health

Department:
Health
PROVINCE OF KWAZULU-NATAL

DISTRICT HEALTH PLAN 2014/2015

ETHEKWNI DISTRICT

STATEMENT BY THE HOD

The Head of Department (HOD) should take the opportunity here to personally endorse the DHP, and undertake to provide leadership to ensure the successful implementation and monitoring and evaluation of the plan.

ACKNOWLEDGEMENTS

Insert a paragraph or two recognising and acknowledging members of the planning committee (or task team) and other participants who contributed to the completion of the DHP. The DMT should also acknowledge the politicians who provided leadership to the District. This should be written by the DMT and District Manager.

OFFICIAL SIGN OFF

It is hereby certified that this District Health Plan:

- Was developed by the district management team of **eThekwini** 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 **KwaZulu-Natal.**

_____

Name: District Manager **Signature**

Date: _____

_____

Name: Provincial Manager Responsible for DHS **Signature**

Date: _____

_____

Name: Accounting Officer (HOD) **Signature**

Date: _____

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LIST OF ACRONYMS

Abbreviations	Description
A	
ACSM	Advocacy, Communication and Social Mobilisation
AFP	Acute Flaccid Paralysis
AGSA	Auditor General of South Africa
AIDS	Acquired Immune Deficiency Syndrome
ALS	Advanced Life Support
AMS	Air Medical Services
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
CDC	Communicable Disease Control
CEO(s)	Chief Executive Officer(s)
CFO	Chief Financial Officer
CHC(s)	Community Health Centre(s)
CMAM	Community Based Management of Acute Malnutrition
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	
ECP	Emergency Care Practitioner
ECT	Emergency Care Technician
EHP	Environmental Health Practitioner
EMS	Emergency Medical Services
EPI	Expanded Programme on Immunisation
EPT	Emergency Patient Transport

Abbreviations	Description
ESMOE	Essential Steps in Management of Obstetric Emergencies
ETB.R	Electronic Tuberculosis Register
ETR.net	Electronic Register for TB
F	
FPS	Forensic Pathology Services
G	
G&S	Goods and Services
H	
HAART	Highly Active Ante-Retroviral Therapy
HAST	HIV, AIDS, STI and TB
HCRW	Health Care Risk Waste
HCT	HIV Counselling and Testing
HIV	Human Immuno Virus
HOD	Head of Department
HPS	Health Promoting Schools
HR	Human Resources
I	
IDP(s)	Integrated Development Plan(s)
ILS	Intermediate Life Support
IMCI	Integrated Management of Childhood Illnesses
IPT	Ionized Preventive Therapy
IUCD	Intra Uterine Contraceptive Device
J	
JIT	Just In Time
K	
KZN	KwaZulu-Natal
KZNPSP	KwaZulu-Natal Provincial Strategic Plan for HIV, AIDS, STI and TB
L	
LG	Local Government
M	
M&E	Monitoring and Evaluation
MC&WH	Maternal Child & Women's Health
MDG	Millennium Development Goals
MDR-TB	Multi Drug Resistant Tuberculosis
MEC	Member of the Executive Council
MMC	Medical Male Circumcision
MMR	Maternal Mortality Rate/Ratio
MNC&WH	Maternal, Neonatal, Child & Women's Health
MO	Medical Officers
MOU	Maternity Obstetric Unit
MTEF	Medium Term Expenditure Framework

Abbreviations	Description
MTSF	Medium Term Strategic Framework
MTCT	Mother To Child Transmission
MUAC	Mid-Upper Arm Circumference
N	
NDOH	National Department of Health
NGO(s)	Non-Governmental Organisation(s)
NHI	National Health Insurance
NIMART	Nurse Initiated and Managed Antiretroviral Therapy
NSDA	Negotiated Service Delivery Agreement
O	
OPD	Out-Patient Department
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
PFMA	Public Finance Management Act
PGDP	Provincial Growth and Development Plan
PHC	Primary Health Care
PICT	Provider-Initiated Counselling and Testing
PMSC	Provincial Medical Supply Centre
PMTCT	Prevention of Mother to Child Transmission
PN	Professional Nurse
PPSD	Provincial Pharmaceutical Supply Depot
PPT	Planned Patient Transport
PTB	Pulmonary Tuberculosis
R	
RV	Rota Virus Vaccine
S	
SCM	Supply Chain Management
SHS	School Health Services
SLA	Service Level Agreement
Stats SA	Statistics South Africa
STI(s)	Sexually Transmitted Infection(s)
T	
TB	Tuberculosis
U	
V	

Abbreviations	Description
VCT	Voluntary Counselling and Testing
W	
X	
XDR-TB	Extreme Drug Resistant Tuberculosis
Y and Z	

EXECUTIVE SUMMARY BY DISTRICT MANAGER

Once the DHP is completed, provide a complete summary of all five components namely Service Delivery, Support Services, Infrastructure, Human Resources and Finances of the plan. This should provide the strategic direction on the implementation of the DHP including the main challenges, objectives, indicators and targets set.

Accurately reflect on the performance targets which the **eThekwini district in KwaZulu-Natal** will endeavour to achieve given the resources made available in the budget for **FY14/15.**

PART A - STRATEGIC OVERVIEW

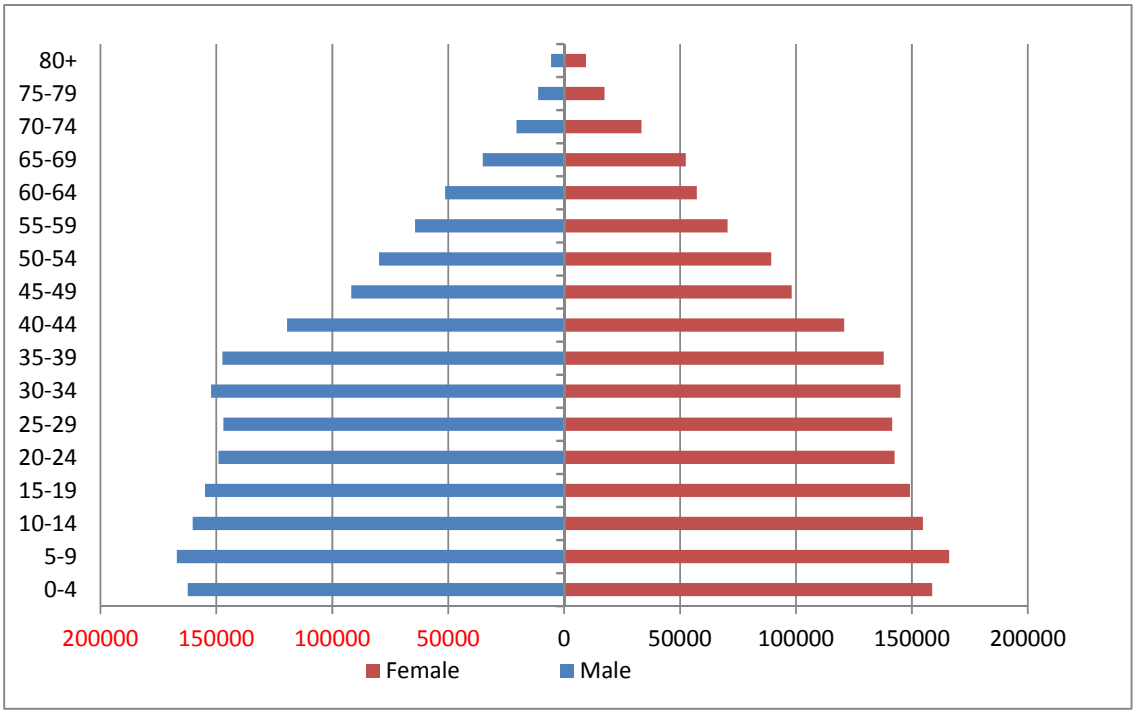
1. SITUATION ANALYSIS

The eThekwini District is a Metropolitan Health District comprising of 103 wards that are urban, rural and peri-rural. The municipal 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.

Data from the 2011 survey indicates the population in the district has largely remained constant with 3 442 361 individuals residing in the district. The greatest concentrations occur in the South Region (41%), followed by North Region (31%) and West Region (28%). Of the 18 PHC Areas, the most densely populated are West 1 (9%) encompassing the formal and informal populations of KwaDabeka and the rural Valley of thousand Hills area, followed by West 2 (Hlengisizwe, Fredville) and West 3 (Kloof, New Germany) with 7%.These PHC Areas have the highest catchment population rates. The least populated PHC Area is North 2 (3%) on the outskirts of KwaMashu. Hospitals are concentrated close to the city centre (South 4) and in the North. Facilities are not equitably distributed, with the South Service Area having fewer hospitals and only one CHC, while the West Sub- district has 2 CHC and the North Sub- district has 5 CHC. PHC Areas serviced largely or entirely by local authority include South 7 (the area around Clairwood Hospital), West 4 (Westville/Reservoir Hills/Pinetown) and South 8 (Chatsworth and surrounds). Resources are also not equitably spread, with lower expenditure in the South than the North and West.

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, and routes focus on central areas and hubs rather than providing access to PHC services located in less central locations. Transport safety and cost is also a concern for individuals seeking health services.

Graph 1: Major demographic characteristics



Source: Midyear population estimates as at 2013. STATSSA

Individuals within the 0-14 year old group comprise of 28% and the 15 - 34 age group is 34% of the total population. The 35- 59 age group comprises of 29% and those 60 years and above comprises of 9%. In terms of gender the municipal population comprises of 49.6% males and 51.4% females. The female population has a longer life expectancy than males as found nationally. The sex ratio for eThekwini population is 96 males per 100 females.

Table 1: District Population 2012/13.

Service Area	SDP Region	Population	% of Total District Population
North/ West	Western SDP Region	± 338 000	9.82%
	Northern SDP Region	±1.15 million	33.61%
South Service Area	Central Region (Urban Core)	± 1.18 million	34.5%
	Southern SDP Region	± 758 00	22.03%
eThekwini District Total		± 3.5 million	100%

Source: eThekwini Municipality 2013/2014 IDP

EThekwini is divided into three large sub-districts – North (with 6 PHC areas), West (with 4 PHC Areas) and South (8 PHC areas). Of the 18 PHC areas, the most densely populated are West 1 (9%) encompassing the formal and informal populations of KwaDabeka and the rural Valley of thousand Hills area, followed by West 2 (Hlengisizwe, Fredville) and West 3 (Kloof, New Germany) with 7%.These sub-districts have the highest catchment population rates. The least

populated PHC area is North 2 (3%) on the outskirts of KwaMashu. Hospitals are concentrated close to the city centre (South 4) and in the North. Facilities are not equitably distributed, with the South having fewer hospitals and only one CHC, while the West has 2 CHC and the North has 5 CHC. Sub-districts serviced largely or entirely by local authority include South 7 (the area around Clairwood Hospital), West 4 (Westville/Reservoir Hills/Pinetown) and South 8 (Chatsworth and surrounds).

Key considerations in terms of service delivery are that cross-border utilisation of services occurs in the district which is seen when one compares total head count (35%) to population (33%) and that eThekwini 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.

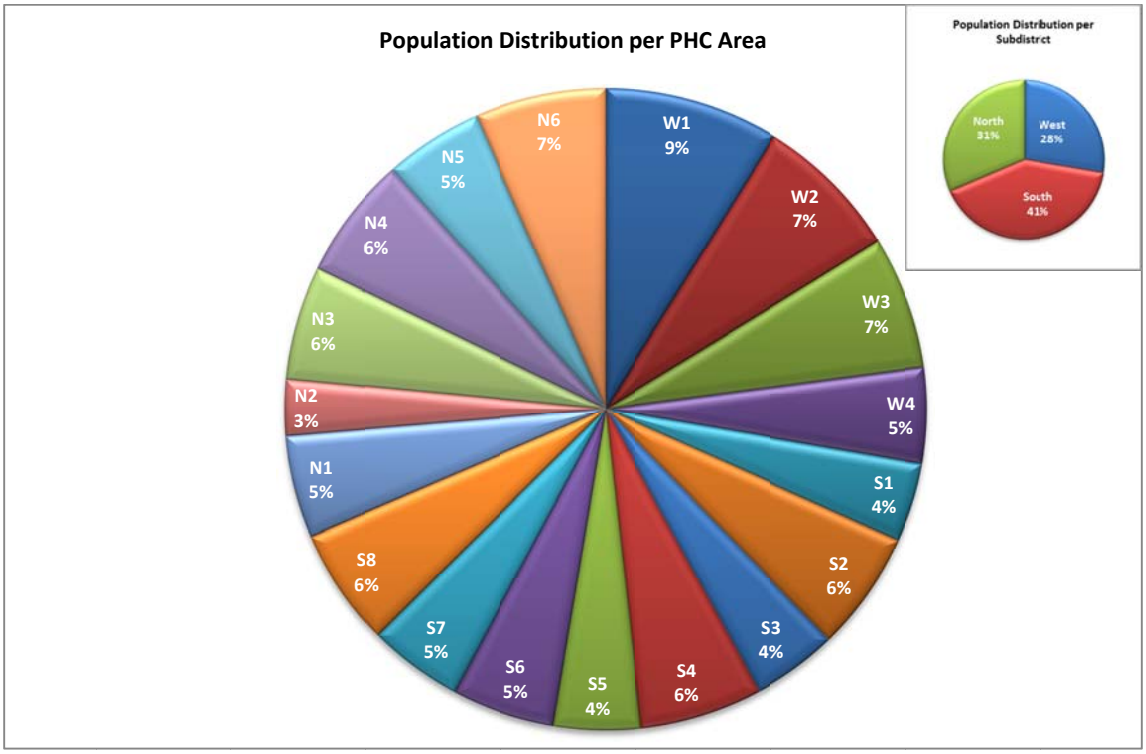
Table 2: District Population 2012/13.

Organisation unit	SD Total Population	SD % pop uninsured[1]	Uninsured Population
W1	315394	82%	258623
W2	265498	82%	217708
W3	239582	82%	196457
W4	171953	82%	141001
S1	142867	82%	117151
S2	217067	82%	177995
S3	155084	82%	127169
S4	220244	82%	180600
S5	157959	82%	129526
S6	185132	82%	151808
S7	169447	82%	138947
S8	214024	82%	175500
N1	185602	82%	152194
N2	102150	82%	83763
N3	205317	82%	168360
N4	221081	82%	181286
N5	177467	82%	145523
N6	237087	82%	194411

Source: DHER 2012/13

[1] Based on APP 2013/14 estimates for eThekwini Uninsured population (82%)

Graph 2: Population distribution per Municipality



Source: DHIS

1.1 SOCIAL DETERMINANTS OF HEALTH

Main causes of Years of Life Lost (YLLs) in the district were due to non-communicable diseases (31.8%), followed by HIV and TB (31.3%), communicable diseases, together with maternal, perinatal and nutritional conditions, (25.5%) ranked third whilst the lowest proportion (11.4%) of YLLs was due to injuries. Females make up 51% of the population while males constitute 49%. 28% of the population is under the age of 19 years (Census 2011). While the official unemployment rates for the district is below the national average at 20.4%, this excludes discouraged job seekers and many job seekers come to eThekwini to look for employment. 54% of the unemployed in the province live in eThekwini. 31% of the population live in poverty. This results in a high reliance on public sector services and increases vulnerability to communicable diseases and non-communicable diseases. In terms of housing, there are 524,582 formal, 103,715 traditional and 317,613 informal households. The high proportion of traditional and informal households has implications for communicable disease transmission and diseases relating to hygiene and sanitation. Literacy rates and education outcomes are improving in the district, but 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.

