Mpumalanga Department of Health

ANNUAL PERFORMANCE PLAN FOR 2012/13

MPUMALANGA
A Pioneering Spirit

Date of Tabling

02 April 2012

health
Department:
Health
MPUMALANGA PROVINCE

MPUMALANGA DEPARTMENT OF HEALTH
ANNUAL PERFORMANCE PLAN
2012/2013 TO 2014/2015

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ACRONYMS	
AIDS	Acquired Immune Deficiency Syndrome
ALOS	Average Length of Stay
APP	Annual Performance Plan
ART	Antiretroviral Treatment
AZT	Zidovudine
BANC	Basic Antenatal Care
BAS	Basic Accounting System
BOD	Burden of Disease
BOR	Bed Occupancy Rate
CDC	Community Day Centre
CEO	Chief Executive Officer
CFM	Clinical Forensic Medicine
CFO	Chief Financial Officer
CHC	Community Health Centre
CHWs	Community Health Workers
CPIX	Consumer Price Index
CTOP	Choice of Termination of Pregnancy
DHC	District Health Council
DHER	District Health Expenditure Review
DHS	District Health Services
DHIS	District Health Information System
DOH	Department of Health
DORA	Division of Revenue Act
DOTS	Directly Observed Treatment Sort Course
DPC	Disease Prevention and Control
DPWR&T	Department of Public Works, Roads and Transport
DR	Drug Resistant
ETR.net	Electronic TB Register
EDL	Essential Drug List
EMS	Emergency Medical Services
FPS	Forensic Pathology Services
HAART	Highly Active Antiretroviral Therapy
HAST	HIV & AIDS, STI and TB Control
HBC	Home Based Care
HCSS	Health Care Support Services
HCT	HIV Counselling and Testing
HFM	Health Facilities Management
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
HOD	Head of Department
HPCSA	Health Professions Council of South Africa
HPTDG	Health Professional Training and Development Grant

ACRONYMS	
HR	Human Resources
HRD	Human Resource Development
HRM	Human Resource Management
HST	Health Sciences and Training
HTA	High Transmission Area
IDP	Integrated Development Plan
IHPF	Integrated Health Planning Framework
ICT	Information, Communication Technology
IMCI	Integrated Management of Childhood Illnesses
IT	Information Technology
IPT	Isoniazid Preventive Therapy
KZN	Kwazulu-Natal
LAN	Local Area Network
MCWH&N	Maternal, Child, Women's Health and Nutrition
MDGs	Millennium Development Goals
MDR	Multi-drug Resistant
MEC	Minister of Executive Council
MESH	Management Economic Social and Human Resource
MISP	Master Information Systems Plan
MMC	Male Medical Circumcision
MOP	Medical Orthotic and Prosthetic
MTEF	Medium-term Expenditure Framework
MTSF	Medium-term Strategic Framework
NDOH	National Department of Health
NGO	Non-governmental Organisation
NHA	National Health Act
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NHS	National Health Systems
NIMART	Nurse Initiating & Management of Antiretroviral Therapy
NPO	Non-profit Organisation
NSDA	Negotiated Service Delivery Agreement
NTSG	National Tertiary Services Grant
NVP	Nevirapine
OPD	Outpatient Department
OSD	Occupational Specific Dispensation
PAAB	Patient Administration and Billing System
PCR	Polymerase Chain Reaction (a laboratory HIV detection Test)
PCV	Pneumococcal Vaccine
PDE	Patient Day Equivalent
PDOH	Provincial Department of Health
PDMS	Performance Development and Management System
PEP	Post Exposure Prophylaxis

ACRONYMS	
PFMA	Public Finance Management Act
PHC	Primary Health Care
PHS	Provincial Hospital Services
PMTCT	Prevention of mother-to-child Transmission
PPP	Public/Private Partnership
PPT	Planned Patient Transport
PTB	Pulmonary Tuberculosis
QIP	Quality Improvement Plan
QPR	Quarterly Performance Report
RSA	Republic of South Africa
RTC	Regional Training Centre
RV	Rota Virus
SADHS	South African Demographic Health Survey
SALGA	South African Local Government Agency
SLA	Service Level Agreement
SMS	Senior Management Service
SQL	Structured Queried Language
STATS SA	Statistics South Africa
STC	Step Down Care
STP	Service Transformation Plan
TB	Tuberculosis
THS	Tertiary Hospital Services
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

1. INTRODUCTION

POLITICAL AND LEGISLATIVE MANDATES

ALIGNMENT WITH GOVERNMENT STRATEGIC PRIORITIES

The production of the Annual Performance Plan (APP) for each financial year, is a legal requirement in terms of the National Health Act (NHA) of 2003. Section 25 (3) of the NHA of 2003 requires the Head of the Provincial Department of Health to "prepare health plans annually and submit to the Director General for approval". Also, Section 25 (4) of the NHA of 2003 stipulates that "provincial health plans must conform with national health policy".

In the light of the above, the strategic direction for the Mpumalanga Department of Health for 2012/13 is derived from the following:

- Medium Term Strategic Framework, 2009 – 2014
- State of the Nation Address and State of the Province Address, 2011
- National Health System Priorities (Health Sector 10 Point Plan), 2009 – 2014
- Health Sector Negotiated Service Delivery Agreement
- Strategic Plan for Mpumalanga Department of Health, 2009 – 2014

2. BACKGROUND TO THE ANNUAL PERFORMANCE PLAN OF THE DEPARTMENT

The Annual Performance Plan of the Mpumalanga Department of Health is developed from the customised Health Sector format "*Format for Annual Performance Plans of Provincial Health Departments*" which was adapted from the generic format from National Treasury in 2009.

It is divided into the following three parts:

- **Part A** which reviews the recent developments in the operational environment and links the annual budget to the achievement of strategic goals and objectives set out.
- **Part B** provides the detailed planning of individual budget programmes and sub-programmes, specifying annual- and MTEF performance targets for both strategic objectives and programme performance indicators.
- **Part C** considers details of budgets for infrastructure and other capital projects and any planned changes to conditional grants, public entities and public-private partnerships.
- It also covers any changes to the Strategic Plan where the department has decided not to issue a completely new plan and provides technical indicator descriptions (**Annexure E)** of each indicator used in the APP as required by Treasury Guidelines.

3.1 FOREWORD BY THE MEC FOR HEALTH

The provision of health care remains a second highest priority of government as agreed and outlined by the ruling party. With 18 years into democracy, significant strides have been made towards improving the health of our people.

This Annual Performance Plan gives account of the performance assessment of the department of Health in Mpumalanga against health priorities as pronounced by the government. The plan provides critical alignment of the four key outputs of the health outcome as outlined in the service delivery agreement signed with the Premier. Most importantly, the plan provides a shape of future direction in which the department will improve the delivery of health outcome in the province.

It is envisaged that the coming year, health care delivery will not be the same again since the roll out of National Health Insurance will be the key policy direction to improving the health of our people. The provision of health care is a human right issue for which all people of the country should enjoy. The implementation of the NHI will cover the comprehensive health package such as the establishment of the district health specialists units, establish and roll out the municipal ward-system. This process will allow the department to expand its consultation and improve community participation in the provision of health care.

The province is recorded as the second highest in the country in terms of the high prevalence of HIV and AIDS. This annual performance plan will focus on the key strategies and plans to deal with these challenges of HIV and AIDS in the province. The roll out of the Provincial Strategic Plan of HIV and AIDS by MPAC, will bring hope in the management of the scourge of this disease.

Our policies and priorities will address the aspirations and admirations of all our people and ensure that they all live healthier in the years to come. This plan is a mirror and window through which the provision of health care to the people of Mpumalanga will be evident.

Dr. R C Mkasi, MPL

MEC: DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT

DATE: 15 FEBRUARY 2012

3.2 STATEMEMENT BY THE ACTING HEAD OF DEPARTMENT (ACCOUNTING OFFICER)

The health sector has for the past two years outlined the four key outputs which are aligned to health outcome "**A long and healthy lifestyle for all South Africans".** These priorities are the importance and integral departing point to deliver the health care to the majority of our population whom depend largely on the public health system.

This Annual Performance Plan for 2012/2013 has taken into cognisance the key priorities and outputs of the health sector as negotiated and agreed upon with the Minister of Health. More importantly, the plan also provides a synopsis of performance assessment of the department of health for the past few years. Critical milestones towards achieving full compliance against the six priority areas such as **staff attitude, drug supply, patient care and safety, infection control and prevention, long waiting period as well as cleanliness** has also been realised. All 278 PHC facilities and 33 hospitals have developed the quality improvement plans which will also be rolled out within the medium term expenditure framework.

The plan provides detail account of the realistic indicators and targets within which these six priority areas will be carried out in the 2012/2013 financial year. The plan explicitly outlined the much aligned Performance indicators and targets against the following four key outputs:

- **Increasing Life Expectancy**
- **Decreasing Maternal and Child Mortality**
- **Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis**
- **Strengthening Health System Effectiveness**

Amongst all the health sector priorities, more focus will be the piloting of the national health insurance within one district in the province. This key priority is line with the strengthening of health system effectiveness which will give effect to the provision of essential health care to the people. In order to realise this objective, Primary Health Care re-engineering as the central part of the health system will be fully implemented in this financial year. The department will establish Primary Health Care outreach teams, roll out school health programmes and establish the district specialist services.

To deal with the scourge of HIV and AIDS including TB, the department will implement the Provincial Strategic Plan for HIV and AIDS which has been approved during 2011/2012. The Annual Performance Plan outlines all the key indicators and targets such as increasing the medical male circumcisions to 50 000, increase the number of patients on antiretroviral treatment to 172 855 and increase number of medical sites offering HCT to 65.

The department will improve access to health facilities through delivering a number of community health centres and clinics in this financial year. The Annual Performance Plan gives detailed targets of a number of these facilities amongst which are the targeted CRDP areas in the province. This plan is a culmination of an extensive consultation process with various stakeholders and partners as outlined in our Service Delivery Agreements.

In conclusion, I will therefore wish to appreciate the MEC for providing strategic and policy direction to which the department should focus on for the coming Medium Term Expenditure period as a result this plan has been developed with well informed strategies and targets.

MR. M R MNISI

DATE: 15 FEBRUARY 2012

3.3 OFFICIAL SIGN OFF OF PROVINCIAL ANNUAL PERFORMANCE PLAN BY THE CHIEF FINANCIAL OFFICER, HEAD OF STRATEGIC PLANNING, HEAD OF DEPARTMENT AND MEC FOR HEALTH

It is hereby certified that this Annual Performance Plan:

- was developed by the **Provincial Department of Health in Mpumalanga**.
- was prepared in line with the current Strategic Plan of the Department of Health of Mpumalanga under the guidance of the **MEC: Department of Health and Social Development, Dr R.C. Mkasi**.
- accurately reflects the performance targets which the **Provincial Department of Health in Mpumalanga** will endeavour to achieve given the resources made available in the budget for 2012/13.

Ms. G Milazi

Chief Financial Officer Signature: GMilazi

Mr. M.T. Matlou

Chief Director: Integrated Health Planning Signature:

Mr. M.R. Mnisi

ACTING HEAD OF DEPARTMENT

APPROVED BY:

.....

Dr. R C Mkasi, MPL

Executive Authority

4. PART A - STRATEGIC OVERVIEW

4.1. VISION

*"**A Healthy Developed Society***".

4.2 MISSION

The Mpumalanga Department of Health is committed to improve the quality of health and well-being of all people of Mpumalanga by providing needs based, people centred, equitable health care delivery system through an integrated network of health care services provided by a cadre of dedicated and well skilled health workers.

4.3 VALUES

- Commitment
- Reliability
- Accountability
- Accessibility
- Affordability
- Appropriateness
- Timeousness
- Empathy
- Collectiveness
- Competency
- Ethical
- Confidentiality
- Integrity
- Honesty

4.4 STRATEGIC GOALS

TABLE A1: STRATEGIC GOALS FOR MPUMALANGA DEPARTMENT OF HEALTH

The four strategic goals for Mpumalanga Department of Health are presented in the following table:

STRATEGIC GOAL		GOAL STATEMENT	EXPECTED OUTCOMES
1	**Increasing Life Expectancy**	Life expectancy increased to 58 years for males and 60 years for females by 2014.	**A Long and Healthy Life for all South Africans**
2	**Decreasing Maternal and Child Mortality**	Maternal Mortality Ratio decreased to 117 per 100 (or less) 000 live births by 2014.	
		Child mortality rate decreased to 6 deaths (or less) per 1 000 live births by 2014.	
3	**Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis**	TB Cure Rate improved to 85% by 2014.	
		All eligible people living with HIV and AIDS have access antiretroviral treatment by 2014.	
		New HIV infections reduced to 50% by 2014.	
4	**Strengthening Health System Effectiveness**	Health System based on a primary health care (PHC) approach with more emphasis on promotive and preventive healthcare.	
		Implementation of the National Health Insurance.	
		Accelerate the delivery and maintenance of physical infrastructure.	

4.5 SITUATION ANALYSIS

4.5.1 Population Profile

Mpumalanga Province is located in the north-eastern part of South Africa and is bordered by two countries i.e. Mozambique to the east and Swaziland to the south-east. Mpumalanga shares common borders with the Limpopo Province to the north, Gauteng Province to the west, Free State Province to the south-west and KwaZulu-Natal to the south east. The Mpumalanga Province has a land surface area of 78,370 km square that represents 6.4% of South Africa's total land area.

Mpumalanga's economy is primary driven by agriculture, mining, manufacturing, tourism and electricity generation. The capital city of Mpumalanga is Nelspruit, which is one of the fastest growing cities in South Africa. Other main towns and their economic activities, include:

- Emalahleni – mining, steel manufacturing, industry, agriculture;
- Middelburg – stainless steel production, agriculture;
- Secunda – power generation, coal processing;
- Mashishing – agriculture, fish farming, mining, tourism;
- Malalane – tourism, sugar production, agriculture; and
- Baberton – mining town, correctional services, farming centre.

The mid-year population estimates released by Statistics South Africa (STATSSA) in July 2011 indicate that Mpumalanga's population grew slightly from 3,617,600 in 2010 to 3,657,181 in 2011. A comparative analysis of population growth between 2004 and 2011 in **Table A1** below, reflects a growth of 5.6% for Mpumalanga Province. Mpumalanga has the sixth largest share of the South African population, constituting approximately 7,23% of the national population of 50,586,757 and distributed across three districts comprising nineteen municipalities.

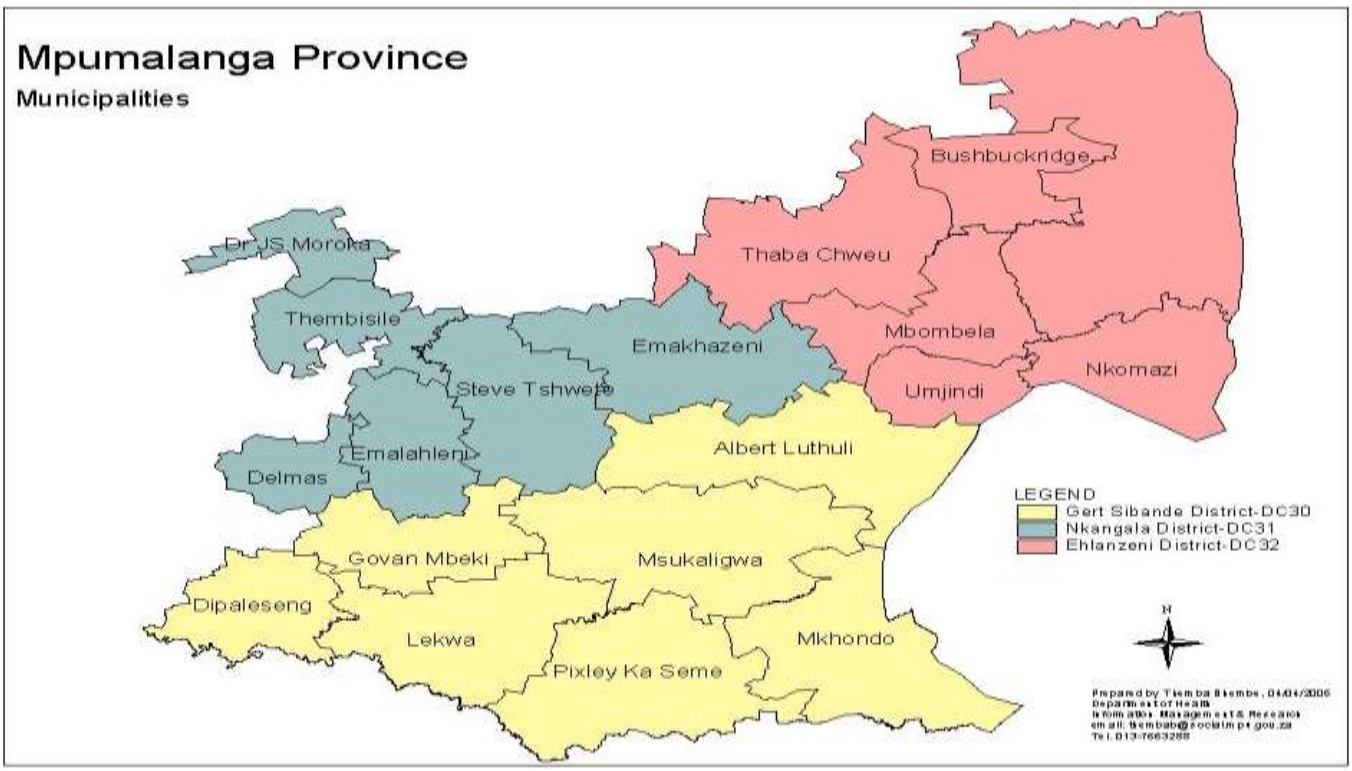
Table 1: Percentage distribution of projected share of total population: 2004 – 2011

Province	2004	% Share	2011	% share	% change
Gauteng	9,577,200	20.5%	11,328,203	22.39%	18.3%
KwaZulu-Natal	9,914,605	21.2%	10,819,130	21,39%	9.1%
Eastern Cape	6,558,090	14.1%	6,829,958	13,50%	4.1%
Western Cape	4,980,573	10.7%	5,287,863	10,45%	6.2%
Limpopo	5,080,831	10.9%	5,554,657	10.98%	9.3%
Mpumalanga	3,464,432	7.4%	3,657,181	7,23%	5.6%
North West	3,293,469	7.1%	3,253,390	6,43%	-1.2%
Free State	2,811,045	6.0%	2,759,644	5,46%	-1.8%
Northern Cape	985,077	2.1%	1,096,731	2,17%	11.3%
South Africa	**46,664,322**	**100.0%**	**50,586,757**	**100.0%**	**6.9%**

(Source: Stats SA Mid-year Population estimates, July 2004 , July 2011)
**The National Department of Health: HISP of February 2010, represents a 2011 population figure of 3,661,849 for Mpumalanga Province*

Mpumalanga is divided into three districts i.e. Ehlanzeni, Nkangala and Gert Sibande with 18 sub-districts as represented in **Figure 1** below.

Figure 1: Mpumalanga Health Districts



***Source**: Mpumalanga Department of Health Information Systems*

4.5.1.1 Demographics in Ehlanzeni District

Ehlanzeni District has a catchment population of 1 578 289 and consists of five sub-districts which are Bushbuckridge, Mbombela, Nkomazi, Thaba Chweu and Umjindi. Nkomazi is further divided into Nkomazi East and West and Mbombela into Mbombela South and North.

There are 120 Primary Health Care Facilities (105 clinics and 15 Community Health Centres), 8 district hospitals, two regional hospitals, one tertiary hospital, two TB specialized hospitals and 28 mobile clinic vehicles which have 981 points.

4.5.1.2 Demographics in Nkangala District

Nkangala District has a catchment population of 1 138 858 and consists of six sub-districts which are Dr JS Moroka, Thembilile, Emalahleni, Emakhazeni, Dr Victor Khanye and Steve Tshwete.

There are 86 Primary Health Care Facilities (68 clinics and 18 Community Health Centres), 7 district hospitals, one tertiary hospital, one TB specialized hospitals and 22 mobile clinic vehicles which have 481 points.

4.5.1.3 Demographics in Gert Sibande District

Gert Sibande District has a catchment population of 944 702 which is less than the other two districts. It consists of seven sub-districts

There are 53 clinics, 5 satellite clinics, 19 Community Health Centres, 8 district hospitals, one regional hospital, two TB specialized hospitals and 25 mobile clinic vehicles which have 1003 points.

Tables 2 and 3 represent the Mpumalanga population per district and sub-district respectively. The next up to date information will be available after Census 2011 has been analysed, verified and published in late 2012 or early 2013.

Table 2: Population by Geographic Distribution (Districts)

District Municipality	Population (Census 2001)	Population (Community Survey 2007)	Population: Mid Year Estimates 2011
Ehlanzeni District Municipality	1 447 053	1 526 236	1 578 289
Gert Sibande District Municipality	900 007	890 699	944 702
Nkangala District Municipality	1 018 826	1 226 500	1 138 858
Total	**3 365 885**	**3 643 435**	**3 661 849**

(Source: Stats SA 2007: Census 2001 and Community Survey 2007, Stats SA November 2009, NDOH/HISP February 2010)

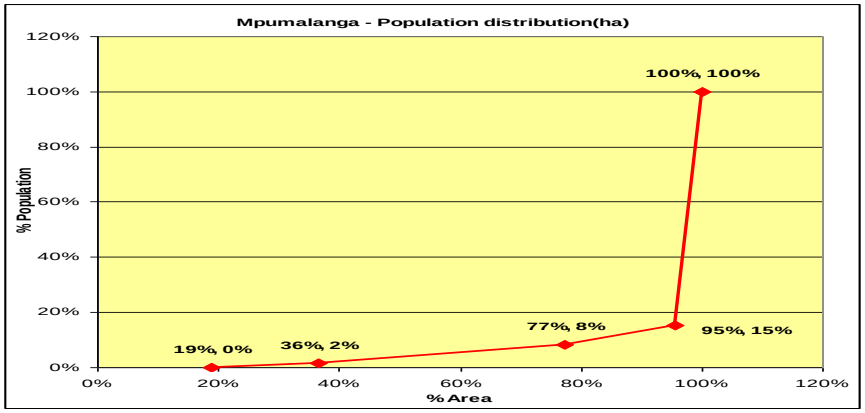
Table 3: Population by Geographic Distribution (Local Municipalities) within the total population per municipality

Local Municipality	Population (Census 2001)	Population (Community Survey 2007)	Population: Mid Year Estimates 2011
Thaba Chweu	81 681	87 545	85,047
Mbombela	476 593	527 203	488,076
Umjindi	53 744	60 475	56,080
Nkomazi	334 420	338 095	338,730
Bushbuckridge	497 958	509 970	610,356
Kruger National Park	2 656	2 948	-
Ehlanzeni	**1 447 053**	**152 6236**	**1 578 289**
Albert Luthuli	187 936	194 083	195 570
Dipaleseng	38 618	37 873	40 940
Govan Mbeki	221 747	268 954	233 768
Lekwa	103 265	91 136	109 108
Mkhondo	142 892	106 452	149 304
Msukaligwa	124 812	126 268	131 311
Pixley Ka Seme	80 737	65 932	84 701
Gert Sibande	**900 007**	**890 699**	**944 702**
Dr JS Moroka	243 313	246 969	270 948
Emakhazeni	43 007	32 840	48 500
Emalahleni	276 413	435 217	310 879
Steve Tshwete	142 772	182 503	160 351
Thembisile	257 113	278 517	284 874
Victor Khanya	56 208	50 455	63 308
Nkangala Total	**1 018 826**	**1 226 500**	**1 138 858**
Mpumalanga Total	**3 365 885**	**3 643 435**	**3 661 849**

(Source: Stats SA 2007: Census 2001 and Community Survey 2007, Stats SA / NDOH/HISP February 2010)

The distribution of population per hectare (population density) provides interesting figures for Mpumalanga, which correlates with the distribution in South Africa. **Figure 2** below, depicts the distribution where it can be seen that 95 % of the population within the Mpumalanga province lives on only 15 % of the land. This is quite expectable, taking into consideration the huge areas that are used for agricultural and forestry as well as the number of active mines in the Mpumalanga Province.

Figure 2: Graphical Presentation of % Population on % Land



(Source: Stats SA Population Estimates)

The following three additional aspects need to be considered:

- Cross boundary and border population;
- Immigrants; and
- Tourism

The population numbers related to the abovementioned aspects are very difficult to determine. It is estimated that there are between 3,000,000 and 10,000,000 immigrants in South Africa. Based on the assumption that the proportion of immigrants will be the same as the population proportion per province, Mpumalanga accommodates approximately 700,000 immigrants. The following table provides an outlay of the projected uninsured population for the province:

Table 4: Total 2014/15 uninsured population to be served including tourism, immigrants, cross border and cross boundary

Population	2008/09	2014/15
Cross Border	100,000	100,000
Cross Boundary	270,000	270,000
Ehlanzeni	1,447,119	1,612,500
Nkangala	1,019,607	1,116,555
Gert Sibande	900,000	986,490
Tourists	500,000	500,000
Immigrants	250,000	250,000
TOTAL	**4,486,726**	**4,835,546**
Less Insured (at 12%)	538,407	580,265
Total uninsured	**3,948,319**	**4,255,280**

The population of 4,2 million of the Mpumalanga Province will be used as the projected 2015 uninsured population for further analysis.

Uninsured Population

Feedback from stakeholders indicates that 88% (3,168,000) of total population in the Mpumalanga Province is uninsured (i.e. does not have medical aid and will make use of public facilities) and rely on the public health sector for health care, placing an excessive burden on the primary health care system. The Integrated Health Planning Framework (IHPF) per National Department of Health uses uninsured/public population of 88%, which correlates with feedback obtained from stakeholders in the province.

4.5.2 Socio-Economic Profile

Mpumalanga is ranked the third most rural province in South Africa with 66% of its total population living in rural areas. The majority of the population resides in the former homelands of Kwa-Ndebele, Kwangwane and Lebowa, areas that have historically lagged behind in terms of development and delivery of basic services such as health and education. Relative to other provinces, Mpumalanga's population base exhibits low economic activity and the poverty rate (with an index of 50.5%) is higher than the national average. It is estimated that approximately 23% of households in the province have no regular source of income.

Table 5 indicates the urban and rural percentage of Mpumalanga Province versus that of South Africa. It is evident that Mpumalanga Province is extremely rural when compared with the rest of the country, which will affect the distribution of health facilities.

Table 5: Urban versus Rural Percentage

Urban / Rural Distribution		
Per Stats SA 2001	**Mpumalanga**	**South Africa**
Rural Percentage	66%	46.3%
Urban Percentage	34%	53.7%

(Source: Stats SA Census 2001)

Table 6 as per Census 2001, estimates the number of persons living in urban versus rural areas in each District of the Mpumalanga Province.

Table 6: Urban / Rural per District

Urban / Rural per District					
District	**Urban**	**%**	**Rural**	**%**	**Total Population**
Ehlanzeni District	244,502	17	1,199,894	83	1,444,396
Nkangala District	502,435	48	551,604	52	1,054,039
Gert Sibande District	415,594	46	484,414	54	900,007
Provincial Total	**1,162,531**	**34**	**2,235,912**	**66**	**3,398,443**

(Source: Stats SA Census 2001)

Census 2001 further indicates that 28.4% of Mpumalanga population aged 20 years and older, received no schooling or formal education. These high levels of illiteracy in the province have implications for health education and health promotion strategies.

Table 7 as per 2007 Community Survey, estimates the unemployment rate per District in Mpumalanga Province. A higher unemployment rate represents a higher the demand on public health care services.

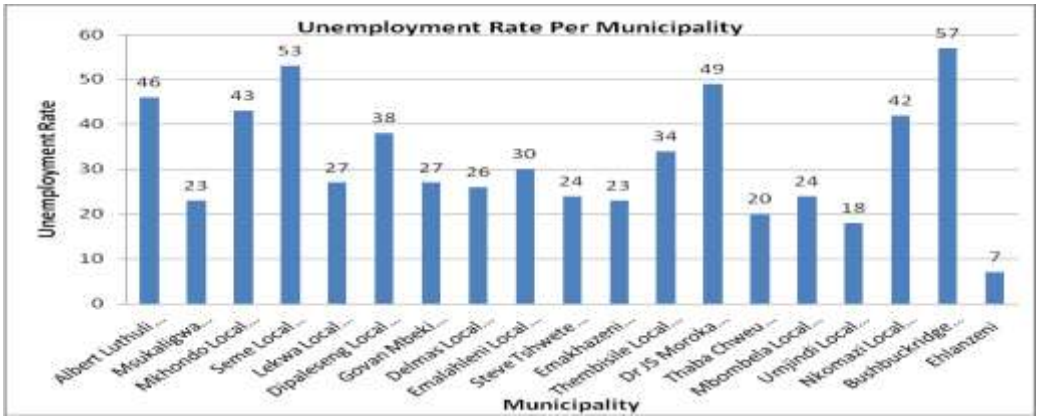
Table 7: Unemployment Rate per District

Unemployment Rate – per district	
Ehlanzeni District	35%
Nkangala District	32%
Gert Sibande District	33%

(Source: Stats SA: Community Survey 2007)

Unemployment remains a major formidable economic challenge with some local authority/magisterial districts recording levels higher than 42% (**Figure 3).** The following municipalities recorded the highest unemployment rates in Census 2001:

Figure 3: Local municipalities with unemployment rate >50%



(Source: Stats SA: Census 2001)

Increased unemployment rates translate directly into poverty. These poverty levels in the province, place a high demand on public health resources. As outlined in the World Health Organisation Commission on Social Determinants of Health, poor people and those from socially disadvantaged groups get sicker and die sooner than people in more privileged social positions. Income poverty is a powerful predictor of health outcomes, but other social factors such as nutrition and diet, housing, education, working conditions, rural versus urban habitat and gender and ethnic discrimination also determine people's chances to be healthy.

Climate change

Climate change is a new threat to public health and to the advances being made by South Africa in achieving the Millennium Development Goals (MDGs) as well as other key service delivery issues. For this reason, climate change needs to be considered a priority area when addressing health inequalities.

Sanitation

The 2007 Community Survey indicates that sanitation has improved between 2001 and 2007. Pit latrine without ventilation and bucket latrines are almost eliminated. More people have access to either flush toilet or pit latrine with ventilation – an estimated 8% is without any form of toilet.

Pipe Water

According to the 2007 Community Survey, 90% of Mpumalanga residents have access to piped water however, despite this the province continues to experience outbreaks of waterborne diseases.

PERFORMANCE DELIVERY ENVIRONMENT

4.5.3 Epidemiological Profile

Like the rest of the country, Mpumalanga Province faces a quadruple Burden of Disease (BoD) consisting of HIV and AIDS and Tuberculosis, high Maternal and Child Mortality, Non-Communicable Diseases as well as violence and injuries.

This quadruple BOD is occurring in the face of a reasonable amount of health expenditure as a proportion of the GDP. Available evidence indicates that South Africa spends 8,7% of its GDP on health which is significantly more than any other country on the African continent however, the health outcomes are much worse than those of countries spending much less than South Africa. The South African health care system has been characterized as fragmented and inequitable due to the huge disparities that exist between the public- and private health sectors with regard to the availability of financial- and human resources, accessibility and delivery of health services.

The inequity in the health system is worsened by the fact that access to health care is unequal with the majority of the population relying on a public health care system which has a disproportionately lower

amount of financial- and human resources, relative to the private sector serving approximately 16% of the population. The distribution of key health professionals between the two sectors is also skewed for example, the doctor patient ratio is as high as 1:4000 in the public sector while it is 1:250 in the private sector. The poor health outcomes can be attributed to a number of factors however, are evidenced through a decline in life expectancy in the country.

4.5.3.1 LIFE EXPECTANCY

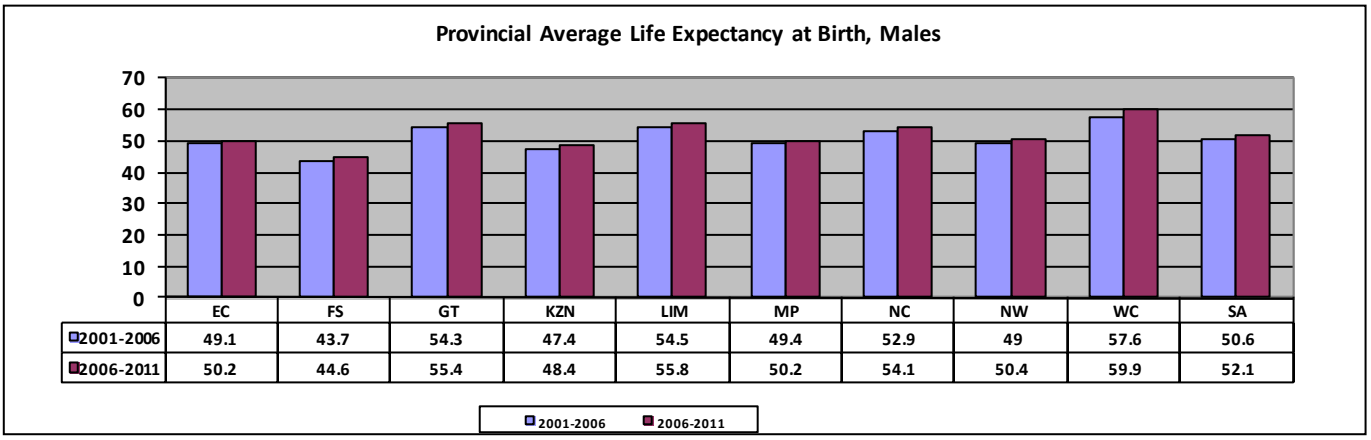
Life expectancy is affected by communicable diseases such as HIV, TB, malaria, respiratory infections and diarrheal diseases; increased maternal and child mortality; non-communicable diseases such as diabetes and cardio vascular diseases as well as trauma-related injuries.

Life expectancy in South Africa has declined. During the period 1985-1994, Statistics SA estimated life expectancy at birth at about 54.12 years for males and 64.38 years for females.

Mpumalanga province is associated with low life expectancy at birth for both sexes. Various socio-economic determinants and the epidemiological profile of the province, directly affects the life expectancy of the citizens of Mpumalanga at birth. The life expectancy at birth is defined as "The average number of new hears newborn babies can be expected to live, based on current health conditions".

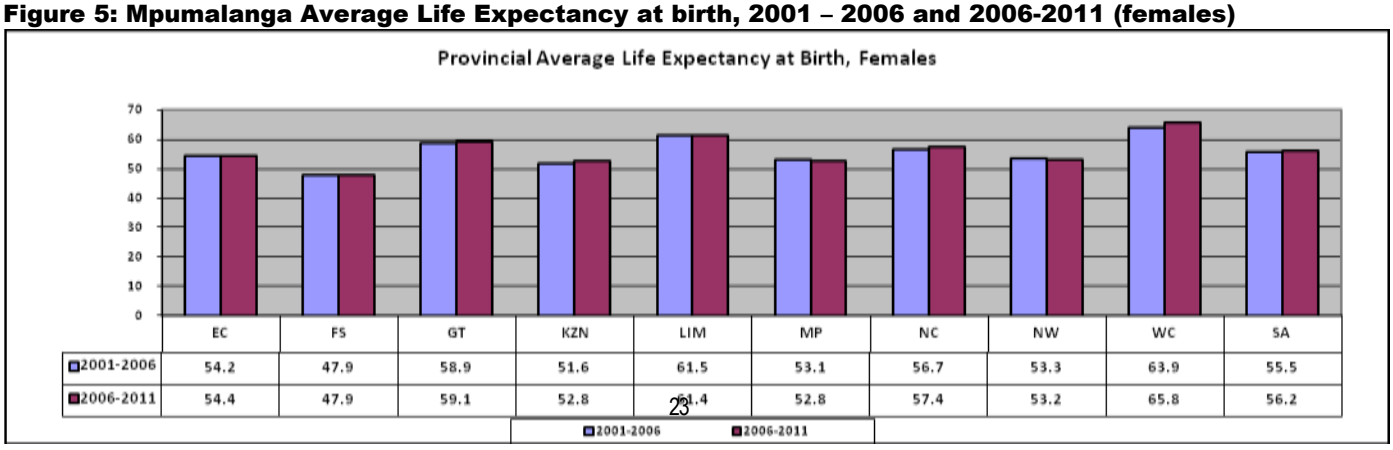
The 2007 Community Survey indicated that life expectancy was 43,6 years for males and 45,3 for females. **Figures 4 and 5** show the average provincial life expectancies at birth for males and females for the periods 2001-2006 and 2006-2011. The assumptions for this projection were that Western Cape has the highest life expectancy at birth for both males and females; while the Free State has the lowest life expectancy at birth. It is assumed that Mpumalanga's life expectancy at birth will increase from 49.4 to 50.2 years for males and decrease from 53.1 to 52.8 years for females.

Figure 4: Mpumalanga Average Life Expectancy at birth, 2001 – 2006 and 2006-2011 (males)



Source: Statistics SA: Mid-year Population Estimates 2011

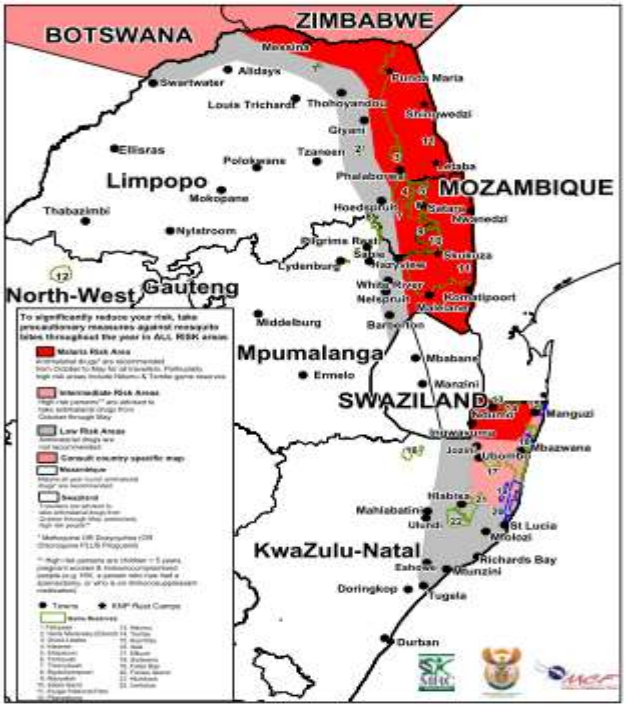
Figure 5: Mpumalanga Average Life Expectancy at birth, 2001 – 2006 and 2006-2011 (females)



Source: Statistics SA: Mid-year Population Estimates 2011

Malaria continues to contribute to the reduction in life expectancy and more than 1 million deaths per annum associated with malaria, occur in Africa of which most deaths are among children under the age of 5 years of age. In South Africa, malaria is mainly transmitted along the border areas shared with Mozambique, Swaziland and Zimbabwe.

Figure 5: Malaria High Risk Areas in South Africa



Source: National Department of Health

Mpumalanga as one of three provinces that is endemic for malaria is progressively doing well on the Management of Malaria. Malaria transmission in Mpumalanga normally occurs in October after the fist rains with high peaks in January and February and waning towards May. One million five hundred and sixty three thousand, eight hundred and fifty seven (1 563 857) of the population is at risk of contracting the disease locally in Ehlanzeni District thus, affecting the five Ehlanzeni municipalities and Kruger National Park. Local malaria transmission is most intense in Kruger National Park areas, Nkomazi and Bushbuckridge Municipalities. The Malaria Control Programme has been actively involved in managing and controlling malaria in Mpumalanga through vector control, outbreak response, disease surveillance, effective malaria information and awareness, malaria case management and regional collaboration with its neighbouring countries (Mozambique and Swaziland).

More than half of women and three quarters of men requiring some intervention for hypertension and diabetes, do not even know they are suffering from these conditions. Only a small percentage of cases of high blood pressure reflect good management of the condition. Late detection results in increased costs and unnecessary suffering and increased risk of death. In order to address this, the department will direct greater effort and resources towards prevention, screening and early detection as well as effective management to improve life expectancy and quality of life.

Some of the factors that contribute to the high burden of non communicable diseases (NCD) are a lack of focused disease prevention programs and interventions, poor health seeking behaviour and late detection of diseases.

4.5.3.2 MATERNAL AND CHILD MORTALITY

According to the MDG Country Report, the maternal mortality ratio in South Africa is estimated at 625 per 100,000 and the perinatal mortality stands at 31.1 deaths per 1000 births, which is much higher than those of countries with similar socio economic development. The vision is to reduce maternal mortality through the implementation of Primary Health Care and a functional referral system as s responsive support system of hospitals.

The Maternal Mortality Ratio in Mpumalanga has decreased from 168.2 (2008) to 156.8 (2009) however, shows an increase again in 2010 with a MMR of 194 per 100 000 live births. The leading causes of maternal mortalities are as follows:

a) Non-pregnancy Related Infections
b) Post Partum Haemorrhage
c) Hypertension
d) Pre-existing Medical Disorders

The First Report of the Committee on Morbidity and Mortality in Children under 5 years (CoMMiC) estimated that over 60,000 South African children between the ages of one month and five years, die each year. The trend in under-5 deaths has shown a recent upswing after years of steady downward tendency.

Due to the fact that children are sensitive to environmental factors, the social determinants of health are a major contributor to morbidity and mortality among children. The availability of water, sanitation, food security and guidance and protection by parents/guardians, determine the survival of this part of the population.

Mpumalanga Province shows a slight decline in child facility mortality rates from 8 per 1000 (2008) to 6.9 per 1000 (2010) however, from 2009 to 2010 a slight increase of 0.45.

The leading causes of death under the 5 year old age group are as follows:

a) Acute Respiratory Infections (ARI)
b) Diarrhoea
c) Septicaemia
d) Severe Malnutrition
e) Tuberculosis

Mpumalanga Province shows a slight decline in infant facility mortality rates from 18.2 (2008) to 9.6 per 1000 (2010) live births however, from 2009 to 2010 there is a slight increase of 0.71. The leading causes of death in the under 1 year old age group are as follows:

a) Prematurity
b) Infections
c) Asphyxia
d) Diarrhoea

4.5.3.3 HIV PREVALENCE

The HIV epidemic in the country has a profound impact on society, the economy as well as the health sector and contributes to a decline in life expectancy, increased infant and child mortality and maternal deaths as well as a negative impact on socio-economic development.

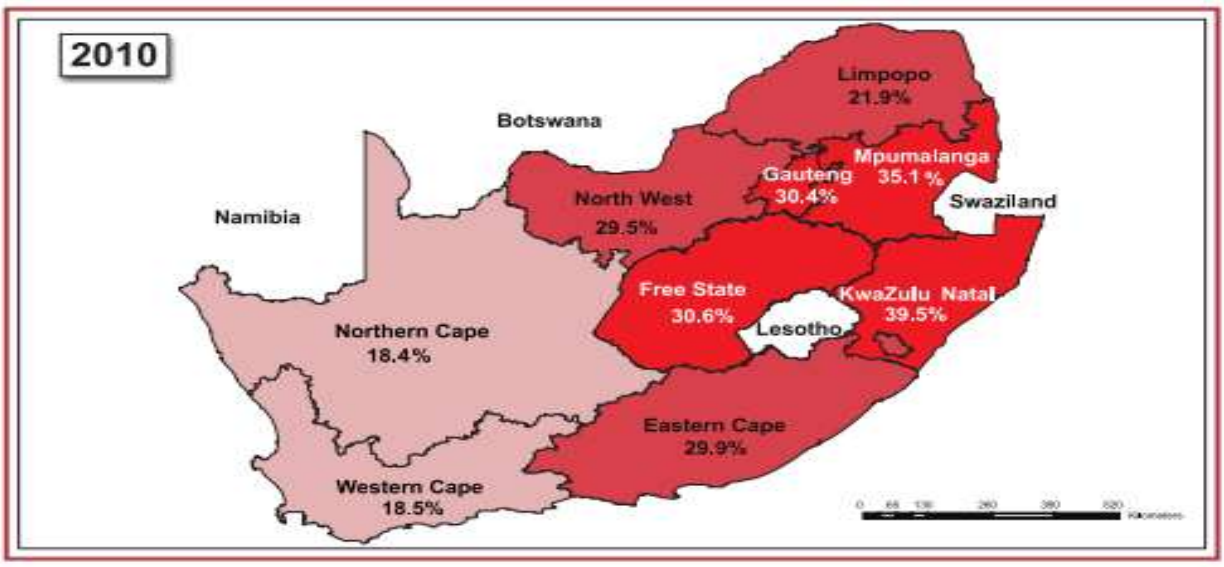
The National Antenatal Sentinel HIV and Syphilis Prevalence Survey which is being conducted annually for the past 21 years, is being used as an instrument to monitor the HIV prevalence trends since 1990. Prevalence usually reflects the burden of HIV on the health care system and changes (increases)

may be the cumulative effect of many factors that may work individually or collectively to drive the epidemic.

HIV Prevalence by Province, 2008 – 2010

The HIV prevalence results show that the highest HIV prevalence rates are located in the Central and Eastern parts of the country, and the lowest prevalence in the Western Cape and Northern Cape (Figure 6).

Figure 6: HIV prevalence by Province, South Africa, 2008 - 2010

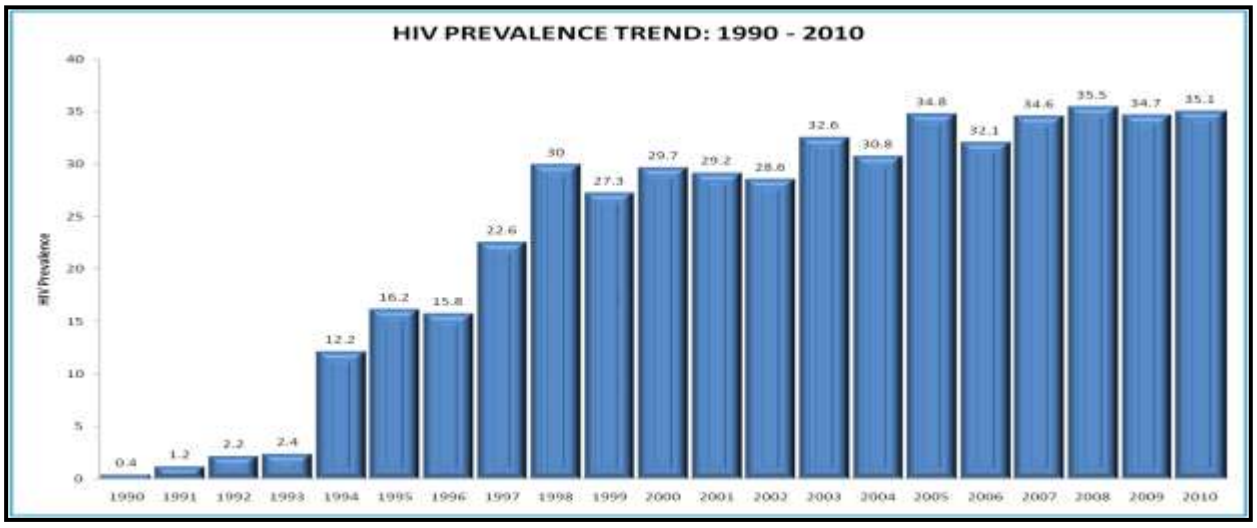


(Source: National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2010)

KwaZulu-Natal has the highest HIV prevalence followed by Mpumalanga, the Free State and Gauteng with overall prevalence greater than 30.0%. Although KwaZulu-Natal remained at 39.5% when compared with 2009, Mpumalanga province shows slight increase from 34.6% (2009) to 35.1% (2010).

In 2010, the Mpumalanga provincial HIV prevalence amongst antenatal women was 35.1%, a slight increase from 34.7% in 2009. The Mpumalanga HIV epidemic graph from 1990 to 2010 is shown in **Figure 7**, below.

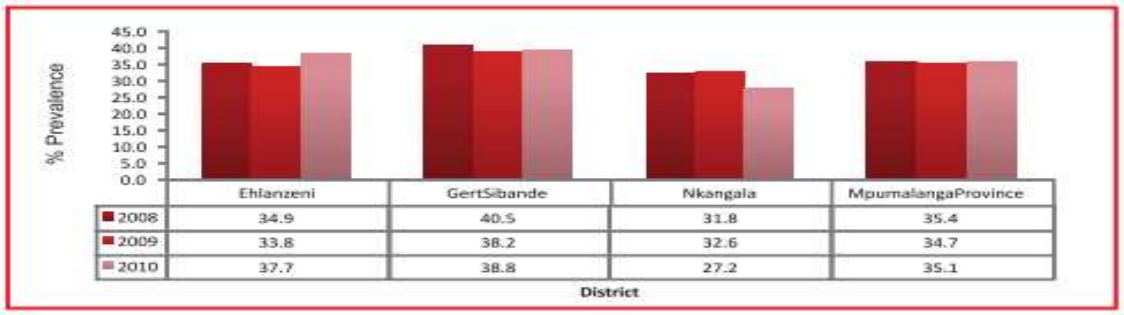
Figure 7: Mpumalanga HIV Epidemic Graph 1990 – 2010



***Source**: Mpumalanga Antenatal Sentinel HIV and Syphilis Prevalence Survey in Mpumalanga, 2010*

Two districts in Mpumalanga, viz., Ehlanzeni and Gert Sibande recorded the 6th and 7th highest HIV prevalence among the 52 health districts in the country. Nkangala antenatal HIV prevalence has declined from 32.6% in 2009 to 27.2% in 2010, a decrease by 5.4%. The HIV prevalence estimates in all three districts of Mpumalanga are above 26% as reflected in **Figure 8** below.

