could contribute to the higher expenditure. However it is also likely that the population may be under-represented because of the large proportion of informal settlements that could be accessing the services. This is reflected in the high headcount; however the headcount data is questionable in some facilities. There are no CHCs in this subdistrict and all services are rendered by the PHCs resulting in higher headcount.

In the Greater Inanda/ Tongaat region, the population is high but the share of the expenditure and nurses is low. This subdistrict has 4 CHCs which can cater for the population. The outliers are Amaoti and Sivananda clinics with a very high headcounts (>95 000) and high PN workload (>50). The headcount data in these facilities must be reviewed.

Table 12 (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	Nurse Assistant	Pharmacist Assistant Post Basic	Professional Nurse	Staff Nurse
South Central	141 549	0	47 183	94 366	28 310	31 455	0	10 888	25 736
South-West	0	0	0	0	74 722	0	0	5 337	14 944
Umlazi/Engonyameni	158 403	0	65 225	221 765	79 202	33 601	0	12 969	22 176
Lower South	125 024	0	52 094	625 122	62 512	21 556	0	12 257	16 029
North Central	75 629	0	31 512	378 147	21 008	22 244	378 147	6 520	11 459
Greater Inanda/ Tongaat Region	36 581	0	32 008	85 355	51 213	23 279	0	7 113	12 803
Inner West	62 628	281 826	28 182	563 651	33 156	16 104	0	5 171	9 553
Outer West	72 725	0	39 159	127 268	63 634	25 454	0	7 832	16 422
District	84 067	1 205 513	36 920	261 959	51 720	21 712	4 822 052	8 511	16 140

There are no MOs, Pharmacists, Specialists or PA Basic allocated within the Clinics. There is only 1 PA Post Basic assistant linked to clinics. This person is based in Lindelani clinic and is incorrectly linked. This matter will be taken up with HR.

In general all provincial clinics need more staff. Areas of serious concerns are the low numbers of data capturers, staff nurses and nursing assistants. There also seems to be a shortage of counselors and Professional Nurses in the South areas. While there could be poor linkages as pointed out in the DHER, overall the low number of nurses coupled with the low number of nursing assistants could be impacting on the service delivery

Table 13 (NDoH 7 (b)): Number of patients to staff type (Sub-District) – CHC's

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
Hlengisizwe CHC	9 190	32 676	15 478	98 027	29 408	58 816	26 735	42 012	0	73 521	4 743	9 487
Inanda C CHC	13 257	44 191	40 792	530 296	40 792	53 030	37 878	265 148	176 765	132 574	6 978	15 597
KwaDabeka CHC	14 298	34 851	37 174	557 614	37 174	42 893	39 830	69 702	92 936	92 936	5 521	19 915
KwaMashu CHC	9 227	25 629	27 137	153 778	12 140	36 444	18 453	46 133	115 332	51 259	4 083	9 611
Newtown A CHC	11 663	112 746	33 824	169 120	30 749	56 373	37 582	0	338 239	112 746	7 353	13 009
Phoenix CHC	12 884	49 195	60 127	270 571	60 127	54 114	54 114	135 286	49 195	45 095	6 850	20 813
Tongaat CHC	7 256	22 977	30 636	137 864	12 533	27 573	27 573	34 466	0	54 955	4 308	14 512
District	11 111	46 038	35 024	273 895	31 846	47 320	34 959	84 746	110 352	79 155	5 691	14 706

Source: DHER 2013/14 Customised District Report, DHIS

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

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

Similar to the clinics, there is a need to increase the total number of staff to serve the population. In the CHCs, there is an urgent need to increase the number of Pharmacy staff including both PA Post Basic and Pharmacists, especially in Newtown A.

There is a need for counselors in Newtown A CHC. More Data Capturers are required in Inanda C and KwaDabeka CHC. There is a high population to MO ratio in most CHCs. Review of the PN to SN ratio shows that more SNs are required in Newtown A. Regarding pharmacy staff, most facilities require PA Basic especially Inanda C and PA Post Basic requires PA post basic staff.

It must be noted that this information is heavily reliant on headcount data. The reliability of headcount information is a challenge and it does skew the actual need for HR.

Table 14 (NDoH 8): Population to Staff per sub-district – 2013/14[2]

Sub-District	Population to Medical Officers		Population to Professional Nurses	
	Total Population	Uninsured Population	Total Population	Uninsured Population
South Central	27 722	22 177	20 258	16 207
South-West	0	0	14 781	11 825
Umlazi/Engonyameni	0	0	3 167	2 534
Lower South	0	0	2 708	2 167
North Central	119 181	95 345	2 788	2 230
Greater Inanda/ Tongaat Region	18 075	14 460	2 042	1 633
Inner West	53 658	42 927	2 555	2 044
Outer West	140 984	112 387	3 330	2 664
District Average	**71 924**	**57 459**	**6 454**	**5 163**

Source: DHER 2013/14 Customised District Report, DHIS

Notes:

The table above reflects the Population to PN ratio at Provincial Clinics. No information was available for the LG clinics. This table also excludes the number of PNs that work in Mobile Units as mobiles move across sub-districts.

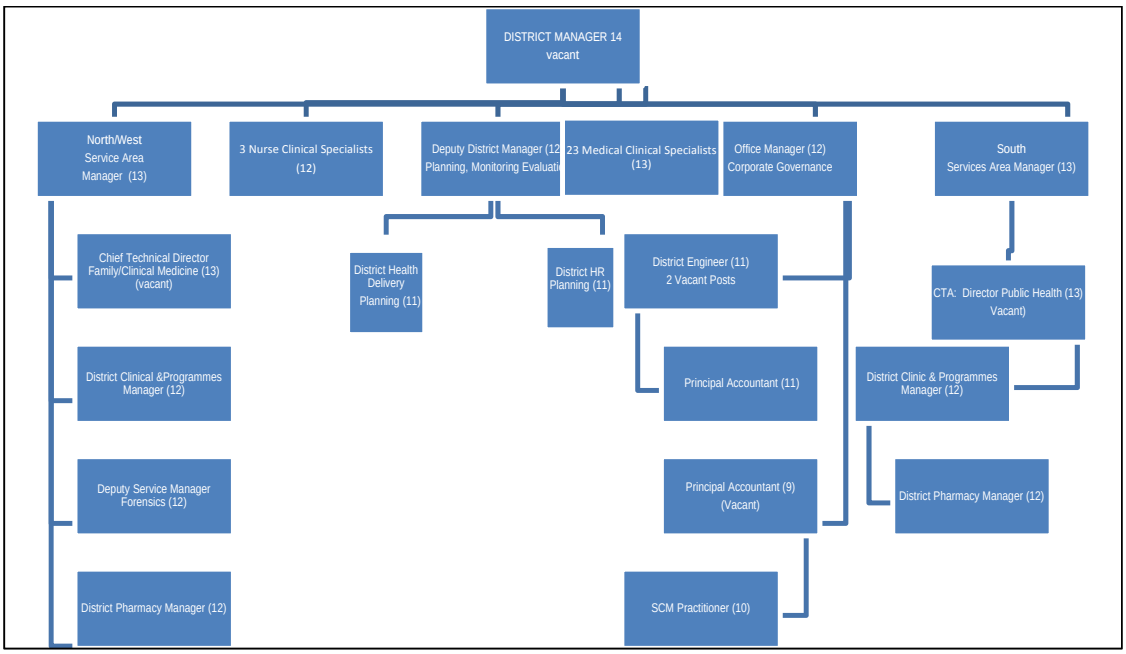
The population to PN ratio is high and implies an overall shortage of PNs in the district. However, this data does not take into account the number of LG nurses to determine an accurate reflection of access and equity of primary health care.

The proposed 8 sub-districts in eThekwini can now provide some insight regarding equity in distribution of PNs. Overall, there seems to be pockets of high inequity that needs to be addressed.

[2] District hospital plus PHC

11. ORGANISATIONAL ENVIRONMENT

11.1 ORGANISATIONAL STRUCTURE OF THE DISTRICT MANAGEMENT TEAM



11.2 HUMAN RESOURCES

The population to PN ratio, as per the data in Table 8.4.2 of the DHER 2013/14 appears high and suggest a need for more PNs. On closer examination, it is evident that there is currently an uneven deployment of PNs in the District. The uneven deployment, as well as the number of LG nurses, should be investigated to ensure that the most appropriate actions are taken to achieve equitable allocation of human resources.

An analysis of the staff establishment reveals that there are incorrect linkages (eg. School Health Services). As a result, expenditure does not always follow service delivery nor does it reflect correctly when reviewing PN equity between facilities / sub-districts. There is also incorrect allocation of staff in terms of the components in which they are employed and the components in which they are actually performing duties. This results in a skewed workload data. These are currently being investigated and corrected.

An examination of the available data in respect of PHC Utilisation rate in relation to PN Workload reveals that the Umlazi/ Engonyameni sub-district is above the norm of 35 and has the highest average catchment population per clinic. The sub-district has 16% of the population and has 16% of the total PN complement. However, this is a sub-district with a very high burden of disease as revealed in component B of this plan. There are 12 provincial clinics and 5 LG clinics to cater for the population. This sub-district, therefore, requires further consideration in terms of increasing the number of PNs .

The South West sub-district also has a high Population to PN ratio. This sub-district has one of the lowest percentages of the overall population and the lowest number of PNs. This sub-district has one Provincial facility (RK Khan Gateway) and a number of LG clinics that are not reflected above. The Gateway does not have a high PN workload, thus, the headcount data is misleading in determining an accurate reflection of access and equity of primary health care.

Recruitment initiatives are hampered by the Department's financial constraints. Whilst the OSD and rural allowances have been introduced as recruitment and retention strategies, factors such as increased workload and infrastructure inadequacies are negatively impacting on these strategies.

High turnover rates and high absenteeism is a challenge in eThekwini. According to Vulindlela, in excess of 8000 work days were lost due to sick leave during the 2013 year. Assuming that this was only for PN's and based on approximations of 215 work days per annum, this translates to a loss of 372 PNs for the year due to absenteeism. The actual root cause may vary per facility and some of the factors could be job stresses (such as burn-out) or poor management.

To minimise the impact of exits in relation to workload, recruitment and selection processes should be expedited. The employment of interns (nursing assistants, pharmacy assistants and dental assistant) as well as the allocation of post community service PNs are strategies that are being used to bridge the gap between exit and recruitment.

Table 15: 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
South Central	0.0	0.3	0.2	0.1	0.06	
South-West	0.0	0.3	0.1	0.02	0.02	
Umlazi/Engonyameni	0.0	0.6	0.4	0.3	0.05	
Lower South	00	0.7	0.5	0.4	0.004	
North Central	0.3	1.8	1.0	0.6	0.1	
Greater Inanda/ Tongaat Region	0.08	1.1	0.7	0.3	0.04	
Inner West	0.08	1.4	0.7	0.4	0.1	
Outer West	0.04	1.2	0.8	0.4	0.1	
District Average	**0.1**	**0.9**	**0.6**	**0.3**	**0.06**	

Source: DHER 2013/14 Customised District Report

Table 16: 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
South Central	89.41	35	10 888
South-West	71.94	35	5 337
Umlazi/Engonyameni	48.27	55	12 969
Lower South	41.66	60	12 257

Sub-Districts and District	Total Staff Cost per PHC Headcount	PN Workload	Staff to Patient ratio at Provincial Clinics - PN
North Central	81.59	26	6 520
Greater Inanda/ Tongaat Region	96.26	36	7 113
Inner West	95.59	26	5 171
Outer West	50.16	37	7 832
District	69.58	39	8 511

Source: DHER 2012/13 Customised District Report, DHIS

The CHC data was not included in the analysis of this table for reasons justified above. Similar to Cost per headcount, the Lower South, Umlazi and Outer West Sub-districts have the lowest CoE per headcount, with the Greater Inanda/ Tongaat region as well as the Inner West that have the highest CoE per headcount.

The facilities that are outliers for CoE/ Headcounts were

- Wentworth Gateway, within South Central, has a CoE/Headcount of R205.24. This facility does not offer the full PHC service package and hence has low headcounts which contributes to the high cost. Wentworth Hospital is working on a plan to address this.
- Umlazi U21, Umlazi D, Fredville have a CoE/ Headcount of less than R30.00. These facilities have been flagged to look at the shortage of staff and strengthen their collection of headcount data. The HR linkages also needs to be investigated

- RK Khan Gateway is the only facility in South West sub district. It has the highest % CoE/ Headcount. Even though this facility now offers the full package of service it still has low headcounts. The facility must therefore market it's services better.

The greater Inanda/ Tongaat region has the highest percentage of the population and the highest proportion of nurses. However, this is not equitably distributed. The region accounts for almost one third of the entire PN staffing complement but only 18% of the population. Nevertheless, this is an area with high burden of disease and the population to PN ratio is still high suggesting a shortage of staff.

The Umlazi/ Engonyameni subdistrict has a high population/ PN ratio. The sub district has 16% of the population and has 16% of the total PN compliment. However, this is a sub district has the highest number of patients on ART (>56 000) and the highest number of patients receiving chronic care (>9 000) compared to any other subdistrict. It has very high PN workloads (average PN workload: 54, range: 25 – 90). There are more provincial clinics (12) than LG clinics (5) to cater for the population. This sub district therefore requires a lot more attention for better distribution of staff and resources.

Table 17: 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
Osindisweni	5 221	475	5 528	10 442	1 033
Wentworth	7 628	372	4 052	7 204	1 365

Source: DHER 2012/13 Customised District Report

Comparison of the two district hospital's PDE/ Staff ratio show variation in the number of patients seen per category of staff at each facility.

- Regarding Pharmacy staff, The PDE/ Pharmacy Staff is lower at Wentworth Hospital. Wentworth hospital has 32 staff compared to 17 staff at Osindisweni
- Regarding Medical Staff, both hospitals have similar number of Medical staff – 19 at WWH and 18 staff at Osindisweni. However, there is high Medical staff workload at WWH due to the high PDE. The facility is using sessional doctors to assist with the workload. The lack of rural allowance, could contribute to the higher MO attrition at WWH.
- There seems to an equal distribution of PDE/ support staff
- Wentworth Hospital has a slightly lower PDE to nursing staff ratio due to a higher number of nursing staff allocation. There are a high number of PNs (121 vs 79), and SNs (147 vs 51) at WWH as there are more services offered eg. CTOP, STOMA

12. DISTRICT HEALTH EXPENDITURE

Table 18 (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	28 977 000	0.00	0.00	28 976 316	0.00	0.00
DF - 2.2: Clinics	509 428 000	129 600 000	0.00	510 044 624	61 051 000	0.00
DF - 2.3: Community Health Centres	543 786 000	0.00	0.00	543 816 308	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	186 891 000	0.00	0.00	186 192 751	0.00	0.00
DF - 2.6: HIV/AIDS	591 899 000	0.00	0.00	587 498 450	0.00	0.00
DF - 2.7: Nutrition	10 819 000	0.00	0.00	10 819 044	0.00	0.00
DF - 2.9: District Hospitals	961 703 000	0.00	0.00	1 005 638 550	0.00	0.00
DF – 2.12: Donor Funding						
TOTAL DISTRICT	**2 833 503 000**	**129 600 000**	**0.00**	**2 872 986 043**	**61 051 000**	**0.00**

Source: DHER 13/14 District Customised Template

In Sub-Programme 2.2, there was a budget of R129 600 000 transferred to Municipality. The table above reflects an expenditure of R61 051 000, however the District BAS report shows that the Municipality have an expenditure of R126 844 696. This discrepancy must be checked.

No budget was allocated for Sub-Programme 2.4 (Community Services) in eThekwini and no expenditure was incurred. The HIV/AIDS (Sub-Programme 2.6), incurred expenditure within the allocated budget. This is in contrast to the last financial year which saw an over-expenditure of 1% (R688 726.00).

The expenditure under sub-programme 2.9 includes 2 district hospitals. There was an over-expenditure of R43 935 550.47. This was mainly contributed to by a R20 000 000 expenditure for other transfers (cash) that was not budgeted for and was used for litigations. The other factors contributing to over-expenditure included transfers to Non Profit Institutions (Such as St Mary's) and Medicine amongst others.

Regarding proportions of expenditure:

- District Management only accounts for1% of the overall expenditure. This remains as one of the lowest proportions on District Management in the country. It is below the provincial average of 2.1% and national average of 5.8% according to 2012/13 DHB report. The low expenditure can be attributed to the high number of vacant district management posts (>30%) including vacant posts for a District Manager, District Program Coordinators and a District Planner amongst others
- PHC expenditure accounts for 65% of the overall expenditure which is in line with the national average of 57%. This includes 20% on HIV/AIDS, 19% clinics, 19% CHCs and 6% Other Community services and 1% Nutrition and other.
- It is important to note that there are vast differences in expenditure between clinics ranging from R 2,275,311 (at Starwood) to R 17,702,525 (at U21). The expenditure among CHCs also differs vastly from R 43,928,678.71at Newtown A to R 130,666,412 at KwaMashu. While there are various reasons that could contribute to this, the headcount data must improve to ensure better planning and redistribution of resources.
- District Hospitals accounts for 34% of overall expenditure, which is in line with national expenditure of 37% (2012/13 DHB report). While there are only 2 district hospitals in eThekwini to cater for the population, there are 19 other hospitals (Regional, tertiary, etc.) to assist with this level of care.

