health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

Annual Performance Plan 2017/18

Tabling Date: 10 April 2017

TABLE OF CONTENTS

ACRONYMS	
AIDS	Acquired Immune Deficiency Syndrome
APP	Annual Performance Plan
ARI	Acute Respiratory Infections
ART	Anti-retroviral Treatment
BANC	Basic Antenatal Care
BOD	Burden of Disease
CARMMA	Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa
CDC	Community Day Centre
CEO	Chief Executive Officer
CHC	Community Health Centre
CHWs	Community Health Workers
CMR	Child Mortality Rate
CoE	Compensation of Employees
CPIX	Consumer Price Index
CRDP	Comprehensive Rural Development Programme
CSR	Cataract Surgery Rate
DHER	District Health Expenditure Review
DHP	District Health Plan
DHS	District Health Services
DHIS	District Health Information System
DHMIS	District Health Management Information System
DoE	Department of Education
DOH	Department of Health
DORA	Division of Revenue Act
DOTS	Directly Observed Treatment Sort Course
DPC	Disease Prevention and Control
DPSA	Department of Public Service and Administration
DR	Drug Resistant
DSD	Department of Social Development
ESMOE	Essential Steps in Managing Obstetric Emergencies
ETR.Net	Electronic TB Register
EDL	Essential Drug List
EMS	Emergency Medical Services
GDP	Gross Domestic Product
HAST	HIV & AIDS, STI and TB Control
HCSS	Health Care Support Services
HCT	Health Care Provider Initiated Counseling and Testing

ACRONYMS	
HFM	Health Facilities Management
HHCC	Household Community Components
HIV	Human Immuno-deficiency Virus
HOD	Head of Department
HPTDG	Health Professional Training and Development Grant
HPRS	
HR	Human Resources
HRD	Human Resource Development
HRM	Human Resource Management
HST	Health Sciences and Training
HTA	High Transmission Area
ICT	Information Communication Technology
IDP	Integrated Development Plan
IHPF	Integrated Health Planning Framework
IMCI	Integrated Management of Childhood Illnesses
IPT	Isoniazid Preventive Therapy
KMC	Kangaroo Mother Care
MBFI	Mother and Baby Friendly Hospital Initiative
MCWH&N	Maternal, Child, Women's Health and Nutrition
MDGs	Millennium Development Goals
MDR	Multi-drug Resistant
MEC	Minister of Executive Council
MMC	Male Medical Circumcision
MMR	Maternal Mortality Rate
MPAC	Mpumalanga Provincial AIDS Council
MRC	Medical Research Council
MTEF	Medium-term Expenditure Framework
MTSF	Medium-term Strategic Framework
NDOH	National Department of Health
NCD	Non Communicable Diseases
NDP	National Development Plan
NGO	Non-governmental Organisation
NHA	National Health Act
NHI	National Health Insurance
NHIRD	National Health Repository and Data Warehousing
NHLS	National Health Laboratory Services
NHS	National Health Systems

ACRONYMS	
NPO	Non-profit Organisation
NSDA	Negotiated Service Delivery Agreement
NSP	National Strategic Plan
NTSG	National Tertiary Services Grant
OPD	Outpatient Department
OSD	Occupational Specific Dispensation
PCR	Polymerase Chain Reaction (a laboratory HIV detection Test)
PCV	Pneumococcal Vaccine
PDE	Patient Day Equivalent
PDOH	Provincial Department of Health
PHC	Primary Health Care
PHS	Provincial Hospital Services
PMTCT	Prevention of mother-to-child Transmission
PPP	Public/Private Partnership
PPTS	Planned Patient Transport Services
PSP	Provincial Strategic Plan
PTC	Pharmaceutical Therapeutic Committees
RV	Rota Virus
SADHS	South African Demographic Health Survey
SALGA	South African Local Government Agency
SANAC	South African National AIDS Council
SOP	Standard Operating Procedures
STATS SA	Statistics South Africa
STC	Step Down Care
STP	Service Transformation Plan
TB	Tuberculosis
THS	Tertiary Hospital Services
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 2014/15 derives from the following:

- National Development Plan, Vision 2030
- Medium Term Strategic Framework (MTSF), 2014 – 2019
- State of the Nation Address and State of the Province Address
- Health Sector Negotiated Service Delivery Agreement
- Strategic Plan for Mpumalanga Department of Health, 2014/15 – 2019/20

2. BACKGROUND TO THE ANNUAL PERFORMANCE PLANS (APPs) OF PROVINCIAL DEPARTMENTS OF HEALTH

This Format for Annual Performance Plans (APPs) of Provincial Departments of Health (DoHs) is adapted from the generic format developed by National Treasury in 2010. The APP is divided into three parts. Part A aims to provide a strategic overview of the provincial health sector. Part B allows for the detailed planning of individual budget programmes and sub-programmes and is the core of the Strategic and Annual Performance Plan. Part C provides for linkages with other long-term and conditional grant plans of the health sector.

The APP format is structured to promote improved delivery of provincial health services and to account for the use of public funds. Most importantly, the APP Format provides for linkages between Outcome 2 priorities of Medium Term Strategic Framework (MTSF) 2014-2019 and Provincial objectives for the MTEF period.

Treasury Guidelines require that the technical definitions of each indicator used in the APP should be provided and posted on the Department's Website together with the APP.

3. FORMAT FOR PROVINCIAL APPs-

3.1. FOREWORD BY THE MEC FOR HEALTH

The Mpumalanga Department has indeed has turned the corner in delivering better health services to the people. All health officials have been on their toes to ensure that the Department is performing according to its strategic objectives. One of the biggest challenges the Department grabbled with was the shortage of managers and health professionals. The Department has indeed met its plans of filling most vacant posts; key being that of the appointment of a female HOD who has moved with speed to instil stability in the Department.

The Department has for many years operated without a Director for Supply Chain Management which has now been addressed. Other managers who have come to the party include that of Chief Director Financial Management and many other positions that have been filled in the Finance, Infrastructure and in hospital services. This has indeed contributed to the stability of the Department. All the hospitals have also been grabbling as the province experienced shortage of medical specialists. This problem has been partially addressed as some specialist like Orthopaedic Surgeons have been drawn into the province to assist with back logs.

The Department has also improved on Infrastructural programme. Many Primary Health care facilities have undergone revitalizations, renovation and upgrades. In the previous financial year of 2016/17 the Department maintained 240 of the 286 Primary Health Care facilities. The Department has also completed constructions of five hospitals such as Evander, Kwa-Mhlanga, Middelburg, Witbank and Sabie.
The Department has also progressed with the implementation of the National Health Insurance (NHI). The work on the implementation of the e health patient registration in all our PHC facilities in Gert Sibande has started. About 1.2 Million patients have already been registered on e-HPRS

The province like the rest of the country faces a quadruple burden of diseases. HIV and AIDS, Tuberculosis, high Maternal and Child Mortality, Non-Communicable Diseases. The Department has already distributed millions of males and females condoms, put many patients on ART and increased the pace of curing TB. The Department has also partnered with NGO stakeholders and the population groups in order to fight the pandemic.

The Department received qualification on immovable assets, irregular expenditure, commitments, movable assets, contingent liabilities, compensation of employees and transfers and subsidies during 2015/2016 financial year. The Department has introduced an assets verification project, which will resolve the asset related findings during forthcoming audits. In addition, the Office of the Chief Financial Officer has introduced monthly reconciliation schedules to ensure that the Department produce accurate Annual Financial Statements. The Department has established committee to monitor the

investigation of Unauthorised, Irregular and Fruitless and Wasteful expenditure on a monthly basis.

More work to ensure that the Department is moving towards the right direction will be done so that the people of Mpumalanga and South Africa benefit on a well implemented health system.

MR C.P. MASHEGO
MEC: HEALTH

07/04/2017
DATE

3.2. STATEMEMENT BY THE HEAD OF DEPARTMENT (HOD)

The Mpumalanga province's population has significantly grown. According to Census 2016 survey, the population in the province has grown by 7.3%. The increase in the population warrants more resources for attainment of health outcomes.

The department has taken note of these needs hence the infrastructure programme works around the clock to ensure that all health facilities are functional. This is a programme that builds, upgrade, renovate, rehabilitate and maintain health facilities. Despite the financial challenges the country is experiencing, more work has been carried out including upgrading of hospitals, clinics and Primary Health care facilities. To ensure that the public continues to have better health facilities.

The Ideal Clinic Realisation and Maintenance, is being implemented according to the guidelines to benefit all health care users at all levels of service. The Department is on course to ensure that more clinics reach the Ideal Status by 2019.

The Department has (43) School Health Teams established throughout the Province, 13 of which were appointed during 2016/17 financial year. Since 2012, the teams have managed to assess Three Hundred and Fifty Four Two Hundred and Ninety Six (354 296) learners and referred Fifty Three Thousand and Forty Four (53 044) for further management.

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. As a province we have long declared an intensive fight against these quadruple burden of diseases. In Mpumalanga, a decrease of 15% was recorded in the number of TB case findings. The TB client treatment success rate was standing at 88.6% in 2015/16 financial year.

The Department's resolution to fight Malaria, is still on course. Malaria continues to contribute to the reduction in life expectancy and is associated with more than one million deaths per annum in Africa.

Diet-related non-communicable ailments such as obesity, diabetes and cardiovascular disease account for a large proportion of South Africa's disease burden, with approximately two (2) out of five (5) deaths in South Africa (RSA) attributable to non-communicable disease conditions (NCDs). The Department has also declared war on the fight against these diseases.

The Department will continue to manage its finances better to ensure that there is no more qualified reports and irregular expenditures. Systems have also been placed to manage movable and immovable assets. All this to ensure that better health services are offered to the people of the province of the Rising Sun.

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DR S MOHANGI
HEAD: HEALTH

07/04/2017

DATE

3.3. OFFICIAL SIGN OFF OF THE PROVINCIAL APP BY THE CHIEF FINANCIAL OFFICER; HEAD OF STRATEGIC PLANNING; HOD AND MEC FOR HEALTH

The 2010 Treasury Guidelines require the Chief Financial Officer (CFO) and the Head of Strategic Planning in each Province to also sign off the APPs, as shown below.

It is hereby certified that this Annual Performance Plan:

- Was developed by the Provincial Department of Health in **Mpumalanga Province**.
- Was prepared in line with the current Strategic Plan of the Department of Health of Mpumalanga Province under the guidance of the **Executive Authority for Health, Mr GP Mashego**
- Accurately reflects the performance targets, which the Provincial Department of Health in **Mpumalanga Province** will endeavour to achieve given the resources made available in the budget for 2017/18**.**

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Mr C.B. Mnisi
Chief Financial Officer

2017/04/06
.....
Date

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Ms M.N. Shabangu
Chief Director: Integrated Health Planning

06/04/17
.....
Date

.....
Dr S Mohangi
Accounting Office

07/04/2017
.....
Date

APPROVED BY:

.....
Mr G.P. Mashego
Executive Authority

07/04/2017
.....
Date

PART A –

4. 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
- Appropriateness
- Timeousness
- Collectiveness
- Competency

4.4 STRATEGIC GOALS

National Development Plan 2030

The National Development Plan (NDP) sets out nine (9) long-term health goals for South Africa. Five of these goals relate to improving the health and well-being of the population, and the other four deals with aspects of health systems strengthening.

By 2030, South Africa should have:

1. Raised the life expectancy of South Africans to at least 70 years;
2. Progressively improve TB prevention and cure
3. Reduce maternal, infant and child mortality
4. Significantly reduce prevalence of non-communicable diseases
5. Reduce injury, accidents and violence by 50 percent from 2010 levels
6. Complete Health system reforms
7. Primary healthcare teams provide care to families and communities

8. Universal health care coverage
9. Fill posts with skilled, committed and competent individuals

Sustainable Development Goals 2030

The Sustainable Development Goals 2030 built on Millennium Development Goals 2015 were adopted as Global Goals by the world leaders on 25 September 2015. There are 17 Sustainable Development Goals (SDGs) to end poverty, fight in equality and tackle climate change by 2030.

There are 13 targets in Goal 3 “Ensure healthy lives and promote well-being for all at all ages”. There are:

1. By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
2. By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
3. By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
4. By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being, strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
5. By 2020, halve the number of global deaths and injuries from road traffic accidents
6. By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
7. Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
8. By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
9. Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
10. Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

11. Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States
12. Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

NDP Goals 2030	SDG Goals 2030
Average male and female life expectancy at birth increased to 70 years	
Tuberculosis (TB) prevention and cure progressively improved;	• End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
Maternal, infant and child mortality reduced	• Reduce the global maternal mortality ratio to less than 70 per 100,000 live births. • End preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
Prevalence of Non-Communicable Diseases reduced	• Reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol • Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
Injury, accidents and violence reduced by 50% from 2010 levels	• By 2020, halve the number of global deaths and injuries from road traffic accidents
Health systems reforms completed	• Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
Primary health care teams deployed to provide care to families and communities	• ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

NDP Goals 2030	SDG Goals 2030
Universal health coverage achieved	• Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
Posts filled with skilled, committed and competent individuals	• Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States

Strategic Goals 2020

TABLE A1: STRATEGIC GOALS AND STRATEGIC OBJECTIVES

STRATEGIC GOAL	GOAL STATEMENT	STRATEGIC OBJECTIVE STATEMENT	LINKAGE WITH MTSF 2014-2019
1. To improve access to health care services and continuously attain health care outcome	To improve access to health care services and continuously attaining health outcome thereby rolling out NHI, improving quality of service, implementing ward base outreach teams, reducing HIV new infection, Improving TB cure rate, reducing maternal & child mortality and implementation of other health care programmes	• Expand access to health care services • Improve health care outcomes • Improve quality of health care	• Universal Health coverage progressively achieved through implementation of National Health Insurance • HIV & AIDS and Tuberculosis prevented and successfully managed • Maternal, infant and child mortality reduced • Implement the re-engineering of Primary Health Care • Improved quality of health care
2. Overhaul health system and progressively reduce health care cost	Overhaul health system and progressively reduce health care cost by executing WISN system, improving human resource management, strengthening leadership in health facilities, accelerating delivery of infrastructure, strengthening of health information system and provision of efficient support to health care service	• Re-alignment of human resource to Departmental needs • Strengthening Health Systems Effectiveness • Improved health facility planning and accelerate infrastructure delivery	• Improved health facility planning and infrastructure delivery • Efficient Health Management Information System developed and implemented for improved decision making • Improved health management and leadership • Improved human resources for health • Reduced health care costs

TABLE A2: IMPACT INDICATORS AND TARGETS

Impact Indicator	South Africa Baseline (2009[1])	South Africa Baseline (2014[2])	2019 Targets (South Africa)	2012 Baseline (Province)	2019 Target (Province) (Consistent with targets with your SP 2020)
Life expectancy at birth: Total	57.1 years	62.9 years (increase of 3,5years)	Life expectancy of at least 65 years by March 2019	59.3 (Statistics SA: Mid-year Population Estimates 2013)	67 years
Life expectancy at birth: Male	54.6 years	60.0 years	Life expectancy of at least 61.5 years amongst Males by March 2019 (increase of 3 years)	51.5 years (Statistics SA: Mid-year Population Estimates 2013)	55 years
Life expectancy at birth: Female	59.7 years	65.8 years	Life expectancy of at least 67 years amongst females by March 2019 (increase of 3years)	55.5years (Statistics SA: Mid-year Population Estimates 2013)	60 years
Under-5 Mortality Rate (U5MR)	56 per 1,000 live-births	39 under 5 deaths per 1,000 live-births (25% decrease)	33 under 5 year deaths per 1,000 live-births by March 2019	5.6 per 1000 live births	5 per 1000 live births
Neonatal Mortality Rate	-	14 neonatal deaths per 1000 live births	8 neonate deaths per 1000 live births	No data	6 per 1000 live births

[1] Medical Research Council (2014): Rapid Mortality Surveillance (RMS) Report 2015
[2] Medical Research Council (2014): Rapid Mortality Surveillance (RMS) Report 2015

Impact Indicator	South Africa Baseline (20091)	South Africa Baseline (20142)	2019 Targets (South Africa)	2012 Baseline (Province)	2019 Target (Province) (Consistent with targets with your SP 2020)
Infant Mortality Rate (IMR)	39 per 1,000 live-births	28 infant deaths per 1,000 live-births (25% decrease)	23 infant deaths per 1000 live births (15% decrease)	9.7 per 1000 live births	6 per 1000 live births
Maternal Mortality Ratio	280 per 100,000 live-births (2008 data)	269 maternal deaths per 100,000 live-births (2010 data)	<100 maternal deaths per 100,000live-births by March 2019	196.3/100 000 live births	< 50 per 100 000 live births
Live Birth under 2500g in facility rate		12.9%	11.6% (10 percentage point reduction)	No data	8%

4.5 SITUATIONAL ANALYSIS

4.5.1 Demographic Profile

Mpumalanga Province, with a total surface area of 76 495 square kilometres, is the second smallest province after Gauteng, taking up 6.3% of South Africa's total land area and with a population of just over 4,3-million people. The Province is located in the north-eastern part of country bordering Swaziland to the south-east and Mozambique to the east. It 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 (see figure 1 below).

