STRATEGIC PLAN

2010 – 2014
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ENDORSEMENT BY THE MEC FOR HEALTH

The Strategic Plan of the Department represents the opportunity to give tangible effect to responding to the prevailing disease profile in the Province. The value of a comprehensive plan that integrates key elements of service delivery, human resources, infrastructure and finance cannot be underestimated as it provides the long-term framework that guides the annual planning and budget cycle.

There are four overarching priorities for the forthcoming planning cycle based on the prevailing health needs in the Province namely: to reduce mortality and increase life expectancy; to reduce HIV incidence; to decrease TB caseload and to improve health system effectiveness.

KwaZulu-Natal needs to exhibit foresight and decisive action in achieving the aforementioned priorities through a comprehensive paradigm shift which prioritises prevention. The Department plans to implement robust prevention and treatment programmes to give credence to our commitment to improve quality of life and increase life expectancy of all our citizens.

Preparation for the roll-out of the National Campaign for accelerated HIV Counselling and Testing (HCT) commenced in March 2010 and will be accelerated to include all facilities in 2010. The HCT campaign, focusing on provider-initiated counselling and testing as opposed to voluntary counselling and testing will serve to expand preventive and treatment services and accelerate progress towards achieving Millennium Development Goal 6 aimed at reversing the spread of HIV and AIDS.

The HCT strategy makes provision for the Medical Male Circumcision strategy that commenced in 2010, aimed at reducing HIV transmission. Integration of TB-HIV services, an important component of the HCT campaign will ensure that all HIV-positive patients are routinely screened for TB to expedite the treatment of eligible persons.

Improving maternal and child health is paramount and the Department plans to invest considerable resources to turn the tide on child and maternal morbidity and mortality. Immunisation services, including vaccination to reduce pneumonia and diarrhoea in children, and antenatal, intrapartum and postnatal care will be targeted to accelerate progress towards the Millennium Development Goal targets.

The Department’s Strategic Goals for the next 5 years take cognizance of the NHS 10-Point Plan, the MTSF priorities as well as province-specific health needs and include:

- Overhauling Provincial Health Services: Rationalisation of health services, revitalisation of PHC, improving governance, strengthen management capacity, eliminate bureaucracy and decentralise delegations and accountability.
- Improving the efficiency and quality of Health Services. Implement the National Core Standards for Quality towards health facility accreditation, improve patient care, satisfaction and safety, and begin to prepare facilities for the forthcoming National Health Insurance.
- Reducing morbidity and mortality due to communicable diseases and non-communicable conditions and illnesses. Appropriate response to the burden of disease.

The Strategic Plan is a genuine confirmation of our commitment to meeting our constitutional mandate and an honour to the heroes and heroines who paid supreme sacrifices so that all our people live in a society where basic human rights are respected. They reflect our purpose for existence and the basis for future generations to sustain.

Dr S Dhlomo
MEC for Health
In crafting the Strategic Plan targets have been projected to 2014/15 based on anticipated population and utilisation rates.

The Department will finalise the Service Transformation Plan during the 2010/2012 MTEF to guide the rationalisation, revitalisation, maintenance and development of infrastructure and requisite skills to deliver on mandates.

Whilst it is true that we need to reverse the trend of poor health outcomes, we are conscious of the enormous challenges ahead of us. These challenges call upon us to consciously explore new options which will enable a fit between available resources and needs of the populace of KwaZulu-Natal. This Strategic Plan will serve as compass to assist the Department to bridge the gap between current and expected service delivery.

Improving maternal and child health (MDG 4 and 5) is central to improving the quality of life of families and communities and increasing life expectancy as prioritised in the Medium Term Strategic Framework (Output 1). The Accelerated PMTCT Programme and 5-year Strategy for integrated Maternal, Child and Women’s Health and Nutrition will be scaled up to accelerate progress towards the targets of the Millennium Development Goals.

Reduction in HIV infection is imperative in dealing with this pandemic as for each individual placed on ART two more become infected. An effective and sustainable response to the pandemic is one that has prevention as its fulcrum. The success of prevention interventions depends largely on collective societal commitments that support individual behaviour change which is a responsibility of all South Africans.

As per Presidential declaration on the 1st of December 2009, the Province is preparing for the implementation and roll-out of the HCT campaign. The key objective of HCT is to increase HIV testing and improve health seeking behaviour with a focus on prevention rather than cure. The Department is anticipating to increase the number of people tested for HIV from 700 000 to 3 365 157 by 2014/15.

The new policy changes announced by the President on the 1st of December 2009 will improve access to treatment and make provision for:

1. All children under one year of age get treatment if they test positive for HIV.
2. All patients with both TB and HIV get ARV treatment if their CD4 count is 350 or less.
3. TB and HIV & AIDS treated under the same roof.
4. All pregnant HIV-positive women with CD4 counts of 350 or with symptoms, regardless of the CD4 count, have access to ARV treatment.
5. All other pregnant women not falling into this category, but who are HIV-positive, will receive treatment at 14 weeks of pregnancy to protect the baby.

Plans to improve quality and efficiency in health care will be implemented with vigor in line with national core standards towards accreditation. This will serve as vehicle to capacitate service providers and managers to respond to the increasing demands on the public health system.

I am looking forward to this new phase of development and consolidation in the Department and from a personal perspective, I am committed to leading and facilitating the process to implement and institutionalise these plans during my tenure.
OFFICIAL SIGN OFF OF THE 2010 – 2014 STRATEGIC PLAN

- Was developed by the Department under guidance of the Head of Department Dr S Zungu and the MEC for Health Dr S Dhlomo.

- Takes into account all relevant policies, legislation and mandates that the Department is responsible for.

- Was developed with due consideration to priorities identified in the National Health System 10-Point Plan and the Medium Term Strategic Framework.

- Accurately reflects the Strategic Goals, Objectives and Performance Targets which the Provincial Department of Health will endeavour to achieve over the period 2010 – 2014.

Mr. Ndoda Biyela
Mr. N. Biyela
Chief Financial Officer

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Acting General Manager
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Dr S. Zungu
Accounting Officer

APPROVED BY
Dr S. Dhlomo
Executive Authority

Signature

Signature

Signature

Signature
PART A: STRATEGIC OVERVIEW

1. VISION, MISSION & CORE VALUES

Vision

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

Mission

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

Core Values

Trust built on truth
Open communication
Commitment to performance
Integrity and reconciliation
Transparency and consultation
Courage to learn, change and innovate

2. LEGISLATIVE AND OTHER MANDATES

2.1 Constitutional Mandates


In terms of the Constitutional provisions, the Department is guided by amongst others the following sections and schedules:

- Section 27(1): “Everyone has the right to have access to ...health care services, including reproductive health care”.

- Section 27 (2): The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

- Section 27(3): “No one may be refused emergency medical treatment”.

- Section 28(1): “Every child has the right to ...basic health care services...”

- Schedule 4 list health services as a concurrent national and provincial legislative competence.

- Section 195: Public administration must be governed by the democratic values and principles enshrined in the Constitution.

- Section 195 (1b): Efficient, economic and effective use of resources must be promoted.
Section 195 (1d): Services must be provided impartially, fairly, equitably and without bias.

Section 195 (1h): Good human resource management and career development practices, to maximise human potential must be cultivated.

2.2 Legal Mandates

In carrying out its functions, the Department is governed mainly by the following Acts and Regulations:

- National Health Act (Act No. 61 of 2003): Provides for a transformed National Health System to the entire Republic.

- Mental Health Care Act (Act No. 17 of 2002): Provides a legal framework for mental health and in particular the admission and discharge of mental health patients in mental health institutions.

- Public Finance Management Act (Act No. 1 of 1999 as amended) and Treasury Regulations: Provides for the administration of State funds by functionaries, their responsibilities and incidental matters.

- Preferential Procurement Policy Framework Act (Act No. 5 of 2000): Provides for the implementation on the policy for preferential procurement pertaining to historically disadvantaged entrepreneurs.

- Division of Revenue Act (Act 7 of 2003): Provides for the manner in which revenue generated may be disbursed.

- Public Service Act (Act No. 103 of 1994) and the Public Service Regulations: Provisions for the administration of the public service in its national and provincial spheres, as well as provides for the powers of ministers to hire and fire.

- Medicines and Related Substances Act (Act No. 101 of 1965 as amended): Provides for the registration of medicines and other medicinal products to ensure their safety, quality and efficacy, and also provides for transparency in the pricing of medicines.

- Pharmacy Act (Act No. 53 of 1974 as amended): Provides for the regulation of the pharmacy profession, including community service by pharmacists.

- Nursing Act (Act 33 of 2005): Provides for the regulation of the nursing profession.

- Choice of Termination of Pregnancy Act (Act No. 92 of 1996, as amended): Provides a legal framework for termination of pregnancies (under certain circumstances) and based on informed choice.

- Labour Relations Act (Act No. 66 of 1995): Provides for the law governing labour relations and incidental matters.

- Basic Conditions of Employment Act (Act No. 75 of 1997): Provides for the minimum conditions of employment that employers must comply with in their workplace.

- Skills Development Act (Act No. 97 of 1998): Provides for the measures that employers are required to take to improve the levels of skills of employees in the workplace.

- National Health Laboratories Services Act (Act No. 37 of 2000): Provides for a statutory body that provides laboratory services to the public health sector.

- Occupational Health and Safety Act (Act No. 85 of 1993): Provides for the requirements that employees must comply with in order to create a safe working environment in the workplace.

- Traditional Health Practitioners Act (Act No. 35 of 2004): Regulates the practice and conduct of Traditional Health Practitioners.

- Health Professions Act (Act No. 56 of 1974): Provides for the regulation of health professions, in particular medical practitioners, dentists, psychologists and other related health professions, including community service by these professionals.

- Human Tissue Act (Act No. 65 of 1983): Provides for the administration of matters pertaining to human tissue.
2.3 Policy Mandates

The Litigation Policy has been drafted within the framework issued by the Department of Justice “Draft Blueprint Strategy Framework”. It informs internal stakeholders on processes to be followed in litigation processes.

To ensure effective implementation of service delivery imperatives (in line with legislative and national policy directives) and to improve efficiency, the Province will review and/or develop relevant policies and vigorously monitor the implementation thereof.

Policies will align with the strategic long-term vision of the Department e.g. Service Transformation Plan and supportive long-term plans. Management systems and processes will be aligned to support the effective translation of policy to service delivery.

The following policies will be reviewed/developed in line with the current strategic vision:

- Provincial Supply Chain Management Policy Framework.
- Provincial Integrated HIV and AIDS Policy & Guidelines to include circumcision, HCT and the national policy changes announced by the President on the 1st of December 2009.
- Provincial Finance Policy Framework – in line with the PFMA and Treasury Regulations.
- Provincial TB Policy Guidelines to ensure incorporation of national policy changes announced by the President on the 1st of December 2009 as well as intended community management of MDR and XDR TB.
- Provincial MC&WH and Nutrition Policy and Guidelines to ensure incorporation of national policy changes announced by the President on the 1st of December 2009 as well as the National 5-Year Strategy.
- Provincial integrated PHC Policy & Guidelines – in line with the rationalisation of PHC services.
- Provincial Policies & Guidelines to guide implementation of community-based services e.g. Governance, Community Health Workers and Community Based Carers.
- Data and Information Management Policy & Guidelines.
- Health Research & Knowledge Management Policy & Guidelines.

2.4 Relevant Court Rulings

There are currently no specific court rulings that have a significant impact on the operational performance or service delivery obligations of the Department.
3. SITUATION ANALYSIS

3.1 Service Delivery Environment

3.1.1 Demographic Profile

KwaZulu-Natal is the second most populous province in South Africa with a total population of 10,449,300 accounting for 21.4% of the total South African population. The uninsured population is estimated at approximately 9,195,384. The Province occupies 7.6% (92,100 sq km) of the total land surface of South Africa.¹

The Province shares borders with Swaziland and Mozambique in the North, Mpumalanga in the North-West, Free State and Lesotho in the West and the Eastern Cape in the South. The Northern Districts of Umkhanyakude and Zululand attract patients from Mozambique and Swaziland and patients from the Eastern Cape utilise health services in the Southern Districts of Ugu and Sisonke. Natural features including rivers, wetlands and mountainous terrain, and the scattered distribution of homesteads in the rural areas pose unique transport and access challenges for equitable distribution of health services.

Performance measurement, using population-based indicators, are to a certain extent influenced by the in- and out-migration of people utilising health services in a specific catchment area. According to Stats SA, the Province has a net migration of 12,100 people (out-migration of approximately 195,200 and 207,300 in-migration).²

The in-migration of people into the eThekwini Metropol contributes to the huge increase in population (35% uninsured) as compared to an average increase of ±10% in other districts.³ Day patients, not formally residing in eThekwini, further complicate analysis of performance (without the provisional adjustment of population denominators). Transport routes, referral patterns, specific disease patterns and trends must therefore take cognisance of population characteristics to ensure equity in the allocation of resources.

² Statistics South Africa
³ Statistics South Africa

The 2007 Community Survey data show substantial variances in population numbers in certain municipalities compared to the 2001 Census estimates. This may have a significant impact on a range of indicators using population-based denominators. The Community Survey confirmed the under-estimation of children under-5 years in both the previous censuses, which resulted in an over-estimation of data using denominators derived from these estimates i.e. immunisation coverage.

The population density is estimated at 107.52 people per km². Sisonke has the lowest population density with approximately 42 people per km², and eThekwini the highest with approximately 1,394 people per km² which have a definite impact on the burden of disease and disease profiles, availability, access to and utilisation of health services. Map 1: Age and Gender Distribution and Map 2: Population Density visually compares municipalities.

Population composition and density, age, male/ female distribution, social development, etc. have a significant impact on health and service delivery and must be considered as integral to disease profiles and trends in order to contextualize health needs, service delivery imperatives and appropriate resource allocation to address inequality with respect to access and service delivery. Although some variables e.g. population numbers and headcounts are considered in budget allocation, a more suitable and inclusive model should be developed to align with disease profiles and service delivery demands.
Approximately 54% of the population live in rural areas, and approximately 10% of the urban population live in under-developed informal settlements\(^4\) which, as a result of under-development and non-availability of essential resources (necessary to maintain health), have significant health and service delivery implications.

Population statistics indicate that approximately 70% of the population in KwaZulu-Natal are below the age of 35 years which has significant implications for planning, resource allocation and service delivery, especially with relation to the current burden of disease (including but not exclusive to HIV and AIDS, TB and increasing non-communicable diseases) and the country’s commitment towards achieving the health Millennium Development Goals.

### 3.1.2 Socio-Economic Profile

According to the District Health Barometer the ten most deprived districts in South Africa fell within three provinces namely KwaZulu-Natal, Eastern Cape and Limpopo with households living on less than R800 per month ranging between 63% and 82% in 2006.\(^5\)

The KZN Department of Health (Strategic Planning and GIS Components) developed provincial poverty profiles (to municipal level) using variables considered a priority for material and social deprivation. This provides valuable information to inform planning and decision-making in direct response to the National Health System (NHS) 10-Point Plan and addressing inequalities in service delivery.

Indicators considered for the development of these profiles include economic (income, dependency ratio); education (schooling); basic services at household level (water, sanitation, electricity, communication, refuge); demographic (population construction); social (heads of household); and roads (accessibility). Map 3: Poverty profile per Municipality and Map 4: People living below the poverty line visually illustrate the poverty index per Municipality in KZN.\(^6\)

The importance of access to basic essential services was highlighted in the 2003 South African Demographic and Health Survey (SADHS) Report. The report indicated that child mortality more than doubled if the source of drinking water was anything other than piped water, and increased from 7.7/1000 (no flush toilets) to 34.9/1000 where there was access to flush toilets.\(^7\)

Unsafe water and poor sanitation contributed to 13,434 (2.6%) of the total deaths reported in the National Burden of Disease Study (2000). The greatest impact was reported in children <5 years with 9.3% of deaths contributed to unsafe water and poor sanitation. In addition, unsafe water and poor sanitation was attributed to 84% of all deaths due to diarrhoea, of which 66.4% were children <5 years.

Map 5: Access to Water and Map 6: Access to Sanitation compares access to basic services per health district. This information has relevance for the development of integrated programmes including the Social Sector Flagship Programme.

Environmental Health services monitor water quality throughout the Province. Water sampling for analysis is however compromised as a result of limited human resources (Environmental Health Officers), inadequate financial resources, and slow progress with the transfer of Environmental Health Services.

The Premier’s Flagship Programme, focusing on community-based services at Ward level commenced in 2009 and will contribute significantly towards addressing issues of poverty and inequity.

### 3.1.3 Epidemiology Profile

Fertility rates declined from an average of 3.03 children per woman in 2001 to 2.60 in 2009 (2.87 and 2.38 nationally).\(^8\)

There is positive population growth (Figure 1) between 2001 and 2009 for both male and female. Improved management of mother to child transmission of HIV (currently 7% transmission rate) and the rapidly increasing

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\(^4\) Extracted from Statistics South Africa and projected from 2001 using growth rates obtained from the mid-year estimates

\(^5\) District Health Barometer 2007/08 by Health Systems Trust

\(^6\) Developed by GIS and Strategic Planning (KZN DOH) using data from Census 2001 and Community & Household Survey 2007 with variables considered priority for material & social deprivation weighted from 1-5 (economic, education, basic services at household level, demographic, social & roads)

\(^7\) SA Demographic and Health Survey 2003

\(^8\) Statistical Release P0302 Mid-Year Population Estimates 2009
number of HIV-positive qualifying patients on ART might begin to show a positive impact on the life expectancy.

Figure 1: Population Pyramid 2001, 2007, 2009

In South Africa, the national decline in life expectancy is considered largely due to HIV and TB which constitute 46% of disability-adjusted life years (DALY) lost in SA.

The KwaZulu-Natal burden of disease, including but not exclusive to HIV, AIDS, TB and increasing non-communicable diseases have a significant impact on life expectancy, although there is a slight increase in both male and female life expectancy between 2001-2006 to 2006-2011.\textsuperscript{10}

\begin{table}[h]
\centering
\begin{tabular}{|l|l|l|}
\hline
Year & Male & Female \\
\hline
2001 - 2006 & 46.4 years & 50.6 years \\
\hline
2006 - 2011 & 47.3 years & 51.0 years \\
\hline
\multicolumn{2}{|l|}{(National 53.5)} & \multicolumn{1}{l|}{(National 57.2)} \\
\hline
\end{tabular}
\caption{Life expectancy at birth in KwaZulu-Natal}
\end{table}

To reverse the declining life expectancy, the 2010/11 Medium Term Strategic Framework (MTSF) focuses on 4 core areas namely:

1. Increasing life expectancy at birth.
2. Combating HIV and AIDS.
3. Decreasing the burden of diseases related to TB.
4. Improving health systems effectiveness.

Inconsistent data on infant and child mortality rates still impact significantly on planning, decision-making and results-based monitoring. Data on under-5 and child mortality in the 2003 SADHS is questioned and therefore not cited as part of the Provincial profile.

KwaZulu-Natal Burden of Disease Study – Phase 1: PHC Disease Profile

Preliminary results of this study indicate that out of a total of 10,009 PHC patients, the highest number of patients (12.4%) presented with hypertension followed by TB (9.9%), respiratory illnesses (9.4%), upper respiratory tract illnesses (5.4%) and HIV (5.0%).

According to the National Burden of Disease in South Africa\textsuperscript{12} the most common causes of mortality in public hospitals are TB; gastroenteritis; pneumonia; hypertension and cancer – reflected in the graph below.

Graph 2: Twenty leading causes of death recorded in Public Hospitals

The study highlights that a significant component of the burden of illness is still attributable to communicable diseases and nutritional, maternal and peri-natal conditions. Diarrhoeal and respiratory conditions were found to be common causes of mortality and morbidity with

\begin{itemize}
\item \textsuperscript{9} Population data from Stats SA
\item \textsuperscript{10} Statistical Release P0302 Mid-Year Population Estimates 2009
\item \textsuperscript{11} Statistical Release P0302 Mid-Year Population Estimates 2009
\item \textsuperscript{12} Burden of Disease in SA – Linked cross-sectional survey of Public and private Health Facilities Draft Report May 2009
\end{itemize}
diarrhoea resulting in dehydration one of the most common causes of death in young children. Co-infection of TB-HIV could not be determined in this study although TB has been found to be the most common cause of both morbidity and mortality.

This supports the importance of improving access to water and sanitation as well as improving PHC services in an effort to address the preventable causes of morbidity and mortality.

According to the Burden of Disease Study, the leading causes of morbidity in public health facilities are TB; upper respiratory tract infection; STI’s; diarrhoeal diseases; urinary tract infection and otitis media as indicated in Graph 3 below.

According to the Burden of Disease Study, the leading causes of morbidity in public health facilities are TB; upper respiratory tract infection; STI’s; diarrhoeal diseases; urinary tract infection and otitis media as indicated in Graph 3 below.

**Graph 3: Leading specific diagnosis in Public Health Facilities**

3.2 Organisational Environment

The Province is divided into 50 Municipalities, 1 Metropolitan and 10 Health Districts. The health service boundaries are aligned with the municipal boundaries as determined by the Municipal Demarcation Board.

In 2008/09 there were 67,594 employees in the KwaZulu-Natal Department of Health as compared with 67,213 in 2007/08 and 52,643 in 2005/06.

In 2008/09 the health worker per population ratio was 28/100,000 for Medical Officers (12/100,000 in rural areas) and 111/100,000 for Professional Nurses (50/100,000 in rural areas) which confirms the unequal distribution of resources.

The current burden of disease places immense physical, social, emotional and psychological demands on health care providers (both personally and professionally) which in turn have significant implications for service delivery. According to previous Departmental Annual Reports and Persal records, service terminations due to death increased from 9.5% in 2002/03 to 11.77% in 2008/09.

The national PHC staffing norms of 1:30 patients for Medical Officers (16 minutes per patient per day) and 1:40 patients for Professional Nurses (12 minutes per patient per day) should be reviewed based on the current disease profile.

Vacancy rates for critical skills show a consistent increase between 2003/04 to 2006/07 and then stabilized in 2007/08. The vacancy rate for Medical Officers increased from 20.7% in 2004/05 to 35.16% in 2009/10, and the vacancy rate for Medical Specialists increased sharply from 39.6% in 2004/05 to 62.6% in 2009/10. This has serious implications for the delivery of specialist services at Regional and Tertiary/ Central levels of care.

Although the vacancy rates for Professional Nurses showed an initial increase from 22.7% in 2004/05 to 42.2% in 2005/06 it since improved to 21.63% in 2009/10. An analysis on PHC staffing supply in the 2nd quarter of 2008/09 indicated a net gain of 313 nursing personnel in PHC facilities between March and August 2008. By inference it appears that OSD is having the desired impact in the PHC setting. Further analysis is however necessary to inform recruitment and retention strategies.

High vacancy rates of 76.96% and 75.4% for Pharmacists and Nutritionists/ Dieticians have serious implications for the intended roll-out of priority programmes i.e. HIV and AIDS, TB and MC&WH and Nutrition.

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13 2008/09 Annual Report
14 It must be noted that this data is subject to change as institutions effect backdated service terminations and appointments which will impact on total staff numbers. In addition, transactions on the suspense file on Persal also impact on the staffing numbers e.g. a service termination may be effected but not all transactions are updated on Persal – therefore although an employee’s salary may be stopped, the post will be reflected as filled.
15 Persal data
16 Based on a normal 8-hour working day for both Medical Officers and Professional Nurses.
High vacancy rates for Occupational Therapists (58.8%), Physiotherapists (60%), Psychologists (63.6%) and Social Workers (58%) will impact on the revitalisation of PHC services, specifically referring to improving access through out-reach services.

Table 2: Vacancy Rates 2005/06 – 2009/10

<table>
<thead>
<tr>
<th>Category</th>
<th>05/06</th>
<th>06/07</th>
<th>07/08</th>
<th>08/09</th>
<th>09/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Officers</td>
<td>31.3%</td>
<td>38.2%</td>
<td>35.2%</td>
<td>38.6%</td>
<td>35.16%</td>
</tr>
<tr>
<td>Medical Specialists</td>
<td>58.6%</td>
<td>56.3%</td>
<td>55.8%</td>
<td>69.5%</td>
<td>62.60%</td>
</tr>
<tr>
<td>Professional Nurses</td>
<td>42.2%</td>
<td>41.7%</td>
<td>39.6%</td>
<td>21.4%</td>
<td>21.63%</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>75.2%</td>
<td>73.8%</td>
<td>73.8%</td>
<td>75.4%</td>
<td>76.96%</td>
</tr>
</tbody>
</table>

Note: Filled posts are reflected in green

Significant variances between service delivery points necessitate an assessment of staff placement and skills mix to ensure appropriate placement and utilisation of available resources. This will inform the re-engineering of health services to comply with service standards.

The increased demand for and utilisation of public health services significantly increased the workload and clinical demands on health care providers.

The World Health Organisation (WHO) estimates that South Africa will need three times the current active human resources to ensure universal coverage of ART by 2017. This has significant implications for resource allocation in order to achieve the MDG targets.

Turn-over rates for all critical skills (except Pharmacists) show a steady decrease between 2005/06 to 2008/09 as indicated in Table 3.

Table 3: Turnover Rates 2005/06 – 2008/09

<table>
<thead>
<tr>
<th>Category</th>
<th>2005/06</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Officers</td>
<td>34%</td>
<td>28.8%</td>
<td>23%</td>
<td>21.3%</td>
</tr>
<tr>
<td>Medical Specialists</td>
<td>31.9%</td>
<td>22.3%</td>
<td>16%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Professional Nurses</td>
<td>9.2%</td>
<td>No data</td>
<td>6.4%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>26.2%</td>
<td>22.8%</td>
<td>25.9%</td>
<td>38.4%</td>
</tr>
</tbody>
</table>

Macro plans, including the Service Transformation Plan (STP), Human Resource Plan (HRP) and Infrastructure Plan, will make provision for resource allocation based on the Departments’ long-term vision within the framework of the National Health System priorities.

The Provincial HRP has been developed as contemplated in Chapter 1, Part III of the Public Service Regulations, 2001 (as amended). The White Paper on Human Resource Management in the Public Service (December 1997) notes that “Human Resource Planning is essential in order to ensure that an organisation’s human resources are capable of meeting its operational objectives.”

Human resource allocation is however challenged by the unique topography of the Province, the location of facilities in deep rural areas, inadequate staff accommodation, and a limited funding envelope as a result of previous over-expenditure.

Reviewed staffing norms, expected to be finalised by the National Department of Health in 2010, will be factored into the HRP once available.

Over-expenditure of R 1,320,116 billion in the previous MTEF impact on service delivery including sustaining current services and planning for future expansion in line with the NHS 10-Point Plan and burden of disease. In response, the Department instituted cost containment measures in 2009/10 to curtail over-expenditure.
### 3.3 Millennium Development Goals

#### Table 4: Progress towards the Millennium Development Goal Targets (2004 – 2009)

|---------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| Goal 1: Eradicate extreme poverty and hunger. | Prevalence of underweight children (under 5 years).  
**Target:** Halve, between 1990 and 2015, the proportion of people who suffer from hunger.  
**National Target:** Not more than 14,582 children presenting to health facilities with severe malnutrition. | 29,165 children suffered from malnutrition in 2007.  
**Data Source:** Development indicators Mid-Term Review published by the Presidency, RSA, 2008 | 6,662 children diagnosed with severe malnutrition at PHC level in 2008/09.  
**Data Source:** DHIS  
Severe malnutrition under-5 years incidence (annualised) 6.2/1000 (2009/10).  
**Data Source:** DHIS |
**Target:** Reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate.  
**National Target:** 19.7/1000 (or less) | 58/1000  
**Data Source:** SADHS 2003 | 95/1000  
**Data Source:** Medical Research Council  
Facility mortality under-5 years rate 19.3% (Q2 2009/10).  
**Data Source:** DHIS |
|                      | Infant mortality rate.  
**National Target:** 14.3/1000 (or less) | 43/1000  
**Data Source:** SADHS 2003 | 60/1000  
**Data Source:** Medical Research Council  
46/1000  
**Data Source:** Statistics SA Mid-Year Estimates 2009  
Facility mortality under-1 year rate 15.3% (Q2 – 2009/10).  
**Data Source:** DHIS |
|                      | Proportion of one-year-old children immunised against measles.  
**National Target:** 100% | 85.8% in 2007  
**Data Source:** DHIS, National DOH 2007 | 88% (2009/10)  
**Data Source:** DHIS |
**Target:** Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate.  
**National Target:** 36.8/100 000 (or less) | 147/100 000  
**Data Source:** National Confidential Enquiries into Maternal Deaths 2002-2004 | 224.4/100 000  
**Data Source:** National Confidential Enquiries into Maternal Deaths 2004-2007 (KZN data)  
168 facility-based deaths reported Q1 and Q2 of 2009/10.  
**Data Source:** DHIS |
|                      | Proportion of births attended by skilled health personnel.  
**National Target:** 100% | 92%  
**Data Source:** SADHS 2003 | 91.1%  
**Data Source:** SADHS 2003 |

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17 The data quality for child mortality (58/1000) in the SADHS 2003 is considered unreliable and is therefore not quoted
18 SADHS 2003 (43/1000) is considered unreliable and therefore not quoted
<table>
<thead>
<tr>
<th><strong>MDG Goals &amp; Targets</strong></th>
<th><strong>MDG Indicators</strong></th>
<th><strong>National Progress 2004 - 2009</strong></th>
<th><strong>Provincial Progress 2004 - 2009</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 6: Combat HIV and AIDS, Malaria and other diseases.</td>
<td>HIV prevalence among 15-24 year old pregnant women.</td>
<td>19%</td>
<td>29%</td>
</tr>
<tr>
<td><strong>Target:</strong> Have halted by 2015, and begin to reverse the spread of HIV and AIDS.</td>
<td><strong>National Target:</strong> 9.5% (or less) – 50% reduction in prevalence.</td>
<td><strong>Data Source:</strong> National HIV &amp; Syphilis Prevalence Survey of SA 2007</td>
<td><strong>Data Source:</strong> National HIV &amp; Syphilis Prevalence Survey of SA 2008</td>
</tr>
<tr>
<td></td>
<td>Contraceptive prevalence rate.</td>
<td>65%</td>
<td>76.8%</td>
</tr>
<tr>
<td><strong>Target:</strong> Have halted by 2015, and begin to reverse the spread of HIV and AIDS.</td>
<td><strong>National Target:</strong> 85%</td>
<td><strong>Data Source:</strong> SADHS 2003</td>
<td><strong>Data Source:</strong> SADHS 2003</td>
</tr>
<tr>
<td></td>
<td>Mother to Child Transmission Rate</td>
<td></td>
<td>20.8% (2004/05) and 7% (2008/09)</td>
</tr>
<tr>
<td><strong>Target:</strong> Have halted by 2015, and begin to reverse the incidence of malaria and other major diseases.</td>
<td>Proportion of TB cases detected and cured under directly observed treatment, short-course (DOTS).</td>
<td>64%</td>
<td>62% (2008/09) and 58.15% (Q2-2009/10)</td>
</tr>
<tr>
<td></td>
<td><strong>National Target:</strong> 85%</td>
<td><strong>Data Source:</strong> DHIS 2008</td>
<td><strong>Data Source:</strong> Electronic TB Register</td>
</tr>
<tr>
<td></td>
<td>Incidence and death rates associated with malaria.</td>
<td></td>
<td>244 Cases and 3 Deaths (2009)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Data Source:</strong> Programme Report</td>
<td><strong>Data Source:</strong> Notifiable Conditions Database</td>
</tr>
</tbody>
</table>
3.4 Progress: National Health System Priorities 2004 – 2009

Priority 1: Improve Governance and Management of the NHS

- Implemented National Policies and Guidelines.

Priority 2: Promote healthy lifestyles

Develop a national strategy to promote healthy lifestyles

- 88 PHC clinics and 9 hospitals implement the Health Promotion principles which are inclusive of the 5 action areas outlined in the Ottawa Charter. Six of the 88 PHC clinics have been accredited as Health Promoting facilities, including the Community Component in service delivery.
- There are 27 Health Promoting Homes (Ugu 16) and (Umzinyathi 11).

Initiate and maintain Healthy Lifestyles Campaigns

- The 5 healthy lifestyle components i.e. nutrition, tobacco control, safe sexual practices, alcohol/ drug use/ control and physical activity are included in outreach activities.

Strengthen the Health Promoting Schools (HPS) initiative

- A total of 162 Schools are accredited as HPS, and the concept introduced in 2,105 schools in 2008/09 and 2009/10.

Initiate and maintain the diabetes movement

- Diabetes patients on treatment (PHC) increased from 826,105 in 2005/06 to 903,441 in 2008/09 (9.3% increase).
- The partnership with Novo Nodirks increased diabetes awareness and screening. In 2008/09, a total of 6,961 people were screened for diabetes, 536 were newly diagnosed and 953 diabetes clients on oral medication and 229 on insulin were seen during district awareness programmes.
- 280 Professional Nurses were trained through a partnership with the South African Sugar Association.

Develop and implement strategies to reduce chronic diseases of lifestyle

- Screening for chronic diseases was prioritised at all health events to promote early diagnosis, effective referral, treatment and treatment compliance.
- Tracing of defaulters remain a challenge mainly because of a lack of integrated tracing teams, inadequate Community Care Givers and supervisors/ facilitators to fulfill community-based functions, and inadequate communication (telephones) at some PHC clinics. Districts reported a reduction in detection of new hypertension and diabetic patients as a result of reduced outreach events due to cost containment measures.
- The cervical cancer screening coverage is 6.2%.

Implement activities and interventions to improve key family practices that impact on child health

- 26 Local Municipalities implement the Community Component of IMCI.
- The Reach Every District (RED) strategy to improve immunisation coverage and reduce vaccine preventable diseases has been introduced in 11 districts.

Priority 3: Contribute towards human dignity by improving quality of care

Strengthen community participation at all levels

- Interim Clinic Committees have been established at 80% PHC clinics and 81% CHC’s.

Improve clinical management of care at all levels of the health care delivery system

- 85% of District and 87% Regional Hospitals conduct monthly clinical audit meetings, 88% Districts and 89% Regional Hospitals implement the Quality Assurance Package and 89% District and 98% Regional Hospitals conduct monthly morbidity & mortality meetings.
Strengthen the hospital accreditation system in each province in line with national norms and standards

- The following hospitals received the Premier’s Award for Service Excellence: Greys: Silver in 2003/04 and Gold in 2004/05; St Apollinaris: Bronze in 2005/06 and 2006/07; Itshelejuba: Silver in 2007/08; and Estcourt: Gold in 2008/09.
- Implementation of the “Look like a Hospital Project” to improve quality and efficiency commenced in 12 identified hospitals in 2009/10.

Priority 4: Improve management of communicable diseases and non-communicable illnesses

Scale up surveillance to enhance epidemic preparedness and response

- Acute Flaccid Paralysis: 62/66 cases were detected between January to December 2008 of which 51.82% were fully investigated with adequate stools (target 80%).
- Adverse Events Following Immunisation: 22 cases were reported between January and December 2008 of which 17 cases (77.2%) were fully investigated and reported.
- Measles: 1,198 suspected measles cases were reported between January and December 2008. All cases were fully investigated.
- Nil Neonatal Tetanus reported in 2009/10.
- 49 Hospitals and 3 clinics routinely reported on Genetic disorders in 2009. Eleven Professional Nurses successfully qualified as Genetic Practitioners in the Medical Genetics Programme.

Improve immunisation coverage

- The immunisation coverage increased from 76.4% in 2005/06 to 86% in 2009/10.
- The drop-out rate between 6 weeks (1st dose) and 14 weeks (3rd dose) is below 10%. The drop-out rate between measles 1 and 2 is 12.4% with Zululand (23.4%), Uthukela (18.3%), Umkhanganyude (17%), eThekwini (14.2%) and Sisonke (11.8%) exceeding the target of <10%.
- Measles coverage increased from 79% in 2005/06 to 88% in 2009/10.

Improve the management of all children under-5 years presenting with illnesses such as pneumonia, diarrhoea, malaria and HIV

- 55% of professionals at PHC were trained in IMCI in 2009/10, although only 33% of Professional Nurses at PHC level were trained in both the clinical and community and household components of IMCI.
- The IMCI Community Component is implemented in 26 local municipalities.
- 6,299 Community-Based Carers were trained in the IMCI community component in 2009.