Figure 8: Mpumalanga HIV Prevalence by Geographic Distribution (District), 2008 - 2010



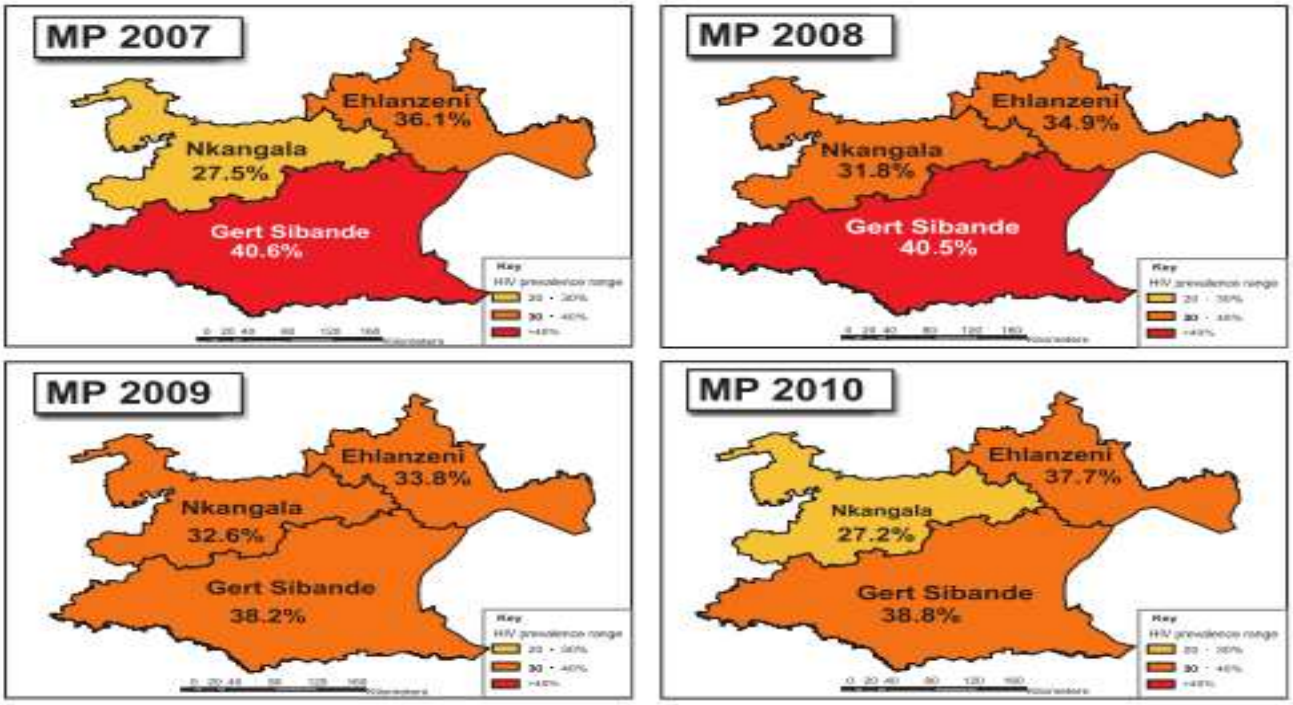
	Ehlanzeni	GertSibande	Nkangala	MpumalangaProvince
2008	34.9	40.5	31.8	35.4
2009	33.8	38.2	32.6	34.7
2010	37.7	38.8	27.2	35.1

Source: National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2010

In Mpumalanga, the age distribution of pregnant women who participated in the survey, ranged from 10 – 49 years old. The majority of the survey participants were teenagers and young women (15-24 year olds). In 2010, the HIV prevalence among 15-24 year olds (Millennium Development Goal 6, Target 7) remained the second highest following KwaZulu Natal in this age group, from 26.7% in 2008 to 25.0% in 2009 to 25.6% in 2010. There was an increase in HIV prevalence among young women in the age group 15-19 years, from 12.9% in 2009 to 17.4% in 2010.

The variation in HIV prevalence distribution in Mpumalanga from 2008 – 2010 is shown in **Figure 9**below:

Figure 9: HIV Prevalence distribution among antenatal women by District, Mpumalanga, 2007-2010



***Source**: National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2010*

SYPHILIS PREVALENCE

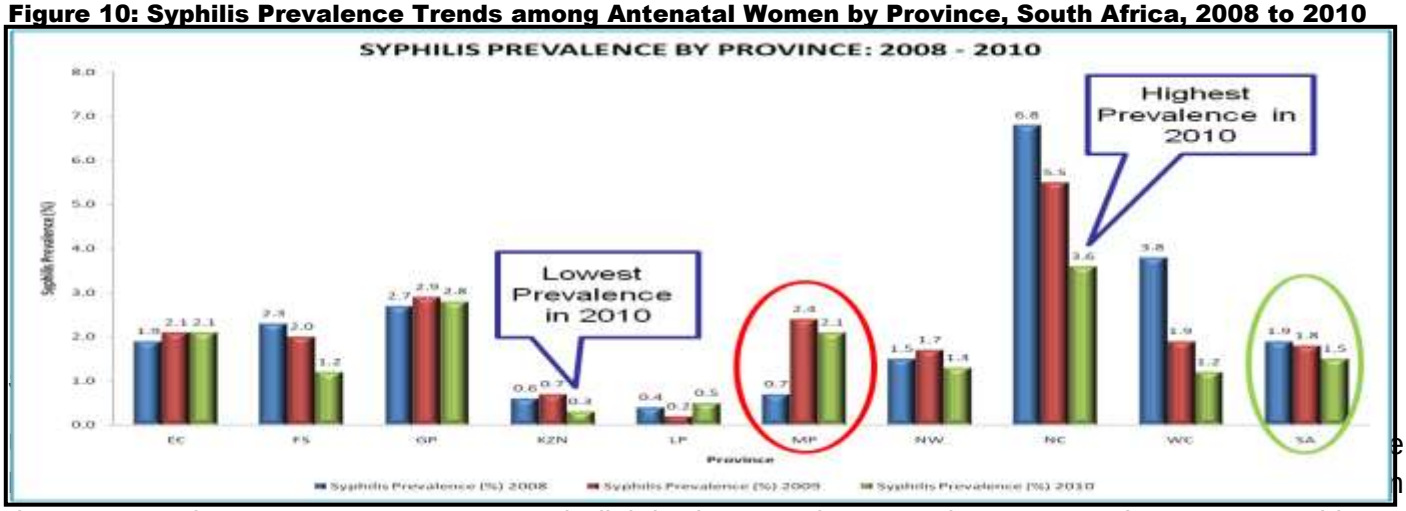
In 2010, the overall national syphilis prevalence was 1.5% of pregnant women served at public antenatal care clinics, a decrease of 0.4% from 2009. This is the lowest recorded since 1997 when it was standing on 11.2%.

Syphilis Prevalence by Province, 2008 – 2010

Figure 10 shows that the estimated highest[27]

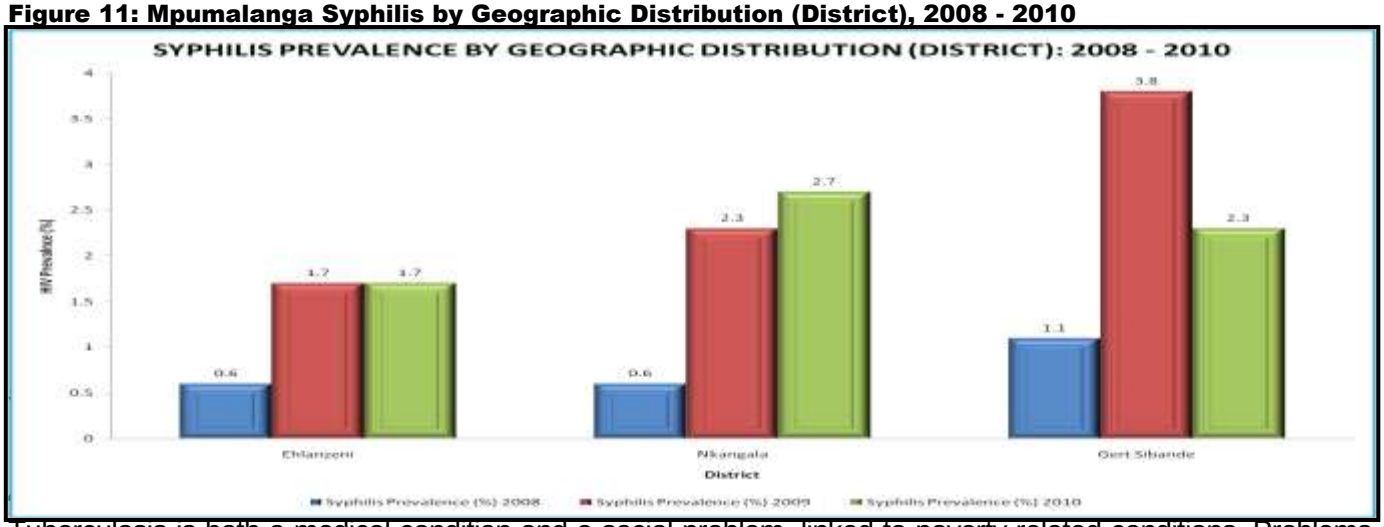
prevalence of syphilis (3.6%) in 2010 was recorded in the Northern Cape and was 2.0% lower than in 2009. Mpumalanga syphilis prevalence has more than doubled from 0.7% in 2008 to 2.1% in 2010. The lowest syphilis prevalence was 0.3% recorded in KwaZulu Natal, which has the highest HIV prevalence in the country. In general all the provinces have shown a decline in syphilis prevalence with the exception observed in Eastern Cape, where it remained the same and Limpopo where there was slight increase in the prevalence. Hence, South Africa has shown a downward in syphilis prevalence from 1.9 to 1.5 in 2008 to 2010, respectively.

Figure 10: Syphilis Prevalence Trends among Antenatal Women by Province, South Africa, 2008 to 2010



the 15-19 and 35-39 year age group and slightly decreased among the 40-44 and 25-29 year old age groups, and there was only a 1.0% decrease in syphilis prevalence in the 30-34 year old age group. Figu**re 11** below, represents the Mpumalanga Syphilis by District for the period 2008 to 2010 with only Nkangala that shows a slight increase from 2.3 in 2009, to 207 in 2010. Ehlanzeni remained at 1.7 and Gert Sibande shows a steady decrease from 3.8 in 2008 to 2.3 in 2010.

Figure 11: Mpumalanga Syphilis by Geographic Distribution (District), 2008 - 2010



Tuberculosis is both a medical condition and a social problem, linked to poverty related conditions. Problems of overcrowding and poor social conditions as well as environmental factors are contributory factors to its increased burden.

The World Health Organisation (WHO) estimates that about 1% of South Africans (roughly 490,000) contracted Tuberculosis in 2008, giving an incidence rate of 949 TB cases per 100,000 population.

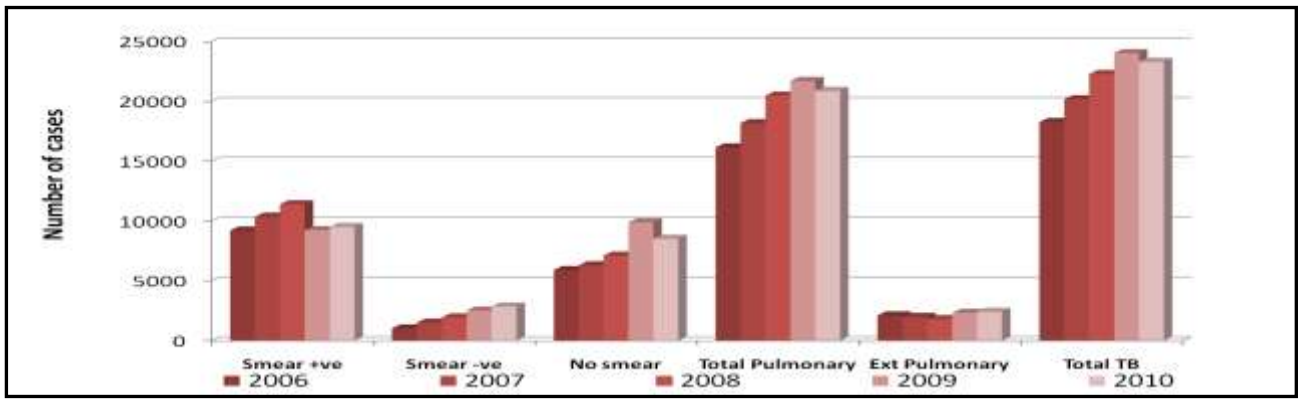
Due to late detection, poor treatment, management and failure to retain TB patients on treatment, drug resistant forms of TB (XDR-TB and MDR-TB) have increased significantly. The combination of TB, HIV and DR TB has led to a situation where TB is the number one common cause of death among infected South Africans.

Mpumalanga remains burdened by Tuberculosis (as

the number one cause of death among the top ten causes of deaths in the province) as the HIV prevalence correlates well with the increase in case findings. There is an improvement in the TB Cure Rate for New Smear Positive Cases from 60.8% in 2007 to 73% in 2009 however, the province has not reached the national target of 85% yet.

Figure 12 represents the TB Case Findings for Mpumalanga for the period 2006 – 2010 and **Figure 15** represents the TB Case findings per District for 2010.

Figure 12: Mpumalanga TB Case Findings: 2006 to 2010



***Source**: Mpumalanga TB Database*

Out of a total of 23 312 TB case findings, 12 459 were from Ehlanzeni, 7 323 from Gert Sibande and 3 530 from Nkangala district as presented in **Figure 13** below:

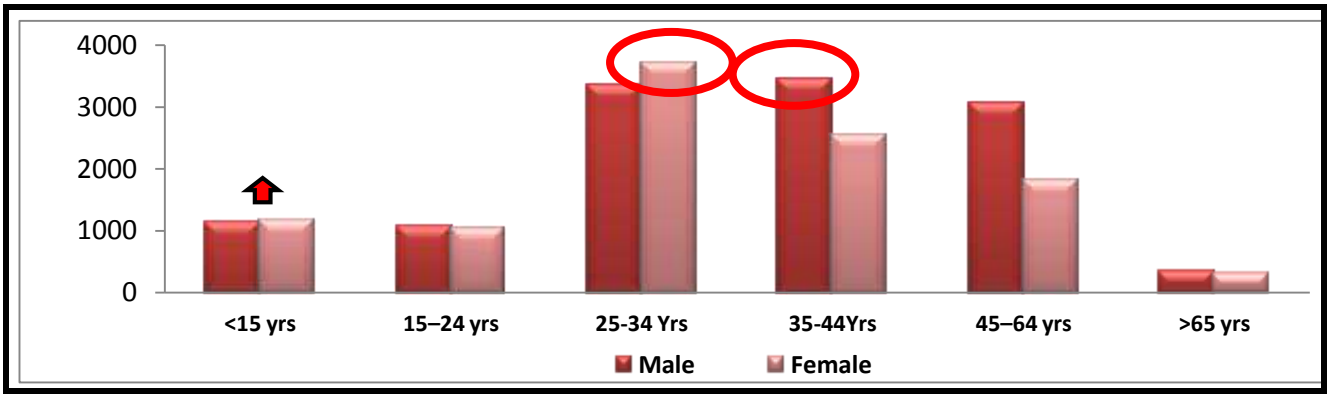
Figure 13: TB Case Finding per District, 2010

Districts	Pulmonary Tuberculosis				Bacteriological Coverage	Extra Pulmonary TB	TOTAL
	Smear Positive	Smear Negative	No Smear	Total			
Ehlanzeni	5815 (53.2%)	1624 (14.9%)	3493 (32%)	10 932	72.3%	1527 (12.3%)	**12 459**
Gert Sibande	1627 (24.1%)	482 (7.1%)	4654 (68.8%)	6 763	33.6%	560 (7.6%)	**7 323**
Nkangala	2070 (64.8%)	750 (23.5%)	376 (11.8%)	3 196	90.4%	334 (9.5%)	**3 530**
TOTAL	**9512 (45.5%)**	**2856 (13.7%)**	**8523 (40.8%)**	**20 891**	**62.8%**	**2421 (10.4%)**	**23 312**

***Source**: Mpumalanga TB Database*

Figure 14 below, shows that the highest TB cases in 2010 were recorded in the 25-34 year old female age group and the 35 – 44 year old male age groups.

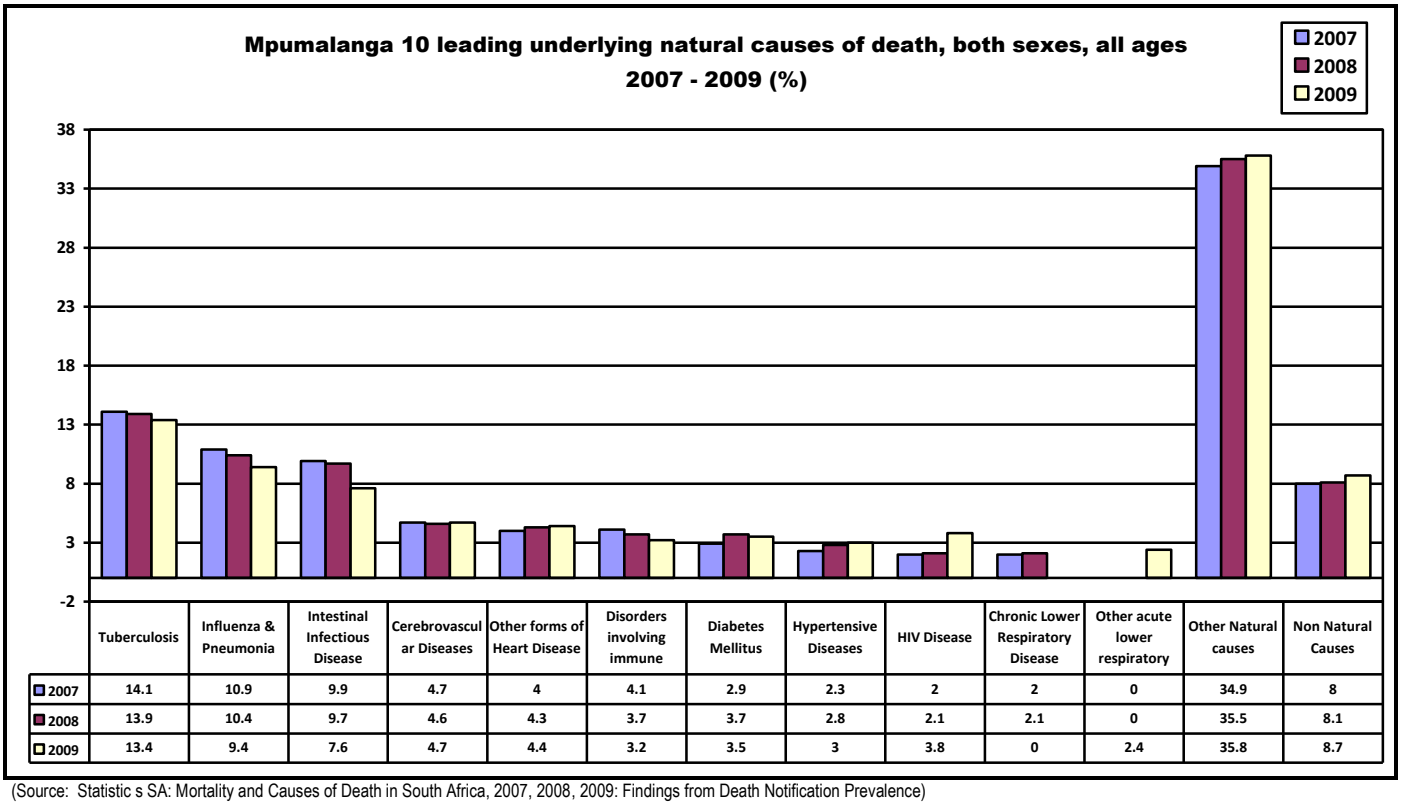
Figure 15: TB Cases by Age Group and Gender, 2010



***Source**: Mpumalanga TB Database*

For the Department to be able to increase the life expectancy and address the health needs of Mpumalanga citizens, there is a need to determine the leading causes of death in the province. Based on the "Findings of the Mortality and Causes of Death in South Africa Report, 2009" by Statistics South Africa, tuberculosis continued to be the most commonly mentioned cause of death on death notification forms, as well as the leading underlying natural cause of death in the country however, the number of deaths has been decreasing since 2007. Influenza and pneumonia were the second leading cause of death followed by intestinal infectious diseases, cerebro-vascular diseases and other forms of heart disease. HIV was the sixth leading cause of death in Mpumalanga, accounting for 3.8% of all deaths in 2009. This is represented in **Figure 16** below.

Figure 16: Mpumalanga 10 Leading Underlying Natural Causes of Death, Both Sexes, All Ages 2007 - 2009



	Tuberculosis	Influenza & Pneumonia	Intestinal Infectious Disease	Cerebrovascular Diseases	Other forms of Heart Disease	Disorders involving immune	Diabetes Mellitus	Hypertensive Diseases	HIV Disease	Chronic Lower Respiratory Disease	Other acute lower respiratory	Other Natural causes	Non Natural Causes
2007	14.1	10.9	9.9	4.7	4	4.1	2.9	2.3	2	2	0	34.9	8
2008	13.9	10.4	9.7	4.6	4.3	3.7	3.7	2.8	2.1	2.1	0	35.5	8.1
2009	13.4	9.4	7.6	4.7	4.4	3.2	3.5	3	3.8	0	2.4	35.8	8.7

(Source: Statistic s SA: Mortality and Causes of Death in South Africa, 2007, 2008, 2009: Findings from Death Notification Prevalence)

The leading causes of death in the cohort of 15-49 years of age in Mpumalanga are Tuberculosis, Influenza and Pneumonia, Intestinal Infectious Diseases, Certain disorders involving the immune mechanism, with HIV as the 4th leading cause of death in this age group. Men are dying more from non-natural causes whilst females are dying mostly from natural causes. **Table 8** shows the underlying non-natural causes of death for 2008 and 2009 in Mpumalanga Province.

Table 8: Mpumalanga Underlying Non-natural Causes of Death, 2008 to 2009

	2008		2009	
Causes of death*	**Number**	**Percentage**	**Number**	**Percentage**
Other external causes of accidental injury	2 922	75,3	3 373	84,9
Event of undetermined intent	123	3,2	79	2,0
Transport Accidents	521	13,4	330	8,3
Assault	198	5,1	125	3,1
Complications of medical and surgical care	47	1,2	38	1,0
Intentional self-harm	65	1,7	24	0,6
Sequelae of external causes of morbidity and mortality	5	0,1	2	0,1
Subtotal	**3 881**	**100,0**	**3 971**	**100,0**
Non-natural causes	3 881	8,1	3 971	8,7
Natural causes	43 770	91,9	41 732	91,3
All causes	**47 651**	**100,0**	**45 703**	**100,0**

**based on the Tenth Revision, International Classification of Diseases, 1992*

***Source**: Statistics SA: Mortality and Causes of death in South Africa, 2008: Findings from Death Notification*

4.6 PROVINCIAL SERVICE DELIVERY ENVIRONMENT

The department has continued with its effort to implement the four key health outputs in order to achieve Outcome Number 2: "**A long and healthy life for all South Africans**".

This Annual Performance Plan outlines key achievements against the Medium Term Strategic Framework (MTSF) priorities, the Millennium Development Goals (MDGs), National Health Plan and the Ten Point Plan of the health sector.

In keeping with the revised, outcome-based Medium Term Strategic Framework (MTSF) for 2009 – 2014, adopted by Cabinet in January 2010, as well as the signed Negotiated Service Delivery Agreement (NSDA) the department will focus on the following four key strategic outputs to be achieved by the health sector – linked to these outputs, are clearly articulated indicators and targets:

- **Output 1:** Increasing Life Expectancy
- **Output 2**: Decreasing Maternal and Child Mortality
- **Output 3:** Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis
- **Output 4**: Strengthening Health System Effectiveness

The continuous increase of the HIV and AIDS prevalence in the province necessitated that the department identifies its strength to combat the spread of the disease. The Provincial Strategic Plan for HIV and AIDS has been developed in this regard and will be rolled out in the coming MTEF period.

Life expectancy is one of the key outputs that the province is struggling to make the significant improvement and remained a serious challenge. Life expectancy is affected by communicable diseases such as HIV, TB, malaria, respiratory infections, and non-communicable diseases such as diabetes and cardio vascular diseases. These are compounded by high burden of trauma related injuries. The department however will continue to make strides and effort to ensure that many lives are saved through focused health interventions.

One of the important and critical aspects of strengthening the effectiveness of the health system is the ability to recruit, train and retain skilled personnel in the Department. The scarcity of health professionals is a global challenge, and developing countries like ours are worst affected. Another thorny issue with regard to retaining of health professionals is the improvement of conditions of service, in particular adjusting salary levels through the Occupation Specific Dispensation introduced in 2007. Implementation of this new approach has been skewed and provinces unfortunately implemented on different interpretations. The province has developed and implemented the Human Resources Plan which will ensure recruitment and retention of scarce skills.

One of the important matters which had been of serious concern for the department, is to have prudent financial management. The department during the 2009/10 had accruals of R421 million which has been able to significantly reduce this accrual to R99.275 million during 2010/11. The department aims to reduce these accruals to a manageable rate and subsequently eliminate them.

During the 2011/12 financial year, the department has completed the reviewal of the organogram and has since been approved. This led to the process matching and placing against critical posts as identified from the approved organogram.

TABLE A2: TRENDS IN KEY PROVINCIAL SERVICE VOLUMES

Indicator	2008/09 (actual)	2009/10 (actual)	2010/11 (actual)	2011/12 (estimate)
PHC headcount - Total	7,908 638	7,951,818	7,625,505	8,797,047
OPD Headcount - new case not referred*	No Data	No Data	33,184	430 000
Separations District Hospitals	158,885	156,614	301,458	275 474
Separations Regional Hospitals	56,482	57,500	109,315	62,000
Separations Tertiary/ Central Hospitals	14,939	16,020	55,344	18,000

***Source**: DHIS*

*No data was available from DHIS for 2008/09 and 2009/10 as reporting on the indicator only started in 2010/11

TABLE A3: REVIEW OF PROGRESS TOWARDS THE HEALTH-RELATED MILLENNIUM DEVELOPMENT GOALS (MDGs) AND PROGRESS REQUIRED BY THE UNITED NATIONS IN 2015

MDG GOAL	TARGET	INDICATOR	MPUMALANGA BASELINE 2009/10	MPUMALANGA PROGRESS MADE DURING 2010/11	SOURCE OF DATA	MPUMALANGA REQUIRED PROGRESS BY 2015
Goal 1: Eradicate Extreme Poverty And Hunger	Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	Prevalence of underweight in children (under 5 years of age)	Not gaining weight rate: 0.4 Underweight for age rate: 0.4	Not gaining weight rate: 1 Underweight for age rate: 0.4	District Health Information System (DHIS)	Not gaining weight rate 0.5 Underweight for age rate 0.2
		Incidence of severe malnutrition in children (under 5 years of age).	Severe malnutrition admission rate 4.2 Severe malnutrition case fatality rate 16.3	Severe malnutrition admission rate: 5.3 Severe malnutrition case fatality rate: 22.7		Severe malnutrition admission rate 3 Severe malnutrition case fatality rate 7
Goal 4: Reduce Child Mortality	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Under-five mortality rate.*	Under five Facility Mortality Rate 6.1 per 1000 live births (2009 DHIS)	Facility Under 5 Mortality Rate: 6.8 per 1000 live births (2010 DHIS)	SADHS 2003	Under-five facility mortality rate reduced to 6 per 1000 live births
		Infant mortality rate.*	Facility Infant Mortality Rate 8.5 per 1000 live births (2009 DHIS)	Facility Under 1 Mortality Rate: 9.5 per 1000 live births (2010 DHIS)		Facility Infant Mortality Rate reduced to 7.5 per 1000 live births
		Proportion of one year old children immunized against measles	95,5% Measles Immunisation Coverage under 1 year.	85.3% Measles Immunisation Coverage under 1 year.	District Health Information System (DHIS)	100% of one year old children immunized against measles.
Goal 5: Improve Maternal Health	Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate	Maternal Mortality Ratio*	Maternal Mortality Rate 119 per 100 000 live births (2009 DHIS)	Maternal Mortality Rate 194.8 per 100 000 live births (2010 DHIS)	National Confidential Enquiries into Maternal Deaths	Maternal Mortality Ratio 117 per 100 000 live births
		Proportion of births attended by skilled health personnel.*	No Baseline	No Baseline	SADHS 2003	100% of births attended by skilled health personnel.

MDG GOAL	TARGET	INDICATOR	MPUMALANGA BASELINE 2009/10	MPUMALANGA PROGRESS MADE DURING 2010/11	SOURCE OF DATA	MPUMALANGA REQUIRED PROGRESS BY 2015
Goal 6: Combat HIV and AIDS, malaria and other diseases	Have halted by 2015, and begin to reverse the spread of HIV and AIDS.	HIV prevalence among 15- to 24-year-old pregnant women.	HIV Prevalence among 15-24 year olds: 25.0% HIV Prevalence among 15-19 years: 12.9%	HIV Prevalence among 15-24 year olds: 25.6% HIV Prevalence among 15-19 years: 17.4%	National HIV and Syphilis Prevalence Survey of South Africa, 2009 and 2010	18% of the youth aged between 15 and 24 years.
		Contraceptive Prevalence Rate*	27% Contraceptive Prevalence Rate	28.9% Contraceptive Prevalence Rate	SADHS 2003	40% Contraceptive Prevalence Rate
	Have halted by 2015, and begin to reverse the incidence of malaria and other major diseases.	Proportion of tuberculosis cases detected and cured under directly observed treatment, short-course (DOTS).	64.5% TB Cure Rate (2008)	73.1% TB Cure Rate (2009)	ETR.net outcomes	85% TB Cure Rate

* *Data are not frequently available. Empirical data are available from the South African Demographic Health Survey, which is conducted every 5 years*

The Medium Term Strategic Framework (MTSF) for National Government for the period 2009 – 2014

The Medium Term Strategic Framework is a statement of government intent that identifies the development challenges facing South Africa with a medium-term strategy to improve the living conditions of South Africans.

One of government's major goals in the **Medium Term Strategic Framework (MTSF) for 2009** – 2014 is to improve the health profile of all South Africans. The MTSF identifies the following five developmental objectives:

1) Halve poverty and unemployment by 2012;
2) Ensure a more equitable distribution of the benefits of economic growth and reduce inequality;
3) **Improve the nation's health profile and skills base and ensure universal access to basic services;**
4) Build a nation free of all forms of racism, sexism, tribalism and xenophobia;
5) Improve the safety of citizens by reducing incidents of crime and corruption.

Linked to the five over-arching objectives, the MTSF has outlined ten priority areas that are intended to give effect to these strategic objectives. Within this framework, the overall objective is to implement a comprehensive strategy that will meet the development needs of all South Africans. The table below, demonstrates how the **Millennium Development Goals (MDGs)** have been domesticated into the current priority area of government:

MTSF STRATEGIC ELEMENTS		**ALIGNMENT TO MDGs**
1	Strategic Priority 1: Speeding up growth and transforming the economy to create decent work and sustainable livelihoods.	MDG 1, MDG 2, MDG 3, MDG 8
2	Strategic Priority 2: Massive programme to build economic and social infrastructure.	MDG 1, MDG 3, MDG 8
3	Strategic Priority 3: Comprehensive rural development strategy linked to land and agrarian reform and food security.	MDG 1, MDG 3, MDG 8
4	Strategic Priority 4: Strengthen the skills and human resource base.	MDG 2
5	**Strategic Priority 5: Improve the health profile of all South Africans.**	**MDG 4, MDG 5, MDG 6**
6	Strategic Priority 6: Intensify the fight against crime and corruption.	MDG 2, MDG 3
7	Strategic Priority 7: Build cohesive, caring and sustainable communities.	MDG 2, MDG 3, MDG 7
8	Strategic Priority 8: Pursuing African advancement and enhanced international cooperation.	MDG 8
9	Strategic Priority 9: Sustainable resource management in use.	MDG 2, MDG 3, MDG 7
10	Strategic Priority 10: Building a developmental state, including improvement of public services and strengthening democratic institutions.	MDG 1, MDG 2, MDG 3, MDG 8

Government has adopted an outcome-based approach to service delivery which consists of 12 outcomes and which are articulated in the revised **Medium Term Strategic Framework (MTSF)** for 2009-2014:

1) Improved quality of Basic Education.

2) A long and healthy life for all South Africans.

3) All people in South Africa are and feel safe.

4) Decent employment through inclusive economic growth.

5) A skilled and capable workforce to support an inclusive growth path.

6) An efficient, competitive and responsive economic infrastructure network.

7) Vibrant, equitable, sustainable rural communities contributing towards food security for all.

8) Sustainable human settlements and improved quality of household life.

9) Responsive, accountable, effective and efficient Local Government System.

10) Protect and enhance our environmental assets and natural resources.

11) Create a better South Africa, a better Africa and a better world.

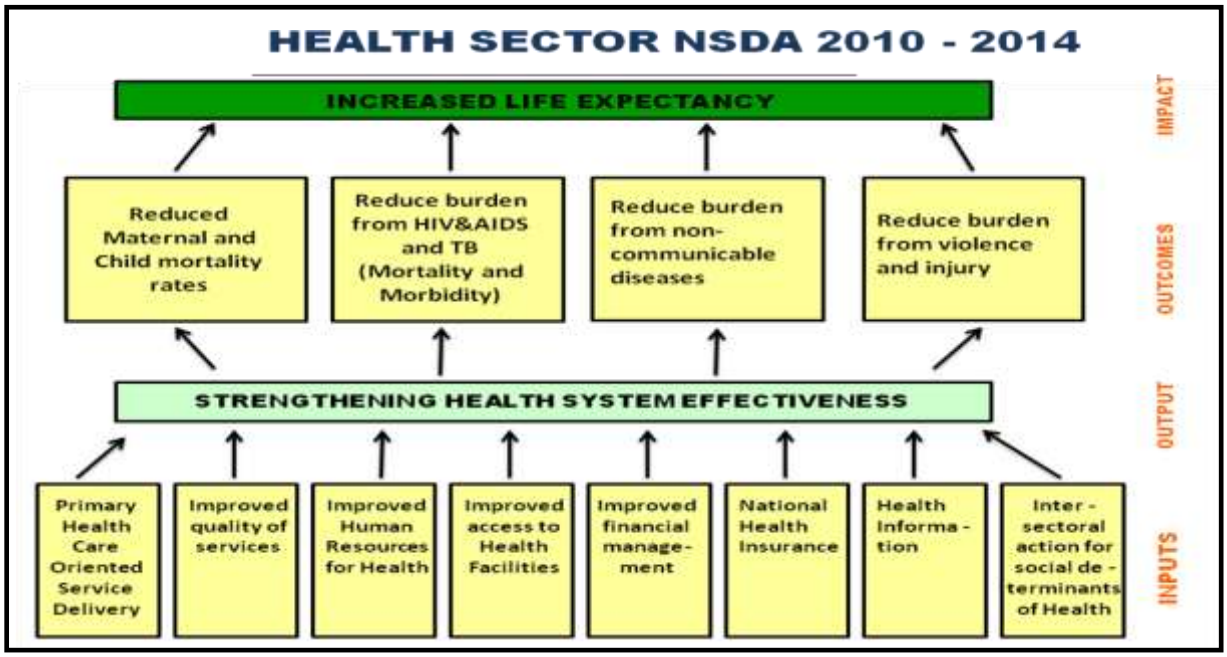
12) An efficient, effective and development oriented public service and an empowered, fair and inclusive citizenship.

The health sector is responsible for the achievement of **Outcome 2 i.e. “”A long and healthy life for all South Africans”.** The strategic thrust of the health sector will be centred around the four outputs of the **Negotiated Service Delivery Agreement (NSDA) 2010-2014**, which are as follows:

Output 1: Increasing Life Expectancy
Output 2: Decreasing Maternal and Child Mortality
Output 3: Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis
Output 4: Strengthening Health System Effectiveness

The four outputs can be stratified into four layers i.e. inputs, outputs, outcomes and impact. The impact the country seeks to attain, is to increase the life expectancy for all South Africans. Improving health outcomes such as infant and child mortality rates, morbidity and mortality from HIV and AIDS and Tuberculosis, will contribute to enhancing life expectancy. The foundation on which successful interventions can be built to improve health outcomes, is by strengthening the effectiveness of the health system, as illustrated in **Figure17**below:

Figure 17: Health Sector Negotiated Service Delivery Agreement 2010 - 2014



***Source**: National Department of Health NSDA*

The **National Development Plan (Vision for 2030)** was published on 11 November 2011 as a step in the process of charting a new path for the country. By 2030, government seeks to eliminate poverty and reduce inequality in order to change the lives of the people of South Africa. According to Chapter 10 of this plan, "Promoting Health", **the vision for health for South Africa by 2030** is as follows:

- men and women has a life expectancy rate of at least 70 years;
- the generation of under-twenty is largely free of HIV;
- the quadruple burden of disease has been radically reduced compared to the two previous decades;
- an infant mortality rate of less than 20 deaths per 1000 live births and an under five mortality rate of less than 30 per 1000 live births;
- there has been a significant shift in equity, efficiency, effectiveness and quality of health care provision;
- universal coverage is available, and
- the risks posed by the social determinants of disease and adverse ecological factors have been reduced significantly.

4.6.1 NATIONAL HEALTH SYSTEMS (NHS) PRIORITIES FOR 2009-2014: THE 10 POINT PLAN

TABLE A4: NATIONAL HEALTH SYSTEMS PRIORITIES FOR 2009-2014 (THE 10 POINT PLAN)

The health sector's 10 Point Plan for 2009-2014 has served as an important overaching and macro framework for overhauling the health system, to enhance its capacity to improve health outcomes and to harness focused interventions towards the Millennium Development Goals (MDGs). The following table outlines the ten priorities and key activities for the health sector:

PRIORITY	KEY ACTIVITIES
1. Provision of Strategic leadership and creation of Social compact for better health outcomes	• Ensure unified action across the health sector in pursuit of common goals
	• Mobilize leadership structures of society and communities
	• Communicate to promote policy and buy in to support government programs
	• Review of policies to achieve goals
	• Impact assessment and program evaluation
	• Development of a social compact
	• Grassroots mobilization campaign
2. Implementation of National Health Insurance (NHI)	• Finalisation of NHI policies and implementation plan
	• Immediate implementation of steps to prepare for the introduction of the NHI, e.g. Budgeting, Initiation of the drafting of legislation
3. Improving the Quality of Health Services	• Focus on 18 Health districts
	• Refine and scale up the detailed plan on the improvement of Quality of services and directing its immediate implementation
	• Consolidate and expand the implementation of the Health Facilities Improvement Plans
	• Establish a National Quality Management and Accreditation Body
4. Overhauling the health care system and improving its management	• Identify existing constitutional and legal provisions to unify the public health service; • Draft proposals for legal and constitutional reform
	• Development of a decentralised operational model, including new governance arrangements
	• Training managers in leadership, management and governance
	• Decentralization of management
	• Development of an accountability framework for the public and private sectors
5. Improved Human Resources Planning Development and Management	• Refinement of the Human Resources plan for health
	• Re-opening of nursing schools and colleges
	• Recruitment and retention of professionals, including urgent collaboration with countries that have excess of these professionals
	• Specify staff shortages and training targets for the next 5 years
	• Make an assessment of and also review the role of the Health Professional Training and Development Grant (HPTDG) and the National Tertiary Services Grant (NTSG)
	• Manage the coherent integration and standardisation of all categories of Community Health Workers
6. Revitalization of infrastructure	• Urgent implementation of refurbishment and preventative maintenance of all health facilities
	• Submit a progress report on Revitalization
	• Assess progress on revitalization
	• Review the funding of the Revitalization program and submit proposals to get the participation of the private sector to speed up this program

PRIORITY	KEY ACTIVITIES
7. Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases	• Implementation of PMTCT, Paediatric Treatment guidelines • Implementation of Adult Treatment Guidelines • Urgently strengthen programs against TB, MDR-TB and XDR-TB
8. Mass mobilisation for the better health for the population	• Intensify health promotion programs
	• Strengthen programmes focusing on Maternal, Child • and Women's Health
	• Place more focus on the programs to attain the Millennium Development Goals (MDGs)
	• Place more focus on non-communicable diseases and patients' rights, quality and provide accountability
9. Review of drug policy:	• Complete and submit proposals and a strategy, with the involvement of various stakeholders
	• Draft plans for the establishment of a State-owned drug manufacturing entity
10. Strengthening Research and Development	• Commission research to accurately quantify Infant mortality
	• Commission research into the impact of social determinants of health and nutrition
	• Support research studies to promote indigenous knowledge systems and the use of appropriate traditional medicines

4.6.2 MPUMALANGA DEPARTMENT OF HEALTH PRIORITIES

In an effort to realise the vision of "A **Long and Healthy Life for all South Africans**", the Mpumalanga Department of Health will focus on the following priorities over the 2012/13 planning period:

1. Increasing Life Expectancy

Mpumalanga's life expectancy must increase from 49.6 years for males and 50.3 years for females (Statistics SA 2009) to 58 years for males and 60 years for females by 2014.

During 2012/13, the department will focus on the following key interventions which contribute to increasing Life Expectancy to combat Chronic Diseases; Non-Communicable diseases and HIV and AIDS and Tuberculosis:

- Rapidly scaling up access to Antiretroviral Therapy (ART) for people living with HIV and AIDS.
- Scale up a combination of prevention interventions to reduce new HIV infections.
- Strengthen the TB Control Programme.
- Strengthen immunization programmes to protect children against vaccine preventable diseases.
- Increasing the early detection of people with chronic conditions (hypertension, diabetes).

2. Decreasing Maternal and Child Mortality

Mpumalanga's Maternal Mortality Rate must decrease from 194.8 per 100 000 live births (2010) to 117 per 100 000 live births (or less) by 2014. The child mortality rate must decrease from 6.8 per 1000 (2010) live births to 6 per 1000 live births (or less) and infant mortality rate must decrease from 9.5 per 1000 (2010) to 7.5 by 2014. During 2012/13, the department will focus on the implementation of interventions to decrease the high maternal- and child mortality rates.

3. Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis

Mpumalanga's TB cure rate must improve from 73.1% in 2009 to 85% and all eligible people living with HIV and AIDS must access antiretroviral treatment by 2014.

The department will roll out the Provincial Strategic Plan for HIV and AIDS, STI and Tuberculosis for 2012-2016 as an overaching priority for the coming MTEF period. During 2012/13 the department will prioritise the following interventions:

- Increase the number of Male Medical Circumcisions from 38 970 to 50 000.
- Roll out Anti-retroviral treatment services to patients initiated on ARV.
- Expand the HIV Counseling and Testing programme

4. Strengthening Health System Effectiveness

This year is crucial in the transformation of the health care system re-engineering in order to provide and expand quality of health care. During 2012/13, the department will prioritise the following:

- Pilot the National Health Insurance within Gert Sibande District.
- Re-engineering of Primary Health Care by establishing PHC Outreach teams.
- Roll out the school health services programme.
- Speedily implementation and upgrading of Health Infrastructure
- Filling of critical posts with suitably qualified personnel.
- Ensuring the sustainable availability of medicines in all facilities.

4.6.3 MPUMALANGA CONTRIBUTION TOWARDS THE HEALTH SECTOR NEGOTIATED SERVICE DELIVERY AGREEMENT

Government has agreed on 12 key outcomes as the key indicators for its Program of Action for the period 2010 to 2014. Relevant to the Health Sector in Outcome 2 which prioritise the improvement of the health status of the entire population and therefore, contribute to the vision of "A Long and Healthy Life for all South Africans". The Negotiated Service Delivery Agreement is a charter that reflects the commitment of key sectoral and intersectoral partners, linked to the delivery of the identified inputs. In line with the Health Sector Negotiated Service Delivery Agreement (NSDA), Mpumalanga Department of Health has developed a draft Service Delivery Agreement for 2012/13 which is in process of being consulted with key partners/stakeholders in order to achieve the four identified strategic outputs which the Health Sector must achieve.

OUTPUT 1: INCREASING LIFE EXPECTANCY

Output	Indicator/ Measure	Baseline (2009)	5 Year Targets	2012/13 Targets	2012/13 Budget R'000	Key Partners
1. Increasing life expectancy from 49.6 years to 58 years for males and 50.3 years to 60 years for females	Decrease the incidence of malaria per 1000 population at risk.	0.37 per 1000 population	0.2 per 1000 population	0.4 per 1000 population	59,137	COGTA, DHS, NICD DIRCO and DoE
	Chronic Disease Management Register implemented in all PHC Facilities.	None	100%	100%	150,000	Department of Health
	Intentional and unintentional injuries reduced through co-ordinated intersectoral interventions.	None	5% reduction from baseline	5% reduction from baseline	-	MPAC Stakeholders Business, Medical Research Council, Organized Labour Civil Society, NGOs

OUTPUT 2 : DECREASE MATERNAL AND CHILD MORTALITY

Output	Indicator/ Measure	Baseline (2009)	5 Year Targets	2012/13 Targets	2012/13 Budget R'000	Key Partners
2. Decrease maternal and child mortality	Reduce maternal mortality rate from 157 to 117 (or less) per 100 000 live births	157 per 100 000 live births	117 per 100 000 live births	141 per 100 000 live births	35,000	DSD, DoE, OTP
	Reduce child mortality rate from 6.4 to 5 (or less) per 1000 live births.	6.4 per 1000 live births	5 (or less) per 1000 live births	5 per 1000 live births	141,000	DSD, DoE, COGTA, ARDLA
	Increase the immunization coverage of children under one year of age.	76%	90%	90%	4,852 Infant and Child Mortality 66,000 for new vaccines	DoH and DoE
	Increase the percentage of pregnant women booking for antenatal care before 20 weeks gestation.	33%	39%	37%	29,000	MPAC Stakeholders Business Organized Labour Civil Society, NGOs DSD, DoE, COGTA
	Strengthen facilities which review maternal and perinatal deaths.	92.8%	100%	100%	7,000	MRC
	Increase the proportion of facilities providing Basic Antenatal Care (BANC)	185	278 (100%)	254	20,000	MCR
	Increase the proportion of designated health facilities that provide Choice of Termination of Pregnancy	25% (7)	60.7% (17)	53.6% (15)	6, 000	Ipas DSD DoE COGTA

OUTPUT 3: COMBAT HIV AND AIDS & STI'S AND DECREASE THE BURDEN OF DISEASE FROM TUBERCULOSIS

Output	Indicator/ Measure	Baseline (2009)	5 Year Targets	2012/13 Targets	2012/13 Budget R'000	Key Partners
Combating HIV and AIDS & STIs and decreasing the Burden of disease from TB	Increase the national average TB Cure Rate	64.5%	85%	80%	21,593	MPAC Stakeholders Business Organized Labour Civil Society, NGOs
	Reduce the TB Defaulter Rate annually.	8.2%	<5%	<6%		MPAC Stakeholders Business Organized Labour Civil Society, NGOs
	Increase the total number of patients (children and adults) on ART.	70 064	237 855	172 855	28,202	MPAC Stakeholders Business Organized Labour Civil Society, NGOs
	Increase the number of facilities providing ART services.	34 facilities	278 PHC facilities and 33 hospitals	278 PHC facilities and 33 hospitals		MPAC Stakeholders Business Organized Labour Civil Society, NGOs
	Increase the percentage of HIV and AIDS & TB co-morbidity patients with a CD4 count of 350 or less, initiated on ART.	100% (2010)	100%	100%	103,373	MPAC Stakeholders Business Organized Labour Civil Society, NGOs

Output	Indicator/ Measure	Baseline (2009)	5 Year Targets	2012/13 Targets	2012/13 Budget R'000	Key Partners
…continue	Scale up condom distribution for both male and female condoms.	38,943,442 male condoms	55,000,000	48,000,000	18,504	All Dept, Business, Organized Labour, Civil Society, NGOs
		230,698 female condoms	200,000	100,000		
	Increase the proportion of pregnant women tested through health care provider initiated counseling and testing (HCT).	95%	98%	96%	39,198	
	Increase the percentage of public health facilities providing HCT.	100%	100%	100%		
	Increase the number of non-medical sites offering HCT.	25	75	65	1,260	
	Increase the number of male clients medically circumcised.	3500 (2010)	120 000	50 000	27,309	
	Increase the number of MMC high volume, high quality sites.	5 sites (2010)	15 sites	12 sites		
	Increase the number of High Transmission Area (HTA) intervention sites.	56 sites	76 sites	68 sites	8,847	
	Increase the STI Partner Treatment Rate.	26.7	33	31	1,414	
	Increase the antenatal client initiated on ART during antenatal care rate.	70.4%	98%	96%	14,894	
	Increase the baby Nevirapine uptake rate.	96%	100%	100%		

OUTPUT 4 : STRENGTHEN HEALTH SYSTEM EFFECTIVENESS

Output	Indicator/ Measure	Baseline (2009)	5 Year Targets	2012/13 Targets	2012/13 Budget R'000	Key Partners
4. Strengthen Health System Effectiveness	Number of sub districts with Primary Health Care Teams	0	18 sub districts (199 teams)	9 sub districts (40 teams)	32,141	NDOH PHC Chief Directorate Districts
	% of quintile 1 and 2 primary schools reached through school health services.	0	75%	25%	20	DoH and DoE
	Number of NGOs / NPOs funded to provide Community Based Health Services.	199	200	200	79,600	PHC Chief Directorate Districts
	Number of PHC facilities with Pharmacist Assistants	-	100	60	1,224	CD: Corporate services
	Number of PHC facilities with Data Capturers appointed.	-	278 (100%)	278	30,671	CD: Corporate services
	Number of facilities with functional computers.	-	278 (100%)	278	15,199	IT Unit
	Number of PHC facilities with at least two PHC trained nurses.	28 (2010)	142	105	R448 (Nkangala)	Districts
	Number of health facilities with available essential drugs, including ART.		278 (100%)	278	R38,000 (Nkangala)	Districts
	Number of PHC supervisors appointed.	21	46	35	R696(Nka)	Districts
	Number of health facilities implementing Quality Improvement Plans in line with the 6 priorities of the core standards.		278 PHC facilities 23 District Hospitals 3 Regional Hospitals	278 PHC facilities 23 District Hospitals 3 Regional Hospitals 5 TB Hospitals	R39,000	All Facilities

Output	Indicator/ Measure	Baseline (2009)	5 Year Targets	2012/13 Targets	2012/13 Budget R'000	Key Partners
			5 TB Hospitals 2 Tertiary Hospitals	2 Tertiary Hospitals		
	Number of Human Resource Plans Reviewed and implemented.	0	1	1	R230	NDOH and DOH
	Number of Medical Officers per 100,000 people	14 (490)	19 (670)	17 (610)	R8,300	NDOH & DOE
	Number of Professional Nurses per 100,000 people	89 (3200)	101 (3630)	91 (3285)	R13,594	NDOH & DOE
	Number of Pharmacists per 100,000 people	3 (120)	6 (210)	4 (160)	R1,628	NDOH & DOE
	Roll out of ICT Network infrastructure to all health facilities.	0	120/278	40/278	R2,180	NDOH & DOE
	Number of clinics and CHCs with accommodation constructed	22 new CHC's/clinic constructed	11 new CHCs and clinics with accommodation constructed	5 Construction	R37,000	DPWR & T COGTA HS Eskom
	Number of new accommodation units constructed.	24 new accommodation units	24 new accommodation units constructed	5	R5,000	DPWR & T Local Municipality Eskom
	Number of hospitals upgraded and/or renovated.	19 hospitals upgraded.	25 new accommodation unit constructed	10 hospitals upgraded	R151,658	DPWR & T Local Municipality Eskom

4.7 PROVINCIAL ORGANISATIONAL ENVIRONMENT

The Department was engaged in the process of reviewing its organizational structure. Broader consultation was undertaken to involve wider spectrum of managers within the Department. The observation made is that trimming the number of posts on the current bloated organogram has become an unenviable task.