Table 19 (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 2011/12	Cot per Uninsured Capita 2012/13
South Central	R37 491 285	R42.45	R53.06	15%	1%		R30.38
South-West	R7 716 981	R31.94	R39.93	6%	1%		R29.81
Umlazi/Engonyameni	R127 161 563	R230.50	R288.12	16%	14%		R276.00
Lower South	R36 046 320	R260.96	R326.19	4%	4%		R320.32
North Central	R175 457 244	R86.31	R107.89	14%	2192%		R97.29
Greater Inanda/ Tongaat Region	R290 939 284	R42.22	R52.77	18%	31%		R44.79
Inner West	R164 361 803	R131.05	R163.81	15%	18%		R151.48
Outer West	R90 007 651	R86.21	R107.77	12%	10%		R119.31
District	**R929 182 131**	**R104.99**	**R132.90**	**100%**	**100%**		**R121.68**

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

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

Table 20 (NDoH 11): PHC Budget and Expenditure (%) excluding "Other Donor Funding" – 2013/14

	Budget Amount	Budget	Expenditure Amount	Expenditure
District Management (2.1)	28 977 000	1%	28 976 316	1%
PHC (2.2 – 2.7)	1 842 823 000	65%	1 838 371 177	64%
District Hospitals (2.9)	961 703 000	34%	1 005 638 550	35%

Source: DHER 2013/14 Customised District Report

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

Table 21 (NDoH 12): PHC Cost per Headcount– 2013/14

	LG PHC Facilities	Provincial PHC Facilities	Total Staff Cost per PHC Headcount
District	N/A	74.12	69.58

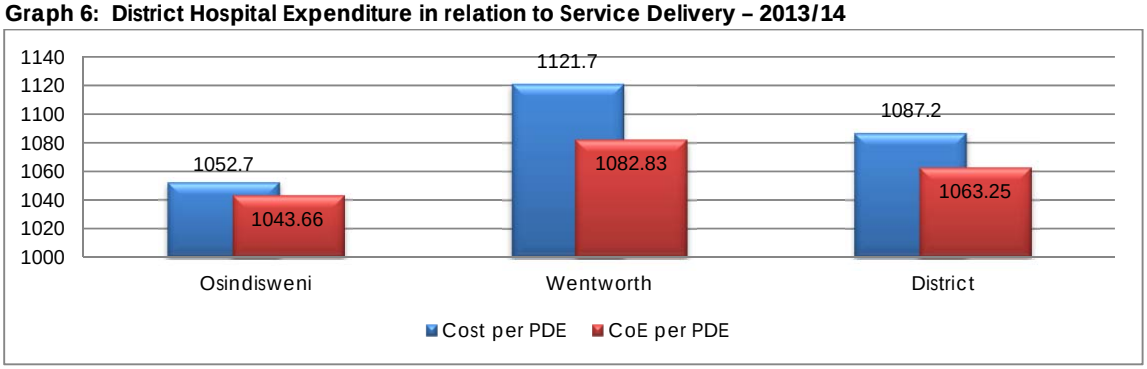
Table 22: District Hospital Expenditure

District Hospital	Expenditure per PDE	ALOS	BUR	Proportion (%) of expenditure spent on staff (CoE)
Osindisweni	R1052.7	6.6 days	68.4%	75%
Wentworth	R1121.7	7.5 days	89.8%	74%
District	R1087.2	**7.1 days**	**79.1%**	**75%**

Source: DHER 2013/14 Customised District Report

The ALOS for both hospitals increased since 2012/13 with Osindisweni increasing from 5.8 to 6.6 and Wentworth Hospital from 5.7 to 7.5. The increase in Wentworth is as a result of the increased referrals from Addington, King Edward and PMMH whilst Osindisweni has been receiving patients from the iLembe district. Both facilities have now implemented grand ward rounds to address this.

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



Source: DHER 2012/13 Customised District Report

The current data reflects that the proportion of CoE/PDE is very high to the total Cost/PDE. This information does not take into account the transactions that have not yet been processed by the time the DHER was drawn. It is anticipated that the CoE would be 70% once all transactions are captured. Moving forward, the system will be strengthened to ensure that the information is captured timeously

Table 23: Non-Negotiable Expenditure per PDE

Non-Negotiable		Osindisweni	Wentworth
Infrastructure Maintenance	Rands per PDE	R0	R1.20
	% over / under spent	0.0	-41.6
Food Services per PDE	Rands per PDE	R19.90	R32.70
	% over / under spent	67.5	-0.4
Medicine Expenditure per PDE	Rands per PDE	R96.10	R106.50
	% over / under spent	-20.3	-19.2
Medical Sundries (Supplies) Expenditure per PDE	Rands per PDE	R61.90	R47.80
	% over / under spent	6.1	0.0

Non-Negotiable		Osindisweni	Wentworth
Essential Equipment per PDE	Rands per PDE	R1.50	R1.90
	% over / under spent	-0.7	15.3
Laundry Expenditure Per PDE	Rands per PDE	R0	R0
	% over / under spent	0.0	0.0
Vaccination Expenditure per PDE	Rands per PDE	R3.30	R2.00
	% over / under spent	25.8	35.4
Blood Support Expenditure per PDE	Rands per PDE	R17.70	R21.20
	% over / under spent	2.4	7.5
Infection Control Expenditure per PDE	Rands per PDE	R26.60	R32.50
	% over / under spent	-30	17
Medical Waste Expenditure per PDE	Rands per PDE	R7.90	R8.00
	% over / under spent	-4.1	8.7
Laboratory Services Expenditure per PDE	Rands per PDE	R0	R0
	% over / under spent	0	0
Security Services per PDE	Rands per PDE	R58.50	R30.90
	% over / under spent	8	-11
District	Rands per PDE	**R293**	**R284.70**
	% over / under spent		

Source: DHER 2013/14 Customised District Report

At Osindisweni Hospital there was under expenditure of Children's Vaccines, a budget of R422, 000 was allocated with an expenditure of R303, 009. This facility has a low paediatric utilisation rate that could account for the under expenditure. There was also under expenditure on Security Services with an allocated a budget of R5, 954, 000 and expenditure of R5, 479, 339. Osindisweni also underspent on medical supplies. These factors are an indication of poor budgeting

There was gross over expenditure on Infection Control at Osindisweni Hospital. The facility allocated a budget of R170, 000 but had expenditure of R601, 841. No explanation was provided by the facility. The facility also overspent on Medicines, with an allocation of R7, 459, 000 and expenditure R8, 972, 708 as well as Medical Waste (R738, 782 expenditure vs. R710, 000 budget).

The table above reflects under expenditure for Food Services and Relevant Supplies. However, on BAS there is indication of over spending for this line item. BAS data shows a budget of R 1, 763, 000 was allocated with an expenditure of R1, 873, 929. The contradictory information requires further review.

Osindisweni Hospital management needs to review the budget allocation for each of the line items to achieve better financial efficiency. There is also a need for capacitation on finance and operational management at this facility.

Review of expenditure at Wentworth Hospital shows an over expenditure on Infrastructure Maintenance, Medicines and Security services

- **Infrastructure Maintenance** has a budget and expenditure of R108 000 vs. R150 000 respectively. The X-ray machine in the A&E department needed urgent repairs. This was recorded under the "Medical and Allied Equipment" line item which was reclassified
- For **Medicines**, the facility had a budget of R11 million and expenditure of R14 million. The facility explained that the high cost of medicines in this financial year could have also been attributed to the delay in PPSD which resulted in budget carry overs from last financial year. Furthermore the facility incurs tertiary expenditure for medicines which accounted for approximately R2 million. It was recommended that the facility refer tertiary clients
- Over expenditure on **Security Services** was unforeseen. The contract of the initial company was terminated and a new service provider had to be sourced. The latter was more expensive hence the allocated budget was not sufficient

Wentworth hospital had an under expenditure on Children's Vaccines DH, Essential Equipment& Maintenance, Medical Waste, Blood Supply and Services as well as Infection Control.

- The under expenditure on **Children's Vaccines DH** can be attributed to the low paediatric utilisation rate and an under utilisation of paediatric beds. Most children visit the neighboring facilities for care. This budget line item can be reduced
- **Essential Equipment& Maintenance** had a budget of R286 000 with an expenditure of R242 000. The budget was not fully utilized due to delays in the SCM processes
- WWH underspent on **medical waste** with a budget of R1, 143, 000 and expenditure of R1, 043, 595. The budget allocation must be reviewed for this line item.
- **Blood Supply and Services** was allocated a budget of R2, 970, 000 with an expenditure of R 2, 747, 000. This accounts 92% of the allocated budget
- The under expenditure of **Infection Control** can be attributed to the reclassification of Medical/ Allied Equipment line item (as explained above). The facility grossly under spent on Glove and Disposable sundries due to delays in the SCM processes. There was also under expenditure on toiletries, which will be reviewed in the next financial year.

Comparison of the Expenditure per PDE between the district hospitals shows vast differences in the costs of Medicines, Blood supply and Services, Infection Control, Medical Supplies and Security Services.

The cost of Medicines is high at both facilities; it should be around R65 per PDE. The higher cost of medicines at WWH could be due to purchasing of tertiary medicines. While the high cost of medicines at Osindisweni was raised as an issue with the residing Pharmacy and Medical Manager and it was discovered that the collected data was not correct. The FIO at Osindisweni hospital embarked on an exercise with the District Information team to correct this. Subsequent to that, a meeting was held with all prescribers, the Finance Manager, M&E Manager and CEO to address this high cost driver.

Blood Supply and Services costs are higher at WWH. The facility has a higher number of caesarean sections and surgeries compared to Osindisweni and had therefore allotted a higher proportion of the budget to this line item. In addition, the higher patient volumes at WWH could account for the lower PDE for medical supplies and security services

PART B - COMPONENT PLANS

13. SERVICE DELIVERY PLANS FOR DISTRICT HEALTH SERVICES

13.1 SUB-PROGRAMME : DISTRICT HEALTH SERVICES

13.1.1 PHC SUB-PROGRAMME OVERVIEW

The purpose of this programme is to deliver comprehensive community-oriented Primary Health Care and District hospital services to the eThekwini District community. Total PHC headcount for the Financial Year 2013/14 is 10 829 179, of which, 390 810 (DHIS) is by mobile services.

EThekwini district has 2 district hospitals and 102 Primary Health Care clinics: 43 (including four hospital Gateways) of these are managed by the Provincial Health services and 59 by Municipality and 8 Provincial CHCs. eThekwini also has 10 State Aided clinics, 1 State Aided Hospital as well as central, regional and specialized hospitals.

The PHC for both the Provincial Health Services and Local Municipality comprise of facility based clinical staff including professional nurses and other categories; 30 outreach teams including family health and 40 school health teams. Community Care Givers form part of the outreach teams and provide ward-based PHC service through Operation Sukuma Sakhe.

Provincial Health services within the District are currently functionally divided into two service areas for efficiency purposes, namely South and North West. Management structures are such that Primary Health Care supervisors are based at the district office and not under the mother institutions.

Despite the large budget allocated every financial year (approximately R9.4 billion) into health care in eThekwini some of the health outcomes indicators such as infant mortality, maternal mortality, and HIV and TB prevalence rates are sub -optimal and do not commensurate with the expenditure on health.

Taking into cognizance the current health structural arrangement it therefore means that innovative and creative service delivery models are explored with an aim of ensuring that there is improved efficiencies and effectiveness for better health outcomes.

To affect this, Health Service Delivery arrangements have to be reorganized and rearranged into smaller Sub –Units of Management that will provide health services for smaller clearly defined populations with higher levels of care and adequate supervision of health services.

Ethekwini District has proposed the possible functional sub- district demarcations with the view to provide the optimal service delivery, within available resources for eThekwini populations. The proposed model envisages eight (8) sub-districts based on population density, these are South Central 526 720 (15%), South West 206 931(6%); Umlazi/ Engonyameni 541 593 (16%); Lower South 138 132 (4%); North Central 476 727 (14%); Great Inanda/ Tongaat Region 614 568 (18%), Inner West 536 582 (15%) and Outer West 422 953

(12%). Though separate geographically, the Lower South and South West due to their population size could be combined for administrative purposes.

Local Municipality functional areas are divided into 3 sub- districts. Each sub-district is managed by a Deputy Head. Primary health clinics at the Local Municipality are managed by the Nursing Services Managers who are based in the facilities and report to Area Managers.

Strategic challenges for the sub-program

- There is inequitable distribution of health facilities in the district resulting in large communities without access to services. Areas in the Inanda, Greater Inanda, Amatikwe, Mzinyathi, Qadi tribal Authority, and informal settlements in Amaoti and eTafuleni have poor access to health care. Greater Inanda/Tongaat sub-district has the largest total population (614 568 - 18%) of eThekwini. The presence of 5 CHCs in the North relieves the congestion at Osindisweni district hospital.
- The Umlazi/Engonyameni is the second most populated sub- district. The absence of a District hospital and a CHC results in over-congestion in provincial PHCs. Meanwhile the closest district hospital (Wentworth) has a Gateway clinic which reports very low PHC headcount (13 761) and PN workload (11) in FY 2013/14. The matter is receiving attention by the district and by the hospital management.
- Different service conditions for staff between the two authorities are also a challenge resulting in competitions for experienced staff.
- Quadruple disease burden with Communicable, Non-Communicable, Perinatal and Injury related continues to undermine the achievement of millennium Development Goals.
- PHC Supervision reporting poses a challenge. The South Service area does not have dedicated PHC Supervisors posts. There is a need to assess the quality of PHC Supervision in relation to clinical outcomes and improvement of implementation of the National Core Standards.
- The total district OPD non- referred cases (25 424, FY 2013/14), is an indication for systems and health care improvements at PHC facilities.
- The inadequate number of vehicles for outreach and School Health teams limits the number of visits to communities

Table 24 (NDoH 13): Situation Analysis: Indicators for District Health Services 2013/14 Financial Year

Indicators	Type	South Central	South West	Umlazi /Ngonyame ni	Lower South	North Central	Greater Inanda	Inner West	Outer West	District Average
1. Percentage of fixed PHC facilities compliant with all extreme measures of the National Core Standards	Quarterly %	0	0	0	0	0	0	0	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*	*0*	*0*	*0*	*0*
Fixed PHC clinics plus fixed CHCs / CDCs	*No*	*18*	*8*	*17*	*10*	*13*	*18*	*16*	*10*	*110*
2. Patient experience of Care Survey rate (PHC Facilities)	Quarterly %	0	0	0	0	0	0	0	40%	40%
Fixed PHC facilities that have conducted Patient Satisfaction Surveys	*No*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*4*	*4*
Fixed PHC clinics plus fixed CHCs / CDCs	*No*	*18*	*8*	*17*	*10*	*13*	*18*	*16*	*10*	*110*
3. Patient experience of Care rate at PHC facilities	Annual %	0	0	0	0	0	0	0	80%	80%
Patient satisfied with health services	*No*	*-*	*-*	*-*	*-*	*-*	*-*	*-*	*64*	*64*
Patients participating in PSS	*No*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*80*	*80*
4. OHH registration visit coverage	Annual %	0	0	76%	0	20%	100%	75%	3%	47.5%
OHH registration visit	*No*			2 128		393	277	8 398	232	11 428
OHH in Population	*No*			2 800		1 920	277	11 169	7 884	24 050
5. Number of District Clinical Specialist Teams (DCST's)	Quarterly No	0	0	0	0	0	0	0	0	1
6. PHC utilisation rate	Annual %	1.5	2.1	4.7	6.2	2.5	4.1	2.3	2.8	3.1
PHC headcount total	*No*	796 567	428 812	2 548 779	858 904	1 203 872	2 542 436	1 265 209	1 184 600	10 829 179

Indicators	Type	South Central	South West	Umlazi /Ngonyame ni	Lower South	North Central	Greater Inanda	Inner West	Outer West	District Average
Population Total	*No*	526 720	206 931	541 593	138 132	476 727	614 568	536 582	422 952	3 464 205
7. *Complaints Resolution Rate*	Quarterly %	*92%*	*100%*	*94%*	*100%*	*91%*	*93%*	*83%*	*86%*	*90%*
Complaints resolved	*No*	*160*	*8*	*77*	*13*	*227*	*241*	*152*	*192*	*1070*
Complaints received	*No*	*173*	*8*	*82*	*13*	*249*	*260*	*184*	*223*	*1192*
8. Complaint resolution within 25 working days rate	Quarterly %	*81%*	*50%*	*90%*	*92%*	*74%*	*85%*	*97%*	*66%*	*87%*
Complaint resolved within 25 working days	*No.*	*129*	*4*	*69*	*12*	*168*	*206*	*148*	*192*	*928*
Complaints resolved	*No.*	*160*	*8*	*77*	*13*	*227*	*241*	*152*	*292*	*1 070*

Table 25 (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%	0%	0%	0%	-
Fixed PHC facilities compliant with all the extreme measures of the National Core Standards for health facilities	*QA assessment records*	*No*	-	*0*	*0*	*0*	0	0	0	-
Fixed PHC clinics plus fixed CHCs / CDCs	*DHIS calculates*	*No*	-	*110*	*110*	111	*111*	*111*	*111*	-
2. Patient satisfaction survey rate (PHC Facilities)	QA calculates	% Quarterly	Not reported	Not reported	Not reported	62%	70%	80%	100%	100%