This population requires preventative services including for prevention of HIV, TB, fertility planning and substance abuse, as well as curative services for communicable and non-communicable diseases both of poverty and lifestyle. There is also a need to address mortality and morbidity rates as a result of violence and other non-disease related causes. 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. Strategic programmes addressing maternal and child health include the School Health, Family Health and District Specialist Teams. Home visits as part of OSS conducted by CCG, 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. 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.

Table 3 (A1): Social Determinants of Health

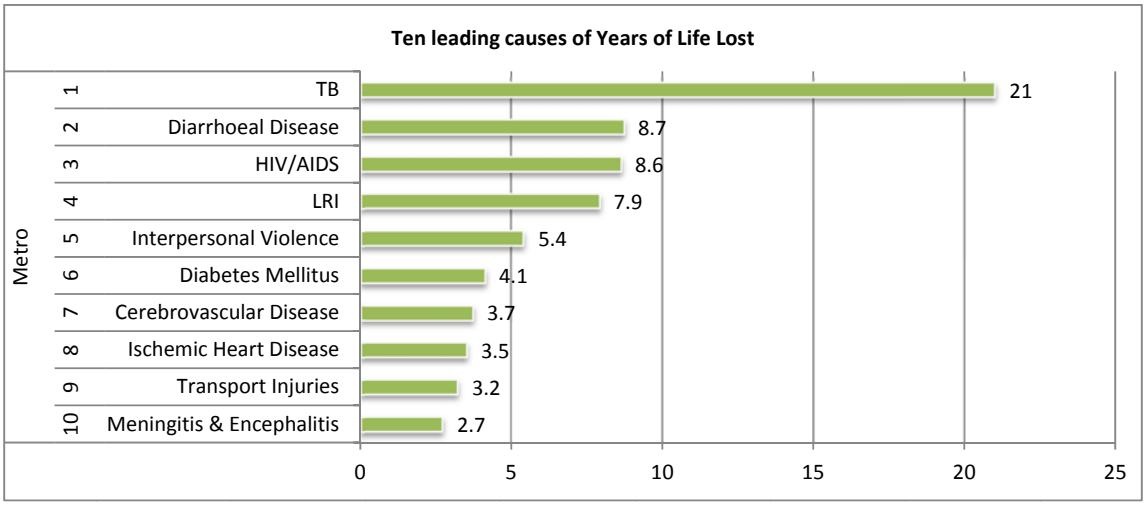
	Data Source	Unemployment rate	Percentage of population living below poverty line of R283 per month	Number of households in Informal dwelling	Number of households in traditional structures	Percentage of Households with access to sanitation	Households with access to potable water	Percentage of Households with access to electricity	Adult literacy rate
eThekwini	EThekwini Municipality 2012/2013 IDP	53.8%	41.8%	317,613	103,715	76%	92,2%	66.3%	84%

Source: IDP 12/13

Unemployment is high in the district. Job opportunities are concentrated in a few industries including seasonal and high risk industries such as agriculture and manufacturing, that impact on health. The portion of the population with access to medical insurance is 18%, which is higher than the provincial average. PHC services need to focus on reaching the population that require free health services and whose health is at risk as a result of their occupation, living environment and socioeconomic status. Access to basic services, although improving, still shows a backlog which has an impact on the health of this community e.g. lack of adequate infrastructure in informal settlements and the rural periphery results in continued high incidence of diarrhoeal diseases at a rate of 165/1000 based on FY 2011/12 DHIS data. The 2011 informal dwelling count within eThekwini Municipality constitutes of 265,542 shacks, 48, 975 backyard dwellings and 3, 096 formal informal dwellings, making a total of 317,613 (2011 Aerial Photography, in IDP 12/13 Plan). In terms of the eThekwini Comprehensive Infrastructure Plan the cost of addressing the backlog (currently estimated to be approximately 412, 000) in housing is in the order of R55 billion; which according to the current funding levels will still not be eradicated by the year 2050. R1. 1 billion is allocated for the financial year 2011/12 (IDP 12/13). 2013/2014 IDP provides the adult illiteracy rate of 16%. Data on literacy rates varied across sources consulted. The eThekwini municipality cited a rate of 64% but no source was provided.

eThekwini has both a burden of communicable, chronic and non-communicable diseases and needs to structure PHC services accordingly. In order to address the social determinants of health, the district will intensify its strategies to reduce incidents of diarrhoea through community outreach programmes utilizing the CCGs and clinical PHC teams and addressing the issues of personal hygiene. Enhanced implementation and monitoring of rehydration corners in health facilities forms part of intensified strategy.

Graph 3: EPIDEMIOLOGICAL (DISEASE) PROFILE OF THE DISTRICT



Source: District Health Barometer 2010/11* No data for 2011/12 available.

Main causes of disease in the district are TB, diarrhoea, HIV, respiratory infections and diabetes. The disease burden includes both communicable and non-communicable diseases. PHC services need to respond to the top causes of mortality and morbidity.

eThekwini has the second highest TB incidence (all cases) in the province at 1 126 per 100,000, which double the national rate of 687 per 100,000. The district has the highest case load of infectious TB in the country. The new smear positive rate is declining but is still higher than the national incidence rate. The TB new smear positive cure rate is 70.8%, below the provincial target. The TB defaulter rate is 8.2%. TB success rate is 76.2% (DHB, 2012/13). Key areas for programming will include addressing the 5 Is.

The 2011 ANC sero-prevalence survey found 38% of pregnant women HIV positive, a decrease from 41% in 2010. Nearly 90% of ANC clients were initiated on ART. Maternity deaths continue to rise in the district. The causes of death and priority strategies will be addressed through PPIP and Maternal Mortality Reviews. The district has the largest ART programme in the country with over 250,000 individuals currently on ART. Although HIV infection in exposed infants at 6 weeks has dropped significantly (1.8%), more attention is needed to following up infants at 18 months and address nutrition and feeding. HIV screening, case finding, treatment and retention in care will be prioritized in the district.

Some improvement has been observed in childhood diarrhoea incidence (18.9 episodes) and fatalities are in line with the national average of 4.3%. Pneumonia incidence has also been reduced, but remains higher than the provincial average. Malnutrition among children under 5 has increased but is below the national average. Vitamin A coverage is the highest in the province at 57%. Strategies to address infant feeding and nutrition will be prioritized in the DHP.

Table 4: (additional Table) Mortality trend data 2010-2013

	2010/11	2011/12	2012/13
Perinatal Mortality	7.1/ 1000	7.2/ 1000	9.4/ 1000
Neonatal Mortality	8.2/ 1000	8.3/ 1000	9.5/1000
Facility Infant Mortality rate (under 1year)	7/1000	4/1000	3/1000
Facility Child Mortality rate (under 5 years)	5/1000	2/1000	2/1000
Facility Maternal Mortality	222/100 000	185/100 000	220/100 000
Maternity Deaths (numbers)	123	127	128
Total number of patients (children and adults) on ART	112375	152149	220892
Patients newly diagnosed with TB	32 852	33 914	33 655

Source: DHIS, ETR. NET

2. DISTRICT SERVICE DELIVERY ENVIRONMENT

DISTRICT HEALTH FACILITIES

2.1.1. PRIMARY HEALTH CARE FACILITIES

Table 5 (A3): PHC facilities per Sub-District as at 31 March 2013

Sub-Districts/ District	Health Posts		Mobile Vehicles		Mobile Points		Satellites		Clinics		CHC	
	LG	P	LG	P	LG	P	LG	P	LG	P	LG	P
W1	5	11		7		38	7		3	5	0	1
W2	8			3		19	7		0	5	0	1
W3							6		4	3	0	0
W4	1	2					1		4	0	0	0
S1									6	4	0	0
S2	5						5		2	4	0	0
S3			1		3				4	1	0	0
S4				4		15			7	3	0	1
S5									0	5	0	0
S6									3	3	0	0
S7									2	0	0	0
S8				1		5	4		7	1	0	0
N1	2		4		0		2		5	1	0	0
N2									1	1	0	0
N3				2		14			1	2	0	1
N4			1	2	0	6	0		1	1	0	2
N5									3	2	0	1
N6			1	3	4	31			6	1	0	1
District	**21**	**13**	**7**	**22**	**7**	**128**	**32**	**0**	**59**	**42**	**0**	**8**

Source: DHIS

The distribution of clinics per population is not well matched. The most heavily populated PHC Area (West 1) has 7 PHC clinics. South 4 and West 3 have 8 PHC clinics each. South 1 has the second lowest population but has 9 clinics. North 4 has the 5th highest population, but only two clinics. In terms of local government facilities, there are now 59 clinics, with 3 satellite clinics being upgraded to clinics. The ratio for clinics (including both provincial and local government) ranges from 0.12 in South 7, to 0.45 in South 4 with an average of 0.29 below the recommended norm of 1: 10,000. The ratio of CHC per 10,000 is even worse, with only 0.02 per CHC. 11 sub-districts have no CHC. North 4 is most well served at 0.09 and West 1 at 0.03. The wards identified as underserved and most deprived include South 2 with ward 100 (Umbumbulu) and 96 (Odidini); Ward 3 (Qadi) in West 1, Ward 1 (Msunduzi Clinic) in West 2, Ward 38 (Lindelani) in North 3, and Ward 53 (Amaoti) in North 5, Cross border service use is likely to be clustered around town centre and informal settlements, particularly in North 3 (KwaMashu area) as well as in areas neighbouring other districts.

There are 32 satellite clinics in the district, all managed by local government, mostly concentrated in the West (66%). There are 29 mobile vehicles in the district, 22 belonging to province and 7 to local government. These service 135 mobile points concentrated mainly in the West (42%), followed by the North (41%) and South (17%). The district is also served by School Health and Family Health Teams. The North/West has 27 SHT and 20 FHT, while the South has 13 SHT and 7 FHT. This is the first year data has been broken down by sub-district and PHC service areas and this has helped to identify areas where equity and access need to be addressed.

Table 6: Provincial Clinic/LG Facility to Population Ratio [per 10 000] – 2012/13

Sub-Districts/ District	PHC facility per pop ratio - Health Post	PHC facilities per pop - Mob Points	PHC facilities per pop ratio - Sat	PHC facilities per pop ratio - Clin	PHC facilities per pop ratio - CHC provincial
W1	0.51	1.20	0.22	0.25	0.03
W2	0.30	0.72	0.26	0.19	0.04
W3	0.00	0.00	0.25	0.29	0
W4	0.17	0.00	0.06	0.23	0
S1	0.00	0.00	0.00	0.70	0
S2	0.23	0.00	0.23	0.28	0
S3	0	0.19	0.00	0.32	0
S4	0	0.68	0.00	0.45	0.05
S5	0	0.00	0.00	0.32	0
S6	0	0.00	0.00	0.32	0
S7	0	0.00	0.00	0.12	0
S8	0	0.23	0.19	0.37	0
N1	0.11	0.00	0.11	0.32	0
N2	0	0.00	0.00	0.20	0
N3	0	0.68	0.00	0.15	0.05
N4	0	0.27	0.00	0.09	0.09
N5	0	0.00	0.00	0.28	0.06
N6	0	1.48	0.00	0.30	0.04
District	**0.9**	**0.38**	**0.09**	**0.28**	**0.02**

Source: DHER 2012/13 Customised District Report Note includes LG and PHC clinics.

Table 7 (A4): District Hospital Catchment Populations 2012/13.

District Hospital	Catchment Population		District Hospital	Catchment Population		District Hospital	Catchment Population
Osindisweni	409 696		McCord	432 060		King Dinizulu	TBC

District Hospital	Catchment Population		District Hospital	Catchment Population		District Hospital	Catchment Population
Wentworth	407 000		St. Mary's (Mariannhill)	507 852			

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

There are five level 1 hospitals including 2 state-aided (St Mary's and McCord) hospitals in the district. State aided hospitals face efficiency and sustainability challenges and are currently being reviewed with McCord in the process of a provincial take over and St Mary's having to draft a three year turnaround strategy. King Dinizulu Hospital has not yet been re-categorised. Going forward it will be split into relevant services (TB, Psychiatric and district services). The DHP will include the referral pathways and services relevant to PHC. Part B will also include how regional hospitals support PHC service delivery. The level 1 hospitals are not equitably distributed and are concentrated in the South and North. Patients requiring these levels of care in other sub-districts often access level 2 hospitals, increasing costs. While the OPD new clients not referred has reduced since 2010/11 from 86.5% to 51.8%, there is still a need to review referral pathways to ensure that PHC services are accessed first. This has cost implications for the district.