Update malaria guidelines, integrate malaria control into comprehensive communicable diseases control programme and ensure reduction of cases

- The Province successfully sustained control measures towards achieving malaria elimination as prescribed in the SADC Strategy for the Africa Malaria Elimination Campaign, and achievements exceed the Millennium Development Goal to halve malaria morbidity and mortality by 2015.
- The Province reported a malaria incidence of below 1/1000 population in 2008/09 and a reduction of reported cases from 606 cases in 2007/08 to 429 cases in 2008/09.
- The Provincial malaria case fatality rate is 0% (2009/10) compared to the national case fatality rate target of 0.5%.
- The Indoor Residual Spraying coverage of 93% (compared to 86% in 2007/08) ensured that more than 280,000 people in malaria risk areas were protected from malaria in 2008/09.
- More than 30,000 community members, including Traditional Leaders and Healers, were reached with information and health education/promotion on malaria transmission and prevention, and a total of 121 health professionals were trained on malaria case management.
- The Province reported a decrease of 90% in notified malaria cases and 95% in malaria deaths from 293/35,672 cases in 1999 to 17/1,211 cases in 2005/06 (1st year of 5-year planning cycle) and 5/429 cases in 2008/09.
Implement the TB programme review recommendations

- TB cases with DOT supporters decreased from 80% in 2005/06 to 75% in 2009/10 due to difficulty in sustaining voluntary programmes.
- The Flagship Programme (Premier's Office) commenced in 2009/10. TB constitutes an important component of the Programme.
- The TB treatment interruption rate decreased from 14% in 2004/05 to 8.7% in 2009/10 (Q2).
- The TB sputa turn-around time of <48 hours increased from 15% in 2005/06 to 60.3% in 2008/09 and decreased to 53.8% in 2009/10.
- New MDR TB cases reported increased from 555 in 2005/06 to 1,134 in 2008/09.
- New XDR TB cases reported increased from 35 in 2005/06 to 109 in 2008/09.
- The TB smear conversion rate increased from 48% in 2005 to 60.5% in 2008.
- The TB cure rate increased from 35% in 2004 to 62% in 2008 and decreased to 58.1% in 2009/10 (Q2).
- Although the number of TB beds increased from 240 in 2005 to 581 in 2008 it is still inadequate to accommodate the increasing number of TB cases in the Province. The decrease in patients on waiting lists, from approximately 170 patients/2-4 weeks to 50 patients/1-2 weeks, suggests that improved screening, access and treatment outcomes have a positive effect on management of patients in the community.

Accelerate implementation of the Comprehensive Plan for HIV and AIDS

- The VCT Programme is supported by 1,904 Lay Counsellors and 95 Site Mentors who contributed to the increase in the number of people tested from 288,536 in 2005/06 to 635,814 in 2008/09 (120% increase).
- During 2008/09 and 2009/10 a total of 488,599 patients were cared for by HBC's, and in 2009/10 a total of 653,802 patients were served by CHW's. In 2009/10, 4,727 CHW's and 3,780 HBC's received stipends.
- High Transmission Area Intervention Sites increased from 19 in 2007/08 to 42 in 2009/10.
- Registered ART service points increased from 55 in 2005/06 to 89 in 2009/10.
- Total patients on ART increased from 11,449 in 2005/06 to 335,148 in Q3 2009/10 (average of 30% males, 61% females and 9% children).
- The STI partner treatment rate decreased from 22% in 2005/06 to 21% in 2008/09 and 20% in 2009/10.
- Nevirapine dose to baby coverage rate increased from 39% in 2005/06 to 85% in 2008/09, and the Nevirapine uptake (antenatal clients) increased from 25% in 2005/06 to 75% in 2008/09.
- The PMTCT dual therapy was rolled out to 98% of health facilities, resulting in decreasing the MTCT to 7%.
- The HIV testing rate of ANC clients increased from 80% in 2007/08 to 96% in 2008/09, although the Nevirapine uptake rate of ANC clients decreased slightly from 76% in 2007/08 to 75% in 2008/09.
- According to the 2008 ANC Sero-Prevalence Study, the HIV prevalence in pregnant women decreased slightly from 39.1% to 37.4%.

Strengthen free health care for people with disabilities

- The Department issued 1,988 wheelchairs and 1,113 hearing aids in 2008/09.
- The placement of 140 Community Service Therapists strengthened access to services at PHC level. Therapists spend 40% of their time in PHC clinics and CHC's which improved PHC coverage to a total of 1,406 clinic visits by therapists in 2008/09 and 80% of hospitals being able to access some rehabilitative service.
- There are 24 Audio Sites in the Province.
- Disabled People South Africa manages the Wheelchair Repair and Maintenance Project with 23 workshops in which 54 people with disabilities are employed to repair wheelchairs.
- A total of 22 Community Based Rehabilitation Workers are employed through a service level agreement.

Strengthen programmes on women and maternal health

- A total of 308 maternal deaths were reported in 2008/09 (168 in Q1 and 2 of 2009/10).
All hospitals implement at least 80% of the Saving Mothers Recommendations to reduce the preventable causes of maternal deaths.

The leading causes of maternal death are still non-pregnancy related infections (49%) with AIDS contributing to 18%, hypertension (12%) and obstetric haemorrhage (8.3%).

The Provincial Maternal Mortality Ratio increased from 166 per 100,000 in 1996 to 210 per 100,000 in 2007.

Equal distribution of termination of pregnancy services has not been achieved and services are provided in 22/54 designated public health facilities. An additional 5 private facilities are rendering 1st trimester services and 2 public health facilities are rendering 2nd trimester services.

The 2005-2006 KZN Maternal Death Report indicated that septic abortion was responsible for 3.6% of maternal deaths as compared to 3.2% in 2002-2004.

In 2008/09, 12,528 legal terminations were performed in designated facilities compared to 14,435 in 2007/08. During the same time 305 septic abortions (201 in 2007/08) and 11,343 incomplete abortions (8,860 in 2007/08) were reported.

The women-year protection rate increased from 19.2% in 2005/06 to 23% in 2009/10.

Basic Ante Natal Care (BANC) is implemented in 82% of facilities. As a result, early booking (ANC) is evident in eThekwini (from 28% to 34%) and Umgungundlovu (from 51% to 59%).

Kangaroo Mother Care (KMC) is implemented in 86% of facilities with 100% of facilities in Ilembe, Ugu, Umgungundlovu, Uthukela, Amajuba and Sisonke Districts.

Colposcopy services, for the management of abnormal Pap smears, are provided in 14 hospitals (8 districts). According to 2008/09 results, 20.15% of Pap smears were abnormal (12.95% low-grade lesions, 7.2% high-grade lesions and 0.25% invasive cancer).

During 2008/09, a total of 10,423 new sexual assault cases were reported in Public Health facilities of which 3,604 (34.5%) received ARV prophylaxis.

A total of 38 Health Care Practitioners were trained on caring for sexual assault and rape survivors, 45 Doctors were trained on sexual assault and 3 providers working in crisis centres received training on the management of rape and sexual assault.

**Improve risk management of non-communicable illnesses**

- Through the Child Eye Care Project, in partnership with the Department of Education and International Centre for Eye Care Education (ICEE), a total of 237,556 children were screened across the Province, 6,687 received refraction and 1,900 received spectacles.
- The Department signed a Memorandum of Understanding with the ICEE through the Giving Sight in Africa Project for the period June 2008 to July 2012. Access to refraction services has increased from 40% to 100% and the refraction rate increased from 15% to 40% through affordable spectacle provision.
- There are 13 Sight Saver Hospitals.
- **Vision 2020 (Prevention of Blindness Programme):** A total of 9,315 cataract operations were done in 2008/09 and 11,653 spectacles provided.
- 86% of PHC facilities have fast queues compared with 40% in 2005/06.
- Patients on treatment for hypertension increased from 2,534,713 in 2005/06 to 2,779,755 in 2008/09 (9.6% increase).
- The number of cataract surgeries increased from 2,534,713 in 2005/06 to 2,779,755 in 2008/09 (9.6% increase).
- There is a slight improvement of the extraction of teeth versus restoration of teeth rate from 30:1 in 2005/06 to 28:1 in 2008/09.

**Improve mental health services**

- See implementation of the Mental Health Care Act.

**Strengthen programmes for survivors of sexual abuse and victim empowerment**

- 100% of hospitals and 75% of CHC’s provide post exposure prophylaxis for sexual assault.
Priority 5: Strengthen Primary Health Care, EMS and hospital delivery systems

Strengthen PHC

- The PHC headcount increased from 19,210,359 in 2005/06 to 23,838,854 in 2008/09.
- The OPD headcount (District Hospitals) increased from 1,733,618 in 2005/06 to 2,775,255 in 2008/09.
- Utilisation rates for PHC increased slightly from 2 visits per person per year in 2005/06 to 2.5 visits in 2008/09; and the under-5 utilisation increased from 4 visits per child per year in 2005/06 to 4.4 in 2008/09.
- The supervision rate is low at 65%.
- PHC clinics increased from 539 in 2005/06 to 577 in 2008/09. There are 16 CHC’s AND 37 District Hospitals.
- There are 2,512 mobile stopping points and 49 Health Posts to extend services to under-served communities.
- The doctor clinical workload is 1:25 and professional nurse workload 1:40.

Implement Provincial EMS plans

- The Department has not been able to comply with the national norm of 1 emergency vehicle per 10,000 population and is currently functioning at 1:44,000.
- The rural response times <40 minutes is 39% and the urban response time <15 minutes is 28%.
- Upgrades on 4 Communication Centres have been completed, including the upgrading of computerised communication systems and reconfiguration of the floor layout to ensure a more conducive work environment. Communication Centres at Ugu, Uthukela, Umgungundlovu and Ilembe Districts are complete.
- Emergencies are logged on the toll-free number (10177) and automatically directed to the nearest control centre (one control centre per district).
- During 2008/09 a total of 711,126 calls were logged with ambulances attending to a total of 705,534 patients.
- Total rostered ambulances increased marginally from 207 in 2006/07 to 226 in 2008/09.

Strengthen hospital services

Regional Hospitals (2005/06 – 2008/09):

- OPD headcounts increased from 2,392,992 to 2,752,678.
- Separations increased from 288,610 to 355,778.
- Average length of stay increased from 5 days to 5.3 days.
- Bed occupancy rates increased from 67% to 71.3%.
- Case fatality rate for surgical separations increased from 4.2% to 5.6%.
- The caesarean section rate decreased from 35% to 31.6%.

Tertiary Hospitals (2005/06 – 2008/09):

- Caesarean section rate decreased from 73% to 69.4%.
- Separations decreased from 15,486 to 11,919.
- OPD headcounts increased from 178,493 to 196,857.
- Average length of stay increased from 6.5 days to 9.9 days.
- Bed occupancy rate decreased from 77% to 70.9%.
- Case fatality rate for surgical separations decreased from 7% to 6.2%.

Central Hospital (2005/06 – 2008/09):

- Caesarean section rate increased from 74% to 81.5%.
- Separations increased from 14,733 to 20,886.
- OPD headcounts increased from 145,768 to 174,704.
- Average length of stay decreased from 10 days to 8.8 days.
- Bed occupancy rate increased from 61% to 62.8%.
- Case fatality rate for surgery separations decreased from 6% to 3%.

Priority 6: Strengthen support services

Transfer Forensic labs including mortuaries to provinces

- There are 40 Medico Legal Mortuaries (25 in 2005/06).
- The organisational structure and post establishment of the Forensic Pathology Services has been reviewed
and makes provision for a total of 1,010 posts for an effective 24-hour service. The current vacancy rate is 48.9% with 530/1,010 posts filled.

- One mortuary in Richards Bay was completed in 2008/09 the upgrade of Gale Street Mortuary in Durban is complete with 9 mortuaries still under construction. The upgrade/construction of the remaining 24 mortuaries has not commenced due to budgetary constraints.

- Forensic pathology and mortuary services have a fleet of 135/215 vehicles to render a 24-hour service in the Province. The shortfall of 80 vehicles affects service delivery and increased maintenance costs in 2009/10. The fleet management and supervision of mortuary drivers have been devolved to the District EMS and forms part of Disaster Management.

- The Province offers a 2-year training programme that allows student Mortuary Technicians to obtain professional registration as Mortuary Technicians with the HPSCA. The training of the 1st cohort of Mortuary Technicians (120) at the Durban University of Technology (DUT) commenced and will be completed in June 2009. The 2nd cohort will commence training in the beginning of 2009.

**Implement health technology management system**

- Due to severe financial constraints the Telemedicine and Information Technology Unit could only maintain the existing services through the State Information Technology Agent (SITA) Service Level Agreements.

- The Unit was unable to implement critical new projects, e.g. implementation of the Master Systems Plan, upgrading of data lines in hospitals, the implementation of the Hospital Information System, implementation of telemedicine, etc.

- Upgrading of the existing 128K lines to 1MB at the 5 Revitalisation sites (using National Department of Health funds) and the implementation of Meditech Hospital Information System are in progress.

- Little progress has been made with the development and implementation of the Master Systems Plan (MSP). The tender was awarded in 2008/09 and the draft implementation plan presented to the Health Operations Committee.

- There are 37 operational Telehealth Sites.

**Priority 7: Human Resource Planning, Development and Management**

**Implement the National HRP**

- The Provincial HRP has been developed and approved by the Head of Department in 2009.

**Strengthen implementation of the CHW Programme and expand the mid-level worker programme**

- The Home and Community Based Care (HCBC) Programme has 1 Provincial NPO contracted for the Community Care Giver (CCG) Programme, and 13 local NPO’s sub-contracted at district level. The Provincial target of contracting 33 local NPO’s could not be met due to financial constraints.

- There are currently a total of 5,362 CCG’s rendering services in the Department. All contracted CCG’s received stipends in 2008/09 as part of the poverty alleviation project of the Expanded Public Works Programme (EPWP).

- The number of active HCBC increased from 4,000 in 2005/06 to 14,525 in 2008/09.

- Number of patients served by HCBC increased from 164,480 in 2006/07 to 2,161,280 in 2008/09.

- Number of home visits by HCBC decreased from 7,275,600 in 2006/07 to 1,445,019 in 2008/09.

- A total of 343,473 patients were referred by HCBC in 2008/09.

**Priority 8: Planning, budgeting and monitoring & evaluation**

**Strengthen health system planning and budgeting**

- All districts submitted DHP’s as per National Health Act of 2003 requirements.

- Health trends and profiles were developed to inform evidence-based planning.

**Strengthen use of the health information system**

- DHIS 1.4 was rolled out to all district offices and facilities in 2009/10. District and Facility Information Officers completed two orientation courses on the implementation of the system.
Core indicators have been included in the DHIS 1.4 system to improve collection, collation, reporting and monitoring of progress towards targets.

All core indicators are included in the M&E Framework to improve monthly, quarterly and annual reporting on progress and service delivery.

A web-based reporting system pilot project to improve data commenced in 2010/11.

Priority 9: Prepare and implement legislation
Implement the Mental Health Care Act
- The mental health headcount increased from 323,915 in 2005/06 to 481,186 in 2008/09.
- 26 Facilities have seclusion facilities.
- Health review boards have been established for all areas.
- There are currently 7 Specialised Psychiatric Hospitals with 2,835 useable beds.
- The Provincial mental health bed norms for District Hospitals (139 beds) and for Provincial Hospitals (75 beds) is currently being reviewed by the Mental Health Directorate for inclusion in the STP.
- The Child and Adolescent units are not fully operational. The only in-patient service is rendered at the King George V Hospital (6 bed unit).
- In 2008/09 subsidies were paid to 14 Day Care Centres, 11 Residential Care Facilities and 5 Half-Way Houses.

Provincial Health Acts implemented
- KZN Health Act 1 of 2009. Regulations have not yet been promulgated.

Priority 10: Strengthen international relations
- Strengthened implementation of NEPPAD strategy and SADC.

4. STRATEGIC PLANNING PROCESS
Under guidance and with visible leadership and support from the MEC for Health and the Head of Department, the Department embarked on a series of strategic planning workshops that commenced with a workshop on the 14th of August 2009 (MANCO, District and Hospital Management). This was followed by 4 decentralised workshops that concluded on the 29th of October 2009.

Participants included Senior Managers and Managers from Head Office, District Office Management Teams, and Management Teams from Hospitals and Community Health Centres (including Hospital CEO’s, Medical, Nursing, Finance & HR Managers). A total of 567 Managers attended the decentralised workshops i.e. 227 in Area 1; 191 in Area 2, and 149 in Area 3. Area workshops were supported by Area General Managers and facilitated by the Strategic Planning Directorate.

The recommended ‘top-down-bottom-up’ consultation approach (recommended by the MEC and HOD) have the potential to nurture ownership and accountability for the intended turn-around strategies to improve health service delivery, and give credence to the maxim "SAVE LIVES. Make Health Facilities Serve the People" - Quote from the MEC’s 2009 Budget Speech.

4.1 Strategic Planning Workshops Output
1. Identified core service delivery challenges and root causes that impact on service delivery and health outcomes.
2. Recommended strategic interventions in response to core service delivery challenges (within the existing funding envelope) with the greatest potential to improve service delivery.

4.2 Strategic Planning Workshops Outcome
A well consulted discussion document (per Budget Programme and aligned with the NHS priorities) based on the identified core challenges and recommended interventions to inform the final consultations to determine the Department’s core business for the next 5 years – including the Service Transformation Plan, Strategic Plan (2010 – 2014), Annual Performance Plans and District/Facility Health Plans.

The final draft documents were submitted to Senior Management on the 29th of January for finalising of core strategic priorities.
On the 15th of March 2010, a workshop was conducted with Senior Management and District Managers to discuss rationalisation of services and budget allocation for the MTEF.

Although there are still challenges to align strategic processes at operational level, the inclusive process that commenced in 2010/11 will be cultivated during the forthcoming revitalisation of services to ensure participative planning and improved accountability. The plans will, subsequent to final approval and tabling, be translated into operational plans at institutional level.

Consultation with the Provincial Health Forum is planned for April 2010.

4.3 Other Priorities

The Provincial priorities for the 2010 – 2014 planning cycle have in addition been informed by the following:

A. Medium Term Strategic Framework (MTSF) (Outcome 2) – A long and healthy life for all South Africans

The overarching goal being to *Increase life expectancy at birth* from 47-51 years to 58-60 years, with focus on 4 key priority areas namely:

1. Increasing life expectancy;
2. Combating HIV and AIDS;
3. Decreasing the burden of diseases from TB; and
4. Improving health system effectiveness.

**Expected 20 Outputs:**

1. Increased life expectancy at birth.
2. Reduced child mortality.
3. Decreased maternal mortality.
5. Reduced HIV incidence.
7. Improved TB case finding.
8. Improved TB outcomes.
9. Improved access to ART for HIV/TB co-infected patients.
10. Decreased prevalence of MDR TB.
11. Revitalisation of PHC.
12. Improved physical infrastructure for healthcare delivery.
13. Improved patient care and satisfaction.
15. Enhanced operational management of health facilities.
16. Improved access to human resources for health.
17. Improved health care financing.
18. Strengthened health information systems.
19. Improved health services for the youth.
20. Expanded access to home based care and Community Health Workers.

B. National Health System (NHS) 10-Point Plan

Priority 1: Provision of strategic leadership and creation of social compact for better health outcomes.
Priority 3: Improving the Quality of Health Services.
Priority 4: Overhauling the health care system and improving its management.
Priority 5: Improved Human Resources Planning Development and Management.
Priority 6: Revitalisation of infrastructure.
Priority 7: Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases.
Priority 8: Mass mobilisation for the better health for the population.
Priority 10: Strengthening Research and Development.

C. KwaZulu-Natal Cabinet Indaba June 2009 and February 2010

The Province will focus on integration of services to achieve the priorities in the NHS 10-Point Plan as well as the Medium Term Strategic Framework (20 Key Outputs). Expansion of the Flagship Programme will be prioritised.
D. Social Cluster Flagship Programme (Office of the Premier) – aligned with the MTSF

Poverty and deprivation are considered major drivers of disease, and meeting the development needs of individuals therefore becomes central to meeting the health needs of communities. The Flagship Programme (through the Office of the Premier) prioritises development processes in communities to enable individuals to become owners of development. Communities are targeted as the centres of wellness, therefore investing in sustainable development.

The Flagship Programme, implemented at Ward level, used the Provincial Indices of Multiple Deprivation to identify the most deprived areas within the Province. The 5 domains considered include:

- Income and Material Deprivation;
- Educational Deprivation;
- Living Environment Deprivation;
- Employment Deprivation; and
- Health Deprivation.

The Programme commenced in 2009/10 and focuses on integration of services rendered by existing Community-Based Health Care Workers (CBHC) and volunteers at ward level. A total of 2,167 of the 4,000 cadres will be allocated to the 52 most deprived wards, 1,050 cadres will be distributed to the second 53-400 wards and the remaining 783 will be distributed in the remaining 350 wards.

E. Budget Speech (2009) MEC for Health

The MEC's priorities are aligned with the NHS 10-Point Plan, and in addition the MTSF. Although priorities 2 and 9 have a national mandate the transformation of the Provincial Health System forms an integral part of both priorities.

F. Other Strategies and Plans

- The Service Transformation Plan (including 10 Components) will guide the rationalisation of health services to improve efficiency and effectiveness.
- The Comprehensive Plan for HIV and AIDS, including the policy changes announced by the President on the 1st of December 2009, HCT and circumcision.
- The TB Management Plan, including new policy changes.
- 18 Priority Districts Project (NDOH). Although the National Department of Health will focus on monitoring and evaluating progress in the 4 priority districts in KZN, the Province will not exclude other districts.
- The Accelerated Plan for PMTCT.

4.4 Notes on presentation of core business for the forthcoming planning cycle

The official format for the Strategic and Annual Performance Plans has been determined by National Treasury and the National Department of Health to ensure unified monitoring and reporting.

The National Department of Health and National Treasury, in consultation with Provincial Departments, identified a core group of indicators per Budget Programme. This is reported on quarterly in the Provincial Quarterly Performance Reports (QPR) that is submitted to both departments on a quarterly basis.

Provincial departments have the responsibility to add additional core indicators to track performance against targets (output, outcome and impact).

Based on the national guidelines, the Strategic and Annual Performance Plans incorporate core priorities identified for the forthcoming planning cycle. This does not exclude other service delivery obligations which will be monitored routinely through the Monitoring & Evaluation Framework and Quality Improvement Plans at facility level.

KwaZulu-Natal included all performance indicators (including the sub-set of indicators in support of core indicators presented in the Strategic and Annual Performance Plans) in the approved Monitoring & Evaluation Framework to ensure robust quarterly (results-based) performance monitoring and reporting.

The Department acknowledge national performance targets for the forthcoming planning cycle, and will strive to achieve these targets. It is however imperative that the Province
consider current performance and availability of resources in determining Provincial performance targets. Targets will be reviewed annually to ensure realistic progress towards national targets.

At the time of finalising the Strategic Plan and Annual Performance Plan (2010/12 – 2012/13) the Service Transformation Plan (with attached Core Components) which will direct rationalization of Provincial health services has not been finalised. Specific details (including deliverables and timelines) will therefore be based on current draft documents and processes until Implementation Plans for the STP and attached Core Components have been finalised.
Strategic Plan 2010 - 2014

5. STRATEGIC PRIORITIES 2010-2014

Strategic Priorities aligned with the NHS 10-Point Plan

Table 5: Implementation of the National Health System Priorities 2009 – 2014

<table>
<thead>
<tr>
<th>Provincial Priorities</th>
<th>Key Activities</th>
<th>Targets for 2014/15</th>
<th>Strategic Goal, MTSF &amp; MDG’s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS Priority 1: Provision of strategic leadership and creation of a social compact for better health outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Ensure unified action in pursuit of common goals.</td>
<td>Align Provincial macro plans (within funding envelope) with the NHS and MTEF priorities.</td>
<td>Approved Strategic Plan aligned with NHS and MTSF priorities tabled in April 2010.</td>
<td>Strategic Goal 1: To overhaul Provincial Health Services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annual Performance Plan (APP) tabled for each year of the planning cycle.</td>
<td>MTSF Output 15: Enhanced operational management of health facilities (Health system effectiveness).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11 approved District Health Plans per annum aligned with the APP, NHS and MTSF priorities.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>To finalise and implement the 2010-2020 KZN Service Transformation Plan including 10 Core Components aligned with the NHS Priorities.</td>
<td></td>
</tr>
<tr>
<td>1.2 Mobilise leadership structures of society and communities.</td>
<td>Appointment of Hospital Boards and Clinic Committees.</td>
<td>100% Hospital Boards established by 2012/13.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>188/558 (30%) Clinic Committees established by 2012/13 and 70% (390/558) by 2014/15.</td>
<td></td>
</tr>
<tr>
<td>1.3 Communicate to promote policy &amp; buy-in to support Government Programmes.</td>
<td>Establish and convene Provincial and District Consultative Health Forums.</td>
<td>Convene annual Provincial and 11 District Consultative Health Forums as prescribed in terms of the National Health Act of 2003.</td>
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<td></td>
<td>Regulations promulgated in 2010 and KZN Health Act 2009 commence.</td>
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</tr>
</tbody>
</table>

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16 Currently interim Hospital Boards
20 Currently interim Clinic Committees
### Provincial Priorities

<table>
<thead>
<tr>
<th>Strategic Goal, MTSF &amp; MDG’s</th>
</tr>
</thead>
</table>

| | | Annual unqualified audit opinion for performance information from the AGSA 2011/12 – 2014/15. | |
| | | Integrated information systems as per MSP Implementation Plan commencing by 2010/11. | |
| | | Quarterly PQRS total assessment score improved from 85% to 100% by 2012/13. | |
| | | Submit 4 quarterly progress reports per year on progress towards implementation of the 10-Point Plan (as per Strategic Plan and Annual Performance Plan targets). | |
| | | Table 5 Annual Reports as per Treasury Regulations. | |
| | | Conduct a 5-year evaluation of Provincial performance by March 2015. | |

**NHS Priority 2: Implementation of National Health Insurance – National Mandate (Improvement of Hospital services in line with National imperatives in preparation of NHI)**

### Strategic Goal 2: To improve the efficiency and quality of health services.

<table>
<thead>
<tr>
<th>Strategic Goal, MTSF &amp; MDG’s</th>
</tr>
</thead>
</table>

| 3.1 Scale up implementation of plans to improve the quality of health services. | Implementation of National Core Standards towards accreditation of health facilities. | Core Standards implemented in 100% PHC facilities, CHC’s and Hospitals by 2010/11. | MTSF Output 14: Accreditation of health facilities for quality (Health system effectiveness). |
| | “Look like a Hospital” Project (implemented as part of this initiative). | Facilities accredited: 279/558 (50%) PHC clinics by 2014/15 (10% per year); 16/16 CHC’s; 37/37 District Hospitals; 14/14 Regional Hospitals; 1/1 Tertiary and 1/1 Central Hospital by 2012/13. | |
| | | Average patient waiting time at OPD ≤1 hour by 2014/15. | |

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21 Cumulative numbers determined by Project Plan – Quality Improvement Plans forms part of the strategy and are not mentioned separately in the strategic & Annual Performance Plan (included in Operational Plans)
<table>
<thead>
<tr>
<th>Provincial Priorities</th>
<th>Key Activities</th>
<th>Targets for 2014/15</th>
<th>Strategic Goal, MTSF &amp; MDG’s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS Priority 4: Overhauling the health care system and improving its management</strong></td>
<td></td>
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</tr>
<tr>
<td>4.1 Implement the PHC strategy to revitalise PHC services as fundamental approach in service delivery.</td>
<td>Revitalisation of PHC services as per STP Implementation Plan.</td>
<td>PHC strategy implemented in 11 districts by 2010/11 as per Implementation Plan.</td>
<td>Strategic Goal 1: To overhaul Provincial Health Services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase PHC utilisation rate from 2.9 to 4 visits per client per year by 2014/15.</td>
<td>MTSF Output 13: Improved patient care and satisfaction (Health system effectiveness).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase PHC utilisation rate for children under-5 from 4.5 to 5 visits per child per year by 2014/15.</td>
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<tr>
<td></td>
<td></td>
<td>Increase the PHC supervision rate to 100% by 2014/15.</td>
<td>MTSF Output 11: Revitalisation of PHC (Health system effectiveness).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decrease District Hospital average length of stay from 5.2 to 4.4 days by 2014/15.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Increase the bed occupancy rate from 69% to 75% by 2014/15.</td>
<td></td>
</tr>
<tr>
<td>4.2 Implement a decentralised operational model including new governance arrangements.</td>
<td>To implement the nationally approved delegations for District &amp; Hospital Managers by 2010/11.</td>
<td>Implement the approved national delegations for District Managers in 11 health districts by 2011/12.</td>
<td>Strategic Goal 1: To overhaul Provincial Health Services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% Hospital Managers signed reviewed delegations of authorities by 2010/11 and annually thereafter.</td>
<td>MTSF Output 15: Enhanced operational management of health facilities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% (11) District Health Plans, aligned with the 10-Point Plan, Strategic Plan and Annual Performance Plan, approved annually.</td>
<td></td>
</tr>
</tbody>
</table>

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22 Achievement of this target is dependent on national progress (National Strategic Health Plan 2010/11-2012/13)
23 This is dependent on reviewed delegations as per National Strategic Plan 2010/11 – 2012/13
<table>
<thead>
<tr>
<th>Provincial Priorities</th>
<th>Key Activities</th>
<th>Targets for 2014/15</th>
<th>Strategic Goal, MTSF &amp; MDG’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.3 Train managers in leadership, management and governance.</td>
<td>Develop and implement a Management Training Strategy including succession training and mentoring programmes.</td>
<td>100% (11) District Health Expenditure Reviews approved annually.</td>
<td>MTSF Output 17: Improved healthcare financing.</td>
</tr>
<tr>
<td>4.5 Improve the efficiency and effectiveness of Emergency Medical Services.</td>
<td>Revitalisation of EMS services (as part of the rationalisation of health services)</td>
<td>1:10000 Rostered ambulances per 10 000 population by 2014/15.</td>
<td>Strategic Goal 1: To overhaul Provincial Health Services. MTSF Output 17: Improved health care financing (Health system effectiveness). MTSF Output 15: Enhanced operational management of health facilities.</td>
</tr>
<tr>
<td>NHS Priority 5: Improved Human Resources Planning Development and Management</td>
<td>To align the Human Resources Plan with the STP and implement as part of the Human Resources Turn-Around Strategy.</td>
<td>Approved Provincial Human Resources Plan (HRP) aligned with the STP and published with the STP by August 2010.</td>
<td>Strategic Goal 1: To overhaul Provincial Health Services. MTSF Output 16: Improved access to Human Resources for Health (Health systems effectiveness).</td>
</tr>
<tr>
<td>5.1 Refine the Human Resources Plan (HRP) for health.</td>
<td></td>
<td>Persal data verified by March 2011.</td>
<td></td>
</tr>
<tr>
<td>5.2 Improve Human Resources Management Systems.</td>
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</tbody>
</table>
## Strategic Plan 2010 - 2014

### Provincial Priorities

<table>
<thead>
<tr>
<th>NHS Priority 6: Revitalisation of infrastructure</th>
<th>Key Activities</th>
<th>Targets for 2014/15</th>
<th>Strategic Goal, MTSF &amp; MDG’s</th>
</tr>
</thead>
</table>
| 6.1 Urgent implementation of a clean-up, refurbishment and preventative maintenance of all health facilities. | Align Infrastructure Plans with STP and National Infrastructure Plan. | Health Infrastructure Plan aligned with STP (taking into account the national audit outcomes) approved and published with the STP by August 2010. | Strategic Goal 1: To overhaul Provincial Health Services.  
MTSF Output 12: Improved physical infrastructure for health care delivery (Health system effectiveness). |
| 6.2 To accelerate the provision of new clinical buildings and infrastructure. | To deliver new clinical infrastructure in line with the STP and approved Infrastructure Programme Implementation Plan (IPIP). | Infrastructure Programme Implementation Plan.  
52 Projects fully commissioned by 2014/15. | Strategic Goal 1: To overhaul Provincial Health Services. |
| 6.3 To upgrade and maintain existing infrastructure and buildings. | To upgrade and renovate existing clinical infrastructure in accordance with the STP and approved IPIP. | 89 Projects fully commissioned by 2014/15. |  |
| 6.4 Ensure the effective provision of Property Management/ Real Estate services. | To undertake the acquisition of properties including vacant land for building purposes. | Plan implemented. |  |

### NHS Priority 7: Accelerated implementation of the HIV and AIDS Strategic Plan and the increased focus on TB and other communicable diseases

| 7.1 Scale up implementation of the NSP for HIV & AIDS and STI’s – including policy changes effective from April 2010. | Accelerate implementation of the NSP for HIV and AIDS – including new policy changes and HCT. | Reduce HIV incidence with 50% by 2011/12.  
Increase the % of HIV+ qualifying patients on ART to 90% by 2014/15.  
Increase the number of patients initiated on ART from 335,148 to 695,557 by 2012/13.  
100% of TB-HIV co-infected patients with CD4 count of 350 or less initiated on ART.  
Increase STI partner treatment rate to 30% by 2014/15. | Strategic Goal 3: To reduce morbidity and mortality due to communicable diseases and non-communicable conditions and illnesses.  
MTSF Output 1: Increased life expectancy at birth.  
MTSF Output 2: Reduce child mortality.  
MTSF Output 4: Manage HIV prevalence.  
MTSF Output 5: Reduce HIV incidence.  
MTSF Output 9: Improved access to ART for HIV-TB co-infected patients.  
MTSF Output 6: Expanded PMTCT Programme.  
MDG 4: Reduce child mortality. |
| Implement Voluntary Male Medical Circumcision Campaign. | 96,001 neonatal males circumcised by 2012/13.24 |  |  |

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24 Acceptance rate of 80% of the KZN neonatal male population defined as the target group – 100% of target group circumcised per annum
### Provincial Priorities

<table>
<thead>
<tr>
<th>Key Activities</th>
<th>Targets for 2014/15</th>
<th>Strategic Goal, MTSF &amp; MDG’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand integrated Flagship Programme.</td>
<td>373,406 adult males circumcised by 2012/13.</td>
<td>MDG 6: Combat HIV and AIDS, Malaria &amp; other diseases.</td>
</tr>
<tr>
<td>Increase coverage at ward level from 57 Wards to 750 Wards by 2014/15.</td>
<td>100% facilities implement HCT campaign by 2011.</td>
<td></td>
</tr>
<tr>
<td>Reduce mother to child transmission to ≤ 5% by 2014/15.</td>
<td>MTSF Output 20: Expanded access to HBC and CHW (Health system effectiveness)</td>
<td></td>
</tr>
<tr>
<td>Increase the proportion of pregnant women counselled and tested for HIV to 100% by 2011/12.</td>
<td></td>
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</tr>
<tr>
<td>Increase the % eligible pregnant women placed on HAART to 95% by 2014/15.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase ANC clients initiated on AZT during ANC to 100% by 2012/13.</td>
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</tbody>
</table>

7.2 Scale up implementation of the TB Crisis Plan including MDR and XDR TB and integrated HIV & AIDS strategy.

<table>
<thead>
<tr>
<th>Key Activities</th>
<th>Targets for 2014/15</th>
<th>Strategic Goal, MTSF &amp; MDG’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement the TB Crisis Plan and expand the integrated Flagship Programme.</td>
<td>Increase the TB cure rate from 58.15% to 75% by 2014/15.</td>
<td>Strategic Goal 3: To reduce morbidity and mortality due to communicable diseases and non-communicable conditions and illnesses.</td>
</tr>
<tr>
<td>Decrease the TB defaulter rate from 9.6% to &lt; 5% by 2014/15.</td>
<td>MTSF Output 8: Improved TB outcomes.</td>
<td></td>
</tr>
<tr>
<td>Increase the proportion of TB patients tested for HIV to 100% by 2012/13</td>
<td>MTSF Output 7: Improved TB case finding (TB case load – increased life expectancy).</td>
<td></td>
</tr>
<tr>
<td>Increase the % of TB patients with DOTS supporters to 90% in 2014/15</td>
<td>MTSF Output 10: Decreased prevalence of MDR TB (TB case load – Increased life expectancy).</td>
<td></td>
</tr>
<tr>
<td>Reduce the MDR TB cases reported (% annual change) to 4% by 2014/15</td>
<td>MDG 6: Combating HIV and AIDS, Malaria and other diseases.</td>
<td></td>
</tr>
</tbody>
</table>

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25 Acceptance rate of 80% of the KZN male population between the age 15 – 49 years defined as the target group – 100% of target group circumcised over the 5-year period
26 At the time of preparing the Strategic Plan final targets have not been identified
27 The national target of 85% is not realistic for the province especially in light of the high HIV infection rate – all although will however be made to exceed the current provincial target
## Provincial Priorities

<table>
<thead>
<tr>
<th>Strategic Goal, MTSF &amp; MDG’s</th>
<th>Targets for 2014/15</th>
<th>Key Activities</th>
<th>Provincial Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reduce the new XDR TB cases reported (% annual change) to 35% by 2014/15</td>
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</tbody>
</table>

### NHS Priority 8: Mass mobilisation for better health for the population

#### 8.1 Implementation an integrated Health Promotion Strategy (within national framework) in 11 districts.

- **Key Activities:**
  - Implement the National Health Promotion Strategy once available.
  - Accelerate implementation of the integrated School Health and Health Promoting Schools Programme.