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
Fixed PHC facilities that have conducted Patient Satisfaction Surveys	*OSS records*	*No*	-	-	-	*69*	*56*	*89*	*111*	*654*
Fixed PHC clinics plus fixed CHCs / CDCs	*DHIS calculates*	*No*	-	-	-	*111*	*111*	*111*	*111*	*654*
3. PHC patient satisfaction rate at PHC facilities	DHIS calculates	% Annual	Not reported	Not reported	Not reported	0%	75%	80%	85%	75%
Patient satisfied with health services	*PSS results*	*No*	-	-	-	-	*120*	*352*	*680*	-
Patients participating in PSS	*PSS records*	*No*	-	-	-	-	*160*	*440*	*800*	-
4. OHH registration visit coverage	DHIS calculates	Annual %	Not reported	Not reported	39%	18%	25%	30%	40%	-
OHH registration visit	*DHIS/Tick register WBOT*	*No*			29 382	39 174	58 729	73 999	103 599	-
OHH in Population	*District Records*	*No*			75 403	223 732	234 919	246 664	258 997	-
5. Number of District Clinical Specialist Teams (DCST's)	Persal/ District Records	Quarterly No	0	0	1	1	1	1	1	11
6. PHC utilisation rate	DHIS calculates	Annual	2.9	3.1	3.1	3.1	3.2	3.2	3.2	3.1
PHC headcount total	*DHIS/PHC tick register*	*No*	*10 571 941*	*10 775 282*	*10 829 179*	*10 979 096*	*11 265 782*	*11 355 251*	*11 443 821*	34 052 067
Population Total	*DHIS/Stats SA*	*No*	*3 474 033*	*3 508 776*	*3 464 205*	*3 492 349*	*3 520 557*	*3 548 516*	*3 576 194*	10 688 165
7. Complaints Resolution Rate	DHIS calculates	Quarterly %	87%	91%	90%	90%	90%	90%	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
Complaints resolved	*DHIS / Complaint records*	*No*	*876*	*997*	*1070*	*1 354*	*1 498*	*2 097*	*2 936*	-
Complaints received	*DHIS / Complaint records*	*No*	*1011*	*1097*	*1192*	*1 500*	*1 669*	*2 336*	*3 271*	-
8. Complaint resolution within 25 working days rate	DHIS calculates	Quarterly %	100%	98%	86%	96%	93%	95%	95%	75%
Complaint resolved within 25 working days	*DHIS / Complaint records*	*No.*	*876*	*980*	*928*	*1 298*	*1 392*	*1 992*	*2 789*	-
Complaint resolved	*DHIS / Complaints record*	*No.*	*876*	*997*	*1 070*	*1 354*	*1 498*	*2 097*	*2 936*	-

Table 26 (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 %	5.2	5.2	4.9	4.5	5.1	5.2	5.3
	PHC headcount under 5	*DHIS/PHC tick register*	*No*	*1 588 792*	*1 631 994*	*1 559 924*	*1426 987*	*1 638 706*	*1 692 558*	*1 747 532*
	Population under 5 years	*DHIS/Stats SA*	*No*	*306 419*	*313 085*	*317 192*	*315 517*	*321 315*	*325 492*	*329 723*
	1.2 PHC Total Headcount under 5 years	DHIS/Tick register SHS	No	*1 588 792*	*1 631 994*	*1 559 924*	1426 987	1 638 706	1 692 558	1 747 532
2.	2.1 Expenditure per PHC headcount	DHIS/BAS	Quarterly R	R185.50	R152.53	R171.64	R145.30	R150.00	R155.00	R160.00
	Total expenditure PHC	BAS (R'000)	R'000	*R1 961 065 991*	*R1 708 640 309*	R1 941 968 606	R1 660 246 260	R1 747 56 7 050	R1 878 052 075	R2 016 179 840
	PHC headcount total	DHIS calculates	No	*10 571 941*	*11 202 353*	*11 314 250*	*11 426 261*	*11 650 447*	*12 116 465*	*12 601 124*
3.	3.1 Number of School Health Teams (cumulative)	District Records/ Persal	Quarterly No	17	39	40	40	46	50	50
4.	4.1 Number of accredited Health Promoting Schools (cumulative)	Health Promotion database	Quarterly No	5	5	5	5	5	5	5
5.	5.1 Dental extraction to restoration ratio	DHIS calculates	Quarterly Ratio	1:22	1:24	1:25	1:22	1:25	1:25	1:25
	Tooth extraction	*DHIS/Tick register*	*No*	*164 425*	*163 994*	*178 351*	*197 380*	*205103*	*235 869*	*271 249*
	Tooth restoration	*DHIS/Tick register*	*No*	*7 588*	*6 865*	*7 207*	*9 170*	8 288	9 531	*10 961*
6.	6.1 Percentage of PHC facilities conditionally compliant to the National Core Standards	QA assessment records	Annual %	0%	0%	0%	0%	5%	9%	14%
	Clinics conditionally compliant (50%-75%)to National Core Standards	*QA assessment records*	*No*	-	0	0	0	6	10	15

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
	CHC's and clinics total	*DHIS calculates*	*No*	113	110	110	111	111	111	111
7.	7.1 District PHC expenditure per uninsured person	BAS / Stats SA	R	R695.80	R599.79	R674.95	R572.76	R601.37	R639.88	R680.14
	Total expenditure on PHC services	*BAS*	*R'000*	R1 961 065 991	R1 708 640 309	R 1 941 968 606	R1 660 246 260	R1 747 56 7 050	R1 878 052 075	R2 016 179 840
	Number of uninsured people in the Province (Stats SA)	*DHIS / Stats SA*	*No*	2 818 433	2 848 707	2 877 196	2 898 690	2 905 968	2 935 028	2 964 378
8.	8.1 PHC supervisor visit rate (fixed clinic/ CHC/ CDC)	DHIS	%	74%	65%	75%	70%	80%	85%	85%
	PHC supervisor visit (fixed clinic/ CHC/ CDC)	*Supervisor checklists*	*No*	*81*	*72*	*83*	*78*	*89*	*94*	*94*
	Fixed clinics plus fixed CHCs/CDCs	*DHIS Calculates*	*No*	*110*	*110*	*110*	111	111	111	111
9.	9.1 Number of functional Ward Based Outreach Teams (Family Health Teams) (cumulative)	District Management / Appointment letters	No	0	13	28	28	35	60	60
10.	10.1 School ISHP coverage (annualised)	DHIS	%	-	-	23%	24%	27%	30%	35%
	Schools with any learner screened	*DHIS / Tick register SHS*	*No*	*-*	*-*	*226*	*233*	*265*	*294*	*343*
	Schools – total	*DHIS / DoE database*	*No*	*-*	*-*	*980*	*980*	*980*	*980*	*980*
11.	11.1 Number of Primary Health Care Clinics that qualify as Ideal Clinics		No	-	-	-	-	11	15	20
12.	12.1 Number of Primary Health Care Clinics with functional Clinic Committees		No	72	72	73	73	75	80	85

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

Strategies for 2015/16	*Activities*
1. Improve PHC supervisory visit	• Employment of PHC supervisors • Follow up for motivated post • Engage Bhekimpilo Trust and Municipality clinics
2. Conduct Yearly patients satisfaction survey	• Co-ordinate and facilitate the conducting of patients satisfaction survey at least once a year
3. Increase the number of functional school health teams	• Appointment of 6 additional school health teams • Increase the number of vehicles for new teams as well as current teams • Increase coverage area, targeting most deprived wards • Integration of services for optimal use resources • Ensure coverage of services in most deprived wards
4. Initiate the implementation of NCS quality improvement plans	• Support facilities to conduct NCS self-assessments • Assist facilities to develop Quality Improvement Plans • Monitor implementation of Quality Improvement Plans

A. SUB-PROGRAM: DISTRICT HOSPITALS

13.2.1 Sub-Programme Overview

The purpose of the sub-programme is to render hospital services at general practitioner level as the first line of referral from PHC services. There are currently two designated Level 1 hospitals in the district namely Wentworth Hospital in the South and Osindisweni Hospital in the North.

The differences in services/ service delivery for both district hospitals have been explained above in section A. There are currently challenges with poor management practices at the facility level. Both facilities must review the admission and discharge rates as well as the down referrals. There are also problems with the data which skews the correct interpretation of efficiencies, especially at Osindisweni.

Strategic challenges for the sub-program

eThekwini has various levels of hospitals including regional, specialist, chronic, psychiatric and central. There is inequitable distribution of health facilities with most hospitals situated in the South Central subdistrict, the Umlazi /Ngonyameni subdistrict has no CHC and only a regional hospital (Prince Mshiyeni Memorial Hospital). The North subdistricts (North Central and Greater Inanda/ Tongaat) have a district hospital but the geographic location is in the extreme outer boundaries, making it difficult to access.

- District Hospitals are geographically far apart from each other and are few in number compared to large populations requiring services, for example the location of Osindisweni Hospital in the far North.
- The inequitable distribution of facilities has led to poor referral patterns throughout the district. In the Umlazi /Ngonyameni subdistrict, PHCs are referring directly to the regional hospital due to the absence of CHCs and a district hospital in the area. The West service area has a population 959 535 which is not serviced by a district hospital. This creates a burden for R K Khan Hospital, complicated by the uncertainty of St Mary's.
- King Dinuzulu has a District Service Component but is under-budgeted. It is has 200 beds and its catchment population extends to and includes KwaMashu. Moreover, in order to reduce congestion at Mahatma Gandhi Hospital and most facilities in North Central and South Central are referring clients to King Dinuzulu. The OPD headcount at King Dinuzulu increased from 99 162 (FY 2011/12) to 145 475 (FY 2012/13) (DHIS), an indication of increase for FY 2015/16.
- Five regional hospitals in eThekwini share level-1 services with the district hospitals, with cost implications and compromising the quality of level-2 services. Often low risk patients end up occupying beds in level-2 hospitals. As an interim measure, McCords is being utilized as a step-down facility to decongest beds in acute medical and surgical wards to accommodate critically ill patients.
- Pharmacies at hospitals are congested and lead to long patients waiting times. This is attributed to the dispensing of chronic medication to patients

Table 27 (NDoH 16): Situational Analysis Indicators for District Hospitals – 2013/14 Financial Year

Indicators	Type	Osindiswen i Hospital	Wentworth Hospital	District Average
1. National Core Standards self-assessment rate	*Quarterly* %	100%	100%	100%
National Core Standards self-assessment	*No*	*1*	*1*	*2*
District Hospitals total	*No*	*1*	*1*	*2*
2. Quality Improvement plan after self-assessment rate	Quarterly %	100%	100%	100%
Quality Improvement plan after self-assessment	*No*	*1*	*1*	*2*
District Hospitals total	*No*	*1*	*1*	*2*
3. Percentage of District Hospitals compliant to all extreme and vital measures of the National Core Standards	Quarterly %	*0*	*0*	*0*
District Hospitals fully compliant (75%-100%) to all extreme and vital measures of National Core Standards	*No*	*0*	*0*	*0*
District Hospitals total	*No*	*1*	*1*	*2*
4. Patient experience of Care Survey rate		100%	100%	100%
Number of district hospitals that have conducted patient satisfaction surveys	*No*	*1*	*1*	*2*
District Hospitals total	*No*	*1*	*1*	*2*
5. Patient experience of Care rate	Annual %	65%	73%	70%
Number satisfied customers	*No*	*52*	*145*	*197*
Number users participated in survey	*No*	*80*	*200*	*280*
6. Average length of stay	Quarterly Days	6.6 days	7.5 days	7.0 days
In-patient days	*No*	*59 876*	*70 883*	*130 759*
Day patients	*No*	*0*	*414*	*414*
Inpatient separations	*No*	*9 122*	*9 499*	*18 621*
7. Inpatient bed utilisation rate	Quarterly %	68.4%	89.8%	79.1%
In-patient days	*No*	*59 876*	*70 883*	*130 759*
Day patients	*No*	*0*	*414*	*414*
Inpatient bed days available	*No*	*87 600*	*79 205*	*166 805*
8. Number of Mental Health Teams established	No	0	0	0
9. Expenditure per PDE	Quarterly R	R1 053	R1 122	R1 429
Expenditure total	*R'000*	*R130 835 209*	*R188 895 453*	*R319 730 662*
Patient day equivalent	*No*	*93 978*	*129 677*	*223 655*
10. Complaint resolution rate	Quarterly %	100%	100%	100%

Indicators	Type	Osindiswen i Hospital	Wentworth Hospital	District Average
Complaint resolved	*No*	*103*	*255*	*358*
Complaint received	*No*	*103*	*255*	*358*
11. Complaint resolution within 25 working days rate	Quarterly %	95%	93%	94%
Complaint resolved within 25 days	*No*	*98*	*237*	*335*
Complaint resolved	*No*	*103*	*255*	*358*

Table 28 (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 %*	100%	100%	100%	100%	100%	100%	100%	100%
National Core Standards self-assessment	*QA assessment records*	*No*	*2*	*2*	*2*	*2*	*2*	*2*	*2*	*37*
District Hospitals total	*DHIS calculates*	*No*	*2*	*2*	*2*	*2*	*2*	*2*	*2*	*37*
2 Quality Improvement plan after self-assessment rate	*QA/DHIS calculates*	*Quarterly %*	100%	100%	100%	100%	100%	100%	100%	*100%*
Quality Improvement plan after self-assessment	*QA assessment records*	*No*	*2*	*2*	*2*	*2*	*2*	*2*	*2*	*37*
District Hospitals total	*QA assessment records*	*No*	*2*	*2*	*2*	*2*	*2*	*2*	*2*	*37*
3 Percentage of District Hospitals compliant to all extreme and vital measures of the National Core Standards	QA/DHIS calculates	Quarterly %	0%	0%	0%	0%	0%	0%	0%	30%
District Hospitals fully compliant (75%-100%) to all extreme and vital measures of National Core Standards	*QA assessment records*	*No*	*-*	*-*	*-*	*0*	*0*	*0*	*0*	*11*
District Hospitals total	*DHIS calculates*	*No*	*2*	*2*	*2*	*2*	*2*	*2*	*2*	*37*

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
4 Patient experience of Care Survey rate	QA / DHIS calculates	Quarterly %	50%	50%	100%	100%	100%	100%	100%	100%
Number of district hospitals that have conducted patient satisfaction surveys	*QA assessment records*	*No*	1	1	2	2	2	2	2	37
District Hospitals total	*DHIS calculates*	*No*	2	2	2	2	2	2	2	37
5 Patient experience of Care rate	DHIS calculates	Annual %	80%	68%	70%	91%	80%	85%	90%	80%
Number satisfied customers	*PSS*	*No*	*24*	*27*	*197*	*492*	*456*	*485*	*513*	*2 240*
Number users participated in survey	*PSS*	*No*	*27*	*40*	*280*	*540*	*570*	*570*	*570*	*2 800*
6 Average length of stay	DHIS calculates	Quarterly Days	6.7	5.7	7.0	7.5	6.5	6.0	5.2	5.5
In-patient days	*Midnight census*	*No*	*138 515*	*123 073*	*130 759*	*148 844*	*152 127*	*164 297*	*177 441*	*2 043 291*
Day patients	*Midnight census*	*No*	*480*	*541*	*414*	*386*	*366*	*330*	*297*	*8 325*
Inpatient separations	*DHIS calculates*	*No*	*20 827*	*21 666*	*18 621*	*19 833*	*23 432*	*27 410*	*34 152*	*374 817*
7 Inpatient bed utilisation rate	DHIS calculates	Quarterly %	85.5%	75.9%	79.1%	80%	82%	89%	95%	64.5%
In-patient days	*Midnight census*	*No*	*138 515*	*123 073*	*130 759*	*148 844*	*152 127*	*164 297*	*177 441*	*2 043 291*
Day patients	*Midnight census*	*No*	*480*	*541*	*414*	*386*	*366*	*330*	*297*	*8 325*

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
Inpatient bed days available	*Management*	*No*	*162 425*	*162 425*	*166 805*	*185 420*	*185 420*	*185 420*	*185 420*	*3 173 310*
8 Number of Mental Health Teams established		No	0	0	0	0	2	2	2	
9 Expenditure per PDE	BAS/DHIS	Quarterly R	R1 076	R1 023	R1 429	R1578	R1 800	R1 980	R2 178	R2 301
Expenditure total	*BAS*	*R'000*	*271 326 312*	*225 266 646*	*R319 730 662*	*R324 304 248*	*R375 820 200*	*R433 455 660*	*R469 812 024*	*6 204 036*
Patient day equivalent	*DHIS calculates*	*No*	*252 162*	*220 202*	*223 655*	*205 516*	*208 789*	*218 917*	*215 708*	*2 695554*
10 Complaint resolution rate	DHIS	Quarterly %	96%	75%	100%	98%	98%	98%	98%	-
Complaint resolved	*PSS*	*No*	*410*	*319*	*358*	*299*	*363*	*365*	*369*	*3 000*
Complaint received	*PSS*	*No*	*427*	*425*	*358*	*304*	*370*	*372*	*377*	*-*
11 Complaint resolution within 25 working days rate	DHIS	Quarterly %	96%	75%	94%	98%	95%	95%	95%	75%
Complaint resolved within 25 days	*PSS*	*No*	*410*	*319*	*335*	*293*	*345*	*347*	*351*	*2 250*
Complaint resolved	*PSS*	*No*	*427*	*425*	*358*	*299*	*363*	*365*	*369*	*3 000*

Table 29 (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 %	29.8%	33.2%	38.6%	39%	35.0%	35.0%	35.0%
	Delivery by caesarean section	*Delivery register*	*No*	*1 110*	*1 562*	*1 897*	*2 230*	*2 217*	*2 859*	*3 689*
	Delivery in facility total	*Delivery register*	*No*	*3 726*	*4 700*	*4 910*	*5 635*	*6 334*	*8 171*	*10 540*
	2. OPD headcount- total	DHIS/OPD tick register	Quarterly No	287 922	284 222	233 380	206 746	186 072	167 465	150 719
	3. OPD headcount not referred new	DHIS/OPD tick register	Quarterly No	43 345	35 368	25 424	36 766	25 170	24 918	24 669
	4. Number of District Hospitals with functional boards			2	2	2	2	2	2	2
	5. Proportion of District Hospitals conditionally compliant to National Core Standards	QA / DHIS calculates	Quarterly %	0%	0%	0%	0%	50%	100%	100%
	District Hospitals conditionally compliant	*QA assessment records*	*No*	*-*	*-*	*-*	*0*	*1*	*2*	*2*
	District Hospitals Total	*DHIS calculates*	*No*	*2*	*2*	*2*	*2*	*2*	*2*	*2*

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

Strategies	*Activities*
1. Revitalize PHC	Osindisweni Hospital to motivate for mobile teams (currently don't have) to reach outer lying areas
2. Reduce ALOS	Implementation of weekly grand rounds to investigate patient stay (on a case by case basis) Conduct regular meetings with referral hospitals
3. Reduce OPD not referred	Strengthen data quality Motivate for a fully functional Gateway clinic at Osindisweni Hospital
4. Rationalization of Services at Wentworth Hospital	Commissioning wards for Obstetrics/Gynaecology services by adding 20 beds Commission High Care ward and Acute Admissions (from 4 to 10 beds) Conduct Ward Rounds
5. Decongest pharmacy	Introduction of a Poly-Pharmacy, where there are fast queues for patients with less than 4 items per script Decanting of chronic patients to feeder clinics and non-medical sites
6. Improving the coordination of referral pathways	Review the current CCG network and improve coordination Regular meetings with DCST and EMS Conduct regular meetings with referral hospitals District Management to work with Wentworth Hospital to address the referral challenges from Kind Edward, King Dinizulu and Addington Hospitals

14. HIV & AIDS & TB CONTROL (HAST)

14.1 PROGRAMME OVERVIEW

The purpose of the programme is to implement preventative, health promotion, care and support strategies that will yield change of perceptions and behaviour towards HIV/AIDS infection thus reducing the incidence and impact of the disease. This will be achieved through coordination of multi-sectoral collaboration to implement activities that will focus on prevention and management of HIV infections of those who are infected or affected. This includes maximising opportunities for annual testing and screening for HIV and TB of everyone in the district.