TRENDS IN KEY DISTRICT HEALTH SERVICE VOLUMES

2.1.2. PRIMARY HEALTH CARE SERVICE VOLUMES

Table 8 (A5): PHC Headcount Trend

Sub-Districts	2011/12			2012/13			Variation		
	PHC Headcount – Provincial	PHC Headcount – LG	PHC Headcount - Total	PHC Headcount – Provincial	PHC Headcount – LG	PHC Headcount - Total	PHC Headcount - Provincial	PHC Headcount – LG	PHC Headcount - Total
W1	555 236	59713	614949	657693	65473	723166	18%	9.6%	17.6%
W2	678 480	-	678480	772908	-	772908	13.9%	-	13.9%
W3	217 154	144769	361923	269559	166719	436278	24%	15%	20.5%
W4	-	167260	167260	-	212081	212081	-	26.8%	26.8%
S1	650363	202316	852679	655367	221007	876374	0.8%	9.2%	2.8%
S2	662558	57125	719683	709121	72218	781339	7%	26%	8.6%
S3	2661	121738	124399	8282	130909	139191	211%	7.5%	11.9%
S4	231980	454228	686208	227267	**516187**	743454	**2%**	**13.6%**	**8.3%**
S5	898810	-	898810	1149786	-	1149786	**27.9%**	**-**	**27.9%**
S6	489493	115878	605371	488289	129435	617724	**-0.2%**	**11.7%**	**2.0%**
S7	-	83483	83483	-	89459	89459	**-**	**7.1%**	**7.1%**
S8	114823	267559	382382	90941	279319	370260	**-20.8%**	**4.4%**	**-3.2%**
N1	19957	241067	261024	21657	256852	278509	**8.5%**	**6.5%**	**6.7%**
N2	65912	52758	118670	68135	55051	123186	**3.4%**	**4.3%**	**3.8%**
N3	604243	42413	646656	760565	50347	810912	**25.9%**	**18.7%**	**25.4%**

Sub-Districts	2011/12			2012/13			Variation		
	PHC Headcount – Provincial	PHC Headcount – LG	PHC Headcount - Total	PHC Headcount – Provincial	PHC Headcount – LG	PHC Headcount - Total	PHC Headcount - Provincial	PHC Headcount – LG	PHC Headcount - Total
N4	848441	46427	894868	933499	47870	981369	**10%**	**3.1%**	**9.6%**
N5	594587	108699	703286	670884	119841	790725	**12.8%**	**10.2%**	**12.4%**
N6	306450	204629	511079	321983	229616	551599	**5.1%**	**12.2%**	**7.9%**
	6941148	**2370062**	**9311210**	**7805936**	**2642384**	**10448320**	**12.4%**	**11.5%**	**12.2%**

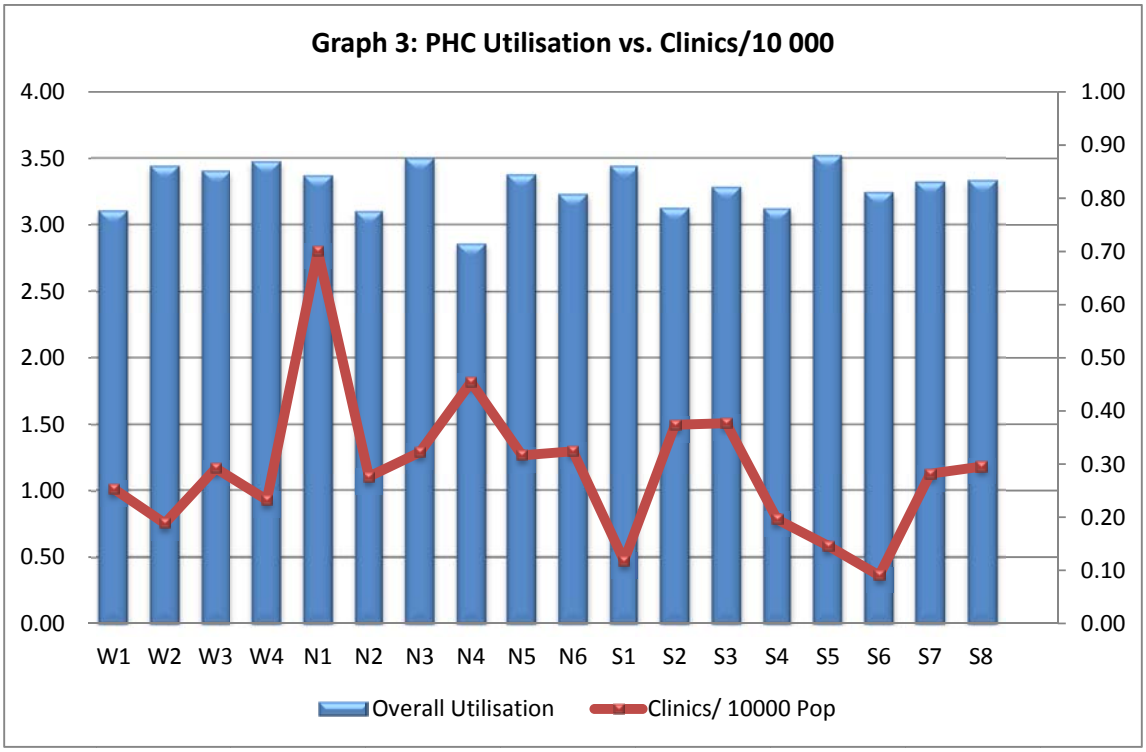
Source: DHIS

Table 9 (A6): PHC Utilisation Rate

	Utilisation Rate		
Name: Sub-District	2011/12	2012/13	Variation
W1	3.2	3.11	-2.8%
W2	3.2	3.44	7.5%
W3	3.2	3.41	6.6%
W4	3.2	3.48	8.8%
S1	3.2	3.37	5.3%
S2	3.15	3.10	-1.6%
S3	2.82	3.50	24.%
S4	2.6	2.86	10%
S5	3.2	3.38	5.6%
S6	3.2	3.23	0.9%
S7	3.2	3.44	24%
S8	3.2	3.13	-2.2%
N1	3.2	3.28	2.5%
N2	3.2	3.12	-2.5%
N3	3.2	3.52	10%
N4	3.2	3.25	1.6%
N5	3.2	3.32	12%
N6	3.1	3.34	7.7%
District Average	**3.14**	**3.29**	4.8%

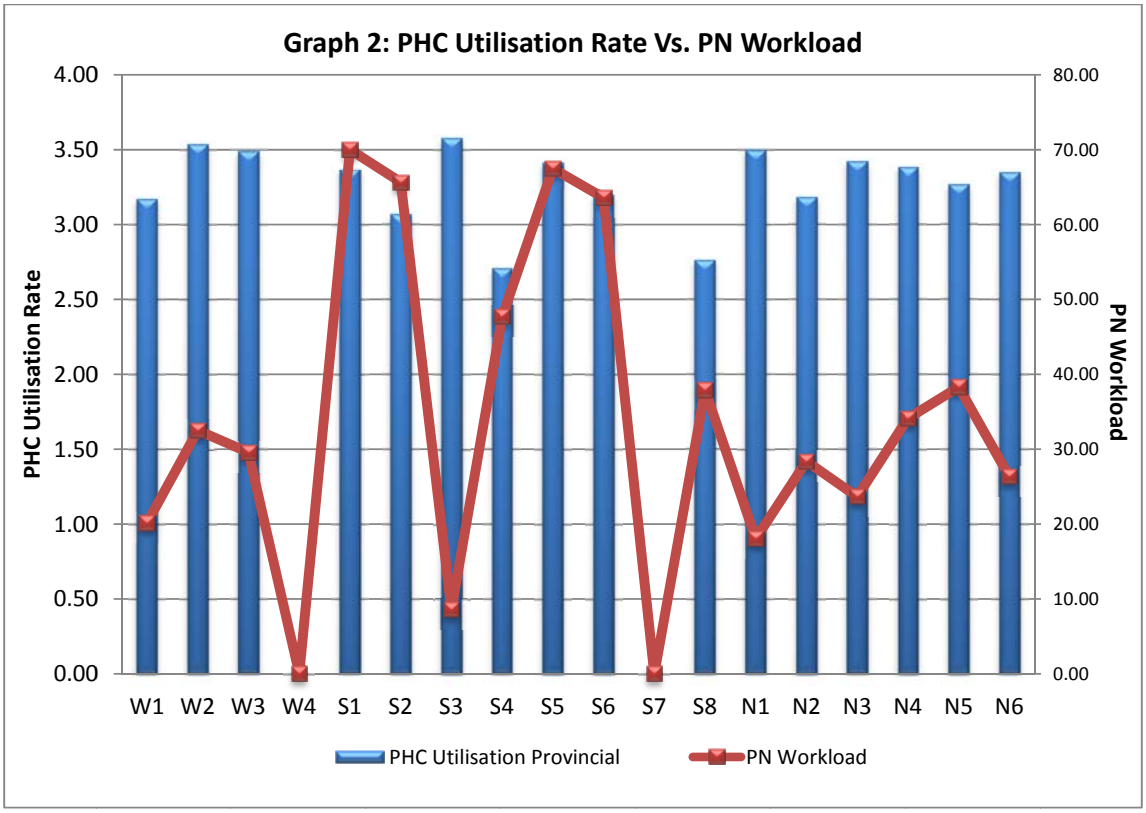
Head count has increased from 8.23 million in 2010/11, to 9.49 million in 2011/12 (15%) to 10, 44 million in the current financial year (10% increase). Projected headcount for 2013/14 was slightly higher at 10,545 400, with actual usage 1% below the projected target. The above table includes data for provincial and local government clinics. PHC utilisation has increased from 2.8 in 2011/12 to 3.14 in 2012/13 to 3.29 in 2013/14. PHC Utilisation rate was projected at 3.3, slightly below the actual rate. The utilisation rate is slightly below the national norm of 3.5 visits. Best performing sub-districts in terms of utilisation are North 3, South 3 and West 4 performing at the national norm. Lowest utilisation rates are in South 4 (2.86), South 2 (3.1) and West 1 (3.11). Three clinics with the lowest utilisation rates (two in South 4) do not offer the full package of services (Commercial City, Beatrice Street) and Overport clinic suffered flood damage and services were moved to another location impacting on head count. The other two PHC Areas with low utilisation rates are largely served by local authority clinics with lower levels of utilisation. The PHC Areas with the highest headcounts are North 3 (1.14m) and South 4 (981,369) and the lowest in North 5 (89,459).

Graph 3: PHC Utilisation vs. PHC facilities per 10 000 Population (Provincial clinics) – 2012/13.



Source: DHIS & DHER 2012/13 Customised District Report

Graph 4: PHC Utilisation rate in relation to PN Workload and PN to Patient Ratio for Provincial Clinics.



Source: DHIS, DHER

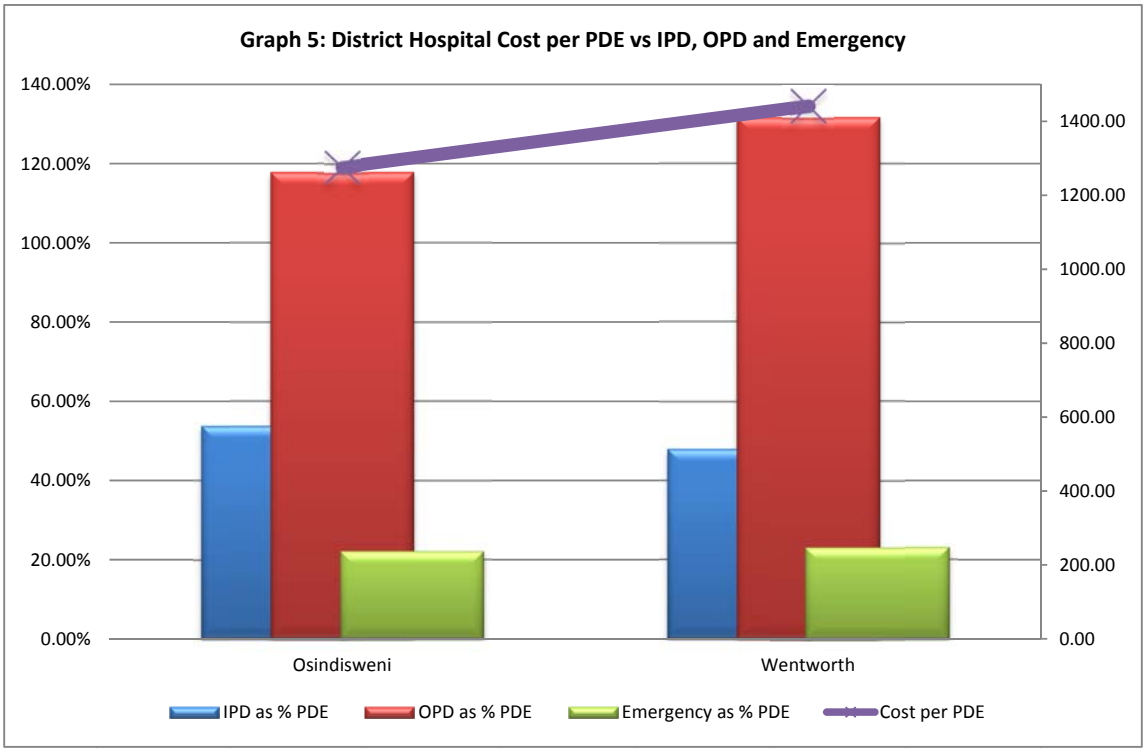
This graph shows only provincial data as no HR and budget information from local government was available. Several PHC Areas have no provincial PHC facilities (South 7, West 4). PN workload is highest in South 1 and South 5 as these PHC Areas have clinics with high headcounts, but low numbers of PN such as Umnini with a workload of 93; Umlazi L (88), Nsimbini (88), U21 (83) and Magabheni (80.5). Further investigation of PHC head count data and the correct linking of staff to facilities will be undertaken to ensure the data are accurately reflecting workload. The absence of a CHC in these districts results in high volumes of clients accessing PHC services. Some of the facilities are also offering 24 hour services using the same staff complement. Further review of 24 hour facilities will be undertaken to better understand usage patterns and optimal staffing levels. Low PN workloads are found in South 3 (Wentworth Gateway), North 1 (Newlands East) and West 1 (Maphephethweni and other rural outlying areas). Other facilities with low PN workloads are Maphephethweni (extremely rural), Halley Stott (24 hours) and one CHC (KwaMashu CHC). A review of KwaMashu CHC is being undertaken to assess efficiency. Facilities with workloads in line with the national norm include Newtown A, Odidini, Addington Gateway, Ntuzuma, Inanda C, R K Khan Gateway, Phoenix, Lindelani, Msunduzi, Clermont and V clinic with workloads of between 32-41 clients. Verulam has both provincial and local authority staff.

Table 10 (A7): District Hospital activities – 2012/13.

District Hospitals	Year	Osindisweni	Wentworth	District
1. IPD	2011/12	81 374	57 141	**138 515**
	2012/13	57033	66040	**123 073**
2. Day patient	2011/12	0	480	**480**
	2012/13	0	2164	**2 164**
3. OPD – new cases not referred	2011/12	40 479	2866	**43 345**
	2012/13	9 966	4737	**14 703**
4. Separations	2011/12	12 055	8 292	**20 347**
	2012/13	9862	9640	**19 502**
5. Inpatient deaths	2011/12	730	667	**1 397**
	2012/13	767	708	**1 475**
6. OPD Headcount (Total)	2011/12	124 290	162 861	**287 151**
	2012/13	124863	180890	**30 5753**
7. Emergency headcounts	2011/12	20 047	28 847	**48 894**
	2012/13	23457	31786	**55 243**
8. PDEs	2011/12	129 486	121 284	**250 770**
	2012/13	95332	125839	**221 171**
9. Cost per PDE	2011/12	R847	R1 306	**R1 076**
	2012/13	1276	1441	**1 359**
10. Caesarean section rate	2011/12	29%	10%	**20%**
	2012/13	30.00%	38.00%	**1 448**
11. ALOS	2011/12	6.8%	6.9%	**6.8%**
	2012/13	5.8	5.7	**5.8**
12. Bed utilisation rate	2011/12	93%	72%	**82%**
	2012/13	65.00%	84.70%	**74.85%**

Source:DHS DHIS

Graph 5: District Hospitals Cost per PDE vs. IPD, OPD and Emergency Headcount



Source: DHER 2012/13 Customised District Report

District hospitals account for 33% of district expenditure. These are only district hospitals in eThekwini in the two PHC Areas – North 6 and South 3. IPD are 53% of PDE for North 6 (Osindisweni) and 48% for South 3 (Wentworth). Emergency accounts for around 22%. OPD rates are 118% for Osindisweni and 132% for Wentworth. The cost per PDE for Osindisweni is R1276, while Wentworth is R1441. Cost drivers at Wentworth include COE and Medicines (TB, ART). Recording on IPD and OPD data will be reviewed as well as the cost per PDE to ensure all costs have been captured. Referral patterns do not seem to be operating optimally at both hospitals and need to be reviewed.