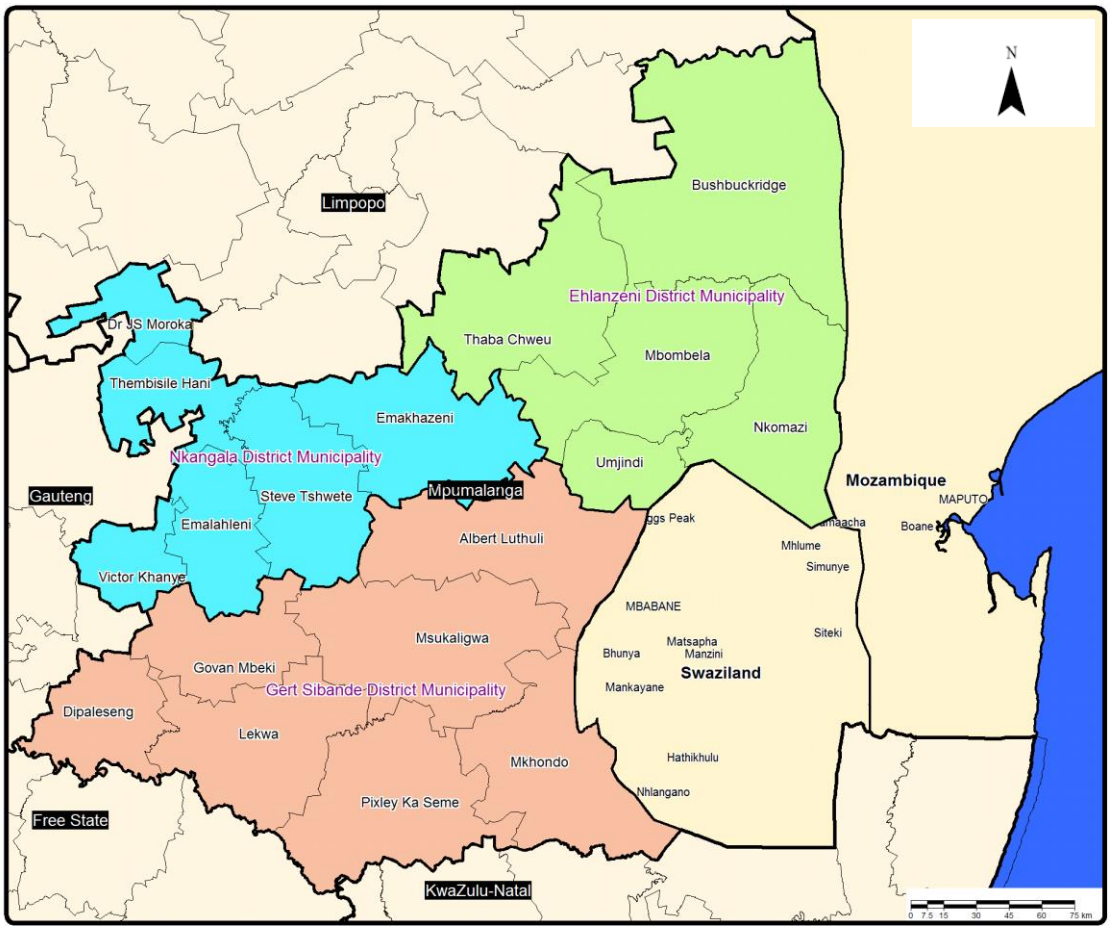


Figure 1: Mpumalanga Health Districts
Source: Mpumalanga Department of Health Information System, NHIRD-GIS

Other major towns include eMalahleni (Witbank), Ermelo, Standerton, Piet Retief, Secunda, Barberton, Malelane and Sabie. The best-performing sectors in the province include agriculture, mining, manufacturing, tourism and electricity generation. The following are the main economic activities per selected main towns:

Table 1: Main Towns and Economic Activities

Main Town	Economic Activity
eMalahleni	Mining, steel manufacturing, industry, agriculture
Middelburg	Stainless steel production, agriculture
Secunda	Power generation, coal processing
Mashishing	Agriculture, fish farming, mining, tourism
Malelane	Tourism, sugar production, agriculture
Barberton	Mining town, correctional services, farming centre

Source: CS 2016: Community Survey STATSSA

The community survey of 2016 by Statistics South Africa indicates that Mpumalanga population grew from 3,365,554 to 4,335,964 (CS 2016). A comparative analysis of population growth in the past 20 years, between 1996 and 2016 in Table 2 below, reflects a growth of 28%, demonstrating an addition of 605,888 people per annum. Furthermore, Mpumalanga Province has the sixth largest share of the South African population, constituting approximately 7.8% of the national population of 55,653,655 and distributed across three districts comprising nineteen municipalities. Males represent 49.3% (50.7% females) of the population with youth of the age 15-34 years accounting for 38.4% total population in the province.

Table 2: Percentage distribution of projected share of total population: 1996-2016

Provinces	Census 1996	Census 2001	% Change 1996/2001	CS 2007	Census 2011	CS 2016	% Change 2011/2016
Eastern Cape	6,147,244	6,278,651	2.1	6,527,747	6,562,053	6,996,976	6.6
Free State	2,633,504	2,706,775	2.8	2,773,059	2,745,590	2,834,714	3.2
Gauteng	7,624,893	9,178,873	20.1	10,451,713	12,272,263	13,399,725	9.2
Kwazulu-Natal	8,572,302	9,584,129	11.8	10,259,230	10,267,300	11,065,240	7.8
Limpopo	4,576,133	4,995,534	9.2	5,238,286	5,404,868	5,799,090	7.3
Mpumalanga	**3,124,203**	**3,365,885**	**7.7**	**3,643,435**	**4,039,939**	**4,335,964**	**7.3**
Northern Cape	1,011,864	1,058,060	4.6	1,058,060	1,145,861	1,193,780	4.2
North West	2,936,554	3,271,948	11.4	3,271,948	3,509,953	3,748,436	6.8
Western Cape	3,956,875	4,524,335	14.3	5278585	5,822,734	6,279,730	7.8
South Africa	40,583,573	44,819,778	10.4	48,502,063	51,770,560	55,653,655	7.5

(Source: Census 1996: Census 2001, Community Survey 2007, Census 2011, and CS 2016)

Provincial Population Pyramids

The figure below shows the provincial pyramid as per the community survey of 2016 indicating a tremendous growth of 7.3% as compared to Census 2011. The pyramid shows that there is a large proportion of females in all the ages with the exception of young age group (from 0 to 29) where proportion of males is higher. Furthermore, it can be deduced from the figure below that there is a marked decrease in both males and females aged 5 to 14.

The increase in the population warrant more resources for attainment of health outcomes, furthermore it re-emphasise prioritizing on mother and child programme. Further analysis should be done since this is a nationwide phenomenon. The same observation has been noticed in the three districts as depicted in the subsequent section.

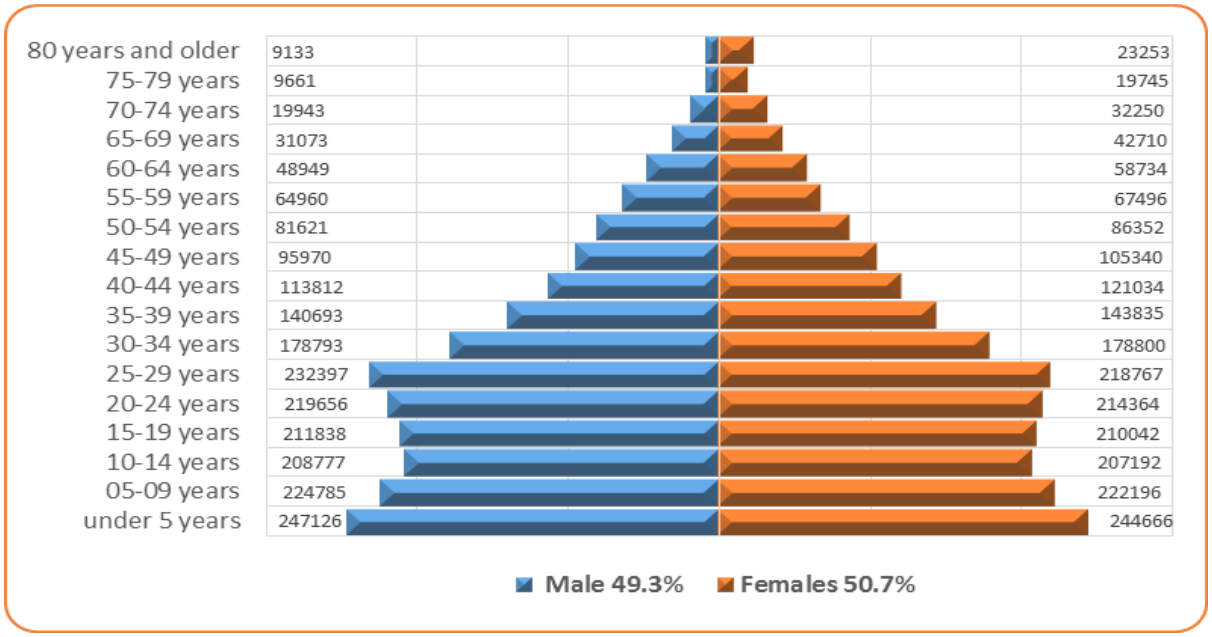
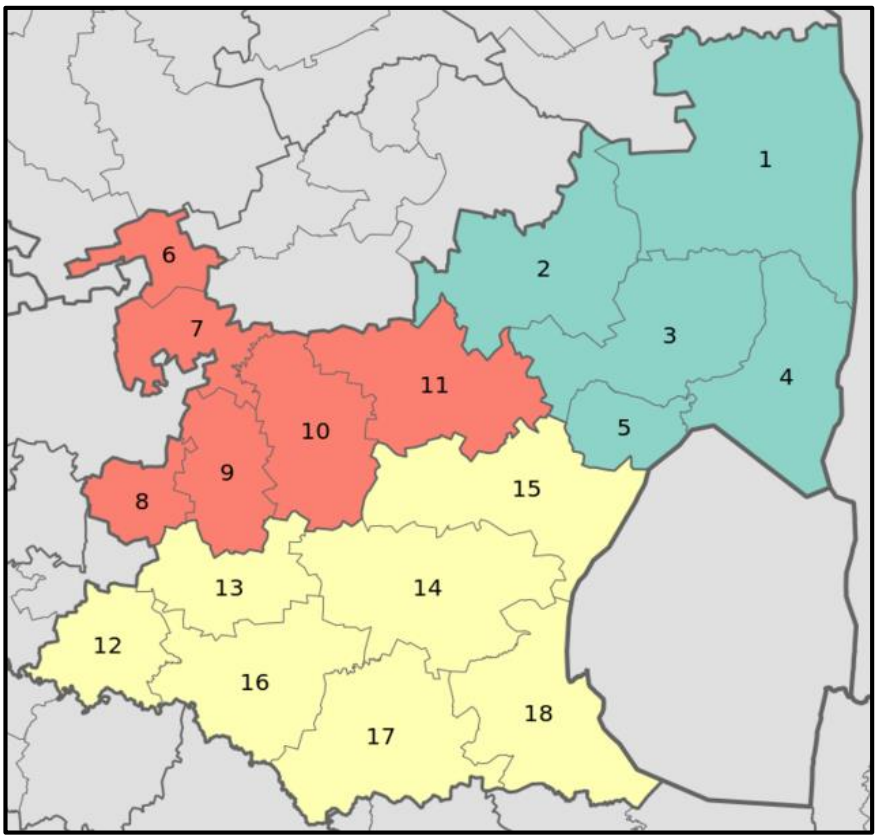


Figure 2: Population pyramid: Gender vs. Age (CS 2016)

Mpumalanga Health Districts

Mpumalanga Province consists of three districts, namely Ehlanzeni, Gert Sibande and Nkangala Districts and are shown in figure 3 below.



LEGEND	DISTRICT	AREA
1–5	Ehlanzeni District Municipality	27,896
12–18	Gert Sibande District Municipality	31,841
6–11	Nkangala District Municipality	16,758
	MUNICIPALITIES	
15	Albert Luthuli Local Municipality	5,559
1	Bushbuckridge Local Municipality	10,250
3	Mbombela Local Municipality	5,394
4	Nkomazi Local Municipality	4,787
2	Thaba Chweu Local Municipality	5,719
5	Umjindi Local Municipality	1,745
12	Dipaleseng Local Municipality	2,617
13	Govan Mbeki Local Municipality	2,955
16	Lekwa Local Municipality	4,585
18	Mkhondo Local Municipality	4,882
14	Msukaligwa Local Municipality	6,016
17	Pixley Ka Seme Local Municipality	5,227
6	Dr JS Moroka Local Municipality	1,416
11	Emakhazeni Local Municipality	4,736
9	Emalahleni Local Municipality	2,678
10	Steve Tshwete Local Municipality	3,976
7	Thembisile Hani Local Municipality	2,384
8	Victor Khanye Local Municipality	1,568

Figure 3: Mpumalanga Health Districts
Source: Mpumalanga Department of Health Information System, NHIRD-GIS

Ehlanzeni District has a catchment population of 1,754,931 (CS 2016) 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. The district comprises of more people per square meter that Gert Sibande District.

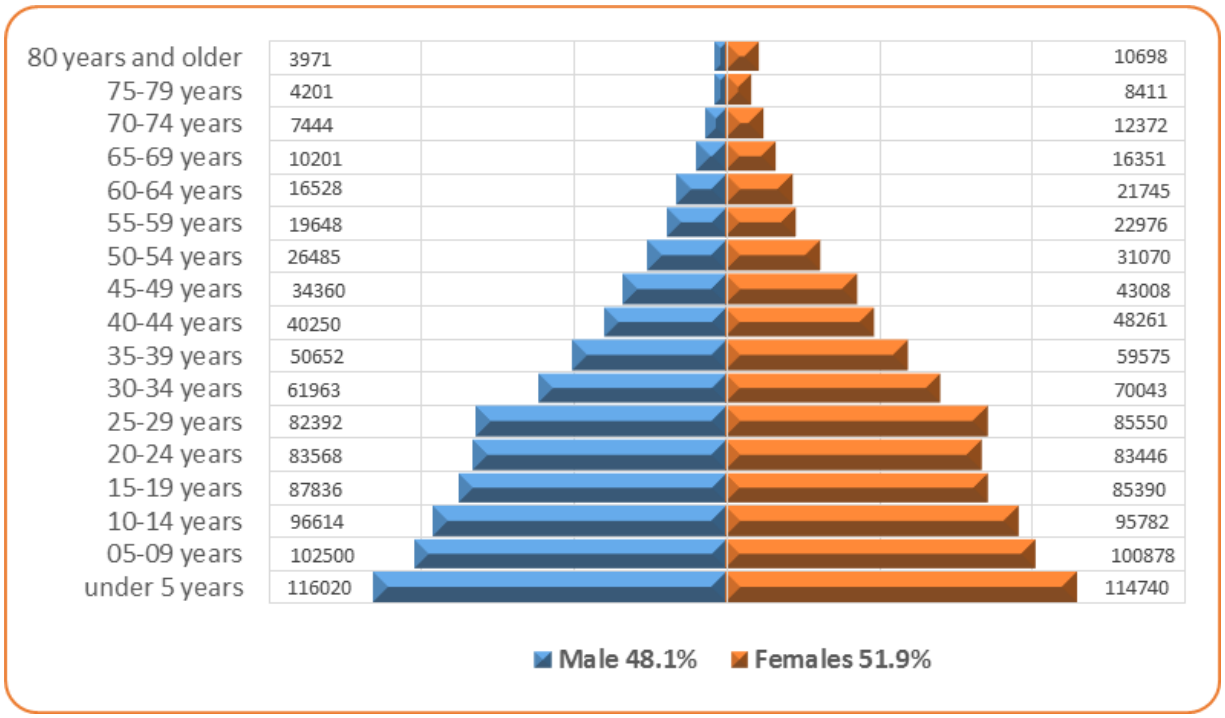


Figure 1: Ehlanzeni District: Source CS 2016

Ehlanzeni District depict similar pattern as the provincial pyramid with large proportions of females in all age categories except from the age group under 5 to age 24, where the proportion of males is higher (Indicated in figure 4 above).

Demographics in Gert Sibande District

Gert Sibande District has a catchment population 1,135,409 (CS 2016) which is less than the other two districts. It consists of seven sub-districts, which are Albert Luthuli, Dipaliseng, Govan Mbeki, Lekwa, Mkhonto, Msukaligwa, Pixley Ka Seme. The district has the highest total surface area of 31 841 square kilometres, with the least number of people per square meter.

With regard to gender distribution, Gert Sibande District Municipality almost shows an equal distribution of males and females, with males contributing 49.7%, while females at 50.3%, a 0.3% higher than males (see figure 5 below). It can also be noted that the age group 25-29 contribute the highest proportion of both males and females.

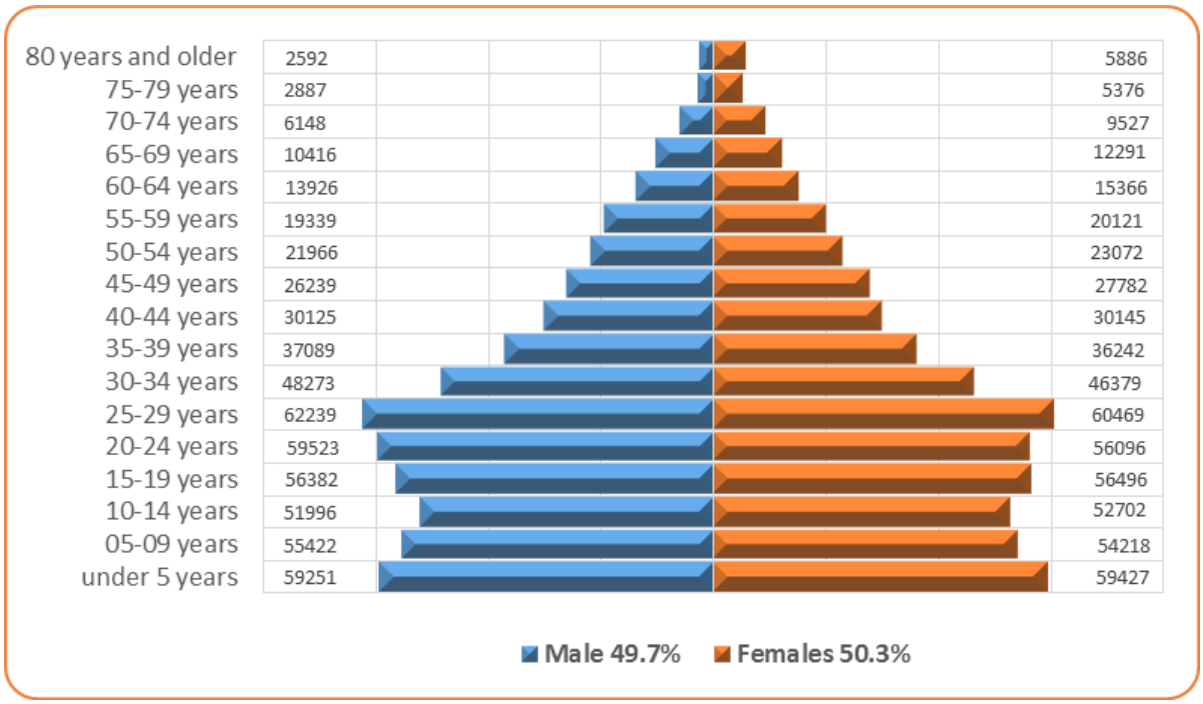


Figure 2: Gert Sibande District: Source CS 2016

Demographics in Nkangala District

Nkangala District has a catchment population of 1,445,624 (CS 2016) and consists of six sub-districts which are Dr JS Moroka, Thembisile, Emalahleni, Emakhazeni, Dr Victor Khanye and Steve Tshwete.