It also focuses on prevention of mother to child HIV transmission (PMTCT) and includes increasing access to a package of sexual and reproductive health (SRH) services including for people living with HIV and young people, as well as preventive activities in non-traditional outlets. The SRH package includes medical male circumcision (for adults and neonates), emphasis on dual protection, and termination of pregnancy, provision of contraception and syndromic management of STIs. The expansion of HTA programmes through interventions directed to key population or most at risk population (MARPS) forms part of the programme.

Equally important is scaling up ART programme in all identified medical and non-medical facilities to ensure that all qualifying HIV positive clients including children, adolescents and pregnant women receive treatment. The number of ART initiating sites has increased from 110 during FY 2012/13 to 120 (including regional hospitals) in 2013/14 and more patients are being initiated with the implementation of NIMART in the district.

The establishment of the Mpilonde clubs has made it easier for patients to access treatment thereby improving retention on care. The programme is more than just issuing of tablets but also provides counselling, nutritional support and proper management of opportunistic infections. The programme also seeks to strengthen post exposure prophylaxis for the victims of sexual assault, discordant couples as well as health personnel that are exposed to potential infected body fluids. There is also an integrated community based care programme which seeks to improve quality of care for those in need of home based care and tracing of defaulters.

The DOT support programme aims at supporting TB patients to adhere to their treatment to improve cure rate and reduce TB defaulter rate. The purpose of the TB Control Programme is to prevent morbidity and mortality due to TB by increasing the capacity to implement DOTS strategy, improving sputa turnaround time, intensifying case finding, strengthening case retention of patients diagnosed with TB by ensuring an adequate supply of drugs, and standardized, accurate and timely recording and reporting system.

STRATEGIC CHALLENGES

Poor Integration of HAST services

Increasing coverage of MMC services is a challenge, particularly for neonates and males (25+)

Poor Case Finding of HIV exposed children

The need to increase HCT

High HIV prevalence rates noted in Greater Inanda/Tongaat (Verulam and Tongaat), Umlazi, South Sub-district (Pine Town and Hlengisizwe)

Access to health care services for key populations

Poor case finding and diagnosis of TB in children

Several hotspot areas for TB found in most subdistricts (as discussed above)

High MDR defaulter rate due to poor tracing systems between King Dinizulu and facilities

Poor data quality continues to be a challenge, especially for TB

Table 30 (NDoH 19): Situational Analysis Indicators for HIV & AIDS, STI's and TB Control - 2013/14 Financial Year

Indicator	Type	South Central	South West	Umlazi /Ngonyameni	Lower South	North Central	Greater Inanda	Inner West	Outer West	District Average
1. Total clients remaining on ART month	Quarterly No	54 452	17 046	56 066	9 022	31 922	46 108	38 706	22 188	275 510
2. Clients tested for HIV (incl ANC)	Quarterly No	123 176	53 145	91 880	45 170	87 397	122 122	81 454	67 653	672 457
3. TB symptom 5 years and older screened rate	Quarterly %	6.4%	2.6%	3.5%	1.9%	1.9%	1.5%	1.5%	1.7%	2.5%
Client 5 years and older screened for TB symptoms	*No.*	*58 279*	*9 494*	*75 757*	*14 246*	*19 312*	*34 212*	*20 067*	*17 415*	*248 782*
PHC headcount 5 years and older	*No.*	*914 555*	*358 458*	*2 163 525*	*752 722*	*1 023 874*	*2 212 684*	*1 303 794*	*1022 311*	*9 847 790*
4. Male condom distribution Rate	Quarterly Rate per male	104	10	7	9	10	9	11	10	21
Male condoms distributed	*No*	*15 575 822*	*534 501*	*1 992 622*	*825 191*	*1 287 569*	*2 523 803*	*1 737 869*	*1 097 570*	*25 574 947*
Population 15 years and older male	*Population*	*149 271*	*51 554*	*266 856*	*93 499*	*127 265*	*274 671*	*155 244*	*111 584*	*1 229 944*
5. Female condom distribution Rate	Quarterly Rate per female	3	0.3	0.6	0.2	0.5	0.2	0.4	0.3	0.7
Female condoms distributed	*No*	*462 659*	*16 860*	*151 833*	*21 335*	*70 885*	*67 371*	*59 867*	*34 589*	*885 399*
Population 15 years and older female	*Population*	*155 112*	*52 329*	*274 464*	*96 162*	*130 890*	*281 610*	*159 671*	*114 763*	*1 265 001*

Indicator	Type	South Central	South West	Umlazi /Ngonyameni	Lower South	North Central	Greater Inanda	Inner West	Outer West	District Average
6. Medical male circumcision performed – Total	Quarterly No	9 097	1 045	9 755	422	4 199	3 385	2 438	1 393	31 734
7. TB client treatment success rate	Quarterly %	78.8%	78.1%	87.8%	84.9%	79.5%	81.9%	85.3%	75.9%	81.3%
TB client successfully completed treatment	*No*	*1 559*	*385*	*869*	*382*	*1 794*	*1 551*	*1 433*	*742*	*8 715*
TB client start on treatment	*No*	*1 978*	*493*	*990*	*450*	*2 257*	*1 894*	*1 679*	*978*	*10 719*
8. TB client lost to follow up rate	Quarterly %	9.8%	8.3%	3.9%	5.3%	10.1%	8.1%	4.8%	5.4%	7.1%
TB client lost to follow up	*No*	*193*	*41*	*106*	*24*	*228*	*153*	*81*	*53*	*879*
TB client start on treatment	*No*	*1 978*	*493*	*2 723*	*450*	*2 257*	*1 894*	*1 679*	*978*	*12 452*
9. TB client death Rate	Annual %	3.3%	6.5%	3.9%	4.9%	4%	3.9%	4.6%	4.8%	3.8%
TB client died during treatment	*No*	*66*	*32*	*39*	*22*	*90*	*73*	*78*	*47*	*469*
TB client start on treatment	*No*	*1 978*	*493*	*990*	*450*	*2 257*	*1 894*	*1 679*	*978*	*10 719*
10. TB MDR confirmed treatment start rate	Annual %	100%								100%
TB MDR confirmed client start on treatment	*No*	*896*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*896*
TB MDR confirmed client	*No*	*896*								*896*

Indicator	Type	South Central	South West	Umlazi /Ngonyameni	Lower South	North Central	Greater Inanda	Inner West	Outer West	District Average
11. TB MDR treatment success rate	Annual %	54%								54%
TB MDR client successfully treated	*No.*	*581*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*581*
TB MDR confirmed client start on treatment	*No.*	*896*								*896*

Table 31 (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	143 113	220 892	275 510	306 116	356 602	427 166	497 650	1 192 247
2. Clients tested for HIV (incl ANC)	DHIS calculates	Quarterly No	646 705	597 923	672 457	709 478	746 427	828 534	919 673	-
3. TB symptom 5 yrs and older screened rate	DHIS	Quarterly %		2.6%	2.5%	4%	5%	7%	10%	-
Client 5 years and older screened for TB symptoms	*TB Register*	*No.*	*Not Reported*	*250 630*	*248 475*	*388 635*	*497 004*	*724 325*	*1 079 678*	*-*
PHC headcount 5 years and older	*DHIS calculates*	*No.*	*8 876 786*	*9 548 931*	*9 847 790*	*9 715 887*	*9 940 073*	*10 347 496*	*10 796 776*	*-*
4. Male condom distribution Rate	DHIS calculates	Quarterly Rate per male	5	10	21	30	33	37	41	63

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
Male condoms distributed	*DHIS/Stock cards*	*No*	*6 230 566*	*11 995 770*	*25 574 947*	*37 383 519*	*41 650 290*	*47 305 906*	*53 101 478*	*212 000 000*
Population 15 years and older male	*DHIS/Stats SA*	*Population*	*1 197 817*	*1 213 997*	*1 229 944*	*1 245 933*	*1 262 130*	*1 278 538*	*1 295 158*	*3 370 510*
5. Female condom distribution Rate	DHIS calculates	Quarterly Rate per female	0.2	0.4	0.7	1.1	1.5	1.9	2.4	-
Female condoms distributed	*DHIS/Stock cards*	*No*	*293 063*	*446 532*	*885 399*	*1 458 098*	*1 943 313*	*2 491 069*	*3 184 373*	*-*
Population 15 years and older female	*DHIS/Stats SA*	*Population*	*1 235 248*	*1 250 254*	*1 265 001*	*1 280 180*	*1 295 542*	*1 311 089*	*1 326 822*	*-*
6. Medical male circumcision performed – Total	DHIS / MMC register	Quarterly No	11 119	35 080	31 734	31 834	222 824	270 629	Not available	1 097 577
7. TB client treatment success rate	ETR.Net calculates	%	80.2%	78%	81.3%	84%	>85%	>85%	>85%	85%
TB client successfully completed treatment	*TB Register*	*No*	*10 633*	*8 564*	*8 715*	*9 889*	*10 796*	*11 012*	*11 232*	*32 257*
TB client start on treatment	*TB Register*	*No*	*13 253*	*11 016*	*10 719*	*11 751*	*12 701*	*12 955*	*13 214*	*37 949*
8. TB client lost to follow-up rate	ETR.Net calculates	Quarterly%	7.9%	7.8%	7.1%	6.0%	5%	5%	5%	-
TB client lost to follow up	*TB Register*	*No*	*1 053*	*859*	*879*	*705*	*635*	*648*	661	-
TB client start on treatment	*TB Register*	*No*	*13 253*	*11 016*	*12 452*	*11 751*	*12 701*	*12 955*	*13 214*	-
9. TB client death Rate	ETR.Net calculates	Annual %	4.3%	4.3%	3.8%	3.7%	<5%	<5%	<5%	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
TB client died during treatment	*TB Register*	*No*	*566*	*472*	*469*	*436*	*635*	*648*	*660*	*1 140*
TB client start on treatment	*TB register*	*No*	*13 253*	*11 016*	*12 452*	*11 751*	*12 701*	*12 955*	*13 214*	*28 500*
10. TB MDR confirmed treatment start rate	ETR.Net calculates	Annual %	100%	100%	100%	100%	100%	100%	100%	100%
TB MDR confirmed client start on treatment	*TB Register*	*No*	*719*	*696*	*896*	*1 276*	*1 299*	*1 884*	*2 734*	-
TB MDR confirmed client	*TB Register*	*No*	*719*	*696*	*896*	*1 276*	*1 299*	*1 884*	*2 734*	-
11. TB MDR treatment success rate	EDR calculates	*Annual %*	*35%*	*21%*	54%	55%	57%	59%	61%	*61%*
TB MDR client successfully treated	*EDR Register*	*No*	*379*	*235*	*581*	*702*	*740*	*1 112*	*1 668*	-
TB MDR confirmed client start on treatment	*EDR Register*	*No*	*719*	*696*	*896*	*1 276*	*1 299*	*1 884*	*2 734*	-

Table 32 (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	1 068	1 099	1 720	2 163	2 055	1 952	1 854
	2. MDR-TB Six month interim outcome	EDR.Net calculates	Annual %	44%	30%	26%	35%	40%	50%	60%
	Number of clients with a negative culture at 6 months who started treatment for 9 months	*EDR Register*	*No*	*459*	*276*	*149*	*746*	*810*	*962*	*1 097*

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
	Total patients who started treatment in the same period	*EDR Register*	*No*	*1 053*	*913*	*573*	*2 132*	*2 025*	*1 924*	*1 828*
	3. Number of patients that started XDR-TB treatment	ETR.Net calculates	Annual No	169	230	183	274	268	259	248
	4. XDR-TB Six month interim outcome	EDR.Net calculates	Annual %	25%	30%	12%	22%	30%	40%	50%
	Number of clients with a negative culture at 6 months who started treatment for 9 months	*EDR Register*	*No*	*43*	*70*	*21*	*60*	*80*	*104*	*124*
	Total patients who started treatment in the same period	*EDR Register*	*No*	*169*	*230*	*183*	*274*	*268*	*259*	*248*
	5. TB incidence (per 100 000 population)	ETR.Net	Annual No per 100,000	289	355	448	678	529	485	441
	New TB infections	*ETR.Net*	*No*	*9 839*	*12 186*	*15 522*	*23 695*	*18 623*	*17 213*	*15 778*
	Total population	*DHIS/Stats SA*	*Population*	*3 408 192*	*3 436 241*	*3 464 202*	*3 492 349*	*3 520 557*	*3 549 074*	*3 577 821*
	6. HIV incidence (annual)	ASSA2008	Annual %	4.4%	3.8%	3.7%	-	3.5%	3.3%	3.1%
	7. STI treated new episode incidence (annualised)	DHIS calculates	Quarterly No per 1000	72 per 1000	67 per 1000	63 per 1000	60 per 1000	58 per 1000	53 per 1000	48 per 1000
	STI treated new episode	*DHIS/Tick register PHC/ casualty*	*No*	*181 261*	*169 536*	*156 974*	*152 680*	*148 345*	*137 250*	*125 855*
	Population 15 years and older	*DHIS/Stats SA*	*Population*	*2 516 309*	*2 516 309*	*2 494 944*	*2 526 113*	*2 557 672*	*2 589 627*	*2 621 980*
	8. TB (new pulmonary) defaulter rate	ETR.Net calculates	%	8%	9%	11%	6%	<5%	<5%	<5%

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
	TB(new pulmonary)treatment defaulter	*TB Register*	*No*	*1 053*	*1 035*	*1 353*	*747*	*635*	*648*	*661*
	TB(new pulmonary)client initiated on treatment	*TB Register*	*No*	*13 253*	*11 381*	*12 452*	*11 751*	*12 701*	*12 955*	*13 214*
	9. TB AFB sputum result turn-around time under 48 hours rate	ETR.Net calculates	%	66%	60%	73%	79%	85%	85%	85%
	TB AFB sputum result received within 48 hours	*TB Register*	*No*	*199 547*	*220 547*	*230 908*	*162 271*	*281 059*	*295111*	*309 868*
	TB AFB sputum sample sent	*TB Register*	*No*	*302 913*	*367 428*	*314 912*	*205 288*	*330 658*	*347 190*	*364 550*
	10. TB (new pulmonary) cure rate	ETR.Net calculates	%	67.8%	66%	75%	76%	80%	82%	85%
	TB (new pulmonary) client cured	*TB Register*	*No*	*8 980*	*7 511*	*9 276*	*8 950*	*10 161*	*10 623*	*11 232*
	TB (new pulmonary) client initiated on treatment	*TB Register*	*No*	*13 253*	*11 381*	*12452*	*11 751*	*12 701*	*12 955*	*13 214*

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

Strategies	*Activities*
1. Increase Advocacy of TB Adherence	- Increase Advocacy and awareness by: o Roll out of TB information to all health care workers within the facilities o Involvement of the management in advocacy and awareness o Increase awareness and screening in Hotspot areas (including informal settlements)
2. Reduce TB Drug Resistance	- Implement and monitor decentralized management of MDR TB - Active screening for drug resistance TB - Initiation of TB treatment within 5 days of diagnoses - Active case finding and screening of all contacts for 2 years
3. Improve data quality particularly for HAST	- Improve the quality of data through regular usage and closer monitoring - Facility information meetings to review the HIV/TB data - Conduct performance reviews at all levels - Conduct regular data verification of the ETR and DHIS at all levels
4. Expand the HIV Counselling and Testing Campaign (HCT)	- Collaborate with institutions of higher learning to conduct HCT campaigns such as Hlolamanje Zivikele Campaign, First Thing First and Graduate Alive - Conduct HCT in Taxi rank, Harbour and in all HTA sites - Increase the number of patients receiving PICT across facilities
5. Sustain ART programme and monitor treatment outcomes	- Allocate roving teams in the facilities to monitor treatment failure - Improve the management of adverse drug reactions - Complete mentorship for nurses trained on NIMART to reach full capacity in ARV Management for both Adult and Paediatrics. - Optimize the use of existing functions of TIER. Net
6. Strengthen HIV/TB integration	- Facilitate the implementation of HIV/TB integration in facilities - Increase number of HIV/TB co-infected patients who started ARV - Increase access to Isoniazid Prophylaxis Treatment - Close monitoring of IPT policy implementation - Increase of Screening of TB in Pregnant women
7. Upscale Male Medical Circumcision Campaign	- Promote neonatal circumcision through sensitization particularly of young parents - Explore the possibility of male circumcision by trained nurses through task shifting - Continuing engagement / collaboration with traditional leaders and circumcision practitioners - Create demand for MMC in the 15-49 male population through advocacy and collaboration with stakeholders and partners
8. Scale up interventions in High Transmission Areas.	- Identify new HTA sites (extend to include Farms, Tertiary Institutions, truckers and taxi ranks.) - Collaborate with identified high transmission areas to provide services
9. Increase condom distribution	- Improve the coordination and distribution of condoms - Involve NGOs and non-medical institutions in condom distribution - Promote female condom usage - Improve the recording and reporting of condom distribution

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

15.1 PROGRAMME OVERVIEW

The purpose of this programme is to implement interventions/activities including the following: SRH with special focus on Family Planning (Tubal ligations; IUCD's & sub dermal implants); promotion of early ANC booking; improving skilled birth attendance by establishment of Maternity waiting homes & EMS Harmonisation, ESMOE; Improving Child survival though KINC, Phila Mntwana, RED Strategy & KMC and intensifying management of PMTCT (including paediatric art initiation. Implementation of CARMMA will improve the quality of care for antenatal, intra partum & post natal women & children thus ameliorating their morbidity & mortality. This involves collaboration between hospitals, specialists' clinical teams, MOU's, mobile units, care givers, specialised Family health teams, & community IMCI. Integral to this programme is the identification of malnourished children at community level through Phila Mntwana. This programme is concomitant with nutrition supplementation. Furthermore the programme also prioritises integration of TB, HIV (PMTCT) & ANC. Early ANC initiation is considered as the corner stone of the programme in order to reduce maternal deaths.