DISTRICT PROGRESS TOWARDS THE ACHIEVEMENT OF THE MDGS

Table 11 (A4): Review of Progress towards the Health-Related Millennium Development Goals (MDGs) and required progress by 2014

MDG GOAL	TARGET	INDICATOR	PROVINCIAL PROGRESS 2009	SOURCE OF DATA	DISTRICT PROGRESS 2009	DISTRICT TARGETED PROGRESS 2014
Goal 1: Eradicate Extreme Poverty And Hunger	Halve, between 1990 and 2015, the proportion of people who suffer from hunger	Prevalence of underweight in children (under 5 years of age)		DHIS	0.5%	0.4%
		Incidence of severe malnutrition in children (under 5 years of age)		DHIS	6.5 per 1 000	4 per 1 000
Goal 4: Reduce Child Mortality	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Under-five mortality rate		DHIS	4 per 1000	2 per1000
		Infant mortality rate		DHIS	5 per 1000	2.3 per 1000
Goal 4: Reduce Child Mortality	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Measles 2nd dose coverage (annualised)		DHIS	95%	100%
Goal 5: Improve Maternal Health	Reduce by three-quarters, between 1990 and 2015, the maternal	Maternal mortality ratio		DHIS	122/100K	120/100K
		Delivery in facility rate (annualised)(Use delivery in facility as proxy indicator)		DHIS	10%	8%

MDG GOAL	TARGET	INDICATOR	PROVINCIAL PROGRESS 2009	SOURCE OF DATA	DISTRICT PROGRESS 2009	DISTRICT TARGETED PROGRESS 2014
	mortality rate					
Goal 6: Combat HIV and AIDS, malaria and other diseases	Have halted by 2015, and begin to reverse the spread of HIV and AIDS	HIV prevalence among 15- to 19-year-old pregnant women		DHIS	40%	35%
		HIV prevalence among 20- to 24-year-old pregnant women		ANC Survey		
		Contraceptive prevalence rate (use Couple year protection rate as proxy)		DHIS	18%	35%
		Proportion of tuberculosis cases detected and cured under directly observed treatment, short-course (DOTS) (cure rate)		ETR.NET	54%	86%

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

The government has agreed on 12 key outcomes as the key indicators for its program of action for the period 2010 to 2014. Relevant to the Health Sector in Outcome 2 which prioritises the improvement of the health status of the entire population and therefore contribute to the Governments' vision of "A Long and Healthy life for All South Africans". To realise this vision, government has identified four strategic outputs which the Health Sector must achieve and these are:

- Output 1: Increasing life expectancy;
- Output 2: Decreasing Maternal and Child Mortality;
- Output 3: Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis; and
- Output 4: Strengthening Health System Effectiveness – with a focus on:
  - Revitalisation of Primary Health Care;
  - Health Care Financing and Management;
  - Human Resources for Health;
  - Quality of Health and the Accreditation of Health Establishments;
  - Health Infrastructure; and
  - Information, Communication & Technology and Health Information Systems.

Table 12 (A5): District and Provincial Contribution towards the achievements of the four NSDA Outputs

Provincial Priorities for 2013/14	District Priorities for 2013/14	Planned District Strategies and activities	Target (Required district performance by 2014/15
OUTPUT 1: INCREASING LIFE EXPECTANCY			
	PHC Re-engeneering	• Develop and implement proposed district demarcation model • Focus services on areas of high demand using information from community profiles and DHIS information. • Increase integration of community and facility services through outreach teams • Implement Integrated School Health Programme in collaboration with other sectors • Scale up Integrated Healthy Lifestyle Strategy • Establish and maintain Phila Mntwana Centers	
	Improve Quality and Clinical Governance	**Implementation of the National Core Standard to improve:**	
OUTPUT 2: DECREASING MATERNAL AND CHILD MORTALITY			
	Reduce Maternal and Child Mortality	**Early ANC initiation and diagnosis before 20/40** • Engage communities through Family Health Teams to mobilize women for ANC and institutionalize early booking policy. • Conduct clinical audits on re testing in clinics	

Provincial Priorities for 2013/14	District Priorities for 2013/14	Planned District Strategies and activities	Target (Required district performance by 2014/15
		• Increase Couple year protection rate • Monitor if trained PNs achieve their targets on provision of various contraceptive methods especially targets for IUCDs insertions and TLs. **Integration of HIV and TB care in maternal care** Facilitate implementation of "one stop shop" (maternal, TB and HIV Services provided comprehensively) in line with existing HIV and TB guidelines. • On- site monitoring and coaching • Monthly Data Reviews	
		Upscale antibody testing at 18months • Conduct Update training for PNs and ENs on PMTCT Guidelines, and monitor performance (clinical audits and data reviews).	
OUTPUT 3:COMBATING HIV AND AIDS AND DECREASING THE BURDEN OF DISEASE FROM TUBERCULOSIS			
	Reduce TB incidence and improve TB outcomes	**Maximize TB Infection Control in Community and in health facilities** • Education of Communities by the Outreach Teams and through Operation Sukuma Sakhe • Actively monitor implementation of Infection Control Policy in facilities	
		Active TB case finding	

Provincial Priorities for 2013/14	District Priorities for 2013/14	Planned District Strategies and activities	Target (Required district performance by 2014/15
		• Identify suspects at community/household level using the TB screening tool by FHTs • Improve diagnosis of TB in children	
		Integration of HIV and TB care in all programmes Identify and implement feasible integration models • Joint Planning meetings at district level • Joint Facility support visits	
		Decentralize MDR Management to community level • Appointment of community based injection teams	
		Scale -up ARV initiation to HIV/TB co-infected patients Facilitate implementation of "one stop shop" (maternal, TB and HIV Services provided comprehensively) in line with existing HIV and TB guidelines. • On- site monitoring and coaching • Data reviews	
		Improve identification and tracking of loss to follow up patients on ART • Optimally utilize TIER. NET reporting system to identify patients with early missed appointments • Use of Family Health Teams to follow patients at community level.	
		Scale up ARV paediatric uptake	

Provincial Priorities for 2013/14	District Priorities for 2013/14	Planned District Strategies and activities	Target (Required district performance by 2014/15
		• Increase identification of HIV exposed/infected children • Closely monitor the outcomes of NIMART trained and mentored nurses/doctors • Offer every child HIV Testing • Provide on-site coaching of service provider on IMCI case management • Re-orientate service providers on HIV testing guidelines	
		Accelerate HIV prevention efforts • Increase facility access to MMC for neonates and older men • Institutionalize HCT policy in every service point (including hospital wards) • Closely monitor recording and reporting of condom distribution • Ensure that sexual assault survivors timeously receive Post Exposure Prophylaxis-with special focus on Children • Collaborate and support activities on HTA sites.	
OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVENESS **Revitalisation of Primary Health Care**			
	Improve access to PHC services	• **Monitor the quality of PHC indicators** • **Improve access to areas with high demand**	

Provincial Priorities for 2013/14	District Priorities for 2013/14	Planned District Strategies and activities	Target (Required district performance by 2014/15
		• **Improve quality and rate of supervision**	
OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVENESS **Health Care Financing and Management**			
	Financial Turn-Around Strategy to align with Clean Audit 2014/15	• Strengthen Financial Management and Accountability	
		• Improve and strengthen alignment between budget/s and service delivery plans	
		• Strengthen Supply Chain Management System	
		• Stringent monitoring of institutions to improve turnaround times and compliance	
OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVENESS **Human Resources for Health**			
OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVENESS **Quality of Health and the Accreditation of Health Establishments**			
	Improve quality of health and the Accreditation of Health	• **Accredit at least one clinic in the South Service Area and one in the North& West**	

Provincial Priorities for 2013/14	District Priorities for 2013/14	Planned District Strategies and activities	Target (Required district performance by 2014/15
	Establishments	**Service Area**	
		• **Accredit at least four (4) schools in eThekwini District**	
OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVENESS **Health Infrastructure**			
	Align Infrastructure Plans with STP and Provincial Infrastructure Plan.	• Implement Infrastructure plan in line with the STP	100%
	Deliver new clinical infrastructure in line with the STP and approved Infrastructure Programme Implementation Plan (IPIP) - address infrastructure backlogs.	• Accelerate development of infrastructure plan for the proposed new clinics and MOUs	100% identified new clinics and MOUs built
	Upgrade and renovate existing clinical infrastructure in accordance with the STP and approved IPIP.	• Accelerate development of infrastructure plan for the proposed new clinics and MOUs	100% projects completed

OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVENESS **Information, Communication &Technology and Health Information Systems**			
	Improve Information Management through M &E	Improve Quality of data • Develop, implement and monitor data improvement plan	

		Use information for planning as evidence.	
OUTPUT 5: REDUCE NON-COMMUNICABLE DISEASES, VIOLENCE AND TRAUMATIC INJURIES			

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

The eThekwini Metropolitan Municipality in KwaZulu-Natal has estimated medical scheme coverage of between 18% and 20.5%, the highest in the province (APP, District Health Barometer, 2013).

Achievements

- Achieved 1.3%, proportion of district health expenditure on district management which was the third lowest in the province and below the provincial and national averages of 2.1% and 5.8% respectively (DHB, 2013).
- Achieved a 32.2% expenditure on district hospital services, the second lowest provincially. (DHB, 2013).
- The expenditure per patient day equivalent (PDE) at R1 348 is the lowest in the province and well below the national average of R1 823. (DHB, 2013).
- The antenatal 1st visit before 20 weeks rate increased from 39.1 in 2011 to 45.3% in 2012/13, in line with the provincial rate of 46.4% and higher than the national rate of 44%. (DHB, 2013).
- The immunization coverage under 1 year was 94.7%, in line with the national coverage of 94.0%
- Change of Medical Model Approach to Primary Health Care approach which resulted in improvement of PHC utilization rate for both children under 5 (5.3% and adults 3.2%).
- Appointment of community care givers integrated into Operation Sukuma Sakhe which provide much needed education, health awareness and early identification of diseases
- Appointment of Family Health Teams and School Health Teams
- Increased HIV testing rate for pregnant women
- Increased immunisation and Vitamin A coverage.
- Decline in ANC sero-prevalence rate to 38%
- Increase in number of males medically circumcised
- Increase in TB cure rate from 35% to 62%
- Infrastructure development and maintenance has improved with the clinic maintenance and upgrading programme.

Challenges

- The distribution of clinics per population is not well matched, for example the most heavily populated PHC Area (West 1) has 7 PHC clinics. South 4 and West 3 have 8 PHC clinics each. South Service Area though having the highest population of 41% compared to West and North, 28% and 31% respectively.

- Facility mortality rate has increased from 174.8 per 100 000 live births in 2011/12 to 220/100 0000 in 2013.
- EThekwini Caesarian section rate of 37.0% is the second highest in the province and above the national rate of 20.8% (DHB, 2013).
- The TB incidence of all cases is 1 126.4 per 100 000 people and is the second highest provincially and nationally. The district remains with the highest case load of infectious case load in the country (DHB, 2013).

INTRA DISTRICT EQUITY IN THE PROVISION OF SERVICES

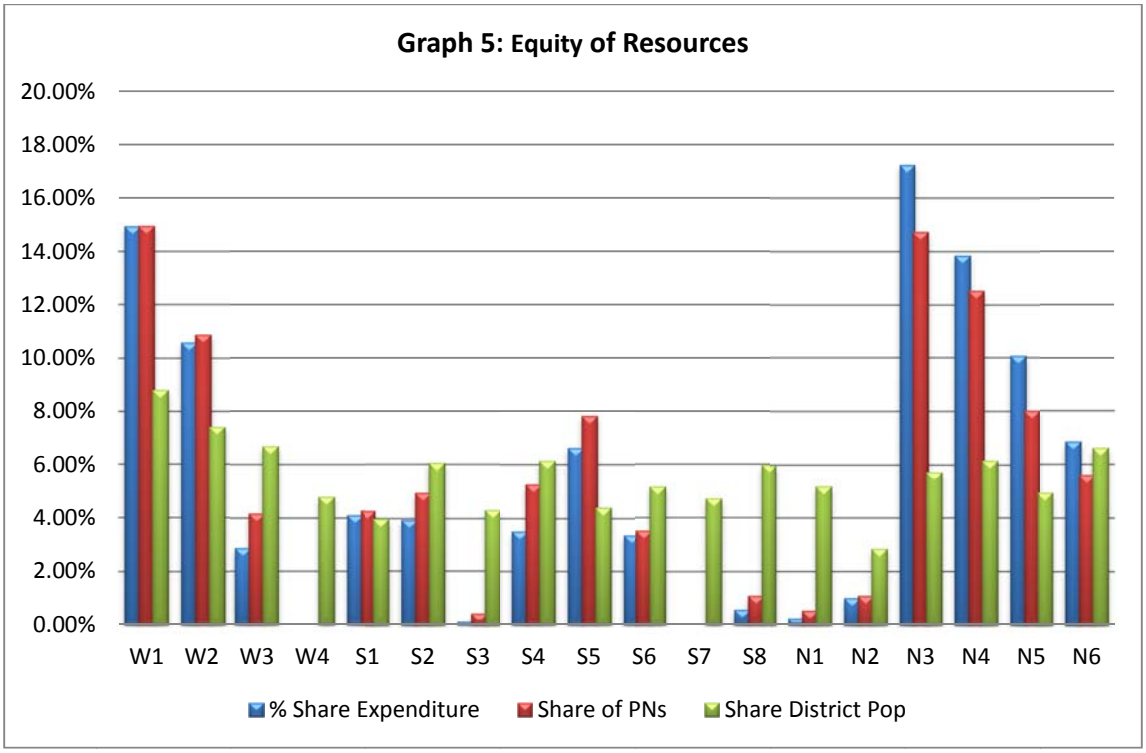
Table 13: Sub-District PHC Equity – 2012/13

Sub-District	PHC Expenditure / Capita (Uninsured)	PHC Utilisation Rate	Staff to Patient Ratio at Provincial clinics – PN's (per 10 000)	PHC Facilities per population ratio – Prov Clinic (per 10 000)	% Share of District Population
W1	642.93	3.17	16.47	0.16	8.80%
W2	550.11	3.54	7.68	0.19	7.41%
W3	162.89	3.49	4.94	0.13	6.69%
W4	0.00		0	0.00	4.80%
S1	390.63	3.37	2.01	0.28	3.99%
S2	245.98	3.07	1.95	0.18	6.06%
S3	12.97	3.58	17.29	0.06	4.33%
S4	216.91	2.71	4.01	0.14	6.15%
S5	477.89	3.41	2.09	0.32	4.41%
S6	245.12	3.20	2.08	0.16	5.17%
S7	0.00		0	0.00	4.73%
S8	36.35	2.76	3.04	0.00	5.97%
N1	18.42	3.50	8.08	0.05	5.18%
N2	134.52	3.18	4.67	0.10	2.85%
N3	1135.04	3.42	31.68	0.10	5.73%
N4	848.67	3.38	63.74	0.05	6.17%
N5	768.38	3.27	18.59	0.11	4.95%
N6	398.29	3.35	58.92	0.04	6.62%

Source: DHER 2012/13 Customised District Report, DHIS

The above table includes data only for provincial clinics. Costs are highest in N3 and N5.In N3 Ntuzuma clinic had an increase of COE by 25% due to staff appointments, and Goods & Services (medicine and vaccines) by 79%, and Lindelani clinic had an increase of COE by 7% also due to staff appointments and Goods & Services (medicine and ARV drugs) by 48%.