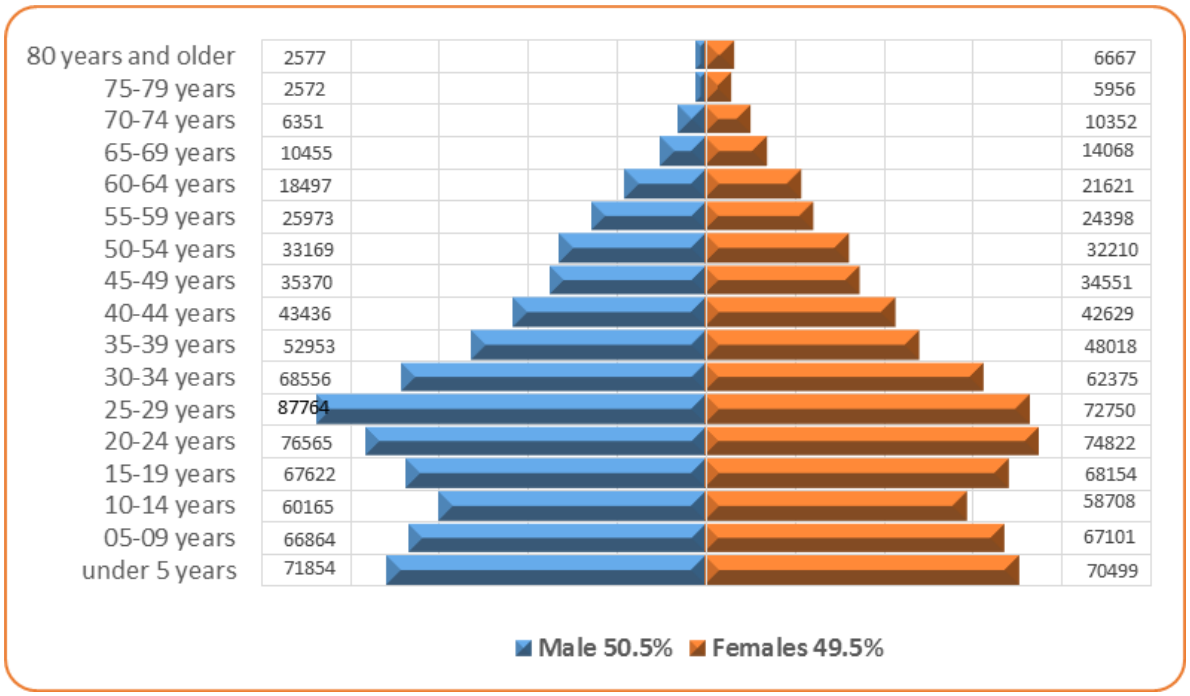


Figure 3: Nkangala District Municipality: Source CS 2016

The proportion of males is slightly above that of females at Nkangala District Municipality. Males contribute 50.5% of the total population, while females at 49.5% (see figure 4 below). This is in contrast to the provincial proportions, which depicts females slightly above the males.

Population by Geographic Distribution (Districts)

The table below shows that from 2001 to 2016, Mpumalanga Province recorded 28.8% of population growth. Nkangala District experience the highest population growth of 41.9%, which can be attributed to economic activities as discussed above.

Table 3: Population by Geographic Distribution (Districts)

District Municipality	Population (Census 2001)	Population (Community Survey 2007)	Population (Census 2011)	Population Community Survey 2016	% Change from 2001-2016
Ehlanzeni District Municipality	1,447,053	1,526,236	1,688,615	1,754,931	21.3
Gert Sibande District Municipality	900,007	890,699	1,043,194	1,135,409	26.2
Nkangala District Municipality	1,018,826	1,226,500	1,308,129	1,445,624	41.9
Total	**3,365,885**	**3 ,643,435**	**4,039,939**	**4,335,964**	**28.8**

(Source: Stats SA 2007: Census 2001, Community Survey 2007, and Census 2011-Midyear estimates 2015, CS 2016)

Population by Geographic Distribution (Sub-Districts)

The province comprises of 18 local municipalities (sub-districts) in the three districts as indicated in Table 4 below.

From the year 2001 to 2016 (15 year period), Steve Tshwete Local Municipality almost doubled the population size, with a percentage change of 95.2. It is followed by Emalahleni Local Municipality at a percentage change of 64.7 population growth from 2001 to 2016. Govan Mbeki and Victor Khanye Local Municipalities registered 53.4 and 49.7 respectively of population growth in a 15-year period, which affect access to health care services.

Only Chief Albert Luthuli Local Municipality registered a negative population growth of -0.2. Dr JS Moroka and Pixley Ka Seme Local Municipalities grew by less than 10% for the period 2001 to 2016, as indicated in Table 4 below.

Table 4: Population by Geographic Distribution (Local Municipalities) within the total population per municipality

Local Municipality	Population (Census 2001)	Population (Community Survey 2007)	Population (Census 2011)	Population (Community Survey 2016)	% Change from 2001-2016
Thaba Chweu	81,681	87,545	98,387	101,895	24.7
Mbombela	476,593	527,203	588,794	622,158	30.5
Umjindi	53,744	60,475	67,156	71,211	32.5
Nkomazi	334,420	338,095	393,030	410,907	22.9
Bushbuckridge	497,958	509,970	541,248	548,760	10.2
Kruger National Park	2,656	2,948	-	-	-
Ehlanzeni	**1 447 053**	**152 6236**	**1,688,615**	**1,754,931**	**21.3**

Local Municipality	Population (Census 2001)	Population (Community Survey 2007)	Population (Census 2011)	Population (Community Survey 2016)	% Change from 2001-2016
Albert Luthuli	187,936	194,083	186,010	187,630	-0.2
Dipaleseng	38,618	37,873	42,390	45,232	17.1
Govan Mbeki	221,747	268,954	294,538	340,091	53.4
Lekwa	103,265	91,136	115,662	123,419	19.5
Mkhondo	142,892	106,452	171,982	189,036	32.3
Msukaligwa	124,812	126,268	149,377	164,608	31.9
Pixley Ka Seme	80,737	65,932	83,235	85,395	5.8
Gert Sibande	**900 007**	**890 699**	**1,043,194**	**1,135,409**	**26.2**
Dr JS Moroka	243,313	246,969	249,705	246,016	1.1
Emakhazeni	43,007	32,840	47,216	48,149	12.0
Emalahleni	276,413	435,217	395,466	455,228	64.7
Steve Tshwete	142,772	182,503	229,831	278,749	95.2
Thembisile	257,113	278,517	310,458	333,331	29.6
Victor Khanye	56,208	50,455	75,452	84,151	49.7
Nkangala Total	**1,018,826**	**1,226,500**	**1,308,129**	**1,445,624**	**41.9**
Mpumalanga Total	**3,365,885**	**3,643,435**	**4,235,608**	**4,335,964**	**28.8**

(Source: Stats SA 2007: Census 2001, Community Survey 2007, and Census 2011-Midyear estimates 2015, CS 2016)

4.5.2 Socio-Economic Profile

Mpumalanga is ranked the third most rural province in South Africa with 56% of its total population living in rural areas (CS 2016). 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 one of the extremely rural provinces in South Africa, which will affect access to health care services. It is indicated from the table below that majority of the people in Mpumalanga reside in rural areas.

Table 5: Rural vs. Urban Areas of Mpumalanga Province

	2016 Classification of Population			
	South Africa		Mpumalanga	
	Frequency	Percentage	Frequency	Percentage
Traditional	18019427	32.4	2127106	49.1
Farms	2178781	3.9	297683	6.9
Urban	35455447	63.7	1911175	44.1
Total	**55653654**	**100.0**	**4335964**	**100.0**

(Source: CS 2016)

Of the 56% living in rural areas, approximately 88% lives in traditional rural villages, while 12% live in farm areas. It is expected that the majority of these people rely on public healthcare facilities. At present, the Provincial Department of Health comprises of 33 hospitals and 279 Primary Health Care Facilities (Annual Performance Plan, 2015/16). These facilities together with mobile clinics service a total number of approximately 2 424 789 people residing in rural and farm areas (StatsSA, 2016). The main challenge with people living in rural areas is that there are often fewer doctors and dentists, and certain specialists might not be available at all. Furthermore, there are still pockets of villages without healthcare services, with most relying on scheduled visits by mobile clinics.

Climate change

Climate change is a new threat to public health and to the advances 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.

Access to basic services

Lack of basic services such as roads, water, and refuse removal greatly affects the supply of healthcare services to communities, and therefore needs to be considered when allocating healthcare resources. Five leading challenges facing the municipality presently as perceived by households by province, as percentage of all main challenges, CS 2016:

- 30.6% indicated lack of safe and reliable water supply;
- 13.2% indicated lack of / Inadequate employment opportunities;
- 11.4% indicated inadequate roads;
- 7.0% indicated cost of electricity;
- 6.8% indicated cost of water.

Table 6: Percentage households with no access to improved sanitation

Main Type of Toilet Facility	Frequency	Percentage
Flush toilet connected to a public sewerage system	1717273	39.6
Flush toilet connected to a septic tank or conservancy tank	106880	2.5
Chemical toilet	146208	3.4
Pit latrine/toilet with ventilation pipe	707532	16.3
Pit latrine/toilet without ventilation pipe	1350560	31.1
Ecological toilet (e.g. urine diversion; enviroloo; etc.)	22333	0.5
Bucket toilet (collected by municipality)	7605	0.2
Bucket toilet (emptied by household)	29058	0.7
Other	128618	3.0
None	119896	2.8
Grand Total	**4335964**	**100.0**

Source: CS 2016

The tables above illustrates the severity of lack of basics services in the province.

- One percent of the people in Mpumalanga Province still uses bucket toilets, while 5.8% either uses a different form of toilet system or do not have toilets;

- About 3.7% fetch water from river, dam, stream, well, spring or any other than the tap, which may expose people to a number of diseases;
- About 6.0% do not have refuse removal;
- About 6.8% have no access to electricity for lighting.

Table 7: Percentage households with no access to electricity for lighting

Main Source of Water	Frequency	Percentage
Piped (tap) water inside the dwelling/house	1210646	27.9
Piped (tap) water inside yard	1980179	45.7
Piped water on community stand	236394	5.5
Borehole in the yard	76193	1.8
Rain-water tank in yard	19333	0.4
Neighbours tap	165916	3.8
Public/communal tap	220698	5.1
Water-carrier/tanker	175090	4.0
Borehole outside the yard	90998	2.1
Flowing water/stream/river	93967	2.2
Well	7097	0.2
Spring	10810	0.2
Other	48644	1.1
Grand Total	**4335964**	**100.0**

Source: CS 2016

Table 8: Percentage households with no access to refuse removal by local authority or private company

Access to refuse removal	Frequency	Percentage
Removed by local authority/private company/community members at least once a week	1598974	36.9
Removed by local authority/private company/community members less often than once a week	131876	3.0
Communal refuse dump	183389	4.2
Communal container/central collection point	39743	0.9
Own refuse dump	2054914	47.4
Dump or leave rubbish anywhere (no rubbish disposal)	260346	6.0
Other	66722	1.5
Grand Total	**4335964**	**100.0**

Source: CS 2016

Table 9: Percentage households with no access to electricity for lighting

Access to electricity	Frequency	Percentage
In-house conventional meter	416614	9.6
In-house prepaid meter	3531211	81.4
Connected to other source which household pays for (e.g. con	35088	0.8
Connected to other source which household is not paying for	26041	0.6
Generator	4242	0.1
Solar home system	3478	0.1
Battery	567	0.0
Other	24644	0.6
No access to electricity	294078	6.8
Grand Total	**4335964**	**100.0**

Source: CS 2016

Reliance on Public Facilities

The 2015 General Household Survey reveals that seven in every ten (70,5%) households in the country went to public clinics and hospitals as their first point of access when household members fell ill or got injured, with many households (92.8%) using the nearest health facility. Figure 7 below illustrate the population belonging to a medical aid scheme as per General Household Survey of 2015 increased slightly from 14.5% in 2011 to 15.5% in 2015.

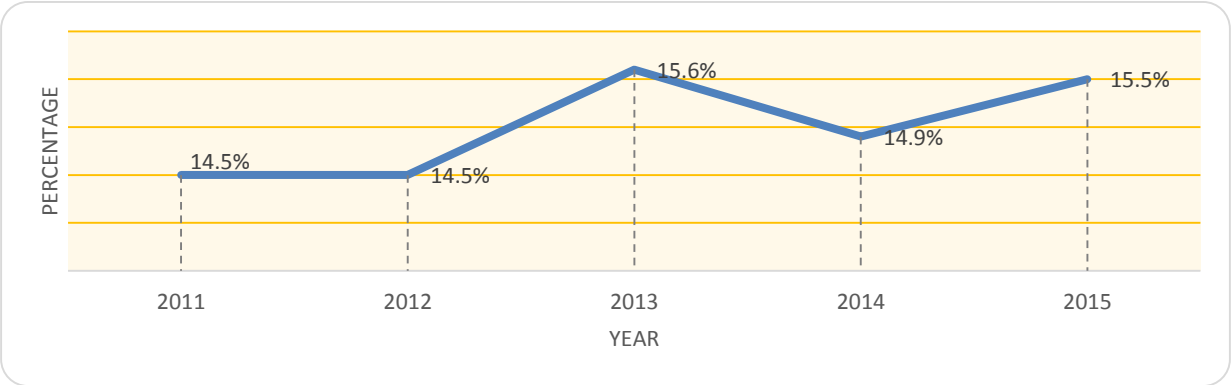


Figure 7: Illustrates insured and uninsured population (Source...)

Uninsured Population

StatsSA (Quarterly Labour Force Survey: Quarter: 1:2016), indicates that approximately 88% of total population is uninsured and rely on the public health sector for health care, placing an excessive burden on the primary health care system in Mpumalanga. The table below further illustrates the reason for people relying on the public health sector for health care.

Table 10: Unemployment Rate by Province

Province	Official Unemployment rate (Jan-Mar 2016)*	Year-on-Year change	Expanded Unemployment Rate (Jan-Mar 2016)**	Year-on-Year change
South Africa	26.7	0.3	36.3	0.2
Western Cape	20.9	-0.1	23.0	-0.3
Eastern Cape	28.6	-1.0	44.5	1.3
Northern Cape	27.8	-6.3	38.7	-3.9
Free State	33.9	3.5	39.4	1.0
KwaZulu-Natal	23.2	-0.4	39.3	1.1
North West	28.1	-0.3	43.0	-0.2
Gauteng	30.1	1.7	33.3	0.5
Mpumalanga	**29.8**	**1.4**	**41.2**	**0.5**
Limpopo	18.2	-1.9	38.4	-2.4

Source: StatsSA (Quarterly Labour Force Survey: Quarter: 1:2016)
* According to the strict definition, only those people who take active steps to find employment, but fail to do so, are regarded as unemployed.
** The expanded definition, on the other hand, includes everyone who desires employment, irrespective of whether or not they actively tried to obtain a job.

According the Quarterly Labour Force Survey (Quarter 1: 2016), Mpumalanga Province comprises of a labour force participation rate of 59.3%. Of this, 41.7% were employed, while the employment rate is at 29.8%. A higher unemployment rate represents a higher demand on public health care services. An increased unemployment rate 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 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 determine people's chances to be healthy.

4.5.3 Epidemiological Profile

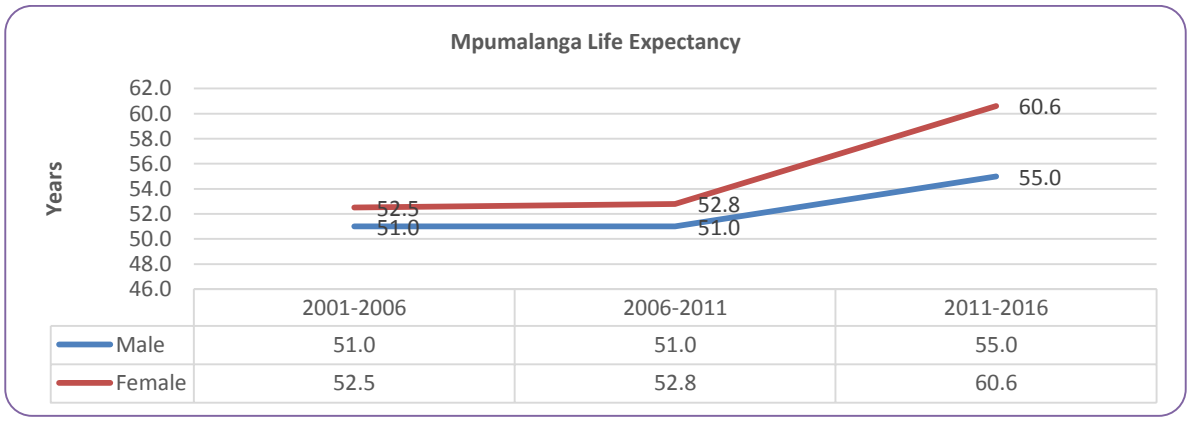
Mpumalanga Province like the rest of the country faces a quadruple burden of diseases. HIV and AIDS, Tuberculosis, high Maternal and Child Mortality, Non-Communicable Diseases and Violence and Injuries continue to take a toll on the Province's citizens. Compounding on these unfavourable conditions, are adverse socio-economic determinants such as poverty and inadequate access to essential services such as electricity, proper sanitation and access to potable water.