STRATEGIC CHALLENGES

Maternal Health

Maternal deaths were highest in South Central, South West and Umlazi districts as most deaths occur at regional hospitals (King Edward, MGMH, PMMH and RK Khan. Strategic challenges include:

- Late ANC booking
- Low contraception up-take resulting in un-planned pregnancies
- Poor TB Screening for pregnant women

Child Health

- Inadequate TB screening of children
- Poor identification of malnourished and HIV exposed children
- Inadequate identification of children eligible for HAART

Table 33 (NDoH 22): Situational Analysis Indicators for MCNWH & N – 2013/14 Financial Year

Indicator	Type	South Central	South West	Umlazi /Ngonyameni	Lower South	North Central	Greater Inanda	Inner West	Outer West	District Average
1. Antenatal 1st visit before 20 weeks rate	Quarterly %	28%	37%	49%	57%	48%	49%	47%	53%	52%
Antenatal 1st visit before 20 weeks	*No*	*3 452*	*1 372*	*3 740*	*1 426*	*2 367*	*3 696*	*2 836*	*2 476*	*42 087*
Antenatal 1st visit total	*No*	*12 165*	*3 684*	*7 629*	*2 512*	*4 885*	*7 530*	*6 036*	*4 703*	*80 464*
2. Proportion of mothers visited within 6 days of delivering their babies	Quarterly %	28%	33%	42%	826%	362%	78%	92%	476%	70.0%
Mother postnatal visit within 6 days after delivery	*No*	*4 800*	*2 314*	*5514*	*2 099*	*6 131*	*10 353*	*5 890*	*3 671*	*40 469*
Delivery in facility total	*No*	*17 277*	*6 975*	*13 117*	*254*	*1 693*	*13 293*	*6 427*	*772*	*57 768*
3. Antenatal client initiated on ART rate	Annual %	88%	82%	52%	84%	80%	70%	75%	87%	73%
ANC client started on ART	*ART Register*	*3 014*	*929*	*2 697*	*902*	*2 861*	*2 866*	*2 036*	*1 654*	*16 959*
ANC client eligible for ART initiation	*ART Register*	*3 418*	*1 129*	*5 220*	*1 073*	*3 568*	*4 106*	*2 711*	*1 899*	*23 124*
4. Infant 1st PCR test positive around 6 weeks rate	Quarterly %	2%	2%	1%	2%	1%	2%	1%	1%	1.3%
Infant 1st PCR test positive around 6 weeks	*No*	*41*	*32*	*39*	*22*	*23*	*68*	*33*	*23*	*301*
Infant 1st PCR test around 6 weeks	*No*	*2 544*	*1 413*	*4 683*	*1 279*	*3 019*	*4 507*	*3 041*	*2 024*	*22 699*

Indicator	Type	South Central	South West	Umlazi /Ngonyameni	Lower South	North Central	Greater Inanda	Inner West	Outer West	District Average
5. Immunisation coverage under 1 year (annualised)	Quarterly %	162%	197%	103%	82%	101%	92%	106%	97%	92%
Immunised fully under 1 year new	*No*	7 784	4 835	15 445	3 309	7 143	11 028	8 147	5 784	63 113
Population under 1 year	*No*	4 798	2 450	14 998	4 032	7 041	12 025	7 669	5 948	68 632
6. Measles 2nd dose coverage	Quarterly %	143%	173%	100%	72%	89%	81%	95%	97%	85%
Measles 2nd dose	*No*	*6 847*	*4 244*	*14 925*	*2 912*	*6 281*	*9 797*	*7 280*	*5 751*	*58 037*
Population 1 year	*No*	4 798	2 450	14 998	4 032	7 041	12 025	7 669	5 948	*68 632*
7. DTaP-IPV-HepB-Hib 3 - Measles 1st dose drop-out rate	Quarterly %	-85%	-77%	-77%	-87%	-88%	-89%	-89%	-84%	-84%
DTaP-IPV-HepB-Hib 3 to Measles1st dose drop-out	*No*	*1 115*	*1 061*	*3 652*	*442*	*876*	*1 175*	*899*	*971*	*10 191*
DTaP-IPV-HepB-Hib 3rd dose	*No*	*7 752*	*4 604*	*15 613*	*3 330*	*7 299*	*11 064*	*8287*	*6 115*	*64 064*
8. Child under 5 years diarrhoea case fatality rate	Quarterly %	1%	1%	0%	0%	0%	2%	8%	0%	1.4%
Child under 5 years with diarrhoea death	*No*	*8*	*3*	*3*	*0*	*0*	*7*	*17*	*0*	*33*
Child under 5 years with diarrhoea admitted	*No*	*743*	*360*	*680*	*0*	*95*	*328*	*212*	*0*	*2 321*
9. Child under 5 years pneumonia case fatality rate	Quarterly %	6%	0%	1%	0%	1%	2%	8%	0%	3.0%

Indicator	Type	South Central	South West	Umlazi /Ngonyameni	Lower South	North Central	Greater Inanda	Inner West	Outer West	District Average
Child under 5 years pneumonia death	*No*	*37*	*1*	*4*	*0*	*1*	*5*	*17*	*0*	*59*
Child under 5 years pneumonia admitted	*No*	*646*	*228*	*623*	*0*	*68*	*235*	*215*	*0*	*1 984*
10. Child under 5 years severe acute malnutrition case fatality rate	Quarterly %	2%	4%	8%	0%	0%	14%	8%	0%	5.9%
Child under 5 years severe acute malnutrition death	*No*	*6*	*1*	*15*	*0*	*0*	*8*	*10*	*0*	*45*
Child under 5 years severe acute malnutrition admitted	*No*	*281*	*26*	*188*	*0*	*1*	*59*	*133*	*0*	*765*
11. School Grade R screening coverage	Quarterly %	-	-	-	-	-	-	-	-	-
School Grade R learners screened	*No.*									
School Grade R learners - total	*No.*									
12. School Grade 1 screening coverage	Quarterly %	-	-	-	-	-	-	-	-	-
School Grade 1 learners screened	*No.*									
School Grade 1 learners - total	*No.*									
13. School Grade 8 screening coverage	Quarterly %	-	-	-	-	-	-	-	-	-

Indicator	Type	South Central	South West	Umlazi /Ngonyam eni	Lower South	North Central	Greater Inanda	Inner West	Outer West	District Average
School Grade 8 learners screened	*No.*									
School Grade 8 learners - total	*No.*									
14. Couple year protection rate	Quarterly %	78%	41%	24%	18%	27%	29%	29%	29%	32%
Contraceptive years dispensed	*No*	*60 522*	*11 997*	*44 486*	*11 500*	*23 996*	*53 993*	*30 508*	*24 280*	*287 967*
Population 15-49 years female	*No*	*77 289*	*29217*	*181 589*	*63 621*	*86 596*	*183 289*	*105 417*	*84 729*	913 577
15. Cervical cancer screening coverage (amongst women)	*Quarterly %*	188%	169%	46%	61%	86%	71%	73%	93%	80%
Cervical cancer screening in women 30 years and older	*No*	*14 457*	*4 905*	*8 228*	*3 862*	*7 416*	*12 866*	*7 674*	*7 857*	*66 857*
Population 30 years and older female/10	*No*	*7 681*	*2 904*	*18 047*	*6 321*	*8 607*	*18 216*	*10 476*	*8 420*	*83 513*
16. Human Papilloma Virus Vaccine 1st Dose coverage	Annual %	-	-	-	-	-	-	-	-	85%
HPV vaccine Grade 4 girls	*No*	-	-	-	-	-	-	-	-	*24 426*
Grade 4 girls (multiply by 2)	*No*	-	-	-	-	-	-	-	-	*28 736*
17. Vitamin A dose12 – 59 months coverage	Quarterly %	87%	61%	65%	70%	57%	54%	50%	56%	63.8%
Vitamin A dose 12 - 59 months	*No*	*35 711*	*21 252*	*84 249*	*24 262*	*34 337*	*55 464*	*32 925*	*28 565*	*317 083*

Indicator	Type	South Central	South West	Umlazi /Ngonyameni	Lower South	North Central	Greater Inanda	Inner West	Outer West	District Average
Population 12-59 months (multiplied by 2)	*No*	*41 266*	*34 690*	*129 088*	*34 690*	*60 582*	*103 496*	*65 988*	*51 194*	*497 120*
18. Maternal mortality in facility ratio	Annual No per 100K	220 per 100K	191 per 100K	292 per 100K	0 per 100K	0 per 100K	86 per 100K	32 per 100K	0 per 100K	172 per 100K
Maternal death in facility	*No*	*37*	*13*	*35*	*0*	*0*	*10*	*2*	*0*	*97*
Live birth in facility	*No*	*16 837*	*6 823*	*11 992*	*255*	*1 686*	*11 624*	*6 236*	*766*	*56 083*
19. Early neonatal death in facility rate	Annual Per 1 000	10.0	13.2	8.2	0	5.3	8.4	2.4	2.6	9.4
Death in facility 0-7 days	*No*	*169*	*90*	*99*	*0*	*9*	*142*	*15*	*2*	*526*
Live birth in facility	*No*	*16 838*	*6 823*	*11 992*	*255*	*1686*	*11 624*	*6 236*	*766*	*56 220*

Table 34 (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 %	39%	45%	52%	53%	56%	60%	64%	*60%*
Antenatal 1st visit before 20 weeks	*DHIS / Tick register PHC*	*No*	*27 075*	*32 395*	*42 087*	*37 958*	*41 008*	*45 535*	*50 216*	*140 402*
Antenatal 1st visit total	*DHIS calculates*	*No*	*69 236*	*71 369*	*80 464*	*71 438*	*73 229*	*75 891*	*78 463*	*234 003*
2. Proportion of mothers visited within 6 days of delivering their babies	DHIS	Quarterly %	61.1%	69.0%	70.0%	66%	69%	72%	75%	74.4%

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
Mother postnatal visit within 6 days after delivery	*DHIS / Tick Register PHC*	*No*	36 294	40 850	40 469	40 232	43 846	50 327	57 667	151 711
Delivery in facility total	*DHIS / Delivery register*	*No*	59 346	59 213	57 768	60 675	63 545	69 899	76 889	203 910
3. Antenatal client initiated on ART rate	DHIS calculates	Annual %	-	-	73%	90%	90%	90%	90%	-
ANC client started on ART	*ART Register*	*No*	-	-	16 959	18 075	20 784	22 939	23 256	-
ANC client eligible for ART initiation	*ART Register*	*No*	-	-	23 124	20 101	23 093	25 488	25 840	-
4. Infant 1st PCR test positive around 6 weeks rate	DHIS	Quarterly %	6%	1.8%	1.3%	1.2%	1.1%	1.0%	<1.0%	<1.0%
Infant 1st PCR test positive around 6 weeks	*DHIS / Tick register PHC*	*No*	1 295	419	301	261	248	236	224	905
Infant 1st PCR test around 6 weeks	*DHS / Tick Register PHC*	*No*	21 580	23 262	22 699	22 620	22 545	23 600	22 400	90 535
5. Immunisation coverage under 1 year	DHIS	Quarterly %	108%	95%	92%	105%	96%	97%	98%	96.3%
Immunised fully under 1 year new	*DHIS / Tick register PHC*	*No*	70 637	64 369	63 133	62 448	56 459	58 187	59 553	*207 619*
Population under 1 year	*DHIS / Stats SA*	*No*	65 140	67 892	68 632	59 593	58 812	59 987	60 768	*215 481*
6. Measles 2nd dose coverage	DHIS	Quarterly %	96%	85%	85%	97%	95%	95%	95%	-
Measles 2nd dose	*DHIS / Tick register PHC*	*No*	*62 621*	*57 862*	*58 037*	*58 040*	*55 871*	*56 988*	*57 729*	-
Population under 1 year	*DHIS / Stats SA*	*No*	*65 140*	*67 892*	*68 632*	*59 593*	*58 812*	*59 987*	*60 768*	-

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
7. DTaP-IPV-HepB-Hib 3 - Measles 1st Dose drop-out rate	DHIS	Quarterly %	-	-	-84%	-90%	-80%	-80%	-80%	-
DTaP-IPV-HepB-Hib 3 to Measles1st dose drop-out	*DHIS / Tick register PHC*	*No*	*-*	*-*	*10 191*	*6 897*	*14 638*	*15 370*	*16 138*	*-*
DTaP-IPV-HepB-Hib 3rd dose	*DHIS / Tick register PHC*	*No*	*-*	*-*	*64 064*	*69 705*	*73 190*	*76 850*	*80 692*	*-*
8. Child under 5 years diarrhoea case fatality rate	DHIS	Quarterly %	3.0%	4.2%	1.4%	1.8%	1.0%	1.0%	1.0%	3.2%
Child under 5 years with diarrhoea death	*DHIS / Tick register*	*No*	*66*	*66*	*33*	*48*	*27*	*32*	*37*	*329*
Child under 5 years with diarrhoea admitted	*Admission Records*	*No*	*2 175*	*1 590*	*2 321*	*2 679*	*2 716*	*3 177*	*3 717*	*10 224*
9. Child under 5 years pneumonia case fatality rate	DHIS	Quarterly %	1.8%	1.0%	3.0%	2.9%	2.5%	2.0%	1.5%	2.4%
Child under 5 years pneumonia death	*DHIS / Tick register*	*No*	*50*	*19*	*59*	*74*	*64*	*67*	*65*	*227*
Child under 5 years pneumonia admitted	*Admission records*	*No*	*2 780*	*1 806*	*1 984*	*2 531*	*2 579*	*3 353*	*4 359*	*9 199*
10. Child under 5 years severe acute malnutrition case fatality rate	DHIS	Quarterly %	3.2%	4.0%	5.9%	6.6%	5.5%	5.0%	4.5%	8.7%
Child under 5 years severe acute malnutrition death	*DHIS / Tick register*	*No*	*40*	*34*	*45*	*61*	*55*	*65*	*76*	*310*
Child under 5 years severe acute malnutrition admitted	*Admission records*	*No*	*1 258*	*836*	*765*	*921*	*995*	*1 293*	*1 681*	*3 533*
11. School Grade R screening coverage	DHIS	Quarterly %	-	-	-	14%	20%	25%	30%	-
School Grade R learners screened	*DHIS / Tick register SHS*	*No.*	-	-	-	*6 076*	*8 784*	*11 089*	*13 440*	-

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
School Grade R learners - total	*DHIS / DoE database*	*No.*	-	-	-	*43 483*	*43 918*	*44 357*	*44 801*	-
12. School Grade 1 screening coverage	DHIS	Quarterly %	-	-	-	27%	35%	40%	45%	-
School Grade 1 learners screened	*DHIS / Tick register SHS*	*No.*	-	-	-	*18 678*	*24 099*	*27 817*	*31 607*	-
School Grade 1 learners – total	*DHIS / DoE database*	*No.*	-	-	-	*68 174*	*68 855*	*69 543*	*70 238*	-
13. School Grade 8 screening coverage	DHIS	Quarterly %	-	-	-	11%	16%	21%	26%	-
School Grade 8 learners screened	*DHIS / Tick register SHS*	*No.*	-	-	-	6 309	9 796	*14 143*	*19 261*	-
School Grade 8 learners – total	*DHIS / DoE database*	*No.*	-	-	-	55 658	61 224	67 347	74 082	-
14. Couple year protection rate	DHIS	Quarterly %	24%	27%	32%	39%	42%	45%	48%	50%
Contraceptive years dispensed	*DHIS calculates*	*No*	*217 489*	*247 542*	*287 967*	*366 935*	*396 084*	*427 218*	*460 125*	*1464 872*
Population 15-49 years female	*DHIS/Stats SA*	*No*	*889 415*	*901 190*	*913 577*	*938 733*	*943 057*	*949 373*	*958 594*	*2 929 745*
15. Cervical cancer screening coverage (amongst women)	DHIS	*Quarterly* %	81%	81%	80%	78%	83%	85%	88%	80.4%
Cervical cancer screening in women 30 years and older	*DHS / Tick register PHC / Hospital register*	*No*	*65 295*	*66 355*	*66 857*	*66 242*	*70 425*	*73 275*	*77 075*	*188 319*
Population 30 years and older female/10	*DHIS / Stats SA*	*No*	*80 765*	*82 187*	*83 513*	*84 727*	*84 849*	*86 206*	*87 585*	*234 228*
16. Human Papilloma Virus vaccine 1st Dose coverage	DHIS	Annual %	Not reported	Not reported	85%	68%	75%	85%	90%	-