Graph 5: Equity of resources vs population and headcount – 2012/13

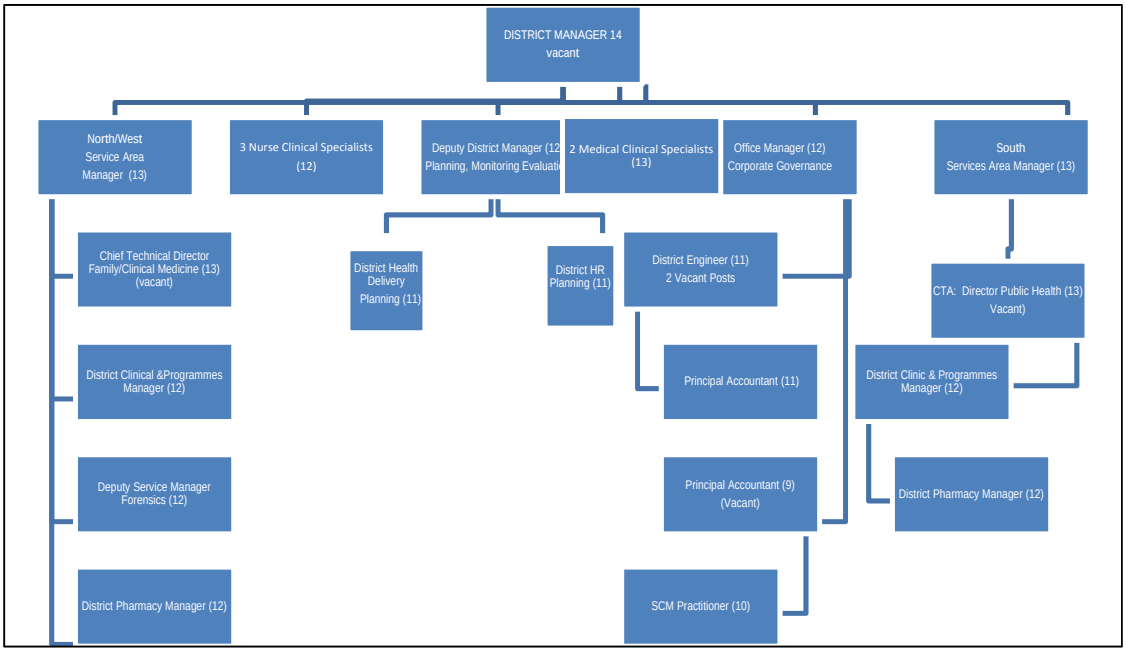


Source: DHER 2012/13 Customised District Report

From this graph, North 3 has the highest expenditure (17% of the district expenditure) and a very high proportion of PN, while serving only 5.7% of the population. On the other hand, West 1 has the highest population (8.8% of the district) accounting for 14.9% of the expenditure with the highest share of PN (14.96%). Few provincial facilities are found in South 3, with only one Gateway clinic, although 4.33% of the population resides in this sub-district. Provincial spending is low in these sub-districts. High expenditure is correlated with high numbers of staff. PHC Areas with CHC have higher staffing numbers and costs. The North has 31.5% of the population, but accounts for 49% of expenditure and 43% of the PN, while the South had 41% of the population, but only 22% of expenditure and 27% of the PN. The West accounts for 28% of the population and accounts for 28% of the expenditure and 30% of the PN. The equitable distribution of resources and efficiency in terms of staffing needs to be reviewed in the three sub-districts. Correct linking of staff from hospitals needs to be reviewed. Local government financial and human resource information is needed in order to better assess sustainability and cost efficiency at district and sub-district level.

3. ORGANISATIONAL ENVIRONMENT

Graph 6: Organisational Structure of the District Management Team



Source: eThekwini District Management Team Structure

Appointment of the full team of district clinical specialists team should have a significant impact in addressing the issues that undermine the progress towards the 2015 MGDs, particularly the reduction of maternal and child mortality rates. This team is seen to play a critical role in the implementation of the Millennium Acceleration Framework (MAF Plan) in the next two years. Absence of district Engineers results in lack of maintenance support to institutions.

3.1.1. Human Resources

Table 14: Staff type to Patient Ratio in Facilities [per 10 000] – Provincial Clinics

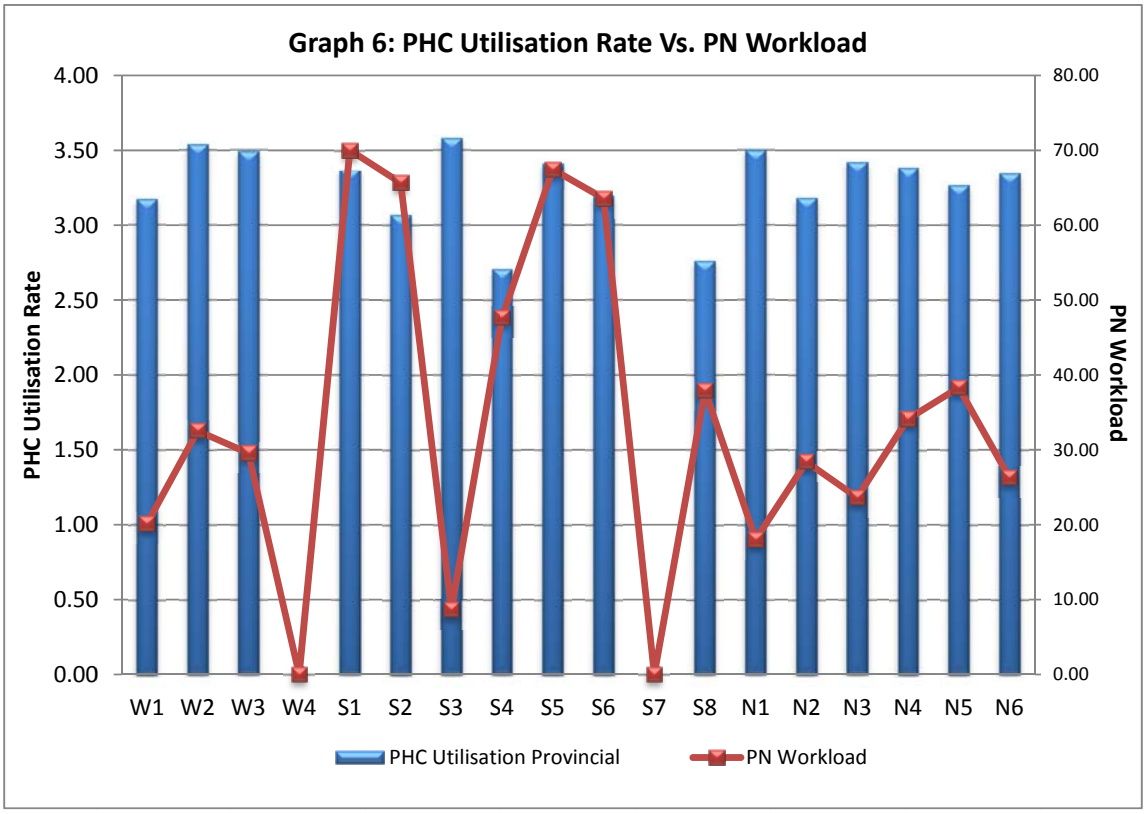
Sub-Districts	Staff Patient ratio at Provincial Clinics – MO	Staff Patient ratio at Provincial Clinics – PN	Staff Patient ratio at Provincial Clinics – EN	Staff Patient ratio at Provincial Clinics – ENA	Staff Patient ratio at Provincial Clinics – Data Capturer	Staff Patient ratio at Provincial Clinics – General Worker
W1	0	2.33	1.37	0.92	0.00	0.30
W2	0	1.15	0.65	0.41	0.00	0.15
W3	0	1.41	0.89	0.59	0.00	0.22
W4	0	0.00	0.00	0.00	0.00	0.00
S1	0	0.60	0.15	0.09	0.00	0.02
S2	0	0.63	0.00	0.00	0.00	0.00

Sub-Districts	Staff Patient ratio at Provincial Clinics – MO	Staff Patient ratio at Provincial Clinics – PN	Staff Patient ratio at Provincial Clinics – EN	Staff Patient ratio at Provincial Clinics – ENA	Staff Patient ratio at Provincial Clinics – Data Capturer	Staff Patient ratio at Provincial Clinics – General Worker
S3	0	4.83	36.22	13.28	3.62	12.07
S4	0	0.57	1.50	0.66	0.13	0.44
S5	0	0.62	0.37	0.18	0.04	0.11
S6	0	0.66	0.98	0.51	0.12	0.29
S7	0	0.00	0.00	0.00	0.00	0.00
S8	0	1.10	3.63	2.64	0.55	0.88
N1	0	2.31	13.39	9.23	2.31	3.69
N2	0	1.47	2.94	2.05	0.44	0.73
N3	0	2.23	1.08	0.72	0.14	0.29
N4	0	8.07	1.52	0.91	0.15	0.46
N5	0	1.09	0.00	0.00	0.00	0.00
N6	0	3.02	3.36	1.34	0.00	1.01
District	0	2.00	4.86	2.40	0.83	1.48

Source: DHER 2012/13 Customised District Report – Note only data for Provincial Clinics is provided.

There are no MOs at any provincial clinics. Highest ratios of PN to patients are found North 4 (8.07) where there are two CHC and South 3 (4.8) skewed by Wentworth Gateway, which serves a low population and has a high staff complement. In addition, referral patterns from the Gateway clinic to the hospital will be reviewed as the Gateway clinic should reduce patients attending OPD services at the hospital. OPD services remain high despite the clinic. Lowest ratios are found in South 4 (0.57) and South 1 (0.6). In terms of EN and ENA, South 3 has the highest EN ratio, followed by North 1. Low numbers of EN are found in South 1 and South 5. The distribution of ENAs is similar to EN. Data capturers are also not equitably allocated with the most in South 3 (although this is again skewed by a small catchment population and one clinic) and North 1. Only 9 sub-districts have data capturers. Not all clinics have the required one data capturer. This does not take into account contract data capturers. All outliers will be reviewed by HR to ensure staff are correctly linked. Staff shortages are apparent in several sub-districts and will be included in the HR plan.

Graph 7: Workload in relation to utilisation – 2012/13.



Source: DHIS Note only Provincial Data analysed here.

Table 15: 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
W1	176.91	20.15	2.33
W2	104.19	32.53	1.15
W3	83.75	29.56	1.41
W4	0	0.00	0.00
S1	46.61	70.02	0.60
S2	40.52	65.66	0.63
S3	172.94	8.63	4.83
S4	79.13	47.70	0.88
S5	41.84	67.48	0.62
S6	46.30	63.58	0.66
S7	0	0.00	0.00
S8	55.66	37.89	1.10
N1	93.16	18.05	2.31

Sub-Districts and District	Total Staff Cost per PHC Headcount	PN Workload	Staff to Patient ratio at Provincial Clinics - PN
N2	107.73	28.39	1.47
N3	174.47	23.65	2.23
N4	112.07	34.12	8.07
N5	114.40	38.29	1.09
N6	167.03	26.31	3.02
District	101.04	38.25	2.02

Source: DHER 2012/13 Customised District Report, DHIS

West 1, North 3, South 3 and North 6 have the highest costs but the lowest workloads. This is particularly marked in Wentworth Gateway (South 3). This will be investigated with hospital management in order to better understand the arrangement of services. In the South most sub-districts have the lowest costs with the highest workloads. Data will be further analysed to ensure correct linking of staff and accurate recording of PHC headcounts. If the data are verified, these facilities will require additional resources. The inequitable distribution of facilities, particularly CHC and hospitals, in the South has resulted in clinics (and level 2 hospitals) seeing high numbers of patients. There is a need to look at the distribution of staff across the district, particularly in the underserved South.

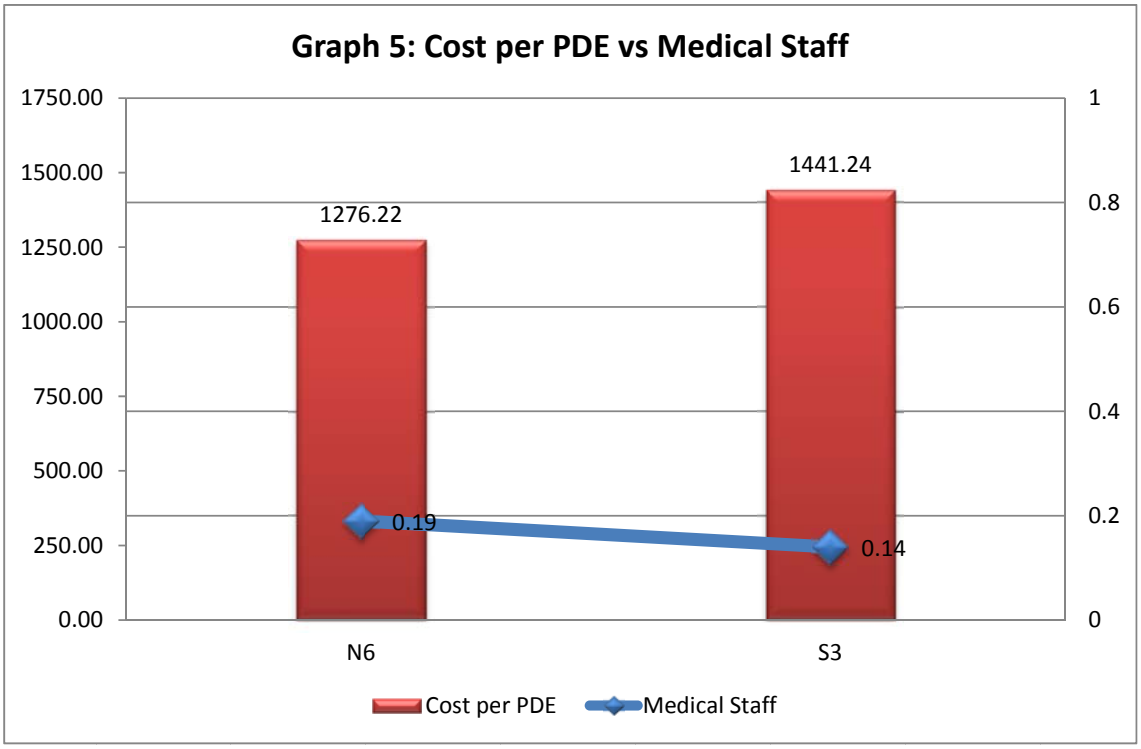
Table 16: District Hospital Staff to PDE Ratio

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	0.19	2	0.18	0.09	0.09
Wentworth	0.14	2.6	0.25	0.16	0.75

Source: DHER 2012/13 Customised District Report

Each of these hospitals only has one provincial clinic. Staff are correctly linked.