- **Strategic Goal:** To reduce morbidity and mortality due to communicable diseases and non-communicable conditions and illnesses.

- **MTSF Output 1:** Increased life expectancy at birth.

- **MTSF Output 19:** Improved health services for the youth (Health system effectiveness).

#### 8.2 Scale up MNCWH & N services through implementation of the 5-year strategy for Maternal, Neonatal, Child and Women’s Health and Nutrition in 11 districts.

- **Key Activities:**
  - Implement the WHO 10-Steps for Management of Children with Severe Malnutrition.
  - Expand integrated Flagship & CHW Programme.
  - Scale up implementation of integrated child health services.

- **Strategic Goal:** To reduce morbidity and mortality due to communicable diseases and non-communicable conditions and illnesses.

- **MTSF Output 1:** Increased life expectancy at birth.

- **MTSF Output 2:** Reduced child mortality.

- **MDG 4:** Reduced child mortality.

---

28 National target
<table>
<thead>
<tr>
<th>Provincial Priorities</th>
<th>Key Activities</th>
<th>Targets for 2014/15</th>
<th>Strategic Goal, MTSF &amp; MDG’s</th>
</tr>
</thead>
</table>
|                      |               | Increase the Vitamin A coverage 12-59 months from 45% to 90% in all districts by 2014/15. | Strategic Goal 3: To reduce morbidity and mortality due to communicable diseases and non-communicable conditions and illnesses.  
MTSF Output 1: Increased life expectancy at birth.  
MTSF Output 3: Decrease the maternal mortality ratio.  
MTSF Output 4: Managing HIV prevalence.  
MTSF Output 5: Reducing HIV incidence.  
MDG 4: Reduce child mortality.  
MDG 5: Improve maternal health. |
|                      |               | Increase Pneumococcal 1st dose coverage from 64% to 90% in 11 districts by 2014/15. |               |
|                      | Scale up implementation of IMCI. | 100% of PHC facilities with IMCI trained Professional nurses by 2014/15. |               |
|                      | Implement the Maternal and Neonatal Health Strategy. | Reduce maternal mortality to ≤ 100/100000 by 2014/15. |               |
|                      |               | Reduce infant mortality rate to 20/1000 live births. |               |
|                      |               | Increase PPIP reporting sites from 29 to 56 by 2014/15. |               |
|                      |               | 100% facilities conduct perinatal and maternal mortality meetings and address challenges. |               |
|                      |               | 100% women eligible for ART placed on treatment. |               |
|                      | Scale up implementation of BANC. | 80% of mothers and babies receive post partum care within 6 days after delivery by 2014/15. |               |
|                      | Implement the Phila Ma Project to improve Cervical cancer Screening. | Improve ANC visits before 20 weeks from 47.6% to 90% by 2014/15. |               |
|                      |               | Increase cervical cancer screening coverage from 6.4% to 56.4% by 2014/15 (10% per year). |               |

29 Child PIP: Child Problem Identification Programme  
30 National target
<table>
<thead>
<tr>
<th>Provincial Priorities</th>
<th>Key Activities</th>
<th>Targets for 2014/15</th>
<th>Strategic Goal, MTSF &amp; MDG’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Halt malaria transmission and prevent re-introduction of malaria in non-endemic areas.</td>
<td>Implement the Contraceptive Strategy.</td>
<td>Increase the women year protection rate from 23% to 70% by 2014/15.</td>
<td>Strategic Goal 3: To reduce morbidity and mortality due to communicable diseases and non-communicable conditions and illnesses. MTSF Output 1: Increased life expectancy at birth. MDG 6: Combating HIV and AIDS, Malaria and other diseases.</td>
</tr>
<tr>
<td>Maintain preventative strategies for malaria control e.g. malaria spraying coverage.</td>
<td>Increase the malaria spraying coverage from 93% to 98% in 2014/15.</td>
<td>Malaria incidence &lt;1/1000 population.</td>
<td></td>
</tr>
<tr>
<td>9.1 Improved compliance with Pharmaceutical legislative imperatives.</td>
<td>Pharmaceutical Warehouse licensed in line with Good Manufacturing Practice Regulations and Pharmacies graded as per SAPC standards.</td>
<td>80% of Pharmacies obtained A or B grading on inspection by 2014.</td>
<td>Strategic Goal 1: To overhaul Provincial Health Services. MTSF Output 12: Improved physical infrastructure for health care delivery (Health system effectiveness). MTSF Output 13: Improved patient care and satisfaction (Health system effectiveness).</td>
</tr>
<tr>
<td>9.2 To improve the management of Pharmaceutical services.</td>
<td>Reduce tracer medicine (including ARV and TB medicines) stock-out rate.</td>
<td>Tracer medicines stock out rate &lt;1% by 2014.</td>
<td>Strategic Goal 2: To improve the efficiency and quality of health services.</td>
</tr>
<tr>
<td>NHS Priority 10: Strengthening Research and Development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic Goal 10.1 Research priorities established and used to guide research in the Province.</td>
<td>Five-year Health Review.</td>
<td>5-Year evaluation on Provincial performance against strategic targets conducted by March 2015.</td>
<td>Strategic Goal 1: To overhaul Provincial Health Services. MTSF Output 18: Strengthened Health Information Systems (Health system effectiveness).</td>
</tr>
<tr>
<td>Maintain Health Research &amp; Knowledge Management functions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic Goal 10.2 Provincial Health research Committee established as per Health Act of 2003 and KZN Health Act (1 of 2009).</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Strategic Priorities targeting the Millennium Development Goals

#### Table 6: Key Provincial Activities to Accelerate Progress towards the MDG Targets

<table>
<thead>
<tr>
<th>MDG Goals &amp; Targets</th>
<th>Indicators</th>
<th>Key Activities</th>
<th>Targets for 2014</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1: Eradicate extreme poverty and hunger</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger.</strong></td>
<td>1. Prevalence of underweight children (under 5 years).</td>
<td>Expand integrated Flagship &amp; CHW Programme.</td>
<td>Increase coverage at ward level from 57 Wards to 750 Wards in 2014/15.</td>
<td>1. Reduce prevalence of underweight children (under 5 years) from 1.3% to 1%</td>
</tr>
<tr>
<td></td>
<td>2. Severe malnutrition under-5 year incidence.</td>
<td>Implement WHO 10-Steps for the Management of Children with Severe Malnutrition.</td>
<td>Implement in 100% hospitals with paediatric beds.</td>
<td>2. Reduce severe malnutrition under-5 years incidence from 6.2/1000 to 6/1000</td>
</tr>
<tr>
<td><strong>Goal 4: Reduce Child Mortality</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Target 5: Reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate.</strong></td>
<td>1. Under-5 mortality rate.</td>
<td>Scale up implementation of integrated child health services including:</td>
<td>Increase the Pneumococcal (PCV) 1st dose coverage from 87.7% to 90% in all districts by 2014/15.</td>
<td>1. Reduce under-5 mortality rate to 29/1000 live births[^35]</td>
</tr>
<tr>
<td></td>
<td>2. Child mortality rate.</td>
<td>Immunisation coverage – reduce vaccine preventable morbidity and mortality.</td>
<td>Increase the Rota Virus (RV) 1st dose coverage from 51% to 90% in all districts by 2014/15.</td>
<td>2. Reduce child mortality to 30-45/1000[^32]</td>
</tr>
<tr>
<td></td>
<td>3. Infant mortality rate.</td>
<td>Increase the Immunisation coverage under-1 year from 85% to 90% in all districts by 2014/15.</td>
<td>Increase the measles coverage under-1 year from 88% to 90% in all districts by 2014/15.</td>
<td>3. Reduce infant mortality rate to 20/1000 live births[^33]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vitamin A supplementation to improve child health.</td>
<td>Increase the Vitamin A coverage under-1 year from 94.2% to 95% in all districts by 2014/15.</td>
<td></td>
</tr>
<tr>
<td>MDG Goals &amp; Targets</td>
<td>Indicators</td>
<td>Key Activities</td>
<td>Targets for 2014</td>
<td>Outcome</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase the Vitamin A coverage 12-59 months from 28.5% to 90% in all districts by 2014/15.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child PIP(^{34}) to improve management of childhood illnesses.</td>
<td>Increase Child PIP reporting sites from 27 to 40 in 2014/15.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PPIP(^{35}) to improve perinatal services.</td>
<td>Increase PPIP reporting sites from 29 to 56 by 2014/15.</td>
<td></td>
</tr>
</tbody>
</table>

**Goal 5: Improve Maternal Health**

**Target:** Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate.

<table>
<thead>
<tr>
<th>Maternal mortality ratio</th>
<th>Accelerate implementation of the Maternal Health Strategy.</th>
<th>Improve ANC visits before 20 weeks from 30.5% to 90% by 2014/15.</th>
<th>Reduce maternal mortality ratio to 100/100 000 or less(^{36})</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Increase the % of mothers and babies who receive post partum care within 6 days after delivery to 80% by 2014/15.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase cervical cancer screening coverage from 6.4% to 56.4% by 2014/15 (10% per year).</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase the women year protection rate from 23% to 70%.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase the proportion of pregnant women tested for HIV from 90% to 100% by 2011/12.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% of maternity care facilities conduct maternal mortality meetings and quality improvement plans to address challenges.</td>
<td></td>
</tr>
</tbody>
</table>

\(^{34}\) Child PIP: Child Problem Identification Programme  
\(^{35}\) PPIP: Perinatal Problem Identification Programme  
\(^{36}\) National target
## MDG Goals & Targets

<table>
<thead>
<tr>
<th>Goal 6: Combat HIV and AIDS, Malaria &amp; other diseases</th>
</tr>
</thead>
</table>

### Target 7: Have halted by 2015, and begin to reverse the spread of HIV and AIDS.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Key Activities</th>
<th>Targets for 2014</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV incidence</td>
<td>Implement new policy changes (HIV and AIDS) announced on the 1st of December 2009.</td>
<td>Increase HIV+ qualifying patients on ART from ±60% to 90% by 2014/15.</td>
<td>HIV incidence reduced with 50% by 2011&lt;sup&gt;15&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduce the MTCT rate from 7% to ≤ 5% by 2014/15.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accelerate implementation of the Accelerated Plan for PMTCT</td>
<td>96,001 neonatal males circumcised by 2012/13.&lt;sup&gt;37&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Implement Voluntary Male Medical Circumcision Campaign</td>
<td>373,406 adult males circumcised by 2012/13.&lt;sup&gt;38&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Implement Provider Initiated Counselling &amp; Testing for HIV</td>
<td>100% facilities implement campaign.&lt;sup&gt;39&lt;/sup&gt;</td>
<td></td>
</tr>
</tbody>
</table>

### Target 8: Have halted by 2015, and begin to reverse the incidence of malaria and other major diseases.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Key Activities</th>
<th>Targets for 2014</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria case fatality rate</td>
<td>Increase the malaria spraying coverage.</td>
<td>Increase the malaria spraying coverage from 93% to 98% in 2014/15.</td>
<td>Malaria case fatality rate &lt;1%.</td>
</tr>
<tr>
<td>TB cure rate</td>
<td>Accelerate implementation of the TB Crisis Plan – including the Flagship Programme.</td>
<td>Increase the TB cure rate from 58.15% to 75% in 2014/15.</td>
<td>TB cure rate 75%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decrease the TB defaulter rate from 9.6% to &lt;5% by 2014/15.</td>
<td></td>
</tr>
</tbody>
</table>

---

<sup>37</sup> Acceptance rate of 80% of the KZN neonatal male population defined as the target group – 100% of target group circumcised per annum

<sup>38</sup> Acceptance rate of 80% of the KZN male population between the age 15 – 49 years defined as the target group – 100% of target group circumcised over the 5-year period

<sup>39</sup> At the time of preparing the Strategic Plan final targets have not been identified
### 6. **STRATEGIC GOALS 2010–2014**

<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Goal Statement</th>
<th>Rationale</th>
<th>Expected Outcomes</th>
</tr>
</thead>
</table>
| 1. Overhaul Provincial Health Services.             | Transform the Provincial health care system through implementation of the STP (including 10 core components) to improve equity, availability, efficiency, quality and effective management to enhance service delivery and improve health outcomes of all citizens in the province. | An efficient and well functioning health care system with the potential to respond to the burden of disease and health needs in the Province. | • Transformation in line with STP imperatives and NHS 10-Point Plan.  
• Improved access, equity, efficiency, effectiveness and utilisation of services.  
• Improved Human Resource Management Services including reconfiguration of organisational structures, appropriate placement of staff (appropriate skills mix and competencies), appropriate norms and standards to respond to burden of disease and package of services, strengthened performance management and decreased vacancy rates.  
• Improved Financial & SCM efficiency and accountability to curb over-expenditure, improve return on investment and value for money, budget aligned with service delivery priorities and needs.  
• Appropriate response to the burden of disease and consequent health needs.  
• Improved governance including regulatory framework, policies and delegations to facilitate implementation of the Strategic Plan.  
• Decentralised delegations, controls and accountability.  
• Improved information systems, data quality and management and improved performance monitoring and reporting. |
<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Goal Statement</th>
<th>Rationale</th>
<th>Expected Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Improve the efficiency and quality of health services.</td>
<td>Achieving the best possible health outcomes within the funding envelope and available resources.</td>
<td>Improved compliance with legislative/ policy requirements and Core Standards for quality service delivery in order to improve clinical/ health outcomes.</td>
<td>• Strengthened infrastructure to improve service delivery. • Accreditation of health facilities in line with National Core Standards for Quality. • Improved management capacity. • Improved health outcomes and increased life expectancy at birth as a result of improved clinical governance. • Improved performance towards achieving the MDG targets. • Patient satisfaction.</td>
</tr>
<tr>
<td>3. Reduce morbidity and mortality due to communicable diseases and non-communicable conditions and illnesses.</td>
<td>Implement integrated high impact strategies to improve prevention, detection, management and support of communicable diseases &amp; non-communicable illnesses and conditions at all levels of care.</td>
<td>Reduction of preventable/ modifiable causes of morbidity and mortality at community and facility level contributing to a reduction in morbidity and mortality rates.</td>
<td>• Decrease in morbidity and mortality – with specific reference to preventable causes. • Improved performance towards achievement of MDG targets i.e. HIV and AIDS; TB; Maternal &amp; Child Health; Malaria. • Change in trends of non-communicable disease patterns.</td>
</tr>
</tbody>
</table>
7. OUTLINE OF THE RESOURCE ENVELOPE AND UNFUNDED PRIORITIES

7.1 The Resource Envelope

Table 8(a): Expenditure Estimates

<table>
<thead>
<tr>
<th>Programme</th>
<th>Audited Outcomes</th>
<th>Main Appropriation</th>
<th>Adjusted Appropriation</th>
<th>Revised Estimate</th>
<th>Medium-Term Expenditure Estimate</th>
<th>Outer-Year Estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Administration</td>
<td>225 035</td>
<td>279 730</td>
<td>284 066</td>
<td>302 307</td>
<td>1 043 371</td>
<td>1 032 930</td>
</tr>
<tr>
<td>2. District Health Services</td>
<td>5 370 301</td>
<td>7 209 609</td>
<td>8 132 272</td>
<td>8 253 100</td>
<td>8 428 417</td>
<td>9 290 076</td>
</tr>
<tr>
<td>3. Emergency Medical Services</td>
<td>474 023</td>
<td>548 796</td>
<td>672 360</td>
<td>737 930</td>
<td>696 263</td>
<td>774 379</td>
</tr>
<tr>
<td>4. Provincial Hospital Services</td>
<td>3 138 945</td>
<td>3 883 814</td>
<td>4 378 814</td>
<td>4 450 442</td>
<td>4 304 454</td>
<td>5 226 601</td>
</tr>
<tr>
<td>5. Central Hospital Services</td>
<td>1 191 810</td>
<td>1 407 703</td>
<td>1 821 221</td>
<td>1 646 185</td>
<td>1 780 877</td>
<td>2 087 145</td>
</tr>
<tr>
<td>6. Health Sciences and Training</td>
<td>421 069</td>
<td>524 333</td>
<td>676 601</td>
<td>653 811</td>
<td>671 064</td>
<td>756 276</td>
</tr>
<tr>
<td>8. Health Facilities Management</td>
<td>813 208</td>
<td>1 092 807</td>
<td>1 103 558</td>
<td>1 377 223</td>
<td>1 377 189</td>
<td>1 446 244</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>11 663 951</td>
<td>14 959 441</td>
<td>17 103 101</td>
<td>17 448 526</td>
<td>18 329 163</td>
<td>20 641 179</td>
</tr>
</tbody>
</table>

Unauthorised expenditure (1st charge) not available for spending

Baseline available for spending after 1st charge

Data Source: BAS & Finance Section
Table 8(b): Summary of Provincial Expenditure Estimates by Economic Classification

<table>
<thead>
<tr>
<th>Economic Classification</th>
<th>Audited Outcomes</th>
<th>Main Appropriation</th>
<th>Adjusted Appropriation</th>
<th>Revised Estimate</th>
<th>Medium-Term Expenditure Estimate</th>
<th>Outer-Year Estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2006/07</td>
<td>2007/08</td>
<td>2008/09</td>
<td>2009/10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current payments</td>
<td>10 359 369</td>
<td>13 542 486</td>
<td>15 466 848</td>
<td>15 621 672</td>
<td>15 539 517</td>
<td>17 762 332</td>
</tr>
<tr>
<td>Compensation of employees</td>
<td>6 628 829</td>
<td>8 643 767</td>
<td>10 077 044</td>
<td>10 210 534</td>
<td>11 551 483</td>
<td>12 739 583</td>
</tr>
<tr>
<td>Goods and services</td>
<td>3 730 540</td>
<td>4 898 719</td>
<td>5 389 804</td>
<td>5 328 983</td>
<td>6 210 849</td>
<td>6 748 029</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfers and subsidies to:</td>
<td>366 242</td>
<td>345 978</td>
<td>447 706</td>
<td>494 948</td>
<td>534 921</td>
<td>543 657</td>
</tr>
<tr>
<td>Provinces and municipalities</td>
<td>76 148</td>
<td>63 463</td>
<td>51 538</td>
<td>87 823</td>
<td>120 650</td>
<td>93 009</td>
</tr>
<tr>
<td>Departmental agencies and accounts</td>
<td>33 529</td>
<td>17 119</td>
<td>39 957</td>
<td>34 364</td>
<td>34 312</td>
<td>18 640</td>
</tr>
<tr>
<td>Universities and Technicons</td>
<td>100</td>
<td>-</td>
<td>40</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-profit institutions</td>
<td>190 624</td>
<td>199 011</td>
<td>243 734</td>
<td>284 777</td>
<td>291 975</td>
<td>313 614</td>
</tr>
<tr>
<td>Households</td>
<td>65 841</td>
<td>66 385</td>
<td>112 437</td>
<td>87 984</td>
<td>96 720</td>
<td>95 658</td>
</tr>
<tr>
<td>Payments for capital assets</td>
<td>938 208</td>
<td>1 070 936</td>
<td>1 188 449</td>
<td>1 331 906</td>
<td>1 496 725</td>
<td>1 577 108</td>
</tr>
<tr>
<td>Buildings and other fixed structures</td>
<td>549 366</td>
<td>623 762</td>
<td>635 593</td>
<td>752 743</td>
<td>943 652</td>
<td>1 030 817</td>
</tr>
<tr>
<td>Machinery and equipment</td>
<td>388 460</td>
<td>429 978</td>
<td>552 856</td>
<td>579 101</td>
<td>553 073</td>
<td>546 291</td>
</tr>
<tr>
<td>Software and other intangible assets</td>
<td>382</td>
<td>17 196</td>
<td>-</td>
<td>62</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Payment for financial assets</td>
<td>132</td>
<td>41</td>
<td>98</td>
<td>758 000</td>
<td>758 082</td>
<td>-</td>
</tr>
<tr>
<td>Total economic classification</td>
<td>11 663 951</td>
<td>14 959 441</td>
<td>17 103 101</td>
<td>17 448 526</td>
<td>18 329 163</td>
<td>20 641 179</td>
</tr>
</tbody>
</table>

|                         | 2010/11          | 2011/12            | 2012/13                | 2013/14         | 2014/15                          |
| Current payments        | 19 487 612       | 21 317 054         | 22 662 015             | 24 021 735      | 25 463 039                       |
| Compensation of employees | 12 739 583 | 13 797 683         | 14 491 748             | 15 361 252      | 16 282 927                       |
| Goods and services      | 6 748 029        | 7 519 371          | 8 170 267              | 8 660 483       | 9 180 111                        |
| Other                   |                  |                    |                        |                 |                                  |                      |
| Transfers and subsidies to: | 547 512    | 520 608             | 580 632                | 615 469         |                                  |                      |
| Provinces and municipalities |          |                    |                        |                 |                                  |                      |
| Departmental agencies and accounts |          |                    |                        |                 |                                  |                      |
| Universities and Technicons |            |                    |                        |                 |                                  |                      |
| Non-profit institutions |                  |                    |                        |                 |                                  |                      |
| Households              |                  |                    |                        |                 |                                  |                      |
| Payments for capital assets |          |                    |                        |                 |                                  |                      |
| Buildings and other fixed structures |          |                    |                        |                 |                                  |                      |
| Machinery and equipment |                  |                    |                        |                 |                                  |                      |
| Software and other intangible assets |          |                    |                        |                 |                                  |                      |
| Payment for financial assets |            |                    |                        |                 |                                  |                      |
| Total economic classification |          |                    |                        |                 |                                  |                      |
### Table 8(c): Trends in Provincial Public Health Expenditure (R Million)

<table>
<thead>
<tr>
<th>Economic Classification</th>
<th>Audited/ Actual</th>
<th>Estimate</th>
<th>Medium-Term Projection</th>
<th>Outer-Year Estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>R 11 663 951</td>
<td>R 14 959 441</td>
<td>R17 103 101</td>
<td>R20 641 179</td>
</tr>
<tr>
<td>Total per person</td>
<td>R 1 175.33</td>
<td>R 1 495.95</td>
<td>R1 697.66</td>
<td>R2 033.70</td>
</tr>
<tr>
<td>Total per uninsured person</td>
<td>R 1 241.15</td>
<td>R 1 513.90</td>
<td>R1 583.58</td>
<td>R1 789.65</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% of Total spent on</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DHS</td>
<td>46.04%</td>
<td>48.19%</td>
<td>47.55%</td>
<td>45.01%</td>
<td>47.98%</td>
<td>48.70%</td>
<td>49.24%</td>
<td>49.24%</td>
<td>49.24%</td>
</tr>
<tr>
<td>PHS</td>
<td>26.91%</td>
<td>25.96%</td>
<td>25.60%</td>
<td>25.32%</td>
<td>25.62%</td>
<td>25.36%</td>
<td>25.06%</td>
<td>25.06%</td>
<td>25.06%</td>
</tr>
<tr>
<td>CHS</td>
<td>10.22%</td>
<td>9.41%</td>
<td>10.65%</td>
<td>10.11%</td>
<td>9.90%</td>
<td>9.69%</td>
<td>9.58%</td>
<td>9.58%</td>
<td>9.58%</td>
</tr>
<tr>
<td>All personnel</td>
<td>R 6 628 829</td>
<td>R 8 643 767</td>
<td>R10 077 044</td>
<td>R11 551 483</td>
<td>R12 739 583</td>
<td>R13 797 683</td>
<td>R14 491 748</td>
<td>R 15 361 252</td>
<td>R 16 282 927</td>
</tr>
<tr>
<td>Capital</td>
<td>R 598 555</td>
<td>R 736 636</td>
<td>R765 222</td>
<td>R1 137 536</td>
<td>R1 234 717</td>
<td>R1 348 730</td>
<td>R1 429 978</td>
<td>R1 504 978</td>
<td>R1 584 978</td>
</tr>
<tr>
<td>Health as % of total public expenditure</td>
<td>31.6%</td>
<td>33.6%</td>
<td>30.79%</td>
<td>39.35%</td>
<td>31.35%</td>
<td>31.65%</td>
<td>31.83%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data Source: BAS & Finance Section
7.2 Expenditure Trends

The Department reported a deficit of R1.034 billion for 2007/08, mainly related to the increase in Compensation of Employees as a result of the implementation of OSD for nurses and the high general and medical inflation rates.

This trend continued into 2008/09, with a deficit of R1.320 billion mainly from the carry-through costs for the OSD for nurses, the carry-through costs for the 2007 wage agreement and the transfer of the Department’s laboratory services to NHLS, as well as inflationary pressures on medically related Goods and Services.

In the 2008/09 Adjustments Estimate, an additional R105.071 million was allocated from Provincial cash resources to partly fund the higher than anticipated 2008 wage agreement.

The significant increase in the estimated deficit in 2009/10, which amounts to R2.312 billion, results from pressures in Compensation of Employees and Goods and Services (under review by the Joint Finance Task Team), the carry-through costs of the unfunded mandates mentioned above, as well as the first charge of R758 million against the Department, being the first repayment (in terms of Section 34(2) of the PFMA) of the accumulated over-spending incurred in 2007/08 and 2008/09.

Total receipts are expected to increase from R18.221 billion in the 2009/10 Adjusted Appropriation, to R25.107 billion in 2012/13. In 2009/10, the Department was affected by the implementation of the first charge rule in terms of S34(2) of the PFMA, being the installment for the amount the Department over-spent in 2007/08 and 2008/09. This amounted to R758 million in 2009/10.

The increase in equitable share in the 2010/11 MTEF relates mainly relates to additional funding allocated in the 2008/09 budget process, but with the funding only commencing in 2010/11 for Emergency Medical Services (R60 million), modernisation of Tertiary Services (R150 million), Infrastructure Development (R282 million), and the implementation of Primary Health Care structures (R410 million).

The Provincial allocation is expected to increase from R14.946 billion in 2009/10, to R17.764 billion in 2010/11 and growing to R20.160 billion in 2012/13.

New funding for the 2010/11 MTEF includes:

- The carry-through costs for increase in general health capacity of the higher than anticipated 2009 wage agreement in the amount of R301.158 million in 2011/12.
- The reallocation of the funding for the OSD for doctors, pharmacists, dentists and emergency care workers (hereafter referred to as OSD for doctors) from Vote 6: Provincial Treasury. Also the carry-through costs of variance funding allocated in the 2009/10 Adjustments Estimate and further funding for OSD based on actuarial work done.
- Funding to provide for the Policy on Incapacity Leave and Ill Health Retirement (PILIR) - R8.647 million.
- New funding for the next phase of OSD namely for therapists, medical officers and medical specialists, pharmacists and EMS practitioners – R291.202 million.

The following broad assumptions were made compiling the budget:

- Salary increases (and carry-through costs) of 5.3% for 2010/11, 5.5% for 2011/12 and 5% for 2012/13 were taken into account, as well as the pay progression of approximately 1.5% of the wage bill, and the relevant carry-through costs.
- The carry-through costs of an average of 11.5% increase in terms of the 2009 wage agreement has also been taken into account.
- Where feasible, CPIX indicators were used to calculate inflation related items. However, it was not possible to apply these calculations in all instances, owing to paucity of funds.
- The need to move towards equity at district level, while at the same time balancing the levels of other services, was taken into consideration.
- Provision has been made for the funding of the municipal clinics as transfer payments in 2010/11, as the negotiations for the Provincialisation of these clinics are still not finalised.
- The cost-cutting measures as defined in Provincial Treasury Circular PT (11) of 2009/10 will be adhered to by the Department over the 2010/11 MTEF.
- Provision has been made for the filling of vacant posts. However, if the moratorium on the filling of non-critical
posts is not lifted, these funds may be reallocated in the Adjustments Estimate process.

The additional funding allocated in the 2008/09 MTEF and commencing in 2010/11 includes:

**7.3 Conditional Grants**

Conditional Grant transfers increase from R3.275 billion in the 2009/10 Adjusted Appropriation to R4.946 billion in 2012/13. The Department has been allocated eight National Conditional Grants over the seven-year period.

1. The **Health Professionals Training and Development Grant**, supporting the provisioning of service costs associated with training and development of health professionals will increase from R222 425 million in 2010/11 to R261 660 million in 2012/13.

2. The **Hospital Revitalisation Grant**, used to plan, manage, modernise, rationalise and transform infrastructure and health technology will increase from R449 558 million in 2010/11 to R572 559 million in 2012/13.

3. The **National Tertiary Services Grant**, used to plan, modernise, rationalise and transform the Tertiary Hospital service delivery platform in line with national policy objectives will increase from R983 948 million in 2010/11 to R1 220 448 million in 2012/13.

4. The **Comprehensive HIV and AIDS Grant**, used to develop effective and integrated programmes for the management of HIV and AIDS, and support the implementation of the National Strategic Plan for HIV and AIDS and Sexually Transmitted Infections will increase from R1 121 575 billion in 2010/11 to R2 241 412 billion in 2012/13.

5. The **Infrastructure Grant**, used to accelerate the construction, maintenance, upgrading and rehabilitation of new and existing health infrastructure will increase from R359 717 million in 2010/11 to R480 578 million in 2012/13.

6. The **Forensic Pathology Services Grant**, used for the development and provision of a comprehensive Forensic Pathology Service, will increase from R134 538 million in 2010/11 to R169 627 million in 2012/13.

7. The **EPWP Grant** for the Social Sector, used to subsidise non-profit organisations working in Home and Community-Based Care Programmes to ensure that volunteers receive stipends received R 2 688 million for 2010/11.\(^40\)

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\(^{40}\) Information from Vote 7
PART B: STRATEGIC OBJECTIVES

PROGRAMME 1 : ADMINISTRATION

1.1. PROGRAMME PURPOSE

Administration comprises of two Sub-Programmes namely
the Office of the MEC and Management under the
stewardship of the Head of Department.

The objectives of the programme are:

- To provide overall strategic leadership, coordination and
  management to ensure the achievement of strategic
  goals in pursuit of improved health status of all the
  people in the Province of KwaZulu-Natal.
- Administration in line with legislative imperatives,
  national and provincial directives and good governance
  practices.
- To formulate and/or review policies and strategies in line
  with legislative imperatives and national and provincial
  priorities.
- An accountable public administration;
- Transparency by providing the public with timely,
  accessible and accurate information;
- Good human resource management and career
  development practices to maximise human potential; and
- A public administration broadly representative of the
  South African people.

The KZN Health Act (1 of 2009) was passed on the 5th of
March 2009. The Act serves to reinforce the legal mandates
of the Department in line with the National Health Act, 2003.
In 2009/10 the Department commenced with preparation of
the KZN Health Act Regulations for promulgation in 2010/11.

1.2. SITUATION ANALYSIS

The role of Management (Programme 1) as Strategic
Enabler comprises a host of support functions which is
critical for effective and efficient service delivery.

The policies that govern Administration stem from the
prevailing legislative framework that governs the Public
Service as a whole. These policies are both transversal and
sector specific and whilst the Department subscribes to and
adopts the legal prescripts in all its activities, it is cognisant
of the democratic values and principles enshrined in Section
195 of the Constitution namely:

- A high standard of professional ethics;
- Efficient, economic and effective use of resources;
- Development orientated public administration;
- Services being provided impartially, fairly, equitably and
  without bias;
- Participative consultation and decision-making to ensure
  an appropriate response to people’s needs;
- Historical under-funding and non-alignment of budget
  with service delivery demands partly due to the lack
  of an effective costing model.
- The lack of reliable and updated information on the
  current burden of disease and the impact on service
  delivery.
- Disconnected resource allocation to ensure policy
  implementation. This in essence may result in
  defensive conduct especially at institutional level i.e.
  adherence to budget to the detriment of service
  delivery needs and policy implementation.
Lack of an effective accountability framework.
Poor financial management and inadequate management competencies, inefficient controls and discipline and limited development programmes especially at facility level.
Ineffective Supply Chain Management Systems.
Poor contract management, controls and oversight. Centralised non-core contracts not aligned with institutional budgets.
Unfunded mandates.

A Joint Task Team (Department and Provincial Treasury) was established in 2009/10 to manage a multi-year Turn-Around Strategy to improve financial management and curb over-expenditure.

Cost containment measures
- Postpone or cancel capital projects not yet started.
- Moratorium on the filling of non-clinical posts.
- Eliminate expenditure on advertising and overseas traveling.
- Re-prioritise to achieve savings.

Fiscal Adjustment Plan
- Investigate mismanagement of funds.
- Improve Supply Chain Management (SCM). SCM since entered into 17 National RT contracts, and commence the establishment of new bid committees, review of policies and procedures to improve governance, and revising business models for Central Provincial Stores and the Provincial Pharmaceutical Supply Depot.
- Commence with Persal clean-up.
- Submission of outstanding RAF claims. To date billed in excess of R12m to increase revenue.
- Review the Joint Health Establishment (JHE) Contract to ensure improved management of the PPP agreement and terms.

Human Resources Management Systems
The burden of disease and changing disease profiles, resource constraints and service delivery demands necessitate a review of the current structures to ensure effective utilisation of resources to ensure that a high standard of service delivery is maintained.

Human Resource Management challenges identified during Strategic Planning Workshops
- Lack of appropriate staffing norms to inform appropriate organisational reform.
- Inadequate management capacity and competencies in critical positions.
- Poor operational management not limited to but inclusive of abuse of sick leave, delay in meeting timeframes for incapacity leave, out-of-adjustments reflected on Persal and increased workloads due to inappropriate placement of staff.
- Ineffective recruitment & retention strategies. Contributing towards increased vacancy, attrition and absenteeism rates. The disproportionate increase in clinical workload impact on quality of care, staff morale and burn-out.
- Inaccurate Persal data compromising planning, decision-making and expenditure.
- Poor payroll control.
- Poor management of the Employee Performance Management and Development System (PMDS).
- Inequity in the distribution of Community Service Officers (CSO), especially in deep rural areas.
- Provincial and District HRP’s not aligned with service delivery requirements.

Although organisational structures for Head Office, District Offices, Specialised Hospitals and Tertiary Hospitals were approved in 2007/08, filling of posts were delayed as a result of over-expenditure. Structures for the Central Hospital, EMS, and Regional and District Hospitals have been developed during 2008/09 and await approval. PHC structures are not yet finalised resulting in service delivery challenges.

The Provincial Human Resources Plan (HRP) has been developed as contemplated in Part III, Chapter 1 of the Public Service Regulations, 2001 (as amended) and has been approved by the Head of Department in 2009/10. In 2009/10 the Department commenced with the development of District HRP’s as per Public Service Regulations.
Although the HRP makes provision for the allocation of suitably qualified and skilled personnel, actioning of the plan is challenged by amongst others the geographical distribution of facilities; inadequate staff accommodation; limited financial resources and cost containment measures; increasing demand for compensation of employees on expenditure allocations; lack of scarce resources and the size of the workforce.

The HRMS Unit commenced with verification of Persal data in 2009/10 – which should be concluded in 2010/11. Headcounts were conducted at pay points to verify employees on the payroll.

Health Information and Monitoring & Evaluation

Central to any system of accountability is the collation, analysis, monitoring and systematic use of information. The status of the health information system is therefore indicative of whether such information is seen as important for the purposes of accountability, as well as indicating its capacity to make effective decisions.