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
HPV vaccine Grade 4 girls	*DHIS / Tick register SHS*	*No*	*-*	*-*	*24 426*	*33 922*	*37 519*	*42 946*	*45 927*	*-*
Grade 4 girls (multiply by 2)	*DHIS / DoE enrolment*	*No*	*-*	*-*	*28 736*	*49 530*	*50 025*	*50 525*	*51 030*	*-*
17. Vitamin A dose12 – 59 months coverage	DHIS	Quarterly %	55.8%	57.9%	63.8%	57%	60%	65%	70%	60%
Vitamin A dose 12 - 59 months	*DHIS / Tick register PHC*	*No*	*269 174*	*284 064*	*317 083*	*293 567*	*302 447*	*332 238*	*362 804*	*1 072 060*
Population 12-59 months (multiplied by 2)	*DHIS / Stats SA*	*No*	*482 566*	*490 374*	*497 120*	*511 830*	*504 079*	*511 136*	*518 292*	*1 786 768*
18. Maternal mortality in facility ratio	DHIS	Annual No per 100K	404	175	172	121	150	150	150	
Maternal death in facility	*DHIS / Midnight census*	*No*	*121*	*102*	*97*	*64*	*84*	*86*	*87*	
Live birth in facility	*DHIS / Delivery register*	*No*	*58 446*	*58 353*	*56 083*	*53 073*	*56 644*	*57 210*	*57 782*	
19. Early neonatal death in facility rate	DHIS	Annual per 1000	8.7	9.6	9.4	12.0	11.5	11.0	10.5	9.5
Death in facility 0-7 days		*No*	*510*	*560*	*526*	*637*	*651*	*629*	*607*	*1 923*
Live birth in facility		*No*	*58 446*	*58 353*	*56 220*	*53 073*	*56 644*	*57 210*	*57 782*	*202 473*

Table 35 (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
1.	1.1 Neonatal mortality in facility rate (annualised)	DHIS calculates	Quarterly Rate per 1000	7.6	8.0	8.5	8.9	8.0	7.5	7.0
	Inpatient death early neonatal	*DHIS/Midnight census*	*No*	*510*	*560*	*602*	*637*	*571*	*542*	*511*
	Population estimated live births	*DHIS/Delivery register*	*No*	*67 094*	*69 929*	*70 691*	*70 895*	*71 454*	*72 223*	*73 005*
2.	2.1 Infant mortality rate	ASSA2008	Annual Rate per 1000	31	28	56	55	50	45	40
3.	3.1 Child under 1 year mortality in facility rate (annualized)	DHIS	Annual Per 1 K	4.6	7.7	18	17	15	12	10
	Inpatient death under 1 year	*DHIS calculates*	*No*	*306*	*537*	*1 277*	*1 209*	*1 072*	*867*	*730*
	Population estimated live births	*DHS calculates*	*No*	*67 094*	*69 929*	*70 691*	*70 895*	*71 454*	*72 223*	*73 005*
4.	4.1 Under 5 mortality rate	ASSA2008	Annual Rate per 1000	16	26	45	49	40	35	30
5.	5.1 Inpatient death under 5 years rate	DHIS	Annual Per 1 K	*Not available*	*Not available*	*48*	*49*	*5.0*	*4.5*	*4.0*
	Inpatient death under 5 years	*DHIS calculates*	*No*	*-*	*-*	*1 545*	*1 583*	*-*	*-*	*-*
	Inpatient separations under 5 years	*DHS calculates*	*No*	*-*	*-*	*31 889*	*31 908*	*-*	*-*	*-*

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
6.	6.1 Child under 5 years diarrhoea with dehydration incidence (annualised)	DHIS calculates	Annual No per 1000	36	19	18	15	15	10	5
	Child under 5 years diarrhoea with dehydration new	*PHC Tick Register*	*No*	*11 110*	*5 929*	*5 842*	*4 738*	*4 819*	*3 255*	*1 649*
	Population under 5 years	*DHIS/Stats SA*	*No*	*306 419*	*313 085*	*317 192*	*315 517*	*321 315*	*325 492*	*329 723*
7.	7.1 Child under 5 years pneumonia incidence (annualised)	DHIS calculates	Annual No per 1000	169	129	98	101	95	90	90
	Child under 5 years with pneumonia new	*PHC Tick Register*	*No*	*51 691*	*40 437*	*30 992*	*31 873*	*30 525*	*29 294*	*29 675*
	Population under 5 years	*DHIS/Stats SA*	*No*	*306 419*	*313 805*	*317 192*	*315 517*	*321 315*	*325 492*	*329 723*
8.	8.1 Child under 5 years severe acute malnutrition incidence (annualised)	DHIS calculates	Annual No per 1000	4.8	4.7	3.7	4.6	4.0	3.5	3.0
	Child under 5 years with severe acute malnutrition new	*DHIS/Tick register PHC*	*No*	*1 474*	*1 459*	*1 176*	*1 464*	*1 285*	*1 139*	*989*
	Population under 5 years	*DHIS/Stats SA*	*No*	*306 419*	*313 085*	*317 192*	*315 517*	*321 315*	*325 492*	*329 723*

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
9.	9.1 Weighing coverage under 1 year (annualised)	DHIS calculates	Quarterly %	-	*59%*	*71%*	*79%*	*80%*	*85%*	*90%*
	Children under 1 year weighed	*DHIS/Tick register PHC/CCG records*	*No*	-	*482 380*	*584 092*	*565 694*	*55 498*	*59 604*	*63 791*
	Population under 1 year	*DHIS/Stats SA*	*No*	-	*62 014*	*60 559*	*59 593*	*69 373*	*70 122*	*70 879*
10.	10.21 Child under 2 years underweight for age incidence (annualised)	DHIS	No per 1000 Annual	Not Reported	Not Reported	17 per 1K	34.9 per 1 000	20 per 1K	15 per 1K	10 per 1K
	Child under 2 years underweight - new (weight between -2SD and - 3SD new)	*DHIS / Tick register PHC*	*No*	-	-	*2 059*	*4 234*	*2 391*	*1 809*	*1 219*
	Population under 2 years	*DHIS / Stats SA*	*No*	-	-	*120 264*	*121 389*	*119 525*	*120 650*	*121 927*
11.	11.1 Deworming dose 12-59 months coverage (annualised)	DHIS	Quarterly %	Not reported	Not reported	49%	54%	60%	65%	70%
	Deworming dose 12-59 months	*Tick Register PHC*	*No.*	-	-	*242 144*	*274 525*	*302 447*	*332 238*	*362 804*
	Population 12-59 months (multiplied by 2)	*DHIS / Stats SA*	*No*	-	-	*497 120*	*511 830*	*504 079*	*511 136*	*518 292*

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
12.	12.1 Measles 1st dose under 1 year coverage (annualized)	DHIS	Quarterly %	109%	95%	93%	107%	98%	98%	98%
	Measles 1st dose under 1 year	*DHIS / Tick register PHC*	*No*	*71 072*	*64 531*	*63 783*	*63 580*	*57 636*	*58 787*	*59 553*
	Population under 1 year	*DHIS / Stats SA*	*No*	*65 140*	*67 892*	*68 632*	*59 593*	*58 812*	*59 987*	*60 768*
	12.2 PCV 3rd dose coverage (annualized)	DHIS	Quarterly %	102%	95%	97%	108%	97%	97%	97%
	PCV 3rd dose	*DHIS / Tick Register PHC*	*No*	*66 583*	*65 983*	*66 523*	*64 249*	*57 048*	*58 187*	*58 945*
	Population under 1 year	*DHIS / Stats SA*	*No*	*65 140*	*67 892*	*68 632*	*59 593*	*58 812*	*59 987*	*60 768*
	12.3 RV 2nd dose coverage (annualised)	DHIS	Quarterly %	120%	105%	105%	116%	98%	98%	98%
	RV 2nd dose	*DHIS / Tick Register PHC*	*No*	*78 374*	*71 010*	*72 272*	*69 083*	*57 636*	*58 787*	*59 553*
	Population under 1 year	*DHIS / Stats SA*	*No*	*65 140*	*67 892*	*68 632*	*59 593*	*58 812*	*59 987*	*60 768*
13.	13.1 Infant given NVP within 72 hours after birth uptake rate [3]	DHIS	Quarterly %	97%	87%	98%	101%	98%	98%	98%

[3] Baby Nevirapine uptake rate

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
	Infant given NVP within 72 hours after birth	*DHIS / Tick register OPD/ PHC, delivery register*	*No*	*21 643*	*18 237*	*20 653*	*22 152*	*21 626*	*22 707*	*23 824*
	Live birth to HIV positive woman	*DHIS / delivery register*	*No*	*22 317*	*21 025*	*21 016*	*22 004*	*22 067*	*23 170*	*24 329*
14.	14.1 Delivery in facility under 18 years rate	DHIS	Annual %	7.6%	8.0%	7.8%	7.7%	7.5%	7.0%	7.0%
	Delivery in facility to woman under 18 years	*DHIS / Delivery register*	*No*	*4 530*	*4 716*	*4 493*	*4 652*	*4 766*	*4 893*	*5 382*
	Delivery in facility total	*DHIS / Delivery register*	*No*	*59 346*	*59 213*	*57 768*	*60 675*	*63 545*	*69 899*	*76 889*
15.	15.1 Infants exclusively breastfed at Hepatitis B 3rd dose	DHIS	Quarterly %	23%	52%	48%	41%	45%	50%	55%
	Infant exclusively breastfed at HepB3rd dose	*Tick register PHC*	*No*	*18 334*	*37 995*	*35 445*	28 964	33 439	37 526	*41 691*
	HepB 3rd Dose	*Tick register PHC*	*No*	*79 367*	*72 431*	*73 573*	69 693	74 309	75 052	*75 802*

15.2 STRATEGIES/ ACTIVITIES TO BE IMPLEMENTED 2015/16

Strategies	*Activities*
1.Increase accessibility of SRH: FP and Cervical Cancer Screening	Monitor integration of Family Planning into HIV and TB services in all departments. Training of all health care personnel i.e. nurses & doctors especially on the methods that provide prolonged protection including emergency contraception Expand the Colposcopy services Improve the adequacy of Cervical Cancer Screening specimens through onsite mentorship
1.1 Increase CTOP	Increase number of accredited sites for CTOP Train Nurses and Doctors on Medical TOP
2. Labour and delivery management	Community advocacy. Identification of pregnant teenagers in & out of school Facilitate implementation of ESMOE Fire drills Ensure availability of dedicated ambulances Strengthening current MOUs to facilitate the decongestion particularly at PMMH Increase the number of deliveries at the MOUs (min 50 per month)
3.Early detection/ treatment of HIV and Improving ANC	Implement PICT at all service points and at each visit Facility to conduct data verification before submitting to district Engage with GPs to provide standardised high quality care during ANC
4.TB management in pregnant women	Increase Pre ART screening and monthly symptom screening Training of all staff on managing TB/HIV
5. MgSO4 - for pre-eclampsia	Provision of guidelines & protocols on pre-eclampsia Onsite coaching & mentoring
6. Clean birth practices	Strengthen implementation of National infection control guidelines
7. Hypertensive disease case management	Onsite mentoring and coaching.
8. Promotion of breastfeeding	Facilitate increase of BFHI facilities. Establish milk banks in the three facilities identified.
10. Therapeutic feeding - for severe wasting	Ensure rolling out of IMAM and ETAT guidelines and promote nutritional screening
11. Antenatal corticosteroids for preterm labour.	Ensure utilisation of the cortico steroids in all facilities conducting deliveries
13. KMC - Kangaroo mother care	Encourage KMC to all babies @ postnatal care (intermittent) and continuous care for all premature infants Increase number of KMC beds, establish a central KMC SITE- Clairwood
13. PMTCT	Implement integration through facility visits. Mother and baby pair to be seen together postnatal
15.Case management of severe neonatal infection	Support and monitor adherence to protocols
16. Oral antibiotics : case management of pneumonia in children	Proper implementation of the IMCI strategy. Conduct ongoing training and update of clinicians.

Strategies	*Activities*
17. Appropriate complementary feeding	Ensure implementation of Community IMCI
	Conduct community awareness
	Onsite mentoring & support
	Strengthen OSS & Phila Mntwana centres

16. DISEASE PREVENTION AND CONTROL (ENVIRONMENTAL HEALTH INDICATORS)

16.1 PROGRAMME OVERVIEW

Environmental Health renders services for the management of Environmental Health which includes Port Health and Hazardous substances as well as providing support for the provision and improvement of environmental health services in order to ensure a safe and healthy environment that support human health. Environmental health service plays a big role in health promotion and prevention programmes. According to the Health Act, 2003, the process of devolution to Municipality has commenced and will be effective as from the 1st July 2015, Environmental Health Services excluding hazardous substances are the responsibility of Metropolitan Municipality within municipal health services. Port Health Services will become the National competency as of 1st July 2015 and Hazardous substance will be retained at Provincial level.

Currently the Environmental health functions are rendered by both Provincial and Municipality with some of the functions remaining the responsibility of Province like the inspection of the state buildings. Health and hygiene remains one of the key components of environmental health services, the main focus being on water and sanitation programmes. This is because many people within the district live in areas where the risk of water and sanitation related diseases is still a problem due to poor access to water and sanitation services and also poor hygiene practices. EThekwini district may be regarded as an urban area but challenges relating to poor sanitation and informal settlements still exist. Some of the key responsibilities for Environmental health include the inspection of food premises which ensures consumption of safe food. Health Education is also given to informal food handlers for the safe and hygienic preparation of food.

In partnership with the University of KwaZulu Natal, as a disease control measure the Local Municipality is currently addressing the concern of antibiotic resistant Sexually Transmitted Infections (STIs) to ensure that these are treated appropriately.

Re- engineering of Primary Health Care provides the opportunity for early identification of chronic illnesses such as hypertension and diabetes in the community using ward based services through OSS. Provincial Department of Health continues to fund Municipality Primary health care to sustain PHC coverage.

STRATEGIC CHALLENGES

- Absence of enabling legislation that allows for effective execution of services.
- Lack of suitable storage areas in the PHC facilities for medical waste, medicines and supplies
- Lack of support staff for waste management officers
- Poor management of waste within the institutions
- Very few surgeons are able to conduct cataract surgery in the district
- There is a need to increase awareness on chronic diseases (hypertension, diabetes, epilepsy) and general health

Table 36 (NDoH 25): Situational Analysis for Disease Prevention and Control - 2013/14 Financial Year

Indicator	Type	South Central	South West	Umlazi /Ngonyameni	Lower South	North Central	Greater Inanda	Inner West	Outer West	District Avg
1. Clients screened for hypertension	Quarterly No	4 421	1 313	9 644	704	2 151	6 401	1 329	1 729	27 692
2. Clients screened for diabetes	Quarterly No	2 479	599	2957	358	695	3 213	653	506	11 458
3. Percentage of people screened for mental disorders	Quarterly %	6.6%	1.3%	1.7%	0.7%	2.0%	2.6%	1.3%	1.7%	2.2%
PHC Client screened for mental disorders	*No*	*52 865*	*5 710*	*43 891*	*6 036*	*24 142*	*67 351*	*16 842*	*20 365*	*237 202*
PHC headcount total	*No*	*796 567*	*428 812*	*2 548 779*	*858 904*	*1 203 872*	*2 542 436*	*1 265 209*	*1 184 600*	10 829 179
4. Percentage of people treated for mental disorders	Quarterly %									New Indicator
Client treated for mental disorders at PHC level	*No*	-	-	-	-	-	-	-	-	-
Clients screened for mental disorders at PHC level	*No*	*52 865*	*5 710*	*43 891*	*6 036*	*24 142*	*67 351*	*16 842*	*20 365*	*237 202*
5. Cataract surgery rate	No per million uninsured population	4542	0	927	0	0	437		0	924
Cataract surgery total	*No*	*1 914*	*0*	*402*	*0*	*0*	*215*	*0*	*0*	*2531*
Population uninsured total	*No*	*421 376*	*165 544*	*433 274*	*110 506*	*381 382*	*491 655*	*429 266*	*338 362*	*2 736 722*
6. Malaria case fatality rate	%									
Malaria death reported	*No*	-	-	-	-	-	-	-	-	-
Number of malaria cases (new)	*No*									

Table 37 (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	40 095	27 876	27 692	28 382	26 328	25 801	25 285	-
2. Clients screened for diabetes	DHIS / Tick register	Quarterly No	-	-	11 458	10 484	10 375	10 266	10 157	-
3. Percentage of people screened for mental disorders	DHIS calculates	Quarterly %	1.5%	1.6%	2.2%	1.4%	1.8%	2.0%	2.3%	-
PHC Client screened for mental disorders	*DHIS / Tick register*	*No*	*158 027*	*171 011*	*237 202*	*160 796*	*198 057*	*230 213*	*264 624*	-
PHC headcount total	*DHIS / Tick Register*	*No*	*10 571 941*	*10 775 282*	*10 829 179*	*10 979 096*	*11 265 782*	*11 355 251*	*11 443 821*	-
4. Percentage of people treated for mental disorders	DHIS Calculates	Quarterly %	-	-	-	*6.8%*	*7.0%*	*7.2%*	*7.5%*	-
Client treated for mental disorders at PHC level	*DHIS / Tick register*	*No*	-	-	-	*16 889*	*20 388*	*24 427*	*29 298*	-
Clients screened for mental disorders at PHC level	*DHIS / Tick register*	*No*	-	-	-	*249 468*	*291 261*	*339 261*	*390 635*	-
5. Cataract surgery rate	DHIS	Quarterly No per 1 mil uninsured population	1029	678	924	884	670	680	690	930

	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
Cataract surgery total	*DHIS / Theatre register*	*No*	*2 759*	*2 380*	*2 531*	*2 440*	*1 863*	*1 907*	*1 950*	*8 895*
Population uninsured total	*DHIS / Stats SA*	*No*	*2 680 948*	*2 709 742*	*2 736 722*	*2 758 956*	*2 781 240*	*2 803 768*	*2 826 478*	*9 566 487*
6. Malaria case fatality rate	Malaria Register	Annual %	0%	0%	0%	0%	0%	0%	0%	<0.5%
Malaria death reported	*Malaria register / Tick register PHC*	*No*	*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*	-