The reality faced is that it becomes cumbersome to fund most of those posts. As matters stand, the department has a huge vacancy rate. This challenge will remain entrenched, unless it is accepted that a gradual phased in approach to increase the number of posts so as to respond to policy imperatives has to be adopted.

For over seven years, the Department was operating with the organizational structure that was last reviewed in 2003, the Executing Authority signed off the revised Organogram in the last quarter of the 2009/10 financial year. An increase of 10 941 posts was effected as a result of the review of the 2003 Organogram, which had 26 116 posts, whilst the 2009 /2010 has a total of 37 057 posts

Whilst engaged with the process of reviewing the organizational structure of the Department, it arose that the Department of Public Service Administration has been assigned to coordinate the development of generic organizational structures for Provincial Health Departments as directed by National Health Council. The Department will have a delegation participating in that project, which will constitute a broader process nationally.

During this review period, the department has allied behind the call of the Minister of Health that Primary Health Care has to be re-engineered to establish Primary Health Care teams to strengthen District Health Services. The department will on the outlook of the MTEF, finalise the Primary Health Care re-engineering process which also include taking over of the Community Health Workers to extensively provide healthy lifestyles for the people of the province.

District Management will also be strengthened to capacitate districts with full complements of human and financial resources in the next MTEF period, starting in the coming financial year.

TABLE A 6: PUBLIC HEALTH PERSONNEL IN 2010/11

Categories	Number employed	% of total employed	Number per 100, 000 people	Number per 100,000 uninsured people[2]	Vacancy rate[5]
Medical officers[3]	518	2.8	14	No Data	76%
Medical specialists	61	0.3	1.6	No Data	71%
Dentists[3]	101	1	2.7	No Data	56%
Dental specialists	0	0	0	No Data	0%
Professional nurses	4293	24	116	No Data	54%
Enrolled Nurses	1611	9	43.5	No Data	59%
Enrolled Nursing Auxiliaries	2024	11	54.7	No Data	62%
Student nurses	755	5	20.4	No Data	7%
Pharmacists[3]	175	1	4.7	No Data	78%
Physiotherapists	63	0.3	1.7	No Data	78%
Occupational therapists	64	0.3	1.7	No Data	76%
Radiographers	86	1	2.3	No Data	76%
Emergency medical staff	771	5	20.8	No Data	9%
Nutritionists	0	0	0	No Data	0%
Dieticians	86	1	2.3	No Data	62%
Community Care-Givers (even though not part of the PDoH staff establishment)	No Data	No Data	No Data	No Data	No Data
Total	10608	61.7	286.4	No Data	

***Source**: Human Resources - and Finance Reports*

4.8 LEGISLATIVE MANDATES AND NEW POLICY INITIATIVES

Legislative Mandates

The legislative mandate of the Department is derived from the Constitution and legislation passed by Parliament.

4.8.1 CONSTITUTIONAL MANDATES

In terms of the Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996), the Department is guided by the following sections and schedules:

- Section 27 (1): "Everyone has the right to have access to –
  (a) health care services, including reproductive health care;…
  (3) No one may be refused emergency medical treatment:
- Section 28 (1): "Every child has the right to …basic health care services…"
- Schedule 4, which lists health services as a concurrent national and provincial legislative competence.

4.8.2 LEGAL MANDATES

- **National Health Act (Act No. 61 of 2003)**
  Provides a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the constitution and other laws on the national, provincial and local governments with regard to health services.

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

- **Medicines and Related Substance Control Act, 1965 (Act No. 101 of 1965, amended in 1997)**
  Provides 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.

- **Mental Health Care Act, 2002 (Act No. 17 of 2002)**
  Provides a legal framework for mental health in the Republic and in particular, the admission and discharge of mental health patients in mental health institutions, with an emphasis on human rights for mentally ill patients.

- **Medical Schemes Act (Act No. 55 of 2001, as amended)**
  Provides for the regulation of the medical schemes industry to ensure consonance with national health objectives.

- **Council for Medical Schemes Levy Act (Act 58 of 2000)**
  Provides a legal framework for the Council to charge medical schemes certain fees.

- **Nursing Act of 2005**
  Provides for the regulation of the nursing profession.

- **Human Tissue Act, 1983 (Act No 65 of 1983)**
  Provides for the administration of matters pertaining to human tissue.

- **Sterilization Act, 1998 (Act No. 44 of 1998)**
  Provides a legal framework for sterilizations, including persons with mental challenges.

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

- **Tobacco Products Control Amendment Act, 1999 (Act No. 12 of 1999)**
  Provides for the control of tobacco products, the prohibition of smoking in public places and for advertisements of tobacco products as well as the sponsoring of events by the tobacco industry.

- **National Health Laboratory Service Act, 2000 (Act No.37 of 2000)**
  Provides for a statutory body that offers laboratory services to the public health sector.

- **South African Medical Research Council Act, 1991 (Act 58 of 1991)**
  Provides for the establishment of the South African Medical Research Council and its role in relation to health research.

- **South African Medicines and Medical Devices Regulatory Authority Act, 1998 (Act No. 132 of 1998)**
  To provide for the regulation and registration of medicines intended for human and for animal use, for the regulation and registration of medical devices; for the establishment of the South African Medicines and Medical Devices Regulatory Authority; for the control of orthodox medicines, complementary medicines, veterinary medicines, scheduled substances and medical devices.

- **Chiropractors, Homeopaths and Allied Health Professions Second Amendment, Act 50 of 2000**
  To amend the Chiropractors, Homeopaths and Allied Health Service Professions Act, 1982.

- **Foodstuffs, Cosmetics and Disinfectants Act, 1972 (Act No. 54 of 1972 as amended)**
  Provides for the regulation of foodstuffs, cosmetics and disinfectants, in particular quality standards that must be complied with by manufacturers as well as the importation and exportation of these items.

- **Hazardous Substances Act, 1973 (Act No. 15 of 1973)**
  Provides for the control of hazardous substances, in particular those emitting radiation.

- **Dental Technicians Act, 1979 (Act No. 19 of 1979)**
  Provides for the regulation of dental technicians and for the establishment of a council to regulate the profession.

- **Health Donations Fund Repeal (Act no 31 of 2002)**
  Provides for the regulations of health professions in particular, medical practitioners, dentists, psychologists and other related health professions, including community services by these professionals.

- **Allied Health Professions Act, 1982 (Act No. 63 of 1982, as amended)**
  Provides the regulation of health practitioners such as chiropractors, homeopaths, etc., and for the establishment of a council to regulate these professions.

- **Occupational Diseases in Mines and Works Amendment Act, 1993**
  Provides for medical examinations on persons suspected of having contracted occupational diseases, especially in mines and for compensation in respect of those diseases.

- **Academic Health Centres Act, 86 of 1993**
  Provides for the establishment, management and operation of academic health centres.

Other legislation in terms of which the Department operates, includes the following:

- **Criminal Procedure Act, 1977 (Act 51 of 1997, Sections 212 4(a) and 212 8(a).**
  Provides for establishing the cause of non-natural deaths.

- **Child Care Act, 1983 (Act 74 of 1983)**
  Provides for the protection of the rights and well-being of children.

- **Occupational Health and Safety Amendment Act No. 181 of 1993**
  Provides for the requirements that employers must comply with, in order to create a safe environment for employees in the workplace.

- **Compensation for Occupational Injuries and Diseases Amendment Act (No. 61 of 1997)**
  Provides for compensation disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment and for death resulting from such injuries or diseases.

- **White Paper on the Transformation of the Health Sector, 1997**
  Presents a set of policy objectives and principles upon which the Unified National Health System of South Africa will be based. In addition, this document presents various implementation strategies designed to meet the basic needs of all our people, given the limited resources available.

- **Public Finance Management Act, 1999 (Act No 1 of 1999 as amended by Act No 29 of 1999)**
  Provides for the administration of state funds by functionaries, their responsibilities and incidental matters.

- **Division of Revenue Act, 2007 (Act 1 of 2007)**
  Provides for the manner in which revenue generated, may be disbursed.

- **Promotion of Access to Information Act (Act No 2 of 2000)**
  Amplifies the constitutional provision pertaining to accessing information under the control of various bodies.

- **Promotion of Administrative Justice Act (Act No 3 of 2000)**
  Amplifies the constitutional provision pertaining to accessing information under the control of various bodies.

-

- **Preferential Procurement Policy Framework Act, 2000**
  To give effect to section 217 (3) of the constitution by providing a framework for the implementation of the procurement policy contemplated in section 217(2) of the Constitution; and to provide for matters connected therewith.

- **Broad Based Black Empowerment Act, 53 of 2003**
  Provides for the promotion of black economic empowerment in the manner that the state awards contracts for services to be rendered and incidental matters.

- **Public Service Act (Act No. 38 of 1999)**
  Provides for the organization and administration of the public service of the Republic, the regulation of the conditions of employment, terms of office, discipline, retirement and discharge of members of the public service and matters connected therewith.

- **Labour Relations Act, 1995 (Act No. 66 of 1995)**
  Advance economic development, social justice, labour peace and democratization of the workplace by fulfilling the primary objects of the Act.

- **Basic Conditions of Employment Act, 1997 (Act No. 75 of 1997)**
  To give effect to the right to fair labour practices referred to in section 23(1) of the Constitution by establishing and making provision for the regulation of basic conditions of employment and thereby to comply with the obligations of the Republic as a member state of the International Labour Organisation; and to provide for matters connected therewith.

- **Employment Equity Act (No 55 of 1998)**
  Provides for the measures that must be put into operation in the workplace in order to eliminate discrimination and promote affirmative action.

- **Skills Development Act, 1998 (Act 97 of 1998)**
  Provides for the measures that employers are required to take to improve the levels of skills of employees in the workplace.

4.8.3 POLICY MANDATES

- Medium Term Strategic Framework 2009 -2014
- National Health Systems Priorities 2009 – 2014 (10 Point Plan)
- Mpumalanga Provincial Growth and Development Strategy
- Treasury Regulations
- Public Service Regulations
- Preferential Procurement Policy Framework Regulations
- Integrated Development Plans (IDP)
- Negotiated Service Delivery Agreement
- District Health Management Information System Policy (DHMIS), 2011

4.9 OVERVIEW OF THE 2011/12 BUDGET AND MTEF ESTIMATES

Inflation assumptions

Revised inflation projections (CPI) published in the 2011 Medium Term Budget Policy Statement, are 5.2 per cent in 2012/13, 5.6 per cent in 2013/14 and 5.4 per cent in 2014/15.

Personnel adjustments and policy priorities

This year's fiscal framework is tight and the carry-through costs of the current wage agreement imply very limited available resources for reallocation towards supporting the economy, investing in infrastructure and moderating growth in interest costs. In order to allow for additional resources to be allocated towards priority expenditures, preserve our fiscal credibility, and allow for rising capital spending, it is advised that provincial departments of health and education (accounting for 87 per cent of provincial employment) should enjoy priority in personnel spending adjustments. Other provincial departments may need to find resources to implement the wage agreement through the reprioritization of existing resources. Indications are that this will be possible, without significant disruption to existing service delivery.

Departments must ensure that budgets provide for the full implication of personnel-related costs, including improved condition of service, as well as the policy priorities.

These allocations are in accordance with the Collective Wage Settlement for the 2011/12 financial year as contained in PSCBC Resolution 2 of 2011. It is urged that you familiarize yourself with the contents of this agreement to ensure that your province budgets properly for all personnel related costs flowing from this agreement.

Personnel inflation related adjustments

In preparing budgets for the 2012 MTEF, departments should be advised to budget for personnel budgets growth in non-SMS, SMS, and public entity wages of 5 per cent in 2012/13; 5 per cent in 2013/14 and 5 per cent in 2014/15. These agreements will be implemented in April from 2012/13. Departments must also budget for a built in pay progression of 1.5 per cent.

New conditional grants

Nursing Colleges Grant

The Nursing Colleges Grant has been created by reducing the baseline of the Health Infrastructure Grant for the refurbishment and upgrading of nursing colleges. The National Department of Health will play an active role in the planning, packaging and procurement of projects funded through this grant.

National Health Insurance Grant

The National Health Insurance Grant will fund ten National Health Insurance (NHI) pilots. These are aimed at strengthening primary health care as the platform on which the NHI will be implemented. The purpose of the pilots is to test the feasibility of policy proposals in the NHI Green Paper and models of delivery such as district-based clinical specialist support teams; school-based primary health care services; municipal ward-based primary health care agents; general practitioner services where such services are not available at a primary care clinic and allied health professional services (dentistry, pharmacy, optometry, physiotherapy, etc.) but where such services are needed in the district due to the burden of disease. It is anticipated that the funds allocated for 2012/13, which is R15 million per pilot, will be used for planning.

Table A7: Expenditure estimates

	Programme R'000	Audited Outcomes			Main appropri ation	Adjusted appropriati on	Revised estimate	Medium term expenditure estimate		
		2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
1.	Administration	222 955	198 473	218 964	200 217	210 503	219 835	222 955	198 473	218 964
2.	District Health Services	3 925 513	4 113 021	4 113 021	4 427 144	4 752 235	5 078 654	3 925 513	4 113 021	4 113 021
3.	Emergency Medical Services	243 958	243 958	243 958	255 149	264 588	272 418	243 958	243 958	243 958
4.	Provincial Hospital Services	846 176	904 524	904 524	918 947	1 007 264	1 062 861	846 176	904 524	904 524
5.	Central Hospital Services	771 778	788 365	788 365	781 668	858 851	912 131	771 778	788 365	788 365
6.	Health Sciences and Training	220 994	226 097	224 362	234 105	248 459	261 360	220 994	226 097	224 362
7.	Health Care Support Services	112 590	110 323	110 323	108 238	123 579	131 241	112 590	110 323	110 323
8.	Health Facilities Management	814 645	760 725	696 754	618 721	669 431	681 621	814 645	760 725	696 754
	Sub-total									
	Total	4,319,472	5,592,664	6,347,222	7,158,609	7,345,486	7,300,271	7,544,189	8,134,910	8,620,121
	Change to 2011/12 budget estimate									

The table above indicates a slow increase of 3% for the whole department and services delivery programmes show an average increase of 3.5% with include District Health Services, Emergency Medical Services, Provincial Hospital Services and Central Hospitals.

The slow increase of 1% for 2012/13 financial year in Programme 1: Administration for 2012/13 financial year has been influenced by the shifting of security services function to Department of Safety and Security amounting to R168,663, R 176,925, R205,442 for 2012/13, 2013/14 and 2014/15 respectively. The programme mainly consist of management services which give direction to the Vote and include cost driver amount other such as recruitment of staff, settlement of audit obligations, provision ICT services and settlement of all departmental litigations which always present financial pressure due their nature (Unforseen and Unavoidable).
Programme 2 which is district Health Services shows the highest growth of 8 percent on the Adjusted Baseline for the first year of the Medium Term Expenditure Framework Period. The overall increase is mainly due to the department's commitment to strengthen District Health Services and funding of key cost drivers which include drugs, Laboratory Services, Food for patients, Medical Gas, Oxygen and Blood Services.

The 2012/13 financial year budget increase include additional funding received for HIV/AIDS for ARV's, CPIX increase of 4.8%, OSD for Doctors, Therapists and Nurses, Test 300 000 clients for HIV R47 million, Medical Waste Removal (tender approved) R42 million, CPIX increase on Medical items.

Over the years Programme 2: District Health Services has been under funded if compared with funding per capita in the country. The programme renderers District health services which focus to primary health care which and carry 53 percent of the budget for the Health Department. The programme includes Comprehensive HIV/, Community Health Clinics, Community Health Centres, Nutrition, Community Based Services and District Hospitals.

The budget increase of the programme include

- Maternal and Child Health
- HIV/ART 350 Threshold
- Public Health Norms and standards
- Family Health and Pilot Teams

Programme 3: Emergency Medical Services shows an increase of 5 per cent in the 2012/13 financial year. The continued drive to improve emergency medical services is reflected in the real increase in the Programme 3 funding in 2012/13 and the outer years of the MTEF period. Improvement of EMS and planned patient transport is always prioritised in the programme to improve the response time both in urban and rural areas. Planned Patient transport shall be prioritiesd to ensure improve referral of patients in the province.

The Provincial Hospital Services show growth of 2 per cent for the past seven years with an increase of 17.4 percent in 2008/09 financial year and has been sustained over four year from 2009/10 financial year. The budget increase of the programme includes continues payment of OSD for Nurses, Doctors and Therapists. The trend only provides for inflationary provision of the economy.

Programme 5, Central Hospital Services consists of Rob Ferreira Hospital and Witbank Hospital budget reduction of 1% percent due to the agreed cut on Medicine of R48 million by the Province.

Programme 6, Health Science & Training will increase with 4 percent from the 2011/12 to which is mainly due to the increase on HPTS however general training shall shut down due to inadequate funding of the Vote. An amount of R25.4 million has been surrendered to treasury for the shifting of bursary function to that Vote as per Budget and Finance Committee resolutions. This programme includes the Health Professionals Training and Development grant and bursaries for development of staffing as indicated above.

Programme 7, Health Care Support Services will reduce by 2 percent from the 2011/12 to due to slow spending on orthotic and prosthetic services in the province.

Over a seven year period, Programme 8 which is Health Facilities Management has shown a great growth on the budget due to priorities set the National Department of Health in improvement of Health Infrastructure and extending the life span of facilities. The programme includes Hospital Privatisation conditional Grant and Infrastructure Grant. Health Facilities Management will reduce with 19 percent due to the cut on infrastructure for slow spending progress.

Table A8: Summary of Provincial Expenditure Estimates by Economic Classification

Programme	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
	Audited			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
Current payments	3 845 286	4 803 634	5 612 764	6 201 697	6 382 708	6 378 412	6 775 983	7 283 765	7 749 818
Compensation of employees	2 603 406	3 073 377	3 814 348	3 950 125	4 299 158	4 293 071	4 685 857	4 992 329	5 375 528
Salaries and wages	2 284 847	2 692 944	3 162 858	3 469 371	3 750 258	3 745 446	4 084 159	4 368 371	4 709 891
Social contributions	318 559	380 433	451 490	480 754	548 898	547 625	581 698	623 958	665 637
Goods and services	1 241 880	1 730 181	1 997 825	2 251 572	2 083 590	2 083 178	2 110 106	2 291 436	2 374 288
Administrative fees	3 838	4 389	4 135	2 358	2 352	2 021	1 307	1 305	1 321
Advertising	7 801	8 290	3 693	6 510	4 764	5 318	4 689	4 750	4 989
Assets <R5000	24 141	17 850	11 471	35 628	30 548	24 184	29 087	29 511	31 284
Audit cost: External	12 512	19 052	12 308	14 120	14 120	14 120	11 757	11 757	11 757
Bursaries (employees)			15 996	2 000	2 000	641	561	561	561
Catering: Departmental activities	20 254	16 040	15 188	4 018	3 868	4 531	4 460	4 562	5 376
Communication	35 629	39 711	32 575	33 877	33 815	37 722	38 774	38 954	41 511
Computer services	13 065	21 764	22 216	18 800	19 448	19 485	19 891	19 898	19 981
Consult: Business & advisory services	3 281	799	20 890	4 275	4 275	4 184	4 868	4 868	4 884
Consult: Laboratory services	140 000	245 434	238 354	265 629	265 629	239 447	337 428	389 940	404 512
Consult: Legal cost	666	6 732	1 471	3 100	3 100	3 100	1 471	1 471	1 471
Contractors	165 654	228 280	198 488	209 871	194 150	182 258	171 015	165 489	168 148
Agency & support/outsourced services	22 195	25 093	68 059	123 129	106 901	103 018	84 459	89 150	91 460
Entertainment	248	16				29			
Fleet Services	67 392	67 384	72 209	73 195	68 524	84 005	77 540	77 281	81 906
Inventory: Food and food supplies	47 588	72 249	61 970	84 522	81 000	83 070	77 755	77 198	77 862
Inventory: Fuel, oil and gas	11 723	15 690	17 836	22 387	22 410	19 190	18 112	17 707	17 992
Inventory: Learn & teacher support materi		1		898	898	458	397	397	397
Inventory: Materials & supplies	1 831	5 832	4 212	5 372	2 472	5 280	2 347	2 358	2 529
Inventory: Medical supplies	434 678	669 572	212 995	182 259	174 189	197 470	160 517	189 530	199 268
Inventory: Medicine			698 390	688 382	652 097	675 352	701 170	795 746	821 872
Medas inventory interface						1			
Inventory: Other consumables	35 686	60 604	58 974	89 082	66 384	74 539	58 967	59 810	63 845
Inventory: Stationery and printing	27 354	30 157	23 804	37 292	32 388	35 481	34 221	34 989	37 808
Lease payments (incl. operating leases, e	28 591	41 218	48 047	54 749	52 473	47 740	50 573	51 732	53 989
Rental & hiring						504	409	530	554
Property payments	28 914	43 482	67 227	154 384	109 026	109 457	102 269	104 948	107 129
Transport provided dept activity	16 770	10 782	4 995	5 962	2 910	2 789	4 404	4 501	4 597
Travel and subsistence	55 085	58 919	60 282	78 741	73 508	82 749	75 355	78 518	80 708
Training & staff development	15 159	12 654	11 879	45 669	29 921	29 528	25 044	25 184	25 437
Operating payments	15 670	6 039	3 692	4 430	4 450	5 115	3 827	3 955	4 194
Venues and facilities	10 219	3 760	7 489	4 924	5 998	9 798	7 439	6 841	7 259
Interest and rent on land		78	593			165			
Transfers and subsidies	88 234	105 356	139 755	158 459	188 803	182 805	177 318	188 888	189 877
Provinces and municipalities	21 279	4 657	1 509	13 000	13 949	13 739	13 780	14 607	15 483
Departmental agencies and accounts	1			3 842	3 842	3 842	4 614	4 933	4 885
Non-profit institutions	58 392	81 983	111 193	118 284	145 679	145 681	134 240	143 240	151 834
Households	8 562	21 716	27 053	23 333	25 333	29 548	24 682	28 108	27 695
Payments for capital assets	387 816	672 680	584 703	788 453	788 837	731 051	590 810	682 257	670 428
Buildings and other fixed structures	264 269	568 688	472 325	585 635	588 781	525 519	491 540	540 073	547 310
Machinery and equipment	123 547	109 002	122 378	212 818	205 156	205 532	99 370	122 184	123 058
Software and other intangible assets									
of which:									
Capitalised compensation of employees									
Capitalised goods and services									
Payments for financial assets	156	8 034							
Total economic classification	4 319 472	5 582 654	6 397 222	7 158 609	7 345 468	7 300 271	7 544 109	8 134 910	8 620 121

Compensation of Employees - shows an increase of 9% on the Budget Adjustment which is 1.3% above the CIPX provision. The Department is continuously operating with high rate of vacancy which hampers the ability to achieve predetermined targets in the Annual Performance Plan (APP). In the past years the Department encountered problems on CoE due to introduction of Occupational Specific Dispensation and General Salary negotiation from one financial year to the other. However the provision provides for limited funds to address the high vacancy rate of the Vote. An amount of R64 million has been prioritized to ensure appointment of critical staff in facilities and provincial office.

Goods and Services – The Budget 2012/13 financial year for goods and services has be reduced by R317,8 million due to pressures on compensation of employees. The following non-core items have been reduced to fund the effects of Compensation of Employees.

Cost drivers cut to fund Compensation of Employees, the reduction of the Budget on the Cost drivers shall have a huge impact on the achievement of predetermined targets and importantly delivering health services to the people of Mpumalanga.

Transfers and Subsidies – shows a slow increase over the years due to transfers to the municipalities.

Payments of Capital Assets – shows a slow increase over the years due on going focus on the Buildings and other fixed structures.

4.9.2 RELATING EXPENDITURE TRENDS TO SPECIFIC GOALS

TABLE A9: TRENDS IN PROVINCIAL PUBLIC HEALTH EXPENDITURE (R'000)

Expenditure	Audited/ Actual			Estimate	Medium term projection		
	2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
Current prices[1]							
Total[2]	4,452,526	-		-	---	-	-
Total per person	1,240	-		-	---	-	-
Total per uninsured person	1,378	-		-	---	-	-
Constant (2008/09) prices[3]	-	-		-	-	-	-
Total	-	-		7, 013,846	7, 344,839	-	-
Total per person	-	-		1,896	1,957	-	-
Total per uninsured person	-	-		2,107	2,174	-	-
% of Total spent on:-	-	-		-	-	-	-
DHS[4]	54.21	-		53.04	53.24	-	-
PHS[5]	13.06	-		11.73	11.49	-	-
CHS[6]	12.31	-		10.73	10.69	-	-
All personnel	-	-				-	-
Capital[2]	-	-		870,114	862,106	-	-
Health as % of total public expenditure	-	-		-	-	-	-

TABLE A10: CPIX MULTIPLIERS FOR ADJUSTING CURRENT PRICES TO CONSTANT 2007/08 PRICES

Financial year	Updated CPIX Multiplier as at 16 February 2009	CPIX
2006/07	1.20	5.2
2007/08	1.11	8.1
2008/09	1.00	10.8
2009/10	0.95	5.4
2010/11	0.90	5.1
2011/12	0.86	4.6

Methodological Note from National Treasury:
The CPIX has been phased out and no longer exists. The revised CPI is now the inflation measure, but for historical purposes we still use the old CPIX numbers in historical baselines.

PART B - PROGRAMME AND SUB-PROGRAMME PLANS

1. BUDGET PROGRAMME 1: ADMINISTRATION

1.1 PROGRAMME PURPOSE

The purpose of this programme is to provide the overall management of the Department, and provide strategic planning, legislative, communication services and centralised administrative support through the MEC's office and administration.

NEW DEVELOPMENTS

1.2 PRIORITIES

The strategic goal of this programme is to "***Strengthen Health System Effectiveness***"

The **strategic priorities** of the programme, are as follows:

- Improving the provision of Human Resources.
- Improving the provision of Transformation and Transversal Programmes
- Strengthen financial management and accountability
- Strengthen Health Information Systems and enhance monitoring and evaluation.
- Provide Information, Communication, Technology (ICT) Services to support decision making processes.

Service Transformation Plan (STP)

The Department of Health's Service Transformation Plan was approved in May 2011. The development process was able to provide the department with a clear framework of improving health care in the province which include, optimum utilisation of scarce resources for improved access to quality care for our communities at all levels of the health care system. The department is in process of developing Implementation Plans as per Service Transformation Plan chapter/focus area.

Review of the Organisational Structure

The organizational structure is under review in order to ensure alignment to service delivery imperatives such as the National Health Insurance. The department is committed to the process of reviewing the organizational structure on an annual basis. The department has finalised the process of matching person to post. The Human Resource Plan is in the process of being reviewed to include the needs of the National Health Insurance. The National Department of Health Human Resource Strategy was adopted in November 2011 and the Provincial Department of Health Human Resource Strategy will be developed to conform with the National Strategy.

Management and Leadership

The department strives to provide a sound capacity programme that includes addressing effective succession plan and a strong recruitment and retention strategy. The National Department of Health conducted assessments for all CEOs and District Managers in 2010. The department has engaged all Chief Executive Officers on a one-on-one basis together with Labour Relations. Vacant posts of CEOs for all provinces, will be advertised by National Department of Health. Newly appointed CEOs will undergo intense orientation before resuming duties which is envisioned to be effective by 01 April 2012. The level of District Managers has been raised to Chief Director, Level 14.

Financial Management

The department's financial resources are limited and effective management thereof, remains a high priority. Capacity building on financial delegations need to be rolled out for the department in order to ensure effective decentralisation.

Information Management and Systems Support

The National Health Insurance Information System will ensure portability of services and will be electronic-based with linkages to the National Health Insurance membership database and accredited and contracted health care providers. The National Department of Health will establish a National Health Repository and Data Warehousing (NHIRD) which will be rolled out to the provinces and districts. The province has prioritized the appointment of Information Officers and Data Capturers for the 2012/13 financial year.

The department will be implementing the National District Health Management Information System (DHIMS) Policy which was signed in July 2011. A well-functioning DHMIS will guarantee improvements in the monitoring and evaluation of health sector performance and improved health outcomes. The policy focuses on the following seven high level priority areas, namely:

- Health Information Coordination and Leadership
- Indicators
- Data Management
- Data Security
- Data Analysis and Information Products
- Data Dissemination and
- Health Information System Resources

1.3 SITUATIONAL ANALYSIS AND PROJECTED PERFORMANCE FOR HUMAN RESOURCES

TABLE ADMIN 1: SITUATIONAL ANALYSIS AND PROJECTED PERFORMANCE FOR HUMAN RESOURCES [1]

Annual Indicators	Type	Data Source	Audited/ Actual performance			Estimate	Medium-term targets		
			2008/09	2009/10	2010/11	2011 /12	2012/13	2013/14	2014/15
1. Medical officers per 100,000 people	No	PERSAL Reports	13 (463)	14 (490)	16 (563)	14 (510)	17 (610)	18 (640)	19 (670)
2. Medical officers per 100,000 people in rural districts	No	PERSAL Reports	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3. Professional nurses per 100,000 people	No	PERSAL Reports	88 (3177)	89 (3200)	82 (2954)	90 (3240)	91 (3285)	92 (3300)	101 (3630)
4. Professional nurses per 100,000 people in rural districts	No	PERSAL Reports	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5. Pharmacists per 100,000 people	No	PERSAL Reports	3 (116)	3 (120)	3 (117)	4 (132)	4 (160)	5 (180)	6 (210)
6. Pharmacists per 100,000 people in rural districts	No	PERSAL Reports	N/A	N/A	N/A	N/A	N/A	N/A	N/A
7. Vacancy rate for professional nurses	%	PERSAL Reports	12.3	11.8	39	25	25	22	20
8. Vacancy rate for doctors	%	PERSAL Reports	58	41	41	31	27	25	23
9. Vacancy rate for medical specialists	%	PERSAL Reports	71	35	39	26	24	22	20
10. Vacancy rate for pharmacists	%	PERSAL Reports	45	29	32	22	20	15	10

Source: PERSAL & Mid Term Population Estimates. The actual numbers as per 100,000 have been put in brackets.

1.4 PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR ADMINISTRATION

TABLE ADMIN 2: PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR ADMINISTRATION

BUDGET PROGRAMME: PROVINCIAL MANAGEMENT										
STRATEGIC GOAL 4: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS										
Strategic Objective	**Performance Indicator**	**Strategic Plan target**	**Means of verification/ Data Source**	**Audited/ Actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11 (actual)**	**2011/12 (target)**	**2012/13**	**2013/14**	**2014/15**
Recruitment and Selection										
Improving the provision of Human Resources.	% of vacant funded posts filled within 6 months after being vacant.	Not in Plan	PERSAL Reports	32	31	36	25	80*	80*	80*
	Number of Recruitment and Retention Strategies developed and reviewed.	Not in Plan	Approved Strategy	0	0	0	1	1	1	1
Conditions of Services and Remuneration										
Improving the provision of Human Resources.	Attrition rate for professional nurses	Not in Plan	PERSAL Reports	27	26	35	1%	1%	1%	1%
Practices and Administration										
Improving the provision of Human Resources.	Number of Human Resource Plans reviewed and implemented.	Not in Plan	Approved HR Plan	0	0	1 HR Plan developed and approved	1	1	1	1
Organizational Strategy and Planning										
Improving the provision of Human Resources.	Number of organisational structures reviewed and implemented.	Not in Plan	Approved Organisational Structure	0	0	1	1	1	1	1
Planning Information and PMDS										
Improving the provision of Human Resources.	% of staff implementing PMDS.	Not in Plan	PERSAL Reports	-	-	81.8%	100%	100%	100%	100%

**Finalisation of Human Resource and Financial Delegations to Managers has been taken into consideration when medium term targets were set.*

BUDGET PROGRAMME: PROVINCIAL MANAGEMENT										
STRATEGIC GOAL 4: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS										
Strategic Objective	**Performance Indicator**	**Strategic Plan target**	**Means of verification/ Data Source**	**Audited/ Actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11 (actual)**	**2011/12 (target)**	**2012/13**	**2013/14**	**2014/15**
Employee Health and Wellness										
Improving the provision of Human Resources.	Number of functional Employee Health and Wellness Committees established.	Not in Plan	Approved memorandums and appointment letters, attendance registers and minutes of meetings	0	5	5	11	12	13	14
	Number of Resilience Buildings conducted.	Not in Plan	Referrals, approved memorandums attendance registers	0	0	50	250	350	400	500
Labour Relations										
Improving the provision of Human Resources.	% of disputes attended and resolved as requested.	Not in Plan	Attendance Registers and outcome certificates and awards	-	-	Not in Plan	100	100	100	100
Transformation and Transversal Programmes										
Improving the provision of Transformation and Transversal Programmes.	% of Women, Disability and Youth appointed as SMS.	Not in Plan	Employment Equity Reports	36% (12/33)	43% (19/44)	60% (15/25)	50% women	50% women	50% women	50% women
				0	0	0	2% disabled	1% disabled	1% disabled	1% disabled
				Not in Plan	Not in Plan	Not in Plan	40% youth	20% youth	22% youth	25% youth
	Number of Service Delivery Improvement Plans (SDIP) reviewed.	Not in Plan	Approved SDIP	1	1	1	1	1	1	1

BUDGET PROGRAMME: PROVINCIAL MANAGEMENT										
STRATEGIC GOAL 4: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS										
Strategic Objective	**Performance Indicator**	**Strategic Plan target**	**Means of verification/ Data Source**	**Audited/ Actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11 (actual)**	**2011/12 (target)**	**2012/13**	**2013/14**	**2014/15**
Occupational Health Services										
Improving the provision of Occupational Health Services.	Number of hospitals and Community Health Centres (CHC) with fully implemented occupational health services.	Not in Plan	Occupational Health Audit Reports	23	25	25 hospitals	27 hospitals 2 CHCs	27 hospitals* 2 CHCs*	30 hospitals 3 CHCs	33 hospitals 4 CHCs
Records Management										
Establish efficient Record Management System.	Number of facilities implementing approved filing system.	Not in Plan	Approved Filing System	0	0	0	1 Provincial Office	3 District Offices	12/33 Hospitals 12/278 PHC Facilities	12/33 Hospitals 12/278 PHC Facilities
Financial Management										
Strengthen financial management and accountability.	% of increased revenue collection.	Not in Plan	PAAB Reports	0	0	152%	5	5	5	5
	Number of departmental financial statements receive unqualified audit opinion.	Unqualified Audit opinion by Auditor General	Audit Report	0	0	0	1	1	1	1

** Due to the resignation of Occupational Health Practitioners during 2011/12 financial year, the target for 2012/13 remains unchanged.*

BUDGET PROGRAMME: PROVINCIAL MANAGEMENT										
STRATEGIC GOAL 4: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS										
Strategic Objective	**Performance Indicator**	**Strategic Plan target**	**Means of verification/ Data Source**	**Audited/ Actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11 (actual)**	**2011/12 (target)**	**2012/13**	**2013/14**	**2014/15**
Legal Services										
Improving the provision of Legal Services.	% of litigious cases initiated, defended and settled as per instruction received.	Not in Plan	Register on incoming and outgoing corresponden-ces, litigation database and the court orders	Not in Plan	Not in Plan	100	100	100	100	100
	% of contracts drafted and reviewed.		Signed Contracts	Not in Plan	Not in Plan	Not in Plan	Not in Plan	100	100	100
Communications										
Improving the provision of Communication Services.	% of communication activities implemented as per Communication Strategy	Comprehensive integrated communication strategy for health developed and implemented.	Records for communication activities compared to approved Communication Strategy	0	0	100	100	100	100	100
Internal Audit										
Improving the provision of Internal Audit Services.	% of Audits Performed	Not in plan	Audit Report	0	97	95	100	100	100	100
	% of Risk Mitigating strategies implemented as per approved Risk Treatment Document	Not in plan	Risk Register, Treatment Document & Workshop Attendance Registers	0	100	100	100	100	100	100
	% Fraud Prevention Strategy implemented as per approved Fraud Prevention Plan.	Not in plan	Fraud Prevention Plan & Awareness Workshop Attendance Registers	100	100	100	100	100	100	100

BUDGET PROGRAMME: PROVINCIAL MANAGEMENT										
STRATEGIC GOAL 2: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS										
Strategic Objective	**Performance Indicator**	**Strategic Plan target**	**Means of verification/ Data Source**	**Audited/ Actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11 (actual)**	**2011/12 (target)**	**2012/13**	**2013/14**	**2014/15**
Integrated Health Planning										
Strengthen Health Information Systems and enhance monitoring and evaluation.	Number of Plans developed.	Approved STP in place	Approved STP, APP and Operational Plan	Not in Plan	Not in Plan	3 (APP, STP and Operational Plans)	3 (APP, STP and Operational Plans)	2 (APP and Operational Plans)	2 (APP and Operational Plans)	2 (APP and Operational Plans)
	Number of Performance Reports against the Annual Performance Plan, developed.	Not in Plan	Signed Off Performance Reports	Not in Plan	Not in Plan	5	5	5	5	5
	Number of Quarterly Performance Reviews (QPR) submitted.	Not in Plan	Signed Off QPR Reports	4	4	4	4	4	4	4
	Provincial Health Information System Committee e (PHISC) established as regulated by the National Health Act, 2003	Not in Plan	Appointment Letters, Terms of Reference, Minutes of Meetings	Not in Plan	Not in Plan	Not in Plan	Not in Plan	1	-	-
	Number of Antenatal Surveys conducted.	Not in Plan	Published ANC Survey	Not in Plan	1	1	1	1	1	1
	Provincial Health and Research Ethics Committee (PHREC) established as regulated by the National Health Act, 2003.	Not in Plan	Appointment Letters, Terms of Reference, Minutes of Meetings	Not in Plan	Not in Plan	Not in Plan	Not in Plan	1	-	-
Information Technology										
Provide Information Communication Technology (ICT) Services to support decision making processes.	Number of institutions with complete window 2008/ exchange 2010 architecture.	Improved management and integration of Health Information Systems (upgraded sites)	Quarterly Reports	0	3	0	40/313*	40/61 sites	61 sites	61 sites maintained

BUDGET PROGRAMME: PROVINCIAL MANAGEMENT										
STRATEGIC GOAL 2: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS										
Strategic Objective	**Performance Indicator**	**Strategic Plan target**	**Means of verification/ Data Source**	**Audited/ Actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11 (actual)**	**2011/12 (target)**	**2012/13**	**2013/14**	**2014/15**
	Roll out of ICT Network Infrastructure to all health facilities.	Not in Plan	Upgraded Network	0	0	0	10/278	40/278	80/278	120/278

** The network platform backbone of the department, consists of 61 sites only and not 313 sites. The remaining 252 institutions connect to these sites.*

1.5 QUARTERLY AND ANNUAL TARGETS FOR ADMINISTRATION FOR 2012/13

TABLE ADMIN 3: QUARTERLY AND ANNUAL TARGETS FOR ADMINISTRATION FOR 2012/13

PERFORMANCE INDICATOR	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
1. Medical officers per 100,000 people	ANNUAL	17 (610)	-	-	-	17 (610)
2. Medical officers per 100,000 people in rural districts		N/A	N/A	N/A	N/A	N/A
3. Professional nurses per 100,000 people		91 (3285)	-	-	-	91 (3285)
4. Professional nurses per 100,000 people in rural districts		N/A	N/A	N/A	N/A	N/A
5. Pharmacists per 100,000 people		4 (160)	-	-	-	4 (160)
6. Pharmacists per 100,000 people in rural districts		N/A	N/A	N/A	N/A	N/A
7. Vacancy rate for professional nurses		25	-	-	-	25
8. Vacancy rate for doctors		27	-	-	-	27
9. Vacancy rate for medical specialists		24	-	-	-	24
10. Vacancy rate for pharmacists		20	-	-	-	20
Recruitment and Selection						
% of vacant funded posts filled within 6 months after being vacant.	ANNUAL	80%	-	-	-	80%
Number of Recruitment and Retention Strategies developed and reviewed.		1of 1	-	-	-	1 of 1
Conditions of services and Remuneration						
Attrition rate for professional nurses.	ANNUAL	1%	-	-	-	1%
Practices and Administration						
Number of HR Plans reviewed and implemented.	ANNUAL	1 of 1	-	-	-	1 of 1
Organizational Strategy and Planning						
Number of organisational structures reviewed and implemented.	ANNUAL	1 of 1	-	-	-	1 of 1

PERFORMANCE INDICATOR	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
Planning Information and PMDS						
% of staff implementing PMDS	**ANNUAL**	100%	-	-	-	100%
Employee Health and Wellness						
Number of functional Employee Health and Wellness Committees established.	**QUARTERLY**	12	3	3	3	3
Number of Resilience Building Sessions conducted.	**QUARTERLY**	350	85	90	90	85
Labour Relations						
% of disputes attended and resolved as requested.	**QUARTERLY**	100	100	100	100	100
Transformation and Transversal Programmes						
% of Women, Disability and Youth appointed as SMS.	**ANNUAL**	50% women 1% disabled 20% youth	-	-	-	50% women 1% disabled 20% youth
Number of Service Delivery Improvement Plans reviewed.	**ANNUAL**	1	-	-	-	1
Occupational Health Services						
Number of hospitals and Community Health Centres (CHC) with fully implemented occupational health services.	**QUARTERLY**	3 hospitals, 1 CHC (cumulative 27 hospitals 2 CHCs)	1 hospital	1 hospital	1 hospital	1 CHC
Records Management						
Number of facilities implementing approved filing system.	**QUARTERLY**	3 District Offices	Ehlanzeni	Gert Sibande	Nkangala	Provision of support to Districts
Financial Management						
% of Increased revenue collection.	**QUARTERLY**	5	1	1	1	2
Number of departmental financial statements receive unqualified audit opinion.	**ANNUAL**	1	0	0	0	1
Legal Services						
% of litigious cases initiated, defended and settled as per instruction received.	**QUARTERLY**	100	100	100	100	100
% of contracts drafted and reviewed as per instruction received.	**QUARTERLY**	100	100	100	100	100

PERFORMANCE INDICATOR	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
Communications						
% of communication activities implemented as per the communication strategy	**QUARTERLY**	100 (non cumulative)	25	50	75	100
Internal Audit						
% of Audits performed	**QUARTERLY**	100 (non cumulative)	25	50	75	100
% of Risk Mitigating strategies implemented as per approved Risk Treatment Document.		100 (non cumulative)	35	60	80	100
% Fraud Prevention Strategy implemented as per approved Fraud Prevention Plan.		100 (non cumulative)	35	60	80	100
Integrated Health Planning						
Number of plans developed.	**ANNUAL**	2 Plans Developed	-	-	-	1 Annual Performance Plan 1 Operational Plan
Number of Performance Reports against the Annual Performance Plan, developed.	**QUARTERLY**	5 Performance Reports	1 Performance Report 1 Annual Report	1 Performance Report	1 Performance Report	1 Performance Report
Number of Quarterly Performance Reviews (QPR) submitted.	**QUARTERLY**	4	1	1	1	1
Provincial Health Information System Committee e (PHISC) established as regulated by the National Health Act, 2003	**ANNUAL**	1	1	-	-	-
Number of Antenatal Surveys conducted.	**ANNUAL**	1	-	-	-	1
Provincial Health and Research Ethics Committee established as regulated by the National Health Act, 2003	**ANNUAL**	1	1	-	-	-
Information Technology						
Number of institutions with complete window 2008/ exchange 2010 architecture including voice over Internet protocol.	**QUARTERLY**	40/61 sites	5	15	10	10
Roll out of ICT Network Infrastructure to all health facilities.	**QUARTERLY**	40/278 facilities	10	10	10	10

1.6 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

TABLE ADMIN4: EXPENDITURE ESTIMATES: ADMINISTRATION

Programme	Administration								
	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
Subprogramme	Audited			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
Office of the MEC	2 838	5 648	5 913	9 900	13 900	6 908	9 421	9 879	10 472
Management	126 030	154 005	165 555	213 055	184 573	212 056	190 796	200 624	209 363
Total	128 868	159 653	171 468	222 955	198 473	218 964	200 217	210 503	219 835
Current payments	**124 372**	**141 274**	**150 637**	**209 194**	**180 344**	**200 835**	**189 171**	**198 419**	**207 137**
Compensation of employees	52 368	63 457	70 418	98 253	84 560	82 781	99 445	106 931	114 575
Salaries and wages	46 391	56 050	62 335	86 854	76 161	73 098	87 966	94 594	101 316
Social contributions	5 977	7 407	8 083	11 399	8 399	9 683	11 479	12 337	13 259
Goods and services	72 004	77 817	80 219	110 941	95 784	118 021	89 726	91 488	92 562
Administrative fees	509	402	365	1 270	1 269	1 273	394	393	394
Advertising	3 280	5 610	3 002	4 865	2 865	4 865	3 020	3 020	3 020
Assets <R5000	68	311	34	335	335	55	55	58	60
Audit cost: External	12 512	10 903	11 757	14 120	14 120	14 120	11 757	11 757	11 757
Bursaries (employees)									
Catering: Departmental activities	1 554	606	780	1 591	1 091	1 773	695	695	695
Communication	7 349	2 467	4 360	2 846	2 846	6 465	4 411	4 411	4 411
Computer services	12 647	16 391	20 670	18 600	18 600	18 716	18 600	18 600	18 600
Cons/prof:business & advisory services	1 036	799	3 184	1 110	1 110	1 960	3 184	3 184	3 184
Cons/prof: Legal cost	666	6 732	1 471	3 100	3 100	3 100	1 471	1 471	1 471
Contractors	353	595	306	30	30	1 190			
Agency & support/outsourced services	8 000	1 238	4 155	24 652	19 996	26 584	9 126	10 864	11 200
Entertainment	171								
Fleet Services	3 771	10 640	9 024	5 613	5 613	5 613	5 664	5 902	6 171
Inventory: Food and food supplies	198	8		60	60	73	68	68	69
Inventory: Fuel, oil and gas		(1 268)							
Inventory:Learn & teacher support materi		1							
Inventory: Other consumbles	429	646	208	169	169	262	250	261	272
Inventory: Stationery and printing	1 968	3 220	890	3 572	1 572	3 858	3 893	4 054	4 237
Lease payments (incl. operating leases, e	3 827	6 004	5 867	4 742	4 742	4 742	4 785	4 986	5 214
Rental & hiring						504	409	530	554
Property payments		4							
Transport provided dept activity	67	1 759				35	35	37	38
Travel and subsistence	8 649	8 263	11 091	21 834	16 834	20 400	19 834	19 834	19 834
Training & staff development	559	713	99			118	119	124	130
Operating payments	71	227	105	130	130	275	256	267	279
Venues and facilities	4 320	1 546	2 851	2 302	1 302	2 040	1 700	972	972
Interest and rent on land						33			
Transfers and subsidies	**10**	**14 000**	**17 670**	**9 100**	**10 049**	**10 049**	**9 646**	**10 224**	**10 838**
Provinces and municipalities	4				949	949			
Households	6	14 000	17 670	9 100	9 100	9 100	9 646	10 224	10 838
Payments for capital assets	**4 486**	**4 295**	**3 161**	**4 661**	**8 080**	**8 080**	**1 400**	**1 860**	**1 860**
Buildings and other fixed structures			621						
Machinery and equipment	4 486	4 295	2 540	4 661	8 080	8 080	1 400	1 860	1 860
Software and other intangible assets									
of which:									
Capitalised compensation of employees									
Capitalised goods and services									
Payments for financial assets		84							
Total economic classification	128 868	159 653	171 468	222 955	198 473	218 964	200 217	210 503	219 835

1.7 PERFORMANCE AND EXPENDITURE TRENDS

The programme budget has increased year on year with a 0.1 percent growth from 2011/12 to 2014/15. In 2011/12 Programme 1: Administration budget has decrease with 8.6 percent from the 2010/11 financial year, which is mainly due to Security Services funding moved to Department of Safety and Security:

Security Services funding was moved to the Department of Safety and Security which reduce the departmental baseline. The department's budget was further reduced in the 2012/13 financial year due to funding of core function programmes Compensation of Employees. The department is under enormous budget constrains for the 2012/13 financial year under Goods and Services. The outstanding 64 litigation cases may contribute to a further budget pressure in this programme.

The department further have challenges at a number of hospitals (Shongwe, Tintswalo, Middleburg e.g.) due to stolen data lines or other reasons which contribute to outdated information on the financial systems (BAS, PAAB e.g.). Mitigation plans will be a priority to correct these situations.
The Department receives EU funding from National Department of Health towards asset management. A service Provider I-Chain was appointed by NDoH to assist the department updating their asset register to ensure unqualified audit opinion. The project will continue in the 2012/13 financial year up to end November 2012.

1.8 RISK MANAGEMENT

RISKS	**MITIGATING FACTORS**
Over dependence on IT consultants	Skills transfer clause to be included in External Service Providers contracts.
Lack of Disaster Recovery Plan	Disaster Recovery Plan to be reviewed and approved.
Ineffective Supply Chain Management	Appointment of Departmental Supply Chain Management to be finalised. Enforce adherence to legislation (Zero tolerance).

2. BUDGET PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS)

2.1 PROGRAMME PURPOSE

The purpose of the programme is to render comprehensive Primary Health Care Services to the community using the District Health System model.

NEW DEVELOPMENTS

The National Health Insurance (NHI) is one of ten key priorities of the health sector Programme of Action which will be implemented in phases from 2012 over a fourteen year period. The first five years will be a process of building and preparation. Its objective is to put in place the necessary funding and health service delivery mechanisms that will enable the creation of an efficient, equitable and sustainable health system in South Africa. It is a financing system that will ensure the provision of essential health care to all citizens of South Africa (and legal long-term residents) regardless of their employment status and ability to make a direct monetary contribution to the NHI fund. To successfully implement the NHI there are four key interventions that need to take place simultaneously:

- A **complete transformation** of health care service provision and delivery
- The **total overhaul** of the entire health care system
- The **radical change** of administration and management
- The provision of a comprehensive package of care underpinned by a **re-engineered Primary Health Care**

The following are key focus areas for the preparation of NHI:

- Health System Re engineering
  - District Clinical Specialist Support Team
  - School Health Services
  - Municipal Ward – Based (Primary Health Care Agents)
- Quality Improvements of facilities
- Human Resources Planning and Development
- Information Management and Systems
- Infrastructure Development
- Medical Devices and Equipments
- Management of facilities and health districts

The first steps towards implementation of the National Health Insurance in 2012 will be through piloting. Ten (10) districts in the Country will be selected based on the results of the Audit from National Department of Health as well as demographic profiles and key health indicators.

a) Revitalisation of the health system towards Primary Health Care

The focus of Primary Health Care re-engineering will be more on preventive and promotive care versus the hospicentric and curative approach. The department has aligned itself with the National Framework for Re-engineering Primary Health Care. Primary Health Care services will be implemented through the following three streams:

- **Municipal Ward Based (PHC Agents)**: 627 PHC Outreach Teams requiring 3762 Community Health Workers and 627 Professional Nurses, to be established by 2015;

- **School Health Services**: 178 School-based Primary Health Care Teams to cover quintile 1 and 2 schools (poorest) linking to Community Rural Development Programme (CRDP) areas, established by 2015;
- **District-based Clinical Specialist Support Teams** to be established by 2015.

b) Quality Improvement

Health Care establishments are required to conform to agreed-upon quality standards that have been approved by the National Health Council, in order to be accredited to deliver health services within the NHI.