Graph 8: Total Medical Staff to PDE Ratio (per 10 000) vs Cost per PDE – 2012/13



Source: DHER 2012/13 Customised District Report

The COE for doctors is higher at Wentworth (0.19 per PDE) than in Osindisweni (0.14). Cost per PDE will be reviewed for both hospitals to ensure all expenditure is correctly allocated.

4. DISTRICT HEALTH EXPENDITURE

Table 17 (A15): 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	R29 529 000			R29 527 571		
DF - 2.2: Clinics	R499 487 000	R61 051 000		R501 264 409		
DF - 2.3: Community Health Centres	R512 910 000			R512 995 601		
DF - 2.4: Community Services				R-3005		
DF - 2.5: Other Community Services	R136 713 000			R136 703 436		
DF - 2.6: HIV/AIDS	R539 342 000			R546 229 268		
DF - 2.7: Nutrition	R11 451 000			R11 450 600		
DF - 2.9: District Hospitals	R870 649 000			R871 864 693		

Source: 2012/13

There was a budget of R61 051 000 which was not transferred to Municipality clinics in the FY 2012/13 due to SLA not being signed and an amount of R8 096 000 was transferred to Bhekimpilo clinics and Matikwe clinic who accounted for 97 251 headcounts.

The expenditure under sub-programme 2.9 includes the 2 district hospitals and expenditure for district level services for the regional hospitals. The amount for the two hospitals equates to R 294 959 781 with the remainder, R 576 904 912 being from Regional Hospitals that provide district health services – level 1. The expenditure on HIV/AIDS includes the conditional grant and payment of CCGs which amounted to R35 171 953.

Table 18 (A16): Sustainability of PHC Services – 2012/13

Sub-Districts and District	Population		Service Delivery		
	PHC Expenditure / Capita (ZAR)	PHC Expenditure / Uninsured Capita (ZAR)	Cost per Headcount Provincial PHC facilities (ZAR)	Total Staff cost per PHC Headcount (ZAR)	Medicine Cost per PHC Headcount
W1	527.20	642.93	229.93	176.91	53.20
W2	451.09	550.11	154.95	104.19	35.02
W3	133.57	162.89	73.35	83.75	23.55
W4	0.00	0.00	0.00	0	0
S1	320.32	390.63	164.31	46.61	18.22
S2	201.70	245.98	355.42	40.52	14.50
S3	10.63	12.97	2.03	172.94	12.44
S4	177.86	216.91	39.92	79.13	17.35
S5	391.87	477.89	78.28	41.84	15.41
S6	201.00	245.12	67.46	46.30	22.22
S7	0.00	0.00	0.00	0.00	0.00
S8	29.81	36.35	8.17	55.66	8.41
N1	15.10	18.42	20.14	93.16	19.83
N2	110.30	134.52	15.16	107.73	50.24
N3	930.73	1135.04	166.20	174.47	48.78
N4	695.91	848.67	249.06	112.07	38.11
N5	630.07	768.38	1249.93	114.40	41.32
N6	326.60	398.29	209.13	167.03	48.15
District	307.61	375.14	105.49		

Source: DHER 2012/13 Customised District Report

Projected cost per headcount was R115, while the average actual cost was R105 for the financial year. On average 74% of expenses went to COE and 22% to medicine. Costs per headcount range widely per sub-district and need to be investigated particularly in the South. Costs per headcount are high for the following sub-districts West 1 (KwaDabeka, Halley Stott), North 3 (KwaMashu), North 6 where CHC are located. Staff costs are very high as a proportion of costs for South 3 (Wentworth Gateway). Lowest costs are reported in South 5, South 2 South 1 and South 8 where a high proportion of the total headcount is seen. North 3 sees the highest proportion of the headcount (11%) and 9% in South 4 (central) indicating some cross border usage of services. Costs need to be further reviewed in order to understand the disparities in cost data by sub-district. All clinics are linked to either a hospital or CHC. This will include a review of how staff are linked by HR and of workloads being reported at these facilities. Local government data will also be reviewed to better understand cost of PHC.

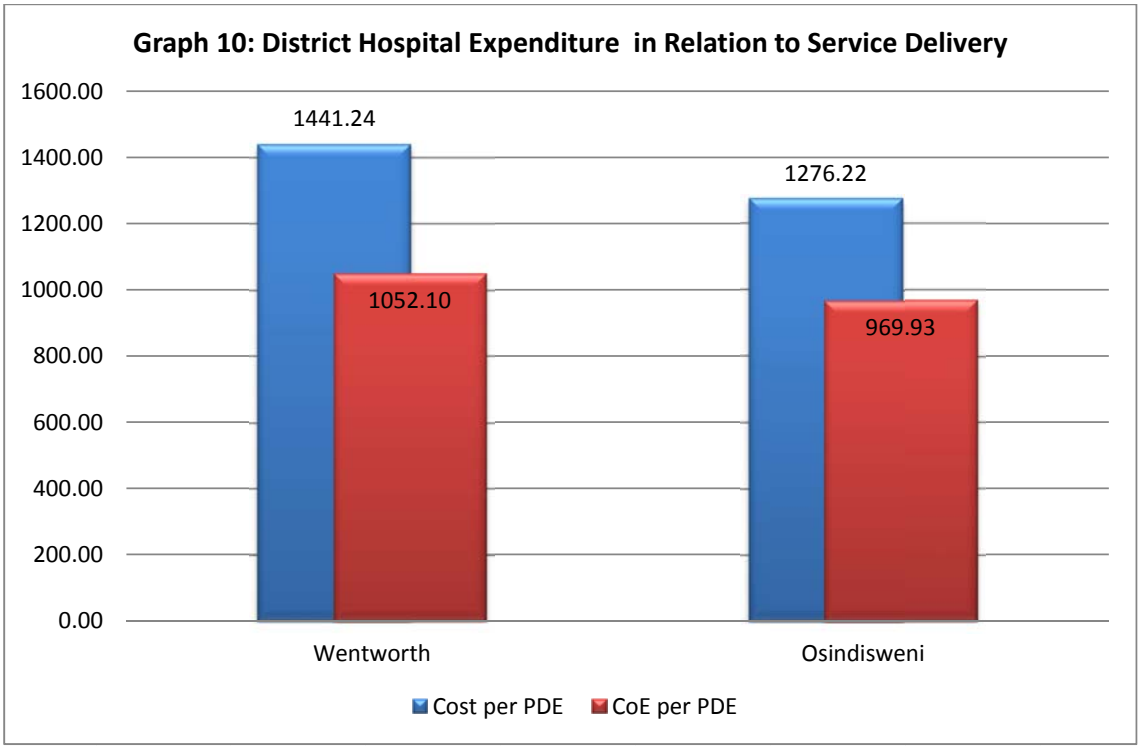
Table 19: District Hospital Expenditure.

District Hospital	Expenditure per PDE	ALOS	BUR	Proportion (%) of expenditure spent on staff (CoE)
Wentworth	1 441	5.7	84.7%	73%
Osindisweni	1 276	5.8	65.1%	76%
District	1 359	5.8	74.9%	75%

Source: DHER 2012/13 Customised District Report

Please add narrative about how McCords and St Mary's affect this.

Graph 9: District Hospital Expenditure in relation to Service Delivery – 2012/13



Source: DHER 2012/13 Customised District Report

COE costs are in line with national averages for district hospitals. ALOS are longer than the norm and reflect the disease burden of the province.

Table 20: Proportion of District Expenditure

Organisation unit	DF proportion spent on DH	DF proportion of exp on management	DF Proportion spent on PHC
kz eThekwini Metropolitan Municipality	33.4%	1.1%	38.9%

1.1% of the budget was spent on district management, 38.9% on PHC services and 33% on district hospitals (excluding state aided hospitals). A greater portion of funding is spent at district hospitals than for PHC. The remainder of 16.7% expenditure was for programmes 2.4 to 2.8. This includes programmes 2.4 – 2.7 of Provincial hospitals which is included under PHC. This DHP will address PHC service delivery priorities and start to cost services (including those provided by LG) required to better position the district to deliver on these services. The current hospi-centric focus will need to be revisited.

Table 21: Non-Negotiable Expenditure per PDE.

Non-Negotiable		Wentworth Hospital	Osindisweni Hospital
Infrastructure Maintenance	Rands	0.95	0
	%	0.33%	0
Food Services per PDE	Rands	31.9	14.1
	%	11.18%	5.57%
Medicine Expenditure per PDE	Rands	103.1	91.5
	%	36.15%	36.17%
Medical Sundries (Supplies) Expenditure per PDE	Rands	53.8	48.2
	%	18.86%	19.05%
Essential Equipment per PDE	Rands	0.48	3.5
	%	0.17%	1.38%
Laundry Expenditure Per PDE	Rands	3.3	0.87
	%	1.16%	0.34%
Vaccination Expenditure per PDE	Rands	2.4	6.3
	%	0.84%	2.49%
Blood Support Expenditure per PDE	Rands	20.3	12.3
	%	7.12%	4.86%
Infection Control Expenditure per PDE	Rands	37.4	25.3
	%	13.11%	10.0%
Medical Waste Expenditure per PDE	Rands	7.2	5.7
	%	2.52%	2.25%
Laboratory Services Expenditure per PDE	Rands	0	0
	%	0	0
Security Services per PDE	Rands	24.4	45.2
	%	8.55%	17.87%
District	**Rands**	285.23	252.97
	%	100	100

Source: DHER 2012/13 Customised District Report

Cost of medicines & COE at Wentworth is higher than Osindisweni. Food services seem to be much more costly at Wentworth. Wentworth is reporting on the purchase of very little essential equipment and may need SCMS support. Laundry costs also seem high at Wentworth. Vaccination costs are higher at Osindisweni with its rural catchment. Infection control costs and blood costs are higher at Wentworth. Wentworth provides C/S support for Prince Mshiyeni Memorial Hospital which may impact on blood costs. Lab services are managed centrally. High levels of nurses may result in additional prescribing costs at both hospitals. Both these hospitals have few provincial referral clinics. ALOS and BUR are high for both hospitals. This seems to impact more on costs at Wentworth than Osindisweni. However, security services are more costly in Osindisweni. The hospital had to hire a private security company which has elevated costs. The referral pathway to Wentworth includes local authority clinics and one Gateway and sees a headcount of 176,000. Osindisweni sees patients from a large rural area and ILembe district and the referral pathway includes Tongaat CHC and sees a headcount of 115,000 patients.

PART B - COMPONENT PLANS

This section of the DHP should be used to set performance targets for the upcoming budget year as well as over the MTEF period for each strategic objective identified in Part B, Programme 2 of the Annual Performance Plan. This is also where the district must set out performance indicators that will facilitate the assessment of the overall performance of each programme, including issues of equity and value for money in relation to the use of resources.

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

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

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

7. SERVICE DELIVERY PLANS FOR DISTRICT HEALTH SERVICES

In this section, it is important that Districts identify if targets will result in:

- Increased visits (quantify the increase), identify whether the district will require additional staff (by category of staff and quantify). This information should be detailed in section 9 and 10 of the DHP;
- Increased consumables (drugs, laboratories and quantify). This information should provide the details for section 10: Finance Plan of the DHP; and
- Increased training requirements (will inform training and financial plan in section 9 and 10 of the DHP.

7.1. PRIMARYHEALTH CARE

7.1.1. 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.

EThekwini district has five district hospitals and 105 Primary Health Care clinics: 66 of these are managed by the Provincial Health services and 59 by Municipality.

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

Provincial Health services within the district are 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 supervise the clinics. Construction of a new clinic in the West has been completed; Ntshongweni clinic is due for commissioning during this financial year.

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.

PLEASE NOTE:

- The indicators included in Part B have not been confirmed by National Health. It is preliminary and will be reviewed at a National Planning Committee meeting on 31 October. I will keep you informed (Ester)

Table 22 (DHS 1): Situation Analysis Indicators for District Health Services

Indicator1	Type	District Average 2012/13
1. PHC expenditure per uninsured person	R	R375
2. Provincial PHC headcount – Total	No	10 448 320
3. PHC headcount under 5 years – Total	No	1 734 283
4. PHC utilisation rate (annualised)	No	3.29
5. PHC utilisation rate under 5 years (annualised)	No	5.3
6. PHC supervisor visit rate (fixed clinic/CHC/CDC)	%	65%
7. Expenditure per PHC Headcount	R	R105
8. Complaint resolution within 25 working days rate	%	90%
9. Number of PHC facilities assessed for compliance against the 6 priorities of the core standards	No	6

Table 23: Quality Improvement Indicators

Quality Improvement Indicators	Type	District Average 2012/13
Percentage of PHC Facilities with Quality Improvement plans focussing on 6 key focus areas : reduced waiting times, improved cleanliness, positive staff attitudes and caring values, improved patient safety, infection prevention and control and availability of medicines and supplies	%	100%
Percentage of PHC Facilities that conduct a patient satisfaction survey once per annum	%	60%

Table 24 (DHS2): District Performance Indicators – District Health Services

Indicator	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
1. Provincial PHC expenditure per uninsured person	R	R475	R655	R650	R650	R630	620		
2. PHC headcount - Total	No	8 694 461	9 721 228	11 201 567	R10 545	R10 756	R10 971		
3. PHC headcount under 5 years - Total	No	1 535 730	1 507 051	1 734 283	1 537 192	1567 936	1 599 295		
4. PHC utilisation rate (annualised)	No	3.2	2.9	3.2	3.3	3.3	3.4		
5. PHC utilisation rate under 5 years (annualised)	No	5.8	5.1	5.3	5.2	5.3	5.4		
6. PHC supervisor visit rate (fixed clinic/CHC/CDC)	%	100%	74%	65%	65%	100%	100%		
7. Expenditure per PHC Headcount	R	R114	R108	R95	R95	R115	R120		
8. Complaint resolution within 25 working days rate	%	N/A	79%	90%	90%	100%	100%		
9. Number of PHC facilities assessed for compliance against the 6 priorities of the core standards	No	0	114	6	100%	100%	100%		

Table 25: Quality Improvement Indicators

Quality Improvement Indicators	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
Percentage of PHC Facilities with Quality Improvement plans focussing on 6 key focus areas : reduced waiting times, improved cleanliness, positive staff attitudes and caring values, improved patient safety, infection prevention and control and availability of medicines and supplies	%	100%	100%	100%	100%	100%	100%		
Percentage of PHC Facilities that conduct a patient satisfaction survey once per annum	%	0%	0%	0%	30%	40%	50%		

Table 26 (DHS3): District Specific Objectives and Performance Indicators – District Health Services.