This quadruple burden of diseases is occurring in the face of a reasonable amount of health expenditure as a proportion of the GDP (Gross Domestic Product). 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.

There is high still inequity to provision of health care services where majority of the population relying on a public health care system, relative to the private sector serving approximately 12% 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.

LIFE EXPECTANCY

Though it was reported in the past that life expectancy in South Africa has been declining, the rapid mortality surveillance report 2011 indicates that life expectancy started to increase since 2005. For males, the life expectancy in South Africa 53.6 in 2002 to 59.7 in 2016. Whereas for females it increased from 56.6 in 2002 to 65.1 in 2016. The average life expectancy for South Africa in 2016 is 62.4 (Mid-Year Estimates, 2016 StatsSA). According to Statistics South Africa, life expectancy for males in the province increased from 49.1 in 2001 to 55.0 in 2016, whereas for females increased from 50.8 in 2001 to 60.6 in 2016 as illustrated in the figure below. The average life expectancy for Mpumalanga Province is 57.8 years (Mid-Year Estimates, 2016 StatsSA). This shows that there has been an improvement as results of mainly ART rollout and Prevention of Mother-to-Child Transmission (PMTCT) programmes.



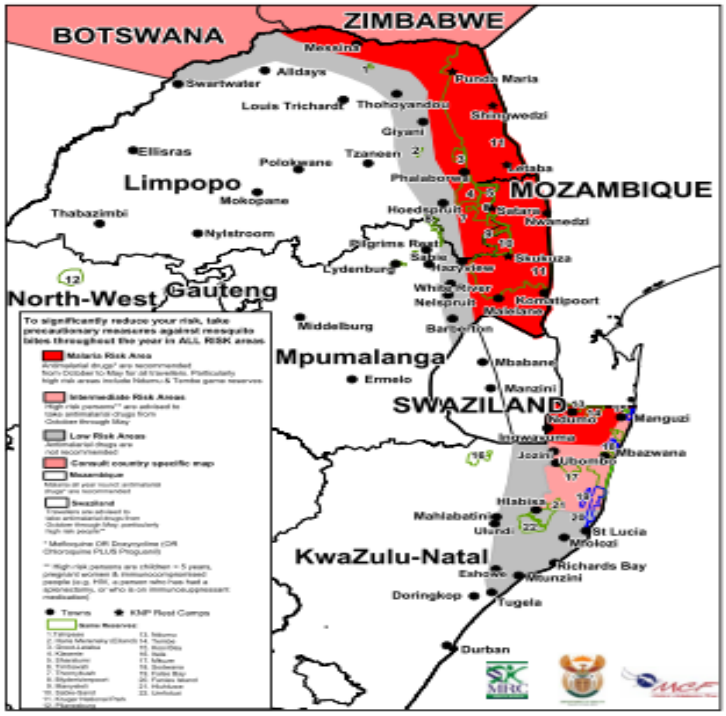
	2001-2006	2006-2011	2011-2016
Male	51.0	51.0	55.0
Female	52.5	52.8	60.6

Figure 8: Illustrates life expectancy pattern since 2001 – 2016

Source: Mid-year population estimates 2015, StatsSA

Malaria High Risk Areas in South Africa

The Department resolution to fight malaria, is still on course. Malaria continues to contribute to the reduction in life expectancy and is associated with more than one million deaths per annum in Africa. Most deaths occur in children under the age of five years. In South Africa, malaria control is exacerbated by management of the disease by our neighbouring countries (See figure 9).



Mpumalanga as one of three provinces endemic for malaria, is progressively doing well on the Management of Malaria. Malaria transmission normally occurs in October after the first rains with high peaks in January and February and waning towards May. An estimated 1,688,615 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.

Figure 9: Malaria High Risk Areas in South

Source: National Department of Health

Diet-related non-communicable ailments such as obesity, diabetes and cardiovascular disease account for a large proportion of South Africa's disease burden, with approximately 2 out of 5 deaths in South Africa (RSA) attributable to non-communicable disease conditions (NCDs). Some 40% of NCD deaths among men and 29% among women are premature. One in four adults is obese and over half are overweight. Half of adults are physically inactive (WHO, 2016). Late detection of disease such as hypertension and diabetes results in increased costs, 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.

MATERNAL AND CHILD MORTALITY

Maternal mortality and morbidity in South Africa remains very high, and according to the 'Saving Mothers' report (2011 - 2013), about 26.7% of cases, the death was thought to have been *probably* avoidable and in a further 32.8%, the death was considered *possibly* avoidable. The South African National Strategic Plan for a Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA) states that these deaths are related to community, administrative and clinical factors. The 'Saving Mothers Report' (2011-2013) further states that the "big 5" causes of maternal deaths were non-pregnancy related infections (NPRI) (34.7%, mainly deaths due to HIV infection complicated by tuberculosis (TB), Pneumocystis Pneumonia and pneumonia), obstetric haemorrhage (15.8%), complications of hypertension in pregnancy (14.8%), medical and surgical disorders (11.4%) and pregnancy related sepsis (9.5%, includes septic miscarriage and puerperal sepsis).

The data in the province shows a steady decline in the Maternal mortality ratio from 166.1 (2012) per 100 000 live births to 108 (2014) per 100 000 live births. The vision is to continue to reduce maternal mortality through the implementation of Provincial Strategy on Reduction of Maternal and Child Mortality (2013), to address clinical factors, and Re-engineer Primary Health Care to improve some of community and administration related factors and strengthen a functional referral system as responsive support system of hospitals. According to the Millennium Development Goals Report (2013) Child, under five mortality rates in sub-Saharan Africa were very high in 1990 due to the high rate of HIV/AIDS. However, in 2007, mortality rates in South Africa started to decline as a number of HIV prevention and treatment programmes were implemented. Owing to this decline in HIV infections and other factors, United Nations (UN) estimates show that under-5 mortality dropped between the years 2000 and 2011 from 74 to 47 per 1000 live births.

The trend in the province of the under-5 deaths has shown an upswing after years of steady downward trends. Child facility mortality rate increased from 5.5/1000 (2012/13) to 8.3 /1000 in 2014/15 Infant mortality also increased from 8.3/1000 (2012/13) to 12/1000. The Second Report of the Committee on Morbidity and Mortality in Children under 5 years (CoMMiC) (2014), reported that the cause of deaths of the under 5 had a quarter (25.3%) of the total reported deaths being due to neonatal causes, whilst gastroenteritis accounted for (15%) and acute respiratory infections (mostly pneumonia) (13%) Non-natural causes (6%), malnutrition (4%), congenital abnormalities (4%) and tuberculosis (2%).

The Department has identified six areas of priority to contribute to the reduction of child mortalities:

- The promotion of early and exclusive breastfeeding, including ensuring that breastfeeding was made as safe as possible for HIV-exposed infants;
- The resuscitation of new-borns;
- The care for small or ill new-borns according to standardised protocols;
- The provision of initiatives for Prevention of Mother to Child Transmission (PMTCT);
- Kangaroo Mother Care (KMC);
- Post-natal visits within six days of childbirth.

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 23 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.

In 2013, the Mpumalanga provincial HIV prevalence amongst antenatal women was 37.3% a slight increase from 35.5% in 2012. This is the highest recorded figure so far in the province. The Mpumalanga HIV epidemic graph from 1990 to 2013 is shown in the figure below.

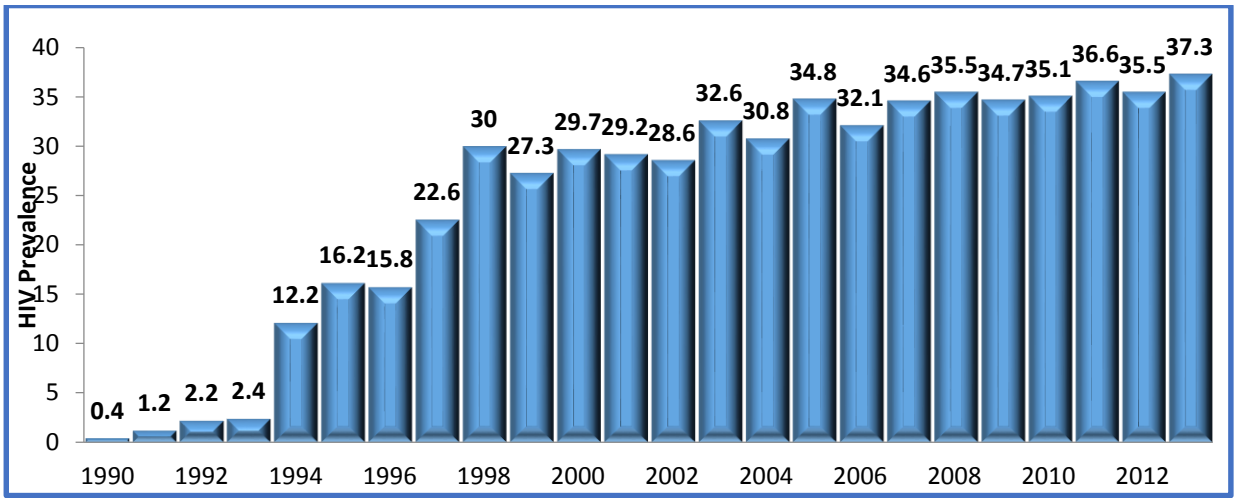


Figure 10: Mpumalanga HIV Epidemic Graph 1990 – 2013

***Source**: Mpumalanga Antenatal Sentinel HIV and Syphilis Prevalence Survey in Mpumalanga, 2013*

All three districts in Mpumalanga Province have shown an increase in the HIV prevalence from 2012 to 2013. The highest HIV prevalence is located in the Gert Sibande District with prevalence of 40.5% an increase of 0.5%, followed by Ehlanzeni and Nkangala with a prevalence of 37.2% and 34.5% respectively.

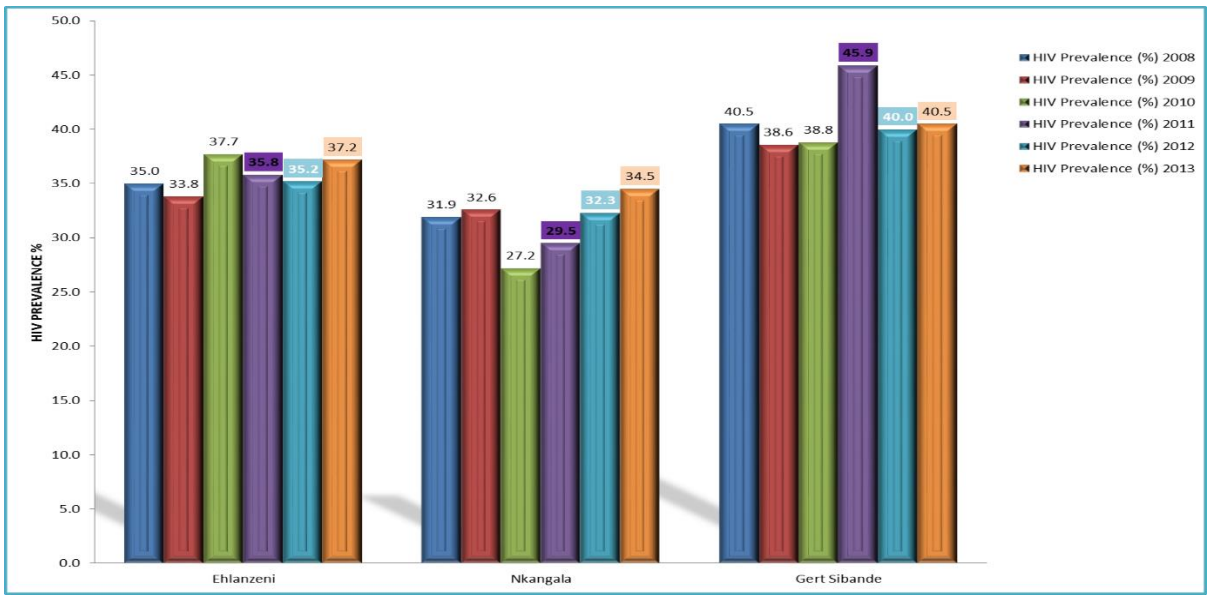


Figure 41: Mpumalanga HIV Epidemic Graph by District: 2008 – 2013

***Source**: Mpumalanga Antenatal Sentinel HIV and Syphilis Prevalence Survey in Mpumalanga, 2013*

In Mpumalanga, the age distribution of pregnant women who participated in the survey, ranged from 15 – 49 years old with some few outliers. The majority of the survey participants were teenagers and young women (15-24 year olds). In 2013, the HIV prevalence among 15-24 year olds (Millennium Development Goal 6, Target 7) is showing a slight increase from 23.9% in 2012 to 25.3% in 2013 (see figure below). HIV prevalence among the age group 15-19 also increased by 2% in 2013 from 14.3% in 2012 to 16.1% in 2013.

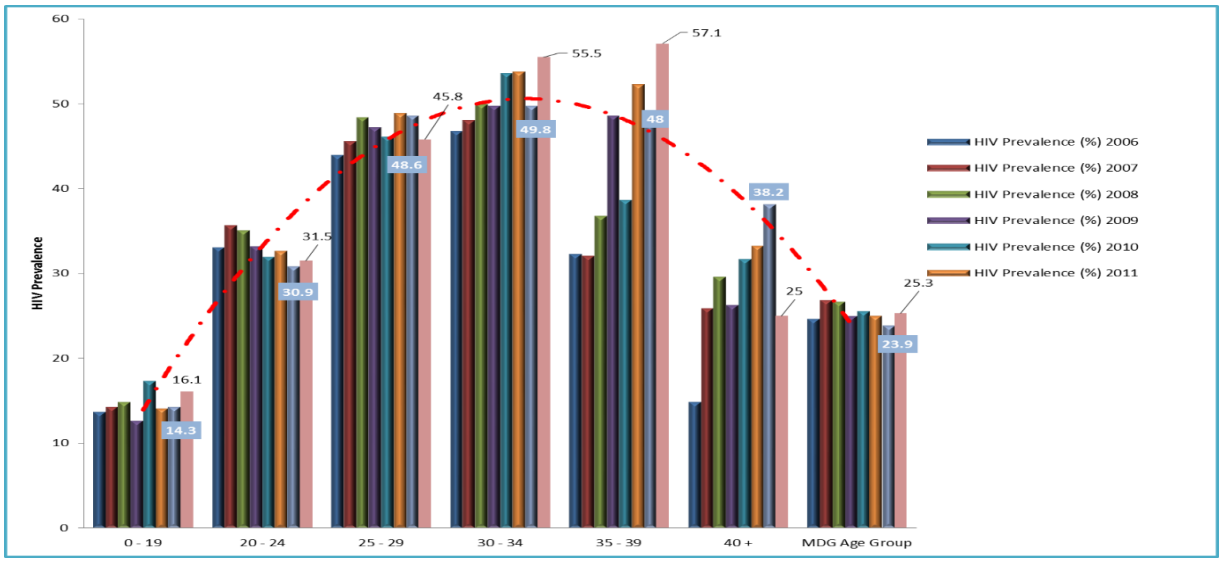


Figure 52: Mpumalanga HIV Epidemic Graph by Age group: 2006 – 2013

Source: National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2010 - 12

TB MANAGEMENT

According to the World Health Organisation (WHO) estimates, South Africa ranks the sixth highest in the world in terms of the TB burden (i.e. after India ,Indonesia, China, Nigeria , Pakistan) with an incidence that increased by 400% over the past 15 years. HIV is fuelling the TB epidemic with more than 60% of TB patients also living with HIV nationally.

Tuberculosis is both a medical condition and a social problem linked to poverty-related conditions. Townships and informal settlement conditions are characterised by overcrowding and low-socio economic status, all of which provide fertile ground for TB infection and disease. It is estimated that approximately 1% of the South African population develops TB disease every year.

Due to late detection, poor treatment, management and failure to retain TB patients on treatment, drug resistant forms of TB (MDR-TB and XDR-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.

In Mpumalanga, a decrease of 15% was recorded in the number of TB case findings from 23,312 in 2010, to 19,816 in 2014. Of these, 9,903 were from Ehlanzeni, 4,961 from Gert Sibande and 4,952 from Nkangala district as represented in Figure 12 below.

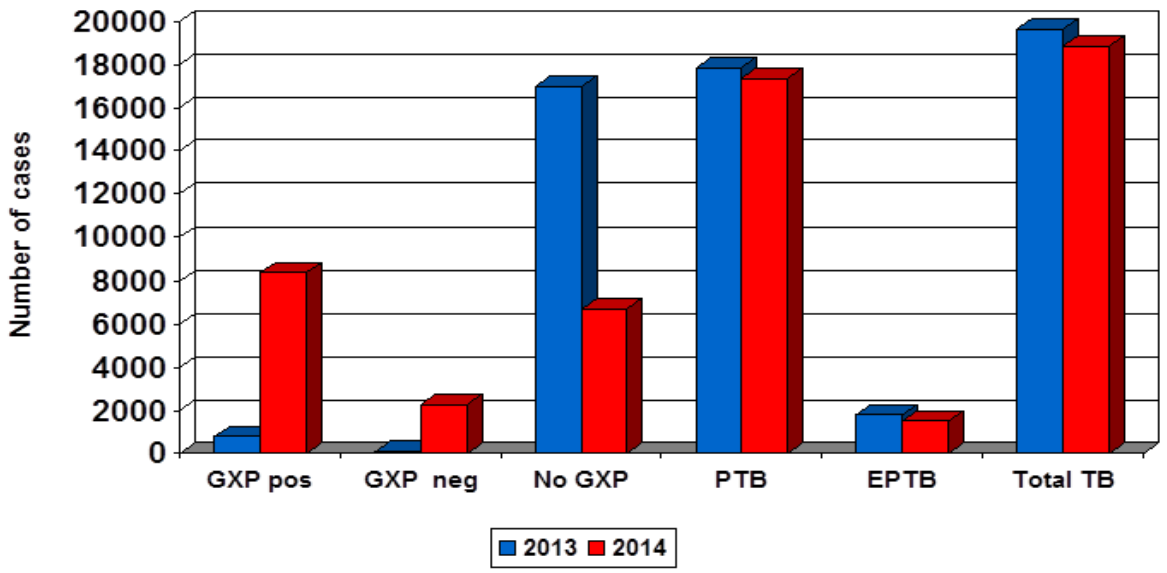


Figure 12: Mpumalanga TB Case Findings: 2013 to 2014 *

Source: Mpumalanga TB Database (ETR.Net)

* PTB: refers to Pulmonary Tuberculosis
* EPTB: refers to Extra pulmonary Tuberculosis
* GXP: GeneXpert diagnosis test

The highest number of TB cases in 2014 was recorded in the 25-34 year old female age group and the 35-44 year old male age group as represented in Figure 13 below.