National Department of Health contracted Health Systems Trust to conduct a Facility Audit of all health establishments in preparation for NHI however, all facilities (33 hospitals and 278 Primary Health Care facilities) have been found to be non-compliant with the national core standards (i.e. patients rights, patient safety, clinical support services, public health, leadership and governance, operational management, facilities and infrastructure) and the 6 priority areas of the core standards for quality health care (i.e. cleanliness, safety and security, waiting times, staff attitudes, infection control and drug supply).

All three districts and institutions have developed Quality Improvement Plans to address the shortcomings and monthly progress reports will be monitored by the Provincial Quality Assurance Team.

c) Mpumalanga Strategic Plan for HIV and AIDS, STIs and TB 2012 - 2016

The Provincial Strategic Plan for HIV and AIDS, STI and TB 2012 – 2016 aligned to the National Strategic Plan 2012-2016, was developed with the vision of "zero new infections, zero AIDS deaths and zero discrimination" which is also in line with the National Development Plan: Vision 2030 to have the under-20 age group a largely HIV-free generation. This multi-sectoral intervention is aimed at providing strategic and policy direction in the province. The departmental implementation plan to roll out this strategy will be carried out during 2012/13.

d) Mpumalanga Comprehensive Rural Development Programme (CRDP)

The department is committed to expand access to health services to rural communities through the implementation of the Provincial Comprehensive Rural Development Programme. This programme is currently being implemented in seven of the poorest of the poor municipalities with the following local municipalities as beneficiaries:

- Mkhondo
- Chief Albert Luthuli
- Dr Pixley ka Isaka Seme
- Bushbuckridge
- Nkomazi
- Dr JS Moroka and
- Thembisile Hani

In a quest to assist rural communities to access health services, the department has entered into partnership with Non-Profit Organisations (NPOs) for provision of Community Based

Health Services. Services provided by these organisations include amongst others, the following:

- Home Based Care
- Health Education and Health Promotion
- Tracing of patients defaulting on chronic medication
- Supporting patients on TB treatment (TB DOTS)
- Referral of Children to facilities for immunisation.

2.2 PRIORITIES

The strategic goals of this programme, is as follows:

- *Increasing Life Expectancy*
- *Decreasing Maternal and Child Mortality*
- *Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis*
- *Strengthen Health System Effectiveness*

The **high level strategic priorities** of the programme, are as follows:

- Strengthen accountability structures and intersectoral collaboration
- Revitalisation of the health system towards Primary Health Care
- Promotion of Healthy Lifestyles
- Implement the 6 priority areas of the core standards for quality health care in all health facilities
- Rapidly scaling up access to Antiretroviral Therapy (ART) for people living with HIV and AIDS
- Strengthen the Tuberculosis Control Programme
- Implement Health Care Provider-initiated HIV Counseling and Testing (HCT) in all health facilities.
- Scale up a combination of prevention interventions to reduce new infections.
- Expand access to home based care and community health workers
- Strengthen immunisation programmes to protect children against vaccine preventable diseases
- Increase the Immunisation Coverage.
- Strengthen efforts to decrease maternal and child mortality.

2.3 SPECIFIC INFORMATION FOR DHS

TABLE DHS1: DISTRICT HEALTH SERVICE FACILITIES BY HEALTH DISTRICT IN 2010/11

Health district[1]	Facility type	Number	Population[2,5]	Population per PHC facility[5] or per hospital bed	Per capita utilisation[6]
Gert Sibande District	Non fixed clinics[3]	25 mobiles 1116 visiting points; 5 satellite clinics	915,452	32695	
	Fixed Clinics[4]	53		14765	
	CHCs	19		53850	
	Sub-total clinics + CHCs	**72**	1101 Beds	8556	
	District hospitals	8		831	
Ehlanzeni District	Non fixed clinics[3]	28 mobiles 984 Visiting points	1, 589,953	49686	2.85
	Fixed Clinics[4]	105		15288	
	CHCs	15		113564	

Health district[1]	Facility type	Number	Population[2,5]	Population per PHC facility[5] or per hospital bed	Per capita utilisation[6]
	Sub-total clinics + CHCs	**120**	1209 Beds	10599	
	District hospitals	8		1315	
Nkangala District	Non fixed clinics[3]	22 mobiles 461 Visiting points	1, 113,878	56694	1.7 Headcount 2025227 / 1121841
	Fixed Clinics[4]	68		16143	
	CHCs	18		65522	
	Sub-total clinics + CHCs	**86**	716 Beds	10508	
	District hospitals	7		1556	0.02
Province	Non fixed clinics[3]	75 mobiles 2561 visiting points	3 643 434 (Stats SA 2007)	45241	2.2
	Fixed Clinics[4]	226	3026 Beds	15467	
	CHCs	52		75401	
	Sub-total clinics + CHCs	**278**		9998	
	District hospitals	23		1196	

Source: District Health Services: Primary Health Care Registers

2.4 SITUATION ANALYSIS INDICATORS FOR DISTRICT HEALTH SERVICES

TABLE DHS 2: SITUATION ANALYSIS INDICATORS FOR DISTRICT HEALTH SERVICES

Quarterly Indicators	Data Source	Type	Province wide value 2010/11	Ehlanzeni District 2010/11	Gert Sibande District 2010/11	Nkangala District 2010/11	National Average 2010/11
1. Provincial PHC expenditure per uninsured person	DHER Report	R	R262	R296	R294	R252	N/A
2. Utilisation rate – PHC	DHIS PHC Registers	No	2.2	2.6	2.3	2.0	N/A
3. Utilisation rate under 5 years - PHC	DHIS PHC Registers	No	4.8	5.8	4.3	4.4	N/A
4. Fixed PHC facilities with a monthly supervisory visits rate	DHIS PHC Registers	%	78.9	71.7	84.1	73.7	N/A
5. Expenditure per PHC Headcount	DHER Report	R	R87.00	R105	R126	R112	N/A

Source: District Health Services, DHIS, PHC Registers & DHER Reports

[1] Fixed PHC facilities' means fixed clinics plus community health centres. 'Public' means provincial plus local government facilities.

[2] Community Health Centres and Community Day Centres

Annual Indicators	Data Source	Type	Province wide value 2010/11	Ehlanzeni District 2010/11	Gert Sibande District 2010/11	Nkangala District 2010/11	National Average 2010/11
6. CHCs/CDCs[2] with resident doctor rate	DHIS	%	0	0	0	0	N/A
7. Number of PHC facilities assessed for compliance against the 6 priorities of the core standards	Assessment Reports	No	New indicator	No Data	No Data	No Data	N/A

Source: District Health Services & DHIS

2.4.1 PROVINCIAL STRATEGIC OBJECTIVES INDICATORS AND ANNUAL TARGETS FOR DHS

TABLE DHS3: PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR DISTRICT HEALTH SERVICES

BUDGET SUB PROGRAMME: DISTRICT MANAGEMENT										
STRATEGIC GOAL 4: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS										
Strategic Objective	**Performance Indicator**	**Strategic Plan Target**	**Means of verification / Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11 (actual)**	**2011 /12 (target)**	**2012/13**	**2013/14**	**2014/15**
Strengthen accountability structures and intersectoral collaboration.	Number of functional Mental Health Review Boards.	1 Mental Health Review Board	Minutes	1	1	1	1	3	3	3
	Number of district hospitals with functional Hospital Boards.	23 District Hospitals with Hospital Boards	Appointment Letters / Minutes	15/23	15/23	21 /23	23/23	23/23	23/23	23/23
	Number of PHC facilities with functional Clinic/CHC Committees.	282 PHC facility Committees	Appointment Letters/ Minutes	253/282	273/282	279/282	283/283	278/278*	278/278*	278/278*
	Number of district hospitals with trained Hospital Boards.	Not in Plan	Attendance Registers	15/15	15/23	15 /23	23/23	23/23	23/23	23/23
	Number of PHC facilities with trained Clinics/CHC Committees.	Not in Plan	Attendance Registers	253/282	273/282	86/278	283/283	278/278*	278/278*	278/278*

*The decrease in the total number of PHC facilities from 283 (2011/12) to 278/278 (2012/13) is as a result of some PHC facilities that were closed. Five (5) satellite clinics in Gert Sibande District, four (4) in Mkhondo and one (1) in Msukaligwa were previously reported as fixed eight-hour clinics. Two (2) Community Health Centres i.e. Dwarsloop and Lochiel, are operational.

BUDGET SUB PROGRAMME: DISTRICT MANAGEMENT										
STRATEGIC GOAL 4: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS										
Strategic Objective	**Performance Indicator**	**Strategic Plan Target**	**Means of verification / Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11 (actual)**	**2011 /12 (target)**	**2012/13**	**2013/14**	**2014/15**
Primary Health Care Re Engineering towards improved health care.	Number of districts with fully established management structures.	3 Districts	Management Economic Social & Human Resource (MESH) Tool	3 districts which do not have fully established management structures	3 district	0 districts	3 districts	3 districts	3 districts	3 districts
	Number of sub - districts with fully established management structures.	18 sub districts	Management Economic Social & Human Resource (MESH) Tool	1 sub-district without fully established management structures	1 sub - district with fully established management structures	7 sub - districts	9 sub – districts: 3 Ehlanzeni, 4 Nkangala 2 Gert Sibande	6 sub-districts: 2 Ehlanzeni, 2 Nkangala 2 Gert Sibande	13 sub-districts: 5 Ehlanzeni, 4 Nkangala 4 Gert Sibande	18 sub-districts: 5 Ehlanzeni, 6 Nkangala 7 Gert Sibande
	PHC Supervision Policies implemented and reviewed.	A Reviewed PHC Supervision Policy	Approved PHC Supervision Policy	PHC Supervision policy in place	PHC Supervision policy in place	Implemented and Reviewed	Implemented and Reviewed	Implemented and Reviewed	Implemented and Reviewed	Implemented and Reviewed
	Number of District Health Plans and District Health Expenditure Review (DHER) developed.	Not in Plan	Approved District Health Plans and	Not in Plan	Not in Plan	3 District Health Plans	3 District Health Plans	3 District Health Plans	3 District Health Plans	3 District Health Plans
			Signed off DHERs	Not in Plan	Not in Plan	3 District Health Expenditure Review Reports	3 District Health Expenditure Review Reports	3 District Health Expenditure Review Reports	3 District Health Expenditure Review Reports	3 District Health Expenditure Review Reports

BUDGET SUB PROGRAMME: DISTRICT MANAGEMENT (HEALTH PROMOTION)										
STRATEGIC GOAL 1: INCREASING LIFE EXPECTANCY										
Strategic Objective	**Performance Indicator**	**Strategic Plan Target**	**Means of verification / Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
Primary Health Care Re Engineering towards improved health care.	Implement healthy lifestyle interventions by establishing support groups in all 3 districts.	Not in Plan	Healthy Lifestyle Support Group Database	27	104	80	30	20	30	30
	Number of additional Health Promoting Schools established in all 3 districts.	Not in Plan	Health Promoting Schools Database	35 (175)	35 (210)	22 (232)	23 (255)	15 (270)	15 (285)	15 (300)
	Number of additional household community components (HHCC) of IMCI established in all 3 districts.	Not in Plan	Household Community Components Database	58	83	23 (88)	30 (118)	15 (133)	15 (148)	15 (163)

BUDGET SUB PROGRAMME: PRIMARY HEALTH CARE (COMMUNITY HEALTH CENTRES AND CLINICS)										
STRATEGIC GOAL 4: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS										
Strategic Objective	**Performance Indicator**	**Strategic Plan Target**	**Means of verification / Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
Primary Health Care Re Engineering towards improved health care.	Number of PHC facilities implementing the quality improvement plans in line with the 6 priorities of the core standards.	Quality Improvement Plans in accordance with Core Standards, implemented in 282 PHC facilities	Monthly/ Quarterly Progress Reports	-	282/282	282/282	283/283	278/278*	278/278*	278/278*
	Number of Primary Health Care supervisors appointed.	Not in Plan	Appointment Letters PERSAL	-	21	28	35	35	40	46

*The decrease in the total number of PHC facilities from 283 (2011/12) to 278/278 (2012/13) is as a result of some PHC facilities that were closed. Five (5) satellite clinics in Gert Sibande District, four (4) in Mkhondo and one (1) in Msukaligwa were previously reported as fixed eight-hour clinics. Two (2) Community Health Centres i.e. Dwarsloop and Lochiel, are operational.

BUDGET SUB PROGRAMME: PRIMARY HEALTH CARE (COMMUNITY HEALTH CENTRES AND CLINICS)										
STRATEGIC GOAL 4: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS										
Strategic Objective	**Performance Indicator**	**Strategic Plan Target**	**Means of verification / Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
Primary Health Care Re Engineering towards improved health care.	Number of Primary Health Care Outreach Teams established in sub districts.	Not in Plan	Clinic Staff establishment	-	-	-	18 teams (9 sub districts)	40 teams (9 sub districts)	155 teams (14 sub districts)	199 teams (18 sub districts)
	Number of School Health Service Teams established	Not in Plan	Clinic Staff establishment	17	23	23	37	65 teams	93 teams	121 teams
	% of quintile 1 and 2 primary schools reached through school health services.	Not in Plan	Quarterly Reports	-	-	-	-	25	50	75
	Number of districts hospitals supported by District Specialist teams	Not in Plan	Health facility Supervision register	-	-	-	-	12/23	23/23	23/23
	Number of NGOs/NPOs funded to provide Community Based Health Services.	Not in Plan	Quarterly Reports/ SLA with funded NPOs	199	199	225	220	200	200	200
	Number of PHC facilities with Pharmacists Assistants.	Not in Plan	Quarterly Reports PERSAL	-	-	31	50	60	70	100
	Number of sub districts with appointed Health Information Officers.	Not in Plan	Quarterly Reports PERSAL	-	-	0	49	18	18	18
	Number of PHC facilities with Data Capturers appointed	Not in Plan	Quarterly Reports PERSAL	-	-	282	285	278*	278*	278*
	Number of PHC facilities with functional computers.	Not in Plan	Quarterly reports	-	-	-	-	278	278	278
	Number of PHC facilities with at least two PHC trained nurses	Not in Plan	Quarterly Reports PERSAL	-	-	28	50	105	126	142
	Number of fixed clinics and CHCs supported by a doctor at least once a week.	Not in Plan	Quarterly Reports DHIS	-	43% (122/282)	126/283	49 CHC's	122/278 All CHC's	144/278 All CHC's	154/278 All CHC's

BUDGET SUB PROGRAMME: PRIMARY HEALTH CARE (COMMUNITY HEALTH CENTRES AND CLINICS)										
STRATEGIC GOAL 4: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS										
Strategic Objective	**Performance Indicator**	**Strategic Plan Target**	**Means of verification / Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
	Number of PHC facilities with available essential drug including ART.	Not in Plan	Quarterly Reports PHC Supervision Report	-	-	282/282	285/285	278/278*	278/278*	278/278*
	Number of PHC facilities with available essential equipment	Not in Plan	PHC Supervision Report	-	-	282/282	285/285	278/278*	278/278*	278/278*

*The decrease in the total number of PHC facilities from 283 (2011/12) to 278/278 (2012/13) is as a result of some PHC facilities that were closed. Five (5) satellite clinics in Gert Sibande District, four (4) in Mkhondo and one (1) in Msukaligwa were previously reported as fixed eight-hour clinics. Two (2) Community Health Centres i.e. Dwarsloop and Lochiel, are operational.

TABLE DHS 4: PERFORMANCE INDICATORS FOR DISTRICT HEALTH SERVICES

Quarterly Indicators	Data Source	Type	Audited/ Actual performance			Estimate	MTEF Projection			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Provincial PHC expenditure per uninsured person	DHER Report	R	R264	R271.00	R262	R298	R300	R300	R300	Provincial
2. Utilisation rate - PHC	DHIS PHC Registers	No	2.6	2.2	2.2	2.6	2.8	3	3.2	Provincial
3. Utilisation rate under 5 years - PHC	DHIS PHC Registers	No	4.6	4.8	4.8	5.5	5.5	5.5	5.5	3.5
4. Fixed PHC facilities with a monthly supervisory visit rate	DHIS PHC Registers	%	31.1	58.5	78.9	70	80	90	100	100
5. Expenditure per PHC Headcount	DHER Report	R	88	108	87	98	95	95	100	100

Annual Indicators	Data Source	Type	Audited/ Actual performance			Estimate	Medium-term targets			National target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	20141/15	2014/15
1. CHCs/CDCs with resident doctor	DHIS	%	Not in Plan	Not in Plan	0%	100%*	0%	0%	0%	n/a
2. Number of PHC facilities assessed for compliance against the 6 priorities of the core standards	Assessment Reports	No	Not in Plan	Not in Plan	Not in Plan	283	278/278	278/278	278/278	All Facilities

Source: DHIS

*The target on the indicator: CHCs/CDCs with a resident doctor, should be “0%” and not “100%”

QUARTERLY AND ANNUAL TARGETS FOR DISTRICT HEALTH SERVICES (DHS)

TABLE DHS 5: QUARTERLY AND ANNUAL TARGETS FOR DISTRICT HEALTH SERVICES FOR 2012/13

QUARTERLY INDICATORS	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
Provincial PHC expenditure per uninsured person	QUARTERLY	R300	R300	R300	R300	R300
Utilisation rate- PHC		2.8	2.2	2.4	2.6	2.8
Utilisation rate under 5 years- PHC		**5.5**	5.5	5.5	5.5	5.5
Percentage of fixed PHC facilities with a monthly supervisory visit		80	80	80	80	80
Expenditure per PHC headcount		R95	R95	R95	R95	R95
Number of additional functional Mental Health Review Boards.	QUARTERLY	2 (cumulative 3)	-	1	1	-
Number of district hospitals with functional Hospital Boards.		23/23	23/23	23/23	23/23	23/23
Number of PHC facilities with functional Clinic/CHC Committees.		278/278	278/278	278/278	278/278	278/278
Number of district hospitals with trained Hospital Boards.		23/23	23/23	23/23	23/23	23/23
Number of PHC facilities with trained Clinics/CHC Committees.		278/278	278/278	278/278	278/278	278/278
Number of districts with fully established management structures.		3 (non cumulative)	3	3	3	3
Number of sub - districts with fully established management structures.		6 sub – districts (2 Ehlanzeni,2 Nkangala and 2 Gert Sibande	1	2	3	-
Number of PHC Supervision Policies implemented and reviewed.		Implemented and Reviewed	1 implemented	-	-	1 reviewed
Number of District Health Plans and District Health Expenditure Review (DHER) Reports developed.	ANNUAL	3 District Health Plans	-	-	-	3 District Health Plans
		3 District Health Expenditure Review Reports	-	-	-	3 District Health Expenditure Review Reports

QUARTERLY INDICATORS	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
Number of PHC facilities implementing the quality improvement plans in line with the 6 priorities of the core standards.	QUARTERLY	278/278	278/278	278/278	278/278	278/278
Number of Primary Health Care supervisors appointed.		7 (35 cumulative)	-	3	4	-
Implement healthy lifestyle interventions by establishment of support groups in all 3 districts.		20	5	5	5	5
Number of additional Health Promoting Schools established in all 3 districts.		15 (cumulative 270)	4	4	3	4
Number of additional household community components (HHCC) of IMCI established in all 3 districts.		15 (cumulative 133)	4	4	3	4
Number of Primary Health Care Outreach Teams established in sub districts.		22 (cumulative 40)	5	6	6	5
Number of School Health Service Teams established		28 (65 cumulative)	**7**	**7**	**7**	**7**
% of quintile 1 and 2 primary schools reached through school health services.	QUARTERLY	25	5	5	5	5
Number of districts hospitals supported by District Specialist teams		12	3	3	3	3
Number of NGOs/NPOs funded to provide Community Based Health Services.		200	200	200	200	200
Number of PHC facilities with Pharmacists Assistants.		29 (cumulative 60)	-	9	10	10
Number of sub districts with appointed Health Information Officers.		18	-	6	6	6
Number of PHC facilities with Data Capturers appointed.		278 PHC facilities with Data Capturers	91	-	-	187
Number of facilities with functional computers		278 PHC facilities with functional computers	50	60	80	88
Number of PHC facilities with at least two PHC trained nurses		55 (cumulative:105)	50	-	-	55

QUARTERLY INDICATORS	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
Number of fixed clinics and CHCs supported by a doctor at least once a week.		122/278	122	122	122	122
Number of PHC facilities with available essential drug including ART.		278/278	278/278	278/278	278/278	278/278
Number of PHC facilities with available essential equipment.		278/278	278/278	278/278	278/278	278/278

2.5 SUB – PROGRAMME DISTRICT HOSPITALS

The purpose of the programme is to render level 1 health services in district hospitals.

TABLE DHS 6 : SITUATION ANALYSIS INDICATORS FOR DISTRICT HOSPITALS

Quarterly Indicators	Data Source	Type	Province wide value 2010/11	Ehlanzeni District 2010/11	Gert Sibande District 2010/11	Nkangala District 2010/11	National Average 2010/11
1. Caesarean section rate	DHIS	%	16.3	15.5	19.1	13.1	N/A
2. Separations – Total	DHIS	No	301 458	135 964	134 138	28 506	N/A
3. Patient Day Equivalents – Total	DHIS	No	1 723 164	477 797	866 953	216 112	N/A
4. OPD Headcount – Total	DHIS	No	1 095 787	392 427	480 105	229 843	N/A
5. Average Length of Stay	DHIS	Days	4.3	4.9	4.4	4.3	N/A
6. Bed Utilisation Rate	DHIS	%	64.6	72.5	64.0	63.6	N/A
7. Expenditure per patient day equivalent (PDE)	Expenditure Reports	R	1 068.38	1,559	1,445	1,860	N/A
8. Percentage of complaints of users of District Hospital Services resolved within 25 days	DHIS	%	50%	53%	50%	50 %	N/A
9. Percentage of District Hospitals with monthly Mortality and Morbidity Meetings	DHIS	%	100	100%	100%	100%	N/A

Source: District Health Services & DHIS

Annual Indicators	Data Source	Type	Province wide value 2010/11	Ehlanzeni District 2010/11	Gert Sibande District 2010/11	Nkangala District 2010/11	National Average 2010/11
10. District Hospital Patient Satisfaction Rate -	DHIS: Patient Satisfaction Module	%	87%	85%	87%	86%	N/A
11. Number of District Hospitals assessed for compliance against the 6 priorities of the core standards	Assessment Reports	No	No Data	No Data	No Data	No Data	N/A

Source: District Health Services & DHIS

2.5.1 PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR DISTRICT HOSPITALS

TABLE DHS 7: PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR DISTRICT HOSPITALS

BUDGET SUB PROGRAMME: DISTRICT HOSPITALS										
STRATEGIC GOAL 4: STRENGTHEN HEALTH SYSTEM EFFECTIVENES										
Strategic objective	**Performance indicator**	**Strategic Plan target**	**Means of verification/ Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
Implement the 6 priority areas of the core standards for quality health care	No of district hospitals implementing the quality improvement plans in line with the 6 priorities of the core standards	Quality Improvement Plans in accordance with Core Standards, implemented in 23 District Hospitals	Assessment Reports	-	23/23	23/23	23/23	23/23	23/23	23/23
	No of hospitals and sub-districts with dedicated infection, prevention and control practitioners.	Not in Plan	Job Description or Delegation Letters	17 hospitals 3 sub-districts	17 hospitals	23/23 hospitals	23/23 hospitals	23/23 hospitals	23/23 hospitals	23/23 hospitals
					3 sub-districts	1 sub-district	9 sub-districts	14 sub-districts	18 sub-districts	20 sub-districts

TABLE DHS 8 : PERFORMANCE INDICATORS FOR DISTRICT HOSPITALS

Quarterly Indicators	Data Source	Type	Audited/ Actual performance			Estimate	Medium-term targets			National target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Caesarean section rate	DHIS	%	14,5	16.2	16.3	16	15	15	15	15% or above
2. Separations – Total	DHIS	No	158 885	156 614	301 458	160 789	158 604	156 712	160 000	Provincial
3. Patient Day Equivalents – Total	DHIS	No	1 018 595	1 028 556	1 723 164	1 176 601	1 218 761	1 287 924	1 300 200	Provincial
4. OPD Headcount – Total	DHIS	No	653 185	865 050	1 095 787	900 000	800 000	700 000	680 000	Provincial
5. Average Length of Stay	DHIS	Days	4.6	4.3	4.3	3.8	3.5	3.4	3.4	3.5 days
6. Bed Utilisation Rate	DHIS	%	73,3	67.5	64.6	73	74	75	75	75% or above
7. Expenditure per patient day equivalent (PDE)	DHIS	R	1, 3 71.24	1,497	1,068	1,424	1,440	1,400	1, 400	Provincial
8. Percentage of complaints of users of District Hospital Services resolved within 25 days	DHIS	%	Not in Plan	Not in Plan	50	100	100	100	100	100
9. Percentage of District Hospitals with monthly Mortality and Morbidity Meetings	DHIS	%	95% (22/23)	100% (23/23)	100	100	100	100	100	100

Source: District Health Services & DHIS

Annual Indicators	Data Source	Type	Audited/ Actual performance			Estimate	Medium-term targets			National target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
10. District Hospital Patient Satisfaction rate -	DHIS: Patient Satisfaction Module	%	Not in Plan	Not in Plan	87%	60%	70%	75%	80%	N/A
11. Number of District Hospitals assessed for compliance against the 6 priorities of the core standards.	Assessment Reports	No	Not in Plan	Not in Plan	Not in Plan	23/23	23/23	23/23	23/23	N/A

Source: District Health Services & DHIS

QUARTERLY TARGETS FOR DISTRICT HOSPITALS

TABLE DHS 9: QUARTERLY TARGETS FOR DISTRICT HOSPITALS FOR 2012/13

QUARTERLY INDICATORS	REPORTING PERIOD	ANNUAL TARGET 2012/103	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
1. Caesarean section rate	QUARTERLY	15	15	15	15	15
2. Separations - Total		158 604	39 651	39 651	39 651	39 651
3. Patient Day Equivalents - Total		1,218,761	304 690	304 690	304 690	304 691
4. OPD Headcount - Total		800 000	200 000	200 000	200 000	200 000
5. Average Length of Stay		3.5	3.5	3.5	3.5	3.5
6. Bed Utilisation Rate		74	74	74	74	74
7. Expenditure per patient day equivalent (PDE)		1,440	1, 440	1, 440	1, 440	1, 440
8. Percentage of complaints of users of District Hospital Services resolved within 25 days		100	100	100	100	100
9. Percentage of District Hospitals with monthly Mortality and Morbidity Meetings		100	100	100	100	100
10. No of district hospitals implementing the quality improvement plans in line with the 6 priorities of the core standards.	QUARTERLY	23	23	23	23	23
11. No of hospitals and sub districts with dedicated infection, prevention and control practitioners.		23 hospitals	23 hospitals	23 hospitals	23 hospitals	23 hospitals
		14 sub-districts	14 sub-districts	14 sub-districts	14 sub-districts	14 sub-districts

Source: District Health Services & DHIS

ANNUAL INDICATORS	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
12. District Hospital Patient Satisfaction rate	ANNUALLY	70%	70%	70%	70%	70%
13. Number of District Hospitals assessed for compliance against the 6 priorities of the core standards.		23/23	5	6	6	6

Source: District Health Services & DHIS

2.6 SUB – PROGRAM : HIV & AIDS, STI & TB CONTROL (HAST)

TABLE HIV1: SITUATION ANALYSIS INDICATORS FOR HIV & AIDS, STIs AND TB CONTROL

Quarterly Indicators	Data Source	Type	Province wide value 2010/11	Ehlanzeni District 2010/11	Gert Sibande District 2010/11	Nkangala District 2010/11	National Average 2010/11
1. Total number of patients (Children and Adults) on ART	Reports	No	111 402	50,123	30,655	30,624	N/A
2. Male condom distribution rate	DHIS	No	19.9	25.1	15.2	13.6	N/A
3. New smear positive PTB defaulter rate	ETR. Net	%	6.9% (2009)	5.4% (2009)	11.2% (2009)	7.6% (2009)	N/A
4. PTB two month smear conversion rate	ETR. Net	%	76.3% (2009)	83.3% (2009)	74.5% (2009)	54.1% (2009)	N/A
5. Percentage of HIV-TB Co-infected patients placed on ART	Reports	%	52.1	53,5	51	52	N/A
6. HCT testing rate	DHIS	%	90	87.8	92.3	92.8	N/A

Source: DHIS

Annual Indicators	Data Source	Type	Province wide value 2010/11	Ehlanzeni District 2010/11	Gert Sibande District 2010/11	Nkangala District 2010/11	National Average 2010/11
7. New smear positive PTB cure rate	ETR	%	73.1% (2009)	79.1% (2009)	61.4% (2009)	64.6% (2009)	N/A

Source: DHIS

TABLE HIV2: PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR HAST

BUDGET SUB PROGRAMME: HIV AND AIDS, STI AND TB CONTROL										
STRATEGIC GOAL 1: INCREASING LIFE EXPECTANCY STRATEGIC GOAL 3: COMBATING HIV AND AIDS AND DECREASING THE BURDEN OF DISEASE FROM TUBERCULOSIS										
Strategic Objective	**Performance Indicator**	**Strategic Plan target**	**Means of verification/ Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11 (actual)**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
Rapidly scaling up access to Antiretroviral Therapy (ART) for people living with HIV and AIDS.	Number of facilities providing ART services.	Not in Plan	District Office Database/ DHIS	33	34	161	283 PHC facilities & 28 hospitals	278 PHC facilities and 33 hospitals	278 PHC facilities and 33 hospitals	278 PHC facilities and 33 hospitals
	Increase the percentage of HIV & AIDS and TB co-morbidity patients with a CD4 count of 350 or less, initiated on ART.	Not in Plan	DHIS	Not in Plan	Not in Plan	100%	100%	100%	100%	100%
	Initiate all MDR patients who are HIV positive, on ART irrespective of CD4 count.	Not in Plan	Reports	Not in Plan	Not in Plan	100%	100%	100%	100%	100%
Strengthen the TB Control Programme	Decrease the incidence of reported TB cases to <1%.	<1%	ETR Net	<1%	<1%	<1%	<1%	<1%	<1%	<1%
	Accelerate TB Contact Tracing to 90%.	Not in Plan	ETR Net	-	-	-	90%	90%	90%	90%
	Eliminate TB Drug Stockouts to 0%.	Not in Plan	TB Register	Not in Plan	Not in Plan	0%	0%	0%	0%	0%

*The decrease in the total number of PHC facilities from 283 (2011/12) to 278/278 (2012/13) is as a result of some PHC facilities that were closed. Five (5) satellite clinics in Gert Sibande District, four (4) in Mkhondo and one (1) in Msukaligwa were previously reported as fixed eight-hour clinics. Two (2) Community Health Centres i.e. Dwarsloop and Lochiel, are operational.

BUDGET SUB PROGRAMME: HIV AND AIDS, STI AND TB CONTROL										
STRATEGIC GOAL 3: COMBATING HIV AND AIDS AND DECREASING THE BURDEN OF DISEASE FROM TUBERCULOSIS										
Strategic Objective	**Performance Indicator**	**Strategic Plan target**	**Means of verification/ Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11 (actual)**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
Implement Health Care Provider-initiated HIV Counselling and Testing (HCT) in all health facilities.	Increase the proportion of pregnant women tested through health care provider-initiated counselling and testing.	Not in Plan	DHIS	86%	95%	95%	95%	96%	97%	98%
	% of public health facilities providing HCT.	100% of public facilities providing VCT	DHIS	100%	100%	100%	100%	100%	100%	100%
	Number of non-medical sites offering HCT	70 non medical sites offering HCT	DORA Report / Provincial Database	25	25	44	60	65	70	75
Scaling up a combination of prevention interventions to reduce new infections.	Scale up condom distribution for both male and female condoms.	Not in Plan	DHIS	19,728,900 male condoms	38,943,442 male condoms	77,933,100 male condoms	45,000,000 male condoms	48,000,000 male condoms	50,000,000 male condoms	55,000,000 male condoms
				28,000 female condoms	230,698 female condoms	400,000 female condoms	40,000 female condoms	100,000 female condoms	150,000 female condoms	200,000 female condoms
	Number of male clients medically circumcised.	Not in Plan	MMC Reports	Not in plan	Not in plan	3500	38 970	50 000	80 000	120 000
	Number of MMC high volume , high quality sites.	Not in Plan	MMC Reports	Not in plan	Not in plan	5	12	12	15	15
	Number of High Transmission Areas (HTA) Intervention Sites.	72 HTA Intervention Sites	DORA Report & HTA Summary Statistics	53	56	60	64	68	72	76
	STI partner treatment rate	Not in Plan	DHIS	25	26,7	25.5	30	31	32	33
	% of new eligible sexual assault cases provided with PEP prophylaxis.	Not in Plan	DHIS / Tick Registers	1489 (actual)	2838 (actual)	70	100	100	100	100

BUDGET SUB PROGRAMME: HIV AND AIDS, STI AND TB CONTROL										
STRATEGIC GOAL 3: COMBATING HIV AND AIDS AND DECREASING THE BURDEN OF DISEASE FROM TUBERCULOSIS										
Strategic Objective	**Performance Indicator**	**Strategic Plan target**	**Means of verification/ Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11 (actual)**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
	Antenatal client initiated on AZT during antenatal care rate.	Reduce vulnerability to HIV infection and the impact of AIDS	DHIS	57%	70,4%	80.2%	95%	96%	97%	98%
	Baby Nevirapine uptake rate.		DHIS	98%	96%	96.4%	98%	100%	100%	100%
	Percentage of HIV positive clients on IPT	Not in Plan	DHIS	Not in Plan	Not in Plan	14.3	20	50%	60%	70%
STRATEGIC GOAL 4: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS										
Expand access to home based care and community health workers.	Number of active community caregivers receiving stipends	Not in Plan	Reports	Not in Plan	2100	3 735	2300	2400	2500	2500

TABLE HIV3: PERFORMANCE INDICATORS FOR HIV & AIDS, STI AND TB CONTROL

Indicator	Data Source	Type	Audited/ actual performance			Estimate	MTEF projection			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Total number of patients (Children and Adults) on ART	DHIS	No	46 310	70 064	111 402	137 855	172 855	207 855	237 855	3.2 million
2. Male condom distribution rate	DHIS	No	12,1	15,7	19.9	13	14	14.5	15	N/A
3. New smear positive PTB defaulter rate	ETR. Net	%	8.2	7	7.1	6	6	<5	<5	<5
4. PTB two month smear conversion rate	ETR. Net	%	71,3	76.3	60.8 (2010)	77	79	80	80	N/A
5. Percentage of HIV-TB Co-infected patients placed on ART	DHIS	%	New Indicator	New Indicator	52.1	100	100	100	100	100
6. HCT Testing rate	DHIS	%	78.4	86.5	90	90	90	90	90	90

Source: DHIS & TB data from ETR Net

Annual Indicators		Type	Audited/ actual performance			Estimate	MTEF projection			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
7. New smear positive PTB cure rate	ETR	%	64.5	67	73,1 (2009)	75	80	85	85	85

Source: ETR Net

2.6.2 QUARTERLY AND ANNUAL TARGETS FOR HAST

TABLE HIV4: QUARTERLY AND ANNUAL TARGETS FOR HIV & AIDS, STI AND TB CONTROL FOR 2012/13

QUARTERLY INDICATORS	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
1. Total number of patients (Children and Adults) on ART	QUARTERLY	35 000 (cumulative 172 855)	8500	8500	8500	9500
2. Male condom distribution rate		14	14	14	14	14
3. New smear positive PTB defaulter rate		6%	6%	6%	6%	6%
4. PTB two month smear conversion rate		79%	79%	79%	79%	79%
5. % of HIV-TB Co-infected patients placed on ART		100%	100%	100%	100%	100%
6. HCT Testing rate		90%	90%	90%	90%	90%
7. Number of facilities providing ART services.	QUARTERLY	117 PHC facilities (cumulative 278)	30 PHC facilities	29 PHC facilities	29 PHC facilities	29 PHC facilities
		33 hospitals	33 hospitals	33 hospitals	33 hospitals	33 hospitals
8. Increase the percentage of HIV & AIDS and TB co-morbidity patients with a CD4 count of 350 or less, initiated on ART.		100%	100%	100%	100%	100%
9. Initiate all MDR patients who are HIV positive, on ART irrespective of CD4 count.		100%	100%	100%	100%	100%
10. Accelerate TB Contact Tracing to 90%.		90%	90%	90%	90%	90%
11. Eliminate TB Drug Stockouts to 0%.		0%	0%	0%	0%	0%
12. Increase the proportion of pregnant women tested through health care provider-initiated counselling and testing.		96%	96%	96%	96%	96%
13. % of public health facilities providing HCT.		100%	100%	100%	100%	100%
14. Number of non-medical sites offering HCT		3 (cumulative 65)	1	1	1	-
15. Scale up condom distribution for both male and female condoms.		48,000,000 male condoms	12,000,000	12,000,000	12,000,000	12,000,000
		100,000 female condoms	25,000	25,000	25,000	25,000

QUARTERLY INDICATORS	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
16. Number of male clients medically circumcised	QUARTERLY	9,000 (cumulative 50 000 males)	2,000	3,000	2,000	2,000
17. Number of MMC high volume , high quality sites		12 existing sites strengthened	-	-	-	-
18. Number of High Transmission Areas (HTA) Intervention Sites.		4 (cumulative 68)	1	1	1	1
19. STI partner treatment rate		31%	29%	30%	31%	31%
20. % of new eligible sexual assault cases provided with PEP prophylaxis.		100%	100%	100%	100%	100%
21. Antenatal client initiated on AZT during antenatal care rate.		96%	95%	95%	96%	96%
22. Baby Nevirapine uptake rate.		100%	100%	100%	100%	100%
23. % of HIV positive clients on IPT		50%	49%	49%	50%	50%
24. Number of active community caregivers receiving stipends.		2400	2400	2400	2400	2400

ANNUAL INDICATORS	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
25. New Smear Positive PTB Cure Rate	ANNUALLY	80%	-	-	-	80%
26. Increase the TB Cure Rate.	ANNUALLY	80%	-	-	-	80%
27. Decrease the incidence of reported TB cases to <1%.		<1%	-	-	-	<1%
28. Reduce the TB Defaulter Rate annually.		<6%	-	-	-	<6%

2.7 MATERNAL, CHILD AND WOMEN'S HEALTH AND NUTRITION (MCWH&N)

TABLE MCWH1: SITUATION ANALYSIS INDICATORS FOR MCWH & N

Quarterly Indicators	Data Source	Type	Province wide value 2010/11	Ehlanzeni District 2010/11	Nkangala District 2010/11	Gert Sibande District 2010/11	National Average 2010/11
1. Immunisation coverage under 1 year	DHIS	%	69.8	69.6	78.7	62.4	N/A
2. Vitamin A coverage 12 – 59 months	DHIS	%	29.2	32.5	19.4	33.3	N/A
3. Measles 1st dose under 1 year coverage	DHIS	%	88.9	95.2	78.1	89	N/A
4. Pneumococcal Vaccine (PCV) 3rd Dose Coverage	DHIS	%	54.2	52.3	59.4	52.5	N/A
5. Rota Virus (RV) 2nd Dose Coverage	DHIS	%	60.9	58.7	61.5	63.8	N/A
6. Cervical cancer screening coverage	DHIS	%	60.3	60.6	70.8	46.0	N/A
7. Antenatal visits before 20 weeks rate	DHIS	%	36	36.7	37.2	34.1	N/A
8. Baby tested PCR Positive six weeks after birth as a proportion of babies tested at six weeks	DHIS	%	7.9	5.2	18.6	8.4	N/A

Source: DHIS

Annual Indicators	Data Source	Type	Province wide value 2010/11	Ehlanzeni District 2010/11	Nkangala District 2010/11	Gert Sibande District 2010/11	National Average 2010/11
9. Couple year protection rate	DHIS	%	28.9	33.4	26.1	26.8	N/A
10. Facility Maternal mortality rate	DHIS	No per 100 000	194.8	152.3	198.0	297.4	N/A
11. Delivery rate for women under 18 years	DHIS	%	10.2	11.0	7.0	11.3	N/A
12. Facility Infant mortality (under 1) rate	DHIS	No per 1000	9.6%	8.5	8.2	11.4	N/A
13. Facility Child mortality (under 5) rate	DHIS	No per 1000	6.9%	6.3	5.7	7.9	N/A

Source: DHIS

2.7.1 PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR MCWH & N

TABLE MCWH2: PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR MCWH&N

BUDGET SUB PROGRAMME: MATERNAL, CHILD AND WOMEN'S HEALTH AND NUTRITION										
STRATEGIC GOAL 1: INCREASING LIFE EXPECTANCY										
Strategic objective	**Performance indicator**	**Strategic Plan target**	**Means of verification/ Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
STRATEGIC GOAL 2: DECREASING MATERNAL AND CHILD MORTALITY										
Strengthen efforts to decrease maternal and child mortality.	Strengthen facilities which review maternal and perinatal deaths.	Not in Plan	DHIS	92,8% (26)	100% (28)	100% (28)	100% (28)	100% (28)	100% (28)	100% (28)
	Increase the number of facilities providing Basic Antenatal Care (BANC).	Not in Plan	DHIS	27	185	203	236	254	278	278
	Increase the proportion of designated health facilities that provides Choice of Termination of Pregnancy (CTOP).	Not in Plan	DHIS	43% (12)	25% (7)	39% (11)	46% (13)	53.6% (15)	57% (16)	60,7% (17)
	Reduce severe malnutrition under 5 years incidence.	Severe malnutrition under 5 years incidence: 0.3	DHIS	4.3	5.3	3.6	4	4/1000	4/1000	4/1000
		Not gaining weight rate under 5: <0.6	DHIS	0.9	0.9	1.1	1	1/1000	1/1000	1/1000

TABLE MCWH3: PERFORMANCE INDICATORS FOR MCWH & N

Quarterly Indicators	Data Source	Type	Audited/ Actual performance			Estimate	MTEF projection			National target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Immunisation coverage under 1 year	DHIS	%	76	91	69.8	90	90	90	90	90%
2. Vitamin A coverage 12 – 59 months	DHIS	%	25.3	29.7	29.2	35	35	40	45	80%
3. Measles 1st dose under 1 year coverage	DHIS	%	79	95.5	88.9	90	90	90	90	90%
4. Pneumococcal Vaccine (PCV) 3rd Dose Coverage	DHIS	%	-	71 (1st dose)	82.6	90	90	90	90	90%
5. Rota Virus (RV) 2nd Dose Coverage	DHIS	%	-	79 (1st dose)	75.8	90	90	90	90	90%
6. Cervical cancer screening coverage	DHIS	%	4.9 (rate)	6.2 (rate)	60.3	55	60	65	70	70%
7. Antenatal visits before 20 weeks rate	DHIS	%	32.3	35.35	36	37	39	41	43	70%
8. Baby tested PCR Positive six weeks after birth as a proportion of babies tested at six weeks	DHIS	%	15%	12.8%	10%	<5%	<5%	<5%	<5%	<5%

Source: DHIS

Annual Indicators	Data Source	Type	Audited/ Actual performance			Estimate	MTEF projection			National Target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
9. Couple year protection rate	DHIS	%	N/A	N/A	33.4	35	37	39	41	75%
10. Public Health facility Maternal mortality rate	DHIS	No per 100 000	13	11.9	194.8	141	132	130	128	120
11. Delivery rate for women under 18 years	DHIS	%	10.3	10.3	10	10	10.5	11	11.5	N/A
12. Public Health Facility Infant mortality (under 1) rate	DHIS	No per 1000	18.2	8.5	9.6	7.9	7.8	7.7	7.6	N/A
13. Public Health Facility Child mortality (under 5) rate	DHIS	No per 1000	7.8	6.1	6.9	5.5	5	5	5	N/A

Source: DHIS

- **QUARTERLY AND ANNUAL TARGETS FOR MCWH &**

TABLE MCWH 4: QUARTERLY AND ANNUAL TARGETS FOR MCWH & N FOR 2012/13

PROGRAMME PERFORMANCE INDICATORS	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
1. Immunisation coverage under 1 year	QUARTERLY	90	90	90	90	90
2. Vitamin A coverage 12 – 59 months		35	30	32	32	35
3. Measles 1st dose under 1 year coverage		90	90	90	90	90
4. Pneumococcal Vaccine (PCV) 3rd Dose Coverage		90	90	90	90	90
5. Rota Virus (RV) 2nd Dose Coverage		90	90	90	90	90
6. Cervical cancer screening coverage		60	60	60	60	60
7. Antenatal visits before 20 weeks rate		37	37	37	37	37
8. Baby tested PCR Positive six weeks after birth as a proportion of babies tested at six weeks		<5%	<5%	<5%	<5%	<5%
9. Strengthen facilities which review maternal and perinatal deaths.	QUARTERLY	100% (28)	100% (28)	100% (28)	100% (28)	100% (28)
10. Increase the proportion of facilities providing Basic Antenatal Care (BANC).		18 (cumulative 254)	4	4	5	5
11. Increase the number of designated health facilities that provides Choice of Termination of Pregnancy (CTOP).		2 (cumulative15)	0	1	1	0
12. Reduce severe malnutrition under 5 years incidence		4/1000	4/1000	4/1000	4/1000	4/1000
		Not gaining weight rate: 1/1000	1/1000	1/1000	1/1000	1/1000

PROGRAMME PERFORMANCE INDICATORS	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
13. Couple year protection rate	ANNUALLY	37	-	-	-	37
14. Public Health facility Maternal mortality rate		132/100 000	-	-	-	132
15. Delivery rate for women under 18 years		10.5	-	-	-	10.5
16. Public Health Facility Infant mortality (under 1) rate		7.8/1000	-	-	-	7.8
17. Public Health Facility Child mortality (under 5) rate		5/1000	-	-	-	5

2.6 DISEASE PREVENTION AND CONTROL (DPC)

TABLE DPC 1: SITUATION ANALYSIS INDICATORS FOR DISEASE PREVENTION AND CONTROL

Annual Indicators	Data Source	Type	Province wide value 2010/11	Ehlanzeni District 2010/11	Gert Sibande District 2010/11	Nkangala District 2010/11	National Average 2010/11
1. Malaria case fatality rate	Malaria Surveillance Reports	%	0.71	0.69	0	0	0.5
2. Cholera fatality rate	Weekly Zero Report compiled by Districts	%	0	0	0	0	0
3. Cataract surgery rate	Provincial Cataract Surgery Report	No per million population	700	600	641	887	1061

Source: DHIS

2.8.1 PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR DPC

TABLE DPC2: PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR DISEASE PREVENTION AND CONTROL

BUDGET SUB PROGRAMME: DISEASE PREVENTION AND CONTROL										
STRATEGIC GOAL 1: INCREASING LIFE EXPECTANCY										
Strategic objective	**Performance indicator**	**Strategic Plan target**	**Means of verification/ Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
Decrease morbidity and mortality as a result of communicable and non communicable diseases	Outbreaks responded to within 24 hours.	Not in Plan	Weekly Zero Reports compiled by Districts	100%	100%	87.5%	100%	100%	100%	100%
	% Reduction in intentional and un intentional injuries	Not in Plan	Medical Research Council Annual Survey	Not in Plan	Not in Plan	Not in Plan	5% reduction	5% reduction	5% reduction	5% reduction
	Decrease the incidence of Malaria per 1000 population at risk.	Not in Plan	DHIS	0.28 per 1000 population	0.37 per 1000 population	0.41 per 1000 population 2010/11	0.5 local case per 1000 population	0.4 local case per 1000 population	0.3 local case per 1000 population	0.2 local case per 1000 population
	Chronic Disease Management Register implemented in all PHC Facilities.	Not in Plan	CDM Register	0	0	0	0	100%	100%	100%

TABLE DCP 3: PERFORMANCE INDICATORS FOR DISEASE PREVENTION AND CONTROL

Annual Indicators	Data Source	Type	Audited/ actual performance			Estimate	MTEF projection			National target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Malaria case fatality rate	Malaria Surveillance Reports	%	0.69	1.13	0.71	0.5	0.5	0.5	0.5	0.5
2. Cholera fatality rate	Weekly Zero Report compiled by Districts	%	0.52	0	0	Less than 1	Less than 1	Less than 1	Less than 1	Less than 1
3. Cataract surgery rate	Provincial Cataract Surgery Report	No per million population	CSR 860	CSR 800 (2,881)	CSR 700	CSR 1000 (3,600)	CSR 1000 (3,600)	CSR 1000 (3,600)	CSR 1000 (3,600)	CSR 1500 (4,500)

Source: DHIS

2.8.2 QUARTERLY AND ANNUAL TARGETS FOR DPC

TABLE DPC4: QUARTERLY AND ANNUAL TARGETS FOR DISEASE PREVENTION AND CONTROL FOR 2012/13

PROGRAMME PERFORMANCE INDICATOR	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
Outbreak responded to within 24 hours	QUARTERLY	100%	100%	100%	100%	100%
% Reduction in intentional and un intentional injuries	ANNUAL	5% reduction	-	-	-	5% reduction
Decrease the incidence of malaria per 1000 population at risk.		0.4 Local case per 1000 population	-	-	-	0.4 Local case per 1000 population
Chronic Disease Management Register implemented in all PHC Facilities.		100%	-	-	-	100%
Malaria fatality rate	ANNUAL	0.5	-	-	-	0.5
Cholera fatality rate		< 1	-	-	-	< 1
Cataract surgery rate		CSR 1000 (3,600)	CSR 195 (700)	CSR 305 (1,100)	CSR 305 (1,100)	CSR 105 (700)

2.9 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE DHS11: DISTRICT HEALTH SERVICES

	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
	Audited			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
Subprogramme									
District Management	141 937	201 928	210 068	254 799	254 182	254 182	261 804	277 742	293 763
Community Health Clinics	454 471	532 334	619 712	643 273	768 524	768 524	789 542	814 272	840 007
Community Health Centres	274 734	346 241	415 716	478 032	458 032	458 032	524 028	554 599	585 271
Community-based Services	-	-	72 311	89 118	92 286	92 286	107 150	110 866	117 496
HIV/Aids	224 708	346 539	419 326	504 701	502 043	502 043	625 665	744 697	783 463
Nutrition	13 841	11 250	13 785	23 994	23 442	23 442	27 733	29 249	30 724
District Hospitals	1 304 162	1 622 196	1 840 994	1 931 596	2 014 512	2 014 512	2 048 436	2 172 678	2 079 200
Total	**2 413 853**	**3 060 488**	**3 591 912**	**3 925 513**	**4 113 021**	**4 113 021**	**4 384 359**	**4 704 103**	**4 729 924**
Current payments	**2 316 010**	**2 949 518**	**3 477 590**	**3 778 248**	**3 939 378**	**3 939 378**	**4 239 114**	**4 553 815**	**4 571 615**
Compensation of employees	1 611 969	1 895 206	2 214 285	2 437 661	2 649 678	2 649 678	2 852 648	3 054 298	3 039 333
Salaries and wages	1 410 898	1 655 369	1 930 205	2 147 990	2 305 376	2 305 667	2 485 175	2 662 613	2 635 833
Social contributions	201 071	239 837	284 080	289 671	344 302	344 011	367 473	391 685	403 500
Goods and services	704 041	1 054 311	1 263 305	1 340 587	1 289 700	1 289 700	1 386 466	1 499 517	1 532 282
Administrative fees	512	344	1 032	575	575	575	207	210	212
Advertising	3 105	1 824	219	1 010	1 010	1 010	1 114	1 174	1 227
Assets <R5000	15 811	9 022	6 616	17 335	12 833	12 833	12 027	12 126	12 308
Audit cost: External	-	8 149	-	-	-	-	-	-	-
Bursaries (employees)	-	-	-	-	-	-	-	-	-
Catering: Departmental activities	8 707	5 462	4 267	1 250	1 250	1 250	1 893	1 900	1 906
Communication	19 333	28 142	19 268	19 934	19 934	19 934	20 454	20 464	20 473
Computer services	151	208	682	-	-	-	270	270	270
Cons/prof:business & advisory services	20	-	-	147	147	147	-	-	-
Cons/prof: Infrastructre & planning	-	-	-	-	-	-	-	-	-
Cons/prof: Laboratory services	99 347	182 636	186 937	197 366	197 366	197 366	270 197	321 893	333 436
Cons/prof: Legal cost	-	-	-	-	-	-	-	-	-
Contractors	74 327	121 771	125 109	130 768	122 387	122 387	118 428	118 451	118 471
Agency & support/outsourced services	7 349	10 877	4 852	42 748	39 748	39 748	18 164	18 720	19 211
Entertainment	-	-	-	-	-	-	-	-	-
Fleet Services	28 753	24 132	25 030	25 772	25 772	25 772	25 539	25 550	25 560
Housing	-	-	-	-	-	-	-	-	-
Inventory: Food and food supplies	25 336	46 647	40 704	55 348	54 826	54 826	52 597	52 647	52 691
Inventory: Fuel, oil and gas	8 621	12 218	13 415	17 108	17 108	17 108	12 425	12 425	12 425
Inventory:Learn & teacher support material	-	-	-	-	-	-	-	-	-
Inventory: Materials & suppplies	1 256	1 167	1 259	1 931	1 931	1 931	1 506	1 506	1 506
Inventory: Medical supplies	308 786	492 233	96 987	79 771	79 771	79 771	198 047	198 047	198 047
Inventory: Medicine	-	-	609 189	580 992	554 249	554 249	520 951	580 959	599 828
Medsas inventory interface	-	-	-	-	-	-	-	-	-
Inventory: Military stores	-	-	-	-	-	-	-	-	-
Inventory: Other consumbles	19 100	31 146	29 624	46 087	40 224	40 224	31 992	31 998	33 073
Inventory: Stationery and printing	16 784	13 759	16 016	22 415	19 415	19 415	18 389	18 554	18 700
Lease payments (Incl. operating leases, excl. financ	9 768	14 451	16 658	20 759	20 759	20 759	18 741	18 825	18 899
Rental & hiring	-	-	-	-	-	-	-	-	-
Property payments	15 197	24 801	39 669	43 619	43 619	43 619	32 150	32 334	32 497
Transport provided dept activity	1 198	432	206	260	260	260	178	178	178
Travel and subsistence	25 142	19 200	20 780	25 377	26 501	26 501	22 630	22 673	22 711
Training & staff development	3 381	3 785	2 661	8 050	8 050	8 050	6 425	6 425	6 425
Operating payments	7 825	707	657	1 035	1 035	1 035	773	773	773
Venues and facilities	4 232	1 198	1 468	930	930	930	1 369	1 415	1 455
Interest and rent on land	-	1	-	-	-	-	-	-	-
Transfers and subsidies	**62 888**	**68 966**	**93 375**	**107 463**	**134 858**	**134 858**	**126 607**	**131 501**	**139 391**
Provinces and municipalities	18 547	4 657	1 509	13 000	13 000	13 000	13 780	14 607	15 483
Departmental agencies and accounts	-	-	-	-	-	-	-	-	-
Non-profit institutions	40 104	58 926	85 042	91 771	119 166	119 166	109 974	113 871	120 703
Households	4 237	5 383	6 824	2 692	2 692	2 692	2 853	3 023	3 205
Payments for capital assets	**34 946**	**33 970**	**20 947**	**39 802**	**38 785**	**38 785**	**18 638**	**18 787**	**18 918**
Buildings and other fixed structures	-	490	-	-	-	-	-	-	-
Machinery and equipment	34 946	33 480	20 947	39 802	38 785	38 785	18 638	18 787	18 918
Software and other intangible assets	-	-	-	-	-	-	-	-	-
Payments for financial assets	**9**	**8 034**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total economic classification	**2 413 853**	**3 060 488**	**3 591 912**	**3 925 513**	**4 113 021**	**4 113 021**	**4 384 359**	**4 704 103**	**4 729 924**

2.10 PERFORMANCE AND EXPENDITURE TRENDS

Expenditure Trends for District Health Services

The programme budget has increased year on year with a 19.4 percent growth from 2008 to 2011 and only average 7.3 percent from 2012 to 2015. In 2012/13 the budget has increase with 7.6 percent which was mainly due to the following factors:
The overall increase is mainly due to the commitment of the department in strengthening District Health Services. The main focus for the 2012/13 financial year will be on appointment of core service delivery professionals, Specialists, Doctors, Nurses and general services (cleaner's e.g) which institutions can not function without. 19 New CHCs and Clinics are prioritised for the new financial year.