STRATEGIC OBJECTIVE	PERFORMANCE INDICATORS	Audited/ Actual performance			Estimate	MTEF Projection		
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
1.1) Strengthen governance structures and social compact for health.	1.1.1) Percentage of Clinics with functional Clinic Committees	67%	62%	64%	90%	90%	90%	
	1.1.2) Percentage of CHCs with functional Clinic Committees	80%	88%	88%	90%	100%	100%	
1.2) Revitalisation of PHC services as per STP imperatives and	1.2.1) Number of accredited Health Promoting Schools	5	5	5	12	15	17	

STRATEGIC OBJECTIVE	PERFORMANCE INDICATORS	Audited/ Actual performance			Estimate	MTEF Projection		
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Implementation Plan	1.2.2) School Health Services coverage (cumulative)	47%	60%	20%	80%	100%	100%	
	1.2.3) Number of operational PHC Outreach Teams	0	0	9	7	10	15	
	1.2.4) Number of operational School Health Teams	13	17	39	40	50	60	
	1.2.5) Number of operational District Specialist Teams	0	0	1	2	2	2	
	1.2.6) Dental extractions to restorations rate	1:25	1:22	1:20	1:20	1:20	1:20	
1.3) To implement the National Core Standards for Quality in 100% of facilities towards accreditation of 50% PHC clinics and 100% CHC's by 2014/15	1.3.1) Percentage of clinics fully compliant with the 6 priorities of the National Core Standards	0%	0%	0%	0%	40%	50%	
	1.3.2) Percentage of CHCs fully compliant with the 6 priorities of the National Core Standards	0%	0%	0%	0%	80%	100%	
	1.3.3) Percentage of CHC's conducting annual Patient Satisfaction Survey's (Annual)	13%	100%	100%	100%	70%	80%	100%

STRATEGIC OBJECTIVE	PERFORMANCE INDICATORS	Audited/ Actual performance			Estimate	MTEF Projection		
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
1.4) To prevent and manage non-communicable diseases with a focus on hypertension and diabetes	1.4.1) Diabetes mellitus case put on treatment - new	16 616	11 293	11 796	11 067	10 846	16 616	
	1.4.2) Hypertension case put on treatment - new	29 747	32 902	22 117	32 244	31 599	29 747	

7.1.2. DISTRICT HEALTH SERVICES: STRATEGIES /ACTIVITIES TO BE IMPLEMENTED 2014/15

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.

EThekwini district has five district hospitals and 105 Primary Health Care clinics: 66 of these are managed by the Provincial Health services and 59 by Municipality.
The PHC for both the Provincial Health Services and Local Municipality comprise of facility based clinical staff including professional nurses and other categories; outreach teams including 27 family health teams Community Care Givers who provide ward-based PHC service through Operation Sukuma Sakhe; and 40 school health teams .

Provincial Health services within the district are functionally divided into two service areas for efficiency purposes, namely South and North West. District demarcation process has commenced as a proposal for the modelling of sub-districts. Management structures are such that Primary Health Care supervisors are based at the district office and supervise the clinics. Construction of a new clinic in the West has been completed; Ntshongweni clinic was commissioned during this financial year.

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.

The following clinics: Newlands East, Maphephetheni, Commercial City and Beatrice Street have been delinked from their custodian institutions to optimize their functionality. Verulam and Chesterville clinics were fully transferred to eThekwini Metro.

The following strategies will be implemented by the district to reach the 2014/15 targets set for the Sub-Program District Health Services

2014/15 STRATEGIES AND ACTIVITIES

The following strategies address the bottlenecks that undermine the achievement of the MDG and NSDA targets and will be implemented in the 14/15 financial year:

PHC Re-engeneering

- Develop and implement proposed district demarcation model
- Finalize service area modelling proposal
- Focus services in areas of high demand using community profiles.
- Increase integration of community and facility services through outreach teams
- Implement Integrated School Health Programme in collaboration with other sectors

Improve Quality and Clinical Governance

Reduce Maternal and Child Mortality

- Early ANC initiation and diagnosis before 20/40
- Engage communities through Family Health Teams to mobilize women for ANC and institutionalize early booking policy.
- Improve the rate of retesting of pregnant and postnatal women
- Increase Couple year protection rate
- Scale up antibody testing at 18month
- Accelerate the implementation of CARMMA
- Integration of HIV and TB care in maternal care

- Facilitate implementation of "one stop shop" (maternal, TB and HIV Services provided comprehensively) in line with existing HIV and TB guidelines.

Reduce TB incidence and improve TB outcomes

- Maximize TB Infection Control in Community and in health facilities
- Education of Communities by the Outreach Teams and through Operation Sukuma Sakhe
- Actively monitor implementation of Infection Control Policy in facilities

Active TB case finding

- Identify suspects at community/household level using the TB screening tool by FHTs
- Improve diagnosis of TB in children
- Integration of HIV and TB care in all programmes

Decentralize MDR Management to community level

- Appointment of community based injection teams

Scale up ARV initiation to HIV/TB co-infected patients

- Facilitate implementation of "one stop shop" (maternal, TB and HIV Services provided comprehensively) in line with existing HIV and TB guidelines.

Scale up ARV paediatric uptake
Accelerate HIV prevention efforts

7.2. SUB-PROGRAM: DISTRICT HOSPITALS

7.2.1. 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 five Level 1 hospitals in the district (two state-aided and three public hospitals). Currently the future state of McCord Hospital is under review and St May's is currently preparing its turn- around strategy. In addition the district has five hospital 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.

Table 27 (DHS 4): Situational Analysis Indicators for District Hospitals (state-aided excluded)

Indicator	Type	Osindisweni 2012/13	Wentworth 2012/13	District Average 2012/13
1. Delivery by caesarean section rate	%	29.9%	34%	31.9%
2. Inpatient Separations – Total	No	9 862	9640	19 502
3. Patient Day Equivalents – Total	No	190 664	251679	442 343
4. OPD Headcount – Total	No	114 897	176153	291050
5. Average Length of Stay	Days	5.8	7	6.4 days
6. Inpatient bed utilisation rate - total	%	65%	85%	76.5%
7. Expenditure per patient day equivalent (PDE)	R	R847	R1306	
8. Complaint resolution within 25 working days rate	%	80%	96%	96%
9. Percentage of District Hospitals with monthly Mortality and Morbidity Meetings	%	100%	100%	100%
10. Percentage of District Hospitals conducting patient satisfaction surveys at least once per annum	%	100%	100%	100%
11. Patient Satisfaction Rate		80%	85%	
12. Number of Hospitals assessed for compliance against the 6 priorities of the core standards	No	1	1	2

Indicator	Type	Osindisweni 2012/13	Wentworth 2012/13	District Average 2012/13
13. Percentage of Hospitals with Quality Improvement Plans focussing on 6 key focus areas : reduced waiting times, improved cleanliness, positive staff attitudes and caring values, improved patient safety, infection prevention and control and availability of medicines and supplies	%	100%	100%	100%

Table 28 (DHS 5): Performance Indicators for District Hospitals (including state-aided hospitals)

Indicator		Audited/ Actual performance			Estimate	MTEF Projection			Provincial target
	Type	2011/12	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
1. Delivery by caesarean section rate	%		33.3%	39%	31.6%	30.1%	28.6%		
2. Inpatient Separations – Total	No		36776	46968	34937	33190	31531		
3. Patient Day Equivalents – Total	No		417764	507497	369876	377032	358180		
4. OPD Headcount – Total	No		523032	554269	496880	472036	448435		
5. Average Length of Stay	%		5.9	6.3	5.3	4.8	4.3		
6. Inpatient bed utilisation rate - total	Days		75%	70%	75%	75%	75%		
7. Expenditure per patient day equivalent (PDE)	%		R 1 076	R1 023	R1 100	R1 150	R1 200		
8. Complaint resolution within 25 working days rate	%		96%	90%	100%	100%	100%		
9. Percentage of Hospitals with monthly Mortality and Morbidity Meetings	%		100%	100%	100%	100%	100%		
10. Percentage of Hospitals conducting patient satisfaction surveys at least once per annum	%		100%	100%	100%	100%	100%		
11. Patient Satisfaction Rate	%		80%	85%	100%	100%	100%		
12. Number of Hospitals assessed for compliance against the 6 priorities of the core standards	No		100%	100%	100%	100%	100%		

Indicator		Audited/ Actual performance			Estimate	MTEF Projection			Provincial target
	Type	2011/12	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
13. Percentage of Hospitals with Quality Improvement Plans focusing on 6 key focus areas : reduced waiting times, improved cleanliness, positive staff attitudes and caring values, improved patient safety, infection prevention and control and availability of medicines and supplies	%		100%	100%	100%	100%	100%		

Table 29 (DHS 6): District Strategic Objectives and Annual Targets for District Hospitals

STRATEGIC OBJECTIVE	PERFOMANCE INDICATORS	Audited/ Actual performance			Estimate	MTEF Projection		
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
1.9) Strengthen governance structures and social compact for health.	1.9.1) Percentage of District Hospitals with functional Hospital Boards		100%	100%	100%	100%	100%	100%
2.2) To implement the National Core Standards in 100% of facilities towards accreditation of 100% District Hospitals by 2014/15	2.2.1) Number of District Hospitals compliant with the 6 priorities of the National Core Standards	-	-	0	0	5	5	5

7.2.2. DISTRICT HOSPITALS: STRATEGIES /ACTIVITIES TO BE IMPLEMENTED 2014/15

7.3. HIV & AIDS & TB CONTROL (HAST)

7.3.1. PROGRAMME OVERVIEW

The purpose of this programme is to implement preventative and supportive programmes that will have a positive effect on changing people's lifestyle and perception on HIV/AIDS thus decreasing the incidence and the impact of the disease. This is achieved through co-ordination of HIV/AIDS activities that are directed at prevention of HIV infections and care for those who are infected and affected. This involves facilitating inter-sectoral collaboration with all partners against combating HIV/AIDS. The main strategic goal is the alleviation of poverty and the enhancement of the nutritional status of individual in order to mitigate the impact of HIV/AIDS. Other focus areas are; the provision of HIV Counseling and Testing as well as Medical Male Circumcision (MMC) to be accessible to all individuals, strengthen programmes for the prevention and treatment of sexual transmitted infections through the use of protocols for the syndromic management of STIs and promotion of the usage of both female and male condoms. The expansion of programmes targeting High Transmission Areas is done to increase access to HIV and STI services for truckers and commercial sex workers.

Equally important is the roll out of ART programme in all identified facilities to ensure that all qualifying HIV positive clients including children adolescents and pregnant women receive treatment. The number of ART initiating site has increased from 53 during FY 2010/11 to 96 in 2011/12 and more patients will be initiated with the appointment of the roving teams in the district. This programme is more than just issuing of tablets but provides counseling, nutritional support and proper management of opportunistic infections. The programme also seek to strengthen post exposure prophylaxis for the victims of sexual assault as well as health personnel that are exposed to potentially infected body fluids. There is also an integrated Home Based Care programme which seeks to improve quality for those infected.

There is also a DOT support programme that aims at supporting TB patients to adhere to their treatment so as 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

- Quality data management proves to be a challenge
- Integration of HAST services is slow

2014/15 STRATEGIES AND ACTIVITIES

- Scale up access to HIV testing to communities.
- Strengthen systems to ensure that survivors of sexual assault and discordant couples are started on post exposure prophylaxis (PEP)
- Increase access to MMC service

Table 30 (HIV 1): Situational Analysis Indicators for HIV & AIDS, STI's and TB Control

Indicators	Type	District Average 2012/13
1. Total clients remaining on ART (TROA) at end of the month	No	220 892
2. Male condom distribution rate	No	6
3. TB (new pulmonary) defaulter rate	%	7.8%
4. TB new client treatment success rate	%	
5. HIV/TB co-infected client initiated on ART rate	%	20%
6. HIV Testing Coverage	%	72%
7. TB (new pulmonary) cure rate	%	66%

Table 31 (HIV 2): Performance Indicators for HIV & AIDS and TB Control

Indicator	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
1. Total clients remaining on ART (TROA) at end of the month	No	112 375	152 149	220 892	214 941	243 805	266 669	214 941	
2. Male condom distribution rate	No	5	5	6	7	8	9	7	
3. TB (new pulmonary) defaulter rate	%	7.6%	10.4%	7.8%	6.2%	3.7%	2.2%	6.2%	
4. TB new client treatment success rate	%				74%	79%	84%	74%	
5. HIV/TB co-infected client initiated on ART rate	%	11%	41%	20%	49%	59%	71%	49%	
6. HIV Testing Coverage	%	84%	78%	72%	95%	95%	95%	95%	
7. TB (new pulmonary) cure rate	%	60.7%	62%	66%	73%	86%	100%	73%	

Table 32 (HIV 3): District Strategic Objectives and Annual Targets for HIV & AIDS.

STRATEGIC OBJECTIVE	PERFORMANCE INDICATORS	Audited/ Actual performance			Estimate	MTEF Projection		
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17

7.3.2. HIV & AIDS, STI & TB CONTROL (HAST): STRATEGIES/ ACTIVITIES TO BE IMPLEMENTED 2014/15

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

7.4.1. PROGRAMME OVERVIEW

The purpose of this programme is implement interventions/activities CARMMA, ESMOE, KINC, Phila Ma, CMAM and Phila Mntwana that will improve the quality of care for antenatal, intrapartum and postnatal women and children thus ameliorating their morbidity and mortality. This involves collaboration between hospitals, specialist clinical teams, MOUs, mobile units, care givers, specialized family health teams and community IMCI. Integral to this programme is the identification of malnourished children concomitant with nutrition supplementation. Furthermore the programme also prioritizes the identification and treatment of TB/ HIV positive women and children. The implementation of the Five Point Contraceptive Strategy is central to the sub-programme

NUTRITION

The programme aims to prevent and reduce morbidity and mortality resulting from malnutrition, diseases of the lifestyle and infectious diseases. It does this through promotion of growth monitoring, support of breastfeeding, control of micronutrient malnutrition and provision of supplements to identified patients and clients. . Nutrition enhancement initiatives are established so that food supplements are accessible to vulnerable groups and patients on TB and ART treatment The Integrated Nutrition Programme aims to facilitate a coordinated, inter-sectoral approach to solving the current nutrition problems. Its focus is mainly on children, pregnant and lactating women and other groups. . Exclusive breastfeeding is recommended as the optimal feeding method for infants from 0 – 6 months (how are you doing with this). Reasons for not practicing exclusive breastfeeding are related to inadequate information on the health advantages of breastfeeding, age and maturity of the mother, social class and social status family and community perceptions on reasons for breastfeeding and not breastfeeding.