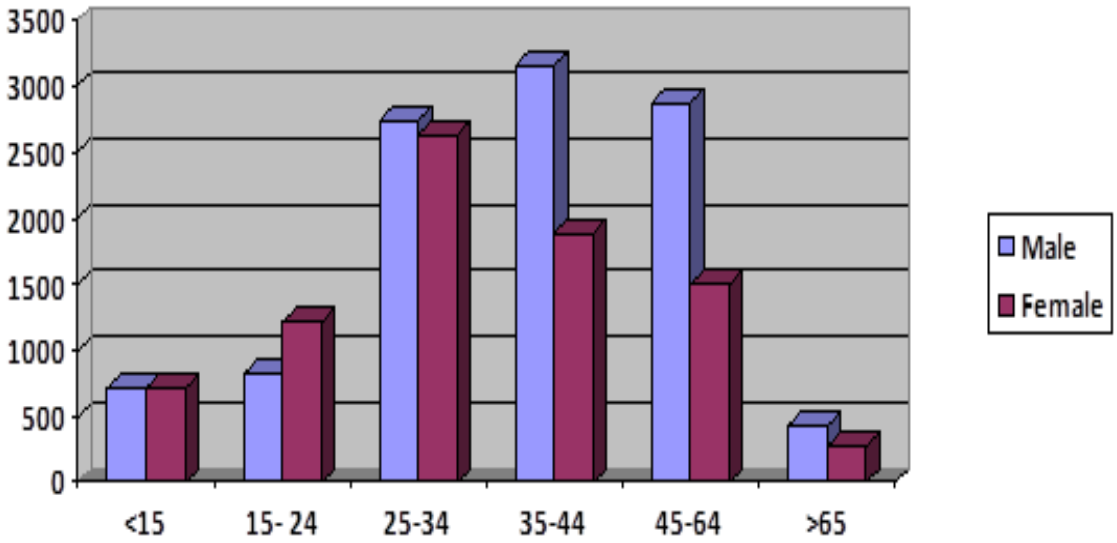


Figure 13: TB Cases by Age Group and Gender, 2014

Source: Mpumalanga TB Database (ETR Net)

Mpumalanga 10 Leading Underlying Natural Causes of Death

According to the "Findings of the Mortality and Causes of Death in South Africa Report, 2014 released 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. HIV was second, followed by Influenza and pneumonia. This is represented in Table 11 below.

Table 11: The ten leading underlying natural causes of death by district municipality of death occurrence, Mpumalanga, 2014*

Ehlanzeni				Gert Sibande				Nkangala			
Causes of death (based on ICD-10)	**Rank**	**No.**	**%**	**Causes of death (based on ICD-10)**	**Rank**	**No.**	**%**	**Causes of death (based on ICD-10)**	**Rank**	**No.**	**%**
Tuberculosis (A15-A19)**	1	1 651	12.2	Tuberculosis (A15-A19)**	1	862	8.8	Tuberculosis (A15-A19)**	1	838	8.1
Human immunodeficiency virus [HIV] disease (B20-B24)	2	1 008	7.5	Human immunodeficiency virus [HIV] disease (B20-B24)	2	623	6.4	Influenza and pneumonia (J09-J18)	2	774	7.5
Cerebrovascular diseases (I60-I69)	3	779	5.8	Influenza and pneumonia (J09-J18)	3	586	6.0	Hypertensive diseases (I10-I15)	3	647	6.3
Intestinal infectious diseases (A00-A09)	4	606	4.5	Other viral diseases (B25-B34)	4	542	5.6	Cerebrovascular diseases (I60-I69)	4	535	5.2
Diabetes mellitus (E10-E14)	5	604	4.5	Intestinal infectious diseases (A00-A09)	5	507	5.2	Diabetes mellitus (E10-E14)	5	526	5.1
Other viral diseases (B25-B34)	6	594	4.4	Diabetes mellitus (E10-E14)	6	464	4.8	Other forms of heart disease (I30-I52)	6	468	4.5
Other forms of heart disease (I30-I52)	7	536	4.0	Cerebrovascular diseases (I60-I69)	7	434	4.4	Human immunodeficiency virus [HIV] disease (B20-B24)	7	446	4.3
Influenza and pneumonia (J09-J18)	8	508	3.8	Hypertensive diseases (I10-I15)	8	427	4.4	Other viral diseases (B25-B34)	8	391	3.8
Hypertensive diseases (I10-I15)	9	399	3.0	Other forms of heart disease (I30-I52)	9	414	4.2	Intestinal infectious diseases (A00-A09)	9	343	3.3
Certain disorders involving the immune mechanism (D80-D89)	10	299	2.2	Certain disorders involving the immune mechanism (D80-D89)	10	379	3.9	Other acute lower respiratory infections (J20-J22)	10	337	3.3
Other natural causes		5 263	39.0	Other natural causes		3 499	35.9	Other natural causes		3 789	36.7
Non-natural causes		1 240	9.2	Non-natural causes		1 022	10.5	Non-natural causes		1 225	11.9
All causes		**13 487**	**100.0**	**All causes**		**9 759**	**100,0**	**All causes**		**10 319**	**100,0**

(Source: Statistic s SA: Mortality and Causes of Death in South Africa, 2014: Findings from Death Notification Prevalence)
*Excluding cases with unspecified district municipality.
**Including deaths due to *MDR-TB* and *XDR-TB*

Table 12 shows the underlying non-natural causes of death for 2009, 2010 and 2014 in Mpumalanga Province.

Table 8: Mpumalanga Underlying Non-natural Causes of Death, 2009 to 2014

	2009		2010		2014	
Causes of death*	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
Other external causes of accidental injury	3 373	84,9	2791	80.8	2 610	70.4
Event of undetermined intent	79	2,0	103	3.0	394	10.6
Transport Accidents	330	8,3	370	10.7	421	11.4
Assault	125	3,1	117	3.4	160	4.3
Complications of medical and surgical care	38	1,0	40	1.2	76	2.0
Intentional self-harm	24	0,6	31	0.9	45	1.2
Sequelae of external causes of morbidity and mortality	2	0,1	3	0.1	2	0.1
Subtotal	**3 971**	**100,0**	**3455**	**100**	**3 708**	**100**
Non-natural causes	3 971	8,7	3455	8.3	3 708	10.6
Natural causes	41 732	91,3	38318	91.7	31 294	89.4
All causes	**45 703**	**100,0**	**41773**	**100**	**35 002**	**100**

*(*based on the Tenth Revision, International Classification of Diseases, 1992)*
Source: Statistic s SA: Mortality and Causes of Death in South Africa, 2010-2014: Findings from Death Notification Prevalence)

4.6 ORGANISATIONAL ENVIRONMENT

4.6.1. Organisational Structure and Human Resources

The organisational structure of the Department was approved in 2010 and is in the process of being reviewed to align it to the strategic goals of the Department and the following models:

- Generic Service Delivery Model
- Infrastructure Model
- Chief Financial Officer Model
- Corporate Management Model

The current structure takes into account the demarcation of the Province in terms of the three District organisational arrangement aimed at the improvement of productivity, provision of health services and development of leadership capability. Cabinet resolved in 2016 that the fourth (4th) district be established.

It has been noted that the current structure does not make provision of the OSD post designation and newly introduced posts including but not limited to Clinical Associates, Case Managers, Waste Management Officer and Queue Marshals.

Factors in the organisation that would impact on service delivery

The following are factors that impact negatively on service delivery:

- Shortage of health specialists
- Low staff morale and staff turn-over
- High litigations

Summary of performance against Provincial Human Resource Plan

The Office of the MEC provides a political mandate for the Department thus giving strategic direction in the Department.

The Department has recently appointed the Head of Department; five (5) Chief Directors and nine (9) Directors in strategic positions. The positions of Chief Executive Officers Matikwane, Bongani, Tonga, Matibidi, Ermelo and Embhuleni Hospitals have also been filled. The Chief Executive Officers for Lydenburg, Shongwe and KwaMhlanga Hospitals are in the process of being filled.

The Department reviewed the recruitment and retention strategy after an analysis has been conducted on the reasons why the staff leave the Department as indicated on the exit interviews questionnaires. The process of head hunting health professionals is being consulted on with relevant stakeholders and the review of the Recruitment and Selection Policy will then be amended accordingly.

The Office of the MEC provides a political mandate for the Department thus giving strategic direction in the Department.

The Department has filled the following strategic positions during the financial year under review:

- Head of Department;
- four (4) Chief Directors [Financial Management, Hospital Services, Integrated Health Planning and District Manager of Gert Sibande]

- Seven (7) Directors [Management Accounting, Supply Chain Management, Strategic Planning, Monitoring & Evaluation, Senior Manager in the Office of the MEC, ICT Manager and Hospital Services at Ehlanzeni District]
- Chief Executive Officers for Matikwana, Bongani, Tonga, Ermelo and Embhuleni Hospitals

The posts of Chief Executive Officers for Lydenburg, Shongwe and KwaMhlanga Hospitals are in the process of being filled. [Two posts of Chief Executive Officers at both Witbank and Standerton are in the process of advertisement]

The Department reviewed the recruitment and retention strategy after an analysis was conducted on the reasons why the staff leave the Department as indicated on the exit interviews questionnaires. The process of head hunting health professionals is being consulted on with relevant stakeholders and the review of the Recruitment and Selection Policy is being finalised.

Staff recruitment and retention systems and challenges

The Department is experiencing an acute shortage of Health Professionals. Recruitment of health professionals in rural areas remains a challenge.

The following initiatives were introduced:-

- Training of twenty three (23) Registrars
- Post Basic training for 143 nurses
- Ten (10) medical students have been sent to study in Cuba.
- Fifty-three (53) medical students have been sent to Russia to train as doctors.

Placement of different categories of health professionals in community service posts is prioritised for the rural facilities on a yearly basis and most of them are bursary holders who are retained on completion of community service since they have contractual obligation.

Absenteeism and staff turnovers

Most employees leave the Department through resignations and medical boarding. The Department is looking at a possibility of involving Employee Health and Wellness Programme to deal with all reasons of terminations and will assist those that require assistance with counselling sessions.

The burden of chronic diseases and stress related challenges is a contributory factor to absences.

In the hospital environment, staff members contract occupational health related diseases such as Tuberculosis (TB). They are given two weeks sick leave when they are initiated on TB treatment. Such employees are scheduled for special Medical Examination on return from leave to establish fitness for duty.

Progress on the rollout of Workload Indicators of Staffing Need (WISN) tool and methodology

National Department of Health deployed the Developmental Partners to collect human resource data from all PHC facilities in the provinces as Phase 1 of the WISN implementation. Workshops on the WISN Methodology and Implementation Guideline of the Health Workforce Normative Guide and Standards for Fixed Primary Health Care Facilities were conducted with the support of the Developmental Partners for all Operational Managers and Data Capturers for Primary

Health Care facilities as part of Phase 2 of WISN Implementation. They were also trained on how to utilise the automated WISN tool to calculate the staffing requirements. This will ensure that the PHC facilities are staffed according to their workload. The WISN Champions were identified for each District. They were also subjected to the same workshops. The organisational structures of all new PHC facilities have been developed in line with the WISN model to ensure that they have an adequate number of staff.

The activity standards for different categories for District Hospitals have been developed at National level. Embhuleni and Shongwe hospitals have been identified as pilot hospitals for Mpumalanga Province. This is a first step towards developing staffing norms for district hospitals. The regional and tertiary hospital staffing norms will be developed after those of the district hospitals have been finalised and approved by the National Health Council.

TABLE A2: HEALTH PERSONNEL IN 2016/17

Categories	Number employed	% of total employed	Number per 100, 000 people	Number per 100,000 uninsured people[2]	Vacancy rate[5]	% of total personnel budget	Annual cost per staff member
ADMINISTRATIVE RELATED	334	83	7.8	8.8	17	3%	600 234
ALL ARTISANS IN THE BUILDING METAL MACHINERY ETC.	64	90	1.5	1.7	10	0%	262 404
AMBULANCE AND RELATED WORKERS	617	95	14.4	16.3	5	3%	284 079
ARTISAN PROJECT AND RELATED SUPERINTENDENTS	15	100	0.3	0.4	0	0%	246 827
AUXILIARY AND RELATED WORKERS	607	90	14.1	16.1	11	2%	211 936
BIOCHEMISTRY PHARMACOL. ZOOLOGY & LIFE SCIE.TECHNI	9	90	0.2	0.2	10	0%	808 738
BOILER AND RELATED OPERATORS	1	50	0.0	0.0	50	0%	165 709
BUILDING AND OTHER PROPERTY CARETAKERS	273	95	6.4	7.2	5	1%	131 284
BUS AND HEAVY VEHICLE DRIVERS	17	94	0.4	0.5	6	0%	228 103
CLEANERS IN OFFICES WORKSHOPS HOSPITALS ETC.	2705	92	63.1	71.7	8	6%	139 845
CLERKS AND RELATED PERSONNEL	1	100	0.0	0.0	0	0%	230 583
CLIENT INFORM CLERKS(SWITCHB RECEPT INFORM CLERKS)	98	94	2.3	2.6	6	0%	213 339
COMMUNICATION AND INFORMATION RELATED	4	100	0.1	0.1	0	0%	361 857
COMMUNITY DEVELOPMENT WORKERS	14	100	0.3	0.4	0	0%	261 270
COMPUTER PROGRAMMERS.	2	100	0.0	0.1	0	0%	323 749
COMPUTER SYSTEM DESIGNERS AND ANALYSTS.	2	100	0.0	0.1	0	0%	372 853
CUSTOMER SERVICES PERSONNEL	3	100	0.1	0.1	0	0%	248 283
DENTAL PRACTITIONERS	118	84	2.8	3.1	16	2%	884 591
DENTAL SPECIALISTS	3	75	0.1	0.1	25	0%	1 110 854
DENTAL TECHNICIANS	1	100	0.0	0.0	0	0%	351 917