Health Information challenges identified during Strategic Planning Workshops

- The plethora vertical information systems result in duplication and waste of scarce resources, and jeopardise timeliness, completeness and quality of health data.
- The lack of reliable data for key health outcomes e.g. mortality rates impact on planning as well as performance monitoring.
- Poor management of data and performance monitoring.
- Lack of reliable data on the burden of disease.
- Financial constraints impacting on the expansion of Telemedicine.
- Constant change of performance indicators from the National Department of Health during planning cycle impacting on data quality and completeness.

Processes and systems have been put in place for analysis of core indicators and trends. The Department commenced with disease mapping in conjunction with deprivation indices using geographical and spatial information. Composite health and deprivation profiles were developed per Municipality which provide valuable information for planning purposes.

The Department completed Phase 1 of the Burden of Disease Study (PHC clinics and CHCs) in the 2nd quarter of 2009/10. Study results will provide crucial information for planning purposes. Phase 2 (Burden of Disease in Hospitals) will commence in 2010/11.

Systems and processes for Health Research & Knowledge Management have been established and are fully functional. The turn-around time for approval of research improved to 5 working days, and 10 working days for Clinical Trials.

Due to severe financial constraints the Telemedicine and Information Technology Unit only maintained the existing services through the State Information Technology Agent (SITA) Service Level Agreements while being unable to implement critical new projects including the development and implementation of the Master Systems Plan, upgrading of data lines in hospitals and implementation of the Hospital Information System. The Electronic Patient Administration System for Tertiary Hospitals has been postponed due to budget constraints.

The roll-out of the District Health Information System (DHIS) version 1.4 commenced in April 2009. Core service delivery indicators, aligned with the National Treasury and Department of Health priorities, were incorporated into the system as well as the M&E Framework to improve data completeness, quality, and more effective use of health data for performance monitoring and evaluation.

The Provincial Result-Based Monitoring and Evaluation (M&E) Framework are aligned with planning documents (including the Strategic Plan, Annual Performance Plan and Operational Plans) to improve performance management and reporting. A Web-Based Reporting System Pilot Project to improve real time data commenced in 2010/11.

The Service Transformation Plan (STP) has not been finalised however gained new momentum in the 4th quarter of 2009/10.
1.3. PROGRAMME PRIORITIES

The MEC, in his 2009 Budget Speech, referred to the need for a ‘Health Turn-Around Strategy to improve Provincial Health Services’.

The BNET Business Dictionary defines Turn-Around Management as “…the implementation of a set of actions required saving an organisation from business failure and returning it to operational normality and financial solvency. Turnaround management usually requires strong leadership and can include corporate restructuring and redundancies, an investigation of the root causes of failure, and long-term programmes to revitalise the organisation.”

Although Administration comprises a multitude of core services equally important to ensure effective health system delivery, strategic focus will be on core functions considered critical for the delivery of services within the framework of the NHS 10-Point Plan and the MTSF priorities (20 Health Outputs).

Priority 1: Provide strategic leadership and management to ensure improved service delivery.

1.1 Align strategic plans (Strategic Plan, Annual Performance Plan, District Health Plans and Facility Plans) with the NHS 10-Point Plan and MTSF priorities and provide the necessary leadership in translation of priorities into service delivery.

1.2 Finalise the 2010 - 2020 Service Transformation Plan. Two new developments gave new impetus to the development of the STP. The first being the Green Paper on National Strategic Planning released in August 2009 by the Ministry of Planning in the Presidency, urging departments to produce long-term plans. The second being the directive from the National Health Council in October 2009 that departments must produce long-term plans aligned with the NHS 10-Point Plan for 2009/1014.

The following chapters are included in the STP

a) Service Delivery Plan: Outlining the type of services from PHC to Central Hospital level, packages of services, strategies to improve access, organisation and integration of services, quantified health outcomes, skills mix and cost.

b) Service Delivery Platform: Existing and required health facilities and assessment of Health Technology.

c) Human Resources Plan: Health personnel including Community Health Workers and those required to deliver services outlined in the Service Delivery Plan i.e. numbers, skills mix, and utilisation of resources in the private sector.

d) Quality Improvement Plan: Outlining mechanisms to improve the quality of services, accreditation of health facilities and the role of the Ombudsperson.

e) Infrastructure Plan: Reflecting strategies for expanding (or rationalising) the service delivery platform, including partnerships.

f) Medicine Supply and Management Plan: Indicating how the Department will ensure a reliable supply of medicines, dispensed by qualified and competent health workers.

g) Information, Communication, Technology and Health Information Systems Plan: Indicating how the Department will improve quality and reliability of health information.

h) Communication and Mass Mobilisation Plan: To inform communities about aims and objectives of the STP and to mobilise participation.

i) Research and Development Plan: Reflecting how new evidence and knowledge will be generated in collaboration with the scientific community.

j) Health Financing Plan: Outlining the cost implications of the entire STP, current levels of funding and funding gaps, and strategies to mobilise for additional resources.

1.3 Provide transversal legal services in support of efficient health service delivery in compliance with legal prescripts.

Priority 2: Improve Financial and SCM systems and management.

2.1 Implement the Financial and SCM Turn-Around Strategy to improve financial management and accountability, curb over-expenditure and ensure annual unqualified audit opinions from the AGSA.
2.2 Align budget with service delivery imperatives.

2.3 Improve Supply Chain Management systems and management to improve return on investment and value for money.

**Priority 3: Implement the Human Resource Management Turn-Around Strategy.**

3.1 Review and align the Provincial Human Resource Plan with the STP and service delivery platform to ensure adequate allocation of human resources.

3.2 Align District HRP’s with the Provincial Plan in accordance with DPSA and National Guidelines and in response to Provincial needs and strategic vision.

3.3 Review organisational structures and post establishments based on the service delivery platform and standard staffing norms. Complete the project to develop minimum staff establishments for hospitals. *Staffing norms will be developed by the National DOH during 2010/11 as per National Health Annual plan 2010/11.*

3.4 Conduct staff utilisation assessments in institutions to determine appropriate placement and utilisation of existing staff to inform re-configuration.

3.5 Complete the clean-up of Persal.

3.6 Monitor implementation of EPMDS.

**Priority 4: Implement an Information Management Turn-Around Strategy to improve health information systems, data management and performance monitoring and reporting.**

4.1 Implement the Master Systems Plan to ensure integrated health information systems and processes.

4.2 Roll out the Data Management quality programme to improve data completeness and quality and ensure annual unqualified audit opinions on performance information from the AGSA.

4.3 Implement the Results-Based Monitoring & Evaluation Framework to improve performance monitoring and reporting.

4.4 Finalise and roll out the Web-Based Reporting system to 100% districts by 2010/11.

4.5 Complete Phase 2 of the Provincial Burden of Disease Study (Hospital services) and disseminate reports.

**NOTE:**

Only core indicators are reflected in the Strategic Plan. Supporting indicators, to measure performance and progress, will be included in the Annual Performance Plan (output and outcome indicators) while other sub-set indicators (per priority programme) will be included in the Monitoring & Evaluation Framework. All supporting indicators will be monitored quarterly as part of overall monitoring and reporting and included in quarterly reports as indicated per priority.
### Strategic Objectives 

<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Strategic Objective</th>
<th>Objective Statement</th>
<th>Rationale</th>
<th>Indicator</th>
<th>Baseline</th>
<th>Expected Outcome</th>
</tr>
</thead>
</table>
| **Strategic Goal 1**  
**NHS Priority 1**  
Provide strategic leadership to ensure unified action in pursuit of goals. | To finalise and implement Provincial Health Plans aligned with the NHS and MTSF priorities for 2010-2014. | Alignment of provincial & district plans, within the funding envelope, ensures effective utilisation of existing resources in pursuit of common goals and priorities. | Providing strategic leadership to ensure effective performance management and reporting in line with national and provincial priorities. | Approved Strategic Plan aligned with NHS and MTSF priorities tabled in April 2010 | Not yet tabled | Effective performance monitoring and reporting towards achievement of NHS, MTSF, MDG's and Provincial priorities. |
| **Strategic Goal 1**  
**NHS Priority 1**  
Provision of strategic leadership to ensure unified action in pursuit of goals. | To finalise and implement the 2010-2020 KZN Service Transformation Plan including 10 Core Components aligned with the NHS 10-Point Plan. | The STP, aligned with the NHS 10-Point Plan, makes provision for the transformation of public health services in line with service delivery demands and the funding envelope. | Rationalisation of resources and services ensures effective utilisation of resources, equity, efficiency, effectiveness and quality of health services. | Published STP[^42] | STP under review – Draft 3[^43] | Approved STP, aligned with the NHS 10-Point Plan published in August 2010. |

[^41]: DHP’s not aligned with the planning cycle and NHS 10-Point Plan

[^42]: Implementation of the STP will be monitored against targets set in the implementation Plan once finalised

[^43]: STP refers to all supportive and inter-related macro plans including Service Delivery Plan; Service Delivery Platform; HR Plan; Quality Improvement Plan; Infrastructure Plan; Drug Supply and Management Plan; Information Communication Technology (ICT) and Health Information System (HIS) Plan; Communication and Mass Mobilisation Plan; Research and Development Plan; Health Financing Plan
<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Strategic Objective</th>
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<th>Rationale</th>
<th>Indicator</th>
<th>Baseline</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Goal 1</strong>&lt;br&gt;NHS Priority 1</td>
<td>Review legislation and policies to improve service delivery.</td>
<td>To prepare and submit the KZN Health Act (1 of 2009) Regulations for promulgation in 2010.</td>
<td>The KZN Health Act (1 of 2009) re-enforces legal mandates and provides the legal framework for service delivery.</td>
<td>Regulations for the KZN Health Act 2009 promulgated</td>
<td>Drafting of Regulations commenced in 2009/10</td>
<td>Regulations promulgated and commencement of the KZN Health Act 2009.</td>
</tr>
<tr>
<td><strong>Strategic Goal 1</strong>&lt;br&gt;NHS Priority 4</td>
<td>Improve financial audit outcomes through improved management and accountability.</td>
<td>To implement a Finance &amp; SCM Turn-Around Strategy to improve compliance with the PFMA and Treasury Regulations, eliminate over-expenditure by 2012/13 and ensure an annual unqualified audit opinion on financial statements from the AGSA.</td>
<td>Stringent implementation and monitoring of the Fiscal Adjustment Plan and Cost Saving Measures, in line with provincial priorities, will ensure effective allocation and utilisation of resources in response to service delivery needs.</td>
<td>Annual unqualified audit opinion on financial statements</td>
<td>Over-expenditure of R1,320,116 billion in 2008/09</td>
<td>Expenditure within budget by 2012/13 and annually thereafter.</td>
</tr>
</tbody>
</table>

STP facilitates the rationalisation of Provincial health services – including short-, medium- and long-term interventions. Rationalization of Provincial Health Services based on service needs including disease profile. Improved equity, availability, access, utilisation, value for money and cost effectiveness.
<table>
<thead>
<tr>
<th>Strategic Goal</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Goal 1</strong>&lt;br&gt;NHS Priority 4&lt;br&gt;Improve Supply Chain Management (SCM) systems and efficiency.</td>
<td>Improve Supply Chain Management (SCM) systems and efficiency.</td>
<td>Improve value for money through strategic outsourcing.</td>
<td>Procurement of goods and services of discounted prices using the leverage of bulk buying.</td>
<td>Percentage procurement spend on specific &amp; transversal contract management</td>
<td>Over-expenditure of R300 million in 2009/10</td>
<td>80% procurement spent on specific &amp; transversal contract management by 2014/15.</td>
</tr>
<tr>
<td></td>
<td>Improve asset management controls through implementation of an Asset Register in compliance with National Standards.</td>
<td>Fully constituted Asset Management System to ensure effective accounting in the Annual Financial Statements.</td>
<td>Percentage of assets accounted for in the composite Asset Register</td>
<td>Qualified audit opinion in 2008/09</td>
<td>100% assets accounted for in the Asset Register by 2014/15.</td>
<td></td>
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</tbody>
</table>

<sup>44</sup> HRP implemented and monitored as per STP Implementation Plan

Persal data verified
Commenced in Q4 of 2009/10
Persal data verified by March 2011.
<table>
<thead>
<tr>
<th>Strategic Goal</th>
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</thead>
<tbody>
<tr>
<td>Strategic Goal 1</td>
<td>NHS Priority 1</td>
<td>Improve systems for results-based performance monitoring and information management.</td>
<td>To expand the Registrar training programme to increase the pool of Specialists by retaining 75% of qualified Registrars by 2014/15.</td>
<td>Decrease in the vacancy rate will increase availability and access to specialist services and improve efficiency and effectiveness of public health services.</td>
<td>% of Registrars retained after qualifying</td>
<td>25% of registrars retained – 2009/10</td>
</tr>
<tr>
<td>Strategic Goal 1</td>
<td>NHS Priority 1</td>
<td>Improve systems for results-based performance monitoring and information management.</td>
<td>To implement an integrated Health Information Turn-Around Strategy to improve data quality and ensure annual unqualified audit opinion on performance information from the AGSA from 2010/11 – 2014/15.</td>
<td>Improved information systems facilitating improved data quality, data management and performance monitoring &amp; evaluation supporting evidence-based practice.</td>
<td>Annual unqualified audit opinion on performance information</td>
<td>New indicator</td>
</tr>
<tr>
<td>Strategic Goal 1</td>
<td>NHS Priority 1</td>
<td>Improve systems for results-based performance monitoring and information management.</td>
<td>Master System Plan (MSP) implemented</td>
<td>New indicator</td>
<td>Integrated information systems as per MSP. Improved data completeness and quality. Integrated information systems to ensure effective performance monitoring.</td>
<td></td>
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</table>

45 Implementation as per approved Implementation Plan
<table>
<thead>
<tr>
<th>Strategic Goal</th>
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</table>
1.5. RISK MANAGEMENT

Table 9: Key Risk Factors

<table>
<thead>
<tr>
<th>Key Risk Factors</th>
<th>Measures to Mitigate Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Limited budget versus service delivery demands. Un-coordinated planning between national and provincial departments resulting in unfunded mandates and changed priorities during the reporting period.</td>
<td>• Align national and provincial planning processes to co-inside with planning cycle. Alignment of national &amp; provincial priorities (alignment of plans with NHS and MTSF Priorities).</td>
</tr>
<tr>
<td>2. Inadequate management competencies, delegations, controls and accountability (especially at facility level).</td>
<td>• Implement reviewed delegations (once finalised by the National Department of Health). Performance agreements, aligned with priorities, signed by all managers. Development of management skills and competencies, including succession training to make provision for vacancies.</td>
</tr>
<tr>
<td>3. Delays in filling of critical posts in conjunction with high attrition/ vacancy rates, absenteeism, and high number of staff on extended incapacity leave negatively impact on quality of care, cost, staff morale and burn-out.</td>
<td>• Implement the HRMS Turn-Around Strategy – including alignment of HRP with macro plans.</td>
</tr>
<tr>
<td>4. Poor alignment of Provincial &amp; District HR Plans with organisational planning, service delivery demands and package of services within the current funding envelope.</td>
<td>• Alignment of Provincial and District HRP's with service delivery imperatives.</td>
</tr>
<tr>
<td>5. Lack of appropriate information systems to ensure reliable health data to inform planning.</td>
<td>• Implement the Information Management Turn-Around Strategy – including Information Systems, Data Management and Monitoring and Evaluation (M&amp;E Framework).</td>
</tr>
</tbody>
</table>

1.6. RESOURCE CONSIDERATIONS

1.6.1 Expenditure Trends in Administration Programme

The Department’s policy is to keep the budget allocation of the Administration Programme at a maximum of 2% of the total budget. This has been achieved over the past 4 years and will be maintained over the planning cycle.

In terms of Section 34(2) of the PFMA, the Department is liable for the repayment of previous years’ over-expenditure, resulting in a first charge against the Departments’ budget. In 2009/10, the first instalment of R758 million was implemented against the budget. The first charge amount is allocated under the Sub-Programme Management against Payments for Financial Assets, and the amount available for spending in the 2009/10 has been reduced by the instalment amount.

1.6.2 Unfunded Priorities

1. Implementation of the STP for the 2010/11 MTEF. The STP (including attached macro plans) have not been finalised and costed to determine the funding envelope for implementation.

2. Expansion of Telemedicine for the 2010/11 MTEF.

3. Implementation of the Master Systems Plan for 2010/11 MTEF.

1.6.3 Trends in supply of key health personnel

No additions to Part A.
Table 10: Summary of Payments and Estimates – Programme 1: Administration

<table>
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<td>13 782</td>
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<td>12 969</td>
<td>12 155</td>
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<td>17 620</td>
<td>18 365</td>
<td>19 467</td>
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<tr>
<td>Management</td>
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<td>267 832</td>
<td>270 284</td>
<td>289 536</td>
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<td>1 020 775</td>
<td>296 986</td>
<td>318 395</td>
<td>336 166</td>
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<tr>
<td>Total</td>
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<td>279 730</td>
<td>284 066</td>
<td>302 307</td>
<td>1 043 371</td>
<td>1 032 930</td>
<td>313 777</td>
<td>336 015</td>
<td>354 531</td>
<td>375 803</td>
</tr>
<tr>
<td>Unauthorised (1st charge) not available for spending</td>
<td></td>
<td></td>
<td></td>
<td>(758 000)46</td>
<td>(758 000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
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<td>274 930</td>
<td>313 777</td>
<td>336 015</td>
<td>354 531</td>
<td>375 803</td>
</tr>
</tbody>
</table>

Data Source: BAS & Finance Section

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46 In terms of Section 34(2) of the PFMA, the Department is liable for the repayment of previous years’ over-expenditure, resulting in the first charge against the Department’s budget. In 2009/10, the first instalment of R758 million was implemented against the budget. The first charge amount is allocated under the Sub-Programme Management against Payments for financial assets, and the amount available for spending in 2009/10 has been reduced by the instalment amount
Table 11: Summary of Payments and Estimates by Economic Classification – Programme 1: Administration

<table>
<thead>
<tr>
<th>R’000</th>
<th>Outcome</th>
<th>Main Appropriation</th>
<th>Adjusted Appropriation</th>
<th>Revised Estimate</th>
<th>Medium-Term Estimates</th>
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<tr>
<td>Current payments</td>
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<td>279 411</td>
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<tr>
<td>Compensation of employees</td>
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<td>141 966</td>
<td>163 648</td>
<td>184 931</td>
<td>169 770</td>
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<td>Goods and services</td>
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<td>132 987</td>
<td>115 763</td>
<td>115 656</td>
<td>113 915</td>
</tr>
<tr>
<td>Financial transactions in assets and liabilities</td>
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<td>-</td>
<td>-</td>
<td>758 000</td>
</tr>
<tr>
<td>Transfers and subsidies to</td>
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<td>698</td>
<td>726</td>
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<tr>
<td>Provinces and municipalities</td>
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<td>12</td>
<td>4</td>
<td>8</td>
<td>36</td>
</tr>
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<td>Universities and technikons</td>
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<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-profit institutions</td>
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<td>-</td>
<td>-</td>
<td>-</td>
</tr>
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<td>-</td>
<td>-</td>
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<td>Machinery and equipment</td>
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<td>3 011</td>
<td>2 490</td>
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<tr>
<td>Software and other intangible assets</td>
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<td>12</td>
<td>-</td>
<td>62</td>
<td>-</td>
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<tr>
<td>Total economic classification</td>
<td>225 035</td>
<td>279 730</td>
<td>284 066</td>
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</tr>
<tr>
<td>Unauthorised (1st charge) not available for spending</td>
<td>-</td>
<td>-</td>
<td>-</td>
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</tr>
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<td>225 035</td>
<td>279 730</td>
<td>284 066</td>
<td>302 307</td>
<td>285 371</td>
</tr>
</tbody>
</table>

Data Source: BAS & Finance Section
PROGRAMME 2 : DISTRICT HEALTH SERVICES

2.1. PROGRAMME PURPOSE

To render Primary Health Care (PHC) and District Hospital services. The Programme comprises nine Sub-Programmes.

The main objectives of Programme 2 are:

- To provide service planning and administration, managing personnel, financial administration and the coordination and monitoring of district health services including those rendered by District Councils and Non-Governmental Organisations.
- To render nurse-driven PHC services at clinic level including mobile visiting points and local authority clinics.
- To render PHC services with medical officers and rehabilitation therapists in respect of services for mother and child, geriatrics, occupational therapy, physiotherapy, psychiatry, speech therapy, communicable and non-communicable diseases and mental health services.
- To render PHC at non-health facilities in respect of home-based care, abuse victims, mental and chronic care and school health.
- To render PHC services related to the comprehensive management of HIV and AIDS, TB and such related campaigns and special projects.
- To provide services directed at providing nutritional support and information to deserving members of the population.
- To render forensic pathology and medico-legal services in the Province.
- To render hospital services at General Practitioner level.

2.2. SITUATION ANALYSIS

Vertical programme implementation, inadequate supply of resources to comply with demand, under-estimation of the impact of communicable & non-communicable diseases on District Health Services (DHS), and the tendency to focus on curative rather than promotive and preventative services contribute to increasing congestion of PHC services with limited resources to change trends and health behaviours.

It is clear from feedback during the strategic planning workshops that one of the most critical challenges in Programme 2 is the lack of integration and uncoordinated community-based programmes. All focus programmes identified by both the MEC and HOD (HIV & AIDS, TB, PMTCT, MC&WH and Nutrition) referred to the significant impact of poor/ inadequate integrated systems/services on the sustainability and effectiveness of these services. This will be considered as part of the 5-year strategy.

The PHC approach, based on the World Health Organisation (WHO) Alma Ata Declaration, provides the ideological framework for 1st level health care services. The 11 key principles have been captured in the National Health Act as equity, access to services, overcoming fragmentation, quality, effectiveness, comprehensive services, efficiency, local accountability, community participation, developmental and inter-sectoral approach, and sustainability. These principles form the basis for the revitalisation of PHC services.

The current burden of disease in the Province necessitates an in-depth assessment of current systems, processes, resources and community needs to inform the strategic vision and transformation of health services to ensure a more efficient and responsive public health care system. This is considered in the STP process.

There are similarities between the Provincial PHC Disease Profile and the National Burden of Disease study. The top two conditions presenting in PHC facilities are the same, while 6 out of 10 conditions are similar in both studies.

According to the Provincial PHC Profile, hypertension (12.4%), TB (9.9%), and respiratory conditions (9.4%) are the most common conditions seen at PHC clinics in the Province. Clients attending PHC services for reasons other than illness constitutes 28.9% of the total sample.

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47 KwaZulu-Natal Department of Health Disease Profile: PHC Clinics and Community Health Centres - 2009
Graph 4 illustrates the 10 most common conditions seen at PHC clinics and CHC’s. Lack of adequate diagnosis and poor record keeping has been limiting in the study. The low contraception coverage (23%) raises concerns and point towards missed opportunities at PHC level. Utilisation of PHC services for VCT is encouraging although the low population coverage (4%) is a clear indication that more should be done to promote testing.

A total of 727 (24%) teenage girls aged 15-19 years attended PHC for pregnancy related conditions, and teenagers comprised 11.8% of clients utilising family planning clinics.

Graph 6 illustrates a breakdown of the PHC visits for reasons other than disease as per PHC Disease Profile.

25% of people visiting Provincial PHC services for reasons other than illness (except referrals) came for family planning, followed by VCT (20.2%), antenatal care (15.7%) and immunisation (14.4%).

HIV is considered an underestimate in this study. Clients utilising VCT (881/892) and PMTCT (153/224) services are not included under HIV. The high co-infection of HIV-TB has also not been considered for purposes of this study.

Graph 5 illustrates the 10 most common conditions at PHC level as identified in the National Burden of Disease study.

Graph 7 shows the PHC budget versus the total budget for the period 2006/07 to 2012/13. The increased budget over the current MTEF is in line with the intention to revitalise PHC as one of the Department’s priorities for the forthcoming planning cycle.

25% of people visiting Provincial PHC services for reasons other than illness (except referrals) came for family planning, followed by VCT (20.2%), antenatal care (15.7%) and immunisation (14.4%).
The Provincial PHC expenditure per uninsured person decreased from R297.80 in 2006/07 to R234.32 in 2009/10, comparing negatively with the national target of R286.49. The expenditure per PHC client decreased from R89 in 2008/09 to R80 in 2009/10 as compared with the national target of R78.

The expenditure per patient day equivalent (PDE) for District Hospitals decreased from R 2,201 in 2008/09 to R1,255 in 2009/10 (compared with the national target of R814).

Poor costing of services in District Hospitals (especially ‘Combo’ Hospitals\(^51\)) needs urgent attention. The lack of cost centres jeopardise costing and efficiency of services contributing to over-expenditure and service rendering. The STP, making provision for inter alia, standard service platforms and aligned resources, will provide the leverage to ensure effective planning and resource allocation. This will be addressed as part of the Financial Turn-around Strategy.

The KZN poverty and health profiles (referred to in Part A), the 4 National Priority Districts, and Premiers Flagship Programme will be the first point of entry to improve equity.

The National PHC Audit, National 1,000 Facilities Improvement Project and the current integrated STP process will determine the most logical way forward for the planning cycle. Aligned long-term plans will have a strong focus in addressing existing inequities within the framework of the NHS 10-Point Plan.

The Flagship Programme that commenced in 2009/10 and prioritises development processes in communities to enable individuals to become owners of development. Communities are targeted as the centres of wellness therefore investing in sustainable development. The Programme, implemented at Ward level, uses the Provincial Indices of Multiple Deprivation to identify the most deprived areas within the Province with the following 5 domains were considered in developing the deprivation profiles:

- Income and Material Deprivation;
- Educational Deprivation;
- Living Environment Deprivation;
- Employment Deprivation; and
- Health Deprivation.

The focus is on integration of community-based services rendered by existing Community-Based Health Care Workers and volunteers at ward level. A total of 2,167 of the 4,000 cadres will be allocated to the 52 most deprived wards, 1,050 cadres will be distributed to the second 53-400 wards and the remaining 783 will be distributed in the remaining 350 wards.

Four Municipalities were identified in KwaZulu-Natal as part of the National 18 Priority District Project. These include Nongoma in Zululand, Maphumulo in Ilembe, Umhlabuyalingana in Umkhanyakude and Dannhauser in Amajuba.

The project commenced in 2009/10 and aims to accelerate interventions to improve maternal, neonatal, child and women’s health and nutrition, HIV and AIDS, TB, and Non-
Communicable diseases (diabetes, hypertension, trauma, alcohol and substance abuse). Targeted interventions will be in support of improved service delivery towards national targets and the MDG’s.

Rural Development in the Rural Development Nodes focuses on allocation of relevant resources to improve equity, service delivery and health outcomes. Recommended interventions, as per National Framework include: child health, maternal health, HIV & AIDS, women’s health, malaria and TB. The current massification projects that commenced in the previous planning cycle are relevant.

Access to services

Out-reach services from District Hospitals to PHC clinics improved through increased visits by Community Service Therapists and Medical Officers, although shortages of some specialities still impact on service delivery i.e. dentistry. Some specialities are still based at hospitals not extending community-based services i.e. Psychologists.

There are 30 gateway clinics in the Province i.e. Ugu (3), Umngundlovu (3), Uthukela (3), Umzinyathi (4), Amajuba (3), Zululand (4), Umkhanyakude (2), Uthungulu (1), Ilembe (1), Sisonke (3) and eThekwini (3). Establishment of gateway clinics will be reviewed as part of the STP process. The relation between the significant increase in District Hospital OPD headcounts (60%) and access to PHC services will be assessed to inform long-term reform.

Expansion of PHC services, including infrastructure projects, is slowed down as a result of over-expenditure and cost saving measures, and although the Programme 2 budget shows an increase it is not adequate to comply with demands.

Fixed PHC Clinics increased from 450 (including Local Government) in 2005 to 577 (594 including Provincial, Local Government and State Aided) in 2008/09, and CHC’s increased from 14 to 16 during the same period.

Mobile service points increased from 2,391 in 2008/09 to 2,518 in 2009/10 (Q2) reaching a total of 2,304,816 patients.\textsuperscript{52}

The number of Health Posts increased from 40 in 2006/07 to 49, which is in line with the commitment to increase availability and access to PHC services closest to communities.\textsuperscript{53} Health Posts will be reconsidered in the STP to ensure that it serves the purpose it was intended for.

The PHC headcount increased with 21% over the last 4 years, with 23,838,854 clients visiting PHC services in 2008/09. It is not clear how many clients still ‘bypass’ PHC services to enter the health system at inappropriate (hospital) level. The 60% increase in the District Hospital OPD Headcount between 2005/06 and 2008/09 may be as a result of the changing burden of disease or ineffective PHC services and will be further investigated as part of the revitalisation project.

The PHC utilisation rate increased slightly from 2.0 visits per year (2005/06) to 2.5 in 2008/09, and the under-5 utilisation rate increased from 4.3 visits per year (2005/06) to 4. in 2008/09.

Overcoming fragmentation

Services are still fragmented with numerous vertical strategies implemented at especially PHC level. The lack of integration was one of the identified root causes of poor performance identified at strategic planning workshops. The implementation of an integrated Provincial PHC Model, in line with the National Framework for PHC, is a priority to improve service delivery, performance, quality, appropriate utilisation of scarce resources and improved health outcomes.

No progress has been made with the takeover of Local Government clinics due to inadequate funding and a KwaNaLoGa embargo on negotiation of transfers. This is a national priority and will be prioritised in 2010/11.

Quality

Health information and data management is still a challenge, although a paradigm shift towards use of data is evident. The Province rolled out DHIS version 1.4 in 2009/10 and still experience systems challenges that affect data quality. The National HISP Project, aimed at improving data systems and quality commenced in 2009/10.
Vertical information systems, especially at operational level, cause duplication and affect data quality and cost. Implementation of the Master Systems Plan should solve some of the current challenges.

The Provincial Monitoring and Evaluation Framework, approved in 2009/10, already show significant improvement towards performance monitoring and reporting. To improve reporting and monitoring, a web-based reporting tool was developed in 2009/10. Piloting is currently in an advanced stage and roll-out of the system will be pursued in 2010/11.

A Pharmacy Project to improve access to chronic medication was piloted in eThekwini and preliminary data shows positive results.

The supervision rate improved from 55% in 2006/07 to 65% in 2008/09 which is still significantly below the national target of 100%. Improved supervision is critical to ensure quality of care and job descriptions, delegations, etc. will be reviewed as part of the STP process. Supervision and clinical governance, included as part of the National Core Standards for Quality, has been identified as priority for the forthcoming planning cycle.

Medico-legal litigation continues to put a heavy financial burden on the Department with an overall contingent liability amount of R 376 239 253 in 2008/09. There were 920 litigation files, of which 319 were medico-legal matters. Obstetrics and Gynaecology has been the highest cost drivers in medico-legal litigation, while poor medical record keeping and security of patient records increased litigation costs.

Clinical governance is lacking and is included in the Core Standards for PHC and Hospital Services. This will be closely monitored in the forthcoming planning cycle.

Effectiveness

All districts conducted District Health Expenditure Reviews (DHER) and developed District Health Plans (DHP’s) as required by the National Health Act of 2003 and based on the National Department of Health template. Non-alignment of the template to the NHS 10-Point Plan and delays in the strategic planning process however delayed finalisation of the plans. This will be addressed in 2010/11.

Un-coordinated, unfunded and poorly consulted projects still challenge management and implementation at operational level. Current financial constraints require meticulous management of resources at operational level and that will only be possible if districts have appropriate mandates and competencies to manage services at operational level.

Comprehensive services

Although outreach programmes improved there is still fragmentation and duplication which should be addressed by introducing a formal integrated PHC strategy supported by both National and Provincial Departments of Health.

Efficiency

Referral systems are challenged by inadequate resources e.g. inadequate EMS vehicles and staff, high vacancy rates of Specialists and other scarce skills. This will form part of the STP process. A pilot project to develop more effective referral systems and policies commenced in Area 2 during late 2009/10. That will be integrated in the STP and inform the PHC and hospital revitalisation process.

Human resource challenges, including vacancy rates and skills gaps, have a limiting impact on effectiveness, efficiency, quality and expansion of PHC services. The lack of approved and integrated organisational structures and post establishments for PHC services severely delayed the filling of critical posts hence gaps in critical management positions resulting in poor management, quality of care and sustainability of services.

The national PHC audit and Provincial STP process will inform review of the service delivery platforms, package of services, equipment and resources.

Although most clinics have essential equipment, timeous repair and replacement of broken equipment is still a challenge especially as a result of financial constraints and the lack of an Equipment Replacement Plan.

The doctor clinical workload (PHC) of 19 patients per day is well below the national norm of 30 patients per day, and is indicative of poor management and under-utilisation of scarce resources. Interpretation of the indicator must be

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54 2008/09 Annual Report

55 2009/10 PQRS (Actual Q2)
followed up as current vacancy rates would indicate higher workloads.

The Professional Nurse clinical workload (PHC) of 40 patients per day exceeds the national target of 35 patients per day.

Quoted workloads might not be a true reflection taking into consideration the high vacancy rates and absenteeism, number of staff on incapacity leave, and staff being away from services (attending meetings, training, etc.). Significant variances between districts and facilities challenge resource allocation and must be assessed to ensure adequate provision of resources.

Workloads are currently articulated as patient or health worker ratios and based on utilisation rates. Changing disease profiles however challenges this definition or simplified interpretation. Workload per category should be re-considered in alignment with disease profiles and package of services in order to improve efficiency, quality and optimal utilisation of resources.

Client flow at clinics often cause bottle necks that are subjectively perceived as being short staffed. Alternatives should be considered e.g. scope of practice (task shifting) to relieve high case loads of critical categories of staff. Complete re-orientation is necessary as the ‘one stop shop’ may be impeding continuity of care and contributing to staff member burn-out. The new Nursing Act and changed scope of practice for nurses will impact on staffing norms and the intended revitalisation of services.

Local Accountability

Appropriate delegations and performance reviews forms part of the Departments vision to ensure accountability.

Community Participation, Developmental and Inter-Sectoral Approach

Clinic governance has been improved with 82% of PHC clinics and 81% of CHC’s with interim Clinic Committees. Although the training of the Committees has commenced through CUPB, and follow-up training was planned through the contract with KZNPPHC no training has been conducted for the Operations Managers at facility level which jeopardise the effective functioning of these committees.

Sustainability

Sustainability of programmes is jeopardised as a result of inadequate funding and resources. Improved consultation with District Management Teams is critical to ensure sustainability.

2.2.2 HEALTH PROMOTION

Emerging disease patterns require a paradigm shift towards a more focused and integrated health promotion approach including primary and secondary prevention and screening interventions as part of the continuum of care. Current financial constraints and limited resources, coupled with the increasing burden of disease (both communicable and non-communicable) necessitate an integrated and robustly driven Provincial Health Promotion Strategy.

A total of 162 schools are accredited as Health Promoting Schools, and the concept has been introduced to a further 2,105 schools during 2008/09 and 2009/10. Sustainability of programmes in schools is a challenge mainly due to poor buy-in from the Department of Education. Assessment of the programme, to determine the outcome on behaviour commenced in 2008/09.

A total of 88 PHC clinics and 9 hospitals are implementing the Health Promotion principles which are inclusive of the 5 action areas outlined in the Ottawa Charter i.e. skills development, re-orientation of health services, policy development, creating a safe and supportive environment and community involvement. This is in line with the NHS 10-Point Plan. Six of the 88 PHC clinics have been accredited as Health Promoting facilities, including the Community Component in service delivery.

Developing public-private partnerships inter alia Paraffin Association of South Africa, Sugar Association of South Africa, Kids & Care, ABSA Bank through the Provincial Healthy Lifestyle Forum have assisted in health promotion and healthy lifestyle activities being included as integral part of health events, health promotion projects and routine services. The impact is limited due to gross fragmentation
and inadequate allocation of resources. This is one of the most essential services to be expanded in the forthcoming planning cycle.

The lack of a fully funded and integrated Provincial Health Promotion Strategy results in vertical initiatives that are not sustainable and have limited impact. Current financial constraints limit out-reach and community interventions hence impacting on lifestyle and health behaviours as indicated in districts reports.