The 2011/12 financial year budget increase include additional funding received for TB and HIV/AIDS – R2,475 million, CPIX increase of 5.2 percent, OSD for Doctors, Medical Waste Removal R22.071 million, Outreach 3,153 million, funding for additional 4 CHC's R44,527 million and general increase on conditions of services .

Programme 2: District Health Services has been under funded if compared with funding per capita in the country. The programme rendered District services which carried 58.6 percent which has increase with 5.6 percent from the 2011/12 financial year on the total department of Health budget. The increase was mainly on Compensation of Employees which focuses on improving community health. The programme include Comprehensive HIV/AIDS sub programme which is a priority in the entire country. The budget increase of the programme include Infant and Child mortality funding, faster take up of the ARV's within HIV/AIDS sub-programme. The trend only provides for inflationary provision of the economy.

RISK MANAGEMENT

Risk	Mitigating factors
Ineffective referral system	Implementation plan to improve the referral system
Poor medical waste management	Monitor implementation of the Waste Management contract
Ineffective HIV/TB Management Programmes	• Review HIV and TB management strategies. • Integration of HIV & AIDS and STI within the programmes.
Ineffective primary health care services	Overhauling Primary Health Care services
Inadequate clinical support services	• Recruitment according to the approved organogram • Funding and prioritisation of the critical posts • Approval and implementation of the recruitment and retention strategy • Equitable resource allocation
Insufficient and poorly maintained medical equipment	• Development and implementation of preventative Maintenance and ReplacementPlan. • Conducting of medical equipment audit. • Establishment of maintenance of medical equipment contracts.
Interrupted drug supply	Institutionalising the PTC.
Collapse of the programme at district level if partners pulls out.	Districts to develop an Exit Plan with partners.
Failure of the programme (Development of resistant Virus) due to interrupted ART drug supply.	Establishment of sustainable procurement systems.
Overspending on ART drugs and laboratory services due to increased HCT prior to medical circumcision.	Strengthening collaboration with developmental partners.
Loss of trained and experienced staff.	Development of Retention Strategy.
Increased litigation due to adverse effects related to Male Medical Circumcision (MMC).	Training of staff.
Failure to achieve training targets.	Advertisement of tender to appoint accredited service provider for training at Regional Training Centre.
Poor monitoring and evaluation of TB HIV collaboration.	Appointment of TB/HIV collaborator.
People with communicable diseases inter the province	Request a budget to provide communication means at the ports of entries
Illegal food, cosmetics, disinfectants, hazardous Substances inter the country	Implement the 'International Health Regulation Act.' Provide resources to port health services

3. BUDGET PROGRAMME 3: EMERGENCY MEDICAL SERVICES (EMS)

3.1 PROGRAMME PURPOSE

The purpose of Emergency Medical Services is to provide pre-hospital medical services, inter-hospital transfers, Rescue and Planned Patient Transport to all inhabitants of Mpumalanga Province within the national norms of 15 minutes in urban and 40 minutes in rural areas.

NEW DEVELOPMENTS

None

3.2 PRIORITIES

The strategic goal of this programme is as follows:

- *Increasing Life Expectancy*

The **strategic priorities** of the programme are as follows:

- Improvement of response times for P1 calls.
- Establishment of Planned Patient Transport System (PPTS).

The department will improve the services through the recruitment and appointment of emergency care practitioners, increasing the number of EMS based-stations and the number of rostered ambulances in the province.

3.3 SITUATION ANALYSIS INDICATORS FOR EMS

TABLE EMS1: SITUATION ANALYSIS INDICATORS FOR EMS

Quarterly Indicator	Data Source	Type	Province wide value 2010/11	Ehlanzeni 2010/11	Nkangala 2010/11	Gert Sibande 2010/11	National Average 2010/11
1. Rostered Ambulances	EMS Information System	No per 10 000	0.028	0.028	0.030	0.026	N/A
2. P1 calls with a response of time <15 minutes in an urban area	EMS Information System	%	85	89	87	79	N/A
3. P1 calls with a response time of <40 minutes in a rural area	EMS Information System	%	70	67	64	51	N/A
4. All calls with a response time within 60 minutes	EMS Information System	%	70	66	60	54	N/A
5. % of PPTS within EMS	EMS Information System	%	35	30	38	23	N/A

Source: Emergency Medical Services Statistics

3.3.1 PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGET FOR EMS

TABLE EMS2: PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR EMERGENCY MEDICAL HEALTH SERVICES

BUDGET SUB PROGRAMME: EMERGENCY TRANSPORT										
STRATEGIC GOAL 1: INCREASING LIFE EXPECTANCY										
Strategic objective	**Performance indicator**	**Strategic Plan target**	**Means of verification/ Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
Improved response times for P1 calls	Rostered Ambulances per 10 000 people.	Not in Plan	EMS Information System	0.024	0.026	0.028	0.029	0.029	0.030	0.030
	% P1 Calls with response time of less than 15 minutes in urban.	15 minutes = urban areas	EMS Information System	80	80	85	85	85	85	85
	% P1 calls with a response time of less than 40 minutes in a rural area.	40 minutes = rural areas	EMS Information System	60	60	70	70	70	70	75
	All calls with a response time within 60 minutes.	Not in Plan	EMS Information System	65	60	70	70	70	70	75

BUDGET SUB PROGRAMME: PLANNED PATIENT TRANSPORT										
STRATEGIC GOAL 1: INCREASING LIFE EXPECTANCY										
Strategic objective	**Performance indicator**	**Strategic Plan target**	**Means of verification/ Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
Establishment of Planned Patient Transport System (PPTS).	% of PPTS within EMS.	100% of PPTS with EMS by 2015.	EMS Information System	20	20	35	45	36	37	40

TABLE EMS3: PERFORMANCE INDICATORS FOR EMS AND PATIENT TRANSPORT

Indicator	Data Source	Type	Audited/ actual performance			Estimate	MTEF projection			National target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Rostered Ambulances	EMS Information System	per 10 000 population	0.024	0.026	0.028	0.029	0.029	0.030	0.030	1 per 10000 population
2. P1 calls with a response of time <15 minutes in an urban area	EMS Information System	%	80	80	85	85	85	85	85	80%
3. P1 calls with a response time of <40 minutes in a rural area	EMS Information System	%	60	60	60	70	70	70	75	80%
4. All calls with a response time within 60 minutes	EMS Information System	%	65	60	60	70	70	70	75	100%

Note: Target is 1 ambulance per 10 000 population.
Source: EMS Integrated Information System

3.3.2 QUARTERLY AND ANNUAL TARGETS FOR EMS

TABLE EMS4: QUARTERLY AND ANNUAL TARGETS FOR EMS FOR 2012/13

PROGRAMME PERFORMANCE INDICATOR	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
Rostered Ambulances per 10 000 people	**QUARTERLY**	0.029	0.029	0.029	0.029	0.029
% P1 Calls with response time of less than 15 minutes in urban	**QUARTERLY**	85	85	85	85	85
% P1 calls with a response time of less than 40 minutes in a rural area	**QUARTERLY**	70	70	70	70	70
All calls with a response time within 60 minutes	**QUARTERLY**	70	70	70	70	70
% of PPTS within EMS	**QUARTERLY**	36	36	36	36	36

Source: EMS Integrated Information System

3.4 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

TABLE EMS5: EXPENDITURE ESTIMATES: EMERGENCY MEDICAL SERVICES

3.5

	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
	Audited			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
Subprogramme									
Emergency Transport	168 148	179 062	240 716	222 632	231 188	231 188	238 149	245 388	252 918
Planned Patient Transport	9 028	7 776	16 232	21 326	12 770	12 770	17 000	19 200	19 500
Total	177 176	186 838	256 948	243 958	243 958	243 958	255 149	264 588	272 418
Current payments	**151 895**	**171 422**	**205 201**	**218 673**	**224 229**	**223 558**	**234 378**	**241 817**	**249 647**
Compensation of employees	111 607	130 343	151 139	152 766	174 023	174 023	180 984	188 223	195 753
Salaries and wages	97 125	112 771	129 874	123 766	143 714	153 141	149 463	155 441	161 659
Social contributions	14 482	17 572	21 265	29 000	30 309	20 882	31 521	32 782	34 094
Goods and services	40 288	41 063	53 829	65 907	50 206	49 428	53 394	53 594	53 894
Administrative fees						1			
Advertising		11	264	10	264	6	264	264	264
Assets <R5000	282	554	420		420	16	420	420	420
Catering: Departmental activities	337	102	448	100	448	384	448	448	448
Communication	2 441	2 041	1 309	1 371	1 309	1 445	1 309	1 309	1 309
Computer services			648		648	210	648	648	648
Contractors	97	12	884	400	884	396	884	884	884
Agency & support/outsourced services		79	988		988		988	988	988
Entertainment						29			
Fleet Services	24 740	24 305	28 665	30 320	25 803	26 808	28 991	29 191	29 491
Inventory: Food and food supplies	3								
Inventory: Fuel, oil and gas		6	193	170	193	90	193	193	193
Inventory: Medical supplies	181	145	81	150	81	176	81	81	81
Inventory: Medicine			97	100	97	66	97	97	97
Medsas inventory interface						1			
Inventory: Other consumbles	417	214	2 176	15 120	1 415	4 733	1 415	1 415	1 415
Inventory: Stationery and printing	362	378	364	270	364	268	364	364	364
Lease payments (incl. operating leases, e	107	5 032	10 724	13 000	10 724	11 437	10 724	10 724	10 724
Property payments	63	61	65	30	65	1 858	65	65	65
Transport provided dept activity	10 902	7 005	2 374	4 000	2 374	1 013	2 374	2 374	2 374
Travel and subsistence	283	1 070	1 783	866	1 783	392	1 783	1 783	1 783
Training & staff development		8	252		252	90	252	252	252
Operating payments	57	40	20		20		20	20	20
Venues and facilities	16		2 074		2 074	9	2 074	2 074	2 074
Interest and rent on land		16	233			107			
Transfers and subsidies	**20**	**96**	**26**			**22**			
Departmental agencies and accounts	1								
Households	19	96	26			22			
Payments for capital assets	**25 114**	**15 404**	**51 721**	**25 285**	**19 729**	**20 378**	**20 771**	**22 771**	**22 771**
Buildings and other fixed structures									
Machinery and equipment	25 114	15 404	51 721	25 285	19 729	20 378	20 771	22 771	22 771
Software and other intangible assets									
of which:									
Capitalised compensation of employees									
Capitalised goods and services									
Payments for financial assets	**147**	**(84)**							
Total economic classification	177 176	186 838	256 948	243 958	243 958	243 958	255 149	264 588	272 418

3.5 PERFORMANCE AND EXPENDITURE TRENDS

Programme 3 which is Emergency Medical Services show an increase of 11.3 percent in the 2011/12 financial year. The continued drive to improve emergency medical services is reflected in the real increase in the Programme 3 funding in 2012/13 and the outer years of the MTEF period. Improvement of Planned Patient transport are prioritised in the 2012/13 financial year with the allocation of R10 million on this regard.

The following were achieved under this programme:

The purpose of Emergency Medical Services is to provide Pre-hospital medical services, Inter-hospital transfers, Rescue and Planned Patient Transport to all inhabitants of Mpumalanga Province within the national norms of 15 minutes in urban and 40 minutes in rural areas.

The numbers of rostered ambulances have been increased although in total the Province is still very far from the National norms for the population of 3,6 million. The increase in vehicle number as a result of the 2010 FIFA World Cup, has brought the number of ambulances with less than 200,000km to 92% which is a great improvement to the same period previously of 57%. The installation of the integrated information system has been a major step towards the improvement of quality of service rendered by EMS.

There was no accurate data for Nkangala Districts as the transition from their old system records had not been transferred and the system cannot be accessed. Available estimates from manual compilations are not reliable but the current new system will ensure accurate data going forward.

3.6 RISK MANAGEMENT

RISKS	MITIGATING FACTORS
Salary Disparity with other Provinces.	Create parity with other provinces
Severe staff shortages	Appointment of personnel
Lack of Recruitment and Retention Strategy which includes Emergency Medical Services (EMS).	Implementation of the Recruitment and Retention Strategy that is inclusive of EMS.
Ineffective vehicle repair system for Emergency vehicles implemented by Department of Transport.	Proposal to review the system to include emergency vehicles has been submitted

4. BUDGET PROGRAMME 4: PROVINCIAL HOSPITALS (REGIONAL AND SPECIALISED)

4.1 PROGRAMME PURPOSE

The purpose of this programme is to render level 1 and 2 health services in regional hospitals and to render TB specialized hospital services**.**

NEW DEVELOPMENTS

None

4.2 PRIORITIES

The strategic goals of this programme, is to ***Strengthen Health System Effectiveness, Increase Life Expectancy and Reduce Maternal and Child Mortality***

The strategic priority of the programme, is as follows:

- Implement the 6 priority areas of the core standards for quality health care in the three regional hospitals.

In addition to the above, the priorities for TB Hospitals are as follows:

- Procurement and revitalization of the two SANTA hospitals.
- Increase the capacity for MDR beds (e.g. Bongani MDR TB unit project).
- Implement the community management of MDR TB patients

CHALLENGES

The challenges identified for **Regional Hospitals** are as follows:

- Inability to recruit and retain specialist and other health care professionals
- Shortage of support staff at all levels
- Insufficient preventative maintenance of medical equipment and machinery
- Delays in procurement process

The challenges identified for **TB Hospitals** are as follows:

- Shortage of MDR-TB beds
- Few Health Professionals willing to work in TB hospitals
- Inappropriate infrastructure to improve Infection Control Standards
- Barberton and Standerton TB Hospitals are still under lease

In order to address these challenges, the following is in process:

Regional Hospital

- Implementation of recruitment and retention strategy.
- Head hunting of scarce skilled health professionals
- Implementation of Registrar programme through academic institutions.
- Appointment of support staff at all levels

- Recruitment of in-house technicians and support staff
- Decentralisation of procurement process

TB Specialised Hospitals

- A 40 MDR bedded hospital under construction at Bongani Hospital.
- Implement the recruitment and retention strategy to fill key critical posts in TB hospitals
- Motivate the provision accommodation for health care professionals
- Motivate for the revitalisation of infrastructure to conform to infection control standards
- Purchase Barberton and Standerton TB hospitals from SANTA

4.3 PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR REGIONAL HOSPITALS

TABLE PHS1: PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR REGIONAL HOSPITALS

BUDGET SUB PROGRAMME: REGIONAL HOSPITALS										
STRATEGIC GOAL 4: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS										
STRATEGIC OBJECTIVE	**PERFORMANCE INDICATOR**	**Strategic Plan Target**	**Means of Verification/ Data Source**	**Audited/ Actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
Implement the 6 priority areas of the core standards for quality health care	Total number of clinical domains in the 3 regional hospitals.	All 3 regional hospitals providing a complete package of level 2 services (8 clinical domains)	Physical Counting, PERSAL	3	6	5	7	6	7	8
	Number of Regional Hospitals complying with six key priorities of the core standards.	All 3 Regional Hospitals implementing six key priority areas	Assessment Reports	Not in Plan	3	3	3	3	3	3

TABLE PHS2: PERFORMANCE INDICATORS FOR REGIONAL HOSPITALS

Quarterly Indicators	Data Source	Type	Audited /actual performance			Estimate	MTEF projection			National target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Caesarean section rate	DHIS	%	18.7	19	21.9	21	21	21	21	<25
2. Separations – Total	DHIS	No	56 482	143 995	109 315	62 000	64 000	69 000	75 000	Provincial
3. Patient Day Equivalents – Total	DHIS	No	333 365	307 036	591 490	342 000	344 000	350 000	355 000	Provincial
4. OPD Headcount – Total	DHIS	No	193 607	182 882	221 050	180 000	177 000	173 000	170 000	Provincial
5. Average Length of Stay	DHIS	Days	4.1	4.1	4.3	4.7	4.7	4.7	4.7	4.8
6. Bed Utilisation Rate	DHIS	%	75	76	71	75	75	75	75	75
7. Expenditure per patient day equivalent (PDE)	BAS/ DHIS	R	1,493	1,436	1,163	2000	2200	2200	2300	N/A
8. Percentage of complaints of users of Regional Hospital Services resolved within 25 days	DHIS	%	Not in Plan	Not in Plan	Not in Plan	100	**70**	**75**	**80**	100
9. Percentage of Regional Hospitals with monthly Mortality and Morbidity Meetings	DHIS	%	Not in Plan	Not in Plan	Not in Plan	100	100	100	100	100

Source: DHIS

Annual Indicators	Data Source	Type	Audited/ Actual performance			Estimate	Medium-term targets			National target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
10. Regional Hospital Patient Satisfaction rate	Patient Satisfaction Survey	**%**	Not in Plan	Not in Plan	Not in Plan	70	75	80	90	90
11. Number of Regional Hospitals assessed for compliance with the 6 priorities of the core standards	Quality Assurance Assessment Reports	No	Not in Plan	Not in Plan	Not in Plan	3	3	3	3	N/A

4.4 QUARTERLY AND ANNUAL TARGETS FOR GENERAL HOSPITALS

TABLE PHS4: QUARTERLY AND ANNUAL TARGETS FOR REGIONAL HOSPITALS FOR 2012/13

PROGRAMME PERFORMANCE INDICATOR	REPORTING PERIOD	ANNUAL TARGET 2011/12	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
1. Caesarean section rate	QUARTERLY	21	21	21	21	21
2. Separations – Total		8000 (cumulative 64 000)	2000	2 000	2 000	2 000
3. Patient Day Equivalents – Total		39 000 (cumulative 344 000)	10 000	10 000	10 000	9 000
4. OPD Headcount – Total		17 000 (cumulative 177 000)	5 000	5 000	5 000	2 000
5. Average Length of Stay		4.7	4.7	4.7	4.7	4.7
6. Bed Utilisation Rate		75	75	75	75	75
7. Expenditure per patient day equivalent (PDE)		2200	2000	2300	2300	2200
8. Percentage of complaints of users of Regional Hospital Services resolved within 25 days		100	100	100	100	100
9. Percentage of Regional Hospitals with monthly Mortality and Morbidity Meetings		100	100	100	100	100
10. Regional Hospital Patient Satisfaction Rate	ANNUAL	75	-	-	-	75
11. Regional and specialised hospitals assessed for compliance with the 6 priorities of the core standards		3	-	-	-	3
12. Total number of clinical domains in the 3 regional hospitals.	ANNUAL	6	-	-	-	6
13. Number of Regional Hospitals complying with the six key priorities of the core standards.		3	-	-	-	3

4.5 PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR SPECIALISED HOSPITALS

TABLE PHS1: PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR SPECIALISED HOSPITALS

BUDGET SUB PROGRAMME: SPECIALISED HOSPITALS (TB HOSPITALS)										
STRATEGIC GOAL 4: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS										
Strategic Objective	**Performance Indicator**	**Strategic Plan target**	**Means of verification / Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
Improved quality of care in TB Hospitals.	Average length of stay (TB).	Not in Plan	Paper records, Patients' Register	-	-	75	80	75	70	70
	Average length of stay Drug resistance (DR).	Not in Plan		-	-	124	120	180	180	180
	Bed Utilisation Rate (TB).	Not in Plan	Paper records, Patients' Register, Daily Return	-	-	66	71	73	75	75
	Bed Utilisation Rate (DR).	Not in Plan		-	-	196	100	90	85	80
	Effective Discharge Rate (TB).	90% of patients effectively moved	Acknowledgement Slips (pink slips)	-	-	56	83	85	90	95
	Effective Discharge Rate (DR).	Not in Plan		-	-	20	88	90	95	95
	Number of additional MDR units.	3 MDR TB Units (1 per district)	Physical Count of Units	-	-	1	2	3	3	3
	% of patients reporting satisfaction with treatment.	Not in Plan	Discharge questionnaire with positive response	-	-	81	80	80	80	80
	Expenditure PDE in TB Hospitals.	Not in Plan	Registers & BAS System	-	-	R741.80	R850	R950	R1 100	R1 200
	% of patients counselled for HIV testing.	Not in Plan	Monthly HCT Statistics	-		97	100	100	100	100
	% TB patients tested for HIV.	Not in Plan		-	-	73	70	80	90	100

TABLE PHS4: QUARTERLY AND ANNUAL TARGETS FOR SPECIALISED HOSPITALS FOR 2012/13

PROGRAMME PERFORMANCE INDICATOR	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
1. Average length of stay (TB)	QUARTERLY	75	75	75	75	75
2. Average length of stay Drug resistance (DR)		180	180	180	180	180
3.Bed Utilisation rate (TB)		73%	73%	73%	73%	73%
4.Bed Utilisation rate (DR)		90%	90%	90%	90%	90%
5.Effective Discharge rate (TB)		85%	85%	85%	85%	85%
6.Effective Discharge rate (DR)		90%	90%	90%	90%	90%
7.Number additional MDR units		3	-	-	1	-
8.Expenditure PDE in TB Hospitals		R950	R950	R950	R950	R950
9. % of patients counselled for HIV testing		100	100	100	100	100
10.% TB patients tested for HIV		80	80	80	80	80
11.% of patients reporting satisfaction with treatment	ANNUAL	80	-	-	-	80

4.6 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE PHS5: EXPENDITURE ESTIMATES: PROVINCIAL HOSPITAL SERVICES

	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
	Audited			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
Subprogramme									
General (Regional) Hospitals	497 587	581 023	687 977	674 252	750 979	750 979	754 298	830 361	877 269
Tuberculosis Hospitals	65 775	77 164	88 713	145 411	127 032	127 032	136 811	147 534	154 461
Psychiatric/ Mental Hospitals	17 973	22 707	25 678	26 513	26 513	26 513	27 838	29 369	31 131
Sub-acute, Step down and Chronic Medical Hospit									
Dental Training Hospitals									
Other Specialised Hospitals									
Total	**581 335**	**680 894**	**802 368**	**846 176**	**904 524**	**904 524**	**918 947**	**1 007 264**	**1 062 861**
Current payments	**547 021**	**649 415**	**767 893**	**801 510**	**861 951**	**861 951**	**888 241**	**966 942**	**1 020 735**
Compensation of employees	401 512	469 498	566 341	568 549	660 363	660 363	714 856	768 470	822 263
Salaries and wages	355 076	415 010	499 430	506 624	588 734	578 966	642 123	690 282	738 602
Social contributions	46 436	54 488	66 911	61 925	71 629	81 397	72 733	78 188	83 661
Goods and services	145 509	179 909	201 537	232 961	201 588	201 567	173 385	198 472	198 472
Administrative fees	605	57	16	122	122	135	109	116	116
Advertising	350	165	9	40	40	42	39	39	39
Assets <R5000	2 319	1 074	1 748	1 986	986	887	912	937	937
Catering: Departmental activities	988	167	123	30	30	41	28	31	31
Communication	2 999	2 987	3 273	4 294	4 294	4 363	3 921	4 301	4 301
Computer services	47	94	41						
Cons/prof:business & advisory services	1								
Cons/prof: Laboratory services	16 603	23 764	27 187	26 863	26 863	23 363	24 026	26 744	26 744
Contractors	11 854	10 876	4 939	8 086	2 731	2 345	2 353	2 575	2 575
Agency & support/outsourced services	2 299	6 991	19 020	18 686	13 686	14 243	12 683	13 745	13 745
Fleet Services	5 893	4 891	4 859	5 089	5 089	6 576	4 643	5 115	5 115
Inventory: Food and food supplies	14 160	16 774	13 657	19 264	16 264	17 962	13 672	14 737	14 737
Inventory: Fuel, oil and gas	2 235	2 868	1 944	2 497	2 497	2 945	2 189	2 441	2 441
Inventory: Materials & supplies		1 108	887	3 186	286	2 840	277	303	303
Inventory: Medical supplies	51 826	72 379	39 226	39 564	33 529	38 619	25 656	33 125	33 125
Inventory: Medicine			45 030	55 042	49 259	46 942	44 303	52 322	52 322
Inventory: Other consumbles	7 789	11 433	10 549	13 304	11 804	11 863	9 961	10 929	10 929
Inventory: Stationery and printing	3 471	3 136	3 677	6 268	6 268	4 920	4 746	5 159	5 159
Lease payments (incl. operating leases, e	5 099	6 104	7 777	9 589	9 589	6 658	7 707	8 293	8 293
Property payments	5 105	6 118	12 480	12 611	11 811	10 431	10 621	11 528	11 528
Transport provided dept activity	57	27	90	17	17	18	16	16	16
Travel and subsistence	7 659	7 904	4 449	6 103	6 103	6 072	5 252	5 712	5 712
Training & staff development	1 773	279	278			47	5	5	5
Operating payments	1 935	380	201	320	320	138	266	299	299
Venues and facilities	442	333	77			117			
Interest and rent on land		8	15			21			
Transfers and subsidies	**21 812**	**24 721**	**27 792**	**27 143**	**29 143**	**29 143**	**28 506**	**30 077**	**31 881**
Provinces and municipalities	2 127								
Non-profit institutions	18 288	23 057	26 151	26 513	26 513	26 513	27 838	29 369	31 131
Households	1 397	1 664	1 641	630	2 630	2 630	668	708	750
Payments for capital assets	**12 502**	**6 758**	**6 683**	**17 523**	**13 430**	**13 430**	**2 200**	**10 245**	**10 245**
Buildings and other fixed structures	105								
Machinery and equipment	12 397	6 758	6 683	17 523	13 430	13 430	2 200	10 245	10 245
Software and other intangible assets									
of which:									
Capitalised compensation of employees									
Capitalised goods and services									
Payments for financial assets									
Total economic classification	**581 335**	**680 894**	**802 368**	**846 176**	**904 524**	**904 524**	**918 947**	**1 007 264**	**1 062 861**

4.7 PERFORMANCE AND EXPENDITURE TRENDS

The Provincial Hospital Services show growth of 15.9 percent for the past seven years with an increase of 5.5 percent in 2012/13 to 2015/16 financial year and show a substantial low growth for the 2012/13 financial year of 1.6 percent from 2011/12.

The Programme experiences a general reduction under goods and services which contribute to the low growth percentage in the 2012/13 financial year. The programme will mainly focus on strengthening regional hospital services, TB specialized services and Psychiatric services.

4.8 RISK MANAGEMENT

RISKS	MITIGATING FACTORS
Inability to recruit and retain health care professionals.	Implementation of the recruitment and retention strategy.
Poor security services leading to theft of assets	Proper monitoring of contracts and Service Level Agreements.

5. BUDGET PROGRAMME 5: TERTIARY HOSPITALS

5.1 PROGRAMME PURPOSE

The purpose of the programme is to render tertiary health care services and to provide a platform for training of health care workers and to conduct research.

NEW DEVELOPMENTS

None

5.2 PRIORITIES

The strategic goals of this programme, is to ***Strengthen Health System Effectiveness, Increase Life Expectancy and Reduce Maternal and Child Mortality***

The strategic priority of the programme, is as follows:

- Implement the 6 priority areas of the core standards in two tertiary hospitals.

The challenges for tertiary hospitals, can be outlined as follows

- High influx of level 1 patients;
- Inability to recruit and retain specialists and other health care professionals
- Shortage of support staff at all levels
- Poor security services
- Inadequate budget allocation for compensation of existing personnel

Interventions:

- Strengthening of Primary Health Care
- Implementation of referral Policy
- Implementation of recruitment and retention strategy
- Head hunting of scarce skilled health professionals
- Proper monitoring of contracts and Service Level Agreements.
- Motivate for funds as per cost per head analysis

5.3 PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR TERTIARY HOSPITALS

TABLE THS1: PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR TERTIARY HOSPITALS

BUDGET PROGRAMME:TERTIARY HOSPITALS										
STRATEGIC GOAL 4: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS										
Strategic Objective	**Performance Indicator**	**Strategic Plan target**	**Means of verification / Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
Implement the 6 priority areas of the core standards for quality health care	Number of functional specialist domains in tertiary hospitals.	Rob Ferreira and Witbank hospital to have developed a further 4 tertiary services	Physical Counting, PERSAL	11	11	7	9	10	10	11
	Number of Tertiary Hospitals complying with the six key priorities of the core standards.	Not in Plan	Assessment Reports	Not in Plan	Not in Plan	Not in Plan	2	2	2	2

TABLE THS2: PERFORMANCE INDICATORS FOR TERTIARY HOSPITALS

Quarterly Indicators	Data Source	Type	Audited/ actual performance			Estimate	MTEF projection			National target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Caesarean section rate	DHIS	%	19.1	30	30.2	26	25	25	25	25
2. Separations – Total	DHIS	No	14,939	16,020	55,344	18,000	19,000	19,500	20,000	N/A
3. Patient Day Equivalents – Total	DHIS	No	124,587	120,864	375,392	147,000	149,000	149,500	150,000	N/A
4. OPD Headcount – Total	DHIS	No	90,077	94,205	157,754	85,000	84,000	83,000	82,000	N/A
5. Average Length of Stay	DHIS	Days	5.9	5.5	5.5	5.5	5.5	5.4	5.3	5.3 days
6. Bed Utilisation Rate	DHIS	%	85.5	80	69.9	76	75	75	75	75
7. Expenditure per patient day equivalent (PDE)	BAS/ DHIS	R	1,973	2,382	1,888	2,500	2,750	2,950	R3,150	N/A
8. Percentage of complaints of users of Tertiary Hospital Services resolved within 25 days	DHIS	%	Not in Plan	Not in Plan	100	100	70	75	80	N/A
9. Percentage of Tertiary Hospitals with monthly Mortality and Morbidity Meetings.	DHIS	%	Not in Plan	Not in Plan	100	100	100	100	100	N/A

Annual Indicators	Data Source	Type	Audited/ Actual performance			Estimate	Medium-term targets			National target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
10. Tertiary Hospital Patient Satisfaction Rate. -	Patient Satisfaction Survey	%	Not in Plan	Not in Plan	Not in Plan	65	70	80	90	90
11. Tertiary Hospitals assessed for compliance against the 6 priorities of the core standards.	Quality Assurance Assessment Reports	No	Not in Plan	Not in Plan	Not in Plan	2	2	2	2	N/A

QUARTERLY AND ANNUAL TARGETS FOR TERTIARY HOSPITALS

TABLE THS3: QUARTERLY AND ANNUAL TARGETS FOR TERTIARY HOSPITALS

PROGRAMME PERFORMANCE INDICATOR	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
1. Caesarean section rate	QUARTERLY	25	25	25	25	25
2. Separations – Total		19,000	5,000	5,500	4,000	4,500
3. Patient Day Equivalents – Total		149,000	35,000	44,000	30,000	40,000
4. OPD Headcount – Total		84,000	21.000	22,000	19,000	22,000
5. Average Length of Stay		5.5	5.5	5.5	5.5	5.5
6. Bed Utilisation Rate		75	75	75	75	75
7. Expenditure per patient day equivalent (PDE)		2,750	2,750	2,750	2,750	2,750
8. Percentage of complaints of users of Tertiary Hospital Services resolved within 25 days		100	100	100	100	100
9. Percentage of Tertiary Hospitals with monthly Mortality and Morbidity Meetings.		100	100	100	100	100

PROGRAMME PERFORMANCE INDICATOR	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
12. Patient Satisfaction Rate.	ANNUAL	70	-	-	-	70
13. Number of Tertiary Hospitals assessed for compliance against the 6 priorities of the core standards.		2	-	-	-	2
14. Number of functional specialist domains in tertiary hospitals.	ANNUAL	10	-	-	-	10
15. Number of Tertiary Hospitals complying with the six key priorities of the core standards.		2	-	-	-	2

5.4 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

TABLE THS5: EXPENDITURE ESTIMATES: TERTIARY SERVICES

	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
	Audited			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
Subprogramme									
Central Hospital Services									
Provincial Tertiary Hospital Services	548 252	625 754	708 712	771 778	788 365	788 365	781 668	858 851	912 131
Total	**548 252**	**625 754**	**708 712**	**771 778**	**788 365**	**788 365**	**781 668**	**858 851**	**912 131**
Current payments	**540 516**	**619 002**	**697 508**	**745 020**	**761 607**	**761 607**	**769 869**	**844 670**	**901 507**
Compensation of employees	332 898	379 335	444 836	501 968	521 024	521 024	559 448	600 287	642 307
Salaries and wages	294 880	336 675	393 856	438 772	457 828	457 828	497 380	533 689	571 047
Social contributions	38 018	42 660	50 980	63 196	63 196	63 196	62 068	66 598	71 260
Goods and services	207 618	239 667	252 662	243 052	240 583	240 583	210 421	244 383	259 200
Administrative fees	524	18		168	168	124	165	164	173
Advertising	85					21			
Assets <R5000	1 819	3 995	1 001	4 308	4 308	1 259	3 983	4 221	4 474
Catering: Departmental activities		7	7	25	25	21	23	24	25
Communication	2 913	2 998	3 057	3 963	3 963	4 037	3 664	3 883	4 116
Computer services			127	200	200	180	184	195	206
Cons/prof:business & advisory services				18	18	18	16	16	17
Cons/prof: Laboratory services	25 127	39 034	42 230	41 400	41 400	33 594	38 279	40 575	43 010
Contractors	69 543	49 543	33 387	22 204	19 735	15 445	28 880	30 612	32 448
Agency & support/outsourced services	2 145	2 137	13 997	22 515	22 515	18 518	18 156	19 405	20 729
Entertainment	75	16							
Fleet Services	1 866	1 765	2 008	1 860	1 860	2 528	1 719	1 822	1 931
Inventory: Food and food supplies	7 579	8 732	7 609	9 850	9 850	11 477	9 107	9 653	10 232
Inventory: Fuel, oil and gas	852	1 865	2 283	2 610	2 610	2 481	2 413	2 557	2 710
Inventory:Learn & teacher support materi						5			
Inventory: Materials & supplies		33	126	237	237	195	219	232	245
Inventory: Medical supplies	71 948	103 719	74 020	55 281	55 281	65 666	36 114	54 180	57 431
Inventory: Medicine			44 074	47 305	47 305	49 171	38 739	46 363	49 145
Inventory: Other consumbles	5 155	5 426	5 269	6 576	6 576	7 102	6 080	6 444	6 830
Inventory: Stationery and printing	2 283	2 484	2 034	2 685	2 685	2 311	2 482	2 630	2 787
Rental & hiring									
Property payments	3 715	8 727	13 202	13 150	13 150	17 995	12 158	12 887	13 660
Transport provided dept activity	51								
Travel and subsistence	3 102	1 758	1 671	1 942	1 942	2 094	1 795	1 902	2 016
Training & staff development	1 181	9	5	35	35	218	32	33	35
Operating payments	3 392	2 493	1 488	1 720	1 720	2 121	1 590	1 685	1 786
Venues and facilities						1			
Interest and rent on land			10						
Transfers and subsidies	**793**	**541**	**720**	**754**	**754**	**754**	**799**	**847**	**898**
Provinces and municipalities	601								
Households	192	541	720	754	754	754	799	847	898
Payments for capital assets	**6 943**	**6 211**	**10 484**	**26 004**	**26 004**	**26 004**	**11 000**	**13 334**	**9 726**
Buildings and other fixed structures									
Machinery and equipment	6 943	6 211	10 484	26 004	26 004	26 004	11 000	13 334	9 726
Software and other intangible assets									
of which:									
Capitalised compensation of employees									
Capitalised goods and services									
Payments for financial assets									
Total economic classification	**548 252**	**625 754**	**708 712**	**771 778**	**788 365**	**788 365**	**781 668**	**858 851**	**912 131**

5.5 PERFORMANCE AND EXPENDITURE TRENDS

In 2012/13 budget show decrease of 0.8 percent due to the general reduction of the Goods and Service budget. The departmental focus for the 2012/13 financial year is to strengthen community services and only maintain current services at Tertiary Hospitals.

5.6 RISK MANAGEMENT

RISKS	MITIGATING FACTORS
Inability to recruit and retain scarce skills health professionals	• Implementation of a Recruitment and Retention Strategy • Head hunting of scarce skilled health professionals
Influx of level 1 patients	• Implement and monitor the referral policy • Strengthen Primary Health Care
Poor security services leading to loss and theft of assets	• Proper monitoring and evaluation of contracts and Service Level Agreement.
Poor workmanship of contractors	• Proper monitoring of SLA with DPWRT
Lack of contracts for orthopedic implants, patient foods and cleaning materials	• Motivate for advertisement and awarding of tenders.

6. BUDGET PROGRAMME 6: HEALTH SCIENCES AND TRAINING (HST)

6.1 PROGRAMME PURPOSE

The purpose of the Health Sciences and Training programme is to ensure the provision of skills development programmes in support of the attainment of the identified strategic objectives of the Department.

NEW DEVELOPMENTS

- Accelerated training of nurses, pharmacists, allied health professionals required.
- Provision of bursaries is aimed at catering for the scarce skilled health professionals.
- The department aims to expand into District Campuses for Nursing and to increase the intake of nursing students.

6.2 PRIORITIES

The strategic goal of this programme, is to ***Strengthen Health System Effectiveness***

The **strategic priority** of the programme, is as follows:

- Improved provision of Human Resource Development.

6.3 PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR HEALTH SCIENCES AND TRAINING

TABLE HST1: PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR HST

BUDGET SUB PROGRAMME: HEALTH SCIENCES AND TRAINING										
STRATEGIC GOAL 4: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS										
Strategic Objective	**Performance Indicator**	**Strategic Plan target**	**Means of verification**	**Audited/ actual performance**			**Estimated performance**	**MTEF projection**		
				2008/09	**2009/10**	**2010/11**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
Improved provision of Human Resources.	Number of health professionals trained on critical clinical skills.	Train 7000 health professionals in all categories on critical clinical skills	Training Database	7200	1000	2722	1250	1300*	1400*	1500*
	Number of health personnel trained in generic programmes	2500 health personnel on generic priority skills trained	Training Database	3000	3 445	3303	550	550**	600**	600**
	Number of learners on learnerships, internships, and ABET	Not in Plan	Learnership Database	Nursing auxiliary 100; 0 internships; 640 ABET	Nursing auxiliary 100; 14 pharmacist assistants; 66 data capturers; 121 ABET	267 learners; 90 data capturers & 70 interns; 276 ABET learners	350 learners 100 interns 400 ABET	350 learners 100 interns 400 ABET	350 learners 100 interns 400 ABET	350 learners 100 interns 400 ABET
	Number of campuses established at district level.	Establish 2 district health sciences campuses	Accreditation Certificates	0	0	0	1	1 (cumulative 2)	1 (cumulative 3)	0
	Number of nurse students enrolled.	Not in Plan	Enrolment Register	533	835	1000	800	925	1000	1200
	Number of clinical training facilities accredited	Not in Plan	Accreditation Certificates	14	24	3 accredited (cumulative 27)	3 new (cumulative 30)	3 new (cumulative 33)	2 new (cumulative 35)	2 new (cumulative 37)

	Number of learners enrolled for EMS training	Not in Plan	Enrolment Register	45	36	36	45	24 Ambulance Emergency Assistance; 12 Medical rescue	24 Ambulance Assistance; 12 Medical rescue	30 Ambulance Assistance; 15 Medical Rescue

* *Number of health professionals trained on critical clinical skills: The targets are based on the budget allocation trends.*
** *Number of health personnel trained in generic programmes: The targets are based on the budget allocation trends.*

TABLE HST2: PERFORMANCE INDICATORS FOR HEALTH SCIENCES AND TRAINING

Indicator	Data Source	Type	Audited / actual performance			Estimate	MTEF projection			National target
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	
Intake of nurse students	Enrolment Register	No	275	231	185	200	200	250	300	N/A
Students with bursaries from the province	Bursary Database	No	440	641	1490	935	1200	1250	1300	N/A
Basic nurse students graduating	Academic Records	No	90	217	381	390	340	380	400	N/A

6.4 QUARTERLY AND ANNUAL TARGETS FOR HEALTH SCIENCES AND TRAINING

TABLE HST3: QUARTERLY AND ANNUAL TARGETS FOR HEALTH SCIENCES AND TRAINING FOR 2012/13

PROGRAMME PERFORMANCE INDICATOR	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
Intake of nurse students	ANNUALLY	200	200	0	0	0
Students with bursaries from the province		1200	0	0	0	1200
Basic nurse students graduating		340	0	340	0	0
Number of health professionals trained on critical clinical skills	QUARTERLY	1300	300	500	300	200
Number of health personnel trained in generic programmes		550	110	200	140	100
Number of learners on learnerships, internships, and ABET	QUARTERLY	350 learners 100 interns	90 learners	200 learners 100 interns	60 learners	400 ABET

PROGRAMME PERFORMANCE INDICATOR	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
		400 ABET				
Number of campuses established at district level.	ANNUALLY	1	0	0	0	1
Number of nurse students enrolled.		925	925	0	0	0
Number of clinical training facilities accredited		3 new (cumulative 33)	0	0	0	3
Number of learners enrolled for EMS training	BI-ANNUAL	36	18	0	18	0

6.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE HST4: EXPENDITURE ESTIMATES: HEALTH SCIENCES AND TRAINING

	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
	Audited			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
Subprogramme									
Nurse Training College	82 160	99 602	96 115	98 455	113 099	113 137	117 027	125 769	133 113
EMS Training College	1 011	1 891	1 825	1 466	3 466	3 440	3 696	3 899	4 108
Bursaries	780	763	1 203	2 647	2 106	359	2 680	2 791	3 002
Primary Health Care Training	3 973	2 788	5 792	7 106	8 106	8 106	2 573	2 718	2 865
Training Other	15 103	58 675	88 971	111 320	99 320	99 320	108 129	113 282	118 272
Total	103 027	163 719	193 906	220 994	226 097	224 362	234 105	248 459	261 360
Current payments	100 331	163 197	193 741	203 235	208 479	209 028	218 223	231 477	244 057
Compensation of employees	62 826	99 026	124 804	121 819	147 899	143 593	166 871	179 313	191 911
Salaries and wages	54 387	85 657	110 005	104 019	124 599	136 595	141 791	152 361	163 077
Social contributions	8 439	13 369	14 799	17 800	23 300	6 998	25 080	26 952	28 834
Goods and services	37 505	64 171	68 937	81 416	60 580	65 435	51 352	52 164	52 146
Administrative fees	742	3 539	2 703	140	140	349	293	296	296
Advertising	385	680	112	393	393	93	171	171	171
Assets <R5000	1 199	162				587	514	514	514
Audit cost: External			551						
Bursaries (employees)			15 996	2 000	2 000	641	561	561	561
Catering: Departmental activities	7 991	9 464	9 463	781	781	1 214	323	323	323
Communication	237	320	245	365	365	263	341	358	353
Computer services	14		48						
Cons/prof:business & advisory services	180		504	3 000	3 000	2 096	1 663	1 663	1 663
Contractors	1 009	11 597	308	3 036	3 036	427	465	465	458
Agency & support/outsourced services	2 402	289	13 132	13 448	8 888	15 748	12 358	12 665	12 834
Fleet Services	568		671	1 046	1 046	904	1 046	1 109	1 093
Inventory: Food and food supplies	51	20							
Inventory: Fuel, oil and gas	14		1						
Inventory:Learn & teacher support materi				898	898	453	397	397	397
Inventory: Materials & suppplies	301	295							
Inventory: Other consumbles	1 500	3 631	1 241	1 770	1 770	1 662	1 605	1 699	1 676
Inventory: Stationery and printing	1 560	6 349	401	1 015	1 015	307	177	184	72
Lease payments (incl. operating leases, e	2 384	207	521	314	314	126	314	333	329
Property payments	2 566	3 199	234	6 438	6 438	198	496	522	515
Transport provided dept activity	1 610	1 559							
Travel and subsistence	5 919	17 095	15 030	13 998	13 722	21 239	13 777	14 052	14 038
Training & staff development	4 371	3 092	6 532	30 962	14 962	16 013	15 013	15 014	15 015
Operating payments	1 991	2 085	592	1 000	1 000	545	492	492	492
Venues and facilities	511	150	652	812	812	2 570	1 346	1 346	1 346
Interest and rent on land									
Transfers and subsidies	418		155	13 859	13 859	13 357	15 182	16 082	16 703
Provinces and municipalities									
Departmental agencies and accounts				3 842	3 842	3 842	4 614	4 933	4 885
Households	418		155	10 017	10 017	9 515	10 568	11 149	11 818
Payments for capital assets	2 278	522	10	3 900	3 759	1 977	700	900	600
Buildings and other fixed structures									
Machinery and equipment	2 278	522	10	3 900	3 759	1 977	700	900	600
Software and other intangible assets									
of which:									
Capitalised compensation of employees									
Capitalised goods and services									
Payments for financial assets									
Total economic classification	103 027	163 719	193 906	220 994	226 097	224 362	234 105	248 459	261 360

6.6 PERFORMANCE AND EXPENDITURE TRENDS

Programme 6, Health Science & Training will increase with 5.2 percent from the 2012/13 to the 2014/15 financial. The increase is mainly due to renovation on training facilities amounting to R9,740 million, CPIX increase of 5.8 percent and purchasing of student transport amounting to R700 000.