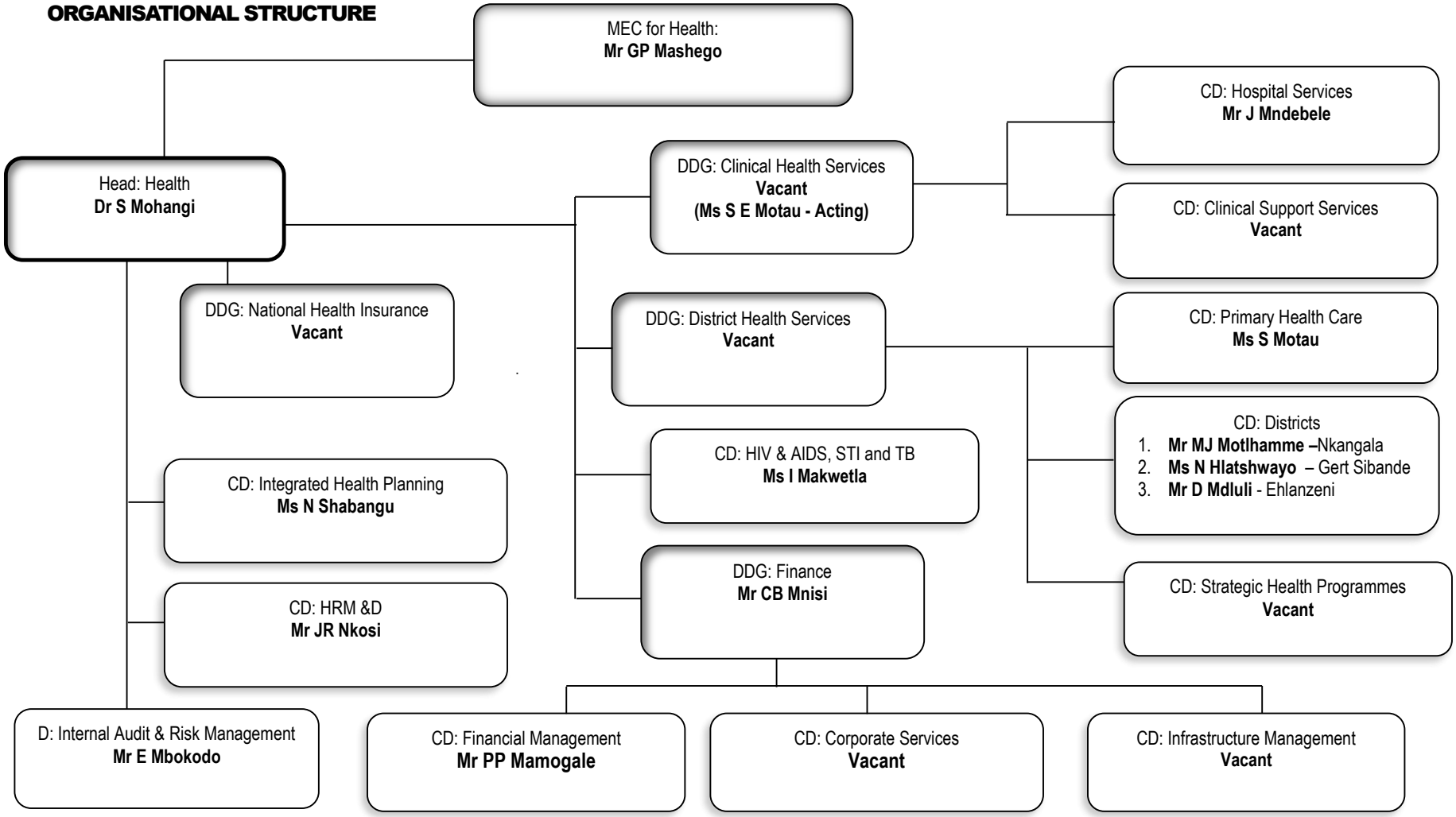
Categories	Number employed	% of total employed	Number per 100, 000 people	Number per 100,000 uninsured people[2]	Vacancy rate[5]	% of total personnel budget	Annual cost per staff member
DENTAL THERAPY	16	70	0.4	0.4	30	0%	357 283
DIETICIANS AND NUTRITIONISTS	118	77	2.8	3.1	23	1%	410 031
DOMEST BUILD& HELPERS CLEAN SWEEP AND LAUNDERERS	1	100	0.0	0.0	0	0%	147 547
ELECTRICAL AND ELECTRONICS ENGINEERING TECHNICIANS	29	97	0.7	0.8	3	0%	389 946
EMERGENCY SERVICES RELATED	269	91	6.3	7.1	9	1%	265 622
ENGINEERING SCIENCES RELATED	1	100	0.0	0.0	0	0%	267 472
ENGINEERS AND RELATED PROFESSIONALS	2	40	0.0	0.1	60	0%	744 838
ENVIRONMENTAL HEALTH	62	61	1.4	1.6	39	0%	442 413
FINANCE AND ECONOMICS RELATED	22	76	0.5	0.6	21	0%	577 370
FINANCIAL AND RELATED PROFESSIONALS	49	86	1.1	1.3	14	0%	430 469
FINANCIAL CLERKS AND CREDIT CONTROLLERS	200	91	4.7	5.3	9	1%	267 616
FOOD SERVICES AIDS AND WAITERS	404	93	9.4	10.7	7	1%	159 739
FOOD SERVICES WORKERS	24	100	0.6	0.6	0	0%	275 185
FORESTRY LABOURERS	1	100	0.0	0.0	0	0%	142 062
HEAD OF DEPARTMENT/CHIEF EXECUTIVE OFFICER	2	100	0.0	0.1	0	0%	964 792
HEALTH SCIENCES RELATED	62	86	1.4	1.6	14	0%	106 368
HORTICULTURISTS FORESTERS AGRICUL.& FORESTRY TECHN	1	100	0.0	0.0	0	0%	267 109
HOUSEHOLD AND LAUNDRY WORKERS	282	92	6.6	7.5	8	1%	161 910
HOUSEHOLD FOOD AND LAUNDRY SERVICES RELATED	3	50	0.1	0.1	50	0%	221 904
HOUSEKEEPERS LAUNDRY AND RELATED WORKERS	7	70	0.2	0.2	30	0%	207 286
HUMAN RESOURCES & ORGANISAT DEVELOPM & RELATE PROF	17	89	0.4	0.5	11	0%	404 977
HUMAN RESOURCES CLERKS	100	90	2.3	2.6	10	0%	315 180
HUMAN RESOURCES RELATED	50	86	1.2	1.3	14	0%	386 354
INFORMATION TECHNOLOGY RELATED	1	50	0.0	0.0	50	0%	529 057
LIBRARIANS AND RELATED PROFESSIONALS	1	100	0.0	0.0	0	0%	290 754
LIBRARY MAIL AND RELATED CLERKS	25	93	0.6	0.7	7	0%	239 036
LIGHT VEHICLE DRIVERS	190	90	4.4	5.0	10	1%	209 523
LOGISTICAL SUPPORT PERSONNEL	21	95	0.5	0.6	5	0%	365 237
MANAGEMENT RELATED SUPPORT PROFESSIONALS	1	100	0.0	0.0	0	0%	680 216
MATERIAL-RECORDING AND TRANSPORT CLERKS	76	95	1.8	2.0	5	0%	224 885
MEDICAL PRACTITIONERS	727	62	16.9	19.3	38	13%	1 170 542

Categories	Number employed	% of total employed	Number per 100, 000 people	Number per 100,000 uninsured people[2]	Vacancy rate[5]	% of total personnel budget	Annual cost per staff member
MEDICAL SPECIALISTS	69	82	1.6	1.8	18	2%	1 551 336
MEDICAL TECHNICIANS/TECHNOLOGISTS	6	60	0.1	0.2	40	0%	481 769
MESSENGERS PORTERS AND DELIVERERS	215	92	5.0	5.7	8	1%	169 999
MOTOR VEHICLE DRIVERS	19	90	0.4	0.5	10	0%	233 292
NURSING ASSISTANTS	1596	80	37.2	42.3	20	4%	181 780
OCCUPATIONAL THERAPY	82	61	1.9	2.2	39	1%	414 192
OFFICE CLERKS AND RELATED KEYBOARD OPERATORS	3	100	0.1	0.1	0	0%	245 502
OPTOMETRISTS AND OPTICIANS	7	88	0.2	0.2	13	0%	422 507
ORAL HYGIENE	11	100	0.3	0.3	0	0%	437 610
OTHER ADMINISTRAT & RELATED CLERKS AND ORGANISERS	1158	92	27.0	30.7	8	4%	245 116
OTHER ADMINISTRATIVE POLICY AND RELATED OFFICERS	140	88	3.3	3.7	13	1%	341 322
OTHER INFORMATION TECHNOLOGY PERSONNEL.	6	100	0.1	0.2	0	0%	596 065
OTHER MANAGEMENT SUPPORT PERSONNEL	1	100	0.0	0.0	0	0%	196 192
OTHER OCCUPATIONS	19	90	0.4	0.5	10	0%	294 109
PHARMACEUTICAL ASSISTANTS	153	91	3.6	4.1	9	1%	250 830
PHARMACISTS	318	71	7.4	8.4	29	3%	574 952
PHARMACOLOGISTS PATHOLOGISTS & RELATED PROFESSIONAL	8	89	0.2	0.2	11	0%	252 037
PHYSICISTS	2	100	0.0	0.1	0	0%	644 956
PHYSIOTHERAPY	96	68	2.2	2.5	32	1%	416 752
PROFESSIONAL NURSE	5245	88	122.3	138.9	12	36%	466 948
PSYCHOLOGISTS AND VOCATIONAL COUNSELLORS	35	76	0.8	0.9	24	0%	672 043
QUANTITY SURVEYORS & RELA PROF NOT CLASS ELSEWHERE	1	50	0.0	0.0	50	0%	612 896
RADIOGRAPHY	111	68	2.6	2.9	32	1%	482 648
RISK MANAGEMENT AND SECURITY SERVICES	5	71	0.1	0.1	29	0%	205 458
ROAD WORKERS	1	100	0.0	0.0	0	0%	133 647
SECRETARIES & OTHER KEYBOARD OPERATING CLERKS	256	88	6.0	6.8	12	1%	218 283
SENIOR MANAGERS	40	82	0.9	1.1	18	1%	930 718
SOCIAL SCIENCES SUPPLEMENTARY WORKERS	1	100	0.0	0.0	0	0%	244 233
SOCIAL WORK AND RELATED PROFESSIONALS	51	96	1.2	1.4	4	0%	393 561
SPEECH THERAPY AND AUDIOLOGY	65	71	1.5	1.7	29	0%	364 490
STAFF NURSES AND PUPIL NURSES	1775	91	41.4	47.0	9	6%	212 178

Categories	Number employed	% of total employed	Number per 100, 000 people	Number per 100,000 uninsured people[2]	Vacancy rate[5]	% of total personnel budget	Annual cost per staff member
STUDENT NURSE	798	93	18.6	21.1	7	2%	176 208
SUPPLEMENTARY DIAGNOSTIC RADIOGRAPHERS	7	100	0.2	0.2	0	0%	286 414
TRADE LABOURERS	4	100	0.1	0.1	0	0%	162 630
Grand Total	**19956**	**87**	**465.2**	**528.6**	**13**		**336 888**

Data Source: Persal (or use latest information from South African Health Review 2015/16 - if Persal data is not available). DHIS for uninsured population.

ORGANISATIONAL STRUCTURE



4.6.2 Improve Financial Management

The Department received an qualified audit on immovable assets, irregular expenditure, commitments, movable assets, contingent liabilities, compensation of employees and transfers and subsidies in 2015/2016 financial year. The Department has introduced an assets verification project, which will resolve the asset related findings during forthcoming audits.

In addition, the Office of the Chief Financial Officer has introduced monthly reconciliation schedules to ensure that the Department produce accurate Annual Financial Statements. The Department has established committee to monitor the investigation of Unauthorised, Irregular and Fruitless and Wasteful expenditure on a monthly basis.

An irregular expenditure database was developed and each irregular expenditure account was analysed and referred to the relevant section for investigation. Furthermore, "economising committees" were appointed in various cost centres to improve speed of procurement of goods and services. The Office of the Chief Financial Officer will continue to strengthen financial management of the Department by strengthening internal controls measures and systems.

4.6.3 Strengthen Information Management

Health information management is one of the fundamental support functions to measure the delivery of health care services. It is key to decision making, monitoring & evaluation and reporting.

Auditing Of Performance information against it's Predetermined Objectives (AOPO) is one of the significant processes to test the usefulness and reliability of performance information effectiveness against monitoring & evaluation and reporting.

In the Financial year 2015/16, The AGSA findings for auditing of performance information outcomes revealed serious concerns on reliability of performance information arising from PHC facilities resulting in a "Disclaimer of Audit Opinion”. These outcomes are because of poor recording in registers, lack of resources such as Data Capturers, web-based information systems to capturer day-to-day activities and poor management/ lack of patient files in health facilities.

The department is implementing a National Health Patient Registration System and DHIS 2 web-based through the eHealth Strategy. This project was initiated in the NHI piloting district, Gert Sibande District to improve management of performance information and audit outcome. All PHC facilities in Gert Sibande are implementing eHealth Strategy (ePHC 700 project). The department has already started with the rollout of these systems to the other two districts, namely, Ehlanzeni and Nkangala Districts. It is anticipated that all PHC facilities will be implementing the systems by March 2017. The department will also be implementing the Stock Visibility System (SVS) and RX Solution for drug management in PHC facilities and hospitals, respectively.

4.6.4 Infrastructure Delivery

In achieving the above, the Infrastructure Unit had to re-engineer its approach in the infrastructure planning, delivery and maintenance. Twenty-three of forty-eight (23/48) posts have been filled with suitably qualified Built Environment professionals. The three director posts i.e. Infrastructure Planning, Delivery and Maintenance, the post of Chief Engineer, Engineering Technicians and other key positions were filled however, there is still a shortage of the required skills. Furthermore, the department had recruited artisans

at districts, which undertake day-to-day maintenance on facilities and equipment positively supporting the intiative of Operation Phakisa for the establishment of maintenance hubs.
The existence of the Built Environment capacity positively affected the performance of the unit as realised by notable financial performance on both sources of funding equitable share and the grant, which previously was a challenge to qualitatively spend on these sources of funding.

The department has immovable assets that have reached their life cycle and mostly prematurely; this is due to inadequate budget for infrastructure maintenance. Thirty-five percent (35%) of immovable assets are in an acceptable condition whereby we have implemented preventative maintenance programme whilst we continue to utilise them however, a deficit of R283,360,000 is required to adequately address the deficiencies. Sixty-four percent (64%) of the current stock immovable assets are suitable to the departmental requirements but require technical condition assessments as the current condition is below the minimum functional requirements of the facility. These facilities would require technical assessment, however through the Rehabilitation, Refurbishment programme we have renovated some of these facilities throughout the province. The department still needs a total budget of R991,760,000 to be spent over a period of 10 years. Lastly, one percent (1%) of immovable assets have been identified as unsuitable to the department's requirements and a new, upgrades and additions programme has assisted in elevating the condition of these facilities.

Furthermore the Department has experienced major challenges in times of shortages of electricity whereby generators were either not there nor serviced. New lifesaving equipment have been purchased for the hospitals and primary health care facilities thus to mitigate disruptions to service delivery. The Department is constructing five PHC facilities in the NHI district as part of health system strengthening and alignment with the NHI directive. The Department is also improving its hospital services by building and upgrading state of the art hospitals, which include latest equipment and technology, however the gap is still too immense to redress within a period of ten years given the current financial constraints.

4.6.5 Other

The challenges in the laundry service unit are mainly as a result of lack of service plan to the laundry equipment. The service provider, appointed to maintain laundry equipment, has been requested to develop a service plan for all laundry equipment in the entire department but did not do so to date. The department will therefore ensure that the new contract on maintenance of laundry equipment includes the development of the service plan and the implementation thereof as part of the Service Level Agreement since the current one is ending in June 2017.

In Supply Chain Management, there are challenges of inadequate staff and skills and these has resulted in non-compliance with SCM legislation. The Department has prioritised appointments and training of SCM practitioners to ensure compliance with SCM legislations. The Department has appointed the SCM Director with effect from August 2016. This appointment will result in improved SCM processes

4.8 REVISIONS TO LEGISLATIVE AND OTHER MANDATES

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 (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 and to provide for matters connected therewith.

- **Pharmacy Act (Act No 53 of 1974, as amended)**
  Provides for the establishment of the South African Pharmacy Council and for its objects and general powers; to extend the control of the council to the public sector; and to provide for pharmacy education and training, requirements for registration, the practice of pharmacy, the ownership of pharmacies and the investigative and disciplinary powers of the council; and to provide for matters connected therewith.

- **Medicines and Related Substance Control Act, (Act No. 101 of 1965 as amended)**
  Provides the registration of medicines intended for human and for animal use; for the registration of medical devices; for the establishment of a Medicines Control Council; for the control of medicines, Scheduled substances and medical devices; for the control of manufacturers, wholesalers and distributors of medicines and medical devices; and for the control of persons who may compound and dispense medicines; and for matters incidental thereto.

- **Mental Health Care Act (Act No. 17 of 2002)**
  Provides a legal framework for the care, treatment and rehabilitation of persons who are mentally ill, to set out different procedures to be followed in the admission of such persons, to establish Review Boards in respect of every health establishment; to determine their powers and functions; to provide for the care and administration of the property of mentally ill persons; to repeal certain laws; and to provide for matters connected therewith.

- **Medical Schemes Act (Act No131 of 1998)**
  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 (Act No 33 of 2005)**
  Provides for the regulation of the nursing profession.

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

- **Sterilisation Act (Act No. 44 of 1998)**
  Provides a legal framework for sterilisations, also for persons with mental health challenges

- **Choice on Termination of Pregnancy Act (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 Act (Act No. 83 of 1993 as amended)**
  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 (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 (Act 58 of 1991)**
  Provides for the establishment of the South African Medical Research Council and its role in relation to health research.

- **The Allied Health Professions Act (Act No.63 of 1982 as amended)**
  To provide for the control of the practice of allied health professions, and for that purpose to establish an Allied Health Professions Council of South Africa and to determine its functions; and to provide for matters connected therewith.

- **Foodstuffs, Cosmetics and Disinfectants Act (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 (Act No. 15 of 1973)**
  Provides for the control of hazardous substances, in particular those emitting radiation.

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

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

- **Allied Health Professions Act (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 Act (Act No 78 of 1973 as amended)**

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 (Act No.86 of 1993)**
  Provides for the establishment, management and operation of academic health centres.

Other general legislation in terms of which the Department operates, includes, but not limited to, the following:

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

- **Public Finance Management Act (Act No 1 of 1999 as amended)**
  To regulate the financial management in the national government and provincial governments; to ensure that all revenue, expenditure, assets and liabilities of those governments are managed efficiently and effectively; to provide for the responsibilities of persons entrusted with financial management in those government; and to provide for matters connected therewith.

- **Division of Revenue Act (Act 5 of 2012)**
  Provides for the manner in which revenue generated, may be disbursed.

- **Promotion of Access to Information Act (Act No 2 of 2000)**
  To give effect to the constitutional right of access to any information held by the State and any information that is held by another person and that is required for the exercise or protection of any rights; and to provide for matters connected therewith.

- **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 (Act No. 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 (Proclamation No. 103 of 1994)**
  Provides for the administration of the public in its national and provincial spheres, as well as for the powers of Ministers to recruit and terminate employment.

- **Labour Relations Act (Act No. 66 of 1995)**
  Regulates the rights of workers, employers and trade unions.

- **Basic Conditions of Employment Act (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 (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.

- **Occupational Health and Safety Act (Act No. 85 of 1993 as amended)**
  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 Act (No. 130 of 1993 as amended)**
  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.

4.8.3 POLICY MANDATES

- Medium Term Strategic Framework 2009 -2014
- National Development Plan (NDP) – Vision for 2030
- National Health Systems Priorities 2009 – 2014 (10 Point Plan)
- Mpumalanga Economic Growth Path
- Mpumalanga Strategic Plan for HIV and AIDS, STIs and TB 2012 - 2016
- Integrated Development Plans (IDPs)
- District Health Management Information System Policy (DHMIS), 2011
- White Paper on the Transformation of the Health Sector, 1997
- Treasury Regulations
- Public Service Regulations
- Preferential Procurement Policy Framework Regulations

4.9 OVERVIEW OF THE 2016/17 BUDGET AND MTEF ESTIMATES

The Department has eight budget programmes, of which four are services delivery programmes and four support programmes. Table 10.3 and 10.4 below provide a summary of payments and estimates according to these eight programmes, as well as per economic classification.

The Department shows an average increase of 8.3 per cent as compared to 2016/17 FY allocated budget. Services delivery programmes show an average increase of 5.5 per cent which include District Health Services, Emergency Medical Services, Provincial Hospital Services and Central Hospitals.

Programme 1: Administration has increased by 12 per cent which due to additional funding of R2.900 million to improve revenue collection in the Department. The Programme is allocated 3 per cent of the Vote's total allocation which is below the National benchmark. In real terms, the Programme is allocated a budget equivalent to adjusted appropriation due to a budget cut. The cost drivers within administration include payment of salaries, settlement of audit obligations, provision ICT services, payment of the PILLIR and settlement of all Departmental litigations which present financial pressure due their nature (unforeseen and unavoidable).