Table 38 (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*

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
	Population	*DHIS/Stats SA*	*Population*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
2.	Hypertension incidence (annualised)	DHIS	Quarterly No per 100	*33*	*22*	24	19	22	25	28
	Hypertension client treatment new	*DHIS / PHC tick registers*	*No*	*32 902*	*22 528*	*25 148*	*19 971*	*24 079*	*28 211*	*32 575*
	Population 40 years and older	*DHIS / Stats SA*	*No*	*986 368*	*1 012 263*	*1 037 708*	*1 061 575*	*1 094 516*	*1 128 446*	*1 163 428*
3.	Diabetes incidence (annualised)	DHIS	Quarterly No per 100	6.5	2.1	2.6	2.4	2.6	2.8	3.0
	Diabetes client treatment new	*DHIS / PHC tick registers*	*No*	*22 341*	*7 154*	*9 219*	*8 339*	*9 153*	*9 937*	*10 731*
	Population total	*DHIS / Stats SA*	*No*	*3 437 113*	*3 474 029*	*3 464 205*	*3 492 349*	*3 520 557*	*3 548 765*	*3 576 973*

16.2 STRATEGIES/ ACTIVITIES TO BE IMPLEMENTED 2015/16

Strategies	Activities
1. Increasing Healthy Lifestyles for all Citizens	Support Healthy Lifestyle Programme for staff in all facilities working with the EAP managers Support staff in implementation of physical activities for government employees in all government facilities. Recruit more senior citizens to the golden games in all municipality wards Sustain golden Wednesday (physical activities) in all communities in the district Collaborate with DSR and NGO for the implementation and sustainability of physical activities
2. Improving Eye Health Services	Appoint sessional Optometrists in CHCs Monitor implementation of the new assistive device policy Support facilities to conduct eye care awareness campaigns in collaboration with Optometrists
3. Improve Cataract Surgeries	Conduct refresher training of cataract surgeons in the district Sustain the district target of conducting 100 cataract surgeries to commemorate world sight day (marathon cataract surgeries in collaboration with NGOs
4. Improve prevention and early detection of Diabetes	Support facilities to conduct awareness campaigns on Diabetes Increase screening of diabetes in patients >35 years Annual Commemoration of world diabetes day by all facilities, to increase community awareness. Conduct 2-3 workshops annually on Diabetes for nursing staff targeting lower categories involved in health promotion and screening of clients
5. Improve prevention and early detection Hypertension	Promoting awareness on the dangers of high salt, and oil intake in communities to decrease incident of newly affected communities Initiate and sustain Support groups in Communities
6. Improve management of Epilepsy, Arthritis and COPD's	Conduct Annual awareness campaigns by all facilities Coordinate workshops on these conditions to promote quality care
7. Reduce obesity	Conduct awareness campaigns on dangers of poor nutrition and obesity Provide individualized counselling for overweight and obese clients

17. INFRASTRUCTURE, EQUIPMENT AND OTHER SUPPORT SERVICES

Table 39 (NDoH 38): Performance Indicators for Health Facilities Management

Indicator	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
1. Expenditure on facility maintenance as % of total district health expenditure	%	1.1%	0.9%	0.9%		1%	1%	1%	-
Numerator		*86 662 852*	*78 242 864*	*80 642 361*					-
Denominator	*Per R'000*	*8 156 377*	*8 700 627*	*9 478 047*					-
2. Number of facilities that have undergone major and minor refurbishment		1	0	0		1	0	0	-
3. Fixed PHC facilities with access to continuous supply of clean portable water	%	100%	100%	100%	100%	100%	100%	100%	-
Numerator		*110*	*110*	*110*	*111*	*111*	*111*	*111*	-
Denominator		*110*	*110*	*110*	*111*	*111*	*111*	*111*	-
4. Fixed PHC facilities with access to continuous supply of electricity	%	96%	96%	96%	97%	100%	100%	100%	-
Numerator		*106*	*106*	*106*	*108*	*111*	*111*	*111*	-
Denominator		*110*	*110*	*110*	*111*	*111*	*111*	*111*	-
5. Fixed PHC facilities with access to sanitation		100%	100%	100%	1000%	100%	100%	100%	-
Numerator		*110*	*110*	*110*	*111*	*111*	*111*	*111*	-
Denominator		*110*	*110*	*110*	*111*	*111*	*111*	*111*	-
6. Fixed PHC facilities with access to fixed telephone line	%	100%	100%	100%	100%	100%	100%	100%	-
Numerator		*110*	*110*	*110*	*111*	*111*	*111*	*111*	-
Denominator		*110*	*110*	*110*	*111*	*111*	*111*	*111*	-
7. Percentage of PHC facilities with network access		7%	7%	7%	7%	11%	20%	30%	-

Indicator	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2015/16
Numerator		*8*	*8*	*8*	*8*	*12*	*22*	*33*	*-*
Denominator		*110*	*110*	*110*	*111*	*111*	*111*	*111*	*-*
8. Number of additional clinics and community health centres constructed		0	0	0	1	0	0	0	-

18. SUPPORT SERVICES

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

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

18.1 PHARMACEUTICAL SERVICES

Table 40 (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)	%	50%	70%	70%	80%	100%	100%	100%	100%
Number of CHC's and District Hospitals with functional Pharmaceutical and Therapeutic Committees		*5*	*7*	*7*	*8*	*10*	*10*	*10*	
Number of District Hospitals and CHC's		*10*	*10*	*10*	*10*	*10*	*10*	*10*	
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*	*0*	*0*	*0*	*0*	

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
Number of ARV's drugs									
3. Any TB Stock Out Rate	%	0%	0%	0%	0%	0%	0%	0%	-
Number of TB drugs out of stock		*0*	*0*	*0*	*0*	*0*	*0*	*0*	-
Number of TB drugs		*6*	*6*	*6*	*6*	*6*	*6*	*6*	-
4. Percentage of Hospitals with Pharmacists	%	100%	100%	100%	100%	100%	100%	100%	100%
Number of District Hospitals with Pharmacists		*2*	*2*	*2*	*2*	*2*	*2*	*2*	
Number of District Hospitals		*2*	*2*	*2*	*2*	*2*	*2*	*2*	
5. Percentage of CHC's with Pharmacists	%	100%	100%	100%	100%	100%	100%	100%	100%
Number of CHC's with pharmacists		*8*	*8*	*8*	*8*	*8*	*8*	*8*	
Number of CHC's		*8*	*8*	*8*	*8*	*8*	*8*	*8*	

Table 41 (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 %	88%	92%	83%	81%	90%	90%	90%

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
	Pharmacies with A or B Grading	*Pharmacy records*	*No*	*23*	*24*	23	21	22	23	*24*
	Number of pharmacies	*Pharmacy records*	*No*	*26*	*26*	26	26	26	26	26
	2. Tracer medicine stock-out rate (PPSD)	Pharmacy records	Quarterly %	0.1%	0.6%	1.8%	1.8%	1.8%	1.7%%	1.6%
	Number of tracer medicine out of stock	*Pharmacy records*	No	*5*	*19*	*60*	***60***	*58*	*57*	*55*
	Total number of tracer medicine expected to be in stock	*Pharmacy records*	No	*3 338*	*3 338*	*3 338*	***3 338***	*3 338*	*3 338*	*3 338*
	3. Tracer medicine stock-out rate (Institutions)	Pharmacy records	Quarterly %	9.0%	6.8%	7.2%	2.4%	2.4%	2.2%	1.9%
	Number of tracer medicines stock out in bulk store	*Pharmacy records*	No	*302*	*226*	*239*	***81***	*80*	*75*	*65*
	Number of tracer medicines expected to be stocked in the bulk store	*Pharmacy records*	No	*3 338*	*3 338*	*3 338*	***3 338***	*3 338*	*3 338*	*3 338*
2.	4. Number of mortuaries rationalized	Management	Annual No	0	0	0	0	0	0	0

18.2 EQUIPMENT AND MAINTENANCE

District Office asset acquisition plan

ITEM DESCRIPTION	FACILITY	QUANTITY	UNIT PRICE	TOTAL COST
Chest Freezer	Phoenix Mortuary	02	R4 000.00	R8 000.00
Bar Fridge	Phoenix Mortuary	01	R1 800.00	R1 800.00
Couch	Phoenix Mortuary	15	R800.00	R12 000.00
Metal chairs (linked 5)	Phoenix Mortuary	20	R3200.00	R64 000.00
Swivel Chairs	Provincial District Office	30	R900.00	R27 000.00
Swivel Chairs	KZN Children Hospital	14	R900.00	R12 600.00
L. Shape office desk	Provincial District Office	30	R4500.00	R135 000.00
L. Shape office desk	KZN Children Hospital	3	R4500.00	R13 500.00
Filling Cabinet	Provincial District Office	10	R1200.00	R12 000.00
Filling Cabinet	KZN Children Hospital	4	R1200.00	R4 800.00
Steel stationery cupboard	Provincial District Office	10	R800.00	R8 000.00
Steel stationery cupboard	KZN Children Hospital	6	R800.00	R4 800.00
Rickstacker Chair	Phoenix Mortuary	20	R600.00	R12 000.00
Double rectangular table	Phoenix Mortuary	10	R800.00	R8 000.00
Round Table	Phoenix Mortuary	1	R5 000.00	R5 000.00
PH Meter	KZN Children Hospital	1	R4 500.00	R4 500.00
Refractometer	KZN Children Hospital	1	R4 500.00	R4 500.00
Specific Gravity Meter	KZN Children Hospital	1	R2 000.00	R2 000.00
Defibrillator	KZN Children Hospital	1	R3 000.00	R3 000.00
Infusion pump	KZN Children Hospital	1	R3 500.00	R3 500.00
Examination bed	KZN Children Hospital	1	R3 600.00	R3 600.00
Office desk	KZN Children Hospital	4	R4 500.00	R18 000.00

Credenza	KZN Children Hospital	2	R2 300.00	R4 600.00
Tables 8 seater (Boardroom)	Phoenix Mortuary	5	R18 000.00	R90 000.00
Visitors Chairs	Provincial District Office	60	R600.00	R36 000.00
Visitors Chairs	KZN Children Hospital	8	R600.00	R4 800

Table 42: 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 %	92.8%	99.7%	94.1%	94%	95%	95%	95%	-
Expenditure on maintenance (preventive and scheduled)	*No*	86 662 438	78 242 864	80 642 361	55 739 007	-	-	-	-
Maintenance budget	*No*	93 349 438	78 494 000	85 701 000	59 416 408	-	-	-	-
2. Proportion of Programme 8 (infrastructure budget) spent on all maintenance (preventative and scheduled)	Annual %	Not available	Not available	Not available	Not available	To be determined	-	-	-
Expenditure on maintenance (preventive and scheduled)	*No*	-	-	-	-	-	-	-	-
Infrastructure budget	*No*	-	-	-	-	-	-	-	-
3. Number of health facilities that have undergone major and minor refurbishments	Annual No.	1	0	0	-	-	-	-	-

18.3 EMERGENCY MEDICAL SERVICES (EMS)

Table 43 (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
eThekwini District	%	0.11	0.12	0.12	0.10	0.13	0.14	0.15	0.32
District Average	%	0.11	0.12	0.12	0.10	0.13	0.14	0.15	0.32

Table 44 (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	
eThekwini District	%	40%	28%	33%	36%	35%	37%	40%	50%
District Average	%	40%	28%	33%	36%	35%	37%	40%	50%

Table 45 (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
eThekwini District	%	7%	5%	4%	5%	5%	7%	10%	22%
District Average	%	7%	5%	4%%	5%	5%	7%	10%	22%

Table 46 (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
eThekwini District	%	28%	31%	30%	31%	31%	32%	33%	37%
District Average	%	28%	31%	30%	31%	31%	32%	33%	37%

*Inter-facility transfer is for operations only and does not include PPT.

19. HUMAN RESOURCES

Table 47 (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
District	**PHC facilities**							
	Medical officers	41	39	44	**51**	**60**	**67**	**74**
	Professional nurses	752	780	965	**1027**	**1105**	**1133**	**1182**
	Pharmacists	37	37	35	**44**	**53**	**61**	**75**
	District hospitals							
	Medical officers	36	35	37	**51**	**57**	**62**	**67**
	Professional nurses	190	197	216	**224**	**231**	**238**	**247**
	Pharmacists	14	18	17	**20**	**24**	**28**	**32**
	Radiographers	13	15	14	**18**	**21**	**24**	**29**

Table 48 (NDoH 33): Plans for Health Science and Training

	INDICATORS	Estimated performance	Medium term targets		
		2014/15	2015/16	2016/17	2017/18
Adult Education and Training	Number Trained	53	30	15	0
Artisan	Number Trained	10	20	20	30
Clinical	Number Trained	75	90	105	115
Computer	Number Trained	100	100	100	100
Customer Service	Number Trained	25	50	50	50
Financial Management	Number Trained	30	50	50	50

	INDICATORS	Estimated performance	Medium term targets		
		2014/15	2015/16	2016/17	2017/18
Grade 12 or equivalent	Number Trained	15	15	20	20
Health and Safety	Number Trained	20	50	50	50
Human Resource Management	Number Trained	8	25	25	25
Leadership and Management development	Number Trained	30	50	50	75
Nursing	Number Trained	300	320	350	380
Mid-level workers	Number Trained	30	45	50	50
Pharmacy	Number Trained	20	20	25	50
Public Service Induction	Number Trained	210	200	150	100
Supply Chain Management	Number Trained	15	25	25	50

20. DISTRICT FINANCE PLAN

Table 49 (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	35 196 948	29 527 572	28 976 316	R 35 909 000	R 35 909 000	R36 000 000	R38 477 000	R40 786 000	R43 233 000
Clinics	507 711 449	501 264 410	571 095 624	R642 610 000	R642 610 000	R704 101 000	R753 000 000	R798 180 000	R846 071 000
Community Health Centers	443 755 312	512 995 601	543 816 308	R612 510 000	R612 510 000	R612 839 000	R655 000 000	R694 300 000	R735 958 000
Community Services	7 433 000	0	0	R0	R0	R0	R0	R0	R0

Other Community	107 452 191	114 802 638	157 124 233	R173 419 000	R173 419 000	R188 632 000	R199 472 000	R211 440 000	R224 127 000
Coroner Services	34 990 775	34 396 401	40 909 000	R 42 915 000	R 42 915 000	R41 925 000	R44 809 000	R47 498 000	R50 347 000
HIV and AIDS	379 507 782	546 229 269	587 498 450	R646 010 000	R646 010 000	R683 069 000	R730 064 000	R773 868 000	R820 300 000
Nutrition	17 042 633	11 450 601	10 819 044	R 11 340 000	R 11 340 000	R12 375 000	R13 226 000	R14 020 000	R14 861 000
District Hospitals	730 818 605	871 864 694	1 005 638 550	R998 076 000	R998 076 000	R1 012 570 000	R1 082 235 000	R 1 147 169 000	R1 215 999 000
Environmental Health Services	20 667 214	21 900 799	29 068 518	R21 425 000	R21 425 000	R28 501 000	R 30 462 000	R32 290 000	R34 227 000
TOTAL	**R2 284 575 909**	**R2 644 431 985**	**R2 974 946 043**	**R3 184 214 000**	R3 184 214 000	R3 320 012 000	R3 546 745 000	**R3 759 551 000**	R3 985 123 000

Table 50 (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	2 030 677 114	2 452 462 663	2 654 652 640	2 879 000 000	2 879 000 000	2 958 826 852	3 162 395 000	3 352 138 000	3 553 266 000
Compensation of employees	1 392 634 639	1 608 275 562	1 774 662 719	1 935 334 000	1 935 334 000	1 922 434 905	2 054 699 000	2 177 980 000	2 308 659 000
Goods and services	638 142 475	844 187 101	879 989 389	943 666 000	943 666 000	1 036 389 487	1 107 693 000	1 174 155 000	1 244 604 000
Transfers and subsidies to	230 776 695	175 013 933	306 009 534	301 016 000	301 016 000	346 050 088	369 858 000	392 050 000	415 573 000
Payments for capital assets	23 092 086	16 952 382	14 283 869	4 198 000	4 198 000	7 651 970	8 178 000	8 669 000	9 190 000
Total economic classification	2 284 545 895	2 644 428 978	2 974 946 043	3 184 214 000	3 184 214 000	3 312 528 908	3 540 431 000	3 752 857 000	3 978 029 000

PART C: LINKS TO OTHER PLANS

21. CONDITIONAL GRANTS

The conditional grant HIV/AIDS allocation has increased by 8.27% in 2013/14 and 14.91 % 2014/15. The budget was not appropriately allocated from a Provincial level to Districts; some sub-programmes of HIV&AIDS did not receive adequate funding therefore Budget Adjustment is necessary. The expenditure increased by 7.56% in 2013/14 and projecting a 14.83 % by end of 2014/15. The following sub-programmes of HIV &AIDS has resulted in the expenditure increasing in 2014/15 as compared to 2013/14. The 354% increase in expenditure under ARV Nutrition programme is due to the price increase of the supplements almost 3 times more expensive. The ARV Therapy programme has increased by 12% due to the increased number of patients pregnant and none pregnant initiated on ARVs and the MMC and VCT programmes by 6%. MMC budget for goods and services patients catering increased due to payment of previous year expenditure in the current budget due to the late submission of supporting documents to necessitate payments.