2.2.3 CHRONIC CONDITIONS

The WHO estimates of the burden of disease in South Africa suggest that non-communicable diseases caused 28% of the total burden of disease measured by disability-adjusted life years (DALYs) in South Africa in 2004.\textsuperscript{59}

Non-communicable diseases are a major contributor to the burden of disease in the Province and are increasing rapidly mainly as a result of changing lifestyles and demographic transition. These diseases are largely attributed to preventable and modifiable risk factors such as obesity, physical inactivity, unhealthy diet, tobacco use and inappropriate use of alcohol.

Hypertension, diabetes and asthma are still the most common non-communicable conditions in KZN, showing a significant increase of 25%, 32% and 8% between 2006/07 and 2008/09.

The KwaZulu-Natal PHC Disease Profile\textsuperscript{60} shows that hypertension (12.4%) is the most common condition seen at PHC level.

Graph 9 shows the steady increase in chronic conditions at PHC level over the period 2006/07 to 2008/09. Although an increase is expected with rising patient numbers it is important to put systems in place to improve prevention and screening programmes at community level. Compliance with treatment regimes will be monitored in the coming planning cycle.

Graph 9: Chronic Conditions 2006/07 – 2008/09

Non-communicable conditions and illnesses represented 31.54% of the PHC profile\textsuperscript{1} although the lack of clear diagnosis and poor patient records has been a limiting factor in the research.

Graph 10: PHC Disease Profile 2009

Diabetes awareness and screening improved through partnerships with Novo Nordirks and the South African Sugar Association.

Amputee clinics are rendered at King Edward VIII, Addington, Prince Mshiyeni, RK Khan and Clairwood Hospitals and Phoenix Assessment Therapy Centre. A total of 519 amputations were conducted on people with diabetes in 2008/09.

Poor compliance with treatment regimes, exacerbated by poor nutritional and lifestyle habits challenge prevention and management of chronic conditions. Integrated preventive and promotive programmes must be up-scaled to ensure

\textsuperscript{59} Bongani M Mayosi, Alan J Fisher, Umesh G Laloo, Freddy Sitas, Stephen M Tollman, Debbie Bradshaw: The burden of non-communicable diseases in South Africa

\textsuperscript{60} Dr A Tefera, KwaZulu-Natal PHC Disease Profile 2009
more effective utilisation of resources to reach clients in the community.

The vacancy rate for Optometrists and Opticians was 65.9% in 2008/09 with an annual turn-over rate of 7.1%, resulting in extensive delays in management of eye care patients.

Eye Care Programmes, supported through partnerships with the Bureau for Prevention of Blindness, Red Cross, Lions International, Giving Sight in Africa Project, Department of Education, the International Centre for Eye Care Education (ICEE) and Nissan increased access to services and increased refraction rates from 15% to 40% through affordable spectacle provision.

Cataract surgery is being jeopardized by limited resources (specialist equipment and financial and human resources), inadequate theatre time, and increased referral to hospitals due to the failure of OSD to recognise Ophthalmic Nurses in PHC.

Cataract case finding are below expectation as a result of the limited number of case finders serving increased catchment populations.

In 2008/09, the Province could only achieve 73% of the annual target (9,315/12,703) with Sisonke and Umgungundlovu Districts the only districts achieving their annual targets.

2.2.4 MENTAL HEALTH

The transformation of mental health care services, from the predominantly authoritarian biomedical model towards a more comprehensive and integrated community-based care approach (as envisaged in the Alma Ata Declaration and the Mental Health Care Act, 2002) is severely challenged by inadequate systems, processes and resources at service delivery level.

The mental health headcount in PHC services increased with 46% between 2005/06 and 2008/09 as illustrated in Graph 12 below.

Human resource constraints including attrition, absenteeism and skills gaps affect the provision of effective continuity of care and support to families and NGO’s.

Financial constraints limit effective communication strategies aimed at changing the paradigms of health workers, families and the community at large.
The de-institutionalisation process to ensure continuum of care to patients with severe and chronic mental disorders is complicated, and translation of policy into practice has been hindered by severe financial constraints. As a result, hospitals still serve a large residual of chronic long-term patients while the number of acutely ill patients seeking care is increasing.

The inability to transfer adequate resources from institutions to communities to ensure continuity of care delay transformation and districts are forced to render services within current limitations.

Development of community residential care facilities and ambulatory services, which is crucial to reduce relapse and increased re-admission amongst de-institutionalised patients, is slow and delay transformation.

Stigmatization of mental health patients still exists which might be one of the reasons why people still prefer hospital as opposed to community care.

Urbanisation is impacting negatively on extended families that are expected to participate in patient care, and high poverty levels exacerbate the ability of families to care for patients at home.

Although all hospitals are able to provide 72-hour observation for mental health care users as stipulated in the Mental Health Care Act, the observation period is often exceeded due to an inadequate number of step-down facilities and specialised psychiatric hospitals. This translates into increased hospital cost, and puts in jeopardy the safety of staff and other patients which might in turn result in litigation.

The Infrastructure Development Plan makes provision for the building of seclusion rooms although this was restricted as a result of budget constraints. The current 34 hospitals with seclusion rooms are inadequate to cater for patient numbers and therefore contravene implementation of the Act.

Mental Health Review Boards have been established as required although functioning should be closely monitored.

There are 7 Specialised Psychiatric Hospitals in the Province situated in Umgungundlovu (3), Sisonke (1), Amajuba (1) and eThekwini (2). This distribution of hospitals (and beds) might delay the shift from custodial to community care especially if linked with the necessary step-down and support functions. The Provincial mental health bed norms for District Hospitals (139 beds) and Regional Hospitals (75 beds) is under review as part of the STP process.

### 2.2.5 REHABILITATION AND DISABILITY

The placement of Community Service Therapists improved access for people with disabilities at PHC and hospital level and alleviated human resource shortages. In 2008/09, 80% of hospitals were able to provide some rehabilitative services and PHC coverage was improved with a total of 1,406 clinic visits.

Vacancy rates for therapists are high which compromises service delivery at PHC level resulting in high referrals to hospitals. Vacancy and attrition rates for Physiotherapists (60% and 36.8%), Occupational Therapists (58.8% and 53.8%), and Speech Therapists and Audiologists (41% and 51.8%) in 2008/09 indicate the gap in service delivery.

There are a total of 24 Audio Sites in the Province, although an audit is necessary to determine the status and quality of services.

In spite of financial constraints the Department issued 1,988 wheelchairs and 1,113 hearing aids in 2008/09.

Future disability and rehabilitation service provision will be aimed at improving the quality of life of people with disabilities by addressing key areas with a series of specific interventions that are aligned with the Provincial priorities.

### 2.2.6 ORAL HEALTH

Access to Oral Health services improved slightly with the establishment of 5 new dental clinics at Nkandla, Kingsburg, Weenen, Pinetown and Assisi where primary Oral Health services were commissioned.

The Children's Oral Health Centre at Imbalenhle in the Umgungundlovu District was commissioned in February 2009. The centre is fully equipped with clinical staff.

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Information from District Quarterly Reports
appointed although the optimal number of chair side assistants was not appointed. This project, in collaboration with the University of Witwatersrand, will inform service delivery before roll-out to other centres.

The Umgungundlovu District completed the re-vitalisation of all Dental Clinics and pioneered the installation of Digital Imaging for intra-oral X-rays.

The use of RT contracts/tenders in the procurement of dental suppliers will enhance service delivery.

The extraction to restoration ratio increased from 25:1 in 2007/08 to 28:1 in 2008/09. Financial constraints, delays in the procurement of equipment and consumables and the inability to recruit and appoint staff impacted negatively on service delivery and the achievement of targets.

The high turnover and vacancy rates for dental health practitioners impact negatively on availability and service delivery. The vacancy rate for Dental Practitioners increased from 34.9% in 2007/08 to 37.3% and the turnover rate from 25.4% to 27.7% in 2008/09. Delays with implementation of OSD and the lack of career pathing negatively impact on recruitment and retention of these scarce skills.

The high vacancy rate for Oral Hygienists (51.9%) and annual turnover rate (7.7%) negatively impact on oral health education and school screening services.

2.2.7 ENVIRONMENTAL HEALTH

High staff turnover (34.2%) and vacancy rates (32.3%) have a serious impact on the sustainability and quality of services. This will undoubtedly have an impact on the effective management and containment of outbreaks and epidemics as well as routine disease surveillance.

The Province successfully sustained control measures towards achieving malaria elimination as prescribed in the SADC Strategy for the Africa Malaria Elimination Campaign, and achievements exceed MDG 6 to halve malaria morbidity and mortality by 2015.

The Province reported a malaria incidence of below 1/1000 population in 2008/09 and a reduction of reported cases from 606 cases in 2007/08 to 429 cases in 2008/09.

Achievements are attributed to the successful implementation of focused intervention strategies including indoor residual spraying, intensive health education and promotion programmes and behaviour change interventions to improve prevention, care seeking and early treatment of malaria. Current budgetary constraints however challenge the sustainability of the programme which could reverse the current impact.

The Indoor Residual Spraying coverage increased from 86% in 2007/08 to 93% in 2008/09 ensuring that more than 280,000 people in malaria risk areas were protected from malaria. More than 30,000 community members, including Traditional Leaders and Healers, were reached with information and health education/promotion on malaria transmission and prevention, and a total of 121 health professionals were trained on malaria case management.

The Province reported a decrease of 90% in notified malaria cases from 35,672 cases in 1999 to 429 in 2008. Malaria deaths decreased with 95% from 293/35,672 deaths in 1999 to 17/1,211 deaths in 2005/06 (1st year of 5-year planning cycle) and 5/429 deaths in 2008/09.

The Malaria Control Programme experience severe challenges to retain Entomologists as a result of the low salary levels in the public sector, high migration rates to the private sector and the demand in the private sector where insecticides are manufactured.
Creation of higher post levels (level 10) for Entomologists at entry grade and salary level 12 for Managers of entomological services is urgently required as recruitment and retention for this category of officials. They provide essential scientific information on vector mosquito distribution, population dynamics and behaviour as well as determine the status of insecticide susceptibility in the malaria vector populations on which the intervention methods of the malaria control programme are based.

Challenges with the transfer of municipal health services to District and Metropolitan Municipalities were not resolved, and the Premiers’ Technical Coordinating Forum, in collaboration with the Department of Health, Provincial Treasury and Local Government and Traditional Affairs, is still dealing with issues pertaining to funding and allocation to municipalities.

The Local Government Turn-Around Strategy, developed in November 2009 by the Department of Cooperative Governance and Traditional Affairs, aims to counteract capacity and skills constraints and weak inter-governmental support and oversight. The strategy places emphasis on capacitating struggling municipalities to execute their service delivery mandates, including rendering municipal health services to promote a safe and healthy environment. Local Government capacity building and support measures require urgent implementation and strengthening.

Backlogs in the supply of potable water and sanitation are still a serious challenge in the Province, and in spite of various health programmes targeting vulnerable groups, the lack of basic services continues to jeopardise health outcomes.

All performance targets, crucial to maintain health, could not be met due to financial limitations.

- Water quality monitoring due to inadequate laboratory capacity for laboratory analysis. This is a concern in light of the link between safe water and health outcomes (relevant to MDG 4).
- Monitoring of implementation of legislation related to undertakers and mortuaries.
- Roll-out of the Health Care Risk Waste Management Plan to all districts.
- Implementation and monitoring of the Environmental Management Plan.
- Implementation of the Framework for Control of Hazardous Substances.
- Implementation of the 2010 Port Health Framework.

### 2.2.8 Communicable Diseases Control

The Cholera and H1N1 outbreaks during 2008/09 stimulated more focused disease vigilance. Surveillance systems were critically assessed and upgraded to ensure an effective early warning system.

Critical success factors to achieve the above include:

- Integrated strategies and action to improve the early warning system and surveillance.
- Increased focus on health promotion and education (with accompanied budget) to reduce preventable causes of morbidity and mortality. **NHS 10-Point Plan Priority 8.**
- Community involvement, including feedback with regards to health issues pertinent to the specific communities. **NHS 10-Point Plan Priority 1 and 8.**
- Evaluation of the impact of health promotion activities to determine value added. **NHS 10-Point Plan Priority 1 and 10.**

The National Notifiable Medical Database is not yet implemented. Although the CDC Unit currently use a spreadsheet provided by the National Department of Health there are concerns regarding information quality and management. Implementation of the Provincial Master Systems Plan is critical to ensure improved data systems for collection of health data that can inform planning and decision-making.

### 2.2.9 Forensic Services and Bioethics

Forensic services are included in Programme 2 to align with budget programme structure. It is however not regarded as one of the district services and are managed as part of Programme 1.
In April 2006 the Department assumed responsibility for the SAPS mortuaries, hospital mortuaries and undertakers premises utilised for the rendering of autopsy services. There are currently 40 Medico-Legal Mortuaries in the Province, with 12 still under construction to improve aged and inadequate infrastructure. The upgrade/ construction of 23 mortuaries has not commenced due to budgetary constraints.

Mortuary and Forensic Pathology services are operationally decentralised to ensure more effective monitoring of operational services.

The organisational structure and post establishment has been reviewed and makes provision for an effective 24-hour service. The current vacancy rate is 48.9% with 531/ 1,040 posts filled. Recruitment and retention is a challenge due to the nature of the work as well as national shortage of these specialised professionals.

The shortfall of 80 mortuary vehicles (to render 24-hour services) affects service delivery and increase maintenance costs.

In 2008/09, over-expenditure of R149.1 million was recorded mostly due to building costs, exorbitant fuel and vehicle repair costs, as well as maintenance costs of current dilapidated infrastructure, especially refrigeration equipment that was taken over from the SAPS.

2.2.10 HIV & AIDS AND STI’s

The AIDS epidemic has had a profound impact on life expectancy. Since 1994 life expectancy has reduced by almost 20 years (54.5 years in 2000 to 50 years in 2008), mainly as a result of the rise in HIV-related mortality. Estimates produced by the ASSA model are very similar and indicate that the life expectancy had dropped from 62.1 in 1994.

HIV & AIDS and TB contributed to 34.6% (30.9% and 3.7%) of the proportion of total DALY’s (%) in South Africa. The co-morbidity of HIV-TB is estimated at 70%, supporting the importance of comprehensive and integrated programmes.

ASSA estimated that approximately 1,567,048 people in KZN were living with HIV in 2009, and approximately 206,294 (13%) were new AIDS sick people. Lawn et al estimated that approximately one third of all patients in need of ART will die before accessing treatment.

The 2009 Saving Children Report indicated that:

- 57% of children under-5 years who died during 2007 were as a result of HIV.
- 50% of these children were eligible for ART with only 3% documented as having been on ART at the time of their death.
- The HIV status of 50% of infants <1 year who died was unknown, while it is estimated that babies who are HIV-positive are 15 times more likely to die within the first 6 months of life than uninfected babies.

The HIV prevalence in KZN increased from 11.7% in 2002 to 15.8% in 2008 (4.1% increase) compared with the national prevalence of 10.9% in 2008. Prevalence remains disproportionately high for females in comparison to males, and peaks in the 25 – 29 year age group, where nationally, one in three (32.7%) were found to be HIV positive in 2008.

The HIV prevalence among 15–24 year old women (MDG 6, Target 7, and Indicator 18) was 15.30% in 2008 compared to 16.10% in 2007 (-0.8%).

The authors of the South African National HIV Survey cautioned that “…interpretation of HIV prevalence trends in South Africa is increasingly complex as increased access to

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63 Stats SA, 2007
64 Actuarial Society of South Africa (ASSA)2003, 2007
ART has the potential effect of increasing HIV prevalence by reducing HIV-related mortality, making it difficult to draw conclusions about the epidemic over time using prevalence as the only measure”.

The HIV prevalence in South Africa is monitored through annual public sector antenatal HIV and syphilis prevalence surveys, conducted by the Department of Health.

KwaZulu-Natal has consistently recorded the highest prevalence since 1990. In 2008, the HIV prevalence in the Province was 38.7% compared with the national prevalence of 29.3%. The epidemic curve shows evidence of stabilization in the past 3 years as illustrated in Graph 16.66

In 2008, three districts showed prevalence’s above 40% with uMgungundlovu recording an alarming 45.7% meaning almost every second pregnant woman in the district is HIV positive. Only Umnzinyathi District recorded prevalence below 30% in 2008. Amajuba shows a consistent decline from 46% in 2006 to 34.7% in 2008, and eThekwini from 41.6% in 2006 to 40.3% in 2008.

The sustained high levels of HIV infection among 15-29 year old females (MDG 6, Target 7, Indicator 18) in the prime of their child-bearing years is a serious concern that must be addressed through comprehensive and integrated preventive and promotive health strategies.

HIV prevalence among 15–24 years old pregnant females was 21.7% in 2008 compared with 22.1 % in 2007 - a decline of 0.4%. There is a slight increase of 1% in HIV prevalence among young women in the age group 15–19 years from 13.1% in 2007 to 14.1% in 2008. The HIV prevalence has remained stable among women aged 25 years and above.

The Province shows considerable progress in the implementation of HIV & AIDS programmes since 2005/06 in spite of considerable challenges including the high number of people in need of ART services and inadequate financial resources with a direct impact on infrastructure and human resources.

A total of 89 registered ART service points (62 hospitals and 27 PHC Clinics) and 3 NGO’s (eThekwini and Umgungundlovu) with clinical capacity to initiate and refer patients were established in the Province since 2005/06. A total of 322 PHC clinics67 serve as down referral sites for stable ART patients where active HIV screening and literacy education are prioritised.

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67 2008/09 Annual Report
There has been an almost annual doubling of patients registered on ART from 11,449 in 2005/06 to the current 335,148\(^{68}\) consisting of approximately 30% males, 61% females and 9% children. A total of 246 patients eligible for ART were on waiting lists.\(^{69}\)

Although the province has the largest ARV programme in the country, a treatment gap still exists. It is estimated that approximately 60% of persons requiring ART have accessed treatment from the public sector as compared with the NSP target of 80%.

To improve access and service delivery a total of 2,800 Traditional Health Practitioners and Traditional Leaders have been trained on HIV and AIDS and clinics at truck stops have been expanded.

The high number of HIV infected and AIDS sick persons in the Province put tremendous pressure on hospitals. To relieve the pressure on acute beds in hospitals, the Department is funding 8 NGO run step-down facilities offering a total of 2,556 beds in addition to the allocated beds in Provincial facilities.

In South Africa, an estimated 7% of the population is tested for HIV every year – and the target is to increase this to 25% per year. Although Voluntary Counselling and Testing (VCT) is available in 100% of facilities and the HIV testing rate in PHC services (excluding antenatal) is 95%, only 3% of the total population is tested.

The 1,904 Lay Counsellors and 95 Site Mentors significantly contributed to the increasing number of people testing for HIV (288,536 in 2005/06 to 635,814 in 2008/09).

The Provincial condom distribution rate is low at 8 condoms per male per year compared with the national target of 11.

The STI partner treatment rate fluctuated between 22% (2005/06) to 28% (2007/08) and 20% in 2009/10 which raises serious concerns considering the direct link between STI's and HIV. The number of new STI's treated (ART) increased from 16,848 in 2005/06 to 24,862 in 2008/09 - an increase of 47.56%.

A total of 6 truck stops clinics at Uthukela, Mooiriver, Kokstad, Marburg, Pongola and Pinetown provide VCT and STI services.

High Transmission Intervention Sites increased from 19 in 2007/08 to 39 in 2009/10 and include sites at correctional services, tertiary institutions, hostels, taxi ranks and 1 mobile unit targeting farming areas. A total of 1,544 patients received STI treatment at these sites in 2008/09 which raised a concern about utilisation of services.

Prevention of mother to child transmission (PMTCT) of HIV is a simple and cost-effective strategy to reduce HIV transmission.

Dual therapy, introduced in April 2008, is implemented in 98% of all health facilities that offer the full package of PMTCT services. 95% of facilities have at least 2 Professional Nurses trained in PMTCT which indicates that availability is no longer a challenge but rather access and quality of care.

The 4 priority districts identified by the National DOH commenced with the implementation of the National PMTCT Accelerated Plan in 2008/09.

89% of first time ANC clients were tested for HIV which falls short of the target of 95%. Timely access to PMTCT and HAART is still limited by the low ANC attendance before 20 weeks and a coherent communication strategy that promotes early booking will be implemented as part of the accelerated plan.

\(^{68}\) Q3: PORS 2009/10
\(^{69}\) Q2: DORA Report
A study to determine the mother to child transmission (MTCT) rate was conducted in six districts between 2008 and 2009. The study revealed that through rapid implementation of the revised PMTCT guidelines (dual antiretroviral therapy), MTCT was reduced from 20.8% in 2004/05 to as low as 4.3% in one district and 7% on average. It is expected that the new policy changes, announced by the President on the 1st of December 2009, will further decrease transmission rates.

The Flagship Programme focuses on integration of services rendered by existing Community Based Health Care Workers (CBHC) and volunteers at ward level. The programme is currently (2009/10) implemented in 97 of the most deprived Wards and will be expanded over the next 5 years to cover all Wards in the Province. Communities are targeted as centres of wellness with a strong focus on achievement of the MDG’s.

100% hospitals and 75% of CHC’s provide Post Exposure Prophylaxis services for sexual assault. During 2008/09, a total of 10,423 new sexual assault cases were reported of which 3,604 (34.5%) received ARV prophylaxis.

Monitoring and evaluation of the HIV & AIDS Programme is still a challenge, mainly due to the lack of an effective electronic information system. The integrated Electronic Patient Record System (ePRS) for HIV & AIDS was piloted in Ugu and is currently in an advanced stage of implementation. Routine data elements have been included in the DHIS in 2009/10 in an effort to improve data collection, reporting and quality.

MDG 6 (Combat HIV & AIDS, Malaria and other Diseases) aims to have halted by 2015, and begin to reverse the spread of HIV and AIDS, and the NHS 10-Point Plan (Priority 8) specifies intensified action to speed up programmes to attain the MDG’s.

1. All children under one year of age get treatment if they test positive for HIV.
2. All patients with both TB and HIV get ARV treatment if their CD4 count is 350 or less.
3. TB and HIV & AIDS treated under the same roof.
4. All pregnant HIV-positive women with CD4 counts of 350 or with symptoms, regardless of the CD4 count, have access to ARV treatment.
5. All other pregnant women not falling into this category, but who are HIV-positive, will receive treatment at 14 weeks of pregnancy to protect the baby.

2.2.11 TUBERCULOSIS

HIV & AIDS and TB contribute to 34.6% (30.9% and 3.7%) of the proportion of total DALY’s (%) in South Africa. The co-morbidity of HIV-TB is estimated at 70%, supporting the importance of comprehensive and integrated programmes.

Before the emergence of the HIV epidemic, the Western Cape had the highest TB rates. Currently, the number of tuberculosis cases and notification rate are highest in KwaZulu-Natal (1,066 per 100 000 population in 2006), reflecting a combination of the highest HIV prevalence (38.7% in pregnant women in 2008) and the worst TB programme performance indicators. The national TB mortality rate increased from 78 per 100 000 population in 1990 to 218 per 100 000 population in 2006.

The combination of increasing TB cases, HIV-TB co-infection, MDR and XDR TB, and increasing TB mortality constitutes a crisis that demands urgent and sustained intervention.

Community outreach programmes and task shifting contribute to improved management of TB. Utilisation of community health workers, tracer teams and treatment

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10 Centre of Rural Health PMTCT Study – Dr C Horwood

71 Salim S Abdool Karim, Gavin J churchyard, Quarraisha Abdool Karim, Stephan D Lawn: HIV infection and Tuberculosis in South Africa: An urgent need to escalate the public health response
supporters improve case detection, follow-up and support to ensure continuity of care from investigation to diagnosis and cure.

Integration of HIV & AIDS and TB programmes have the added advantage of lay counsellors, adherence counselling and home-based care programmes for out-reach to community-based treatment for patients with XDR TB.

MDG 6 (Combat HIV & AIDS, Malaria and other Diseases) sets out to increase the TB cure rate to 85%. The NHS 10-Point Plan (Priority 7) specifies intensified action to strengthen programmes against TB, including MDR and XDR TB.

There is a distinct correlation between poverty and TB, giving credence to the importance of linking poverty reduction programmes with comprehensive and integrated TB programmes. In a study conducted by Health Systems Trust, food insecurity was identified as a major problem with respondents reported that that they, as well as their children, often skipped meals. Only 11% of TB patients reported receiving food from the clinic gardens, with 34% of them indicating that it is not enough. Only 51% of patients received food parcels as part of their TB treatment programme.

In 2005, the Province commenced with the implementation of the TB Crisis Plan in four high risk districts (eThekwini, Umgungundlovu, Umzinyathi and Uthungulu). The 4 districts show improved outcomes since implementation of the Plan in 2005 with the average cure rate improving from 31.9% in 2005 to 55.2% in 2008, and the average defaulter rate decreasing from 13.4% in 2005 to 9.9% in 2008.

Graph 19 provides a breakdown of performance in the priority districts over the period 2005 – 2008. It clearly shows the positive progress towards targets and lessons learned will be used in scaling up implementation of the Crisis Plan in the forthcoming planning cycle.

Appointment of tracer teams (65 TB Community Officers) resulted in improved compliance and an increase in cure rates from 35% in 2004 to 62% in 2008. The interruption rate decreased from 14% in 2004 to 9.6% in 2008. Umzinyathi reported a remarkable defaulter rate of less than 2%.

Case finding and retention has been strengthened with 94% facilities implementing and reporting on the suspect register, although TB data, using the Electronic TB Register, is still a challenge. Timeliness is compromised due to software problems that must be resolved in Cape Town.

Sustaining the DOTS programme remains a challenge with 72% TB patients with DOT supporters (decrease from 80% in 2005/06).

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Graph 19: TB Crisis Districts 2005 - 2008

Graph 20: TB Defaulter and Cure Rate

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72 Elizabeth Lutge, Zimisele Ndiela, Irvin Freedman: An assessment of current support strategies for patients with TB in KZN

73 Data from the previous Annual Report was verified and changed

74 Q2 PQRS 2009/10
Microscopy sites increased from 55 in 2005 to 81 in 2008 which contribute to early diagnosis and treatment.

MDR TB cases increased from 555 in 2005/06 to 1,134 in 2008/9 (+104%) and XDR TB cases increasing from 35 in 2005/06 to 109 in 2008/09 (+211%).

Inadequate beds for the management of MDR and XDR TB patients forced the Department to find alternatives to the standard treatment of MDR and XDR TB, hence implementation of the Community Management Strategy Pilot in the Masinga Sub-District. Although it is too early the option seems viable for the management of MDR and XDR TB in absence of adequate bed space.

- Mobile teams for the project fall under the Greytown MDR TB Unit and are managed by a PHC Professional Nurse from the Church of Scotland Hospital TB DOTS office on a daily basis.
- The team manages approximately 35 patients at home who are in the injection phase of their treatment.
- Profiling the first 81 patients shows an average of 403 home contacts between the 81 patients.
- Preliminary results indicated that 45% of the 403 household contacts had had their 6 monthly follow-up visits with 0% transmission rate.
- One defaulter and zero deaths have been reported, with most patients converting to negative (too early to quantify results), and no patients have had to be removed from the programme as a result of unmanageable side effects.

TB beds increased from 240 in 2005 to 581 in 2008. The decrease in patients on waiting lists, from approximately 170 patients/2-4 weeks to 50 patients/1-2 weeks however suggests that improved screening, access and treatment outcomes have a positive effect on the management of patients in the community.

Rapid Point Prevalence Surveys in response to the WHO 7-Point Plan to determine outbreak trends commenced. Outpatient surveys (in 5 sites) reported MDR rates ranging from 2.5% to 18%. Of concern is the high MDR TB rate in the Umkhanyakude District (18%) with a reported XDR TB rate of <1%.

2.2.12 MATERNAL, NEONATAL, CHILD & WOMEN’S HEALTH & NUTRITION

UN Secretary-General Ban Ki-moon noted that MDG 5 “stands as the slowest moving...of all the MDG’s” and is serious off track to meet its targets by 2015.

Achieving MDG 5 is central to the achievement of other MDG’s i.e. reducing poverty, reducing child mortality, reducing HIV and AIDS, providing education, promoting gender equality, ensuring adequate food and promoting a healthy environment.

Guided by the MDG’s, South Africa aims, by 2015, to have reduced child mortality to 20 per 1000 live births, and the maternal mortality ratio (MMR) to 38 per 100 000 live births.

The NHS 10-Point Plan (Priority 8) refers to scaling up services to accelerate progress towards the MDG targets with specific reference to services for MNC&WH. The National and Provincial Strategic Plans for Maternal, Neonatal, Child, Women’s Health (MNC&WH) and Nutrition aims to accelerate progress towards MDG’s 1, 4 and 5.

Saving Mothers Report 2005-2007

The institutional Maternal Mortality Ratio (MMR) for the reporting period clearly indicates the profound impact of HIV and AIDS on maternal mortality.

- MMR: 34/100 000 live births for HIV-negative women.
- MMR: 328/100 000 live births for those women who were HIV infected.
MMR: 275/100 000 live births for those not tested for HIV.

The top five conditions causing maternal death (as illustrated in the graph) remained the same as reported in the previous reporting period.

Women less than 20 years of age were at greater risk of dying due to complications of hypertension, whereas women 35 years and older were at greater risk of dying of obstetric haemorrhage, ectopic pregnancies, embolism, acute collapse and pre-existing medical disease. This clearly highlights the importance of education programmes (community out-reach), contraceptive services and early ANC attendance.

- During the reporting period, 38.4% of deaths were clearly avoidable compared with 36.7% during 2002-2004.
- The lack of blood for transfusion has increased dramatically over the last triennium from 9.2% to 19%.
- Over 80% of maternal deaths due to unaesthetic complications and postpartum haemorrhage were thought to be avoidable.
- Hypertension, obstetric haemorrhage, pregnancy related sepsis and non-pregnancy related infections were responsible for 4 out of 5 avoidable deaths.
- Non-attendance and delayed attendance at health facilities were the most common patient orientated problems.

- Poor transport facilities, lack of health care facilities and lack of appropriately trained staff were the major administrative problems.
- The most frequent health care provider avoidable factors were failure to follow standard protocols and poor problem recognition and initial assessment.
- 59% of maternal deaths were tested for HIV infection from 2005-2007 as compared with 46.3% in the previous triennium. 79% percent of those tested in 2005-2007 were HIV infected compared with 78% in the previous reporting period.
- Most deaths occurred in the post-partum period (45.4%), compared with 9% in early pregnancy, 36.7% in the antenatal period and 8.7% during the intra-partum period.
- In 2005-2007 there were 477,210 caesarean sections performed in South Africa, giving a caesarean section rate of 18.4%.
- Institutional MMR for vaginal deliveries was 77.8/100000 live births as compared with 198.2/100000 live births for caesarean sections - 2.5 times increase in risk of dying. This is a concern considering the high caesarean section rate in hospitals in the Province.

National Perinatal Morbidity and Mortality Committee Report 2008

Pregnant women 17 years old or less and 35 years old or more had significantly higher perinatal mortality rates than women between the ages of 20 and 34 years. Contraceptive use should be promoted in these groups.

The majority of perinatal deaths occurred in District Hospitals and the "probable" PNMR for labour related problems was highest in these hospitals. This indicated the quality of intra-partum care was poorest at the district hospitals.

Quality of care during childbirth and management of immature or hypoxic neonates were the areas where most preventable deaths occur. The poorest quality of care and most of the perinatal deaths occur in district hospitals. Quality of care is determined by having adequate equipment and drugs, staff, and skills and a caring attitude of health care providers.
Report of the Committee on Morbidity and Mortality in Children Under 5 Years (CoMMiC) April 2009

It is estimated that over 60,000 South African children die each year between the ages of one month and five years. This equates to an under-five mortality rate of between 57.6 and 94.7 deaths per 1000 live births and an infant mortality rate of between 42.5 and 59.1 deaths per 1000 live births.

According to the Saving Children 2007 report the top 5 causes of child deaths are pneumonia (18.7%), septicaemia (15.9%), acute diarrhoea (14.2%), PCP (6.2%) and chronic diarrhoea (4.6%). HIV associated deaths increased from 597 in 2006 to 1,230 in 2007. Malnutrition and lack of safe water and sanitation contributed to half of the deaths.

Five underlying natural causes of death were common for both age groups including intestinal infectious diseases, influenza and pneumonia, malnutrition, certain disorders involving the immune mechanism and other acute lower respiratory tract infections. Almost one in four (24.7%) and one in five (20.1%) of deaths occurring in children aged 1 - 4 years and less than one year respectively, were due to intestinal infectious diseases.

In 2007, almost two-thirds (64%) of children who died were undernourished and one-third were severely malnourished.

Malnutrition was the third leading cause of death for those aged 1 - 4 years and the eighth leading cause for those aged less than one year.

HIV disease ranked sixth for those aged 1 - 4, but was not among the ten leading causes of death for those aged less than one year. However protozoal diseases ranked seventh in children below the age of one – most of these deaths can be assumed to be due to Pneumocystis Pneumonia (PCP), which occurs almost exclusively in young children who are HIV-infected.

The HIV status of 70% of the children who died was known. In 2007, 13% of children who died were HIV-negative, 24% were HIV-exposed and 32% were HIV-infected. Almost half of the children who died between 2005 and 2007 had clinical evidence suggestive of Stage III or IV HIV disease.

Almost all caregivers sought care from multiple sources. Delay in seeking care were however common, and were attributed to a range of factors including failure to recognise severity of illness, ill health in the caregiver, lack of transport from home to the health care facility, inability to pay for public transport, geographical inaccessibility of health care facilities, no access health facilities because of a daily quota system and limited autonomy in decision making by mothers.

Review of the children’s medical records also revealed many failures including inadequate assessment, inappropriate management and failure to refer to next level of care.

Maternal & Neonatal Health

A total of 168 maternal deaths were reported in facilities in 2009/10 (Q2). The leading causes of death (2004 – 2007) were non-pregnancy related infections (49%) with AIDS contributing to 18%, hypertension (12%) and obstetric haemorrhage (8.3%).

HIV testing in ANC increased from 80% in 2007/08 to 96% in 2008/09 although the proportion of mothers entering the PMTCT programme is still a challenge.

Basic antenatal care (BANC) is implemented in 82% of facilities and approximately 50% of nurses have been trained in BANC. Improvement of early booking is evident where the programme is being implemented.

Only 47.6% of women attend ANC before 20 weeks (Q2 2009/10) compared to the target of 75%. This is a serious concern and one of the causes of poor managed pregnancy and childbirth.

Graph 23: Reported Maternal Deaths 1998 - 2008

Reported maternal deaths 1998 - 2008
Women's Health

Good contraceptive coverage is globally recognised as an effective strategy to reduce morbidity and mortality. The Provincial women-year protection rate is 23% against the target of 60%, and would need urgent attention in support of the commitment towards MDG targets.

Cervical cancer screening increased from 0.5% in 2008/09 to 6.1% in 2009/10. The significant increase can be attributed to the Phila Ma Project that commenced in 2009/10 aiming at increasing screening coverage with 10% per annum.

The Pap smear adequacy rate is 49.05% (target 90%) which have significant implications for cost, timely diagnosis and management of abnormal smears and ultimate health outcomes. A total of 14 facilities provide colposcopy services for management of abnormal smears.

The 2004 - 2006 Maternal Death Report indicated that septic abortion was responsible for 3.6% of maternal deaths as compared with 3.2% in 2002 - 2004.

In 2009, 22 Public Health facilities provided termination of pregnancy services. A total of 12,528 legal terminations were performed in designated facilities in 2008/09 compared with 14,435 in 2007/08. During the same time 305 septic abortions (201 in 2007/08) and 11,343 incomplete abortions (compared with 8,860 in 2007/08) were reported, which might indicate that services to prevent unwanted pregnancies are inadequate.

EPI Surveillance:

- 62/66 AFP cases were detected in 2008, 51.82% fully investigated against target of 80%.
- AEFI: 22 events reported following immunisation and 17 cases (77.2%) were fully investigated.
- Total of 1,198 suspected measles cases were reported in 2008 - 5 confirmed measles. Between January and October 2009 there were 986 suspected measles cases with 31 confirmed measles which refers to the importance of the immunisation programme to prevent vaccine preventable diseases towards attainment of the MDG.
- No reported neonatal tetanus in 2008/09.

Clinical management of the Integrated Management of Childhood Illnesses (IMCI) is implemented in 99% of facilities, and the Community Component is implemented in 26 Municipalities.