Programme 2: District Health Services shows a growth of 6 per cent on the revised Baseline for the first year of the Medium Term Expenditure Framework Period. The increase is not adequately non-negotiables accounts which among others include drugs, Laboratory Services, Food for patients, Medical Gas, Oxygen and Blood Services. The 2017/18 financial year budget increase include additional funding received for HIV/AIDS for ARV's, CPIX increase of 6.2 per cent and increase on procurement of Medical items.

Over the years Programme 2: District Health Services is still underfunded when considering funding per capita in the country. The programme is allocated 58 per cent of the departmental budget and includes Comprehensive HIV/Aids Grant, Community Health Clinics, Community Health Centres, Nutrition, Community Based Services and District Hospitals.

Earmarked funds have been dissolved and embedded into the baseline of programme 2 funds after having exceeded the 3 year life span and have been provided to the respective district offices to settle all outstanding issues and the movement of personnel to Voted funds. The above excludes HIV/ART 350 Threshold.

Programme 3: Emergency Medical Services shows an increase of 8.4 per cent in the 2017/18 financial year. The budget has declined as compared to the previous financial years. The programme receives 2.9 per cent of the overall allocation of the Vote.

Programme 4: The Provincial Hospital Services shows a growth of 8.4 per cent the growth is prompted by the need to strengthening General (Regional) hospitals in the Province. The purpose of this programme is to render level 1 and 2 health services in regional hospitals and to render TB specialised hospital services. This programme received 11.4 per cent of the allocated budget for 2017/18 financial year.

Programme 5: Central Hospital Services consists of Rob Ferreira Hospital and Witbank Hospital budget increase of 2.7 per cent in 2017/18 financial year. This is due to the programme's inability to spend the baseline budget. The programme provides tertiary services to patients and includes the National Tertiary Services Grant provided to scale up tertiary services in the two tertiary

facilities. This programme receives 9.2 per cent of the allocated budget for 2017/18 financial year.

Programme 6: Health Science & Training will decrease by 15.0 per cent from the 2016/17 FY adjusted which is mainly due to a need to resolve challenges at the Nursing College. The programme receives 3.6 per cent of the allocated budget for the Vote.

Programme 7: Health Care Support Services will decrease by 0.1 per cent during the 2017/18 financial year due to reduction of the budget baseline. The Department is still facing challenges on capacity of the Medicine Trading Account which requires urgent intervention to ensure efficient spending on the Medicine Account. The Department has still centralised procurement of medical equipment in order to improve compliance on National Core Standards.

Over a seven year period, Programme 8: Health Facilities Management has shown an increase of 117.0 per cent on the budget due to additional funding for construction and upgrade for 4 hospitals. The Department has prioritized the rehabilitation and maintenance of our dilapidated facilities. This programme includes Hospital revitalisation Conditional Grant and Infrastructure Grant.

4.9.1 EXPENDITURE ESTIMATES

Expenditure estimates

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20
1. Administration	221 900	196 542	297 298	424 112	267 426	285 185	300 668	279 182	319 814
2. District Health Services	4 907 169	5 475 431	6 175 406	6 355 241	6 542 488	6 542 488	6 933 514	7 412 256	7 955 198
3. Emergency Medical Services	249 584	319 347	309 596	333 801	324 624	324 624	352 046	354 762	374 629
4. Provincial Hospital Services	947 563	1 047 266	1 174 385	1 212 177	1 201 366	1 201 366	1 304 905	1 387 199	1 464 883
5. Central Hospital Services	812 087	943 975	991 759	1 039 902	1 072 127	1 072 127	1 101 054	1 150 735	1 215 176
6. Health Sciences and Training	271 672	305 208	369 233	386 213	375 873	375 873	433 635	473 415	499 928
7. Health Care Support Services	105 887	101 707	123 451	175 924	160 114	160 114	157 775	192 198	202 964
8. Health Facilities Management	531 120	469 050	639 264	714 774	662 310	662 310	1 436 440	1 439 122	1 520 020
Total payments and estimates:	**8 046 982**	**8 858 526**	**10 080 392**	**10 642 144**	**10 606 328**	**10 624 087**	**12 020 037**	**12 688 869**	**13 552 612**

Table A3: Summary of Provincial Expenditure Estimates by Economic Classification

R thousand	Outcome 2013/14	Outcome 2014/15	Outcome 2015/16	Main appropriation 2016/17	Adjusted appropriation 2016/17	Revised estimate 2016/17	Medium-term estimates 2017/18	Medium-term estimates 2018/19	Medium-term estimates 2019/20
Current payments	**7 214 665**	**8 159 984**	**9 005 288**	**9 765 172**	**9 796 920**	**9 795 940**	**10 319 190**	**10 961 309**	**11 701 143**
Compensation of employees	4 970 826	5 516 897	6 102 017	6 722 932	6 722 932	6 719 097	7 329 114	7 847 371	8 286 825
Salaries and wages	4 241 855	4 874 606	5 353 167	5 860 610	5 873 270	5 869 247	6 435 931	6 877 350	7 262 483
Social contributions	728 971	642 291	748 850	862 322	849 662	849 850	893 183	970 021	1 024 342
Goods and services	2 243 510	2 639 473	2 902 264	3 042 240	3 073 988	3 075 515	2 990 076	3 113 938	3 414 318
Administrative fees	5 369	2 717	3 195	5 065	50 000	113 148	54 991	71 995	96 026
Advertising	4 260	1 879	3 220	5 996	2 120	5 305	1 449	980	1 035
Minor Assets	18 462	8 111	11 079	12 795	6 091	8 829	7 612	8 015	8 464
Audit cost: External	12 744	17 895	16 580	16 171	16 171	16 171	16 171	17 184	18 146
Bursaries: Employees	1 749	2 627	1 798	1 500	600	611	–	–	–
Catering: Departmental activities	4 987	2 497	3 196	2 013	2 344	2 948	1 223	1 294	1 367
Communication (G&S)	40 593	42 342	42 697	40 325	38 393	38 086	38 339	40 739	43 021
Computer services	7 852	19 660	57 478	155 702	30 541	23 631	29 541	30 459	52 164
Consultants and professional services: Busin	8	4 418	10 543	29 252	19 252	15 836	16 675	16 943	17 891
Infrastructure and planning	–	–	3 756	10 000	9 000	–	10 000	5 000	5 280
Laboratory services	227 340	357 413	328 947	335 076	329 826	343 828	329 826	349 906	377 501
Legal costs	3 767	–	27 222	28 227	23 227	21 227	21 227	22 182	23 424
Contractors	136 600	67 224	65 631	24 930	67 868	78 021	69 783	76 270	80 540
Agency and support / outsourced services	73 948	74 436	92 172	93 106	85 000	93 140	74 051	77 584	81 929
Fleet services (including government motor tr	94 840	125 474	110 053	108 356	98 356	102 821	98 293	101 840	107 543
Inventory: Clothing material and accessories	4 897	2 635	2 380	906	–	–	–	–	–
Inventory: Farming supplies	4 163	2 614	4 086	4 255	4 255	–	4 255	4 522	4 775
Inventory: Food and food supplies	72 390	89 969	86 313	92 967	75 328	74 927	86 052	81 375	85 932
Inventory: Fuel, oil and gas	13 971	31 228	40 261	31 307	27 510	26 477	27 510	29 973	31 652
Inventory: Learner and teacher support mater	–	–	–	640	–	–	–	–	–
Inventory: Materials and supplies	3 100	7 638	8 950	6 013	–	–	–	4 267	4 506
Inventory: Medical supplies	330 724	320 387	355 748	359 384	354 101	387 043	357 438	386 716	408 372
Inventory: Medicine	850 983	1 020 330	1 118 218	1 114 732	1 332 353	1 233 288	1 299 458	1 306 664	1 457 838
Inventory: Other supplies	–	46	–	81	–	–	–	–	–
Consumable supplies	45 935	55 929	103 274	111 993	77 108	89 891	81 132	84 416	89 144
Consumable: Stationery,printing and office su	20 221	24 189	29 294	32 169	21 128	18 611	20 325	18 831	19 888
Operating leases	38 464	54 347	42 123	53 252	47 500	44 780	47 288	49 226	51 983
Property payments	116 756	228 295	243 163	270 992	299 155	270 456	247 294	273 346	288 651
Transport provided: Departmental activity	372	979	722	1 089	568	540	546	908	958
Travel and subsistence	82 645	59 880	73 295	58 856	41 722	53 992	37 346	41 786	44 127
Training and development	10 297	6 249	8 147	17 601	7 019	5 499	6 760	6 167	6 512
Operating payments	5 261	4 057	5 590	11 997	5 371	3 969	4 962	5 075	5 359
Venues and facilities	10 375	3 510	2 475	4 404	1 500	1 632	108	114	120
Rental and hiring	437	498	658	1 088	581	808	421	161	170
Interest and rent on land	329	3 614	1 007	–	–	1 328	–	–	–
Interest (Incl. interest on finance leases)	329	3 614	1 007	–	–	1 328	–	–	–
Transfers and subsidies	**278 279**	**264 468**	**479 149**	**298 307**	**272 876**	**294 470**	**335 280**	**303 144**	**320 119**
Provinces and municipalities	444	584	140 141	634	634	453	576	645	681
Provinces	34	229	515	634	634	453	558	567	599
Provincial agencies and funds	34	229	515	634	634	453	558	567	599
Municipalities	410	355	139 626	–	–	–	18	78	82
Municipal bank accounts	105	126	139 626	–	–	–	18	78	82
Municipal agencies and funds	305	229	–	–	–	–	–	–	–
Departmental agencies and accounts	4 436	217	231	234	234	113	9 631	10 390	10 972
Departmental agencies (non-business entities)	4 436	217	231	234	234	113	9 631	10 390	10 972
Non-profit institutions	170 401	202 567	240 706	226 762	187 331	181 009	228 702	200 460	211 686
Households	102 998	61 100	98 071	70 677	84 677	112 895	96 371	91 649	96 780
Social benefits	56 272	53 692	81 092	58 333	72 333	81 698	73 410	77 936	82 300
Other transfers to households	46 726	7 408	16 979	12 344	12 344	31 197	22 961	13 713	14 480
Payments for capital assets	**554 038**	**434 074**	**595 955**	**578 665**	**536 532**	**533 677**	**1 365 567**	**1 424 416**	**1 531 350**
Buildings and other fixed structures	460 130	312 522	453 725	445 363	429 610	440 713	1 263 888	1 301 985	1 375 204
Buildings	460 130	312 522	453 725	445 363	429 610	440 713	1 263 888	1 301 985	1 375 204
Machinery and equipment	93 908	121 552	142 230	133 302	106 922	92 964	101 679	122 431	156 146
Transport equipment	11 379	66 240	81 840	16 338	3 533	5 337	13 391	49 545	74 179
Other machinery and equipment	82 529	55 312	60 390	116 964	103 389	87 627	88 288	72 886	81 967
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification	**8 046 982**	**8 858 526**	**10 080 392**	**10 642 144**	**10 606 328**	**10 624 087**	**12 020 037**	**12 688 869**	**13 552 612**

4.9.2 RELATING EXPENDITURE TRENDS TO STRATEGIC GOALS

Compensation of Employees - shows an increase of 9.0 per cent on the revised estimate which is 0.6 per cent higher than the CPI provision. The Department has continuously operated with high vacancy rate and staff turnover has increased which hampered the ability to achieve predetermined targets in the Annual Performance Plan (APP).

A number of facilities still operate with a minimum number of staff in the provision of service delivery which has resulted to labour unrest. In 2013/14, the Office of the Premier has conducted visits to different facilities and a detailed report clearly shows that most facilities do not have adequate staff to render quality health services. The Department is still unable to fill positions identified due to inadequacy of the budget.

The Department has allocated an amount of R7.329 billion for the payment of salaries of warm bodies carried from the 2017/18 financial year including appointment of new minimum personnel. The allocated funding is adequate for the payment of current warm bodies including payment of salary increments and pay progression and the appointment of critical posts and will allow the department to reduce the high vacancy.

Goods and Services – The Budget 2017/18 financial year for goods and services has reduced by 1.0 per cent which is 7.2% below the prescribed CPI growth. The Department will intensify the efficiencies measures and internal controls in the attempt to provide sustainable health essential services to the community of Mpumalanga, although the Department recognizes a risk of high budget pressures on the non-negotiables due to reduction of the budget baseline.

Transfers and Subsidies – shows a reduction of 23.0 % on the revised estimates due increase in the budget for EPWP social grant. The Budget includes funding for the Non-Profit Organisations, which provide Home Based Care services, and Psychiatric services which is outsourced to private sector.

Payments of Capital Assets – The classification will increase by 143 per cent due to additional funding for infrastructure projects.

The Department will continue to increase the investment on replacement and procurement of New Machinery and Equipment of the Department. The department to replace old fleet according to findings of fleet verification report has allocated an additional amount. The success of the replacement of old fleet the department will yield saving on the pressured account for vehicle repairs due to an old fleet of the Department.

TABLE A4: TRENDS IN PROVINCIAL PUBLIC HEALTH EXPENDITURE (R'000)

Expenditure	Audited/ Actual			Estimate	Medium term projection		
	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Current prices[1]							
Total[2]						---	---
Total per person						---	---
Total per uninsured person						---	---
CPI	5.80%	5.50%	4.60%	6.40%	5.80%	5.80%	5.80%
Index (Multiplier)	84.8	89.5	90	100	105.8	111.9	118.1%
Constant (2016/17) prices[3]							
Total							
Total per person							
Total per uninsured person							
% of Total spent on:-							
DHS[4]							

Expenditure	Audited/ Actual			Estimate	Medium term projection		
	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
PHS[5]							
All personnel							
Capital[2]							
Health as % of total public expenditure							

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.

1.2 PRIORITIES

- Review and implement Human Resource Policies in order ensure uniform implementation of HR processes.
- Review and implement the Departmental of the HR Plan in order to address staff shortages any other HR related challenges
- Review and implement the Organisational Structure in order to address staff shortages any other HR related challenges
- Review and implement the Human Resource Delegations

1.3 PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR ADMINISTRATION

PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
1. Improve Hospital Management by appointing Executive Management teams in all hospitals (Key Management Positions)	Quarterly	No
2. Improve quality of care by developing and implementing Recruitment &Retention strategy	Annually	No
3. Improve quality of information by appointing information officers in all sub-districts	Annual	No
4. Audit opinion from Auditor-General	Annual	Categorical
5. Percentage of Hospitals with broadband access	Quarterly	%
6. Percentage of fixed PHC facilities with broadband access	Quarterly	%

TABLE ADMIN 2: STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR ADMINISTRATION

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
	Strategic Objective/Provincial Indicators									
Re-alignment of human resource to Departmental needs	1. Improve Hospital Management by appointing Executive Management in all hospitals (Key Management Positions)	Number	Not in plan	7/33	10/33	28/33**	28/28	28/28	28/28	28/28
Improve quality of health care	2. Improve quality of care by developing and implementing Recruitment &Retention strategy	Number	Not in plan	Not in plan	1	1 (Develop)	1 Implemented	1 Implemented	1 Implemented	1 Implemented
Strengthening Health Systems Effectiveness	3. Improve quality of information by appointing information officers in all sub-districts	Number	1	0	0	18 maintained	11 appointed (18 cumulative)	18 maintained	18 maintained	18 maintained
	Programme Performance/Customized Indicators (Sector Indicators)									
Improve health care outcome	4. Audit opinion from Auditor-General	Categorical	Not in plan	Not in plan	Qualified	Unqualified	Unqualified	Unqualified	Unqualified	Unqualified
Strengthening Health Systems Effectiveness	5. Percentage of Hospitals with broadband access	%	Not in plan	Not in plan	100% (33/33 maintained)	100% (33/33 maintained)	100% (33/33 maintained)	100% (33/33 maintained)	100% (33/33 maintained)	100% (33/33 maintained)
	6. Percentage of fixed PHC facilities with broadband access	%		34%	29% (80/279)	80% (227/284)	100% (287/287)	100% (287/287 maintained)	100% (287/287 maintained)	100% (287/287 maintained)

1.6 QUARTERLY TARGETS

TABLE ADMIN 3: QUARTERLY TARGETS

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	TARGETS			
				Q1	Q2	Q3	Q4
1. Improve Hospital Management by appointing Executive Management in all hospitals (Key Management Positions)	Quarterly	Number	28/28	Annual Target	28/28	Annual Target	Annual Target
2. Improve quality of care by developing and implementing Recruitment & Retention strategy	Annual	Number	1 Implemented	Annual Target	Annual Target	Annual Target	1 Implemented
3. Improve quality of information by appointing information officers in all sub-districts	Annual	Number	11 appointed (18 cumulative)	Annual Target	Annual Target	Annual Target	11 appointed (18 cumulative)
4. Audit opinion from Auditor-General	Annual	Categorical	Unqualified	Annual Target	Annual Target	Annual Target	Unqualified
5. Percentage of Hospitals with broadband access	Quarterly	Number	100% (33/33 maintained)	100% (33/33 maintained)	100% (33/33 maintained)	100% (33/33 maintained)	100% (33/33 maintained)
6. Percentage of fixed PHC facilities with broadband access	Quarterly	Number	100% (287/287)	80% (230/287)	90% (257/287)	97% (277/287)	100% (287/287)

1.7 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

TABLE ADMIN 4: EXPENDITURE ESTIMATES: ADMINISTRATION

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20
1. Office of the MEC	5 186	7 169	7 600	8 976	8 976	9 083	9 281	10 221	10 794
2. Management	216 714	189 373	289 698	415 136	258 450	276 102	291 387	268 961	309 020
Total payments and estimates	**221 900**	**196 542**	**297 298**	**424 112**	**267 426**	**285 185**	**300 668**	**279 182**	**319 814**

Summary of Provincial Expenditure Estimates by Economic Classification[3]