Nursing Training College – Has shown growth over the past seven years which include the development of professional nurses. The expenditure includes payment of student allowance and providing food in the college. Funds allocated to the college are inadequate due to high demand on intakes.

EMS Training College – Has shown growth over the past seven years which include the development of EMS professionals. The expenditure includes payment of student allowance and providing food in the college. Funds allocated to the college are inadequate due to high demand on intakes.

PHC Training – Has shown growth over the past seven years which include the development of Health professionals.

Bursaries – All bursary funding was transferred to Department of Education from the 2012/13 financial year through out the MTEF period. Only funding for current employees will remain within the Department of Health to facilitate the administration of bursaries for the department.

Training Other – include HPTD conditional grant supports the departmental Health Sciences and Training Programme in funding services relating to training and development of health professions.

The following achievements were realised for the programme:

- Skills development has continued to receive priority in the department.
- The department apportions more than 1 per cent of the personnel budget each year for training.
- The learner ships for auxiliary nurses have been maintained at no less than 100 per year, the learner ships for pharmacists assistants are 14.
- A total of 66 data capturers were recruited in 2010/2011.
- The department has trained 746 Nurses in 2010/2011 as compared to 280 in 2006/2007.
- The number of bursaries awarded was 475 for full time studies and 150 for part-time studies.
- A total of 35 students were participating in the Cuba/RSA programme.
- The number of staff trained in generic programmes increased from 2000 in 2006/2007 to 3445 in 2010/2011.

6.7 RISK MANAGEMENT

RISKS	MITIGATING FACTORS
Inadequate number of training facilities for the provision of health sciences training.	Collaborations with higher education institutions.
Turnover of staff with critical skills.	Recruitment and Retention Strategy should minimize staff turnover.
Poor attendance to training due to shortage of staff.	Implementing on-site mentoring and coaching program.
Breach of contract by bursary holders.	Enforce compliance.
Training not linked to service delivery needs.	To ensure all training is linked to service delivery needs.

7 BUDGET PROGRAMME 7: HEALTH CARE SUPPORT SERVICES (HCSS)

7.1 PROGRAMME PURPOSE

The Health Care Support Service programmes aim to improve the quality and access of health care provided through:

- The availability of pharmaceuticals and other ancillaries.
- Rendering of credible forensic health care which contributes meaningfully to the criminal justice system.
- The availability and maintenance of appropriate health technologies Improvement of quality of life by providing needed assistive devices.
- Coordination and stakeholder management involved in specialized care.
- Rendering in-house services within the health care value chain.

NEW DEVELOPMENTS

There are four directorates within programme 7 namely:

- **Pharmaceutical Services**
- **Forensic Health Services** (Forensic Pathology Services, Clinical Forensic Medicine and Medico-Legal Services)
- **Health Care Support** (Medical Orthotics and Prosthetics, Laboratory, Blood, Tissue and Organ and Laundry Services
- **Health Technology Services** (Clinical Engineering, Imaging)

7.2 PRIORITIES

The strategic goal of this programme, is to ***Strengthen Health System Effectiveness***

The **strategic priorities** of the programme, are as follows:

- Provision of quality pharmaceutical services in all the facilities
- Provision of quality Clinical Forensic Medicine Services
- Provision of guidelines on the use of Laboratory, Blood, Tissue and Organ Transplant available in hospitals.
- Provision of imaging services compliant to Radiation Control prescripts;
- Provision of comprehensive medical orthotic and prosthetic care;

The facility audit conducted by CSIR in all health facilities, identified the basic medical devices and equipment that is required to achieve compliance to the national core standards and the six priority areas. The earmarked funding for Quality Improvement, have been utilized to procure the required basic equipment in the three districts and delivery is being awaited. The province has a standard equipment list for District Hospitals and Primary Health Care facilities. The challenge will be to ensure that regular maintenance schedules will be adhered to. In order to address this challenge, the department plans to ensure that there will be at least 1 Clinical Engineering Workshop per district.

Interventions to improve the overall health system effectiveness, will be prioritized. An efficient and effective system for drug supply, management and distribution will be introduced.

7.3 PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR HEALTH CARE SUPPORT SERVICES

TABLE HCSS 1: PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGTS FOR HEALTH CARE SUPPORT SERVICES

BUDGET SUB PROGRAMME: HEALTH CARE SUPPORT SERVICES										
STRATEGIC GOAL 4: STRENGTHENING HEALTH SYSTEM EFFECTIVENESS										
Strategic objective	**Performance indicator**	**Strategic Plan target**	**Means of verification/ Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
PHARMACEUTICAL SERVICES										
Provision of quality of Pharmaceutical Services.	% of EDL items available in facilities.	95% availability of all pharma-ceuticals in all facilities	EDL Items Lists	97	67	89	95	95	95	95
	No of Pharmaceutical Therapeutic Committees (PTC) established.	Not in Plan	Appointment Letters & PTC Terms of Reference	2 District PTCs	2 District PTCs	2 District PTCs	3 District PTCs	3 District PTCs	3 District PTCs	3 District PTCs
				15 Hospital PTCs	18 Hospital PTCs	13 Hospital PTCs	22 Hospital PTCs	24 Hospital PTCs	28 Hospital PTCs	33 Hospital PTCs
	% Compliance to Pharmaceutical legal prescript.	Not in Plan	MCC Compliance Tool.	Not in Plan	Not in Plan	Not in Plan	30%	60%	80%	100%
CLINICAL FORENSIC MEDICINE (CFM)										
Provision of quality of Clinical Forensic Medicine (CFM) Services.	Number of sites rendering Clinical Forensic Medicine services.	34 sites rendering CFM.	Physical observation and records	15	18	20	24	26	30	34
FORENSIC PATHOLOGY SERVICE (FPS)										
Provision of quality of comprehensive Forensic Pathology Services.	Number of sites rendering Forensic Pathology Services (FPS).	23 sites rendering FPS.	Physical observation and records	19	21	18	23	23	23	23
	Number of Autopsies conducted	Not in Plan	Death Registers in Facilities	4615	4623	4207	5500	5500	5500	5500
LABORATORY BLOOD AND OTHER ANCILLIARY SERVICES										
Provision of guidelines on the use of Laboratory,	Number of hospitals with approved guidelines.	Not in Plan	Approved Guidelines	0	0	0	15	20	28	33

Blood, Tissue and Organ Transplant available in hospitals.	Number of hospitals complying to debtor's 30 days on Laboratory and Blood.	Not in Plan	Quarterly Financial Statements	0	0	0	20	25	32	33
HEALTH CARE SUPPORT SERVICES										
STRATEGIC GOAL 4: STRENGTHEING HEALTH SYSTEM EFFECTIVENESS										
Strategic objective	**Performance indicator**	**Strategic Plan target**	**Means of verification/ Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
CLINICAL ENGINEERING SERVICES										
Provision of health technology services and facilities for management and maintenance of medical equipment.	Number of functional Clinical Engineering workshop facilities.	5 Clinical Engineering Workshop Facilities	Physical Evidence of fully functional workshop facilities	2	2	2	4	4	5	5
	Number of clinical engineering technicians appointed.	45	Persal System	8	15	12	20	20	25	30
IMAGING SERVICES										
Provision of imaging services compliant to Radiation Control prescripts	% of facilities complying with Radiation Control prescripts.	100% of facilities complying with prescripts.	Reports	60	70	70	100	100	100	100
MEDICAL ORTHOTIC AND PROSTHETIC SERVICES (MOP)										
Provision of comprehensive medical orthotic and prosthetic care;	Number of Orthosis and Prosthesis devices supplied.	19 000 Orthosis and Prosthesis devices supplied	Records in the workshop	1780	2574	1259	3500	3500	3500	3500
	Waiting period for receiving devices in month.	Not in plan	Registers in Workshops	8	6	8	6	6	6	2

7.4 QUARTERLY AND ANNUAL TARGETS FOR HEALTH CARE SUPPORT SERVICES

TABLE HCSS2 : QUARTERLY AND ANNUAL TARGETS FOR HEALTH CARE SUPPORT SERVICES FOR 2012/13

PROGRAMME PERFORMANCE INDICATOR	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
PHARMACEUTICAL SERVICES						
% of EDL items available at the Medical Depot.	**QUARTERLY**	95	95	95	95	95
No of Pharmaceutical Therapeutic Committees (PTC) established.		3 District PTCs 1 Provincial PTC	3 District PTCs 1 Provincial PTC	3 District PTCs 1 Provincial PTC	3 District PTCs 1 Provincial PTC	3 District PTCs 1 Provincial PTC
		24 Hospital PTCs	-	-	1 additional Hospital PTC	1 additional hospital PTC
% Compliance to Pharmaceutical legal prescript.		60% compliance	30% compliance	40% compliance	50% compliance	60% compliance
CLINICAL FORENSIC MEDICINE (CFM)						
Number of sites rendering Clinical Forensic Medicine services.	**QUARTERLY**	26	24	24	24	26
FORENSIC PATHOLOGY SERVICE (FPS)						
Number of sites rendering Forensic Pathology Services (FPS).	**QUARTERLY**	23	23	23	23	23
Number of Autopsies conducted		5 500	1 200	1 300	1 800	1 200
LABORATORY BLOOD AND OTHER ANXILLIARY SERVICES						
Number of hospitals with approved guidelines.	**QUARTERLY**	20	15	20	20	20
Number of hospitals complying to debtor's 30 days on Laboratory and Blood.		25	20	25	25	25
CLINICAL ENGINEERING SERVICES						
Number of functional Clinical Engineering workshop facilities.	**QUARTERLY**	4	4	4	4	4

PROGRAMME PERFORMANCE INDICATOR	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
Number of clinical engineering technicians appointed		6 (cumulative 20)	1	2	2	1
IMAGING SERVICES						
% of facilities complying with Radiation Control prescripts.	**QUARTERLY**	100	100	100	100	100
MEDICAL ORTHOTIC AND PROSTHETIC SERVICES (MOP)						
Number of Orthosis and Prosthesis devices supplied	**QUARTERLY**	3 500	750	850	900	1000
Waiting period for receiving devices in month	**QUARTERLY**	6	8	8	7	6

7.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE HCSS 3 : EXPENDITURE ESTIMATES: HEALTH CARE SUPPORT SERVICES

	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
	Audited			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
Subprogramme									
Laundries	12 452	13 588	13 591	27 477	25 827	25 827	24 964	31 618	33 727
Engineering	5 430	5 225	8 980	14 617	15 963	15 963	18 397	20 038	21 551
Forensic Services	65 570	44 702	46 016	53 114	55 607	55 607	50 358	55 116	58 242
Orthotic and Prosthetic services	1 156	5 123	1 507	8 200	5 000	5 000	5 561	6 945	7 348
Medicine Trading Account	5 959	6 467	10 665	9 182	7 926	7 926	8 958	9 862	10 373
Total	**90 567**	**75 105**	**80 759**	**112 590**	**110 323**	**110 323**	**108 238**	**123 579**	**131 241**
Current payments	**52 484**	**57 371**	**67 943**	**102 252**	**91 766**	**92 517**	**102 634**	**109 750**	**116 843**
Compensation of employees	28 539	32 910	37 699	58 144	54 644	54 644	64 936	68 274	73 116
Salaries and wages	24 610	28 248	32 903	51 346	47 846	48 366	57 123	59 994	64 338
Social contributions	3 929	4 662	4 796	6 798	6 798	6 278	7 813	8 280	8 778
Goods and services	23 945	24 461	29 909	44 108	37 122	37 873	37 698	41 476	43 727
Administrative fees			19	18	18	41	13	15	15
Advertising	424		87						
Assets <R5000	1 814	141	160	1 624	1 624	372	1 720	1 824	1 932
Catering: Departmental activities	429	76	89	53	53	47	43	45	47
Communication	373	749	1 038	1 094	1 094	1 106	1 148	1 205	1 255
Computer services	206	1 268				107	121	121	121
Cons/prof:business & advisory services	2 024								
Contractors	5 237	5 158	7 837	11 651	11 651	8 818	11 703	12 404	13 135
Agency & support/outsourced services						48			
Fleet Services	1 801	1 651	1 952	3 495	3 341	4 422	3 780	4 000	4 205
Inventory: Food and food supplies	4	68					68	68	68
Inventory: Fuel, oil and gas	1	1		2	2	2	2	2	2
Inventory:Learn & teacher support materi									
Inventory: Materials & supplies	274	20	1 917	18	18	202	126	133	141
Inventory: Medical supplies	1 917	1 086	2 621	7 527	5 527	6 760	4 859	6 210	6 570
Inventory: Medicine				2 943	1 187	1 033			
Inventory: Other consumbles	1 154	6 757	4 764	6 056	4 406	5 787	3 670	3 951	4 233
Inventory: Stationery and printing	651	772	447	861	861	738	956	1 009	1 058
Lease payments (incl. operating leases, e	1 143	4 502	1 433	1 039	1 039	919	1 359	1 701	1 738
Property payments	268	572	1 577	774	774	586	760	886	913
Transport provided dept activity	2 885		2 325	1 685	259	1 515	1 786	1 893	1 988
Travel and subsistence	2 331	1 548	3 061	2 930	2 930	3 349	3 075	3 352	3 517
Training & staff development	510	40		2 000	2 000	1 246	2 120	2 247	2 359
Operating payments	266	52	582	125	125	283	164	171	179
Venues and facilities	233			213	213	492	225	239	251
Interest and rent on land			335						
Transfers and subsidies	**293**	**32**	**17**	**140**	**140**	**148**	**148**	**157**	**166**
Provinces and municipalities									
Households	293	32	17	140	140	148	148	157	166
Payments for capital assets	**37 790**	**17 702**	**12 799**	**10 198**	**18 417**	**17 658**	**5 456**	**13 672**	**14 232**
Buildings and other fixed structures	31 593	14 962	10 707		7 493	7 493			
Machinery and equipment	6 197	2 740	2 092	10 198	10 924	10 165	5 456	13 672	14 232
Software and other intangible assets									
of which:									
Capitalised compensation of employees									
Capitalised goods and services									
Payments for financial assets									
Total economic classification	**90 567**	**75 105**	**80 759**	**112 590**	**110 323**	**110 323**	**108 238**	**123 579**	**131 241**

7.6 PERFORMANCE AND EXPENDITURE TRENDS

The marked increase over the financial years is due to increase in the stock levels of the ARV medication for HIV/AIDS and to provide a strategic turnover of medicines.

Programme 7, Health Care Support Services will increase with 6.8 percent year on year from 2008/09 to 2011/12 financial year and 6 per cent from 2011/12 to 2014/15 financial year. The 2012/13 financial year show a reduction on the baseline of 1.9 per cent from the 2011/12 financial year which is mainly due to facing out of the Forensic Service Grant and gradual increase in the departmental equitable share budget. Laundry services show also a reduction due to slow movement of the programme in the 2011/12 financial year. The Department however will strengthen this sub-programme in the 2013/14 financial year with an increase of 9.4 per cent.

Programme 7 is a conglomerate of a number of diverse programmes designed and meant to achieving the main key output 4: Strengthening Health System effectiveness. This is achieved through rendering support to both the core clinical and the non-clinical functions of the health care delivery system. The services within programme 7 include the Pharmaceutical Services, Health technology services, Forensic Health Services, Medical Orthotic and Prosthetic Services, Medico-Legal Services, Laboratory, Blood, Tissue and Organ Donor/Transplant Services and the Laundry Services.

Though programme 7 is mainly supportive, highly skilled personnel and high tech equipment have to be managed. On the other hand, such personnel are scarce in the human capital market. Further, the technology needed is quite labile and is one of the cost drivers of health care delivery. Incidents, which entail illegal transaction of human parts for the purpose of organ/transplantation, have highlighted the need for the Department to implement appropriate measures in order to prevent such incidence from occurring within Mpumalanga.

7.7 RISK MANAGEMENT

RISKS	MITIGATING FACTORS
Inadequate infrastructure for rendering services in the Province	Facilitate completion of all projects under construction in conjunction with the DPWR&T.
The availability and the appointment of scarce skilled personnel in the province	Implementation of Recruitment and Retention Strategy
Forensic Health Care officers not yet registered with the Health Professions Council of South Africa (HPCSA).	Speed up the process for recognised training to qualify for registration with the Council.
Failure of recognition of CFM as a speciality by SANC.	Lobbying by all stakeholders, including the employer.
Laundry Services	
Loss of linen and hi-jacking of delivery trucks in transition	Installation of tracking devices and branding of vehicles. Use of delivery locks to secure and manage linen
Labour unrest	Each institution supplied by the central laundry to procure small industrial washing machines for emergencies and unforeseen circumstances
Pharmaceutical Services	
Unavailability of pharmacists	Implementation of Recruitment and Retention Strategy
Outdated information system	Procurement of new information system

8. BUDGET PROGRAMME 8: HEALTH FACILITIES MANAGEMENT (HFM)

8.1 PROGRAMME PURPOSE

The purpose of the programme is to build, upgrade, renovate, rehabilitate and maintain health facilities.

NEW DEVELOPMENTS

The public sector has underperforming institutions that have been attributed to poor management, underfunding and deteriorating infrastructure. A facility audit was done by CSIR on all public health facilities. The report provides insight to the maintenance budget as well as the budget required for upgrading of facilities.

The Infrastructure Plan was developed, based on the findings and recommendations of this report. The department was planning to increase the number of facilities on revitalization, from 3 to 7 however, due to the budget allocation and incomplete projects in Themba, Ermelo and Rob Ferreira Hospitals, this will not be possible and only the three (3) current hospitals will remain.

The delivery of health infrastructure is pivotal to ensuring access to quality health care, including the expansion of health infrastructure as part of the provincial Comprehensive Rural Development Strategy.

8.2 PRIORITIES

The strategic goal of this programme, is to ***Strengthen Health System Effectiveness***

The **high level strategic priority** of the programme, is to “improve physical infrastructure for healthcare delivery”.

8.3 PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR HFM

TABLE HFM 1: PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR HFM

BUDGET SUB PROGRAMME: HEALTH FACILITIES MANAGEMENT										
STRATEGIC GOAL 4: STRENGTHEN HEALTH SYSTEM EFFECTIVENESS										
Strategic objective	**Performance indicator**	**Strategic Plan target**	**Means of verification/ Data Source**	**Audited/ actual performance**			**Estimated performance**	**Medium term targets**		
				2008/09	**2009/10**	**2010/11**	**2011 /12**	**2012/13**	**2013/14**	**2014/15**
	Number of PHC facilities with accommodation, on planning phase.	Not in Plan	Immovable Asset Register & Physical Verification	Not in Plan	Not in Plan	5	9 (14)	6 (20)	5	5
	Number of PHC facilities with accommodation, under construction.	Not in Plan	Immovable Asset Register & Physical Verification	Not in Plan	Not in Plan	Not in Plan	5	9	10	5
	Number of PHC facilities with accommodation, constructed.	20 new clinics with accommodation constructed.	Immovable Asset Register & Physical Verification	5	7	5 CHCs – construction started and at different levels	1 (1 /20)	4 (5/20)	5 (10/20)	10 (20/20)
	Number of hospitals under revitalisation programme, on planning phase	4 hospitals under Revitalization programme	Immovable Asset Register & Physical Verification	Not in Plan	Not in Plan	Not in Plan	Not in Plan	4	3 (7)	
	Number of hospitals under revitalisation programme, under upgrading and renovation.	3 Hospitals under Revitalization programme	Immovable Asset Register & Physical Verification	Not in Plan	3	3	3	3	4	4
	Number of hospitals under revitalisation programme, upgraded/renovated.	-	Immovable Asset Register & Physical Verification	-	-	-	-	-	-	-
	Number of hospitals under Infrastructure Grant on planning phase	25 hospitals upgraded and /or renovated	Immovable Asset Register & Physical Verification	Not in Plan	Not in Plan	Not in Plan	5	5		
	Number of hospitals under Infrastructure Grant under upgrading and renovation.		Immovable Asset Register & Physical Verification	Not in Plan	Not in Plan	Not in Plan	5	8		

Number of hospitals under Infrastructure Grant upgraded/renovated.		Immovable Asset Register & Physical Verification	8	11	1 final delivery, 10 projects at different stages	2	2	5	5

TARGETS FOR HFM

TABLE HFM3: QUARTERLY AND ANNUAL TARGETS FOR HEALTH FACILITES MANAGEMENT FOR 2012/13

PROGRAMME PERFORMANCE INDICATOR	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
Number of PHC facilities with accommodation, on planning phase.	ANNUAL	6 (20)	6 Clinics on planning with DPWR&T Oakley, Klarinet, Makoko, Vlaaglaagte , Sulphurspring and Lefisoane	6 Clinics on planning with DPWR&T Oakley, Klarinet, Makoko, Vlaaglaagte , Sulphurspring and Lefisoane	6 Clinics on planning with DPWR&T Oakley, Klarinet, Makoko, Vlaaglaagte , Sulphurspring and Lefisoane	6 Clinics on planning with DPWR&T Oakley, Klarinet, Makoko, Vlaaglaagte , Sulphurspring and Lefisoane
Number of PHC facilities with accommodation, under construction.		9	The following facilities on different stages of construction: Tweefontein G, Sinqobile, Phosa Village, Mbhejeka,Tekwane, Mashishing, Hluvukani, Wakkerstroom, Pankop, Siyathemba (Greenside sorting site issue)	The following facilities on different stages of construction: Tweefontein G, Sinqobile, Phosa Village, Mbhejeka,Tekwane, Mashishing, Hluvukani, Wakkerstroom, Pankop, Siyathemba (Greenside sorting site issue)	The following facilities on different stages of construction: Tweefontein G, Sinqobile, Phosa Village, Mbhejeka, Hluvukani, Pankop, Siyathemba and Greenside	The following facilities on different stages of construction: Tweefontein G, Sinqobile, Phosa Village, Mbhejeka, Hluvukani, Pankop, Siyathemba and Greenside
Number of PHC facilities with accommodation, constructed.		3 (5/20)	None	None	3 PHC facilities completed Mashishing, Tekwane, Wakkerstroom	3 PHC facilities completed Mashishing, Hluvukani, Wakkerstroom
Number of hospitals under revitalisation programme, on planning phase		4	4 Hospitals on planning: Lydenburg Tintswalo, Barberton and KwaMhlanga	4 Hospitals on planning: Lydenburg Tintswalo, Barberton and KwaMhlanga	4 Hospitals on planning: Lydenburg Tintswalo, Barberton and KwaMhlanga	4 Hospitals on planning: Lydenburg Tintswalo, Barberton and KwaMhlanga
Number of hospitals under revitalisation programme, under upgrading and renovation.		3	3 Hospitals on different stages of upgrading and renovation : Themba, Ermelo and Rob Ferreira	3 Hospitals on different stages of upgrading and renovation : Themba, Ermelo and Rob Ferreira	3 Hospitals on different stages of upgrading and renovation : Themba, Ermelo and Rob Ferreira	3 Hospitals on different stages of upgrading and renovation : Themba, Ermelo, and Rob Ferreira
Number of hospitals under revitalisation programme, upgraded/renovated.		-				
Number of hospitals under Infrastructure Grant on planning phase		5	5 Hospitals on planning stage; Sabie, Elsie Ballot, Bethal ,Standerton, and Mmametlake	5 Hospitals on planning stage; Sabie, Elsie Ballot, Bethal ,Standerton, and Mmametlake	5 Hospitals on planning stage; Sabie, Elsie Ballot, Bethal ,Standerton, and Mmametlake	5 Hospitals on planning stage; Sabie, Elsie Ballot, Bethal ,Standerton, and Mmametlake

PROGRAMME PERFORMANCE INDICATOR	REPORTING PERIOD	ANNUAL TARGET 2012/13	QUARTERLY TARGETS			
			Q1	Q2	Q3	Q4
Number of hospitals under Infrastructure Grant under upgrading and renovation.		8	5 Hospitals under upgrading and renovation: Belfast, Witbank, KwaMhlanga, Mapulaneng and Bongani	8 Hospitals under upgrading and renovation 1 completed; Carolina Standerton,Bethal, Belfast, KwaMhlanga, Witbank, Matibidi, Mapulaneng	8 Hospitals under upgrading and renovation 1 completed; Carolina Standerton,Bethal, Belfast, KwaMhlanga, Witbank, Matibidi, Mapulaneng	8 Hospitals under upgrading and renovation 1 completed; Carolina Standerton,Bethal, Belfast, KwaMhlanga, Witbank, Matibidi, Mapulaneng
Number of hospitals under Infrastructure Grant upgraded/renovated.		2	None	None	2 Hospitals upgraded/renovated; Bongani and Mapulaneng	2 Hospitals upgraded/renovated: Bongani and Mapulaneng

8.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE HFM4: EXPENDITURE ESTIMATES: HEALTH CARE SUPPORT SERVICES

	2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
	Audited			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
Subprogramme									
Community Health Facilities	60 742	182 462	152 108	311 720	257 800	217 891	209 750	253 922	250 736
Emergency Medical Rescue Services									
District Hospital Services	110 343	115 076	90 288	146 368	146 368	138 422	108 971	115 509	126 385
Provincial Hospital Services	105 309	342 675	298 753	356 557	356 557	340 441	300 000	300 000	304 500
Central Hospital Services									
Other Facilities									
Total	**276 394**	**640 213**	**541 149**	**814 645**	**760 725**	**696 754**	**618 721**	**669 431**	**681 621**
Current payments	**12 637**	**52 435**	**52 251**	**143 565**	**94 992**	**92 286**	**85 255**	**87 766**	**88 519**
Compensation of employees	1 687	3 602	4 824	10 965	6 965	6 965	8 195	8 809	9 450
Salaries and wages	1 480	3 164	4 248	10 000	6 000	6 129	7 434	7 991	8 572
Social contributions	207	438	576	965	965	836	761	818	878
Goods and services	10 950	48 782	47 427	132 600	88 027	85 321	77 060	78 957	79 069
Administrative fees	946	9		60	60	66	108	111	115
Advertising	172			192	192	192			
Assets <R5000	829	2 591	1 492	10 040	10 040	8 800	9 732	9 732	9 732
Catering: Departmental activities	248	156	11	188	188	147	110	110	110
Communication	(16)	7	25	10	10	19	243	243	244
Computer services		3 803							
Cons/prof:business & advisory services			17 202						
Cons/prof: Laboratory services	(1 071)								
Contractors	3 234	26 728	13 718	33 696	33 696	32 148			
Agency & support/outsourced services		3 452	9 915	1 080	1 080	1 237	18 818	18 818	18 818
Entertainment	2								
Inventory: Food and food supplies	237					1			
Inventory: Materials & supplies		3 209	23						
Inventory: Medical supplies	20	10				4	350	350	350
Inventory: Other consumbles	142	1 351	143			49	290	290	290
Inventory: Stationery and printing	275	59	35	206	206	175	117	124	131
Lease payments (Incl. operating leases, e		10		306	306	216			
Rental & hiring									
Property payments				77 742	33 169	33 308	43 451	45 282	45 323
Transport provided dept activity							3	3	3
Travel and subsistence	1 950	2 081	2 397	3 691	3 691	3 515	2 457	2 486	2 515
Training & staff development	3 384	4 728	2 052	4 622	4 622	4 726	922	922	922
Operating payments	133	55	47	100	100	76	105	111	118
Venues and facilities	465	533	367	667	667	642	354	375	398
Interest and rent on land		51							
Transfers and subsidies									
Provinces and municipalities									
Departmental agencies and accounts									
Non-profit institutions									
Households									
Payments for capital assets	**263 757**	**587 778**	**488 898**	**671 080**	**665 733**	**604 468**	**533 466**	**581 665**	**593 102**
Buildings and other fixed structures	232 571	548 186	460 997	585 635	581 288	518 026	491 540	540 073	547 370
Machinery and equipment	31 186	39 592	27 901	85 445	84 445	86 442	41 926	41 592	45 732
Software and other intangible assets									
of which:									
Capitalised compensation of employees									
Capitalised goods and services									
Payments for financial assets									
Total economic classification	**276 394**	**640 213**	**541 149**	**814 645**	**760 725**	**696 754**	**618 721**	**669 431**	**681 621**

8.6 PERFORMANCE AND EXPENDITURE TRENDS

Programme 8, Health Facilities Management show a year on year increase of 36.1 percent from the 2008/09 to the 2011/12 financial year and a reduction from the 2011/12 to 2014/15 financial year of 0.7%. In the 2012/13 financial year the budget will decrease with 11.2 per cent. There will be a slight increase over the MTEF period after the reduction o 8.2 percent and 1.8 per cent in the 2013/14 and 14/15 financial year respectively.

The decrease is mainly due to the reduced Hospital Revitalization grant from R356'557 million to R300 million from the 2011/12 financial year. The EPWP grant also does not continue from the 2011/12 financial year which further contributes to the negative growth on this programme. The programme will mainly focus to complete outstanding projects and to strengthen health community services by building new CHC's and Clinics.

8.7 RISK MANAGEMENT

RISKS	MITIGATING FACTORS
Shortage of staff	Appointment of staff in line with the organogram
Lack of skilled personnel e.g. Health Planners	Recruitment of skilled personnel
Poor performance for both consultants and contractors	Improve monitoring of consultants and contractors
Poor monitoring of service level agreement with public works.	Scheduled monthly meetings to monitor the service level agreement
Inadequate monitoring of projects	Ensure regular visits on sites and compile reports
Insufficient budget allocations	Motivate for additional funds

PART C: LINKS TO OTHER PLANS

9. LINKS TO THE LONG-TERM INFRASTRUCTURE AND OTHER CAPITAL PLANS

NO	PROJECT NAME	PROGRAM ME	MUNICIPALITY	OUTPUTS	OUTCOME R'000			R'000			2012/13 BUDGET R'000
								MAIN APPRO PRIATION	ADJUSTED APPRO PRIATION	REVISED ESTIMATE	
					2008/09	2009/10	2010/11	2011/12			2012/13
1	**New and replacement assets (R'thousand)**										
1.1	Wakkerstroom CHC	8	Pixley Ka Seme	Construction of new CHC & accommodation unit	0	0	14 000	14 000	0	14 000	8 000
1.2	Masibekela CHC	8	Nkomazi	Construction of new CHC & accommodation unit	0	0	13 000	8 000	0	8 000	1 700
-1.3	Thekwane CHC	8	Mbombela	Construction of new CHC & accommodation unit	0	0	5 562	14 000	0	14 000	8 000
1.4	Hluvukani CHC	8	Bushbuckridge	Construction of new CHC & accommodation unit	0	0	8 000	14 000	0	14 000	8 000
1.5	Mashishing CHC	8	Thaba-Chweu	Construction of new CHC & accommodation unit	0	0	8 000	14 000	0	14 000	8 000
1.6	Moloto EMS	8	Thembisile	Construction of new EMS Station	891	0	10 000	12 500	0	12 500	7 000
1.7	Pankop CHC	8	Thembisile	Construction of new CHC & accommodation unit	0	0	0	5 000	0	5 000	10 000
1.8	Ntunda CHC	8	Nkomazi	Construction of new CHC and accommodation	0	0	0	5 000	0	5 000	10 000
1.9	Siyathemba CHC	8	Dipaliseng	Construction of new CHC fully fledged CHC	0	0	0	16 000	0	16 000	10 000
1.10	Klarinet Clinic	8	Emalahleni	Construction of new CHC	0	0	0	0	0	0	950
1.11	Dwarsloop CHC	8	Bushbuckridge	Construction of new CHC & 2 accommodation units	0	0	13 000	4 814	0	4 814	0
1.12	Lochiel CHC	8	Albert Luthuli	Construction of new CHC & accommodation unit	0	0	8 360	3 000	0	3 000	0
1.13	Kaapmuiden EMS Station	8	Mbombela	Construction of EMS Station	0	0	0	5 000	0	5 000	950
1.14	Greenside Clinic	8	Dr JS Moroka	Construction of new CHC & 2x2 accommodation units	0	0	0	20 000	0	20 000	5 000

NO	PROJECT NAME	PROGRAM ME	MUNICIPALITY	OUTPUTS	OUTCOME R'000			R'000			2012/13 BUDGET R'000
								MAIN APPRO PRIATION	ADJUSTED APPRO PRIATION	REVISED ESTIMATE	
					2008/09	2009/10	2010/11	2011/12			2012/13
1.15	Tweefontein G Clinic	8	Thembisile	Construction of new CHC & 2x2 accommodation units	0	0	0	20 000	0	20 000	13 000
1.16	Phosa Village CHC -Ward 14	8	Mkhondo	Construction of new CHC & 2x2 accommodation units	0	0	0	20 000	0	20 000	13 000
1.17	Sinqobile Clinic	8	Pixley kaSeme	Construction of new CHC & 2x2 accommodation units	0	0	0	20 000	0	20 000	13 000
1.18	Mbhejeka Clinic	8	Albert Luthuli	Construction of new CHC & 2x2 accommodation units	0	0	0	20 000	0	20 000	13 000
1.19	Warburton CHC	8	Msukaligwa	Construction of new CHC	0	0	2 400	400	0	400	0
1.20	Greylingstad CHC	8	Dipaliseng	Construction of new CHC (final account)	0	0	6 982	300	0	300	0
1.21	Tertiary Hospital	8	Mbombela	Construction of new Tertiary hospital			15 000	0	0		0
1.22	Sulphursprings clinic	8	Mkhondo	Construction of a new clinic & accommodation	0	0	0	0	0	0	950
1.23	Mgwenya CHC:	8	Emakhazeni	Construction of a new CHC and accommodation	0	0	0	0	0	0	0
1.24	Glory Hill CHC	8	Thaba- Chweu	Construction of a new CHC and accommodation	0	0	0	0	0	0	0
1.25	Luphisi CHC :	8	Mbombela	Construction of new CHC and accommodation Units	0	0	0	0	0	0	950
1.26	Nursing College	8	Mbombela	Nursing College	0	0	0	0	0	0	0
1.27	Nursing College	8	Msukaligwa	Nursing College	0	0	0	0	0	0	5 000
1.28	Nursing College	8	Thembisile Hani	Nursing College	0	0	0	0	0	0	0
1.29	Ehlanzeni District offices	8	Bushburidge	Construction of 106 offices, 2 storerooms and 2 boardrooms	0	0	0	0	0	0	5 000
	Gert Sibande District offices	8	Msukaligwa	Construction of 106 offices, 2 storerooms and 2 boardrooms	0	0	0	0	0	0	
Total new and replacement assets											
2	**Maintenance and repairs (R thousand)**										

NO	PROJECT NAME	PROGRAM ME	MUNICIPALITY	OUTPUTS	OUTCOME R'000			R'000			2012/13 BUDGET R'000
								MAIN APPRO PRIATION	ADJUSTED APPRO PRIATION	REVISED ESTIMATE	
					2008/09	2009/10	2010/11	2011/12			2012/13
2.1	Purchase of equipment	8	All Districts	Equipment/furniture: New facilities			9 517	20 259	0	20 259	21 726
2.2	Maintenance of equipment	8	All Districts	Community Health Centres and Clinics			31 993	10 088	0	10 088	27 650
2.3	Purchase of equipment	8	All Districts	Purchase of equipment			18 000	10 088	0	10 088	10 592
2.4	Maintenance of equipment	8	All Districts	Maintenance of facilities			10 019	1908	0	1908	0
Total maintenance and repairs											
3	**Upgrades and additions (R thousand)**										
3.1	Delmas Hospital	8	Delmas	Upgrading of existing theatre, male and female wards and Admin Block.	0	11 457	16 372	1 700	0	1 700	0
3.2	Belfast Hospital	8	Emakhazeni	Upgrade OPD, Casualty, and construction of Pharmacy.	1 351	1 068	19 000	23 103	0	23 103	15 000
3.3	Kwa Mhlanga Hospital	8	Thembisile	Phase 3A, Construction of ICU, Casualty and additions to existing theatre block	0	998	0	25 000	0	25 000	21 000
3.4	Witbank Hospital	8	Emalahleni	Construction of Paediatric wards trauma	13 890	38 996	13 426	2 500	0	2 500	0
3.5	Middleburg Hospital	8	Steve Tshwete	Renovation of existing roofs and two wards. Upgrading of helipad, theatres, Pharmacy and Casualty, Construction of new ICT/High Care	1 069	38 446	15 534	1 500	0	1 500	2 000
3.6	Mapulaneng Hospital	8	Bushbuckridge	Renovations and addition of ward, construction of helipad	0	1 072	10 456	10 456	0	10 456	1 000
3.7	Barberton Hospital	8	Umjindi	Upgrade OPD, Casualty, admission area, ablution facilities and repairing roof, disable facilities at entrance and painting whole hospital.	1 021	44 274	31 801	7 000	0	7 000	2 000
3.8	Carolina Hospital	8	Albert Luthuli	Construction of Admin Block, OPD, Paediatric Ward and extension of Theatre.	0	0	0	10 000	0	10 000	32 127
3.9	Witbank Hospital	8	Emalahleni	Construction of Neo-natal and Kangaroo unit and demolishing	0	0	0	25 000	0	25 000	35 000

NO	PROJECT NAME	PROGRAM ME	MUNICIPALITY	OUTPUTS	OUTCOME R'000			R'000			2012/13 BUDGET R'000
								MAIN APPRO PRIATION	ADJUSTED APPRO PRIATION	REVISED ESTIMATE	
					2008/09	2009/10	2010/11	2011/12			2012/13
				of existing buildings.							
3.10	Embhuleni Hospital	8	Albert Luthuli	Renovation of laundry, replace vinyl floor covering to the entire hospital floor, renovate ambulance parking area and shelter and replace water pipes.	0	686	0	0	0	0	0
3.11	Lydenburg Hospital	8	Mashishing	Upgrading of hospital	0	0	0	0	0	0	0
3.12	Elsie Ballot Hospital	8	Pixley KaSeme	Major Renovations	0	0	0	10 000	0	10 000	0
3.13	Piet Retief Hospital	8	Mkhondo	Construction of M2 Mortuary	0	0	0	15 000	0	15 000	6 000
3.14	Bethal Hospital	8	Govern Mbeki	Removal of asbestos and major upgrade of hospital, construction of rehabilitation , stepdown and oral health unit	0	0	0	10 000	0	10 000	20 000
3.15	Sabie Hospital	8	Thaba-Chweu	Removal of asbestos and construction of maternity	0	0		5 000	0	5 000	0
3.16	Standerton Hospital	8	Lekwa	Completion of a new uncompleted structure	0	0	0	7 871	0	7 871	3 500
3.17	Matibidi Hospital	8	Thaba-Chweu	Construction of Admin block and 10x3 accommodation unit	0	0		10 000	0	10 000	6 000
3.18	Mpumalanga Nursing college	8	Mbombela	Construction of palisade fencing	0	0	0	2 000	0	2 000	0
3.19	Bongani Hospital	8	Mbombela	Construction of 40 beds MDR-TB wards accommodations	0	0	0	20 000	0	20 000	1 000
3.20	Embhuleni Hospital	8	Albert Luthuli	Construction of new palisade fencing	0	0	0	3 000	0	3 000	0
3.21	Mayflower clinic	8	Albert Luthuli	Construction of 2x2 accommodation units	0	0	0	1 800	0	1 800	1 000
3.22	Swallows Nest clinic	8	Albert Luthuli	Construction of 2x2 accommodation units	0	0	0	1 800	0	1 800	1 000
3.23	M'Africa CHC	8	Umjindi	Construction of 2x2 accommodation units	0	0	0	1 800	0	1 800	1 000
3.24	Wonderfontein clinic	8	Emakhazeni	Construction of 2x2 accommodation units	0	0	0	1 800	0	1 800	1 000

NO	PROJECT NAME	PROGRAMME	MUNICIPALITY	OUTPUTS	OUTCOME R'000			R'000			2012/13 BUDGET R'000
								MAIN APPROPRIATION	ADJUSTED APPROPRIATION	REVISED ESTIMATE	
					2008/09	2009/10	2010/11	2011/12			2012/13
3.25	Mthimba clinic	8	Mbombela	Construction of 2x2 accommodation units	0	0	0	1 800	0	1 800	1 000
3.26	Evander Hospital	8	Govan Mbeki	Completion of Medico Legal Laboratory	0	0	0	4 500	0	4 500	1 000
3.26	Evander Hospital	8	Govan Mbeki	Construction of OPD, Maternity Wards, Theatre	0	0	4 400	1 482	0	1482	0
3.27	Nkangala Technical workshop	8	Emallahleni	Construction of a new clinical Engineering workshop (final account)	0	0	316	300	0	300	0
3.28	Verena Clinic	8	Thembisile	Completion of accommodation units (final account)	0	0	865	200	0	200	0
3.29	Lefiso CHC	8	Thembisile	Completion of accommodation units (final account)	0	0	746	200	0	200	0
3..30	Nokaneng CHC	8	Dr JS Moroka	Completion of accommodation units (final account)	0	0	487	200	0	200	0
3.31	Silindile CHC	8	Msukaligwa	Completion of accommodation units (final account)	0	0	1 359	300	0	300	0
3.32	Iswepe CHC	8	Mkhondo	Completion of accommodation units (final account)	0	0	703	200	0	200	0
3.33	KwaMhlanga Hospital	8	Thembisile	Construction of bulk earthworks, roads, and parking including new security gate house and helipad (final account)	0	0	2 134	1 000	0	1 000	0
3.34	Witbank Hospital	8	Emalahleni	Construction of OPD, Casualty, Pharmacy (final account)	0	0	5 727	2 500	0	2 500	0
3.35	Middelburg Pharmaceutical Depot	8	Steve Tshwete	Construction of new Pharmaceutical depot (final account)	0	0	9 000	2 000	0	2 000	0
3.36	Standerton Hospital	8	Lekwa	Construction of 3 wards (final account)	0	0	1 500	1 500	0	1 500	0

NO	PROJECT NAME	PROGRAMME	MUNICIPALITY	OUTPUTS	OUTCOME R'000			R'000			2012/13 BUDGET R'000
								MAIN APPROPRIATION	ADJUSTED APPROPRIATION	REVISED ESTIMATE	
					2008/09	2009/10	2010/11	2011/12			2012/13
	Tekwane North CHC	8	Mbombela	Construction of new CHC and 2x2 accommodation units	0	0	0	950		0	950
	Oakley clinic	8	Bushbuckridge	Construction of new CHC and 2x2 accommodation units	0	0	0	10 000		0	10 000
	Makoko clinic	8	Mbombela	Construction of new CHC and 2x2 accommodation units	0	0	0	10 000		0	950
	Vlaaglaaagte clinic	8		Construction of new CHC and 2x2 accommodation units	0	0	0	950		0	950
	Lefisoane cllinic	8		Construction of new CHC and 2x2 accommodation units	0	0	0	950		0	950
	Mammetlake hospital	8	Dr JS Moroka	Upgading and Additions of wards	0	0	0	5 000		0	5 000
	Rob Ferreira Hospital	8	Mbombela	Revitalization of Hospital	0	0	0	77 000		0	133 967
	Themba Hospital	8	Mbombela	Revitalization of Hospital	0	0	0	99 047		0	70 522
	Ermelo Hospital	8	Msukaligwa	Revitalization of Hospital	0	0	0	88 000		0	62 611
	Lydenburg Hospital	8	Thaba Chewu	Revitalization of Hospital	0	0	0	5 000		0	1 000
	Tinstwalo Hospital	8	Bushbuckridge	Revitalization of Hospital	0	0	0	5 000		0	1 000
	Kwa Mhlanga Hospital	8	Thembisile	Revitalization of Hospital	0	0	0	5 000		0	1 000
	Barberton Hospital	8	Umjindi	Revitalization of Hospital	0	0	0	5 000		0	1 000

NO	PROJECT NAME	PROGRAMME	MUNICIPALITY	OUTPUTS	OUTCOME R'000			R'000			2012/13 BUDGET R'000
								MAIN APPROPRIATION	ADJUSTED APPROPRIATION	REVISED ESTIMATE	
					2008/09	2009/10	2010/11	2011/12			2012/13
					0	0	0			0	
					0	0	0			0	
Total upgrades and additions		**8**			0	0	0			0	

Rehabilitation, renovations and refurbishments (R thousand)										
4.1	Perdekop clinic	Pixley kaSeme	Major Renovations		0	0	3 000	0	3 000	0
4.2	Lebogang CHC	Govan Mbeki	Major Renovations		0	0	3 000	0	3 000	0
4.3	Oakley clinic	Bushbuckridge	Major Renovations		0	0	3 000	0	3 000	0
4.4	Zwelisha clinic	Mbombela	Extension of clinic		0	0	3 000	0	3 000	2 317
4.5	Dingley dake clinic	Bushbuckridge	Major Renovations		0	0	3 000	3 000	0	1 917
4.6	Fig Tree clinic	Bushbuckridge	Major Renovations		0	0	3 000	3 000	0	1 917
4.7	Mpakeni clinic	Mbombela	Major Renovations		0	0	3 000	3 000	0	1 917
4.8	Marite clinic	Bushbuckridge	Major Renovations		0	0	3 000	3 000	0	1 917
4.9	Orinnocco clinic	Bushbuckridge	Major Renovations		0	0	3 000	3 000	0	1 917
4.10	Ogies clinic	Emalahleni	Major Renovations		0	0	3 000	3 000	0	1 916
Total rehabilitation, renovations and refurbishments										

16. CONDITIONAL GRANTS

TABLE: CONDITIONAL GRANTS

Name of conditional grant	Purpose of the grant	Performance Indicators	Indicator Targets for 2012/13
1. Hospital Revitalization Grant	The purpose of the Hospital Revitalisation Grant is to: • provide funding to enable provinces to plan, manage, modernise, rationalise and transform health infrastructure, health technology, monitoring and evaluation of the health facilities in line with national policy objectives • supplement expenditure on health infrastructure delivered through public-private partnerships	• Number of hospitals funded to upgrade, rebuilt and fully commissioned as per approved 2012/13 Project Implementation Plans (PIP)	• 4 projects on planning and design • 3 projects under construction
2. Infrastructure Grant	The purpose of the Infrastructure Grant is to: • supplement provincial funding of health infrastructure to accelerate the provision of health facilities including medical equipments and ensure proper maintenance of provincial health infrastructure • address funding for unfinished projects within in each Province • address continued funding for health facility life cycle maintenance	• Number of health facilities, planned, designed, constructed, maintained and operationalized • Number of work opportunities created	• 5 projects on Planning & Design • 8 projects under Construction • 2 to be completed
3. Comprehensive HIV and AIDS Grant	The purpose of the Comprehensive HIV and AIDS Grant, is: • To enable the health sector to develop an effective response to HIV and Aids including universal access to HIV Counselling and Testing (HCT) • To support the implementation of the National Operational Plan for comprehensive HIV and Aids treatment and care • To subsidise in-part funding for antiretroviral treatment	• No. of fixed public health facilities offering ART services, • No. of new patients started on ART • Total number of patients on ART remaining in care	35 Adults 46 456 Children 5 170 Adult males 68 217 Adult females 102 326 Children 18 938

Name of conditional grant	Purpose of the grant	Performance Indicators	Indicator Targets for 2012/13
	programme	• No. of beneficiaries served by home-based carers • No. of active home-based carers receiving stipends • No. of Male condom distributed • No. of female condoms distributed • No. of HTA intervention sites • No. of ANC clients initiated on life-long ART • No. of babies PCR tested at 6 weeks • No. of HIV positive client screened for TB • No. of HIV positive patients started on IPT • No. of active lay counsellors on stipends • No. of clients pre-test counselled on HIV testing (including antenatal) • No. of clients tested for HIV (including antenatal) • No. of health facilities offering MMC services • No. of Medical Male Circumcision performed • No. of sexual assault cases – new • No. of sexual assault cases offered ARV prophylaxis • No. of SDC facilities/units • No. of doctors and professional nurses trained on HIV/AIDS, STIs, TB and chronic diseases	2400 52 000 000 750 000 68 3295 35 000 825 103 000 000 940 000 28 82 000 3 759 2 820 8

Name of conditional grant	Purpose of the grant	Performance Indicators	Indicator Targets for 2012/13
4. National Tertiary Service Grant	The purpose of the National Tertiary Service Grant is to: • ensure provision of tertiary health services for all South African citizens • compensate tertiary facilities for the additional costs associated with provision of these services including cross border patients	• Provision of designated central and national tertiary services (T1, T2 & T3) in 22 hospitals/complexes as agreed between the Province and the National Department of Health (NDoH)	2 hospitals provide tertiary services in the province i.e. Witbank & Rob Ferreira for the province
5. Health Professional Training and Development Grant	The purpose of the Health Professional Training and Development Grant is to • Support provinces to fund service costs associated with training of health science trainees on the public service platform; • Establish clinical teaching and training capacity as required on the public service platform in earmarked provinces (Northern Cape, North West, Limpopo, Mpumalanga, Eastern Cape) • Co funding of the Human Resource for Health in expanding undergraduate medical education for 2012 and beyond (2025).	• Number of undergraduate health sciences trainees, trained on the public health service platform, by category, training institution and province. • Number of postgraduate health sciences trainees (excluding registrars), trained on the public health service platform, by category, training institution and province. • Number of registrars trained on the public health service platform, per discipline and per training institution in provinces. • Number of community services health professionals on the platform. • Number of other health science trainees supervised on the public health service platform as per statuary requirements for example interns Provinces receiving a developmental portion (Northern Cape, North West, Limpopo, Mpumalanga, Eastern Cape) will also: • Indicate the specific clinical teaching and clinical training personnel capacity established on the public	• 80 Medical students and 40 BCMP • 50 Postgraduate students • 9 registrars trained • 500 health professionals • 60 Pharmacists Assistants, 200 Nursing auxiliaries) • 35 specialists compensated and 6 Lecturers recruited.