There are currently 49 hospitals and 3 clinics that report on birth defects.

School health coverage is 36% with a total of 109,185 Grade R/1 learners receiving health assessments in the 1st 2 quarters of 2009/10.

Child Health

The Child healthcare Problem Identification Programme (ChIP) is implemented in 31 sites, and a Provincial ChIP Coordinating Structure was established in 2008/09 to provide technical support to districts and institutional ChIP teams (paediatric and child health).

Immunisation coverage was 86% in 2009/10, with Amajuba, Zululand and Ilembe districts reporting coverage below 80%. The RED strategy has been introduced to all districts to improve child health services.

2.2.13 NUTRITION

The vacancy rate for Dieticians and Nutritionists increased from 76.2% in 2007/08 to 76.5% in 2008/09. The turn-over rate increased from 29.7% in 2007/08 to 39.7% in 2008/09. Ratio of 1:100000 = Nutritionists and 2:100000 for Dieticians

The high unemployment rate, estimated at 26.5% Food Fortification Baseline (2005) and household food security estimated between 63% and 77% are both contributing to the increased burden of malnutrition and raise the concern of under-reporting of malnutrition data.

Malnutrition remains a major co-morbidity contributing significantly to the under-5 morbidity and mortality. According to the 2007 Saving Children Report, 31% of under-5 in-patient deaths in the Province were in the under-
weight for age category and 21.9% in the severe malnutrition category.

According to DHIS data, the incidence of severe malnutrition for children under-5 remains constant at 0.6% for the past 3 years. This however seems contradictory to the Provincial poverty and disease profile.

The implementation of the WHO 10-Step Protocol for the Management of Severe Malnutrition poses challenges in hospitals due to lack of training and support.

Graph 24: Child mortality and Nutrition status

Improved Vitamin A status of children can increase child survival and reduce child mortality by 25%. The Vitamin A coverage for children under-1 year is 94.2% and for the 12-59 month age group 45% (2009/10).

During the Vitamin A campaign in September 2008 the province achieved 82% coverage. Child Health Weeks to improve vitamin A supplementation, immunisation, de-worming and other missed opportunities have been introduced to improve child health services.

Breastfeeding considered one of the key survival strategies for children and contributing to achievement of MDG 4 are actively promoted.

The department established in excess of 400 clinic gardens, with most districts having food gardens in more than 80% of health facilities.

Weighing coverage increased from 62% in 2007/08 to 76% in 2008/09 which is below the expected output. Interpretation of the growth curve is still poor, and utilisation of the Road to Health Chart (RTHC) needs urgent attention. There are 44 Baby-Friendly Facilities (42 hospitals and 2 clinics).

The Provincial MC&WH and Nutrition Directorates reviewed strategies to improve performance towards the MDG’s. A Provincial 5-year strategy was developed (within national framework) focusing on basic interventions with the best potential to improve health outcomes. Figures 2 and 3 demonstrate the core services that will be targeted for the forthcoming planning cycle.

This strategy is aligned with the National 5-Year Strategy for MNCWH & N, the 18 Priority District Strategy (including Accelerated PMTCT Strategy) and the revised HIV and AIDS Policy changes announced on the 1st of December 2009.

Figure 2: Integrated MNC&WH & Nutrition Strategies
2.2.14 DISTRICT HOSPITALS

The 37 District Hospitals in the Province render generalist level of services focusing on maternal, child and women’s health, basic emergency, surgery and physical medicine services and also provide clinical and non-clinical support services to PHC services functioning in their catchment areas. The catchment populations for District Hospitals vary significantly from national norms as well as hospital to hospital due to geographical location.

The failure to implement approved organisational structures and post establishments, coupled with severe financial constraints have a limiting impact on services and impact on availability, access and quality.

The recruitment for critical hospital posts has been curtailed to the minimum in 2008/09 and 2009/10 as a result of over-expenditure resulting in unacceptable vacancy rates in critical posts. High vacancy rates exasperated by increased absenteeism, sick leave and extended periods on incapacity leave increase the clinical workload and jeopardise availability of services and quality of care.

In spite of critical operational challenges, hospital patient numbers increased steadily as illustrated in Graph 26. The patient day equivalent (PDE) increased with 11% between 2005/06 and 2008/09 and the out-patient department (OPD) headcount with 60% during the same period. The dramatic increase in the OPD headcount is a concern which must be investigated to inform long-term planning.

According to district reports, 95% (35/37) hospitals offer the full package of District Hospital services, although over-expenditure has had a limiting impact on availability of services and quality of care.

A number of hospitals render partial level 2 services. The lack of cost centres and itemized billing for pharmacy and in-patients has not been introduced to determine cost per level of care. This has significant implications for budget forecasting and expenditure.
District Hospital efficiency and quality is a concern although there are variances between facilities. The following table reflects Provincial performance against national targets.

**Table 9: District Hospital efficiency indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Provincial</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average length of stay</td>
<td>5.5 days</td>
<td>3.2 days</td>
</tr>
<tr>
<td>Bed occupancy rate</td>
<td>62.5%</td>
<td>72%</td>
</tr>
<tr>
<td>Caesarean section rate</td>
<td>22.7%</td>
<td>11%</td>
</tr>
<tr>
<td>Cost per patient day equivalent</td>
<td>R 1,441</td>
<td>R 814</td>
</tr>
<tr>
<td>Fatality rate surgery</td>
<td>4.5%</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

Average length of stay (ALOS) is used as a proxy measure for quality of care as well as efficiency of the hospital. The extended average length of stay is generally contributed to the burden of disease, poor health seeking behaviour of clients, lack of adequate step-down facilities for long-term/chronic patients, delayed up-referral of patients due to shortage of specialists at Regional Hospitals, poor compliance with admission and discharge policy, and ineffective referral systems. This has significant cost implications for District Hospitals.

Nine hospitals reported BOR’s below 50% in 2008/09 i.e. McCords (47.8%), Appelsbosch (49.4%), Catherine Booth (47.9%), Ekholmbe (37.5%), Mbongolwane (46.1%), Nkandla (45.9%), Benedictine (45.1%), Ceza (47.3%) and Nkonjeni (48.1%).

Seven hospitals exceeded the national target of 72% i.e. St Mary’s (107.1%), GJ Crookes (74.5%), Murchison (72.1%), Northdale (77%), Manguzi (73.8%), Greytown (72.1%) and Vryheid (72.5%). The high occupancy rate in St Mary’s Hospital is a concern, especially with a 69% vacancy rate for Medical Officers.

Bed norms and allocation will be reviewed as part of the STP process to ensure effective allocation and utilisation of resources.

Actual reasons for low occupancy rates must be investigated to inform long-term planning i.e. revitalisation of hospital services as part of the STP process. Variances between hospitals will be considered in allocation of resources to ensure equity.

Graph 28: District Hospital Bed Occupancy 2008/09

The high caesarean section rate is generally contributed to the high HIV infection and increasing number of teenage pregnancies. The 2005 – 2007 Saving Mothers Report indicated that the institutional MMR for caesarean sections (198.2/100000 live births) was 2.5 times higher than that of vaginal delivery at 77.8/100000 live births.

According to district reports, 85% of District Hospitals conduct monthly clinical audit meetings and 89% conduct...
regular morbidity and mortality meetings which should ideally have a positive impact on quality of care.

The National Perinatal Morbidity and Mortality Committee Report 2008 indicated that the majority of perinatal deaths, due to avoidable factors, occurred in district hospitals. Administrative problems were also highest in district hospitals where avoidable mortality rate was mostly due to lack of facilities and competencies to resuscitate hypoxic and immature neonates.

Hospital Improvement Plans are implemented by 31/37 (86%) of District Hospitals. This will form part of the quality improvement programme in the forthcoming planning cycle.

32/37 (89%) of District Hospitals conduct monthly information review meetings, although data is still a serious challenge that will be addressed as part of the Information Management Turn-Around Strategy in the forthcoming planning cycle.

A total of 33/37 (90%) of District Hospitals have interim Hospital Boards – not yet formally appointed as per KZN Health Care Act (1 of 2009).

2.3. PROVINCIAL PRIORITIES

Challenges identified during Strategic Planning Workshops

- Lack of an appropriate PHC strategy to improve service delivery at PHC level.
- Lack of appropriate staffing norms to inform PHC post establishments.
- Provincial and District HRP’s not aligned with service delivery requirements.
- Poor integration of services (including Health Promotion Strategy) resulting in inadequate utilisation of scarce resources, duplication, missed opportunities and poor health outcomes.
- Inadequate resources/ equipment to render the current package of services contributed to by the lack of an Equipment Replacement Plan and extended turn-around-time for HTU.

- Inadequate infrastructure e.g. inadequate archive areas (poor record keeping), lack of storage facilities and packing areas for PHC medication at hospital level, inadequate seclusion rooms and in-patient units for implementation of the Mental Health Care Act.
- Poor management and supervision of CHW’s resulting in missed opportunities and increased cost.
- Poor management competencies (especially at hospital level) due to high staff turn-over rates and inadequate mentoring and training programmes.
- Ineffective clinical governance structures and systems including poor supervision and feedback resulting in non-adherence to clinical audit and peer review recommendations.
- Ineffective referral systems – partly due to acute shortages of EMS trained staff and vehicles.
- Lack of a clearly defined service delivery platform and package of services (especially relevant to District Hospitals) impacting on efficiency and quality.

Priority 1: Revitalisation of PHC services

1.1 Develop and implement an integrated PHC strategy (including all programmes and integrated Health Promotion) to improve equity, access, affordability, efficiency, effectiveness, continuity of care, responsive to health needs and with full community participation.

- Strategy will be based on the long-term vision for PHC (included in the STP) and aligned with accompanying strategic components in the STP including the HRP and Infrastructure Plan to ensure appropriate resource allocation and sustainability.
- Expansion of the Flagship Programme at Ward level.
- The strategy will make provision for existing national priorities including:
  - Reviewed PHC model (national process).
  - 18 (4 identified districts in KZN) Priority District and Rural Development Project.
  - PHC and Hospital audit results (National Department of Health 2010/11).
Strategic Plan 2010 - 2014

Priority 2: Improve the efficiency and quality of health services

2.1 Implement the National Core Standards for Quality at PHC level (including PHC clinics, CHC’s and District Hospitals) towards accreditation of health facilities.

National Core Standards include:

a) **Patient Rights**: Patient Rights Charter and Batho Pele Principles.

b) **Patient Safety, Clinical Governance and Care**: Management and processes for quality clinical care and ethical practice; reduction of unintended harm to health care users or patients in identified circumstances of clinical risk; management of adverse events including health-care acquired infections.

c) **Clinical Support Services**: Management and support of clinical care through efficient provision of medicines; diagnostic and other clinical support services; and suitable medical technology and patient information.

d) **Public Health**: Active collaboration between facilities (hospitals and PHC facilities), organisations and providers, and communities to ensure an integrated and effective health care system for the catchment population. Active contribution of all role-players in preventing illness and ensuring effective care and rehabilitation.

e) **Leadership and Corporate Governance**: Strategic direction and oversight provided by Senior Management through adequate stakeholder representation on structures of corporate governance.

f) **Operational Management**: Responsibilities to support and ensure the delivery of safe and effective patient care, including management of human resources, finances, assets and consumables, and the information, communication and quality systems required for efficient and effective service delivery.

g) **Facilities and Infrastructure**: Requirements for clean, safe and secure physical infrastructure (buildings, plant and machinery, equipment) and hotel services, including the safe disposal of waste.

2.2 Annual expansion of the "Look like a Hospital Project" to improve hospital efficiency, quality, patient safety and satisfaction. The project is aligned with the National Core Standards and makes provision for vigorous monitoring and reporting through established provincial and district teams (champions). The project is actively monitored and supported by the MEC. The project has the potential to serve as best practice model for the rollout of Core Standards to the rest of health facilities.

Priority 3: Scale up implementation of the National Strategic Plan for HIV & AIDS and STI's

3.1 Scale up implementation of the National Strategic Plan for HIV & AIDS and STI's with emphasis on the policy changes announced by the President on the 1st of December 2009 and effective on the 1st of April 2010. Integration of services will therefore be paramount to strategies.

3.2 Special focus will be on prevention strategies including:
- Prevention of mother to child transmission;
- Male medical circumcision;
- Provider-initiated counselling and testing for HIV.

Priority 4: Scale up implementation of the TB Crisis Plan

4.1 Scale up implementation of the TB Crisis Plan with emphasis on policy changes announced by the President on the 1st of December 2009 and effective on the 1st of April 2010.

4.2 Special emphasis will be on:
- Integration of services to ensure effective management of TB-HIV co-infection;
- Community management of MDR TB;
- Research to determine the effectiveness of the community management of TB in a rural setting.

**Priority 5: Scale up the implementation of the 5-year Strategic Plan for Maternal, Neonatal, Child and Women's Health & Nutrition**

5.1 Scale up the implementation of specific programmes to improve maternal, neonatal, child and women’s health outcomes.

5.2 Special focus will be on:

- Implementation of HIV & AIDS policy changes relevant to MNC&WH services;
- Integrated child health strategies including Child Health Days with the Nutrition Programme (immunisation, vitamin A supplementation, de-worming, growth monitoring, and School Health Services);
- Reducing preventable causes of death (Saving Mothers, Babies & Children Reports);
- Improved antenatal and postnatal care through implementation of the Antenatal and Postnatal Care Policy and early booking strategy (part of the Accelerated PMTCT Strategy);
- Strategy to improve women year protection rate (linked with the Saving Mothers Recommendations);
- Phila Ma Project to improve cervical cancer screening and effective management of abnormal smears;
### 2.4. STRATEGIC OBJECTIVES & EXPECTED OUTCOMES PROGRAMME 2

<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Strategic Objective</th>
<th>Objective Statement</th>
<th>Rationale</th>
<th>Indicator</th>
<th>Baseline</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Goal 1</strong>&lt;br&gt;NHS Priority 4</td>
<td>Revitalise PHC as per STP Implementation Plan.</td>
<td>Revitalisation of services to improve equity, access, efficiency, acceptability and utilisation with improved community out-reach and participation.</td>
<td>PHC endorsed as the strategic approach to improve equity in service delivery.</td>
<td>Provincial PHC Strategy implemented&lt;sup&gt;77&lt;/sup&gt;</td>
<td>Development of the PHC strategy commenced in 2009/10</td>
<td>PHC strategy implemented in 11 districts by 2010/11 as per implementation plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PHC budget as % of total budget</td>
<td>PHC budget 44% of total budget</td>
<td>PHC budget 49% of total budget by 2014/15</td>
</tr>
<tr>
<td><strong>Strategic Goal 2</strong>&lt;br&gt;NHS Priority 3</td>
<td>Implementation of National Core Standards towards accreditation of 50% PHC clinics, 100% CHC’s and 100% District Hospitals by 2014/15.</td>
<td>Implementation of basic quality standards, supported by Quality Improvement Plans will facilitate sustained compliance with standards towards accreditation of health services in line with the National Accreditation requirements.</td>
<td>Comply with the National Core Standards will improve sustained quality and efficiency of health service delivery.</td>
<td>Number of PHC clinics accredited</td>
<td>New indicator</td>
<td>279/ 558 (50%) (10% per year)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Number of CHC’s accredited</td>
<td>New indicator</td>
<td>16/ 16 (100%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Number of District Hospitals accredited&lt;sup&gt;78&lt;/sup&gt;</td>
<td>New indicator</td>
<td>37/ 37 (100%)</td>
</tr>
<tr>
<td><strong>Strategic Goal 3</strong>&lt;br&gt;MDG 6&lt;br&gt;NHS Priority 7</td>
<td>Reduce morbidity and mortality by reducing the HIV incidence with 50% by 2011/12 and 60% by 2014/15.</td>
<td>Scaling up integrated prevention programmes (MMC, PMTCT, provider-initiated counselling &amp; testing) and improving access to treatment through integration (new policy changes) will reduce new infections, improve</td>
<td>Decreasing HIV incidence and increasing the percentage qualifying patients on ART will improve health outcomes, quality of life and ultimately increase life expectancy.</td>
<td>HIV incidence</td>
<td>HIV incidence 1.3% (national)</td>
<td>Reduce HIV incidence by 50% by 2011&lt;sup&gt;79&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Percentage qualifying HIV-positive patients on ART</td>
<td>±60% qualifying HIV-positive patients on treatment</td>
<td>90% of HIV-positive qualifying patients on treatment&lt;sup&gt;80&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

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<sup>77</sup> Implementation and outcomes will be based on the STP and PHC Strategy Implementation Plans – it is expected that all routine PHC indicators will improve with improved access & utilisation of services

<sup>78</sup> Cumulative numbers – determined as per project plan

<sup>79</sup> National target

<sup>80</sup> The NSP target is 80% of clients by 2011
<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Strategic Objective</th>
<th>Objective Statement</th>
<th>Rationale</th>
<th>Indicator</th>
<th>Baseline</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Goal 3 MDG 6 NHS Priority 7</td>
<td>Reduce morbidity and mortality by reducing mother to child transmission to ≤ 5% by 2014/15.</td>
<td>Intensity implementation of the TB Crisis Plan to scale up access to appropriate integrated prevention, detection, surveillance, support and management of TB including MDR and XDR TB.</td>
<td>Decrease TB incidence and morbidity and mortality due to TB.</td>
<td>MTCT rate</td>
<td>MTCT rate 7%</td>
<td>MTCT rate ≤ 5%</td>
</tr>
</tbody>
</table>

| Strategic Goal 3 MDG 6 NHS Priority 8 | Reduce morbidity and mortality by improving the TB cure rate to 70% by 2014/15. | Expand comprehensive and integrated health promotion and screening services to improve prevention, detection and early management of non-communicable conditions and illnesses. | Improved prevention, screening and early detection and management reducing morbidity and mortality due to non-communicable conditions and illnesses. | TB cure rate | TB cure rate 58% | TB cure rate 70% |

| Strategic Goal 3 MDG 6 NHS Priority 8 | Maintain preventative strategies to reduce and maintain the malaria incidence at ≤ 1/1000 population by 2010/11. | Improve ability to detect, manage and reduce morbidity and mortality due to non-communicable conditions and illnesses. | Malaria incidence | Malaria incidence | Malaria incidence |

| Strategic Goal 3 MDG 1, 4, 5 NHS Priority 8 | Reduce maternal mortality to ≤ 100/100000 by 2014/15. | Scale up integrated MNCH and Nutrition services in compliance with National Strategic Plan for MNCH and Nutrition to reduce | Reduction of preventable causes of morbidity and mortality will improve quality of life and increase life expectancy. | Maternal mortality ratio | Maternal mortality ratio 224.4/100 000 | Maternal mortality ratio ≤100/100 000 |

| Strategic Goal 3 MDG 1, 4, 5 NHS Priority 8 | Reduce child mortality to 30-45/1000 live births by 2014/15. | | | Child mortality rate | Child mortality rate 69/1000 live births | Child mortality rate 30-45/1000 live births |

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81 The national target of 85% is not realistic for the province especially in light of the high HIV infection rate – all although will however be made to exceed the current provincial target

82 Confidential Enquiry into Maternal Deaths – KZN 2004-2007

83 National target

84 National target
### Strategic Plan 2010 - 2014

<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Strategic Objective</th>
<th>Objective Statement</th>
<th>Rationale</th>
<th>Indicator</th>
<th>Baseline</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>morbidity and mortality towards achieving the MDG targets</td>
<td>Reduce under-5 mortality to 95/1000 live births by 2014/15.</td>
<td>morbidity and mortality.</td>
<td>Under-5 mortality rate</td>
<td>Under-5 mortality rate 95/1000&lt;sup&gt;7&lt;/sup&gt;</td>
<td>Under-5 mortality rate 29/1000&lt;sup&gt;5&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduce severe malnutrition under-5 year incidence to 6/1000 by 2014/15.</td>
<td>Severe malnutrition under-5 years incidence</td>
<td>Severe malnutrition under-5 years incidence 6.2/1000</td>
<td>Severe malnutrition under-5 years incidence 6/1000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.5. RISK MANAGEMENT

Table 11: Key Risk Factors

<table>
<thead>
<tr>
<th>Key Risk Factors</th>
<th>Measures to Mitigate Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inadequate resources for expansion of services due to over-expenditure and current cost containment measures.</td>
<td>• Alignment of budget with service delivery imperatives as per Strategic Plan and STP to ensure adequate provision of resources to action Provincial priorities.</td>
</tr>
<tr>
<td>2. Impact of factors outside the health mandate e.g. social deprivation and poverty.</td>
<td>• Implementation of the Provincial Flagship Programme, under leadership of the Premier. Programme implemented to Ward level which should assist in addressing social aspects of care.</td>
</tr>
<tr>
<td>3. Unfunded mandates with additional demands on scarce resources.</td>
<td>• Improved screening of poorly aligned initiatives to ensure incorporation into existing plans as per Strategic Plan and STP.</td>
</tr>
<tr>
<td>4. Poor management and integration of community-based programmes including CHW Programme.</td>
<td>• Incorporation of CHW Programme as part of the Flagship Programme.</td>
</tr>
<tr>
<td>5. Lack of reliable data on the current burden of disease and mortality which jeopardise performance monitoring towards expected health outcomes.</td>
<td>• Health Research &amp; Knowledge Management strategy to improve collaboration with scientific community. Ensure collaboration in research based on public health priorities.</td>
</tr>
</tbody>
</table>

2.6. RESOURCE CONSIDERATION

2.6.1 Expenditure Trends

The programme funding provides for commissioning of new clinics and CHC’s, the development and expansion of district offices and comprehensive management of HIV and AIDS and related illnesses including TB.

Growth in the Programme is stronger in 2011/12 as a result of increased funding provided for the carry-through costs for OSD for nurses, to assist with inflationary expenses in medical supplies.

Growth in the programme is stronger in 2011/12 as a result of increased funding provided for the carry-through costs for OSD for nurses, to assist with inflationary expenses in medical supplies and services, as well to improve the infant and child mortalities. Support for infant and child health was also provided from 2009/10 to 2011/12 in line with nationally determined priorities.

Increase in the Sub-Programme: District Management in 2007/08 relates to restructuring of District Offices. The decrease in the 2008/09 adjusted budget is due to the postponement of this process in view of the financial constraints. Reduced trend is continued in 2009/10.

2.6.2 Unfunded Priorities

• Flagship Programme (CHW & HBC Component): ±R8.6million.
• 18 Priority Districts – although most services are considered routine.
• Circumcision campaign: ±R276.9million.
• Contraceptive strategy: ±R62million.
• Phila Ma: ±R37million.

2.6.3 Trends in supply of key health personnel

• Refer to minimum staff establishments for hospitals – under review as part of rationalisation of services as contemplated in the STP (and HRP).
• Vacancy rates as per information in Part A.
Table 12: Summary of Payments and Estimates – Programme 2: District Health Services

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>District Management</td>
<td>113 596</td>
<td>145 144</td>
<td>150 532</td>
<td>160 099</td>
<td>154 398</td>
<td>144 324</td>
<td>165 505</td>
<td>179 705</td>
<td>190 233</td>
<td>201 647</td>
</tr>
<tr>
<td>Community Health Clinics</td>
<td>1 027 389</td>
<td>1 294 981</td>
<td>1 578 640</td>
<td>1 631 322</td>
<td>1 653 002</td>
<td>1 922 250</td>
<td>2 145 578</td>
<td>2 367 691</td>
<td>2 488 297</td>
<td>2 637 595</td>
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<tr>
<td>Community Health Centres</td>
<td>285 742</td>
<td>435 897</td>
<td>503 302</td>
<td>558 011</td>
<td>476 892</td>
<td>555 282</td>
<td>628 739</td>
<td>676 456</td>
<td>710 870</td>
<td>753 522</td>
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<tr>
<td>Community-based Services</td>
<td>84 505</td>
<td>103 291</td>
<td>92 769</td>
<td>99 702</td>
<td>100 106</td>
<td>96 744</td>
<td>116 491</td>
<td>123 336</td>
<td>130 078</td>
<td>137 883</td>
</tr>
<tr>
<td>Community-based Services</td>
<td>375 667</td>
<td>411 552</td>
<td>429 132</td>
<td>485 218</td>
<td>510 906</td>
<td>509 808</td>
<td>595 047</td>
<td>637 047</td>
<td>671 660</td>
<td>711 960</td>
</tr>
<tr>
<td>HIV and AIDS</td>
<td>703 970</td>
<td>1 058 570</td>
<td>1 239 365</td>
<td>1 454 806</td>
<td>1 655 685</td>
<td>1 521 982</td>
<td>1 930 006</td>
<td>2 341 404</td>
<td>2 732 488</td>
<td>2 896 437</td>
</tr>
<tr>
<td>Nutrition</td>
<td>31 594</td>
<td>84 647</td>
<td>21 635</td>
<td>103 275</td>
<td>101 697</td>
<td>101 461</td>
<td>106 016</td>
<td>108 024</td>
<td>113 425</td>
<td>120 231</td>
</tr>
<tr>
<td>Coroner Services</td>
<td>44 840</td>
<td>107 176</td>
<td>96 664</td>
<td>104 538</td>
<td>105 846</td>
<td>109 479</td>
<td>124 289</td>
<td>133 433</td>
<td>141 510</td>
<td>150 001</td>
</tr>
<tr>
<td>District Hospitals</td>
<td>2 702 998</td>
<td>3 568 351</td>
<td>4 020 233</td>
<td>3 656 129</td>
<td>3 669 885</td>
<td>4 328 746</td>
<td>4 580 576</td>
<td>4 939 973</td>
<td>5 183 982</td>
<td>5 495 021</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5 370 301</strong></td>
<td><strong>7 209 609</strong></td>
<td><strong>8 132 272</strong></td>
<td><strong>8 253 100</strong></td>
<td><strong>8 428 417</strong></td>
<td><strong>9 290 076</strong></td>
<td><strong>10 392 247</strong></td>
<td><strong>11 507 069</strong></td>
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<td><strong>13 104 296</strong></td>
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</table>

Data Source: BAS - Finance Section
### Table 13: Summary of Payments and Estimates by Economic Classification – Programme 2: District Health Services

<table>
<thead>
<tr>
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<tr>
<td>Total economic classification</td>
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<td>8 132 272</td>
<td>8 253 100</td>
<td>8 428 417</td>
<td>9 290 076</td>
<td>10 392 247</td>
<td>11 507 069</td>
</tr>
</tbody>
</table>

Data Source: BAS - Finance Section
PROGRAMME 3 : EMERGENCY MEDICAL SERVICES

3.1. PROGRAMME PURPOSE

To render pre-hospital Emergency Medical Services (EMS) including Inter-Hospital Transfers and Planned Patient Transport (PPT)

The Programme objectives are:

- To render emergency response to and stabilise and transport all patients involved in trauma, medical, maternal and other emergencies through the utilisation of specialised vehicles, equipment and skilled Emergency Care Practitioners (ECP).
- To render transport for non-emergency referrals between hospitals and PHC clinics to Community Health Centres and Hospitals for indigent persons with no means of transport.
- To render pre- and in-hospital mass casualty incident management. Conduct surveillance and facilitates action in response to early warning systems for the Department and effective response to protocols – in line with the provisions of the Disaster Management Act of 2002.

3.2. SITUATION ANALYSIS

Effective and efficient EMS is critical to ensure continuum of care and effective implementation of services aimed at improving effective and efficient service delivery to contribute towards the reduction of morbidity and mortality.

EMS have been centralised to improve leadership, management and oversight. Service delivery now operates from 11 Communication Centres at district level.

Four Communication Centres have been completed including the upgrade of computerised communication systems and reconfiguration of floor layout to ensure a more conducive work environment. Communication Centres at Ugu, Uthukela, Umgungundlovu and Ilembe Districts are complete.

Renovations to the eThekwini Communication Centre are complete and the building handed over to EMS on the 15th of December 2009. Computerised equipment has not been approved and still needs to be installed. It is anticipated that the eThekwini Communication Centre will move to the new premises by the 1st of May 2010 when phase two of the project will commence.

To meet the national norm of 1 ambulance per 10000 population, the Department needs a total of 960 ambulances and 9,600 Emergency Care Practitioners (10 ECP’s per ambulance). The current 219 rostered ambulances (1:44000) is far below the national norm and an additional 740 ambulances are needed to comply with the national norm.

The Department purchased a total of 75 ambulances in preparation for the 2010 Soccer World Cup, which will be absorbed into operations after the event. An additional 5 ambulances were purchased by the Umzimkhulu Local Government to accommodate the takeover of areas previously in the Eastern Cape.

The current shortage of service providers for fleet maintenance increases down time of ambulances and further compromise an already inadequate fleet of rostered ambulances.

Aero-Medical Services currently operates on a month to month agreement with Air Mercy Services. An average of R2.3 million is spent per month to offer aero-medical services. In spite of financial constraints, EMS has been given a mandate to maintain the service which places additional pressure on expansion of services to comply with national and provincial targets.

Three Air Ambulances are active in the Province (1 helicopter in Richards Bay, 1 helicopter in Durban and 1 fixed wing aero-plane in Durban). The Richards Bay helicopter services mainly the Umkhanyakude, Uthungulu, Zululand and Ilembe Districts. The Durban helicopter serves eThekwini, Ugu, Sisonke, Ilembe, Umgungundlovu

Q2 of 2009/10
and parts of the Umzinyathi Districts. The fixed wing aeroplane covers the entire Province. Helicopter operations are however limited to daytime whilst the fixed wing operates 24 hours, although night operations are only possible in areas with lit airstrips. Recently aero-medical operations have been rather limited due to adverse weather conditions.

Severe financial constraints (partly due to the current cost containment measures instituted by the Department to curb over-expenditure) impact on expansion of current EMS which is considered inadequate to respond to the growing need in the Province. The unique topography in the Province, high poverty index (adding to the demand for services), severe shortage of staff and vehicles, high rate of inflation on EMS vehicles and high cost of fuel are all contributing to the current challenges.

Response times, both in rural and urban areas, remains a serious concern. The response times are far below national and provincial targets and continue to drop annually as indicated in Graph 29. During the 2$^{nd}$ quarter of 2009/10, the rural response times decreased to 30% (against a target of 52%) and the urban response times decreased to an alarming 14% (against a target of 32%).

A rapid assessment indicated that the decreased response times are partly due to incident-based reports generated by the upgraded computer system as compared with the previous patient-based reports.

A rapid assessment indicated that the decreased response times are partly due to incident-based reports generated by the upgraded computer system as compared with the previous patient-based reports.

Graph 29: Rural and Urban Response Times

Ugu and Umzinyathi Districts, both rural nodes, have good rural response times and lower kilometres travelled per ambulance compared to other rural districts. Only 43% of clinics in Zululand and 50% of clinics in Umkhanyakude have access to tarred roads, resulting in a traveling time of ±69 minutes to the nearest hospital as opposed to 30 minutes on tarred roads. 86

The inability of EMS to respond within the required response time has an impact on efficiency and expected health outcomes. Shortage of adequately qualified staff and emergency vehicles further jeopardise appropriate response within the “golden hour”.

Graph 30: Kilometres travelled versus Response time

Planned Patient Transport (PPT) operates in all districts, and existing personnel have been moved from Operations to PPT to expand services in compliance with protocols. EMS achieved 100% coverage of hospital-to-hospital PPT service and 36% clinic-to-hospital. Performance of PPT between clinics and hospitals is a huge challenge and must be addressed to give credence to the intention of improving Primary Health Care services.

During 2008/09 a total of 760,072 patients were transported by PPT, with a monthly average of 5,758 per district.

EMS challenges identified during Strategic Planning Workshops

- Lack of appropriate organisational structure for EMS including PPT, Disaster Management and Communication Centres.
- Inadequate skills and competencies.

86 “Referral and Support: Area 3: Baseline Study Report” by the CRH published in September 2009
Strategic Plan 2010 - 2014

- Ineffective recruitment and retention strategies partly due to the lack of staff accommodation in rural areas.
- Poor maintenance of ambulances contributed to by inadequate customised wash bays and sluice facilities.
- Inadequate ambulance bases resulting in higher mileage and increased maintenance cost, increased response times and a secondary contributory factor to ineffective referral of patients to ensure continuity of care.
- Inadequate customisation of PPT vehicles (for stretchers) to respond to demand for services.
- High cost of fleet maintenance and extended down-times as a result of services and repairs.

3.3. PROVINCIAL PRIORITIES

Priority 1: Overhaul EMS including PPT and Disaster Management to improve effectiveness and efficiency in response to health demands.

1.1 The new EMS Manager, appointed in March 2010, commenced with an in-depth review of the current status of EMS in the Province. This process will serve to inform the immediate, medium- and long-term vision.

1.2 Inclusion of EMS in the STP will be finalised in 2010/11 and will be informed by the current pilot project that commenced in Area 2 to determine effective referral patterns based on revitalisation of services in the Province. The STP Implementation Plan will determine the process.
3.4. STRATEGIC OBJECTIVES & EXPECTED OUTCOMES PROGRAMME

Table 14: Strategic Objectives and Expected Outcomes: Emergency Medical Services 2010 – 2014

<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Strategic Objective</th>
<th>Objective Statement</th>
<th>Rationale</th>
<th>Indicator</th>
<th>Baseline</th>
<th>Expected Outcome (Targets)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Goal 1</td>
<td>NHS Priority 4</td>
<td>Improve the efficiency and effectiveness of Emergency Medical Services.</td>
<td>Allocation of adequate and appropriate resources to improve response times in compliance with national norms and standards.</td>
<td>Number of rostered ambulances per 10 000 population: 1:44 000 population</td>
<td>Rostered ambulances per 10 000 population: 1:10 000</td>
<td>Rostered ambulances per 10 000 population: ≥ 70%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To revitalise EMS and improve response times to &lt;40 min in rural and &lt;15 min in urban areas in &gt;70% cases by 2014/15.</td>
<td></td>
<td>P1 calls with a response time of &lt;40 minutes in a rural area: 30% (Q2 of 2009/10)</td>
<td>P1 calls with a response time of &lt; 40 minutes in a rural area: ≥ 70%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Improved efficiency &amp; effectiveness contributes to continuum of care and improved health outcomes.</td>
<td>P1 calls with a response time &lt;15 minutes in an urban area: 14% (Q2 of 2009/10)</td>
<td>P1 calls with a response time &lt;15 minutes in an urban area: ≥ 70%</td>
<td></td>
</tr>
</tbody>
</table>

3.5. RISK MANAGEMENT

Table 15: Key Risk Factors

<table>
<thead>
<tr>
<th>Key Risk Factors</th>
<th>Measures to Mitigate Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inadequate financial resources to implement expansion strategies.</td>
<td>• The new Manager, appointed in March 2010 commenced with a review and analysis of the current status of EMS to identify gaps and challenges in service delivery to inform the long-term strategy. Inclusion of EMS in the STP will ensure adequate resources for expansion and response to service delivery needs.</td>
</tr>
<tr>
<td>2. Inadequate staffing and lack of required competencies and skills to render determined services including EMS, Disaster Management and PPT.</td>
<td>• Will be included in the forthcoming strategy.</td>
</tr>
<tr>
<td>3. Inadequate ambulances (as per national norm).</td>
<td>• Inclusion in STP to ensure provision for adequate resources based on identified need.</td>
</tr>
</tbody>
</table>
3.6. **RESOURCE CONSIDERATIONS**

3.6.1 **Expenditure Trends**

The increasing trend in allocation and expenditure is mainly related to the expansion of EMS to under-served areas in the Province. The increase in 2007/08 was largely due to funding provided to appoint additional staff and to purchase additional vehicles to accommodate expansion of the programme in preparation for the 2010 Soccer World Cup.

**Graph 31: EMS Budget versus Expenditure**

<table>
<thead>
<tr>
<th>Programme</th>
<th>Budget</th>
<th>Expenditure</th>
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<td>2005/06</td>
<td>420604</td>
<td>472360</td>
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<td>2006/07</td>
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<td>2007/08</td>
<td>554863</td>
<td>672360</td>
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<tr>
<td>2008/09</td>
<td>672360</td>
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</tr>
</tbody>
</table>

Additional funding has been allocated in the 2009/10 MTEF period to meet national norms while rising fuel costs negatively affected expenditure. The 75 ambulances purchased in preparation for the World Cup will be absorbed into the service after the event.