Table 51 (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*)	The purpose of the HIV/Aids conditional grant is to provide additional and targeted financial resources in order to accelerate the effective implementation of the programme that has been identified as a priority in the 10 point plan of the national Department of Health.	**ART Programme:** • Total number of new adults and children started on ART • Total number of ART patients remaining in care - adult and children (current active)	70 000 407 503
		ART Programme: • Number clients seen at HTA sites (Headcount) • Number of HTA intervention sites(new& old)	30 000 50
		HBC Programme: • Number of active home-based cares receiving stipends • Number of care kits purchased	2 200 12 000

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
		PMTCT Programme:	
		• Antenatal client HIV 1st test	72 000
		• Antenatal client HIV 1st test positive	7 400
		• Antenatal client tested for CD4	20 000
		• Antenatal client initiated on ART	17 000
		• Babies given Nevirapine within 72 hours after birth	21 000
		• Infant 1st PCR test around 6 weeks	23000
		Step Down Care Programme:	
		• Number of Step Down Facilities/Units	1
		• Number of usable beds at Step Down Facilities/Units	12
		HCT Programme	
		• Number of client tested for HIV (including antenatal)	890 092
		• Number of lay counselors receiving salary	415
		MMC Programme	
		• Number of fixed health facilities offering MMC	60
		• Number of medical male circumcisions performed	224 000
		Sexual transmitted Infection Programme	
		• Male Urethral Syndrome (MUS) rate	**4%**
		• Partner treatment rate	**40**

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

Table 52 (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. Impilo Consortium	The PPP contract is about outsourcing of all non-core services.	The Project Company provides the Hospital with medical equipment, information management and technology systems and facilities management services of the highest calibre in order to deliver Clinical Services.	R678, 392	31 January 2017	The Department has initiated two projects in order to ensure the smooth transfer of the responsibilities of the PPP. These projects are: 1. Appointment of consultants to conduct the final works survey 2. Appointment of transactional advisors for the development of the exit strategy. *The Final Works Survey* The terms of reference have been developed and the tender was advertised. The briefing session took place on 4 November 2014. The closing date for the tender is 28 November 2014. *Development of the Exit Strategy* The terms of reference have been finalised for the appointment of the transactional advisors. The Department is finagling the id

Name of PPP or PPM	Purpose	Outputs	Current Annual Budget (R'Thousand)	Date of Termination	Measures to ensure smooth transfer of responsibilities
					documents and will be advertising the tender towards the latter part of November 2014. It is envisaged that the transactional advisors will be appointed by mid February 2015.

NGO/Partner Plan

MATCH 2014/ 2015 Workplan

PROGRAM AREA: HSS

GOAL: Contribute to an effective & sustainable health system capable of responding to HIV and TB.

OBJECTIVE/S: Improve HIV-related Patient Outcomes by Strengthening Health and Patient Management Systems at Facility, Sub-district and District Levels

ACTIVITIES	Indicator	Targets
Improve the quality of services delivered at facilities through Implementation of Ideal Clinic Model		
Conduct In-service training of DOH staff on Ideal clinics	Number of staff trained according to SA Government requirements	At least 2 Staff from 20 facilities
Support Operation Managers to conduct assessments using the Ideal Clinic tool	Number of sites supported to conduct assessments of compliance with SA Government standards	20 facilities assessed in eThekwini
Mentor Operation Managers to draft quality improvement plans to address areas identified in the assessments	Number of sites supported to develop and implement quality improvement plans based on Ideal Clinic Assessments	20 Quality Improvement Plans developed in Ethekwini
Provide on site mentoring for the implementation of the quality improvement plan	Proportion of facilities showing improvement from baseline	At least 75% sites showing improvement from baseline

ACTIVITIES	Indicator	Targets
Improve the clincial quality of pediatric ART services at facilities		
Coduct an assessment on the coverage of NIMART trained nurses	Number of NIMART nurses trained per initiating site	At least 2 Prof Nurses trained on NIMART per initiating site in at least 80% facilities
Mentor professional nurses to complete pediatric component of NIMART	Number of NIMART mentored	70% mentorship completed for relevant staff trained on NIMART
Fast track certification of NIMART using the OSCE method	% Prof Nurses completing mentorship and qualified	70% mentorship completed for relevant staff trained on NIMART
Assess the standard of pediatric ART services at facilities according to South African Guidelines and Policies by conducting annual assessments	Number of sites assessed according to required standards.	50 Facilties assessed in eThekwini
Support facilities to draw up Quality Improvement Plans based on findings from annual assessment	Number of sites supported to develop Quality Improvement Plans	50 Quality Improvement Plans eThekwini
Provide at least monthly mentoring support to facilites to implement quality improvement plan activities	Number mentoring visits to implement Quality Improvement activities/plans (pediatric treatment clinical quality). Proportion of facilities showing improvement from baseline	Monthly visits. At least 80% sites showing improvement from baseline
Mentor Nurses at ART initiating sites to increase TB screening in children on ART	% sites mentored on increasing TB screening in children on ART	70% sites increasing TB screening in children on ART
Mentor ART initiating sites that had a stock-out on paediatric ARVs to improve supply chain reliability	% sites that had a stock out on Paediatric ART	At least 70% of sites that had a stock-out showing improvement from baseline
Conduct bi-annual assessments of pediatric ART treatment failure using standardised tools	Number of sites assessed according to required standards.	50 Facilties assessed in eThekwini
Mentor facilities that have been signed off on TIER.net to generate reports for better montoring of Viral load failure/ defaulters	% TIER signed off facilities mentored on using TIER reports	70% TIER.net signed off facilities using TIER reports
Support facilities to draw up Quality Improvement Plans based on findings from bi-annual assessments	Number of sites supported to develop Quality Improvement Plans	50 Quality Improvement Plans eThekwini
Provide at least monthly mentoring support to facilites to implement quality improvement plan activities for peadiatric treatment failure	Number mentoring visits to implement Quality Improvement activities/plans (pediatric treatment clinical quality). Proportion of facilities with Viral load monitoring systems	At least 80% sites with Viral load monitoring systems

ACTIVITIES	Indicator	Targets
Strengthen routine monitoring of the nutritional status of paediatric patients receiving ART	Number of facilities supported to routinely monitor nutritional status of paediatric patients on ART	50 Facilties assessed in eThekwini
Conduct Inservice training on nutrition and nutrition referal pathways	Number of staff trained on nutrition and nutrition referal pathways. % paediatric ART initiating sites with in-service training on nutrition	At least 2 staff trained per paediatric ART site. 70% paediatric ART sites receiving inservice training
Coordinate quarterly District Task Team Meetings (including DHMT and DCSTs) to review the ART program	Number of district meetings held to review the ART program	4 meetings per district annually
Provide support to the District Health Management Team to set and monitor targets for paediatric services at district, sub-district and facility level	Proportion of paediatrict ART initiating facilities meeting provincial targets	At least 70% paediatric initiating sites meeting at least 70% of provincial targets
Improve the clinical quality of adult ART services at facilities		
Coduct an assessment on the coverage of NIMART trained nurses	Number of NIMART nurses trained per initiating site	At least 2 Prof Nurses trained on NIMART per initiating site
Mentor professional nurses to complete adult component of NIMART	Number of NIMART mentored	70% mentorship completed for relevant staff trained on NIMART
Fast track certification of NIMART using the OSCE method	% Prof Nurses completing mentorship and qualified	70% mentorship completed for relevant staff trained on NIMART
Assess the standard of adult ART services at facilities according to South African Guidelines and Policies by conducting annual assessments	Number of sites assessed according to required standards.	56 Facilties assessed in eThekwini
Support facilities to draw up Quality Improvement Plans based on findings from annual assessment	Number of sites supported to develop Quality Improvement Plans	56 Quality Improvement Plans eThekwini
Provide at least monthly mentoring support to facilites to implement quality improvement plan activities	Number of facilities supported to implement Quality Improvement activities/plans. Proportion of facilities meeting at least 75% of criteria	Monthly visits. At least 75% Adult ART initiating sites showing improvement from baseline
Mentor Nurses at ART initiating sites to increase TB screening in Adult patients on ART	% sites mentored on increasing TB screening in Adult patients on ART	70% sites increasing TB screening in Adult patients on ART
Mentor ART initiating sites that had a stock-out on Adult ARVs to improve supply chain reliability	% sites that had a stock out on Adult ART	At least 70% of sites that had a stock-out showing improvement from baseline

ACTIVITIES	Indicator	Targets
Strengthen Pre-ART Tracking systems and transitioning into care for eligible patients through routine assessments and implementation of Quality Improvement Plans	Number of facilities supported to strengthen Pre-ART tracking systems	56 facilities in eThekwini
Support the implementation of PHDP programs at facilities	Number of facilities supported to implement PHDP	56 facilities in eThekwini
Strengthen routine monitoring of the nutritional status of Adult patients receiving ART	Number of facilities supported to routinely monitor nutritional status of adult patients on ART	56 facilities in eThekwini
Conduct Inservice training on nutrition and nutrition referal pathways	Number of staff trained on nutrition and nutrition referal pathways. % Adult ART initiating sites with in-service training on nutrition	At least 2 staff trained per Adult ART site. 70% Adult ART sites receiving inservice training
Coordinate quarterly District Task Team Meetings (DHMT and DCST) to review the ART program	Number of district meetings held to review the ART program	4 meetings per district annually
Provide support to the District Health Management Team to set and monitor targets for adult services at district, sub-district and facility level	Proportion of Adult Initiating facilities meeting provincial/ district targets for ART	At least 70% Adult initiating sites meeting at least 70% of provincial/ district targets
Improve the clinical quality of TB services at facilities		
Assess the standard of TB services at facilities according to South African Guidelines and Policies by conducting annual assessments	Number of sites assessed according to required standards	57 Facilties assessed in eThekwini
Support facilities to draw up Quality Improvement Plans based on findings from annual assessment	Number of sites supported to develop Quality Improvement Plans	57 Quality Improvement Plans eThekwini
Conduct In-Service training for health care workers on TB management in facilities scoring <75% in the assessment	Number staff trained according to SA Government requirements	At least 2 Prof Nurses per facility scoring <75% in assessment
Provide at least monthly mentoring support to facilites to implement quality improvement plan activities	Number mentoring visits to implement Quality Improvement activities/plans (pediatric treatment clinical quality). Proportion of facilities showing improvement from baseline assessment	Monthly visits. At least 75% sites assessed showing improvement from baseline
Support facilities through a mobile unit to increase paediatric/ adult TB screening through X-Ray Diagnosis as necessary	Number of facilities supported to increase TB screening through X-Ray/ Mobile	Increase # X-Rays done

ACTIVITIES	Indicator	Targets
Monitor implementation of quarterly infection control assessments	Proportion of facilities meeting standards for implementation of TB infection control programs according to guidelines.	At least 80% sites showing improvement from baseline
Support implementation of action plans to address infection control	% sites supported to develop Quality Improvement Plans	At least 80% sites
Mentor ART initiating sites that had a stock-out on TB drugs to improve supply chain reliability	% sites that had a stock out on TB Drugs	At least 70% of sites that had a stock-out showing improvement from baseline
Support the integration of HIV/TB programs through monitoring of CT for TB patients	Proportion of facilities offering CT to TB patients	80% sites offering CT to TB patients
Mentor health care workers to fast-track of Co-infected patients onto ART initiation	Proportion of faciities with >80% Coinfected patients initated on ART	70% sites with CoIntected patients initiated on ART
Support facilities to improve IPT initation rates through routine assessments and mentoring	Number of sites supported on improving IPT initation rates	57 Facilities in eThekwini
Coordinate quarterly District Task Team Meetings to review the TB program	Number of district meetings held to review the TB program	4 meetings per district annually
Provide support to the District Health Management Team to set and monitor targets for TB services at district, sub-district and facility level	Proportion of facilities in district initiating TB care and treatment services according to service planning requirements	At least 70% of sites actively monitoring targets
Improve the clinical quality of PMTCT services at facilities		
Conduct In-Service training for health care workers on PMTCT guideline updates	Number staff trained according to SA Government requirements	At least 2 Prof Nurses from 54 Facilities in eThekwini
Assess the standard of PMTCT services at facilities according to South African Guidelines and Policies by conducting annual assessments	Number of sites assessed according to required standards	54 Facilities assessed in eThekwini
Support facilities to draw up Quality Improvement Plans based on findings from annual assessment	Number of sites supported to develop Quality Improvement Plans	54 Quality Improvement Plans eThekwini
Provide at least monthly mentoring support to facilites to implement quality improvement plan activities	Number of facilities supported to implement Quality Improvement activities/plans. Proportion of facilities meeting at least 75% of criteria	Monthly visits. At least 80% sites showing improvement from baseline

ACTIVITIES	Indicator	Targets
Support the enrollment of HIV positive infants into ART services	Number of facilities support to improve enrollment of infants into ART services	54 Facilities in eThekwini
Support facilities to strengthen tracking systems for pregnant women (incl. HIV positive mothers) through Mom-Connect	% ANC facilities Supported with Mom-Connect	80% facilities supported with Mom-Connect
Coordinate quarterly District Task Team Meetings (DHMT/ DCST) to review the PMTCT program	Number of district meetings held to review the ART program	4 meetings annually
Provide support to the District Health Management Team to set and monitor targets for PMTCT services at district, sub-district and facility level	Proportion of PMTCT facilities meeting provincial/ district targets for PMTCT	At least 80% sites meeting provincial/ district targets for PMTCT
Improve the clinical quality of Prevention services at facilities		
Assess the standard of prevention services and strategies at facilities according to South African Guidelines and Policies by conducting annual assessments	Number of sites assessed according to required standards	58 Facilties assessed in eThekwini
Support facilities to draw up Quality Improvement Plans based on findings from annual assessment	Number of sites supported to develop Quality Improvement Plans	58 Quality Improvement Plans eThekwini
Provide at least monthly mentoring support to facilites to implement quality improvement plan activities	Number of facilities supported to implement Quality Improvement activities/plans. Proportion of facilities meeting at least 75% criteria	Monthly visits. At least 80% sites showing improvement from baselind
Improve condom distribution strategies and uptake across all facilities	Proportion of facilities with increased condom distribution	at least 70% facilities with increased condom distribution
Improve the management of patients on 2nd and 3rd line regimens		
Conduct bi-annual assessments of pediatric and adult ART treatment failure using standardised tools	Number of sites assessed according to required standards.	56 Facilties assessed in eThekwini
Support facilities to draw up Quality Improvement Plans based on findings from bi-annual assessments	Number of sites supported to develop Quality Improvement Plans	56 Quality Improvement Plans in eThekwini
Provide at least monthly mentoring support to facilites to implement quality improvement plan activities for peadiatric and adult treatment failure	Number supported to implement Quality Improvement activities/plans (pediatric treatment clinical quality). Proportion of facilities meeting at least 75% criteria for Viral load monitoring	Monthly visits. At least 70% sites with Viral load monitoring systems in-place

ACTIVITIES	Indicator	Targets
Mentor facilities that have been signed off on TIER.net to generate reports for better montoring of Viral load failure/ defaulters	% TIER signed off facilities mentored on using TIER reports	70% TIER.net signed off facilities using TIER reports
Strengthen Referrals to and from health facilities		
Train CCGs on Ministerial priority project Operation Sukhuma Sakhe to improve quality of home based care (Pending approval)	Number of CCGs trained	At least 80% all CCGs per district
Support the implentation of CCG/ facility referral pathways through mentorship of facility staff	% facilities mentored on use of CCG referral tool	50% facilities that are linked with CCGs showing increased community referrals
Mentor sites to use referral pathways and tools	% facilities mentored on use of CCG referral tool	50% facilities that are linked with CCGs showing increased community referrals
Track use of referral protocol	% facilities mentored on use of CCG referral tool	50% facilities that are linked with CCGs showing increased community referrals
Strengthen service delivery to most at risk populations (MARPs)		
Support district health management team to include most at risk populations in the district health plan and operational plans	Proportion of DHPs that include plans to address key populations, disaggregated by key population	DHP developed
Support quarterly reviews of programmes for MARPs	Number of meetings attended upported to conduct evidence-based planning for service delivery to MARPS	Quarterly meetings
Support Multi Disciplinary Teams to implement quality improvement plans to improve services for MARPs	Number of support visits with MDT to implement Quality Improvement Plan (addressing needs of key populations in service delivery)	Quarterly support visits per district
Monitor service use data for MARP (adolescents, migrants etc)	Number of data reviews on MARPs	Bi-Annual
Support the development and roll out of service delivery innovations		
Strengthen the integration of TB and HIV interventions for paediatric patients and document improved patient outcomes 1) Investigate the paediatric TB screening and HCT pathways 2) Implement on-site QA strategies to improve integration and screening/ detection of HIV or TB in children	Number of sites that demonstrate results in increasing access and uptake of services	1 pilot study/1 pilot study

ACTIVITIES	Indicator	Targets
3) Document innovative cost-effective strategies		
Document roll out of NIMART at PHC facilities and the impact on access to ART 1) Investigate the current coverage of NIMART nurses 2) Determine the impact of NIMART on ART services	% sites that demonstrate results in decentralsing care	At least 60% sites with active decentralised care
Document the roll out of adolescent and transition clinic services & impact on service delivery 1) By Conducting Inservice Training for HCWs on Disclosure and Enhanced Adherence 2) Supporting facilities to create/ actively run support groups for adolescents 3) Coordinate MDT meetings to improve adolescent monitoring and transition	Number of service delivery innovations that demonstrate results in inproving retention and adherence of adolescents	10 facilities eThekwini
Document Innovative approaches to Strengthen the DHIS and Data Usage 1) Investigate current gaps 2) Document methods on Improving data quality and usage	% Sites demonstrating improved Data quality	At least 75% sites showing improvement in data quality
Implement pilot Pregnancy Surveillance Project in eThekwini: 1) To investigate the adverse events rates of Pregnancy outcomes 2) Identify other obstetric, environmental, therapeutic and clinical factors in pregnant women that may contribute to the risk of major congenital anomalies and other adverse birth outcomes. 3) To Support a culture of medicine safety awareness among pregnant women and health staff at sentinel sites and nationally to minimise the likelihood of preventable adverse drug-related pregnancy outcomes and to increase confidence in the medicines used in pregnancy.	Number of sites participating in Pregnancy Surveillience to improve service delivery and improve access to and uptake of HIV related health services	5 Facilities in eThekwini