Name of conditional grant	Purpose of the grant	Performance Indicators	Indicator Targets for 2012/13
		health service platform by reporting on the number of health professionals recruited and retained for this function.	
6. Nursing Colleges Grant	The purpose of the Nursing Colleges Grant is • to supplement provincial funding of health infrastructure to accelerate the provision of health facilities including office furniture and related equipments, and • to ensure proper maintenance of provincial health infrastructure for Nursing Colleges and schools.	• Number of Nursing Colleges & schools, planned, designed, constructed, maintained and operationalized • Number of work opportunities created	• One Nursing College revitalised • 200 work Opportunities created
7. National Health Insurance (NHI) Grant	1. To test innovations necessary for implementing National Health Insurance 2. To undertake health system strengthening initiatives and support selected pilot districts in implementing identified service delivery interventions 3. To strengthen the resource management of selected central hospitals	• Complete situational analysis of basic equipment, infrastructure, Human Resource and logistics of the hospitals and primary health care facilities in Gert Sibande District • Complete audit of IT systems. • Improved Reporting on efficiency indicators.	• Districts Quality Improvement Plans supported. • Institutional Structure established.

17. PUBLIC ENTITIES

NAME OF PUBLIC ENTITY	MANDATE	OUTPUTS	CURRENT ANNUAL BUDGET (R'THOUSAND)	DATE OF NEXT EVALUATION
None	None	None	None	None

12. PUBLIC-PRIVATE PARTNERSHIPS (PPPs)

NAME OF PPP	PURPOSE	OUTPUTS	CURRENT ANNUAL BUDGET (R'THOUSAND)	DATE OF TERMINATION	MEASURES TO ENSURE SMOOTH TRANSFER OF RESPONSIBILITIES
None	None	None	None	None	None

13. CONCLUSIONS

The 2012/13 – 2014/15 takes a leaf out of the previous MTEF plan whereby it lays out key objectives, indicators and targets, the department seeks to achieve. The process of setting indicators and targets was highly inclusive consultative process with the relevant managers and stakeholders. With the limited resources, the Department has prioritized in achieving the set targets.

ANNEXURE E - DEFINITIONS OF INDICATORS AND DATA ELEMENTS IN THE APP 2012/13

SITUATION ANALYSIS

TABLE A2: TRENDS IN KEY PROVINCIAL SERVICE VOLUMES

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Total PHC Headcount in PHC facilities	Number of PHC patients seen during the reporting period in PHC facilities (Clinics and CHCs) Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen	Tracks the uptake of PHC services at each PHC facility for the purposes of allocating staff and other resources.	DHIS	PHC total headcount	Accuracy of headcount depends on the reliability of PHC record management at facility level	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	Programme Manager
OPD General clinic new case not referred rate"	Number of General OPD clinic new cases (seeking medical attention for a condition for the first time) that report to the General OPD department without being referred from a PHC facility or doctor during the reporting period in all Hospitals (district, regional, tertiary and central) as a percentage of the OPD General headcount new visits total. Patients with General OPD follow-up visits, visiting specialised OPD clinics and Emergency patients are not counted in denominator, because this is not regarded as PHC level of care.	Tracks the utilisation of Hospitals by patients to access PHC services , which in fact should be accessed at PHC services. This could also points to the needs for PHC services or gaps in PHC service delivery	DHIS	Numerator: OPD General clinic headcount - new case not referred. Denominator = OPD General clinic headcount new case-total Sum of : • OPD General clinic headcount-new case referred • OPD General clinic headcount -new case not referred	Accuracy of headcount depends on the reliability of district hospital record management at facility level	Output	Percentage	Quarterly	Yes	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	Programme Manager

Total Hospital Separations	Recorded completion of treatment and/or the accommodation of a patient in all hospitals (district, regional, tertiary and central) Separations include inpatients who were discharged, transferred out to other hospitals or who died and includes Day Patients.	Monitoring the service volumes	DHIS	Sum of: • Inpatient deaths • Inpatient discharges • Inpatient transfer out • Day patient	Accuracy dependant on quality of data from reporting facility	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	All Hospital Programmes

TABLE A3: MILLENIUM DEVELOPMENT GOALS

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Prevalence of underweight (children under 5)	A child under 5 years identified as being BELOW the third centile but EQUAL TO or OVER 60% of Estimated Weight for Age (EWA) on the Road-to-Health chart. Include any such child irrespective of the reason for the underweight - malnourishment, premature birth, genetic disorders etc	Essential for growth monitoring in children	DHIS	Numerator Number of children underweight for age during the reporting period Denominator Number of children weighed during the reporting period	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Quarterly	No	Lower levels of prevalence of underweight (children under 5) are desired	Health Information, Epidemiology and Research Programme Nutrition Programme Maternal, Child and Women's Health Programme
Incidence of severe malnutrition in children (under 5 years of age)	The number of children who weigh below 60% Expected Weight for Age (new cases per month) per 1000 children in the target population	Essential for growth monitoring in children	DHIS	Numerator The number of children who weigh below 60% Expected Weight for Age during the reporting period Denominator Children under 5 years x 1000	Accuracy dependent on quality of data from reporting facility	Outcome	Number per 1000	Quarterly (Indicator must be annualised)	No	Lower levels of prevalence of underweight (children under 5) are desired	Health Information, Epidemiology and Research Programme Nutrition Programme Maternal, Child and Women's Health Programme
Infant mortality rate	Number of children less than one year old who die in one year, per 1000 live births during that year	Monitors trends in infant mortality	South African Demographic And Health Surveys (SADHS)	Numerator Number of children less than one year old who die in one year Denominator Total number of live births during that year x 1000	Data are not frequently available. Empirical data are available from the SADHS, which is conducted every 5 years	Outcome	Number per 1000 (rate)	Empirical data are provided by the SADHS every 5 years	No	Lower Infant Mortality Rates are desired	Maternal, Child and Women's Health Programme

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Measles coverage under 1	Percentage of children under 1 year who received their first measles dose	Monitors measles coverage	DHIS	Numerator: Measles 1st dose before 1 year Denominator: Population under 1 year	Reliant on under 1 population estimates from StatsSA	Output	Percentage	Quarterly	No	Higher proportions of children immunised against measles are desired.	Expanded Programme on Immunisation (EPI) Manager
Maternal mortality ratio	Number of women who die as a result of childbearing, during pregnancy or within 42 days of delivery or termination of pregnancy in one year, per 100,000 live births during that year	Monitors trends in maternal mortality	SADHS	Numerator Number of women who die as a result of childbearing, during pregnancy or within 42 days of delivery or termination of pregnancy in one year Denominator Total number of live births during that year x 100,000	Data are not frequently available. Empirical data are available from the SADHS, which is conducted every 5 years	Outcome	Number per 100,000	Empirical data are provided by the SADHS every 5 years	No	Lower Maternal Mortality Ratios are desired Lower	Health Information, Epidemiology and Research Programme MCWH Programme
Proportion of births attended by skilled health personnel	Percentage of women who gave birth in the 5 years preceding the South African Demographic Survey (SADHS) who reported that medical assistance at delivery from either a doctor, nurse or midwife	Monitors trends in maternal mortality	SADHS	Numerator Number of women who gave birth in the 5 years preceding the survey who reported that medical assistance at delivery from either a doctor, nurse or midwife Denominator Total number of women who gave birth in the 5 years preceding the survey	Data are not frequently available. Empirical data are available from the SADHS, which is conducted every 5 years	Output		Empirical data are provided by the SADHS every 5 years	No	Higher levels of skilled births attended by skilled health personnel are desired	Health Information, Epidemiology and Research Programme MCWH Programme

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
HIV and AIDS prevalence among 15-19 year old group (antenatal)	Percentage of women aged 15-19 years surveyed testing positive for HIV	Tracks prevalence of HIV and AIDs in younger women of reproductive age, and the success of efforts to combat HIV and AIDS in South Africa	Annual Antenatal and HIV Survey	Numerator: Women aged 15 – 19 years who tested HIV positive during the survey; Denominator: Women aged 15 – 19 years who were tested for HIV during the survey	Reflects prevalence in surveyed women, not entire population.	Outcome	Percentage	Annual	No	Lower levels of HIV and AIDS prevalence are desired	Health Information, Epidemiology and Research Programme HIV and AIDS Programme
HIV and AIDS prevalence among 20--24 year old group (antenatal)	Percentage of women aged 20-24 years surveyed testing positive for HIV	Tracks prevalence of HIV and AIDs in young adult women of reproductive age, and the success of efforts to combat HIV and AIDS in South Africa	Annual Antenatal and HIV Survey	Numerator: Women aged 20– 24 years who tested HIV positive during the survey; Denominator: Women aged 20 – 24 years who were tested for HIV during the survey.	Reflects prevalence in surveyed women, not entire population	Outcome	Percentage	Annual	No	Lower levels of HIV and AIDS prevalence are desired	Health Information, Epidemiology and Research Programme HIV and AIDS Programme
Contraceptive Prevalence Rate	Percentage of women of reproductive age (15-44) who are using (or whose partner is using) a modern contraceptive method. Contraceptive methods include female and male sterilisation , injectable, and oral hormones, intrauterine devices, diaphragms, spemicides and condoms, natural family planning lactational amenorrhoea.	Track the extent of the use of contraception (any method) amongst women of child bearing age	SADHS		Data are not frequently available. Empirical data are available from the SADHS, which is conducted every 5 years	Output	Percentage	Empirical data are provided by the SADHS every 5 years	No	Higher Contraceptive prevalence levels are desired	Health Information, Epidemiology and Research Programme MCWH&N Programme

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
New smear positive PTB cure rate	Percentage of patients who are proved to be cured using smear microscopy at the end of the treatment (bacteriological proof)	Tracks the success of efforts to combat Tuberculosis in South Africa	ETR.net (TB information system)	Numerator: New smear positive cured Denominator: New smear positive newly registered	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Quarterly	No	Higher percentage indicate better cure rate for the province	TB Programme Manager

ADMINISTRATION: TABLE ADMIN1

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Medical officers per 100,000 people	Medical officers in posts on last day of March per 100 000 people.	Tracks the number of filled Medical officer's posts as part of monitoring availability of Human Resources for Health	Persal	Medical Officers in posts ---------- Total population X 100 000	Dependant on accuracy of Persal system.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of medical officers contributes to improving access to and quality of clinical care	HRM
Medical officers per 100,000 people in rural districts	Medical officers in posts employed in the Rural districts on last day of March per 100 000 people.	Tracks the number of filled Medical officer employed in the rural districts, as part of monitoring availability of Human Resources for Health in Rural Districts. This indicator also assists in assessing urban /rural equity.	Persal	Medical Officers in posts- Rural ---------- Total population in Rural Districts X 100 000	Dependant on accuracy of Persal system.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of medical officers in rural districts i contributes to improving access to and quality of clinical care n rural district.	HRM
Professional nurses per 100,000 people	Professional Nurses in posts on last day of March per 100 000 people.	Tracks the number of filled Professional Nurses posts , as part of monitoring availability of Human Resources for Health	Persal	Professional Nurses in posts ---------- Total population X 100 000	Dependant on accuracy of Persal system.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of professional nurses contributes to improving access to and quality of health services	HRM
Professional nurses per 100,000 people in rural	Professional Nurses in posts employed in rural districts on last day of March per 100	Tracks the number Professional Nurses posts filled in rural districts , as part of	Persal	Professional Nurses in posts- Rural ----------	Dependant on accuracy of Persal system.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of professional nurses in rural districts	HRD

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
districts	000 people.	monitoring availability of Human Resources for Health in Rural Districts. This indicator also assists in assessing urban /rural equity.		Total population in Rural Districts X 100 000						contributes to improving access to and quality of health services rural districts	
Pharmacists per 100,000 people	Pharmacists in posts on last day of March per 100 000 people.	Tracks the number of filled Pharmacists posts to monitor availability of Human Resources	Persal	Pharmacists in posts ---------- Total population X 100 000	Dependant on accuracy of Persal system.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of Pharmacists lead to better quality of care	HRD
Pharmacists per 100,000 people in rural districts	Pharmacists in posts employed in rural districts on last day of March per 100 000 people.	Tracks the number Pharmacists posts filled in rural districts, as part of monitoring availability of Human Resources for Health in Rural Districts. This indicator also assists in assessing urban /rural equity	Persal	Pharmacists in posts - Rural ---------- Total population in Rural Districts X 100 000	Dependant on accuracy of Persal system.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of Pharmacists in rural districts lead to better quality of care in these rural districts	HRD
Vacancy rate for professional nurses	Percentage of **funded** vacant professional Nurses posts on the last day of the reporting period	Tracks the number of **funded** vacant Professional Nurses posts to monitor availability of Human Resources	Persal	Total Number of **funded** vacant Professional Nurses posts ---------- Total number of **funded** professional nurse posts in the province	Dependant on accuracy of Persal data	Process	Ratio per 100 000 population	Quarterly	No	Increase in the number of professional nurses lead to better quality of care	HRD
Vacancy rate for doctors	Percentage of **funded** vacant doctors posts on the last day of the reporting period	Tracks the number of **funded** vacant Doctors posts to monitor availability of Human Resources	Persal	Total Number of **funded** vacant Doctors posts on the last day of the reporting period ---------- Total number of doctors **funded** posts in the province	Dependant on accuracy of Persal data	Process	Percentage	Quarterly	No	Decrease in the vacancy rate lead to better quality of care	Human Resources Management

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Vacancy rate for medical specialists	Percentage of **funded** vacant medical specialists posts on the last day of the reporting period	Tracks the number of **funded** vacant medical specialists posts to monitor availability of Human Resources	Persal	Total Number of **funded** vacant medical specialists posts on the last day of the reporting period --- Total number of medical specialists **funded** posts in the province	Dependant on accuracy of Persal data	Process	Percentage	Quarterly	No	Decrease in the vacancy rate lead to better quality of care	Human Resources Management
Vacancy rate for pharmacists	Percentage of **funded** vacant pharmacists posts on the last day of the reporting period	Tracks the number of **funded** vacant pharmacists posts to monitor availability of Human Resources	Persal	Total Number of **funded** vacant Pharmacists posts on the last day of the reporting period --- Total number of **funded** pharmacists posts in the province	Dependant on accuracy of Persal data	Process	Percentage	Quarterly	No	Decrease in the vacancy rate lead to better quality of care	Human Resources Management

ADMINISTRATION: TABLE ADMIN2

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
% of vacant funded posts filled within 6 months after being vacant	Funded vacant posts filled within a six month period of becoming vacant.	Fill posts to ensure that there is stability and flow of work and avoid having officials acting in higher positions.	PERSAL Reports	Numerator: Nr of funded vacant posts filled within 6 months Denominator Total number of vacant funded posts	Dependant of identification the vacant posts	Process (non cumulative)	Percentage	Annual	No	Vacant funded posts filled	Director: Human Resource Management
Number of Recruitment and Retention Strategies developed and reviewed.	Recruitment and Retention Strategies	Ensure that staff is recruited and those appointed already are retained.	Approved Strategy	Total number of approved Recruitment and Retention Strategy	Financial constraints	Process (non cumulative)	Numbers	Annual	No	Staff recruited and retained.	Director: Human Resource Management
Attrition rate for professional nurses	Percentage of professional nurses in post at the start of the period who exit the system during the period.	Tracks the rate at which Public Health Services lose professional nurses, which has a huge potential impact on service delivery.	PERSAL Reports	Numerator Professional nurses in post who exit the system during the period Denominator Professional nurses in post at the start of the period.	Dependant on accuracy of, and completeness of PERSAL data at end of reporting period	Process (non cumulative)	Percentage	Annual	No	Reporting of lower figures is desired as it reflects lower rates of attrition (losses) of professional nurses.	Director: Human Resource Management
Number of HR Plans reviewed and implemented.	HR Plan	Compliance to HR needs	Approved HR Plan	Number of approved HR Plans	Financial constraints	Process (non cumulative)	Numbers	Annual	No	HR plan operational	Director: Human Resource Management
Number of Organisational Structures reviewed and implemented.	Organisational Structure reviewed and all posts aligned.	Compliance of Public Services Regulations as amended	Approved Organizational structure.	Number of organisational structures reviewed and all posts aligned	Phased in approach due to financial constraints.	Process (non cumulative)	Number	Annual	No	Approved Organizational structure operational.	Director: Human Resource Management
% of staff implementing PMDS	Percentage of employees with signed contracts and quarterly assessments	Compliance with PMDS Policy	PERSAL Report	Percentage of staff complied on PMDS as a percentage to total number of staff	Dependant on accuracy of, and completeness of PERSAL data at end of reporting period	Process (non cumulative)	Percentage	Annual	No	Full compliance with PMDS Policy	Director: Human Resource Management

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of functional Employee Health and Wellness programmes and committees established.	Officials that are trained and supported to effectively promote the Wellness program in the Department	To assist in marketing, coordinating, implementing, monitoring and evaluation the effectiveness of EH&W programmes in the Department.	Approved memorandums and appointment letters signed by the HOD or CEO's. Attendance Registers, Minutes of Meetings	Numbers of committees appointed and approved.	Committees not appointed	Output (Cumulative)	Number	Quarterly	No	Healthy Workforce. improved performance	Programme Manager: Health and Wellness
Number of Resilience Building Sessions conducted.	Officials that are assisted though, debriefing, therapy and team building activities to enhance their coping mechanisms.	Improve interpersonal relationships and morale; reduce stress level and increase performance and service delivery.	Request letters from managers, referrals, approved memorandum, progress reports, attendance registers	Number of resilience buildings sessions conducted.	Financial constrains.	Output (Cumulative)	Number	Quarterly	Yes	Healthy workforce. Improved performance.	
% of disputes attended and resolved as requested	Disputes attended and resolved	To improve dispute resolution	Attendance Registers and outcome certificates and awards	Number of disputes attended and resolved _____ Total number of disputes received	None	Output (Non Cumulative)	Percentage	Quarterly	No	Reduction of dispute	Director: Labour Relations
% of Women, Disability and Youth appointed as SMS.	Percentage of women, people with disabilities and youth appointed in SMS in the department	Ensuring the affirmation of Employment Equity within the Department	Employment Equity Reports	Actual appointments _____ Planned Appointments	None	Input (Non Cumulative)	Percentage	Annual	No	Increased number of appointments in women, youth and people with disabilities.	Programme Manager: Transformation and Transversal Programmes
Number of Service Delivery Improvement Plans reviewed.	Plan to improve service delivery	Improvement of service delivery in line with service standards	Approved SDIP	Number of approved SDIP	Depending on Information received from programmes targeted for service delivery improvement	Input (Cumulative)	Number	Annual	No	Plan to improve service delivery	

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of hospitals and community health centres with fully implemented occupational health services.	Implementation of Occupational Health Services in health facilities	To ensure departmental compliance to the occupational health and safety Act, Act No.93 of 1993	Occupational Health Audit Reports	Number of hospitals and CHCs with fully implemented OHS _____ Total Number of hospitals and CHCs	Implementa-tion of Occupational Health Unit depend on the availability of equipment	Output (Non Cumulative)	Number	Quarterly	No	To have 27 hospitals and 2CHCs with fully implemented OHS	Programme Manager
Number of facilities implementing approved filing system	Development of Record Management Systems within the department	Track down progress on record management systems developed and implemented	Approved Filing System	Number of Record Management Systems developed and Implemented	None	Input (cumulative)	Number	Quarterly	No	Improved Record Management System within the department	Programme Manager: Records Management
% of increased revenue collection.	Revenue collected in the department	Collection of Revenue in line with projected revenue for the financial year.	PAAB report	Revenue collected above estimated revenue projection of the financial year.	Correctness of the PAAB system	Process (non cumulative)	Revenue collected on PAAB against Published revenue projected	Annual	No	Improved revenue collection	Programme Manager: Finance Management
Number of departmental financial statements receive unqualified audit opinion.	Unqualified financial statements submitted to AG	To report the financial outcome of the department	Audit Report	Printed financial statements	Correctness of financial information	Output (non cumulative)	1 Financial statement book	Annual	No	Unqualified financial statements	Programme Manager: Finance Management
% of litigious cases initiated, defended and settled as per instruction received.	Claims against the Department by third parties and for the Department against third parties and	Categorizing of litigious cases	Register of incoming and outgoing correspondence, litigation database and the court orders	Number of litigious cases initiated, defended and settled and contracts drafted and reviewed. Total number of litigious cases and contracts drafted and reviewed.	Inaccessible litigation database	Process (non cumulative)	Percentage	Quarterly	No	Successful defence of litigations	Director: Legal Services
% contracts drafted, reviewed.	Number of contracts drafted and reviewed for the Department	Classification of contracts	Signed Contracts	Number of contracts drafted and reviewed Total number of contracts	Failure to comply with the contract management policy	Process (Non Cumulative)	Percentage	Quarterly	Yes	Compliance of managers in managing contracts.	

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
% of communication activities implemented as per the communication strategy	Percentage of communication activities attended to by the department	Increased communication activities by the department	Records of communication activities against approved communication strategy	Actual Activities / Approved communication strategy activities	None	Input (non cumulative)	Percentage	Quarterly	No	Increase in communication activities undertaken by the department	Programme Manager: Communications
% of Audits Performed	A systematic disciplined approach aimed at assisting the department to achieve its objectives	Provide assurance on efficiency and effectiveness of control, risk management and governance processes	Audit Report	Number of Audits Performed	None	Input (non cumulative)	Percentage	Quarterly	Yes	Working towards clean audit	Programme Manager: Internal Audit
% of Risk Mitigating strategies implemented as per approved Risk Treatment Document	Process of identifying, assessing , rating strategic and operational risks and developing a risk management strategy	To ensure mitigation of possible threats in achieving set objectives	Risk Register, Treatment Document & Workshop Attendance Registers	Number of Risk Mitigating Strategies implemented / Number of Risk Mitigating Strategies as per approved Risk Treatment Document	None	Input (non cumulative)	Percentage	Quarterly	No	Management of Risks within department	Programme Manager: Internal Audit
% Fraud Prevention Strategy implemented as per approved Fraud Prevention Plan	Process of identifying, assessing, rating fraud risks and developing a fraud prevention and response plan	To minimise exposure to fraud and create awareness thereof	Fraud Prevention Plan & Awareness Workshop Attendance Registers	Number of Fraud Prevention Strategies implemented / Number of Fraud Prevention Strategies as per approved Plan	None	Input (non cumulative)	Percentage	Quarterly	No	Reduction in Fraud Cases within the department	Programme Manager: Internal Audit
Number of Plans and Performance Reports developed	Number of departmental plans and performance reports developed and submitted	Compliance with Legislative Requirements and Treasury Regulations	Approved Plans	Numerator Number of Plans/Reports developed per year	Accuracy dependant on the quality of data from the Programmes	Input (cumulative)	Number	Annual	Yes	Well managed departmental performance, working towards a	Integrated Health Planning

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
		Monitoring and evaluation of departmental performance against set priorities and targets	Signed Off Performance Reports	Denominator Number of Plans/Reports required per year	and DHIS	Output (cumulative)	Number	Annual	Yes	clean audit on non-financial information	
Number of QPR submitted.	Submission of Quarterly Performance Report (QPR) within prescribed regulatory deadlines.	Compliance with Legislative Requirements and Treasury Regulations	Signed Off QPR Reports	Number of QPR submitted per year Number of QPR required per year	Accuracy dependant on the quality of data from the Programmes and DHIS	Output (cumulative)	Number	Quarterly	No		Integrated Health Planning
Provincial Health Information Committee established on a three-year basis.	Establish, maintain, facilitate and implement the health information systems contemplated in Section 74 of the National Health Act, Act 61 of 2003 at provincial- and local level.	To comply with the National Health Act, Act 61 of 2003, Section 74.	Appointment Letters Minutes of Meetings	Number of Health Information Committees established	None	Input (non cumulative)	Number	Annual	Yes	Fully functional Committees	Integrated Health Planning
Number of Antenatal Surveys conducted.	No of Antenatal Surveys conducted guided by NDOH surveillance unit	To measure the extent of HIV and syphilis prevalence amongst 15 – 49 age group years old women attending antenatal care services	National and Provincial Antenatal Surveys Database	Number of Antenatal Surveys conducted	None	Output (non cumulative)	Number	Annual	No	Successful antenatal surveillance	Integrated Health Planning
Provincial Health and Research Ethics Committee established on a three-year basis.	Review and approve research proposals and protocols in order to ensure that research conducted, will promote health, contribute to the prevention of communicable / non-communicable diseases or	To comply with the National Health Act, Act 61 of 2003, Section 73.	Appointment Letters Minutes of Meetings	Number of PHERC established	None	Input (non cumulative)	Number	Annual	Yes	Fully functional PHERC	Integrated Health Planning

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
	disability or result in cures for communicable or non-communicable diseases.										
Number of institutions with complete window 2008/ exchange 2010 architecture	Upgrade of network platform	Improved management and integration of Health Information Systems	Quarterly Reports	Per institution completed	None	Process (cumulative)	Number	Quarterly	No	Migration to Windows 2008, Exchange 2010	Information Technology
Roll out of ICT Network Infrastructure to all health facilities.	Connectivity of institutions	To ensure that electronic Communication enhances service delivery	Quarterly reports	Per facility completed	Amount of sites	Process (cumulative)	Number	Quarterly	Yes	All health facilities connected to network	Information Technology

DISTRICT HEALTH SERVICES: TABLES DHS2 AND DHS4

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Provincial PHC expenditure per uninsured person	Total expenditure by the Provincial DoH on PHC services	To monitor adequacy of funding levels for PHC services	BAS	Numerator Total expenditure of the Province on PHC services (Programme 2) Denominator Number of uninsured people in the Provinces as indicated in STATSSA or Council for Medical Scheme data	Accuracy of information	Input (non cumulative)	Annual	Annual	No	Higher levels of expenditure reflect prioritisation of PHC services	DHS Programme Manager Financial Management Officials
Utilisation rate - PHC	Rate at which services are utilised by the target population, represented as the average number of visits per person per period in the target population.	Tracks the uptake of PHC services at each PHC site for the purposes of allocating staff and other resources.	DHIS - PHC Total Headcount StatsSA - Total Population	Numerator: PHC total headcount Denominator: Total Population	Dependant on the accuracy of estimated total population from StatsSA	Output (non cumulative)	Annualised rate	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	Programme Manager
Utilisation rate - PHC under 5 years	Rate at which services are utilised by the target population under 5 years, represented as the average number of visits per person per period in the target population.	Tracks the uptake of PHC services at each PHC site for the purposes of allocating staff and other resources.	DHIS - PHC headcount under 5 years StatsSA - Population under 5 years	Numerator: PHC headcount under 5 years Denominator: Population under 5 years	Dependant on the accuracy of estimated population 5 years an under from StatsSA	Output (non cumulative)	Annualised rate	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	Programme Manager
Percentage of fixed PHC facilities that were visited by a supervisor at least once every month	Percentage of fixed PHC facilities that were visited by a supervisor at least once every month (official supervisor report completed)	Tracks the supervision rate of all PHC facilities.	DHIS	Numerator: Number of fixed PHC facilities that were visited by a supervisor Denominator: Total number of fixed PHC facilities	Dependant on the reporting the purpose of the visit by the supervisor to the PHC facility.	Quality (non cumulative)	Percentage	Quarterly	No	Higher levels indicate better support to the PHC facility	QA Programme Manager
Expenditure per PHC Headcount	Expenditure per PHC headcount by provincial DoH at	Tracks the cost to provincial DoH for every	DHIS – PHC Total Headcount	Numerator: Expenditure on PHC by provincial	Accuracy of headcount depends on	Efficiency (non cumulative)	Rate	Quarterly	No	Lower expenditure could indicate	DHS Programme Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
	provincial PHC facilities.	visit to provincial PHC facility.	BAS – Expenditure on PHC by provincial DoH	DoH Denominator: PHC Total Headcount	the reliability of PHC record management at facility level and accuracy of expenditure depends on the accuracy of correct expenditure allocation					efficient use of financial resources, or incomplete provision of the comprehensive PHC package	
Community Health Centres (CHCs) and Community Day Centres (CDCs) with resident doctor rate	Percentage of CHCs and CDCs with at least one resident Doctor.	Tracks the national norms of the PHC package	DHIS	Numerator: Total number of CHCs and CDCs with at least one resident Doctor. Denominator: Total number of CHCs and CDCs in the province	Accuracy dependant on the quality of data from the reporting facility	Input (non cumulative)	Percentage	Annual	Yes	Higher percentage indicates better compliance to the national norms	Human Resources Management Districts and Development
Number of PHC facilities assessed for compliance against the 6 priorities of the core standards	Total number of PHC facilities assessed for compliance against the core standards	Tracks the levels of compliance against the core standards	Assessment Reports	Total number of PHC facilities assessed against the core standards.		Process (non cumulative)	Sum	Annual	Yes	Higher number indicates better compliance with the core standards	Quality Assurance

DISTRICT HEALTH SERVICES: TABLES DHS3 AND DHS5

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of functional Mental Health Review Boards.	Number of Mental Health Review Boards established and functional with minuted meetings as evidence of existence.	To strengthen community participation in decision making for mental health services.	Minutes and attendance registers	Count of Mental Health Review Boards from all mental hospitals.	Minutes of meetings for verification, are confidential.	Process (cumulative)	Number	Annual	No	All Mental Hospitals must have Mental Health Review Boards.	District Health Services
Number of district hospitals with functional Hospital Boards.	Number of district hospitals with approved Hospital Boards who operate in line with the prescripts of guidelines, establishment, appointment and functioning of hospital boards, including holding at least four meetings per annum.	Hospital Boards support hospital management in meeting its obligations and also ensure that hospitals are responsive to community needs.	Minutes of meetings held by hospital boards & Appointment Letters	Numerator Meetings attended Numerator Total number of meetings to be attended per year.	Number of meetings without other concrete activities performed, does not measure adequately the functionality of Hospital Boards	Output (non cumulative)	Number	Quarterly	No	Improved governance and management of hospitals	PHC Chief Director District Directors Hospital CEOs
Number of PHC facilities with functional Clinic/CHC Committees.	Number of PHC facilities wit approved Committees that operate in line with the prescripts of the guidelines for PHC Facility Committees.	To ensure that PHC facilities are responsive to community needs.	Minutes of meetings attended & Appointment Letters	Numerator Meetings attended Denominator Total number of meetings to be attended per year	Number of meetings attended without other concrete activities performed, does not measure adequately functionality of PHC Facility Committees	Output (non cumulative)	Number	Quarterly	No	Improved governance and management of PHC Facilities.	PHC Chief Director District Directors
Number of district hospitals with trained Hospital Boards.	Total number of hospitals with trained Hospital Boards		Attendance Registers	Number of trained hospital boards Total number of district hospitals	-	Input (non cumulative)	Number	Quarterly	No	Improved governance and management of PHC facilities and hospitals.	PHC Chief Director
Number of PHC facilities with	Total number of PHC facilities with		Attendance Registers	Number of trained	-	Input (non	Number	Quarterly	No		

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
trained Clinics/CHC Committees.	trained clinics/CHC committees			Clinics/CHCs Total number of PHC facilities		cumulative)					
Number of districts with fully established management structures.	Number of districts with fully established District Management Teams	To ensure implementation of appropriately decentralised and more accountable operational management model	District Health Plans, Minutes of District Management Meetings, District Quarterly Reviews	Numerator Number of fully established Districts Denominator Total number of demarcated Districts	None	Output (cumulative)	Number	Quarterly	No	Improved management and accountability	PHC Chief Director
Number of sub - districts with fully established management structures.	Total number of sub-districts with a management structure		Management Economic Social & Human Resource (MESH) Tool, Minutes of sub district management teams	Numerator Number of sub-districts with management structures Denominator Total number of demarcated sub-districts	None	Output (cumulative)	Number	Quarterly	No	Improved management and accountability	Head of Department PHC Chief Director
Number of PHC Supervision Policies implemented and reviewed.	PHC Supervision Policy aimed at guiding practice of PHC Supervisors	To strengthen Supervision and improve the quality of care in PHC facilities.	Availability of revised PHC supervision policy.	None	None	Output (cumulative)	Number	Quarterly	No	Improved supervision and management of PHC facilities	PHC Chief Director
Number of District Health Plans and District Health Expenditure Review (DHER) Reports developed.	Informs planning and budgetary processes at provincial level.	Strengthen decentralised planning and budgeting and promotes better delivery of district health services and to account for the use of public funds.	Approved District Health Plans	Number of Plans Number of Districts	Accuracy dependent on quality of district reports	Input (non cumulative)	Number	Annual	Yes		PHC Chief Director & District Directors
	Diagnosis tool to assess to what extent allocation (budget) and use of resources (expenditure) advance the district/ province objectives of: ❑ Access ❑ Quality	Presents a clear picture of funding, distribution and use of health resources in the District and the province	Signed off DHERs	Number of Reports Number of Districts		Output (non cumulative)	Number	Annual	Yes		PHC Chief Director & District Directors

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
	❑ Efficiency ❑ Equity ❑ Sustainability										
Nr of healthy lifestyle interventions by establishment of support groups in all 3 districts	Provides the number of new support groups established	Contributes to increasing life expectancy	Healthy Lifestyle Support Group Database	Numerator: Number of support groups established	Accuracy dependent on quality of district reports	Output (cumulative)	Number	Quarterly	No	Increase in number of support groups established	Health Promotion Programme Manager
Nr of additional Health Promoting Schools established	Provides the number of new Health Promoting Schools established	Contributes to increasing life expectancy	Health Promoting Schools Database	Numerator: Number of Health Promoting Schools established	Accuracy dependent on quality of district reports	Output (cumulative)	Number	Quarterly	No	Increase in number of Health Promoting Schools established	Health Promotion Programme Manager
Nr of additional household community components (HHCC) of IMCI established	Nr of new household community components of IMCI established	Contributes for decreasing maternal and child mortality	Household Community Components Database	Numerator: Number of household community components of IMCI established	Accuracy dependent on quality of district reports	Output (cumulative)	Numeral	Quarterly	No	Increase in number of household community components established	Health Promotion Programme Manager
Number of PHC facilities implementing the quality improvement plans in line with the 6 priorities of the core standards.	PHC facilities implementing the following six key priorities of the core standards: • Improved Patient Safety • Drug Availability • Positive & Caring Staff Attitude • Reduced Waiting Times • Improved Cleanliness • Infection Prevention and Control	Tracks the levels of implementation at PHC level, against the 6 priority areas of the core standards	Assessment Reports	Numerator: Number of PHC facilities implementing against the 6 priorities of the core standards. Denominator: Total number of PHC facilitie in the province	Accuracy dependant on quality of data from reporting facility	Output (non cumulative)	Number	Annual	No	All 3 Regional Hospitals implementing six key priority areas	PHC Chief Director
Number of Primary Health Care supervisors appointed.	Professional nurses who are supporting PHC facilities at least once a month	To improve on quality of health services rendered in PHC facilities	Appointment Letters PERSAL	Total number of PHC supervisors appointed in the province	Accuracy depends on staff turnover and separation between those who are acting and those	Input (cumulative)	Number	Quarterly	Yes	Improved quality of health care in PHC facilities	PHC Chief Director

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
					appointed						
Number of Primary Health Care **Outreach** Teams established in sub districts.	A team of health workers rendering PHC services at community/ grassroot level	To improve access to PHC services	Clinic Staff establishment	Numerator Number of sub-district PHC teams established Denominator Total number of sub districts	Accuracy dependant on quality of data from reporting facility	Input	Number	Quarterly	Yes	Improved access to PHC	PHC Chief Director
Number of School Health Service Teams established	A team of health workers rendering SHS services IN Schools	To improve access to PHC services BY children	Clinic Staff establishment	Numerator Number of SHS teams established Denominator Total number of sub districts	Accuracy dependant on quality of data from reporting facility	Input	Number	Yearly	Yes	Improved access to PHC by children	PHC Chief Director
% of quintile 1 and 2 primary schools reached through school health services.	Schools that are in socio-economical disadvantaged areas	To improve access to PHC services by learners	Quarterly Reports	Numerator Number of quintile 1&2 schools visited by school health teams Denominator Total number of schools	Accuracy dependant on quality of data from reporting facility	Input	Percentage	Quarterly	Yes	Improved access to PHC	PHC Chief Director
Number of districts hospitals supported by District Specialist teams	A team of health workers with specialized training supporting district hospitals on Maternal and Child Health Care Services	To improve maternal and child health outcomes	Health Facility Supervision register	Number of district hospitals visited by District Specialized Teams Denominator Total number of District Hospitals	Accuracy dependant on quality of data from reporting facility	Input	Number	Quarterly	Yes	Improved maternal and child health outcomes	PHC Chief Director
Number of NGOs/NPOs funded to provide Community Based Health Services.	Number of Non Profit Organisations contracted by the Department of Health to provide community Home Based Health Services	To improve access to PHC through Community Based Health Services	Quarterly Reports/ SLA with funded NPOs	Numerator Number of NPOs funded by the Department of Health Denominator Total number	Inaccurate data based on non-funded organisations	Output	Number	Monthly Quarterly and Annually	No	Improved access to PHC	PHC Chief Director

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
				of NPOs in the Province							
Number of PHC facilities with Pharmacists Assistants.	Availability of Pharmacist Assistants in PHC facilities	Tracks the availability of Pharmacist Assistants in PHC facilities	Quarterly Reports PERSAL	Numerator Total number of Pharmacists Assistants in PHC facilities Denominator Total number of PHC facilities	Accuracy dependant on quality of data from reporting facility	Input	Number	Quarterly	Yes	Improved quality of health care in PHC facilities	PHC Chief Director
Number of sub districts with appointed Health Information Officers.	Availability of Health Information Officers at PHC facilities	Appointment HIOs will improve accuracy of PHC facility data	Quarterly Reports PERSAL	Numerator Total number of HIOs appointed in sub districts Denominator Total number of sub districts	Accuracy dependant on quality of data from reporting facility	Input	Number	Quarterly	Yes	Reliable, quality of data available from PHC facilities	PHC Chief Director
Number of PHC facilities with Data Capturers appointed	Availability of Data Capturers at PHC facilities	Appointment of data capturers will improve accuracy of PHC facility data	Quarterly Reports PERSAL	Numerator Total number of data capturers appointed in PHC facilities Denominator Total number of PHC facilities	Accuracy dependant on quality of data from reporting facility	Input	Number	Quarterly	Yes	Reliable, quality of data available from PHC facilities	PHC Chief Director
Number of facilities with functional computers	PHC facilities with functional computers	For data capturing and reports	Asset Register	Numerator Total number of functional computers **Denominator** Total number of PHC facilities	Functionality dependant on maintenance by IT Section	Input	Number	Quarterly	Yes	Efficient data management	Chief Director: Corporate Services

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of PHC facilities with at least two PHC trained nurses	Availability of trained nurses at PHC facilities	Tracks the availability of trained nurses in PHC facilities	Quarterly Reports PERSAL	Numerator Total number of PHC trained nurses in PHC facilities Denominator Total number of PHC facilities	Accuracy dependant on quality of data from reporting facility	Input	Number	Quarterly	Yes	Improved quality of health care in PHC facilities	PHC Chief Director
Number of fixed clinics supported by a doctor at least once a week	Fixed clinics supported by a doctor at least once a week	Tracks the national norms of the PHC package	Quarterly Reports DHIS	Numerator Total number of fixed clinics supported by a doctor once a week Denominator Total number of fixed clinics	Accuracy dependant on quality of data from reporting facility	Input	Number	Quarterly	Yes	Improved quality of health care in PHC facilities	Human Resource Management District Health Services
Number of health facilities with available essential drug including ART	Availability of essential drugs according to EDL List, including ART, in health facilities.	Tracks the availability of drugs in health facilities	Quarterly Reports PHC Supervision Report	Numerator Available EDL including ART Denominator Total number of health facilities	Accuracy dependant on quality of data from reporting facility	Input	Number	Quarterly	Yes		PHC Chief Director
Number of PHC facilities with available essential equipment	PHC facilities with essential equipment available	Tracks the availability of essential equipment in PHC facilities	PHC Supervision Report	Numerator Available essential equipment Denominator Total number of PHC facilities	Accuracy dependant on quality of data from reporting facility	Input	Number	Quarterly	Yes		PHC Chief Director

DISTRICT HOSPITALS: TABLES DHS8 AND DHS9

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Caesarean section rate in district hospitals	Caesarean section deliveries in hospitals expressed as a percentage of all deliveries in hospitals.	Track the performance of obstetric care of the district hospitals	DHIS	Numerator: Number of Caesarean sections performed Denominator: Total number of deliveries in facility	Accuracy dependant on quality of data from reporting facility	Output	Percentage	Quarterly	No	Higher percentage of Caesarean section indicates higher burden of disease, and/or poorer quality of antenatal care.	MCWH&N Programme Manager
Total separations in District Hospitals	Recorded completion of treatment and/or the accommodation of a patient in district hospitals. Separations include inpatients who were discharged, transferred out to other hospitals or who died and includes Day Patients.	Monitoring the service volumes	DHIS	Sum of: • Inpatient deaths • Inpatient discharges • Inpatient transfer out • Day patient	Accuracy dependant on quality of data from reporting facility	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	District Health Services
Patient Day Equivalent in District Hospitals	Patient day equivalent is weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All hospital activity expressed as a equivalent to one inpatient day	Monitoring the service volumes	DHIS	Sum of: • Inpatient days - total • 1/2 Day patients • 1/3 OPD headcount - total • 1/3 Emergency Headcount OPD Headcount total = sum of: • OPD specialist clinic headcount + • OPD general clinic headcount	Accuracy dependant on quality of data from reporting facility	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	District Health Services

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
OPD Headcount - Total ts in district hospitals	A headcount of all outpatients attending an outpatient clinic.	Monitoring the service volumes	DHIS	Sum of: • OPD specialist clinic headcount • OPD general clinic headcount •	Accuracy dependant on quality of data from reporting facility	Output	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	District Health Services
District hospitals with monthly Maternal Mortality and Morbidity Meetings	Percentage of district hospitals having monthly Maternal Mortality and Morbidity Meetings (3 per quarter)	To monitor the quality of hospital services, as reflected in levels of diseases adverse events; and proportion of deaths	Quality Assurance (QA)	Numerator: Number of district hospitals having Maternal Mortality and Morbidity every month Denominator: Total number of district hospitals	Accuracy dependant on quality of data from reporting facility	Quality	Percentage	Quarterly	No	Higher percentage suggests better clinical governance	Quality Assurance (QA)
Percentage of complaints of users of District Hospital Services resolved within 25 days	Percentage of complaints of users of District Hospital Services resolved within 25 days	To monitor the management of the complaints in District Hospitals	Quality Assurance	Numerator: Total number of complaints resolved within 25 days during the quarter Denominator: Total number of complaints during the quarter	Accuracy of information is dependant on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	Yes	Higher percentage suggest better management of complaints in District Hospitals	Quality Assurance
Average length of stay in district hospitals	Average number of patient days that an admitted patient in the district hospital before separation.	To monitor the efficiency of the district hospital	DHIS	Numerator: Inpatient days + 1/2 Day patients Denominator: Separations	High levels of efficiency could hide poor quality	Efficiency	Ratio	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care	District Health Services

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Bed utilisation rate (based on usable beds) in district hospitals	Patient days during the reporting period, expressed as a percentage of the sum of the daily number of usable beds.	Track the over/under utilisation of district hospital beds	DHIS	Numerator: Inpatient days + 1/2 Day patients Denominator: Number of usable bed days	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels	District Health Services
Expenditure per patient day equivalent (PDE) in district hospitals	Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All hospital activity expressed as a equivalent to one inpatient day	Track the expenditure per PDE in district hospitals in the province	BAS / DHIS	Numerator: Total Expenditure in district hospitals Denominator: Patient Day Equivalent (PDE)*		Efficiency	Rate	Quarterly	No	Lower rate indicating efficient use of financial resources.	District Health Services.
Percentage of users of District Hospital Services satisfied with the services received	The percentage of users that participated in the District Hospital Services survey that were satisfied with the services	Tracks the service satisfaction of the District Hospital users	QA	Numerator: Total number of users that were satisfied with the services rendered in District Hospitals Denominator: Total number of users that participated in the Client Satisfaction Survey (in District Hospitals)	Generalisability depends on the number of users participating in the survey.	Output	Percentage	Annual	Yes	Higher percentage indicates better levels of satisfaction in District Hospital services	Quality Assurance

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Percentage of District Hospitals facilities assessed for compliance against the 6 priorities of the core standards	Percentage of District Hospitals assessed for compliance against the core standards	Tracks the levels of compliance against the core standards	QA	Numerator: Total number of District Hospitals assessed against the 6 priority areas of the core standards. Denominator: Total number of District hospitals in the province.	None	Process	Sum	Annual	Yes	Higher number indicates better compliance with the core standards in District Hospitals	Quality Assurance

DISTRICT HEALTH SERVICES: TABLE 7 AND DHS9

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of district hospitals implementing the quality improvement plans in line with the 6 priorities of the core standards	District Hospitals implementing QIPs in line with 6 priorities of core standards	Tracks the levels of implementing QIPs in line with 6 priorities of the core standards	Monthly/ Quarterly Progress Reports	Numerator: Total number of District Hospitals implementing QIPs in line with 6 priorities of core standards Denominator: Total number of District hospitals	None	Process	Number	Quarterly	No	Improved quality of care in health facilities	District Directors and Hospital CEOs
Number of hospitals and sub-districts with dedicated infection, prevention and control practitioners.	Total number of hospitals and sub districts with officials specifically assigned to ensure implementation of measures aimed at preventing and controlling transmission of infection in health care settings.	To improve effective prevention and management of health care associated infections including improving infection control surveillance	Available dedicated officials for managing the Infection Prevention and Control Programme in 33 hospitals and 18 sub-districts	Numerator Number of dedicated officials Denominator Number of hospitals and sub districts	None	Input	Number	Quarterly	No	Improved patient safety and reduced Average Length of Stay	District Directors and Hospital CEOs

HIV AND AIDS, TB AND STI CONTROL: TABLES HIV3 AND HIV3

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Total number of patients (Children and Adults) on ART	Number of patients on an ARV regimen	Track the number of patients on ARV Treatment	CCMT	Cumulative total of Number of patients on an ARV regimen	Accuracy dependant on quality of data from reporting facility	Input	Cumulative total	Quarterly	No	Higher total indicates a larger population on ART treatment	HIV/AIDS Programme Manager
Male condom distribution rate	Number of male condoms distributed within the province at public health facilities per male population 15 years and over	Track the contraceptive measures	DHIS	Numerator: Male condoms distributed within province Denominator: Male population 15 and over	Indicator reliant on accuracy of population estimates from StatsSA	Process	Rate	Quarterly	No	Higher rate indicates better contraceptive measures which should lead to decrease in HIV/AIDS incidence.	HIV/AIDS Programme manager
New smear positive PTB defaulter rate	Percentage of smear positive PTB cases who interrupted (defaulted) treatment		ETR	Numerator: All smear positive defaulted Denominator: All smear positive newly registered		Output	Percentage	Quarterly	No	Lower levels of interruption reflect improved case holding, which is important for facilitating successful TB treatment	TB Programme manager
Smear result turn-around time under 48 hours rate	Percentage of TB sputa tests completed with turnaround time of less than 48 hours	Monitor the turnaround times of the sputa samples	DHIS	Numerator: TB sputa specimens with turnaround time less than 48 hours Denominator: All TB sputa specimens	Accuracy of capturing the date/time sampled dispatched and/or received	Quality	Percentage	Quarterly	No	Higher percentage indicate faster turnaround	TB Programme manager
Percentage of HIV-TB Co-infected patients placed on ART	Percentage of HIV and TB co-infected patients placed on Ante retrovirus Treatment (ART)	Monitors the coverage of ART among co-infected population	ETR. Net	Numerator: Total number of HIV and TB co-infected people placed on ART Denominator: Total number of co-infected people with a CD4 count of 350 or less.	Dependant on the accuracy of the Electronic TB Register.	Output	Percentage	Quarterly	Yes	Higher percentage indicate better coverage	TB Programme Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
HCT testing rate	Percentage of clients tested to those counselled.	Monitors the number of people convinced for testing	DHIS	Numerator: Total number clients of HCT clients tested for HIV Denominator: Total number of HCT clients pre-test counselled	Dependant on the accuracy of tick and tally sheets	Process	Percentage	Quarterly	Yes	Higher percentage indicate increased population knowing their HIV status.	HIV/AIDS Programme Manager
New smear positive PTB cure rate	Percentage of new smear positive PTB cases cured at first attempt	Monitor the TB Cure rate	ETR	Numerator: New smear positive cured Denominator: New smear positive newly registered	Accuracy dependant on quality of data from reporting facility	Outcome	Percentage	Annual	No	Higher percentage indicate better cure rate for the province	TB Programme Manager