Transfers and subsidies to households were increased in the 2008/09 Adjusted Budget to cover cost of a legal claim against the Department by the First Aid League amounting to R 7.883 million.

The sharp increase in the Main Budget in 2009/10 and 2010/11 pertains to funds provided for the 2010 Soccer World Cup and will be used to purchase emergency vehicles and equipment.

The funding provided under this item in 2011/12 will be utilised to continue the drive to meet the national norms for emergency medical services.

3.6.2 **Unfunded Priorities**

This will depend on the strategy that will be finalised in early 2010/11.

3.6.3 **Trends in supply of key health personnel**

The EMS Expansion Plan, including the freezing of 600 essential posts created for the World Cup, has been put on hold due to financial constraints.

Only 5% of EMS staff are trained in Advanced Life Support (ALS - Paramedics) compared with the national target of 15%. During the preceding 12 months, approximately 13 ALS Practitioners relocated to other provinces and/or the private sector. To curb the high attrition rate, salary adjustments were implemented in January 2009. The impact will be monitored.

The Department entered into a Service Level Agreement with the Durban University of Technology (DUT) to improve training capacity. The agreement is valid until August 2011, and if the Health Professions Council of South Africa allows, training will continue for the agreed upon period.

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87 2008/09 Annual Report
### Table 16: Summary of Payments and Estimates – Programme 3: Emergency Medical Services

<table>
<thead>
<tr>
<th>R'000</th>
<th>Outcome</th>
<th>Audited 2006/07</th>
<th>Audited 2007/08</th>
<th>Audited 2008/09</th>
<th>Main Appropriation</th>
<th>Adjusted Appropriation 2009/10</th>
<th>Revised Estimate</th>
<th>Medium Term Estimates</th>
<th>Outer-Year Projection</th>
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<td></td>
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<td>672 360</td>
<td>737 930</td>
<td>696 263</td>
<td>774 379</td>
<td>866 383</td>
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</table>

Data Source: BAS - Finance Section

### Table 17: Summary of Payments and Estimates by Economic Classification – Programme 3: Emergency Medical Services

<table>
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<tr>
<th>R'000</th>
<th>Outcome</th>
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<th>Audited 2008/09</th>
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<td>Compensation of employees</td>
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<td>Revised Estimate</td>
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<td>Outer-Year Projection</td>
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</tr>
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</table>

Data Source: BAS - Finance Section
PROGRAMME 4: REGIONAL & SPECIALISED HOSPITALS

4.1. PROGRAMME PURPOSE

The purpose of Programme 4 is the delivery of hospital services that are accessible, appropriate and effective, and include the provision of general specialist services, specialised rehabilitation services, provision of training of health professionals and research.

Programme 4 comprises of five Sub-Programmes. The objectives are:

- To render Regional Hospital services at a general specialist level.
- To provide the platform for training of health workers and research.
- To render hospital services for TB, including MDR and XDR TB.
- To render specialist psychiatric hospital services and providing a platform for training of health workers and research in mental health.
- To provide medium to long-term care to patients who require rehabilitation and/or a minimum degree of active medical care.
- To render an affordable and comprehensive oral health service based on the PHC approach.

4.2. SITUATION ANALYSIS

The 14 designated Regional Hospitals are unevenly distributed with concentration of level 2 services in mainly urban areas. This impact negatively on access and cost and place more pressure on already over-burdened and poor performing EMS services.

Regional Hospitals provide specialist services in the 5 basic specialities namely:

- Gynaecology and Obstetrics;
- Paediatrics;
- Surgery;
- Internal Medicine; and
- Orthopaedics.

Service delivery is a challenge especially with relation to availability of specialists for certain specialities i.e. orthopaedic surgery.

All Regional Hospitals provide a combination of service packages and in most instances provide both level 1 and 2 services. Hospitals also provide clinical and non-clinical services to PHC services in their catchment areas. The lack of effective cost centres in these hospitals makes costing of services extremely complicated and logic suggest that it contributes to the current over-expenditure.

Improving efficiency and strengthening clinical governance is critical to improve quality of care and health outcomes. The high surgery fatality rate (5.6% compared to the national target of 2.5%) is a serious concern and a clear indication that clinical governance is lacking. Improving efficiency and strengthening clinical governance and quality of care is included in the NHS 10-Point Plan and one of the core priorities of the Department.

Catchment populations vary significantly from current national norms which add to congestion in hospitals. Determining appropriate norms and standards to inform re-configuration of hospital services is one of the core priorities for the Department in the forthcoming planning cycle. The STP, currently under review, will address this through extensive consultation.

Organisational structures for Regional Hospitals were finalised although there are still extensive delays in the filling of critical posts due to financial constraints and poor human resource management.

Vacancy rates dramatically impact on service delivery (availability and access) and quality of care. Recruitment and retention of staff is still a challenge that needs to be addressed as a matter of urgency. Insufficient accommodation and lack of social networks (especially in rural districts) further impact on attracting health professional to rural areas.

The inability and/or delay in filling of critical posts negatively impact on management capacity, increase in
Strategic Plan 2010 - 2014

clinical workload, sick leave and absenteeism. This ultimately translates to reduced quality of care and negative health outcomes.

Graphs 32 and 33 illustrate the vacancy rates for Medical Officers and Professional Nurses in Regional Hospitals for the period 2005/06 to 2008/09.

The significant drop in the 2008/09 vacancy rates (compared to 2007/08) is due to the abolishment of unfunded vacant posts at the end of July 2008 as per KZN Cabinet instruction.

High Medical Officer and Specialist vacancy rates in Regional Hospitals were identified as one of the challenges causing extended average length of stay in District Hospitals due to delayed referral of patients for level 2 services.

The review of minimum post establishments for hospitals that commenced in late 2009/10 will begin to address the delays in filling of critical posts and therefore addressing high vacancy rates.

Graph 34 illustrates that although the vacancy rate for Specialists has increased from 55.8% to 61.6%, the number of Specialists practicing in the public health sector also increased over the same 4 year period from 561 to 620.

The 2009 statistics are not comparable to previous years as no temporary filled posts have been included in the data for this period. These posts counted for 159 employed staff during the 2008 period and must therefore be considered in determining need.

Graph 35 reflects the number of Specialists per district. The eThekwini and Umgungundlovu Districts has the bulk of Specialists (Central and Tertiary Hospitals). There are no Specialists in Sisonke, Umzinyathi and Umkhanyakude.
as there are no Regional or Tertiary Hospitals in these districts.

Graph 35: Number of Specialists per District

Graph 36 portrays the number of Specialists per hospital classification. Regional Hospitals have the most specialists at 159, with 131 in Tertiary Hospitals. The “Other” category incorporates Specialists who form part of the Joint Health Establishment and Head Office Staff. District Hospitals only employ 42 Specialists of the 429 currently employed by the Department. This would have a definite effect on the referral of patients.

Graph 36: Number of Specialists per Classification

Regional Hospitals are highly dependent on Community Service Officers for rendering medical, dental and rehabilitation services as well as the maintenance of core standards and continuity of services. The unpredictability of community service allocations has a negative impact on service delivery especially relevant to dental and rehabilitation services.

Graph 37: Bed Utilisation Rates: Regional Hospitals

The bed occupancy rate, a measure of efficiency (expressing how well hospitals are using existing capacity) improved from 67% in 2005/06 to 71% (Q2 of 2009/10) which is still slightly lower than the national target of 75%. This however conceals individual hospital variances that should be considered in resource allocation.

Graph 38: Average Length of Stay

The average length of stay (ALOS) is a proxy measure to assess the quality of care and hospital efficiency. The ALOS in Regional Hospitals stayed at an average of 5 days per patient (slight variations during the past 5 years) as compared with the national target of 4.8 days.

Although it is generally expected that the OPD headcount will show a decrease as a result of increased availability of services at PHC level, the headcount still show a slight
increase from 2,702,113 in 2007/08 to 2,752,678 in 2008/09. The patient day equivalent (PDE) also increased from 2,663,297 in 2007/08 to 2,797,350 in 2008/09 which might be an indication of the burden of disease.

The expenditure per patient day equivalent (PDE) at R1 286 is slightly higher than the national target of R1 128 which is an indication of the importance of clients entering the health system at the appropriate level to contain cost.

Challenges identified during Strategic Planning Workshops

- Lack of clearly defined package of services (especially relevant to Combo Hospitals).
- Human Resources not aligned with current package of services and disease profiles.
- Inadequate equipment - poor allocation of resources (MERP ineffective), lack of Equipment Replacement Plans and long turn-around-time for HTU services.
- Poor compliance with service standards and policies due to the lack of effective clinical governance structures, processes, poor supportive supervision and non-implementation of Quality Improvement Programmes.
- Non-adherence to clinical audit and peer review recommendations due to lack of clinical oversight.
- Ineffective referral due to the acute shortage of EMS vehicles and staff with extended EMS response times resulting in extended average length of stay with significant cost implications.
- Lack of computerised IT system in OPD and procurement and supply division as well as inadequate archive areas.

4.3. PROVINCIAL PRIORITIES

Priority 1: Rationalisation of hospital services

1.1. Rationalisation of Regional Hospital services including the service delivery platform, bed allocation, minimum post establishments (per hospital), referral patterns, etc. as per STP imperatives. This process commenced in 2009/10 and will be implemented as per STP Implementation Plan.

1.2. Implement the national delegations for Hospital CEO’s to ensure more effective decentralised operational management, accountability and control. This process is dependent on national processes for finalisation of delegations.

1.3. Mentoring and succession training strategy to address management capacity and efficiency of hospital services.

Priority 2: Improving the quality and efficiency of hospital services

2.1 Implementation of the National Core Standards towards Accreditation. Facility Improvement Plans will serve to monitor performance and progress towards compliance with national standards.

2.2 Expansion of the “Look like a Hospital Project” will continue in support of the Core Standards and implementation of the Quality Improvement Plans.

2.3 Improve community participation and consultation through appointment of Hospital Boards as prescribed in the KZN Health Act (1 of 2009). Although 100% of hospitals currently have interim Hospital Boards, formal appointment as per Act will commence in 2010/11.

2.4 Conducting annual Patient Satisfaction Surveys to monitor patient satisfaction and promote community participation
### Strategic Objectives & Expected Outcomes Programme

#### Table 18: Strategic Objectives & Expected Outcomes 2010/11 – 2014/15

<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Strategic Objective</th>
<th>Objective Statement</th>
<th>Rationale</th>
<th>Indicator</th>
<th>Baseline</th>
<th>Expected Outcome</th>
</tr>
</thead>
</table>
| **Strategic Goal 1**  
**NHS Priority 4**  
Implement a decentralised operationalised model including new governance arrangements. | To implement the nationally approved delegations for Hospital Managers by 2010/11.⁹⁰ | Decentralised governance arrangements make provision for improved operational management and accountability. | Reviewed delegations will contribute towards addressing current bottlenecks with regards to service delivery processes at operational level thus improving efficiency and effectiveness of hospital services. | Number of CEO’s who have signed the national delegation of authorities for Hospital CEO’s | National Department of Health currently in process to finalise reviewed decentralised delegations | 14/14 Hospital Managers signed reviewed delegations of authorities by 2010/11 and annually thereafter⁹¹ |
| **Strategic Goal 1**  
**NHS Priority 4**  
Improve financial audit outcomes through improved management and accountability. | To implement the Financial Turn-Around Strategy to eliminate over-expenditure in 100% Regional Hospitals by 2012/13. | The Financial Turn-Around Strategy includes the Fiscal Adjustment Plan and Cost Saving Measures referred to in Programme 1. | Compliance with the PFMA and Treasury Regulations. | Number of Regional Hospitals with zero over-expenditure | New indicator | 14/14 Regional Hospitals with zero over-expenditure by 2012/13 |
| **Strategic Goal 2**  
**NHS Priority 3**  
Improve quality through implementation of the National Core standards towards accreditation of health facilities. | To implement the National Core Standards in 100% Regional Hospitals by 2010/11 for accreditation of 14/14 Regional Hospitals by 2012/13. | Implementation of basic quality standards, supported by Quality Improvement Plans will facilitate sustained compliance with standards towards accreditation of health services in line with the National Accreditation requirements. | Compliance with the National Core Standards will improve sustained quality and efficiency of health service delivery. | Number of Regional Hospitals accredited | Accreditation must still be finalised by the National Department of Health | 14/14 by 2012/13 |
|  |  |  |  | Average patient waiting time at OPD | New indicator | ≤1 hour by 2014/15 |

⁹⁰ Achievement of this target is dependent on national progress (National Strategic Health Plan 2010/11-2012/13)

⁹¹ This is dependent on reviewed delegations as per National Strategic Plan 2010/11 – 2012/13
Strategic Plan 2010 - 2014

<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Strategic Objective</th>
<th>Objective Statement</th>
<th>Rationale</th>
<th>Indicator</th>
<th>Baseline</th>
<th>Expected Outcome</th>
</tr>
</thead>
</table>
| **Strategic Goal 1**<br>NHS Priority 1 | To rationalise hospital services in line with the approved STP and Service Delivery Plan.
Ensure unified action in pursuit of goals. | The reviewed STP makes provision for the rationalisation of hospital services in line with service delivery needs, disease profile and the funding envelope. The timelines will be determined as part of the STP implementation process. | Rationalisation inclusive of determination of classification of hospital services and service delivery platform, package of services, minimum equipment requirements, post establishment, referral patterns, etc. which will improve equity, availability, efficiency, effectiveness and quality of services. | Rationalisation of Regional Hospital services as per STP Implementation Plan. | STP will be finalised in August 2010. Rationalisation of services commenced in 2010 i.e.  - Minimum post establishment per institution - Project to establish effective referral policy - Process to determine the service delivery platform | Rationalisation of Regional Hospital services as per approved STP Implementation Plan. |

4.5. **RISK MANAGEMENT**

**Table 19: Key Risk Factors**

<table>
<thead>
<tr>
<th>Key Risk Factors</th>
<th>Measures to Mitigate Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Poor alignment of budget with service delivery needs, over-expenditure and cost containment measures affecting service delivery.</td>
<td>• Process commenced to align budgets with service delivery needs.  • Financial Turn-Around strategy including fiscal adjustment plan.</td>
</tr>
<tr>
<td>2. Inadequate human resources (high vacancy and attrition rates) and extended delays in filling of critical posts. Especially relevant to Specialists.</td>
<td>• Determining minimum post establishments commenced to reduce delays with filling of posts and alignment with service delivery platform per institution.</td>
</tr>
<tr>
<td>3. Delays in infrastructure projects and maintenance backlog.</td>
<td>• Included in the Quality Improvement Plans.</td>
</tr>
<tr>
<td>4. Lack of management competencies and inadequate mentoring and succession training programmes.</td>
<td>• Establish additional training programmes for managers using internal expertise.</td>
</tr>
</tbody>
</table>

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92 National processes (National Health Annual Plan 2010/11) to determine staffing norms, skills audit, infrastructure “Shock Treatment Plan” will inform the Provincial processes
4.6. RESOURCE CONSIDERATIONS

4.6.1 Expenditure Trends

Over-expenditure has been a problem the last 2 years (as illustrated in graph 39). This will be addressed through implementation of the Financial Turn-Around Strategy that commenced in 2009/10.

Alignment of budget with service delivery imperatives will be pursued in the upcoming planning cycle. More robust monitoring and performance management should also have a positive impact on over-spending.

Graph 39: Budget & Expenditure: Regional Hospitals

The sustained growth in funding (Tables 20 and 21) is to cater for cost of living adjustments and includes the carry-through costs of the new MDR/XDR TB facilities opened at Greytown, Murchison and Thulasizwe Hospitals in line with national priorities.

The significant increase in expenditure in the Sub-Programme Regional Hospitals for 2007/08 was due to introduction of OSD to nurses and the higher than expected inflation rate on foodstuffs and medical supplies and services, as well as the 7.5% increase for improvement of conditions of service.

The negative growth in the Main Budget in 2008/09 results from insufficient funding being available in the baseline to cover the shortfall in the provision for the carry-through costs of the nurses’ OSD, the extremely high general inflation and the cost of the National Health Laboratory Services.

The large increase in 2007/08 for the Sub-Programme: Psychiatric Hospitals are largely due to the take-over of the Umzimkhulu Psychiatric Hospital from the Eastern Cape.

The increase in Compensation of Employees in 2007/08 relates mainly to the Health Professional Remuneration Review for health professional (OSD), filling of additional posts to improve service delivery, and the take-over of the Eastern Cape TB and Psychiatric institutions.

From the 2008/09 Adjusted Budget, further funding is provided for supplementing the carry-through costs of the OSD. In 2011/12, a portion of funding provided for the improvement of the general health capacity.

4.6.2 Unfunded Priorities

The circumcision campaign, noted under Programme 2 unfunded mandates.

4.6.3 Trends in supply of key health personnel

No additional input from narrative in Part A and Programme 4 of this plan.
### Table 20: Summary of Payments and Estimates

<table>
<thead>
<tr>
<th>R000</th>
<th>Outcome</th>
<th>Current payments</th>
<th>Compensation of employees</th>
<th>Goods and services</th>
<th>Financial transactions in assets and liabilities</th>
<th>Transfers and subsidies</th>
<th>Provinces and municipalities</th>
<th>Non-profit institutions</th>
<th>Households</th>
<th>Payments for capital assets</th>
<th>Buildings and other fixed structures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Audited</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>2007/08</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General (Regional) Hospitals</td>
<td>2 405 363</td>
<td>2 890 364</td>
<td>3 169 928</td>
<td>3 196 444</td>
<td>3 053 818</td>
<td>3 082 548</td>
<td>3 975 671</td>
<td>4 319 406</td>
<td>4 535 098</td>
<td>4 807 204</td>
<td>5 095 636</td>
</tr>
<tr>
<td>Tuberculosis Hospitals</td>
<td>314 451</td>
<td>481 772</td>
<td>653 625</td>
<td>635 941</td>
<td>658 685</td>
<td>770 224</td>
<td>885 059</td>
<td>941 056</td>
<td>988 837</td>
<td>1 048 167</td>
<td>1 111 057</td>
</tr>
<tr>
<td>Psychiatric Hospitals</td>
<td>334 552</td>
<td>409 527</td>
<td>451 429</td>
<td>497 740</td>
<td>484 810</td>
<td>537 619</td>
<td>564 416</td>
<td>598 285</td>
<td>628 996</td>
<td>666 736</td>
<td>706 740</td>
</tr>
<tr>
<td>Sub-acute, step-down and chronic medical hospitals</td>
<td>76 140</td>
<td>92 364</td>
<td>93 865</td>
<td>106 178</td>
<td>96 493</td>
<td>105 290</td>
<td>112 463</td>
<td>119 446</td>
<td>125 809</td>
<td>153 358</td>
<td>141 359</td>
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<tr>
<td>Dental training hospital</td>
<td>8 439</td>
<td>9 787</td>
<td>9 967</td>
<td>12 139</td>
<td>11 848</td>
<td>10 920</td>
<td>11 575</td>
<td>12 977</td>
<td>13 673</td>
<td>14 493</td>
<td>15 363</td>
</tr>
<tr>
<td>Total</td>
<td>3 138 945</td>
<td>3 883 814</td>
<td>4 378 814</td>
<td>4 450 442</td>
<td>5 226 601</td>
<td>5 549 184</td>
<td>5 991 170</td>
<td>6 292 383</td>
<td>6 666 926</td>
<td>7 070 122</td>
<td></td>
</tr>
</tbody>
</table>

Data Source: BAS - Finance Section

### Table 21: Summary of Payments and Estimates by Economic Classification

| R000                          | Outcome   | Current payments | Compensation of employees | Goods and services | Financial transactions in assets and liabilities | Transfers and subsidies | Provinces and municipalities | Non-profit institutions | Households | Payments for capital assets | Buildings and other fixed structures |
|-------------------------------|-----------|------------------|---------------------------|--------------------|---------------------------------------------------|                         |                             |                            |            |                               |                                     |
|                               |           | Audited          |                           |                    |                                                   |                         |                             |                            |            |                               |                                     |
|                               |           | 2007/08          |                           |                    |                                                   |                         |                             |                            |            |                               |                                     |
| General (Regional) Hospitals  | 2 405 363 | 2 890 364        | 3 169 928                | 3 196 444          | 3 053 818                                        | 3 082 548               | 3 975 671                  | 4 319 406                | 4 535 098  | 4 807 204                    | 5 095 636                                 |
| Tuberculosis Hospitals        | 314 451   | 481 772          | 653 625                  | 635 941            | 658 685                                          | 770 224                 | 885 059                   | 941 056                  | 988 837    | 1 048 167                    | 1 111 057                                 |
| Psychiatric Hospitals         | 334 552   | 409 527          | 451 429                  | 497 740            | 484 810                                          | 537 619                 | 564 416                   | 598 285                  | 628 996    | 666 736                      | 706 740                                  |
| Sub-acute, step-down and chronic medical hospitals | 76 140   | 92 364            | 93 865                   | 106 178            | 96 493                                           | 105 290                 | 112 463                   | 119 446                  | 125 809    | 153 358                      | 141 359                                  |
| Dental training hospital      | 8 439     | 9 787             | 9 967                    | 12 139             | 11 848                                           | 10 920                  | 11 575                    | 12 977                   | 13 673     | 14 493                       | 15 363                                   |
| Total                         | 3 138 945 | 3 883 814        | 4 378 814                | 4 450 442          | 5 226 601                                        | 5 549 184               | 5 991 170                 | 6 292 383                | 6 666 926  | 7 070 122                    |                                           |
## Strategic Plan 2010 - 2014

### 107

#### Outcome

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Machinery and equipment</td>
<td>33,642</td>
<td>39,120</td>
<td>24,440</td>
<td>24,725</td>
<td>17,621</td>
<td>26,501</td>
<td>28,796</td>
<td>30,236</td>
<td>32,050</td>
</tr>
<tr>
<td>Payment for financial assets</td>
<td></td>
<td>82</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data Source: BAS - Finance Section
PROGRAMME 5 : TERTIARY AND CENTRAL HOSPITALS

5.1. PROGRAMME PURPOSE
The main purpose of Programme 5 is to provide Tertiary and Central Hospital services and to create a platform for the training of health workers.

The objectives are to:
- Render Central and Quaternary Hospital services.
- Render Tertiary Hospital services.

5.2. SITUATION ANALYSIS
The designated Tertiary and Central Hospitals provide highly specialised care to a total population of 9,426,003 of which 8,294,895 is assumed to be uninsured population.

Although only Greys Hospital is classified as a Tertiary Hospital, Ngwelezane and Lower Umfolozi Memorial Hospitals also provide some tertiary services.

- Inkosi Albert Luthuli Central Hospital (IALCH) provides 100% Tertiary package of services.
- Greys Hospital provides 80% Tertiary and 20% Regional package of services.
- Ngwelezane Hospital provides 33% Tertiary, 42% Regional and 25% District package of services.
- Lower Umfolozi War Memorial Hospital provides 37% Tertiary, 36% Regional and 27% District package of services.

Both Ngwelezane and Lower Umfolozi War Memorial Hospitals are in the early stages of development. Inadequate infrastructure however delays progress and place unduly pressure on the remaining tertiary services.

Reconsideration of the service package in Tertiary Hospitals is necessary to unbundle layered service delivery in these hospitals. This should go a long way in addressing over-expenditure (due to poor costing of services) as well as improving staffing requirements based on the package of services.

The organisational structure for IALCH has been finalised but structures for the other hospitals must still be reviewed and finalised.

Incomplete structures impacted negatively on budget allocation and the filling of critical posts, as critical staff appointments were being motivated for on an individual basis depending on service priority needs. Extended delays in filling of posts put additional strain on existing staff.

The Human Resource expenditure varied between 70% - 75% of the total budget amongst the Tertiary Hospitals.

Appointment of specialist staff has been delayed due to financial constraints and expansion of services had to be curtailed as per directive of the then Acting Head of Department due to over expenditure in the Department in 2007/08 and 2008/09.

High vacancy rates and concomitant skills gaps severely affected service delivery and costs. Expansion of services, as necessitated by the increased burden of disease, has not been possible as a result of inadequate financial and human resources. Failure to develop services will have an impact on eventual long-term cost as well as ability to respond appropriately to the health needs of beneficiaries in the Province.

The OPD Headcount in the Tertiary Hospital shows a steady increase from 178,493 in 2005/06 to 441,012 in 2008/09, and the patient day equivalent increased from 139,844 to 459,149 in 2008/09.

The OPD headcount in the Central Hospital increased slightly from 145,768 to 174,704 in 2008/09 and the patient day equivalent increased from 191,673 – 242,334 in 2008/09.
The cost per PDE in the Tertiary Hospital increased from R1 273 in 2005/06 to R2 947 in 2008/09 and a mammoth R4 432 in the 2nd quarter of 2009/10 (compared with a national target of R1 128).

The cost per PDE in the Central Hospital increased significantly from R3 855 to R6 307 in 2009/10 as compared with the national target of R1 877.

Vacancy rates

Graphs 40 and 41 reflect the vacancy rates for Medical Officers and Professional Nurses in Tertiary and Central Hospitals. The graphs do not reflect vacancies for Specialists which should however be monitored as level 3 services are dependent on adequate numbers of specialised professionals.

The drop in the 2008/09 vacancy rates (compared to 2007/08) is due to the abolishment of unfunded vacant posts on Persal at the end of July 2008 as per KZN Cabinet instruction.

The Department plan to expand the current Registrar training programme in the forthcoming planning cycle to increase the pool of specialists in hospitals. Measures will be put in place to retain qualified Specialists, which is in line with the Human Resource Turn-Around Strategy to improve recruitment and retention of scarce skills personnel in the coming years. An assessment of the placement of staff will be undertaken to ensure appropriate skills mix and placement of staff. This will be part of the revitalisation process.

Average length of stay (ALOS)

The ALOS in the Tertiary Hospital decreased slightly from 6.5 days in 2005/06 to 6.1 days in 2008/09, still exceeding the national target of 5.3 days.

The ALOS in the Central Hospital decreased from 10 days in 2005/06 to 8.8 days in 2008/09, exceeding the national target of 5.3 days.

Bed utilisation Rate

The bed utilisation rate in the Tertiary Hospital increased from 70.5% to 75.8%, exceeding the national target of 75%.
The bed utilisation rate in the Central Hospital increased slightly from 61% to 62.8% in 2008/09 compared with the national target of 75%.

**Graph 43: Bed Utilisation Rates**

![Graph showing bed utilisation rates](image)

<table>
<thead>
<tr>
<th>Department</th>
<th>Tertiary</th>
<th>Central</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ortho</td>
<td>66.70</td>
<td>96.4</td>
</tr>
<tr>
<td>Surgery</td>
<td>89.80</td>
<td>80.7</td>
</tr>
<tr>
<td>Medicine</td>
<td>67.80</td>
<td>34.5</td>
</tr>
<tr>
<td>O&amp;G</td>
<td>72.30</td>
<td></td>
</tr>
</tbody>
</table>

**Caesarean Section Rate**

The caesarean section rate in the Tertiary Hospital decreased from 73% in 2005/06 to 45.4% in 2008/09, although still exceeding the national target of 22%.

The caesarean section rate in the Central Hospital increased from 74% in 2005/06 to 81.5% in 2008/09 compared with the national target of 25%.

Of great concern is the high fatality rate for surgery in the Tertiary Hospital (6.1% in the second quarter of 2009/10) compared with the national target of 2.5%. This raises serious questions about the effectiveness of clinical governance arrangements in hospitals and must be targeted in the next 5 years.

The case fatality rate in the Central Hospital decreased from 6% in 2005/06 to 3.2% in 2009/10 compared with the national target of 3%.

**Challenges identified during Strategic Planning Workshops**

- Ineffective clinical governance systems, lack of clinical oversight and non-adherence with clinical audit and peer review recommendations.
- Inadequate equipment to render standard package of services and ineffective MERP.
- Lack of clearly defined package of services and inadequate human resources for implementation of current package of services.
- Poor compliance with Quality Assurance and Infection Prevention & Control standards and policies.
- Poor management and accountability.

### 5.3. Provincial Priorities

**Priority 1: Rationalisation of hospital services**

1.1 Review delegations to ensure more effective decentralised operational management, accountability and control.

1.2 Improve community participation through the establishment of Hospital Boards.

1.3 Review service delivery platform including hospital structures and post establishments to ensure adequate allocation of financial and human resources and infrastructure to deliver package of services.

1.4 Alignment of STP, HRP (Provincial and District) and Infrastructure Plan to inform long-term planning.

1.5 Review and establish effective referral systems in collaboration with EMRS and aligned with STP imperatives.

**Priority 2: Improve quality of care through improved clinical governance, accountability and oversight.**

2.1 Monitoring of the Conditional Grant Business Plan.

2.2 Implementation of the National Core Standards towards national accreditation.
### Table 22: Strategic Objectives & Expected Outcomes 2010/11 – 2014/15

<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Strategic Objective</th>
<th>Objective Statement</th>
<th>Rationale</th>
<th>Indicator</th>
<th>Baseline</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Goal 1</td>
<td>NHS Priority 4</td>
<td>Implement a decentralised operationalised model including new governance arrangements.</td>
<td>Decentralised governance arrangements make provision for improved operational management and accountability.</td>
<td>Reviewed delegations contribute towards addressing bottlenecks in service delivery at operational level thus improving efficiency and effectiveness of hospital services.</td>
<td>Number of CEO’s who have signed the national delegation of authorities for Hospital CEO’s</td>
<td>National Department of Health currently in process to finalise reviewed decentralised delegations</td>
</tr>
<tr>
<td>Strategic Goal 1</td>
<td>NHS Priority 4</td>
<td>Improve financial audit outcomes through improved management and accountability.</td>
<td>The Financial Turn-Around Strategy includes the Fiscal Adjustment Plan and Cost Saving Measures referred to in Programme 1.</td>
<td>Compliance with the PFMA and Treasury Regulations.</td>
<td>Number of Tertiary/ Central Hospitals with zero over-expenditure</td>
<td>2/2 Tertiary/ Central Hospitals reported over-expenditure in 2009/10</td>
</tr>
<tr>
<td>Strategic Goal 2</td>
<td>NHS Priority 3</td>
<td>Improve quality through implementation of the National Core Standards towards accreditation of health facilities.</td>
<td>Implementation of basic quality standards, supported by Quality Improvement Plans will facilitate sustained compliance with standards towards accreditation of health services in line with the National Accreditation requirements.</td>
<td>Compliance with the National Core Standards will improve sustained quality and efficiency of health service delivery.</td>
<td>Number of Tertiary/ Central Hospitals accredited</td>
<td>Accreditation must still be finalised by the National Department of Health</td>
</tr>
</tbody>
</table>

---

<sup>33</sup> Achievement of this target is dependent on national progress (National Strategic Health Plan 2010/11-2012/13)

<sup>34</sup> This is dependent on reviewed delegations as per National Strategic Plan 2010/11 – 2012/13
### Strategic Plan 2010 - 2014

<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Strategic Objective</th>
<th>Objective Statement</th>
<th>Rationale</th>
<th>Indicator</th>
<th>Baseline</th>
<th>Expected Outcome</th>
</tr>
</thead>
</table>
| **Strategic Goal 1**
NHS Priority 1 | To rationalise hospital services in line with the approved STP Implementation Plan. | The reviewed STP makes provision for the rationalisation of hospital services in line with service delivery needs, disease profile and the funding envelope. The timelines will be determined as part of the STP implementation process. | Rationalisation inclusive of determination of classification of hospital services and service delivery platform, package of services, minimum equipment requirements, post establishment, referral patterns, etc. which will improve equity, availability, efficiency, effectiveness and quality of services. | Rationalisation of Tertiary/ Central Hospital services as per STP timelines. | STP will be finalised in August 2010. Rationalisation of services commenced in 2010 i.e.  
- Minimum post establishment per institution  
- Project to establish effective referral policy  
- Process to determine the service delivery platform | Rationalisation of Tertiary/ Central Hospital services as per approved STP Implementation Plan. |

---

## 5.5. **RISK MANAGEMENT**

**Table 23: Key Risk Factors**

<table>
<thead>
<tr>
<th>Key Risk Factors</th>
<th>Measures to Mitigate Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Poor alignment of budget with service delivery needs, over-expenditure and cost containment measures affecting service delivery.</td>
<td></td>
</tr>
</tbody>
</table>
- Process commenced to align budgets with service delivery needs.  
- Financial Turn-Around strategy including fiscal adjustment plan. |
| 2. Inadequate human resources (high vacancy and attrition rates) and extended delays in filling of critical posts. Especially relevant to Specialists. |  
- Determining minimum post establishments commenced to reduce delays with filling of posts and alignment with service delivery platform per institution. |
| 3. Delays in infrastructure projects and maintenance backlog. |  
- Included in the Quality Improvement Plans. |
| 4. Lack of management competencies and inadequate mentoring and succession training programmes. |  
- Establish additional training programmes for managers using internal expertise. |

---

95 National processes (National Health Annual Plan 2010/11) to determine staffing norms, skills audit, infrastructure “Shock Treatment Plan” will inform the Provincial processes.
5.6. RESOURCE CONSIDERATIONS

5.6.1 Expenditure Trends

Tertiary services receive budget allocation from the equitable share and the National Tertiary Services Grant (NTSG).

The NTSG allocations have been allocated to IALCH (60%), Greys Hospital (30%), Ngwelezane Hospital (10%), and Lower Umfolozi War Memorial Hospital (10%).

The sustained positive growth for this programme is due to the increasing demand for Tertiary and Central Hospital services and the introduction of the programme for the modernization of tertiary services in 2007/08.

The negative growth from the 2008/09 Estimated Actual to 2009/10 in the Sub-Programme: Provincial Tertiary Services results from an additional payment of R51 million for Machinery and Equipment in respect of the PPP agreement that was not paid in 2007/08 being made in 2008/09.

The negative trend between the estimated actual in 2008/09 and 2009/10 relates to the under-provision of carry-through costs for OSD for nurses. The substantial increase in the item in 2010/11 is aimed at funding the filling of vacant posts to manage increased patient loads. Also contributing to the growth in 2010/11 is additional funding for the modernization of Tertiary Services.

The negative growth in Goods and Services between the Estimated Actual for 2008/09 and 2009/10 pertains to the acute pressures experienced by the Department as a result of CPIX peaking at 13% for which limited additional funding was provided.

The increase in Transfers and Subsidies to Households is related mainly to the adjustment for medico-legal claims and the provision of gratuities, both of which are difficult to forecast. The increase in the Estimated Actual for 2008/09 relates to a medico-legal claim against the Department.

5.6.2 Unfunded Priorities

Although no specific priorities are reported, historical under-funding for rendering of package of services impact on service delivery considerably.

5.6.3 Trends in supply of key health personnel

No additional information from Part A and narrative in Programme 5.
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Main Appropriation</th>
<th>Adjusted Appropriation</th>
<th>Revised Estimate</th>
<th>Medium-Term Estimates</th>
<th>Outer-Year Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Hospitals</td>
<td></td>
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<tr>
<td>Audited 2006/07</td>
<td>368 108</td>
<td>427 508</td>
<td>502 028</td>
<td>546 371</td>
<td>562 555</td>
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<tr>
<td>Audited 2007/08</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audited 2008/09</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tertiary Hospitals</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Audited 2006/07</td>
<td>823 702</td>
<td>980 195</td>
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<td>1 218 322</td>
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<tr>
<td>Audited 2007/08</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audited 2008/09</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Total</td>
<td>1 191 810</td>
<td>1 407 703</td>
<td>1 821 221</td>
<td>1 646 185</td>
<td>1 780 877</td>
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</table>

Table 24: Summary of Payments and Estimates – Programme 5: Tertiary and Central Hospital Services

Data Source: BAS - Finance Section

<table>
<thead>
<tr>
<th>Economic Classification</th>
<th>Outcome</th>
<th>Main Appropriation</th>
<th>Adjusted Appropriation</th>
<th>Revised Estimate</th>
<th>Medium-Term Estimates</th>
<th>Outer-Year Projection</th>
</tr>
</thead>
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<tr>
<td>Goods and services</td>
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<td>Financial transactions in assets and liabilities</td>
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<td>-</td>
<td>-</td>
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<tr>
<td>Transfers and subsidies to provinces and municipalities</td>
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<td>627</td>
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<tr>
<td>Households</td>
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<td>Payments for capital assets</td>
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<td>147 249</td>
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<td>258 399</td>
<td>326 000</td>
<td>324 594</td>
</tr>
<tr>
<td>Machinery and equipment</td>
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<td>147 249</td>
<td>265 276</td>
<td>258 399</td>
<td>326 000</td>
<td>324 594</td>
</tr>
<tr>
<td>Total economic classification</td>
<td>1 191 810</td>
<td>1 407 703</td>
<td>1 821 221</td>
<td>1 646 185</td>
<td>1 780 877</td>
<td>2 087 145</td>
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</tbody>
</table>

Data Source: BAS - Finance Section
PROGRAMME 6 : HEALTH SCIENCES & TRAINING

6.1. PROGRAMME PURPOSE

To render training and development opportunities for actual and potential employees of the Department.