STRATEGIC CHALLENGES

- Growth faltering
- Late identification of malnourished children

2013/14 STRATEGIES AND ACTIVITIES

- Implement the community management of acute malnutrition (CMAM)
- Establish and sustain weighing posts in war rooms

Table 33 (MCWH & N1): Situational Analysis Indicators for MCNWH & N

Indicators	Type	District Average 2012/13
1. Immunisation coverage under 1 year (annualised)	%	92%
2. Vitamin A 12-59 months coverage (annualised)	%	57%
3. Measles **2nd dose** coverage (annualised)	%	
4. PCV 3rd dose coverage (annualised)	%	94%
5. RV 2nd dose coverage (annualised)	%	100%
6. Cervical cancer screening coverage	%	79%
7. Antenatal 1st visit before 20 weeks rate	%	45%
8. Infant 1st PCR test positive within 2 months rate	%	4%
9. Couple year protection rate	%	23%
10. Maternal mortality in facility ratio (annualised)	%	220/100k
11. Delivery in facility under 18 years rate	%	8%
12. Child under 1 year mortality in facility rate (annualised)	%	
13. Inpatient death under 5 years rate	%	

Table 34 (MCWH&N 2): Performance Indicators for MCWH&N

Indicators	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
1. Immunisation coverage under 1 year (annualised)	%	88%	107%	92%	100%	100%	100%	100%	100%
2. Vitamin A 12-59 months coverage (annualised)	%	43.5%	54%	57%	76%	100%	100%	76%	100%
3. Measles 2nd dose coverage (annualised)	%				100%	100%	100%	100%	100%
4. PCV 3rd dose coverage (annualised)	%	109%	101%	94%	100%	100%	100%	100%	100%
5. RV 2nd dose coverage (annualised)	%	92%	144%	100%	100%	100%	100%	100%	100%
6. Cervical cancer screening coverage	%	30.3%	80%	79%	86%	92%	98%	86%	92%
7. Antenatal 1st visit before 20 weeks rate	%	37%	41%	45%	55%	75%	100%	55%	75%
8. Infant 1st PCR test positive within 2 months rate	%	10%	5%	4%	5%	4%	3%	5%	4%
9. Couple year protection rate	%	18%	23%	23%	29%	35%	43%	29%	35%
10. Maternal mortality in facility ratio (annualised)	%	222/100k	185/100k	220/100k	150/100K	120/100K	190/100K	150/100K	120/100K
11. Delivery in facility under 18 years rate	%	8%	8%	8%	100%	100%	100%	100%	100%
12. Child under 1 year mortality in facility rate (annualised)	%				76%	100%	100%	76%	100%

Indicators	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
13. Inpatient death under 5 years rate	%				100%	100%	100%	100%	100%

Table 35 (MCWH&N 3): District Objectives and Annual Targets for MCWH & N

STRATEGIC OBJECTIVE	PERFORMANCE INDICATOR	Audited/ Actual performance			Estimate	MTEF Projection		
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17

7.4.2. STRATEGIES/ ACTIVITIES TO BE IMPLEMENTED 2014/15

7.5. DISEASE PREVENTION AND CONTROL (ENVIRONMENTAL HEALTH INDICATORS)

7.5.1. 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, Environmental Health Services excluding Port Health and control of Hazardous substances is the responsibility of Metropolitan Municipality within municipal health services. The two environmental health functions, Port Health 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 still exist. Some of the key responsibilities for Environmental health involve 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.

Table 36: Situational Analysis for Environmental Health Services

Indicators	Type	District Average 2012/13
1. Malaria case fatality rate	%	0%
2. Cholera fatality rate	%	0%
Medical waste safe disposal rate	%	90%
4. Proportion of SLAs for waste management contracts that were monitored for compliance regulations	%	
5. Water sample for human consumption rate	%	90%
6. Number of households without access to safe and portable water supply	No	

Table 37: Performance Indicators for Environmental Health Services

Indicator	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
1. Malaria case findings		0%	0%	0%		0%	0%	0%	0%
2. Malaria case fatality rate		0%	0%	0%		0%	0%	0%	05
3. Medical waste safe disposal rate		70%	85%	90%		100%	100%	100%	90%
4. Water sample for human consumption rate		90%	90%	90%		100%	100%	100%	90%
5. Number of households without access to safe and portable water supply		15 000				1,000	-	-	

Table 38: District Objectives and Annual Targets for Environmental Health Services

STRATEGIC OBJECTIVE	PERFORMANCE INDICATOR	Audited/ Actual performance			Estimate	MTEF Projection		
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17

7.5.2. STRATEGIES/ ACTIVITIES TO BE IMPLEMENTED 2014/15

8. INFRASTRUCTURE, EQUIPMENT AND OTHER SUPPORT SERVICES

Table 39: Health Facilities for the Health District

	Facility type in Numbers	Audited/ Actual			Projection	MTEF Projection		
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
eThekwini	Non fixed clinics	204 Village Posts: Mobiles: Mobile Points:	207 Village Posts: Mobiles: Mobile Points:	Village Posts: Mobiles: Mobile Points:	Village Posts: Mobiles: Mobile Points:	215 Village Posts: Mobiles: Mobile Points:	215 Village Posts: Mobiles: Mobile Points:	Village Posts: Mobiles: Mobile Points:
	Fixed Clinics	Clinics:103 Satellites:2	Clinics:103 Satellites:2	Clinics:104 Satellites:2	Clinics: Satellites:	Clinics:101 Satellites:2	Clinics:101 Satellites:2	Clinics:101 Satellites:2
	CHCs	8	8	8		8	8	
	Sub-total fixed PHC clinics + CHCs	113	113	114		111	111	111
	District hospitals	4	4	5		5	5	5

Table 40: Performance Indicators for Health Facilities Management

Indicator	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
1. Expenditure on facility maintenance as % of total district health expenditure	%								
2. Fixed PHC facilities with access to continuous supply of clean portable water	%	100%	100%	100%		100%	100%	100%	
3. Fixed PHC facilities with access to continuous supply of electricity	%	100%	100%	100%		100%	100%	100%	

Indicator	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
4. Fixed PHC facilities with access to sanitation		100%	1005	100%		100%	100%	100%	
5. Fixed PHC facilities with access to fixed telephone line	%	100%	100%	100%		100%	100%	100%	

8.1. SUPPORT SERVICES – FOR DISCUSSION WITH THE NATIONAL DEPARTMENT OF HEALTH

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.
- Other Non-Negotiable items

Table 41: Support Services

Indicators	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
1. Proportion of hospitals (district, regional, tertiary, central) implementing Electronic Gate Keeping system within the Province.									
2. Percentage of selected tests (CD4, HIV PCR, HIV VL, TB Directs and cervical smears) performed and results available within the agreed turnaround times.									

Indicators	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
3. Percentage of Hospitals (District, Regional, Tertiary, Central) having emergency fridges with emergency blood stock available on site.									
4. Proportion of blood units (RBC) ordered that was not transfused and discarded.									
5. Proportion of facilities with food service units that were monitored (using the Food Service Management Monitoring Tool).									
6. Proportion of facilities that scored >75% on the Food Service Monitoring Standards Grading System									
7. Average cost per piece laundered: In-house									
8. Average cost per piece laundered: Outsourced									

Indicators	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
9. Value of linen procured									
10. Number of districts with operational security committees									
11. Proportion of health facilities fenced with access control at the gate									
12. Number of safety and security audits conducted annually									
13. Proportion of facilities operating with 100% of essential equipment (as per checklist on Essential Equipment)									
13. Proportion of facilities with an essential equipment maintenance plan									
14. Number of facilities monitoring Service Level Agreement (SLA) with service providers appointed to maintain all fixed equipment									
15. Nosocomial infection									

Indicators	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
Rate									
16. Neonatal Nosocomial infection rate									
17. Proportion of clients not satisfied with cleanliness as per the client satisfaction survey									
18. Proportion of facilities that score at least 80% compliance with cleanliness as per the core standards									

8.2. PHARMACEUTICAL SERVICES

Table 42: Pharmaceutical Services

Indicators	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
1. % of institutions (district hospitals and CHCs) with functional Pharmaceutical and Therapeutics Committees (PTCs)	%	70%	53%	75%		100%	100%		
2. % of Hospitals with Pharmacists	%	100%	100%	100%		100%	100%		
3. % of CHC's with Pharmacists	%	100%	100%	100%		100%	100%		
4. Proportion of health facilities with Tracer Drugs out of stock	%	1%	26%	16%					
5. Drug Stock-out rate at drug depots									
6. Total Rand value of disposed/ expired drugs	R								
7. Total Rand value of drugs that had to be bought out of contract	R								

8.2.1. EQUIPMENT AND MAINTENANCE

Include district asset acquisition plan

Table 43: District Equipment and Maintenance

Indicators	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target 2014/15
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	
1. Number of districts spending more than 90% of maintenance budget									
2. Proportion of infrastructure budget allocated to maintenance									
3. Proportion of infrastructure budget spent on all maintenance (preventative and scheduled)									

8.2.2. EMERGENCY MEDICAL SERVICES (EMS)

Table 44: Performance Situational Analysis for Rostered Ambulances per 10,000 Population (inclusive of LG)

Indicator: Rostered Ambulances per 10,000 of Population (Inclusive of LG)	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
Rostered ambulances per 10,000 population		0.50	0.20		0.30	0.35	0.45		
District Average									

Table 45: Performance Situational Analysis for Ambulance Response Time Rural

Indicator : Ambulance Response Time: Rural (Inclusive of LG)	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
P1 calls with a response time of <40 minutes in a rural area		30%	40%			70%	80%		
District Average									

Table 46: Performance Situational Analysis for Ambulance Response Times Urban

Indicator Ambulance Response Time: Urban (Inclusive of LG)	Type	Audited/ Actual performance			Estimate	MTEF Projection			Provincial Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2014/15
P1 calls with a response of time <15 minutes in an urban area		20%	7%			40%	50%		
District Average									

9. HUMAN RESOURCES

9.1. PERFORMANCE FOR HUMAN RESOURCES[2]

Table 47: Performance Situational Analysis for Human Resources

	TOTAL POSTS FILLED	Audited/ Actual performance			Estimate	MTEF Projection		
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Health district	Personnel category1							
Sub-District A	**PHC facilities**							
	Medical officers							
	Professional nurses							
	Pharmacists							
	District hospitals							
	Medical officers							
	Professional nurses							
	Pharmacists							
	Radiographers							
Sub-District B	**PHC facilities**							
	Medical officers							
	Professional nurses							

[2]This table should include local government personnel. Where this is not possible, it must be clearly indicated.

	TOTAL POSTS FILLED	Audited/ Actual performance			Estimate	MTEF Projection		
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	Pharmacists							
	District hospitals							
	Medical officers							
	Professional nurses							
	Pharmacists							
	Radiographers							
Sub-District C etc.	**PHC facilities**							
	Medical officers							
	Professional nurses							
	Pharmacists							
	District hospitals							
	Medical officers							
	Professional nurses							
	Pharmacists							
District	**PHC facilities**							
	Medical officers							
	Professional nurses							
	Pharmacists							
	District hospitals							
	Medical officers							

	TOTAL POSTS FILLED	Audited/ Actual performance			Estimate	MTEF Projection		
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	Professional nurses							
	Pharmacists							

9.1.1. PLANS FOR HEALTH SCIENCES AND TRAINING

CONTINUOUS PROFESSIONAL CAPACITY BUILDING / TRAINING [3]	INDICATORS	Estimated performance	Medium term targets		
		2013/14	2014/15	2015/16	2016/17

Attach the District Training Plan as an Annexure

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

10. DISTRICT FINANCE PLAN

10.1.1. DISTRICT HEALTH MTEF PROJECTIONS

Sub-programme	Audited outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
R' thousand	2010/11	2011/12	2012/13	2013/14			2014/15	2015/16	2016/17
District Management	R19 652 789	R189 665 518	R27 719 000						
Clinics	R444 200 621		R567 691 000						
Community Health Centers		R952 518 935	R522 776 000						
Community Services	R388 013 251	R480 064 722	R0						
Other Community	R10 852 793	R 7 433 000	R133 765 000						
Coroner Services	R101 471 712	R106 823 684	R 37 072 000						
HIV and AIDS	R29 350 109	R34 990 775	R418 705 000						
Nutrition	R311 029 375	R397 183 017	R 12 571 000						
District Hospitals	R1 489 482	R 17 042 633	R991 725 000						
Environmental Health Services	R1 129 589 088	R730 818 605	R21 583 000						
TOTAL	**R17 795 093**	**R 50 374 462**	**R2 733 877 000**						

10.2. DISTRICT MTEF PROJECTION PER ECONOMIC CLASSIFICATION

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
R' Thousands	**2010/11**	**2011/12**	**2012/13**	**2013/14**			**2014/15**	**2015/16**	**2016/17**
Current payments	2010/11	2011/12	2 460 532 000						
Compensation of employees	2 228 836 956	2 030 677 114	1 610 702 000						
Goods and services	1 552 548 517	1 392 634 639	849 830 000						
Transfers and subsidies to	676 288 438	638 042 475	235 268 000						
Payments for capital assets	218 762 073	230 776 695	14 129 000						
Total economic classification	**5 073 283**	**23 092 086**	**2 709 929 000**						

PART C: LINKS TO OTHER PLANS

11. CONDITIONAL GRANTS (WHERE APPLICABLE)

Districts should provide specific information on any changes to Conditional Grants allocations. This should include the process of managing this and outputs to be achieved through the respective conditional grant. Identified priorities should be included for possible donor funding and or additional grant funding. The key success factor is decentralised management of the grants at a district level. The allocated amount per district should be clearly defined.

Name of conditional grant	Purpose of the grant	Performance indicators 2013/14	Indicator targets for 2013/14
COMPREHENSIVE HIV AIDS CONDITIONAL GRANT (*Applicable to all Districts*)	• To enable the health sector to develop an effective response to HIV and AIDS including universal access to HIV Counselling and Testing • To support the implements of the National operational plan for comprehensive HIV and AIDS treatment and care • To subsidise in-part funding for the antiretroviral treatment plan	1. Total Number of fixed public health facilities offering ART Services 2. Number of new patients that started on ART 3. Total number of patients on ART remaining in care. 4. Number of beneficiaries served by home-based categories 5. Number of active home-based carers receiving stipends 6. Number of male and female condoms distributed 7. Number of High Transmission Areas (HTA) intervention sites 8. Number of Antenatal Care (ANC) clients initiated on lifelong ART 9. Number of babies Polymerase Chain Reaction (PCR) tested at 6 weeks 10. Number of HIV positive clients screened for TB 11. Number of HIV positive patients that started on IPT 12. Number of active lay counselors on stipends	

Name of conditional grant	Purpose of the grant	Performance indicators 2013/14	Indicator targets for 2013/14
		13. Number of clients pre-test counselled on HIV testing (including Antenatal) 14. Number of HIV tests done 15. Number of health facilities offering MMC services 16. Number of Medical Male Circumcisions performed 17. Sexual assault cases offered ARV prophylaxis 18. Step down care (SDC) facilities/units 19. Doctors and professional nurses training on HIV/AIDS, STIs, TB and chronic diseases	
NATIONAL HEALTH INSURANCE GRANT *(Applicable to UMgungundlovu and UMzinyathi Districts)*	• Develop frameworks and models that can be used to roll out the National Health Insurance (NHI) pilots in districts and central hospitals critical to achieving the phased implementation of NHI	**Central hospitals:** 1. Strengthening revenue collection and development of alternative hospital reimbursement tools. **NHI Pilot Districts:** 1. Strengthening M&E capacity; 2. Improved supply chain processes to enhance district health system performance (ordering systems, etc); 3. Strengthening referral systems with linkages to PHC streams	

12. DONOR FUNDING

Name of Donor	Purpose of the grant or donation	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant or donation)	Outputs

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

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

Name of PPP or PPM	Purpose	Outputs	Current Annual Budget (R'Thousand)	Date of Termination	Measures to ensure smooth transfer of responsibilities
1.					

Name of PPP or PPM	Purpose	Outputs	Current Annual Budget (R'Thousand)	Date of Termination	Measures to ensure smooth transfer of responsibilities
2.					
3.					
4.					
5.					