HIV AND AIDS, TB AND STI CONTROL: TABLES HIV2 AND HIV4

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of facilities providing ART services.	Number of facilities that provides ART services	Tracks the number of facilities providing ART services in the province.	District Office Database/ DHIS	Cumulative total number of accredited facilities providing ART services	None	Input (cumulative)	Number	Quarterly	No		HIV and AIDS Programme Manager
Increase the number of patients on ART.	Total number of patients on an ARV Regimen.	Tracks the number of patients on ARV treatment	DORA Report	Cumulative total number of patients on ARV Regiment	Accuracy dependant on quality of data from reporting facility	Output (cumulative)	Number	Quarterly	No	Higher total indicates larger population on ART treatment	HIV and AIDS Programme Manager
Increase the percentage of HIV & AIDS and TB co-morbidity patients with a CD4 count of 350 or less, initiated on ART.	The proportion of HIV-TB co-infected clients initiated on ART at a CD4 count of 350 or less	Track implementation of the HIV and AIDS policy and monitor management of integrated HIV and TB programmes	DHIS	Numerator HIV-TB co-infected clients with CD4 count of 350 or less on ART Denominator Total HIV-TB co-infected clients	Data quality and completeness from reporting facilities	Input (non cumulative)	Percentage	Quarterly	No	All HIV-TB co-infected patients receive treatment and care as per policy guidelines	District, HAST and TB Managers
Scale up condom distribution for both male and female condoms.	Number of male- and female condoms distributed. The data is used to calculate female condom distribution rate and the couple year protection rates.	Condoms are used as contraceptives and for prevention of STIs (dual protection).	DHIS	Counting of stock at beginning of each reporting period. Add number in stock at beginning of reporting period to supplies received during the period and subtract what was left at tend of period (beginning of next period). Difference is the number of condoms distributed	Accuracy dependant on quality of data from reporting facility	Input (cumulative)	Number	Quarterly	No	Higher contraceptive prevalence levels are desired	HIV and AIDS Programme Manager
Increase the TB Cure Rate.	Percentage of patients who are proved to be cured using smear microscopy at the end of the treatment.	Tracks the success of efforts to combat Tuberculosis in South Africa	ETR Net	Numerator: New smear positive cured Denominator: New smear positive newly registered	Accuracy dependant on quality of data from reporting facility	Outcome (non cumulative)	Percentage	Quarterly	No	Higher percentage indicates better cure rate for the province	TB Programme Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Decrease the incidence of reported TB cases to <1%.	Total number of TB patients started treatment for a given reporting period	To track the decreased number of reported TB cases	ETR.Net Paper-based TB registers	Numerator: Number of TB patients started treatment for a given reporting period Denominator: Number of estimated TB patients for the stated period	Accuracy dependent on quality of data from reporting facility	Output (non cumulative)	Percentage	Quarterly	no	Reduction on the number of TB cases indicate control of the disease	TB Programme Manager
Reduce the TB Defaulter Rate annually.	Total number of all new smear Positive patients started treatment over a given reporting period that defaulted treatment for a period of 2 months and more before end of treatment	To determine the number of TB defaulters	ETR.Net Paper-based TB registers	Numerator: All new sputum smear Positive PTB patients started treatment in a given reporting period that defaulted before the end of treatment Denominator: All new sputum smear Positive PTB patients started treatment in the stated period	Accuracy dependent on quality of data from reporting facility	Output (non cumulative)	Percentage	Quarterly	no	Reduced number of defaulters is desired	TB Programme Manager
Accelerate TB Contact Tracing to 90%.	A process of identifying contacts, screening and testing them for TB infection and disease, and providing appropriate treatment and follow up	To terminate transmission of TB	Paper – based TB Register s	Number	Accuracy dependent on quality of data from reporting facility	Process (non cumulative)	Number	Quarterly	No	Improved contact tracing and management	TB Programme Manager
Eliminate TB Drug Stock outs to 0%.	Number of drug stockout	To monitor the effectiveness of the TB programme	TB Register	Number of times that the hospital ran out of TB drugs during the quarter	Accuracy dependant on quality of data from reporting facility	Output (non cumulative)	Percentage	Quarterly	No	Reduction of drug Stockout	TB Programme Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Initiate all MDR patients who are HIV positive, on ART irrespective of CD4 count.	Percentage of MDR-TB/HIV co-infected patients started on ART	To monitor administration of ART amongst the MDR-TB patients	Paper – based TB Register s	Numerator: Number of HIV positive MDR TB patients started on ART in a given period Denominator: Total number of HIV positive MDR TB patients in a given period	Accuracy dependent on quality of data from reporting facility	Output (non cumulative)	Percentage	Quarterly	No	Initiate ART to all HIV positive MDR-TB patients	TB Programme Manager
Number of male clients medically circumcised	Measures the number of male clients medically circumcised	To prevent the spread of new infections	MMC Reports	Headcount of male clients medically circumcised	Accuracy dependant on quality of data from reporting facility	Output (cumulative)	Number	Quarterly	Yes	Reduction in STI infection and HIV prevalence	HIV and AIDS Programme Manager
Number of MMC high volume , high quality sites	Number of Male Medical Circumcision sites	Indicates improved access to MMC services	MMC Reports	Number of MMC high volume, high quality sites No denominator	Accuracy dependant on quality of data from reporting facility	Input (cumulative)	Number	Quarterly	Yes	Reduction in STI infection and HIV prevalence	HIV and AIDS Programme Manager
Number of High Transmission Areas (HTA) Intervention Sites.	Geographical and socio demographically defined are with interventions targeting high risk populations	To prevent the spread of new infections	DORA Report/ HTA Monthly Summary Statistics	Number of High Transmission Areas No denominator	Not captured on DHIS – indicator only measures accessibility and not effectiveness	Input (cumulative)	Number	Quarterly	No	Reduction in STI infection and HIV prevalence	HTA Coordinator
Percentage of public health facilities providing HCT.	Public health facilities providing HCT	Tracks down the number of public health facilities that provide HCT services	DHIS	Numerator Public health facilities providing HCT Denominator Total number of Public Health Facilities	Accuracy dependant on quality of data from reporting facility	Input (non cumulative)	Percentage	Quarterly	Yes	Improved percentage indicates better HCT uptake	HIV and AIDS Programme Manager
Number of non-medical sites offering HCT	Number of non medical sites (excluding PHC and public hospitals)	To increase access to HCT services	DORA Report/ Provincial database	Number of non-medical sites offering HCT	Not easy to measure effectiveness of these sites as it does not report to the DHIS	Input (cumulative)	Number	Quarterly	No	Improved HCT coverage	HCT Coordinator

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Percentage of new eligible sexual assault cases provided with PEP prophylaxis.	Proportion of sexual assault cases reporting to health facility that provides ARV Prophylaxis	To reduce the possibility of infections	DHIS/ Tick Registers	Numerator: Sexual assault case given ARV Prophylaxis – New Denominator All sexual assault cases – new	Only count cases where ARV Prophylaxis is prescribed as a direct result of sexual assault and to reduce the possibility of infection	Input (non cumulative)	Percentage	Quarterly	No	Improved percentage indicates better PEP Prophylaxis uptake	HIV and AIDS Programme Manager
Percentage of HIV positive clients on IPT	HIV positive clients receiving Isoniazid Preventive Therapy	Monitor implementation of IPT	DHIS	Numerator: Percentage of HIV positive clients on IPT Denominator all positive clients	Accuracy dependant on quality of data from reporting facility	Input (non cumulative)	Percentage	Quarterly	No	Improved percentage indicates better IPT uptake	HIV and AIDS Programme Manager
STI partner treatment rate	Percentage of partners of STI cases that receive treatment	Successful treatment of STIs requires that both the index patient and their partner(s) be treated	DHIS	Numerator STI Partner Treated Denominator STI treated new episode	Reliant accurate capturing of new episodes	Output (non cumulative)	Percentage	Annual	No	Improved partner treatment rates should contribute towards decreasing levels of STIs and HV	HIV and AIDS Programme Manager
Antenatal client initiated on AZT during antenatal care rate.	HIV positive antenatal clients (not on HAART) initiated on AZT during antenatal care as a proportion of antenatal clients (not on HAART) who tested HIV positive during current pregnancy	Monitor implementation of AZT	DHIS	Numerator Antenatal client initiated on AZT Denominator Antenatal client (not on HAART) tested HIV positive – total	Accuracy dependant on quality of data from reporting facility	Process (non cumulative)	Percentage	Quarterly	No	Improved percentage indicate better AZT uptake	PMTCT Programme Manager
Baby Nevirapine uptake rate.	Babies (including BBAs and known home deliveries) given Nevirapine within 72 hours after birth as a proportion of live births to HIV positive women	Monitor implementation of Nevirapine	DHIS	Numerator Baby given Nevirapine within 72 hours after birth Denominator Live birth to HIV positive woman	Accuracy dependant on quality of data from reporting facility	Process (non cumulative)	Percentage	Quarterly	No	Improved percentage indicates better Nevirapine uptake for babies	PMTCT Programme Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of active community caregivers receiving stipends	Total number of active community caregivers receiving payment (stipend) from the department for services rendered	Monitor number of caregivers receiving stipends monthly	Reports	Number of caregivers receiving stipends	None	Output (non cumulative)	Number	Monthly	No	Improved number indicates increase in community caregivers providing service to community	HIV and AIDS Programme Manager

MATERNAL, CHILD AND WOMAN HEALTH: TABLES MCWH1 & MCHW3

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Immunisation coverage under 1 year	Percentage of all children in the target area under one year who complete their primary course of immunisation during the month (annualised). A Primary Course includes BCG, OPV 1,2 & 3, DTP-Hib 1,2 & 3, HepB 1,2 & 3, and 1st measles at 9 month.	Monitor the implementation of Extended Programme in Immunisation (EPI)	DHIS	Numerator: Immunised fully under 1 year Denominator: Population under 1-year	Reliant on under 1 population estimates from StatsSA	Output (non cumulative)	Percentage Annualised	Quarterly	No	Higher percentage indicates better immunisation coverage reducing the risk of vaccine preventable conditions	EPI Programme manager
Vitamin A coverage under 12 – 59 months (OR 1-4 years)	Percentage of children 12-59 months receiving vitamin A 200,000 units twice a year.(The denominator is therefore the target population 1-4 years multiplied by 2.)	Monitor the Vitamin A coverage of children	DHIS	Numerator: Vitamin A supplement to 12-59 months child Denominator: Target population 1-4 years x 2	Reliant on Child population estimates from StatsSA	Output (non cumulative)	Percentage Annualised	Quarterly	No	Higher percentage indicates better Vitamin A coverage, and better nutritional support to children	Nutrition Programme manager
Measles coverage under 1 year	Percentage of children under 1 year who received measles dose	Monitor the measles coverage	DHIS	Numerator: Measles 1st dose before 1 year Denominator: Population under 1 year	Reliant on under 1 population estimates from StatsSA	Output (non cumulative)	Percentage Annualised	Quarterly	No	Higher percentage indicates better Measles Coverage to eliminate measles	EPI Programme manager
Pneumococcal 3st dose coverage under 1 year	Percentage of children under 1 year who received Pneumococcal 3st dose	Monitor the Pneumococcal coverage	DHIS	Numerator: Pneumococcal 3rd doses before 1 year Denominator: Population under 1 year	Reliant on under 1 population estimates from StatsSA	Output (non cumulative)	Percentage Annualised	Quarterly	No	Higher coverage is expected to have an impact on infant and child morbidity and mortality	EPI Programme manager
Rota Virus 2nd dose coverage under 1 year	Percentage of children under 1 year who received Rota Virus 2nd dose	Monitor the Rota Virus coverage	DHIS	Numerator: Rota Virus 2nd doses before 1 year Denominator: Population under 1 year	Reliant on under 1 population estimates from StatsSA	Output (non cumulative)	Percentage	Quarterly	No	Higher coverage is expected to have an impact on infant and child morbidity and mortality	EPI Programme manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Cervical cancer screening coverage	Percentage of women from 30 years and older who were screened for cervical cancer	Monitor cervical cancer screening coverage	DHIS	Numerator: Cervical smear in woman 30-years and older screened for cervical cancer Denominator: Female population 30-59 years	Reliant on population estimates from StatsSA for women in age category 30-59 years	Output (non cumulative)	Percentage Annualised	Quarterly	No	Increased coverage will improve the management of abnormal smears and reduce the incidence of cervical cancer.	MNCWH Programme Manager
Antenatal visits before 20 weeks rate	The percentage of women who have a booking visit (first visit) before they are 20 weeks (about half way) into their pregnancy.	Utilisation of ANC services	DHIS	Numerator: Antenatal 1st visits before 20 weeks Denominator: Antenatal 1st visits	Reliant on accuracy of number of weeks the client is pregnant	Process (non cumulative)	Percentage	Quarterly	No	Higher percentage indicates better access to antenatal care and improved early booking which is considered core to improved maternal care.	MNCWH programme Manager
Couple Year Protection Rate	Percentage of women of reproductive age (15-44) who are using (or whose partner is using) a modern contraceptive method. Contraceptive methods include female and male sterilisation , injectable, and oral hormones, intrauterine devices, diaphragms, spemicides and condoms	Track the extent of the use of contraception (any method) amongst women of child bearing age	DHIS SADHS	Couple year protection rate: Numerator Contraceptive years equivalent = Sum: • Male sterilisations x 20 • Female sterilisations x10 • Medroxyprogesterone injection /4 • Norethisterone enanthate injection /6 • Oral pill cycles /13 • IUCD x 4 • Male condoms /500 Denominator: Female target population 15-44 years	Reliant on accuracy of data collection	Input (non cumulative)	Percentage	Annual	No	Higher percentage indicates better protection against unwanted and unsafe pregnancy	Health Information, Epidemiology and Research Programme MCWH&N Programme
Delivery rate for women under 18 years	Percentage of deliveries where the mother is under 18 years on the day of delivery.	Monitor the percentage of deliveries among teenagers	DHIS	Numerator: Total number of Deliveries in province to woman under 18 years Denominator: Total Deliveries in province		Outcome	Percentage	Annual	No	Higher percentage indicates increase in the number deliveries among teenagers.	MCWH Programme manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Facility Maternal Mortality Ratio (MMR)	Number of maternal deaths in facility expressed per 100 000 live births. A maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (as cited in ICD 10).	Confidential enquiry into maternal deaths report only released every 3-5 years , so monitoring of maternal deaths on a routine basis is very important to monitor progress towards MDG target. Mortality and causes of death report does not give exact figures for maternal deaths.	DHIS	Numerator: Maternal death in facility Denominator: Live births in facility	Reliant on accuracy of classification of inpatient death	Outcome (non cumulative)	Ratio per 100 000 live births	Annual	No	Lower institutional rate indicate fewer avoidable deaths.	MNCWH programme manager
Facility Infant mortality (under 1 years) rate	The number of children who have died in a health facility between birth and their first birthday, expressed per thousand live births in facility	Monitoring of infant deaths on a routine basis is very important to monitor progress towards MDG.	DHIS	Numerator: Total number of inpatient death under one year Denominator: Inpatients separations under 1 year (Sum of Inpatient discharge < 1 year and Inpatient transfer out < 1)	Reliant on accuracy of in facility live births reporting	Outcome (non cumulative)	Rate	Annual	No	Lower infant mortality rate	N/A
Facility child mortality (under 5 years) rate	The number of children who have died in a health facility between birth and their fifth birthday, expressed per thousand live births in facility	Monitoring of children deaths on a routine basis is very important to monitor progress towards MDG.	DHIS	Numerator: Total number of inpatient deaths under 5 years Denominator: Inpatients separations under 5 year (Sum of Inpatient discharge < 5 year and Inpatient transfer out < 5)	Reliant on accuracy of in facility live births reporting	Outcome (non cumulative)	Rate	Annual	No	Lower children mortality rate	N/A

MATERNAL, CHILD AND WOMAN HEALTH: TABLES MCWH2 & MCWH4

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Strengthen facilities which review maternal and perinatal deaths.	Percentages of Health facilities reviewing maternal and perinatal deaths	Monitor the audits on maternal and Perinatal mortalities	Facility reports	Numerator: Number of health facilities conducting the reviews of maternal and Perinatal mortalities Denominator: Total number of Health facilities	Accuracy dependant on quality of data from reporting of facilities and effective information system	Process indicator (non cumulative)	Percentage	Quarterly	No	Higher number suggests better clinical governance and compliance with the core standards and best practice models.	Hospital & MCWH Manager
Increase the proportion of facilities providing Basic Antenatal Care (BANC)	Proportion of facilities implementing the BANC strategy	Monitor the implementation of Basic Antenatal Care services in facilities	Facility reports	Numerator: Number of facilities implementation of Basic Antenatal Care Denominator: Total number of Health facilities	Accuracy dependant on quality of data from reporting of facilities and effective information system	Process indicator (non cumulative)	Percentage	Quarterly	No	Higher number indicates improved access to ANC servcies	MCWH Manager
Increase the proportion of designated health facilities that provides Choice of Termination of Pregnancy (CTOP)	Proportion of facilities designated to provide Choice of Termination of Pregnancy services	Monitor access to CTOP services	DHIS	Numerator: Number of facilities designated to provide Choice of Termination of Pregnancy services Denominator: Total number of Health facilities	Accuracy dependant on quality of data from reporting of facilities and effective information system	Process indicator (non cumulative)	Percentage	Quarterly	No	Higher number indicates improved access to CTOP servcies	MCWH Manager
Reduce severe malnutrition under 5 years incidence	The number of children who weigh below 60% Expected Weight for Age (new cases that month) per 1,000 children in the target population	Monitor incidence of severe malnutrition	DHIS	Numerator: Severe malnutrition under 5 years – new ambulatory Denominator Population under 5 years	Reliant on under 5 population estimates from Stats SA	Output (non cumulative)	Per 1000	Annual	No	To plan, evaluate and monitor nutrition programmes. Lower incidence indicates a healthy community	MCWH & N Programme Manager

DISEASE CONTROL AND PREVENTION: TABLES DPC1 AND DPC3

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Malaria fatality rate (annual)	Deaths from malaria as a percentage of the number of cases reported	Monitor the number deaths caused by Malaria	Malaria Surveillance Report	Numerator: Deaths from malaria Denominator: Total number of Malaria cases reported	Accuracy dependant on quality of data from health facilities	Outcome (non cumulative)	Rate	Annual	No	Lower percentage indicates a decreasing burden of malaria	Communicable Diseases
Cholera fatality rate (annual)	Deaths from cholera as a percentage of the number of cases reported	Monitor the number deaths caused by Cholera	Weekly Zero Report by Districts	Numerator: Deaths from Cholera Denominator: Total number of cholera cases reported	Accuracy dependant on quality of data from health facilities	Outcome (non cumulative)	Rate	Annual	No	Lower percentage indicates a decreasing burden of cholera	Communicable Diseases
Cataract surgery rate (annual)	Cataract operations completed per 1,000,000 population	Monitor the number of cataract surgery	Provincial Cataract Surgery Report	Numerator: Cataract operations completed Denominator: Total population	Accuracy dependant on quality of data from health facilities	Outcome (non cumulative)	Rate per 1mil population	Annual	No	Higher levels reflects a good contribution to sight restoration, especially amongst the elderly population	Non communicable Diseases

DISEASE CONTROL AND PREVENTION: TABLES DPC2

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Outbreaks responded to within 24 hours	A percentage of outbreaks responded within 24 hours.	Monitor the Outbreak response	DHIS Weekly zero reports from districts	Numerator: The average number of hours between the reporting of an outbreak, and the implementation of the agreed response Denominator: All outbreaks reported	Reliant on time calculations of the outbreak response times.	Quality (non cumulative)	Percentage	Annual	No	Higher percentage indicate a better outbreak response	CDC, MCWH and EPI Manager
% reduction in intentional and unintentional injuries.	Reduction of intentional and unintentional injuries.	Monitor reduction in intentional and unintentional injuries	Medical Research Council Annual Survey	Number of intentional and unintentional injuries Total Population	Availability of data dependant on MRC Annual Survey	Output (non cumulative)	Percentage	Annual	No	Lower percentage indicates reduced intentional and unintentional injuries	Disease Prevention Manager
Decrease the incidence of malaria.	Deaths from malaria as a percentage of the number of cases reported	Monitor the number deaths caused by Malaria	DHIS	Numerator: Deaths from malaria Denominator: Total number of Malaria cases reported (1.5 local case per 1000 population	Accuracy dependant on quality of data from health facilities	Outcome (non cumulative)	Rate	Annual	No	Lower percentage indicates a decreasing burden of malaria	CDC and Environmental Health Manager
Chronic Disease Management Register implemented in all PHC facilities	Register implemented for management of chronic diseases.	Monitor management of chronic diseases	Chronic Diseases Reports	Number of Chronic Disease Management Registers implemented Total number of PHC facilities	Accuracy dependant on quality of data from health facilities	Input (non cumulative)	Number	Annual	Yes	Higher number indicates better management of chronic diseases in PHC Facilities	Chronic Diseases Manager

EMERGENCY MEDICAL & PATIENT TRANSPORT SERVICES: TABLES EMS1, EMS 2 AND EMS3

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Rostered ambulances per 10 000 population	Number of all rostered ambulances per 10 000 people in the province	Track the availability of rostered ambulances	EMS Information Systems	Numerator: Total number of roistered ambulances Denominator: Total population in the province (divided by 10 000)		Input (non cumulative)	Sum	Quarterly	No	Higher number of roistered ambulances may lead to faster response time her	EMS Manager
P1 calls with a response of time <15 minutes in an urban area	Percentage of P1 call outs to urban locations with response times within national urban target (15 mins)	Monitor Response times within national urban target	EMS Information Systems	Numerator: No priority 1 rurban calls where Response times within national urban target Denominator: All priority 1 urban Call outs	Accuracy dependant on quality of data from reporting EMS station	Quality (non cumulative)	Percentage	Quarterly	No	Higher percentage indicate better response times in the urban area	EMS Manager
P1 calls with a response time of <40 minutes in a rural area	Percentage of P1 call outs to rural locations with response times within national rural target (40 mins)	Monitor Response times within national rural target	EMS Information Systems	Numerator: No priority 1 rural calls where Response times within national rural target Denominator: All priority 1 rural Call outs	Accuracy dependant on quality of data from reporting EMS station	Quality (non cumulative)	Percentage	Quarterly	No	Higher percentage indicate better response times in the rural areas	EMS Manager
All calls with response time within 60 minutes	Percentage of all call outs with response times within 60min	Monitor Response times	EMS Information Systems	Numerator: No of calls where Response times within 60min Denominator: All Call outs	Accuracy dependant on quality of data from reporting EMS station	Quality (non cumulative)	Percentage	Quarterly	No	Higher percentage indicate better response times	EMS Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
% of PPTS within EMS	% of patients transported by EMS as PPTS	Transport non emergency patients	EMS Information systems	Numerator: Nr of Non emergency patient transported Denominator total number of patient transported by EMS	Accuracy dependant on quality of data from reporting EMS station	Input (non cumulative)	Percentage	Annual	No	Increase of station with PPT	EMS Manager

REGIONAL HOSPITALS: TABLES PHS1AND PHS4

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Total number of clinical domains in the 3 regional hospitals. (annual)	Clinical domains with appointed specialists.	To provide quality clinical services.	Physical Counting, PERSAL	Physical counting.	Only the clinical domain that has a doctor registered as a specialist by the HPCSA, will be considered.	Output (non cumulative)	Number	Annual	No	Increased number of clinical domains.	Regional Hospital CEOs.
Number of Regional Hospitals complying with six key priorities of the core standards (annual)	Regional hospitals complying with the following six key priorities of the core standards: • Improved Patient Safety • Drug Availability • Positive & Caring Staff Attitude • Reduced Waiting Times • Improved Cleanliness • Infection Prevention and Control	Tracks the levels of compliance against the 6 priority areas of the core standards	Assessment Reports	Numerator: Total number of Regional and specialised hospitals complying against the 6 priorities of the core standards. Denominator: Total number of Regional and specialised hospitals in the province	Accuracy dependant on quality of data and effective information systems	Output (non cumulative)	Number	Annual	No	All 3 Regional Hospitals implementing six key priority areas	Regional Hospital CEOs.

REGIONAL HOSPITALS: TABLES PHS2 AND PHS4

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Caesarean section rate in regional hospitals	Caesarean section deliveries in hospitals expressed as a percentage of all deliveries in hospitals.	Track the performance of obstetric care of the regional hospitals	DHIS	Numerator: Number of Caesarean sections performed Denominator: Total number of deliveries in regional hospitals	Accuracy dependant on quality of data from reporting facility	Output (non cumulative	Percentage	Quarterly	No	Higher percentage of Caesarean section indicates higher burden of disease, and/or poorer quality of antenatal care.	Hospital Services

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Total Separations in regional hospitals	Recorded completion of treatment and/or the accommodation of a patient in district hospitals. Separations include inpatients who were discharged, transferred out to other hospitals or who died and includes Day Patients.	Monitoring the service volumes	DHIS	Sum of: • Inpatient deaths • Inpatient discharges • Inpatient transfer out • Day patient	Accuracy dependant on quality of data from reporting facility	Output (cumulative)	Cumulative totals	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	Hospital Services
Patient Day Equivalent in Regional Hospitals	Patient day equivalent is weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All hospital activity expressed as a equivalent to one inpatient day	Monitoring the service volumes	DHIS	Sum of: • Inpatient days - total • 1/2 Day patients • 1/3 OPD headcount -total • 1/3 Emergency Headcount OPD Headcount total = sum of: • OPD specialist clinic headcount + • OPD general clinic headcount + •	Accuracy dependant on quality of data from reporting facility	Output (cumulative)	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	Hospital Services
OPD Headcount - Total ts in Regional hospitals	A headcount of all outpatients attending an outpatient clinic.	Monitoring the service volumes	DHIS	Sum of: • OPD specialist clinic headcount • OPD general clinic headcount •	Accuracy dependant on quality of data from reporting facility	Output (cumulative)	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	Hospital Services

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Average length of stay in Regional Hospitals	Average number of patient days that an admitted patient in the regional hospital before separation.	To monitor the efficiency of the district hospital	DHIS	Numerator: Inpatient days + 1/2 Day patients Denominator: Separations Sum of: • Inpatient deaths • Inpatient discharges • Inpatient transfer out • Day patient	Accuracy dependant on quality of data from reporting facility	Efficiency (non cumulative)	Ratio	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care	Hospital Services
Bed utilisation rate (based on usable beds) in Regional Hospitals	Patient days during the reporting period, expressed as a percentage of the sum of the daily number of usable beds in regional hospitals	Track the over/under utilisation of regional hospital beds	DHIS	Numerator: Inpatient days + 1/2 Day patients Denominator: Number of usable bed days	Accurate reporting sum of daily usable beds	Efficiency (non cumulative)	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels	Hospital Services
Expenditure per patient day equivalent (PDE) in Regional Hospitals	Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All hospital activity expressed as a equivalent to one inpatient day	Track the expenditure per PDE in regional hospitals in the province	BAS / DHIS	Numerator: Total Expenditure in district hospitals Denominator: Patient Day Equivalent (PDE)*		Efficiency (non cumulative)	Rate	Quarterly	No	Lower rate indicating efficient use of financial resources.	Hospital Services.

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Regional hospitals with monthly Maternal Mortality and Morbidity Meetings	Percentage of Regional hospitals having monthly Maternal Mortality and Morbidity Meetings (3 per quarter)	To monitor the quality of hospital services, as reflected in levels of diseases adverse events; and proportion of deaths	DHIS	Numerator: Number of Regional hospitals having Maternal Mortality and Morbidity every month Denominator: Total number of Regional hospitals	Accuracy dependant on quality of data from reporting facility	Quality (non cumulative)	Percentage	Quarterly	No	Higher percentage suggests better clinical governance	Quality Assurance (QA)
Percentage of complaints of users of Regional Hospital Services resolved within 25 days	Percentage of complaints of users of Regional Hospital Services resolved within 60 days	To monitor the management of the complaints in Regional Hospitals	DHIS	Numerator: Total number of complaints resolved within 25 days during the quarter Denominator: Total number of complaints during the quarter	Accuracy of information is dependant on the accuracy of time stamp for each complaint	Quality (non cumulative)	Percentage	Quarterly	Yes	Higher percentage suggest better management of complaints in Regional Hospitals	Quality Assurance
Regional Hospital Patient Satisfaction rate	The percentage of users that participated in the Regional Hospital Services survey that were satisfied with the services	Tracks the service satisfaction of the Regional Hospital users	Assessment Reports	Numerator: Total number of users that were satisfied with the services rendered in Regional Hospitals Denominator: Total number of users that participated in the Client Satisfaction Survey (in Regional Hospitals)	Generalisability depends on the number of users participating in the survey.	Output (non cumulative)	Percentage	Annual	Yes	Higher percentage indicates better levels of satisfaction in Regional Hospital services	Quality Assurance
Percentage of Regional and specialist Hospitals assessed for compliance against 6 priority areas of the core standards	Percentage of Regional and specialised Hospitals assessed for compliance against the core standards	Tracks the levels of compliance against the 6 priority areas of the core standards	Assessment Reports	Numerator: Total number of Regional and specialised hospitals assessed against the core standards. Denominator: Total number of Regional and specialised hospitals in the province	Accuracy dependant on quality of data and effective information systems	Process (non cumulative)	Sum	Annual	Yes	Higher number indicates better compliance with the core standards in Regional Hospitals	Quality Assurance

SPECIALISED HOSPITALS: TABLES PHS1AND PHS4

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
TB Hospitals											
Average length of stay TB	Number of inpatient days which includes in the "discharges and deaths" patients who abscond and do not return to the hospital	To evaluate the efficiency of the health care service rendered.	Paper records- patient's register	Numerator Number of inpatient days Denominator Number of discharges and deaths during the quarter	Accuracy dependant on quality of data and effective information systems	Output (non cumulative)	Days	Quarterly	No	Norm	TB Directorate
Average length of stay Drug resistance (DR)	Number of inpatient days which includes in the "discharges and deaths" patients who abscond and do not return to the hospital in a drug Resistance TB unit	To evaluate the efficiency of the health care service rendered.	Paper records- patient's register	Numerator Number of inpatient days in drug resistance TB unit Denominator Number of discharges and deaths in the unit during the quarter	Accuracy dependant on quality of data and effective information systems	Output (non cumulative)	Days	Quarterly	No	Norm	TB Directorate
Bed Utilisation rate TB	Rate of beds utilization expressed in percentage -norm	To check bed utilization rate for efficiency of hospital	Paper records- patient's register, daily return	Number of inpatients days multiplied by 100, divided by the available bed days during the quarter.	Accuracy dependant on quality of data and effective information systems	Output (non cumulative)	%	Quarterly	No	Norm	TB Directorate
Bed Utilisation rate DR	Rate of beds utilization expressed in percentage in rug resistance TB unit - norm	To check bed utilization rate for efficiency of hospital	Paper records- patient's register, daily return	Number of inpatients days multiplied by 100, divided by the available bed days during the quarter.	Accuracy dependant on quality of data and effective information systems	Output (non cumulative)	%	Quarterly	No	Norm	TB Directorate
Effective Discharge rate (TB)	A "confirmed" discharge is when the hospital receives confirmation from the next treatment facility(clinic or hospital) that the patient has arrived. Patients that	To monitor the efficiency and effectiveness of the institution	Acknowledgement slips (pink slips)	Number of confirmed discharges multiplied by 100, divided by the total number of discharges during the quarter	Accuracy dependant on quality of data and effective information systems	Output (non cumulative)	%	Quarterly	No	Norm	TB Directorate

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
	continue their treatment via hospital DOT clinic are included as confirmed discharges										
Effective Discharge rate DR	A “confirmed” discharge is when the hospital receives confirmation from the next treatment facility(clinic or hospital) that the patient has arrived. Patients that continue their treatment via hospital DOT clinic are included as confirmed discharges	To know the number of patients that are effectively discharged and to minimize the number of defaulters	Acknowledgement slips (pink slips)	Number of confirmed discharges multiplied by 100, divided by the total number of discharges during the quarter	Accuracy dependant on quality of data and effective information systems	Output (non cumulative	%	Quarterly	No	Norm	TB Directorate
No of MDR units	No of units dedicated to multi-drug resistance patients established	To manage and contain the spread of MDR cases	Physical count of units	Number of MDR units	Accuracy dependant on quality of data and effective information systems	Input (cumulative)	No	Quarterly	Yes	Increase in number of MDR units established	TB Directorate
% of patients reporting satisfaction with treatment (annual)	Feedback mechanism regarding service delivery	To evaluate and measure client satisfaction with the service	Discharge questionnaires with positive response	Number of patients who completed a patient satisfaction survey multiplied by 100, divided by the total number of discharges during the quarter	Accuracy dependant on quality of data and effective information systems	Outcome (non cumulative)	%	Annual	No	Increase in satisfaction	TB Directorate
Expenditure PDE in TB Hospitals (annual)	the average cost per patient, per day, seen at a hospital, and is expressed as Rands per patient day equivalent in TB hospital	Cost per PDE reflects whether a particular hospital is being optimally managed. It measures and compares the inputs (total financial	Registers and BAS System	Value is calculated by dividing the total expenditure of the hospital by the patient day equivalent (PDE). The PDE is calculated by	Accuracy dependant on quality of data and effective information systems	Output (non cumulative)	Rands	Annual	Yes	Reaching the national norm	TB Directorate

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performanc e	Indicator Responsibilit y
		resources available to the hospital) with the outputs (volume of patients seen)		adding the number of inpatients plus ½ of day patients plus $^1/_3$ of outpatient and emergency room visits							
% TB patients tested positive for HIV (annual	Percentage newly of HIV positive patients tested who were diagnosed with TB as entry point	To ensure initiation of HAART, CPT	Monthly VCT statistics	Number of patients tested positive + the number of patients referred in positive multiplied by 100, divided by the total number of patients tested + the number referred in positive	Accuracy dependant on quality of data and effective information systems	Output (non cumulative)	%	Annual	No	Increase in TB patient detected HIV positive	TB Directorate

CENTRAL/TERTIARY HOSPITALS: TABLE THS1, THS 2 AND THS 3

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Total number of functional specialist domains in tertiary hospitals (annual)	Specialist domains with appointed specialists.	To provide quality clinical services.	Physical Counting, PERSAL	Physical counting.	Only the clinical domain that has a doctor registered as a specialist by the HPCSA, will be considered.	Output (cumulative)	Number	Annual	No	Increased number of functional specialist domains.	Tertiary Hospital CEOs.

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of Tertiary Hospitals complying with six key priorities of the core standards (annual)	Tertiary hospitals complying with the following six key priorities of the core standards: • Improved Patient Safety • Drug Availability • Positive & Caring Staff Attitude • Reduced Waiting Times • Improved Cleanliness • Infection Prevention and Control	Tracks the levels of compliance against the 6 priority areas of the core standards	Assessment Reports	Numerator: Total number of Tertiary hospitals complying against the 6 priorities of the core standards. Denominator: Total number of tertiary hospitals in the province	Accuracy dependant on quality of data and effective information systems	Output (cumulative)	Number	Annual	No	Rob Ferreira and Witbank Hospitals implementing six key priority areas	Tertiary Hospital CEOs.

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Caesarean section rate for Central / Tertiary hospitals	Caesarean section deliveries in hospitals expressed as a percentage of all deliveries in central and tertiary hospitals	Track the performance of obstetric care of the central and tertiary hospitals	DHIS	Numerator: Number of Caesarean sections performed in central and tertiary hospitals Denominator: Total number of deliveries in central and tertiary hospitals	Accuracy dependant on quality of data from reporting facility	Output (non cumulative)	Percentage	Quarterly	No	Higher percentage of Caesarean section indicates higher burden of disease, and/or poorer quality of antenatal care.	Hospital
Total Separations in Central/Tertiary Hospitals	Recorded completion of treatment and/or the accommodation of a patient in district hospitals. Separations include inpatients who were discharged, transferred out to other hospitals or who died and	Monitoring the service volumes	DHIS	Sum of: • Inpatient deaths • Inpatient discharges • Inpatient transfer out • Day patient (All above in central and tertiary hospitals)	Accuracy dependant on quality of data from reporting facility	Output (non cumulative)	Cumulative totals	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	Hospital Services

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
	includes Day Patients. (in central and tertiary hospitals)										
Patient Day Equivalent in Central/Tertiary Hospitals	Patient day equivalent is weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All hospital activity expressed as a equivalent to one inpatient day	Monitoring the service volumes	DHIS	Sum of: • Inpatient days -total • 1/2 Day patients • 1/3 OPD headcount - total • 1/3 Emergency Headcount OPD Headcount total = sum of: • OPD specialist clinic headcount + • OPD general clinic headcount '	Accuracy dependant on quality of data from reporting facility	Output (non cumulative)	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	Hospital Services
OPD Headcount -Total ts in Central/Tertiary hospitals	A headcount of all outpatients attending an outpatient clinic.	Monitoring the service volumes	DHIS	Sum of: • OPD specialist clinic headcount • OPD general clinic headcount	Accuracy dependant on quality of data from reporting facility	Output (non cumulative)	Sum	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	Hospital Services

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Average length of stay in central and tertiary hospitals	Average number of patient days that an admitted patient in this hospital spends in hospital before separation.	To monitor the efficiency of the district hospital	DHIS	Numerator: Inpatient days + 1/2 Day patients Denominator: Separations Sum of: • Inpatient deaths • Inpatient discharges • Inpatient transfer out • Day patient	Accuracy dependant on quality of data from reporting facility	Efficiency (non cumulative)	Ratio	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care	Hospital Services
Bed utilisation rate (based on usable beds) in Central and tertiary hospitals	Patient days during the reporting period, expressed as a percentage of the sum of the daily number of usable beds in central and tertiary hospitals	Track the over/under utilisation of central and tertiary hospital beds	DHIS	Numerator: Inpatient days + 1/2 Day patients Denominator: Number of usable bed days	Accurate reporting sum of daily usable beds	Efficiency (non cumulative)	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels	Hospital Services
Expenditure per patient day equivalent (PDE) in central and tertiary hospitals	Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All hospital activity expressed as a equivalent to one inpatient day	Track the expenditure per PDE in regional hospitals in the province	BAS / DHIS	Numerator: Total Expenditure in district hospitals Denominator: Patient Day Equivalent (PDE)*	Accuracy dependant on quality of data from reporting facility	Efficiency (non cumulative)	Rate	Quarterly	No	Lower rate indicating efficient use of financial resources.	Hospital Services.

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Central / Tertiary hospitals with monthly Maternal Mortality and Morbidity Meetings	Percentage of Central / Tertiary hospitals having monthly Maternal Mortality and Morbidity Meetings (3 per quarter)	To monitor the quality of hospital services, as reflected in levels of diseases adverse events; and proportion of deaths	Quality Assurance Reports	Numerator: Number of Central / Tertiary hospitals having Maternal Mortality and Morbidity every month Denominator: Total number of Central / Tertiary hospitals	Accuracy dependant on quality of data from reporting facility	Quality (non cumulative)	Percentage	Quarterly	No	Higher percentage suggests better clinical governance	Quality Assurance (QA)
Percentage of complaints of users of Central / Tertiary Hospital Services resolved within 60 days	Percentage of complaints of users of Central / Tertiary Hospital Services resolved within 60 days	To monitor the management of the complaints in Central / Tertiary Hospitals	DHIS	Numerator: Total number of complaints resolved within 60 days during the quarter Denominator: Total number of complaints during the quarter	Accuracy of information is dependant on the accuracy of time stamp for each complaint	Quality (non cumulative)	Percentage	Quarterly	Yes	Higher percentage suggest better management of complaints in Central / Tertiary Hospitals	Quality Assurance
Central and Tertiary Hospital Patient Satisfaction rate	The percentage of users that participated in the Central and Tertiary Hospital Services survey that were satisfied with the services	Tracks the service satisfaction of the Regional Hospital users	Assessment Reports	Numerator: Total number of users that were satisfied with the services rendered in Central and Tertiary Hospital Denominator: Total number of users that participated in the Client Satisfaction Survey (in Central and Tertiary Hospitals)	Generalisability depends on the number of users participating in the survey.	Output (non cumulative)	Percentage	Annual	Yes	Higher percentage indicates better levels of satisfaction in Central and Tertiary Hospital services	Quality Assurance
Tertiary/Central Hospitals assessed for compliance against 6 priority areas of the core standards	Percentage of Central and Tertiary Hospital assessed for compliance against the core standards	Tracks the levels of compliance against the 6 priority areas of the core standards	Assessment Reports	Numerator: Total number of Central and Tertiary Hospitals assessed against the core standards.	Accuracy dependant on quality of data from reporting facility	Process (cumulative)	Sum	Annual	Yes	Higher number indicates better compliance with the core standards in	Quality Assurance

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
				Denominator: Total number of Central and Tertiary Hospitals in the province						Central and Tertiary Hospitals	

HEALTH SCIENCES AND TRAINING: TABLE HST1, HST2 AND HST3

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Intake of nurse students (annual)	Number of nurses entering the first year of nursing college	Tracks the training of nurses	Human Resources Development	No denominator	Data quality depends on good record keeping by both the Provincial DoH and nursing colleges	Input (non cumulative)	Sum total	Annual	No	Higher levels of intake are desired, to increase the availability of nurses in future	Human Resources Development Programme
Students with bursaries from the province (annual)	Number of students provided with bursaries by the provincial department of health	Tracks the numbers of health science students sponsored by the Province to undergo training as future health care providers	Human Resources Development	No denominator	Data quality depends on good record keeping by both the Provincial DoH and Health Science Training institutions	Input (non cumulative)	Sum total	Annual	No	Higher numbers of students provided with bursaries are desired, as this has the potential to increase future health care providers	Human Resources Development
Basic nurse students graduating (annual)	Number of students who graduate from the basic nursing course	Tracks the production of nurses	Human Resources Development	No denominator	Data quality depends on good record keeping by both the Provincial DoH and nursing colleges	Output (non cumulative)	Sum total	Annual	No	Desired performance level is that higher numbers of nursing students should be graduating	Human Resources Development
No. of health professionals trained on critical clinical skills.	Count of health professionals trained	Tracks the provisioning of training for health professionals	Training Database	Headcount of health professionals trained	Data quality depends on good record keeping by Provincial DoH	Input (cumulative)	Sum total	Quarterly	No	To sustain the number of health professionals trained.	Human Resources Development

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
No. of health personnel trained in generic programmes	Count of health personnel trained on generic programmes	Tracks the provisioning of training in generic programmes	Training Database	Headcount of health personnel trained on generic programmes	Data quality depends on good record keeping by Provincial DoH	Input (cumulative)	Sum total	Quarterly	No	Continual provision of training to health workers	Human Resources Development
No of learners on learnerships, internships, and ABET	Count of learners enrolled for learnerships; interns on internship programme and learners on ABET programme.	Tracks the production of learnerships, internships and ABET learners	Learnership Database Enrollment Registers and ABET Register	Headcounts of learners on learnerships; interns and learners on ABET	Data quality depends on good record keeping by Provincial DoH	Input (cumulative)	Sum total	Annual	No	Continual uptake of learners on learnership programme; interns and ABET learners	Human Resources Development
No of campuses established at district level.	Count of all campuses established and functional at district level	Capacitate nurses for improved health outcomes	Accreditation Certificates	Numerator Number of campuses established Denominator Number of Districts in province	Data quality depends on good record keeping by Provincial DoH	Input (non cumulative)	Sum total	Annual	No	Increased number of campuses established	Human Resources Development
No of nurse students enrolled.	Count of all nurses enrolled as students in a year.	To capacitate nurses and explore their career in nursing field	Enrolment Register	Headcount of all nurses enrolled in registration list	Data quality depends on good record keeping by Provincial DoH	Input (non cumulative)	Sum total	Annual	No	Increased number of nurses enrolled	Human Resources Development
No of clinical training facilities accredited	Count of all facilities accredited for clinical training	To provide a platform for student nurses to do practicals	Accreditation Certificates	Number of accredited facilities	Data quality depends on good record keeping by Provincial DoH	Input (cumulative)	Sum total	Annual	No	Increased number in training facilities	Human Resources Development
No. of learners enrolled for EMS training	Count of official s enrolled for EMS training	To provide efficient provision of EMS through capacity building	Enrolment Register	Number of learners enrolled	Data quality depends on good record keeping by Provincial DoH	Input (cumulative)	Sum total	Bi-Annual	No	Sustain the provision of EMS training	Human Resources Development

HEALTH CARE SUPPORT SERVICES: TABLE HCSS1 AND HCSS2

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
% of EDL items available at the Medical Depot	Percentage of EDL drugs list available at DEPOT for ordering.	Availability of EDL drugs is essential to provide efficient health care services in all health facilities.	EDL Items Lists	Numerator Number of essential drugs available at DEPOT Denominator Total number of Essential Drugs on the list	Only EDL drugs are counted to determine percentage of essential drugs available	Process (non cumulative)	Number	Quarterly	No	0% minimum EDL drugs on stock out	Pharmaceutical Services
No of Pharmaceutical Therapeutic Committees (PTC) established.	PTC established are multi disciplinary committees.	No of PTC for ensuring rational drug use in all facilities	PTC Terms of reference and minutes	Denominator Total number of PTC established	PTC affected by high turnover rate of Pharmacists	Outcome (non cumulative)	Number	Quarterly	Yes	All hospital have PTC	Pharmaceutical Services
% Compliance with the Medicine Control Council (MCC) Standards.	Compliance of the depot with the MCC requirements for safeguarding of medicine.	Compliance with MCC Standards for ensuring maintenance of efficacy of medicine.	MCC compliance tool	Denominator Total number of compliant items on the tool	Requires infrastructure improvement	Efficiency (non cumulative)	Percentage	Quarterly	Yes	100% Compliance with MCC	Pharmaceutical Services
No of sites rendering Clinical Forensic Medicine services.	Assists community in receiving equal access to services and distribution of services	Improved access to services	Physical observation and recording	Counting	Data quality depends on good record keeping	Input (non cumulative)	Number	Quarterly	No	Increased number of sites rendering CFM	Clinical Forensic Medicine Programme Manager
No of sites rendering Forensic Pathology Services (FPS).	Assists community in receiving equal access to services and distribution of services	Improved access to services	Physical observation and recording	Counting	Data quality depends on good record keeping	Input (non cumulative)	Number	Quarterly	No	Increased number of sites rendering FPS	Forensic Pathology Services: Programme Manager
No. of Autopsies conducted	Bodies on which medical investigation have been conducted to determine the cause of death.	Production of reports on causes of unnatural deaths for CJS	Death Registers in Facilities	Number of autopsies conducted	Data quality depends on good record keeping	Input (cumulative)	Number	Quarterly	No	5 500 autopsies conducted	
No of hospitals with approved guidelines.	All hospitals need to have approved guidelines	Tracks compliance of hospitals in terms of approved guidelines	Approved Guidelines	Number of hospitals with approved guidelines	Data quality depends on good record keeping	Input (non cumulative	Number	Quarterly	Yes	All hospitals with approved guidelines	Laboratory Blood and other Auxilliary Services:

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
No of hospitals complying to debtor's 30 days on Laboratory and Blood.	All hospitals to comply to debtors 30 days on Laboratory and Blood	Tracks compliance of hospitals to debtors' 30 days on Laboratory and Blood	Quarterly Financial Statements	Number of hospitals complying to debtor's 30 days on Laboratory and Blood	Data quality depends on good record keeping	Input (non cumulative)	Number	Quarterly	No	Hospitals compliant to debtors 30 days on Laboratory and Blood	Programme Manager
No of functional Clinical Engineering workshop facilities.	Facilities which are well equipped and have sufficient staff	Improved availability of medical equipment	Physical Evidence of fully functional workshop facilities	Actual number of Clinical Engineering Workshop Facilities	Data quality depends on good record keeping	Input (non cumulative)	Cumulative	Quarterly	No	Increased number of functional Clinical Engineering Workshops	Health Technology Manager
Number of clinical engineering technicians appointed.	Technicians that maintain medical equipment.	Ensure maintenance and availability of medical equipment	Persal System	Actual number of Clinical engineering technicians appointed	Data quality depends on good record keeping	Input (cumulative)	Cumulative	Quarterly	No	An increased number of clinical engineering technicians will ensure availability of medical equipment	
% of facilities complying with Radiation Control prescripts.	Facilities need to be compliant to Radiation Control prescripts	Ensures compliance of facilities with Radiation Control prescripts, radiation safety and minimise risks	Reports	Numerator: Number of facilities complying with prescripts Denominator Total number of facilities X 100	Data quality depends on good record keeping	Input (non cumulative)	Non-cumulative	Quarterly	No	All facilities compliant to Radiation Control prescripts	Imaging Services Manager
Number of Orthosis and Prosthesis devices supplied.	Medical orthosis and prosthesis devices given to people with disabilities	Improved access to services	Records in the workshop	Number of O&P devices supplied	Data quality depends on good record keeping	Output (cumulative)	Number	Quarterly	No	Increased number in O&P devices supplied	Medical Orhtotic and Prosthetic Services: Programme Manager
Waiting period for receiving devices in month.	Period of time taken for patients to receive device	Tracks down the waiting period for devices	Registers in Workshops	Actual waiting period vs national norm	Data quality depends on good record keeping	Process (non cumulative)	Number (months)	Quarterly	No	Reduced waiting period to 2 months	

HEALTH FACILITIES MANAGEMENT: TABLE HFM1, HFM2 AND HFM3

Indicator Title	Short Definition	Purpose/ Importance	Means of verification/ Data Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of PHC facilities with accommodation, on planning phase.	Number of PHC facilities with accommodation, on planning phase.	Increased access to health care services	Immovable Asset Register & Physical Verification	Number of PHC facilities with accommodation, on planning phase.	Correctness of data depends on quality of DPWR&T Report	Input	Number	Annual	No	Increased health facilities	Infrastructure Management Programme Manager
Number of PHC facilities with accommodation, under construction.	Number of PHC facilities with accommodation, under construction.	Increased access to health care services	Immovable Asset Register & Physical Verification	Number of PHC facilities with accommodation, under construction.	Correctness of data depends on quality of DPWR&T Report	Input	Number	Annual	No	Increased health facilities	Infrastructure Management Programme Manager
Number of PHC facilities with accommodation, constructed.	Number of PHC facilities with accommodation, constructed.	Increased access to health care services	Immovable Asset Register & Physical Verification	Number of PHC facilities with accommodation, constructed.	Correctness of data depends on quality of DPWR&T Report	Input	Number	Annual	No	Accessibility of health care services	Infrastructure Management Programme Manager
Number of hospitals under revitalisation programme, on planning phase.	Number of hospitals under revitalisation programme, on planning phase.	Increased access to health care services	Immovable Asset Register & Physical Verification	Number of hospitals under revitalisation programme, on planning phase	Correctness of data depends on quality of DPWR&T Report	Input	Number	Annual	No	Accessibility of health care services	Infrastructure Management Programme Manager
Number of hospitals under revitalisation programme, under upgrading and renovation.	Number of hospitals under revitalisation programme, under upgrading and renovation.	Increased access to health care services	Immovable Asset Register & Physical Verification	Number of hospitals under revitalisation programme, under upgrading and renovation.	Correctness of data depends on quality of DPWR&T Report	Input	Number	Annual	No	Accessibility of health care services	Infrastructure Management Programme Manager
Number of hospitals under revitalisation programme, upgraded/renovated.	Number of hospitals under revitalisation programme, upgraded/renovated.	Increased access to health care services	Immovable Asset Register & Physical Verification	Number of hospitals under revitalisation programme, upgraded/renovated.	Correctness of data depends on quality of DPWR&T Report	Input	Number	Annual	No	Accessibility of health care services	Infrastructure Management Programme Manager
Number of hospitals under Infrastructure Grant on planning phase	Number of hospitals under Infrastructure Grant on planning phase	Increased access to health care services	Immovable Asset Register & Physical Verification	Number of hospitals under Infrastructure Grant on planning phase	Correctness of data depends on quality of DPWR&T	Input	Number	Annual	No	Accessibility of health care services	Infrastructure Management Programme Manager

Indicator Title	Short Definition	Purpose/ Importance	Means of verification/ Data Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
					Report						
Number of hospitals under Infrastructure Grant under upgrading and renovation.	Number of hospitals under Infrastructure Grant under upgrading and renovation.	Increased access to health care services	Immovable Asset Register & Physical Verification	Number of hospitals under Infrastructure Grant under upgrading and renovation.	Correctness of data depends on quality of DPWR&T Report	Input	Number	Annual	No	Accessibility of health care services	Infrastructure Management Programme Manager
Number of hospitals under Infrastructure Grant upgraded/renovated.	Number of hospitals under Infrastructure Grant upgraded/renovated.	Increased access to health care services	Immovable Asset Register & Physical Verification	Number of hospitals under Infrastructure Grant upgraded/renovated.	Correctness of data depends on quality of DPWR&T Report	Input	Number	Annual	No	Accessibility of health care services	Infrastructure Management Programme Manager