The programme objectives are:

1. To provide for training for nurses at under-graduate and post-basic level.
2. To provide training for Emergency Care Practitioners.
3. To provide PHC related training for Professional Nurses working in PHC services.
4. To provide skills development interventions for all occupational categories in the Department.
5. To provide bursaries for students studying in health science programmes at under-graduate and post-graduate levels.

6.2. SITUATION ANALYSIS

During strategic planning workshops the lack of management competencies and skills was identified as one of the root causes of poor service delivery (especially relevant to hospital management).

The NHS 10-Point Plan makes provision for capacity building and training to improve health service delivery i.e. Priority 4: Overhauling the Health Care System and improving its Management and Priority 5: Improved Human Resources Planning Development and Management.

As part of the programme to improve management capacity at facility level, 24 Hospital CEO's enrolled for the Masters Programme in Public Health in 2009/10 of which 17 are still in the programme. Due to financial constraints intake for the next group was postponed.

Training and capacity building at service delivery level must be designed to ensure minimum disruption of services taken into account the high vacancy rates and workloads. Training and development plans, including mentorship and learnerships, must be tailor-made and focused in response to the current backlog of competencies and skills.

Vigorous monitoring of post-training output should be up-scaled to ensure cost benefit, improved service delivery and better health outcomes. A training database must be developed to effect optimal monitoring of skills and competencies and to guide appointment to ensure appropriate skills mix at all levels of care.

Due to financial constraints there has been no training of TB DOTS supporters or Community Health Workers. These are all areas in which the focus can remain on training of people with a low skills base while still having a direct impact on health outcomes. It has been proven that economically, prevention is cheaper than cure and therefore this should be the focus of training for the lower skills base in the Department.

The training budget is currently split at 60% for NQF Level 4 and below (matric and below) with the remaining 40% for NQF level 5 and above. The core function of the Department is health service delivery (including preventative and curative health) of which doctors and nurses form the backbone of the workforce. The baseline qualification for a doctor or professional nurse is a NQF Level 5 and the question therefore remains if the budget split should not be re-considered in response to the dire need for training of professionals.

ABET Training

Individual tutors run the programme since the contract with the previous service provider end in 2008. A total of 2,039 employees participated in the programme in 2009/10.

Learnerships

The Department implemented various categories including ABET, PHC, Social Auxiliary and Pharmacy Assistant training to mention a few. The programme is funded by the Health & Welfare Sector Education and Training Authority (HWSETA) through discretionary grants.
Internships
The Department contracted 879 interns in various skill areas in the last 3 years. 85% of the contracted interns however failed to secure permanent employment due to the moratoria placed on appointments in KZN.

Bursaries
A total value of R93 million has been utilised to fund bursaries in the Health sciences field in 2009/10, with a current 877 bursary holders. The Department is currently funding 463 medical students, 8 clinical associate students, 91 nurses and 271 other students. There are 44 students in the Cuban Medical Training Programme.

In January 2010, the Department placed 150 bursary holders in permanent positions to serve back their bursary obligations.

In 2009/10 (Q) the bursary expenditure was R29 466 million against a quarterly target of R13 945 million – this should however even out by the end of the year to equal the annual budgeted amount of R39 224.

Mid-Level Workers
The Department is currently sponsoring 8 students pursuing studies in clinical medical practice (Clinical Associate Programme) with the University of Pretoria. There are currently 10 students in their second year.

Leadership, Management Development Programme
The moratoria on training have hindered implementation of this programme. The intake of Hospital CEO’s in the Masters in Public Health was suspended due to a lack of funds. The deployment of managers participating in the Khaedu Programme was also suspended due to poor attendance and lack of funds.

The KZN College of Nursing (KZNCN) is mandated to provide training for all nursing requirements for the Department and outputs should therefore be aligned to the HR Plan. The current oversupply of EN’s and ENA’s and the shortfall of Professional Nurses and nurses with post basic skills i.e. advanced midwifery, theatre, etc. should therefore be considered in planning for the next 5 years.

Specialities, especially Advanced Midwifes, are critical for strategies to achieve the MDG’s.

In Graph 45, Advanced Midwifery has been combined with Child Nursing as 2 specialties that have the greatest impact on achieving MDG 4 and 5 as compared with the remaining 3 specialties of Critical Care, Orthopeadics and Theatre Nursing. The numbers reflected below are for the number of nurses who have completed their post basic training through the KZNCN per discipline.

Graph 45: Number of graduating KZNCN students per post basic discipline for nursing.

Due to a change in legislation, the KZNCN will have to be accredited as a Tertiary Educational Institution before offering training at NQF Level 5 and above (Professional Nurse Level). Should the institution fail to comply with this requirement, it will be devolved to the Department of Education. This would be to the detriment of the Department.

The EMS College of Training will be relocated to Durban and training will be facilitated by the Training Division of the Office of the Premier. New premises have staff/ student accommodation and will therefore be more accessible to students.

Challenges identified during Strategic Planning Workshops
- Inadequate staff competencies, skills and lack of management capacity - core elements of decreased quality and inefficient health services.
6.3. PROVINCIAL PRIORITIES

Priority 1: Implement the National Nursing Strategy

1.1 The National Nursing Strategy has been finalised and will be disseminated for implementation in 2010/11. The strategy makes provision for addressing the need for various categories of nurses and will be aligned with the STP and HRP.

1.2 Nurse intake, aligned with current needs and macro long-term plans, must be addressed to ensure delivery of high quality public health services.

1.3 Re-alignment of training and development programmes according to service delivery needs at operational and provincial level to ensure effective provision of competent and skilled providers and optimal utilisation of available resources.

Priority 2: Implement a sustainable training strategy for Mid-Level Workers.

2.1 High vacancy rates in scarce skills categories is a serious concern and contributory factor in declining quality of care. A strategy to address this will be developed as part of the revitalisation of health services.


3.1 Poor management capacity has been identified as one of the core challenges facing effective and efficient public health care services.

3.2 Cost containment measures challenge training initiatives, especially utilising external expertise. Innovative and sustainable initiatives are therefore crucial to improve training, mentoring and support programmes.

3.3 The learning strategy, making use of internal expertise, will be developed in collaboration with managers and make provision for succession training in light of high attrition and vacancy rates.

Priority 4: Implement and monitor a training programme for CHW's, CBC's, Hospital Boards and Clinic Committees based on national guidelines.

4.1 Community development and training has been identified as high priorities in the NHS 10-Point Plan as well as the Provincial Plan of Action (Flagship Programme). Numerous vertical programmes however jeopardise training and monitoring and will be addressed in the planning cycle.

4.2 A database will be established to ensure effective utilisation of available resources.
6.4. **STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES PROGRAMME 6**

Table 26: Strategic Objectives & Expected Outcomes

<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Strategic Objective</th>
<th>Objective Statement</th>
<th>Rationale</th>
<th>Indicator</th>
<th>Baseline</th>
<th>Expected Outcome</th>
</tr>
</thead>
</table>
| NHS Priority 5 | Improve management competencies and skills. | To develop and implement a Learning Strategy for Managers based on the skills audit results and enroll 100% Hospital Managers by 2012/13. | Align training and development with service delivery imperatives and training and development needs identified on analysis of national audit. | Improved capacity and appropriate skills mix to ensure effective and efficient service delivery at all levels of care | Learning Strategy | New indicator | Learning Strategy approved  
Improved management capacity  
Appropriate skills mix in response to package of service and service delivery needs |
| | | | | | Number of Hospital Managers who completed the Masters for Public Health | 24 Hospital Managers enrolled in Management course – 7 dropped out | 75 Hospital Managers completed Hospital Management course |

6.5. **RISK MANAGEMENT**

Table 27: Key Risk factors

<table>
<thead>
<tr>
<th>Key Risk Factors</th>
<th>Measures to Mitigate Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Funding constraints impacting on capacity-building and training plans and strategies.</td>
<td>• Training and development programmes will be aligned with gap analysis based on the skills audit currently being conducted by the National Department of Health. Plans will be aligned with Human Resource Plan and STP.</td>
</tr>
<tr>
<td>2. Inadequate resources to conduct a skills audit to inform training arrangements as set out in the NHS 10-Point Plan and the Departmental medium and long term plans.</td>
<td>• Awaiting outcome of national audit.</td>
</tr>
<tr>
<td>3. Coordination of training and development programmes including in-service programmes.</td>
<td></td>
</tr>
</tbody>
</table>
6.6. RESOURCE CONSIDERATIONS

6.6.1 Expenditure Trends

The increasing trend in expenditure can largely be attributed to the training drive, increased bursaries and the provision for the intake of medical interns, dentists, pharmacists and other interns.

The increase in 2007/08 makes provision for the introduction of the compulsory two-year internship for medical doctors and the drive to increase the capacity of nursing personnel.

The increase in the EMS Training Colleges Main Budget in 2008/09 was a provision for training expenditure in respect of the 2010 Soccer World Cup. This has been slower than anticipated due to financial constraints and will be increased significantly in 2009/10.

The increased trend is continued over 2010/11 and 2011/12 in order to provide trained EMS personnel aligned to national norms and expectations.

Graph 46: Budget versus Expenditure

6.6.2 Unfunded Priorities

Concession training for CEO’s estimated at approximately R2.310million (2010/11); R2.448million (2011/12) and R2.596million (2012/13.)
### Table 28: Summary of Payments and Estimates – Programme 6: Health Sciences and Training

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Nurse training colleges</td>
<td>229 513</td>
<td>278 799</td>
<td>336 812</td>
<td>328 749</td>
<td>323 270</td>
<td>382 309</td>
<td>373 615</td>
<td>395 828</td>
<td>416 394</td>
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<td>EMS training colleges</td>
<td>11 220</td>
<td>13 452</td>
<td>16 969</td>
<td>27 788</td>
<td>28 002</td>
<td>14 516</td>
<td>24 233</td>
<td>26 525</td>
<td>28 115</td>
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<tr>
<td>Bursaries</td>
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<td>44 894</td>
<td>41 224</td>
<td>41 224</td>
<td>45 142</td>
<td>48 693</td>
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<td>54 196</td>
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<td>PHC training</td>
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<td>46 892</td>
<td>65 343</td>
<td>63 077</td>
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<td>79 373</td>
<td>83 674</td>
<td>86 906</td>
<td>92 120</td>
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<tr>
<td>Other training</td>
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<td>151 617</td>
<td>212 583</td>
<td>192 884</td>
<td>214 891</td>
<td>14 516</td>
<td>24 233</td>
<td>26 525</td>
<td>28 115</td>
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<td><strong>Total</strong></td>
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<td>756 276</td>
<td>808 461</td>
<td>904 436</td>
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</tr>
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</table>

Data Source: Finance Section - BAS

### Table 29: Summary of Payments and Estimates by Economic Classification – Programme 6: Health Sciences & Training

<table>
<thead>
<tr>
<th></th>
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<tr>
<td>Current payments</td>
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<td>478 758</td>
<td>618 922</td>
<td>598 397</td>
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<td>696 967</td>
<td>744 048</td>
<td>793 863</td>
<td>831 924</td>
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<tr>
<td>Compensation of employees</td>
<td>319 061</td>
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<td>528 940</td>
<td>510 568</td>
<td>522 854</td>
<td>621 106</td>
<td>664 176</td>
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<td>Goods and services</td>
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<td>89 982</td>
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<td>70 464</td>
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<td>5 967</td>
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<td>11 416</td>
<td>12 377</td>
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<td>44 342</td>
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<td>40 323</td>
<td>42 432</td>
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<td>48 114</td>
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<td>1 519</td>
<td>3 465</td>
<td>3 465</td>
<td>772</td>
<td>1 751</td>
<td>1 971</td>
<td>2 048</td>
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<tr>
<td>Buildings and other fixed structures</td>
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### Strategic Plan 2010 - 2014

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</thead>
<tbody>
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<td>Machinery and equipment</td>
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<td>1 403</td>
<td>3 465</td>
<td>772</td>
<td>1 751</td>
<td>1 971</td>
<td>2 048</td>
<td>2 171</td>
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<td>Software and other intangible assets</td>
<td>-</td>
<td>44</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total economic classification</td>
<td>421 069</td>
<td>524 333</td>
<td>676 601</td>
<td>653 811</td>
<td>671 064</td>
<td>756 276</td>
<td>808 491</td>
<td>862 961</td>
<td>904 436</td>
</tr>
</tbody>
</table>

Data Source: Finance Section - BAS
PROGRAMME 7 : HEALTH SUPPORT SERVICES
PHARMACEUTICAL SERVICES

7.1. PROGRAMME PURPOSES
To manage the supply of pharmaceuticals and medical
sundries to Hospitals, Community Health Centres, Clinics
and Local Authorities via the Medicine Trading Account.

The objective of Pharmaceutical services is:
To render Pharmaceutical support services to the
KwaZulu-Natal Department of Health.

7.2. SITUATION ANALYSIS
The Pharmaceutical Service Programme has three core
spheres namely Pharmaceutical Policy and System
Development, Provincial Pharmaceutical Supply Depot
(PPSD), and Pharmaceutical Service Delivery Points (i.e.
Pharmacies at Hospitals, Community Health Centres and
Clinics).

Medicine management has a direct impact on health
outcomes and life expectancy and forms an integral part
of the comprehensive management of patients in the health
care system. For that reason it is considered one of the
core priorities for the forthcoming planning cycle, also
included in the NHS 10-Point Plan (Priority 9).

In 2008/09, the Provincial Pharmaceutical Supply Depot
has shown a trading surplus of R 38 893 million. This has
mainly been due to the effect of increased trading activities
resulting in an annual turn-over of R 1 264 billion - an
increase of 12.1% over the previous year.

There has been a 10% stock-out rate of EDL medicines
during the 2nd quarter of 2009/10 due to financial
constraints, companies not being able to supply sufficient
stock, and intuitions depleting their buffer stockholdings
resulting in emergency orders. This places an additional
burden on the PPSD to carry extra stock to avoid stock-
out’s occurring at a facility level (both EDL and ARV
medicines).

The Provincial Pharmaceutical Supply Depot (PPSD) is
able to maintain a buffer stock of 10% (average
stockholding of R100 million and average issues of R90
million).

The current PPSD Building has reached capacity and no
additional clinics can be added to the direct distribution
system. This seriously affects service delivery as PPSD is
constantly presented with requests to take on additional
demands.

The PPSD has several infrastructural challenges that will
be addressed with construction of the new building. The
challenges include the maintenance of a constant optimal
temperature, packing facilities for distribution and receiving
of stock, adequate size warehouse and administration
office space, and the pre-packing of medicines under
conditions compliant with legislation as defined in Good
Manufacturing Practice Regulations.

The Centralised Chronic Medication Dispensing Unit
(CCMDU), a pilot project to improve efficiency, is currently
being evaluated for roll-out in the Province. The pilot
project, in eThekwini, has 120 service points including PHC
clinics (both provincial and municipal), psychiatric clinics,
old age homes, places of safety and special homes. The
feasibility study, done by MSH/SPS, recommended that
medicines can be collected by patients from nurse run PHC
clinics, pharmacy assistants at PHC clinics or at private
sector pharmacies.

A Public Private Partnership (PPP) can be considered to
manage the project at a Provincial level. Existing
infrastructure can be utilised (including PPSD courier
services) which would maximise efficiency if the CCMDU is
located on the same premises as both the Depot and the
Central Tablet Repacking Unit) although new dispensing
software would be required. The benefits of this project
include point of collection services, improved patient
information and defaulter tracking, improved response to
Strategic Plan 2010 - 2014

acute medication needs, and improved monitoring and evaluation. A review of the pilot project revealed client satisfaction, hospital pharmacy decongestion and improved controls.

Additional benefits would include reducing of dispensing workload at hospital pharmacies, creating capacity at hospital pharmacies to improve the pharmaceutical services, better working conditions at hospital pharmacies, and better service and identification for follow-up of defaulters.

Challenges identified during Strategic Planning Workshops

- The current pharmaceutical warehouse premises failed to acquire a license from the Medicine Control Council (MCC) to operate as a pharmaceutical warehouse due to the lack of temperature control.
- Inadequate warehouse space for storage, packing and distribution of medicines.
- The Central Tablet Repacking Unit (CTRU) is operating under conditions that are not compliant with Good Manufacturing Practices.
- Poor medicine management, security and controls leading to leakages with consequent increase in costs and stock-outs at facility level.

7.3. PROVINCIAL PRIORITIES

Priority 1: Ensure compliance with Pharmaceutical legislative requirements.

1.1 Inclusion of service delivery imperatives in the STP, HRP and Infrastructure Plan to ensure effective long-term planning in line with service delivery needs and legislative requirements.

1.2 Improve compliance with Good Manufacturing Practice Regulations and SAPC standards.

Priority 2: Improve the efficiency of Pharmaceutical Services.

2.1 Improve availability of medicines through improved medicine supply management systems (including competencies and skills for medicine management) at PPSD and facility level.

2.2 Roll-out of the Centralised Chronic Medication Dispensing Unit (CCMDU) to improve controls, patient satisfaction and reduce patient waiting times.

2.3 Enhance quality through enhanced patient care, improved medicine safety, adherence to policies, guidelines, norms and standards and improved supervision, monitoring and evaluation.

2.4 Reduce tracer medicine stock-out rate to <1% by 2014.
<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Strategic Objective</th>
<th>Objective Statement</th>
<th>Rationale</th>
<th>Indicator</th>
<th>Baseline</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Goal 1</td>
<td>NHS Priority 9</td>
<td>Improved compliance with Pharmaceutical Regulations and legislation with 80% of pharmacies obtaining A or B grading on inspection by 2014/15 and PPSD being fully compliant with Regulations by 2012/13.</td>
<td>Compliance in accordance with Good Manufacturing Practice Regulations and SAPC standards.</td>
<td>Percentage of Pharmacies compliant with SAPC standards.</td>
<td>New indicator.</td>
<td>80% of Pharmacies obtained A or B grading on inspection by 2014.</td>
</tr>
<tr>
<td>Strategic Goal 2</td>
<td>NHS Priority 9</td>
<td>To improve the effectiveness and efficiency of pharmaceutical services.</td>
<td>Effective management of pharmaceutical services and treatment of patients in line with treatment protocols.</td>
<td>Tracer medicine stock-out rate.</td>
<td>10%</td>
<td>Tracer medicines stock out rate &lt;1% by 2014.</td>
</tr>
</tbody>
</table>
7.5. RISK MANAGEMENT

Table 31: Key Risk Factors

<table>
<thead>
<tr>
<th>Key Risk Factors</th>
<th>Measures to Mitigate Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Infrastructure challenges affecting storage and packing facilities, which in</td>
<td>• Alignment with macro plans e.g. Infrastructure Plan to ensure</td>
</tr>
<tr>
<td>turn compromises security and the efficient handling, safety and efficacy of</td>
<td>adequate provision of facilities.</td>
</tr>
<tr>
<td>pharmaceuticals.</td>
<td>• Evaluation of the Centralised Chronic Medication Dispensing Unit</td>
</tr>
<tr>
<td></td>
<td>(CCMDU) pilot project to improve efficiency to inform roll-out.</td>
</tr>
<tr>
<td>2. Financial constraints.</td>
<td>• Improved management and controls.</td>
</tr>
<tr>
<td>3. Inadequate human resources with very high vacancy rate for Pharmacists.</td>
<td>• Recruitment and retention strategy.</td>
</tr>
<tr>
<td></td>
<td>• Mid-level Worker training - Pharmacy Assistants.</td>
</tr>
</tbody>
</table>

7.6. RESOURCE CONSIDERATIONS

7.6.1 Expenditure Trends in Programme 7

Operating costs increased by 8.7% which was mainly due to increased inventory purchases, administrative expenditure of 18.78% and operating costs.

See the following graph for budget allocation versus expenditure.

**Graph 47: Programme 7 Budget versus Expenditure**

![Graph showing budget vs expenditure]

Funding in 2010/11 was reduced owing to paucity of funds and the limited storage space currently available. This will be reviewed for outer years pending capacity in PPSD taking into consideration the increased demand for medicines. The growth after 2010/11 is in line with inflation.

7.6.2 Unfunded Priorities

Roll-out of the Centralised Chronic Medication Dispensing Unit (CCMDU) pilot project to improve efficiency.

7.6.3 Trends in supply of key health personnel

The vacancy rate for Pharmacists increased from 75.4% in 2008/09 to 76.96% in 2009/10, and the turn-over rate increased from 25.9% in 2007/08 to 38.4% in 2008/09. There is a severe shortfall between the number of Pharmacists graduating annually and the demand from both public and private sectors.

There is an urgent need for an intense recruitment and retention strategy to increase the workforce in direct response to health needs. This is especially pertinent for hospitals where service delivery is compromised due to shortage of Pharmacists and Pharmacy Assistants.

The shortage also has negative consequences for health outcomes, performance against long-term targets and achievement of the MDG’s.
Table 32: Summary of Payments and Estimates – Programme 7: Health Care Support Services

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
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<tbody>
<tr>
<td></td>
<td>Medicines trading account</td>
<td>29 560</td>
<td>12 649</td>
<td>34 209</td>
<td>27 528</td>
<td>27 528</td>
<td>10 764</td>
<td>13 971</td>
<td>15 170</td>
<td>16 080</td>
<td>17 045</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>29 560</td>
<td>12 649</td>
<td>34 209</td>
<td>27 528</td>
<td>27 528</td>
<td>10 764</td>
<td>13 971</td>
<td>15 170</td>
<td>16 080</td>
<td>17 045</td>
</tr>
</tbody>
</table>

Data Source: BAS - Finance Section

Table 33: Summary of Payments and Estimates by Economic Classification – Programme 7: Health Care Support Services

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
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</thead>
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<tr>
<td></td>
<td>Current payments</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Goods and services</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transfers and subsidies to</td>
<td>29 560</td>
<td>12 649</td>
<td>34 130</td>
<td>27 528</td>
<td>27 528</td>
<td>10 764</td>
<td>13 971</td>
<td>15 170</td>
<td>16 080</td>
<td>17 045</td>
</tr>
<tr>
<td></td>
<td>Departmental agencies and accounts</td>
<td>29 560</td>
<td>12 649</td>
<td>34 130</td>
<td>27 528</td>
<td>27 528</td>
<td>10 764</td>
<td>13 971</td>
<td>15 170</td>
<td>16 080</td>
<td>17 045</td>
</tr>
<tr>
<td></td>
<td>Total economic classification</td>
<td>29 560</td>
<td>12 649</td>
<td>34 209</td>
<td>27 528</td>
<td>27 528</td>
<td>10 764</td>
<td>13 971</td>
<td>15 170</td>
<td>16 080</td>
<td>17 045</td>
</tr>
</tbody>
</table>

Data Source: BAS - Finance Section
PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

8.1. PROGRAMME PURPOSE
Programme 8 consists of six Sub-Programmes. The purpose of the Programme is to deliver new health facilities, and to rehabilitate, upgrade and maintain existing health facilities. This includes the provisioning of additional PHC facilities, to ensure improved access to health services in the under-served areas and the provision of major medical equipment.

8.2. SITUATION ANALYSIS
The current Infrastructure Plan is not fully aligned with service delivery imperatives resulting in an increasing gap between translation of policy and other service delivery priorities and adequate infrastructure. An example in case would be the inadequate infrastructure provision for implementation of the Mental Health Care Act (seclusion rooms) and inadequate warehousing facilities for Pharmaceutical services. Staff accommodation, regularly raised as one of the reasons for poor recruitment and retention of staff, also remains a challenge.

There have been numerous problems associated with implementing agents in relation to Revitalisation Projects. These delays have increased costs to the Department when several projects having over-run.

The laundry services of the Department were last upgraded/ refurbished 21 years ago and the maintenance of the old/ inadequate infrastructure has risen dramatically to the point that it is no longer cost effective to retain these services. Upgrade of facilities has been placed on hold until 2010/11 due to cost containment measures.

The inadequate staff accommodation at rural and deep rural hospitals has often been cited as the reason for hospitals who have failed to retain scarce skills. The Revitalisation criteria however clearly state that staff accommodation is not a priority within the Revitalisation programme and therefore this should be funded from the equitable share.

Graph 48 indicates the expenditure by Infrastructure in terms of the Equitable Share, Infrastructure, Coroner's and the Revitalisation Conditional Grants.

Graph 48: Equitable Share compared to Infrastructure Grant, Coroner's Grant and the Revitalisation Grant.

The above graph clearly shows what the Department has been spending in relation to Capital Expenditure during the previous years with a notable increase between 2005/06 and 2006/07.

During 2006/07 and 2007/08 both the Infrastructure and Revitalisation Grants was increased. With the economic downturn in 2007/08, over-expenditure occurred resulting in superficial cost containment measures being implemented in 2008/09 with the knock on effect that equitable spending on capital was reduced.

The Coroner’s Grant only came into effect in 2007/08 when the Department of Health took over the mortuary services from the SAPS.
Challenges identified during Strategic Planning Workshops

- Infrastructure projects not aligned with service delivery needs i.e.
  - Inadequate provision for rendering of essential services e.g. VCT & PMTCT.
  - Inadequate seclusion facilities for implementation of the Mental Health Care Act;
  - Pharmaceutical Warehouse not compliant with legislative requirements;
  - Completed buildings not commissioned due to poor alignment with HR, etc. resulting in waste of resources.
- Extensive delays in finalising projects resulting in under-expenditure and waste of resources.

8.3. PROVINCIAL PRIORITIES

Priority 1: Infrastructure investment optimisation

1.1 Implementing a Service Delivery Improvement Model to reform the delivery of infrastructure by:

- Improved management of the infrastructure portfolio, decision-making and technical oversight.
- Building capacity internally.
- Focussed planning to align infrastructure development, budgets and organisational readiness at commission stage.
- Improved participative management relations with Infrastructure Implementing Agents.
- The Infrastructure Programme Implementation Plan will be aligned with the STP as one of the 10 components – aligned with the NHS 10-Point Plan.
- Provisions for alignment with the National Infrastructure Strategy “Shock Treatment Plan”. This will be finalised once received from the National Department of Health.

Priority 2: To create enabling environment to support service delivery

2.1 To upgrade and renovate existing clinical infrastructure in accordance with the STP and service delivery needs. Special focus will be on provisioning of clinical infrastructure considered as priorities for the forthcoming planning cycle.

2.2 Provisioning of Property Management/ Real Estate services including the acquisition of properties including vacant land for building purposes.
### STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES PROGRAMME

#### Table 34: Strategic Objectives & Expected Outcomes 2010/11 – 2014/15

<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Strategic Objective</th>
<th>Objective Statement</th>
<th>Rationale</th>
<th>Indicator</th>
<th>Baseline</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Goal 1 NHS Priority 6</td>
<td>To deliver new clinical infrastructure in line with the STP and approved Infrastructure Programme Implementation Plan (IPIP).</td>
<td>Alignment of long-term plans to ensure effective utilisation of resources and provisioning of infrastructure for service delivery.</td>
<td>Enhanced implementation of infrastructure preventive maintenance plans and construction, and revitalisation and upgrading projects in line with STP imperatives and national priorities.</td>
<td>Infrastructure Programme Implementation Plan</td>
<td>IPIP not aligned with STP and National Infrastructure Plan</td>
<td>Fully aligned IPIP</td>
</tr>
<tr>
<td>Strategic Goal 1 NHS Priority 6</td>
<td>To upgrade and renovate existing clinical infrastructure in accordance with the STP and approved IPIP.</td>
<td></td>
<td>Number of upgrade and renovation projects fully commissioned</td>
<td>New indicator</td>
<td></td>
<td>89 Projects fully commissioned by 2014/15.</td>
</tr>
<tr>
<td>Strategic Goal 1 NHS Priority 6</td>
<td>To undertake the acquisition of properties including vacant land for building purposes.</td>
<td></td>
<td>Implementation Plan to optimise Departmental accommodation needs</td>
<td>New indicator</td>
<td></td>
<td>Plan implemented</td>
</tr>
</tbody>
</table>
8.5. **RISK MANAGEMENT**

<table>
<thead>
<tr>
<th>Key Risk Factors</th>
<th>Measures to Mitigate Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Supply Chain Management: Ineffective procurement processes taking in excess of 24 months resulting in completed buildings not being fully commissioned due to lack of equipment.</td>
<td>▪ Alignment of IPIP with the STP and attached components.</td>
</tr>
<tr>
<td>2. Implementation Agent Agreements and non-performance of Implementation Agents continue to delay projects with huge cost implications and under-expenditure.</td>
<td>▪ Consider PPP’s as part of the development and approval of the new IPIP.</td>
</tr>
<tr>
<td>3. Non-employment of critical staff contribute an approximate R 870 000 per month under-expenditure. The Revitalisation posts (14 critical posts) can be funded from Revitalisation funding for up to two years. The Department has, however, not permitted these posts to be filled due to the current over-expenditure.</td>
<td>▪ Unfreezing of critical posts to ensure effective management of projects.</td>
</tr>
<tr>
<td>4. Implementation of Hospital Information System has been delayed due to protracted negotiations over the agreement. This is causing an under-expenditure of approximately R 800 000 per month.</td>
<td>▪ STP will be finalised in 2010 – IPIP aligned.</td>
</tr>
<tr>
<td>5. Delay in finalisation of the STP with consequent delays in alignment of IPIP to ensure appropriate response to service delivery needs.</td>
<td></td>
</tr>
</tbody>
</table>
8.6. RESOURCE CONSIDERATIONS

8.6.1 Expenditure Trends in Programme 8

The increased trend is largely as a result of a drive to improve and maintain infrastructure in the department. The significant increase over the last 7 years has been funded by increasing amounts of both conditional grant funding, especially the Hospital revitalisation Grant and the Infrastructure Grant as well as equitable share.

The under expenditure in the 2008/09 Estimated Actual relates to enforced savings against the Departments’ equitable share, which has been necessary to limit the Departments’ over-expenditure.

The over-expenditure in the 2009/10 Revised Estimate includes under-funding of approximately R112 million in respect of the Forensic Pathology Services Conditional Grant as well as projects that were already on site, which could not be stopped without further costs to the department. A building plan for mortuaries was agreed to with the National Department of Health in 2007/08, which was not adequately funded in the Conditional Grant allocations for 2008/09 and 2009/10.

Under-expenditure of approximately R200 million for the Hospital Revitalisation Grant due to challenges with the tender process is also included in the Revised Estimate.

Due to the Departments’ commitment to the Cabinet-approved Provincial Recovery Plan, as well as under-funding in the main service delivery programmes, it was necessary to re-prioritise an amount of R282 million from Programme 8: Facilities Management in 2010/11, as well as carry-through costs for 2011/12 and 2012/13, to the service delivery programmes in the 2010/11 MTEF.

The significant growth in the two infrastructure conditional grants, namely the Hospital Revitalisation Grant and the Infrastructure Grant to Provinces, relates primarily to the intensive drive to improve the physical health facilities within the province.

The R200 million projected saving within the Hospital Revitalisation Grant in the 2009/10 Revised Estimate is mainly due to challenges experienced with the tender process. Approval is being sought from National Treasury and the Department of National Health for amendments to the Business Plan, for the under-expenditure on this grant to be utilised on other projects within the grant before the end of 2009/10. Both of these grants have been increased substantially in the 2010/11 MTEF period, in line with the above drive.

The 2010/11 priority projects must still be finalised. EMS and the Nursing Colleges facilities will be considered a priority.

8.6.2 Trends in supply of key health personnel

No addition to narrative
### Table 36: Summary of Payments and Estimates – Programme 8: Health Facilities Management

<table>
<thead>
<tr>
<th></th>
<th>Outcome</th>
<th>Main Appropriation</th>
<th>Adjusted Appropriation</th>
<th>Revised Estimate</th>
<th>Medium-Term Estimates</th>
<th>Outer-Year Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Facilities</td>
<td>164 980</td>
<td>240 029</td>
<td>280 625</td>
<td>254 241</td>
<td>407 009</td>
<td>538 731</td>
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<tr>
<td>District Hospitals</td>
<td>330 874</td>
<td>521 236</td>
<td>615 946</td>
<td>661 604</td>
<td>386 493</td>
<td>431 472</td>
</tr>
<tr>
<td>EMS</td>
<td>8 296</td>
<td>8 817</td>
<td>4 734</td>
<td>28 465</td>
<td>4 281</td>
<td>4 384</td>
</tr>
<tr>
<td>Provincial Hospitals</td>
<td>250 336</td>
<td>158 455</td>
<td>111 763</td>
<td>259 239</td>
<td>447 134</td>
<td>316 842</td>
</tr>
<tr>
<td>Central Hospitals</td>
<td>17 610</td>
<td>12 001</td>
<td>15 401</td>
<td>26 209</td>
<td>171 523</td>
<td>18 210</td>
</tr>
<tr>
<td>Other facilities</td>
<td>41 112</td>
<td>152 269</td>
<td>75 089</td>
<td>147 465</td>
<td>111 703</td>
<td>134 362</td>
</tr>
<tr>
<td>Total</td>
<td>813 208</td>
<td>1 092 807</td>
<td>1 103 558</td>
<td>1 377 223</td>
<td>1 377 189</td>
<td>1 446 244</td>
</tr>
</tbody>
</table>

Data Source: BAS - Finance Section

### Table 37: Summary of Payments and Estimates by Economic Classification – Programme 8: Health Facilities Management

<table>
<thead>
<tr>
<th></th>
<th>Outcome</th>
<th>Main Appropriation</th>
<th>Adjusted Appropriation</th>
<th>Revised Estimate</th>
<th>Medium-Term Estimates</th>
<th>Outer-Year Projection</th>
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</thead>
<tbody>
<tr>
<td>Current payments</td>
<td>214 653</td>
<td>356 171</td>
<td>338 010</td>
<td>479 918</td>
<td>325 468</td>
<td>308 708</td>
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<tr>
<td>Compensation of employees</td>
<td>1 140</td>
<td>5 510</td>
<td>5 216</td>
<td>4 734</td>
<td>3 459</td>
<td>5 104</td>
</tr>
<tr>
<td>Goods and services</td>
<td>214 653</td>
<td>332 500</td>
<td>474 702</td>
<td>322 005</td>
<td>305 249</td>
<td>332 197</td>
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<tr>
<td>Transfers and subsidies to households</td>
<td>-</td>
<td>-</td>
<td>326</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Payments for capital assets</td>
<td>598 555</td>
<td>736 636</td>
<td>765 222</td>
<td>897 305</td>
<td>1 051 721</td>
<td>1 137 536</td>
</tr>
<tr>
<td>Buildings and other fixed structures</td>
<td>549 365</td>
<td>621 725</td>
<td>635 339</td>
<td>752 743</td>
<td>943 652</td>
<td>1 030 816</td>
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<tr>
<td>Machinery and equipment</td>
<td>49 189</td>
<td>97 783</td>
<td>129 883</td>
<td>144 562</td>
<td>108 069</td>
<td>106 720</td>
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<tr>
<td>Software and other intangible assets</td>
<td>-</td>
<td>17 128</td>
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<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total economic classification</td>
<td>813 208</td>
<td>1 092 807</td>
<td>1 103 558</td>
<td>1 377 223</td>
<td>1 377 189</td>
<td>1 446 244</td>
</tr>
</tbody>
</table>

Data Source: BAS - Finance Section
Map 1: Age and Gender Structure in KwaZulu-Natal

Map 2: Population Density in KwaZulu-Natal

From KZN Provincial Government Five Year Report 2004-2009; Office of the Premier KZN
Map 4: Poverty Profile per Municipality

Map 4: People living below the poverty line
Map 7: KwaZulu-Natal Health Profile
**ABBREVIATIONS / ACRONYMS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABET</td>
<td>Adult Basic Education and Training</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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