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20
Current payments	**170 374**	**189 938**	**267 454**	**409 531**	**251 388**	**250 830**	**266 921**	**257 476**	**291 893**
Compensation of employees	95 383	101 576	110 825	140 417	133 417	132 859	148 436	145 043	153 166
Salaries and wages	81 075	89 521	97 391	124 933	117 598	117 040	132 070	132 519	139 940
Social contributions	14 308	12 055	13 434	15 484	15 819	15 819	16 366	12 524	13 226
Goods and services	74 828	87 824	156 033	269 114	117 971	117 869	118 485	112 433	138 727
Administrative fees	1 175	660	1 280	1 605	1 121	1 071	1 121	2 083	2 200
Advertising	3 476	813	2 913	4 504	849	4 287	849	846	893
Minor Assets	576	132	218	–	35	665	35	38	40
Audit cost: External	12 744	17 895	16 580	16 171	16 171	16 171	16 171	17 184	18 146
Catering: Departmental activities	1 594	1 032	1 091	1 347	778	977	610	638	674
Communication (G&S)	4 398	5 382	4 427	4 608	4 907	4 929	4 907	5 223	5 515
Computer services	7 426	18 953	57 117	148 891	30 051	23 094	30 051	29 106	50 736
Consultants and professional services: Busin	–	4 418	9 941	25 032	14 651	12 038	14 651	14 794	15 622
Laboratory services	–	31	12	–	–	–	–	–	–
Legal costs	3 767	–	27 222	28 227	23 227	21 227	21 227	22 182	23 424
Contractors	918	1 326	–	–	–	64	–	–	–
Agency and support / outsourced services	1 822	809	660	647	1 988	571	4 488	1 988	2 099
Fleet services (including government motor tr	4 230	7 466	4 486	2 618	1 590	3 250	1 590	559	590
Inventory: Clothing material and accessories	30	–	–	–	–	–	–	–	–
Inventory: Materials and supplies	8	1 030	790	–	–	–	–	–	–
Inventory: Medical supplies	–	–	–	–	6	6	6	6	6
Consumable supplies	594	248	676	1 010	839	2 444	839	1 324	1 397
Consumable: Stationery,printing and office su	3 965	2 782	3 914	4 265	2 490	3 808	2 990	2 486	2 625
Operating leases	5 376	6 282	4 818	6 700	5 240	5 849	5 240	5 224	5 517
Property payments	2 243	6 105	3 458	4 512	3 686	3 990	3 686	4 846	5 117
Transport provided: Departmental activity	74	–	–	–	–	–	–	–	–
Travel and subsistence	18 317	10 318	14 590	10 024	7 862	11 747	7 862	8 039	8 490
Training and development	55	729	430	6 025	1 114	312	1 114	–	–
Operating payments	720	774	904	1 888	940	1 054	940	742	784
Venues and facilities	921	305	506	615	426	315	108	114	120
Rental and hiring	399	334	–	425	–	–	–	11	12
Interest and rent on land	163	538	596	–	–	102	–	–	–
Interest (Incl. interest on finance leases)	163	538	596	–	–	102	–	–	–
Transfers and subsidies	**44 242**	**4 358**	**21 105**	**12 390**	**12 390**	**30 707**	**28 590**	**19 706**	**20 809**
Provinces and municipalities	25	17	515	453	453	453	456	459	485
Provinces	25	17	515	453	453	453	456	459	485
Provincial agencies and funds	25	17	515	453	453	453	456	459	485
Departmental agencies and accounts	–	–	–	–	–	–	5 600	5 986	6 321
Departmental agencies (non-business entities)	–	–	–	–	–	–	5 600	5 986	6 321
Households	44 217	4 341	20 590	11 937	11 937	30 254	22 534	13 261	14 003
Social benefits	–	–	5 378	131	131	696	138	146	154
Other transfers to households	44 217	4 341	15 212	11 806	11 806	29 558	22 396	13 115	13 849
Payments for capital assets	**7 284**	**2 246**	**8 739**	**2 191**	**3 648**	**3 648**	**5 157**	**2 000**	**7 112**
Machinery and equipment	7 284	2 246	8 739	2 191	3 648	3 648	5 157	2 000	7 112
Transport equipment	6 966	1 066	3 656	–	–	–	157	–	–
Other machinery and equipment	318	1 180	5 083	2 191	3 648	3 648	5 000	2 000	7 112
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme (numb	**221 900**	**196 542**	**297 298**	**424 112**	**267 426**	**285 185**	**300 668**	**279 182**	**319 814**

1.2 PERFORMANCE AND EXPENDITURE TRENDS

The increase of 12 per cent from the revised baseline for 2017/18 financial year in Programme 1: Administration which has been influenced by funds for the improvement of revenue collection and increase in COLA for personnel.

1.9 RISK MANAGEMENT

RISK	MITIGATING FACTORS
1. Inability to recruit and retain staff in scarce field	a. Targeted recruitment and improvement of the retention strategy b. Improvement of the attraction strategy and Review the organizational structure and implementation of WISN in PHC facilities c. Implementation of HR delegations d. Adherence to the prescripts when advertising and filling of posts e. Development of an appropriate HR Plan and monitoring the implementation thereof
2. Poor asset management	a. Strengthen the asset verification process through monthly reporting b. Enhance the security system (electronic devices) c. Regular update of the asset register d. Enforce compliance with the asset management policy e. Intensive training of Asset Managers f. Appointment of Loss Control Officers

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.

2.2 PRIORITIES

Universal Health coverage progressively achieved through implementation of National Health Insurance

Mpumalanga Province, through implementing the National Health Insurance (NHI) is aiming to achieve universal coverage with the ultimate goal of creating increased access to health care services to all citizens of the province. Hence, most of the initiatives that were piloted in Gert Sibande District that is a NHI pilot site are being rolled out in phases to the other two Districts namely Nkangala and Ehlanzeni respectively.

Taking our mandate from the National Development Plan 2030, Mpumalanga Province will focus on the World Health Organisation's six building blocks of a health system, in order to improve the health system to adequately provide universal coverage. Affordability and sustainability of universal health coverage is dependent on provision of most services at the Primary Health Care level which has an adequate referral system to other levels of care when need arises. The referral system will further be improved through the development of a Turnaround Strategy of Emergency Medical Services to ensure that the response times are within expected standard. It is believed that this strategy will benefit all health care.

Improved quality of health care

The programme aims to deliver safe quality health care services that meets the needs and expectation of the patients and communities, hence the focus is on improving the systems and processes and use data to analyse service delivery and encourages a team approach to problem solving quality improvement. The progress made will be continously measured through performance reviews and subjective evaluation. Quarterly reports will measure the outcomes and the impact of health care.

All health care facilities will ensure that patients are afforded an opportunity to express their views with regard to the quality of health care through a functional Complaints mechanism whereby complaint resolution will be within 25 days.

Client Satisfaction Surveys will be conducted annually in all health facilities to measure patient experience of care. Gaps identified through the Client Satisfaction survey will be addressed through monitored quality improvement plans. The quality of care will further be improved by increasing availability of medicines and surgical sundries at the Medical Depot.

Implement the Re-engineering of PHC

Primary Health care services are provided within the District Health system (DHS). The overall goal of PHC is to improve access to health care services by the majority of communities. Primary Health Care re-engineering refers to implementation of various interventions that are

aimed at promoting the Preventative and Promotive health care services at community-based level while ensuring improvement of quality of care in PHC facilities. The focus is more preventative than curative

Implementation of the five (5) streams of PHC reengineering will ensure improved access to quality health care.
Hundred and twelve (112) Ward-based Primary Health Care Outreach Teams (WBPHCOT) were established in 2016/17 bringing the total number of established teams to 235 that covers 402 electoral wards**.** These WBPHCOT reach out to the communities at household level. The plan for this financial year is to monitor and evaluate the functioning of these established teams.
Ehlanzeni District remains being the only district with fully-fledged District Clinical Specialist Teams (DCSTs). The team will extend its support to the other two districts to support the improvement of clinical governance on practices of Maternal and Child Health services.
Thirty-two (32) additional School Health Teams will be established to attend to the health needs of the school going children and assist in identifying and addressing the health barriers to learning.
The province is aiming at increasing the number of PHC facilities that are meeting the standards of being an Ideal Clinic by ensuring that 51% (146) of PHC facilities have their Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM).in this financial year

Maternal, infant and child mortality reduced

Reducing maternal, neonatal and child morbidity and mortality is a priority to the province hence the department is planning to strengthen the provision and coverage of family planning services which is the first line of defence in the morbidity and mortality of children and women to be at 50% coverage. Reducing the pregnancy rate of girls below the age of 18 to be below 10%.
Furthermore, the Department is planning to introduce a new strategy that is aimed at reducing the number of women dying from complications of birth by offering more Antenatal visits to the health facility and strengthen the close monitoring of pregnancies through the implementation of Basic Antenatal Health Care Plus (BANC- Plus) initiative. The plan is to roll out the new strategy to all health facilities before the end of the first quarter of the financial year
To reduce the number of neonatal mortality the department will continue training health workers on management of small and sick neonates and the Help Baby Breath strategies. While at the same time the provision of prevention of mother to child transmission of HIV will be strengthen to reduce the transmission rates to Infant around 10 weeks to be below 1.5 %
Reducing the percentage of children who are dying from diarrhoea to be below 3.5% and those dying from Pneumonia to be below 4% and from Severe acute Malnutrition to be below 13% will go a long way in reducing the number of deaths of children below 5 years . To strengthen the health of the under 5 years the Department will be providing health services to the Early Childhood Development Centres in collaboration with the Department of Education and Social Development

HIV and AIDS successfully managed

Management of HIV and AIDS and TB will be strengthened by implementing the 90-90-90 strategy. Awareness campaigns, screening services and VMMC will be conducted in addition to the treatment that is provided to the clients that are living with HIV and AIDS and infected with TB. This initiative will benefit all affected and none affected individuals. The effectiveness of planned activities will be monitored regularly.

Operation Vuka Sisebente (OVS)

The department will participate in Operation Vuka Sisebente initiative by ensuring that key activities outlined in the OVS plan are integrated into Ward Base Outreach Teams. This will guarantee that health care services are accessible to communities at municipal ward level. The key actions include amongst others:

- Make meaningful household interventions on poverty
- Behavioural change to address HIV and AIDS, crime, substance abuse, road accidents, gender-based violence, etc.
- Address the needs of the most vulnerable and deprived communities and households
- Make rural development and sustainable livelihood a realizable vision
- Create opportunities for skills development and employment
- Ensure cooperative governance for better & more fast tracked service delivery

2.3 SERVICE DELIVERY PLATFORM FOR DHS

TABLE DHS1: DISTRICT HEALTH SERVICE FACILITIES BY HEALTH DISTRICT IN 2016/17

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]	28 mobile clinics 1116 mobile clinic points; 3 satellite clinics	1 043 194	32,695	
	Fixed Clinics[4]	54	1,101 Beds	14,765	
	CHCs	22		53,850	
	Sub-total clinics + CHCs	**76**		8,556	
	District hospitals	8		831	
Ehlanzeni District	Non fixed clinics[3]	32 mobile clinics 984 mobile clinic points	1 688 615	3,097	2.85
	Fixed Clinics[4]	106		10,780	
	CHCs	15	1209 Beds	23,840	
	Sub-total clinics + CHCs	**121**		12,399	
	District hospitals	8		1,319	
Nkangala District	Non fixed clinics[3]	24 mobile clinics 461 mobile clinic points	1 308 129	56,694	1.7 Headcount 2,454,830
	Fixed Clinics[4]	68		16,143	
	CHCs	22		65,522	
	Sub-total clinics + CHCs	**90**		10,508	
	District hospitals	7	716 Beds	1,556	0.02
Province	Non fixed clinics[3]	84 mobile clincs 2561 mobile clinc points	4 039 939 (Stats SA 2007)	45,241	2.2
	Fixed Clinics[4]	228	3026 Beds	15,467	
	CHCs	59		75,401	
	Sub-total clinics + CHCs	287		9,998	
	District hospitals	23		1,196	

Source: Population : 2013 mid-year population estimates provided by StatsSA for 2017 year (Refer to Annexure A);

2.4 SITUATIONAL ANALYSIS INDICATORS FOR DISTRICT HEALTH SERVICES

TABLE DHS 2: SITUATIONAL ANALYSIS INDICATORS FOR DISTRICT HEALTH SERVICES

Programme Performance Indicators	Indicator Type	Province wide value 2015/16	Ehlanzeni 2015/16	Gert Sibande 2015/16	Nkangala 2015/16
1. Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) rate (fixed clinic/CHC/CDC)	%	10.4% (29/279)	7.5% (9/120)	15.3% (11/72)	9.3% (9/87)
2. OHH registration visit coverage (annualised)	No	27.3%	19.5%	41.8%	24.3%
3. PHC utilisation rate - Total	No	2.2	2.7	2.0	1.8
4. Complaints resolution rate	%	60.8%	61.8%	72.9%	64.1%
5. Complaint resolution within 25 working days rate (PHC)	%	95.5%	92.4%	99.8%	95.5%

2.4.1 STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR DHS

ROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
1. Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) rate (fixed clinic/CHC/CDC)	Quarterly	%
2. OHH registration visit coverage	Quarterly	No
3. PHC utilisation rate - Total	Quarterly	No
4. Complaints resolution rate (PHC)	Quarterly	%
5. Complaint resolution within 25 working days rate (PHC)	Quarterly	%

TABLE DHS3: STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR DHS

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
	Programme Performance/Customized Indicators (Sector Indicators)									
Improve quality of health care	1. Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) rate (fixed clinic/CHC/CDC)	%	New indicator	New indicator	New indicator	New indicator	100% (287/287)	100% (287/287)	100% (287/287)	100% (287/287)
Expand access to health care services	2. OHH registration visit coverage	No	New indicator	New indicator	27.3%	39%	40% (4000/10000)	59% (5876/10000)	75% (7000/10000)	75% (7000/10000)
	3. PHC utilisation rate - Total	No	2.5	2.3	2.2	2.5	2.6 (11500000/4397250)	2.7 (12000/4507181)	2.8 (13000/4619861)	2.8 (13000/4619861)
Improve quality of health care	4. Complaints resolution rate (PHC)	%	New indicator	52.8%	60.8%	86%	90% (2000/2200}	90% (2079/2310)	90% (2183/2426)	90% (2183/2426)
	5. Complaint resolution within 25 working days rate (PHC)	%	Not in the plan	93.9%	95.5%	90%	95% (1900/2000)	98% (2058/2100)	98% (2161/2205)	98% (2161/2205)

2.4.2 QUARTERLY TARGETS FOR DHS

TABLE DHS 4: QUARTERLY TARGETS FOR DISTRICT HEALTH SERVICES

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	TARGETS			
				Q1	Q2	Q3	Q4
1. Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) rate (fixed clinic/CHC/CDC)	Quarterly	%	100% (287/287)	100%	100%	100%	100%
2. OHH registration visit coverage	Quarterly	No	40% (4000/10000)	40%	40%	40%	40%
3. PHC utilisation rate - Total	Annual	Days	2.6	2.6	2.6	2.6	2.6
4. Complaints resolution rate (PHC)	Quarterly	%	90% (2000/2200)	90%	90%	90%	90%
5. Complaint resolution within 25 working days rate (PHC)	Quarterly	%	95% (1900/2000)	95%	95%	95%	95%

2.5 SUB – PROGRAMME DISTRICT HOSPITALS

TABLE DHS 5: SITUATION ANALYSIS INDICATORS FOR DISTRICT HOSPITALS

Programme Performance Indicator	Indicator Type	Province wide value 2015/16	Ehlanzeni 2015/16	Gert Sibande 2015/16	Nkangala 2015/16
1. Hospital achieved 75% and more on National Core Standards self assessment rate (District Hospitals)	%	0%	0%	0%	0%
2. Average Length of Stay (District Hospitals)	No	4.5 days	4.6 days	4.2days	4.7 days
3. Inpatient Bed Utilisation Rate (District Hospitals)	%	71.4%	72.6%	68.9%	73.5%
4. Expenditure per PDE (District Hospitals)	No	R2.153.40	R2119.30	R2005.20	R2468.80
5. Complaints resolution rate (District Hospitals)	%	70.3%)	69.1	87.4%	64.1%
6. Complaint Resolution within 25 working days rate (District Hospitals)	%	90.6%	87.7%	97.3%	90.5%

2.5.1 STRATEGIC OBJECTIVES, INDICATORS AND MTEF TARGETS FOR DISTRICT HOSPITALS

PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
1. Hospital achieved 75% and more on National Core Standards self assessment rate (District Hospitals)	Quarterly	%
2. Average Length of Stay (District Hospitals)	Quarterly	No
3. Inpatient Bed Utilisation Rate (District Hospitals)	Quarterly	%
4. Expenditure per PDE (District Hospitals)	Quarterly	R
5. Complaints resolution rate (District Hospitals)	Quarterly	%
6. Complaint Resolution within 25 working days rate (District Hospitals)	Quarterly	%

TABLE DHS6: STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR DISTRICT HOSPITALS

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
Improve quality of health care	**Programme Performance/Customized Indicators (Sector Indicators)**									
	1. Hospital achieved 75% and more on National Core Standards self assessment rate (District Hospitals)	%	New Indicator	New Indicator	New Indicator	New Indicator	30% (7/23)	44% (10/23)	57% (13/23)	57% (13/23)
	2. Average Length of Stay (District Hospitals)	No	4.1 days	4.3 days	4.5 days	3.7 days	3.7 days	3.6 days	3..5day	3.5 days
	3. Inpatient Bed Utilisation Rate (District Hospitals)	%	69,9%	70.5%	71.4%	75%	73% (109794/150000)	74% (111000/150000)	75% (113500/151000)	75% (113500/151000)
	4. Expenditure per PDE (District Hospitals)	R	R1,832	R1830	R2.153.40	R2,237	R2,250.00	R2,390.00	R2,700.00	R2,700.00
	5. Complaints resolution rate (District Hospitals)	%	New indicator	New indicator	70.3%)	90%	90% (1100/1220)	90% (1170/1300)	90% (1229/1365)	90% (1229/1365)

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
Improve quality of health care	6. Complaint Resolution within 25 working days rate (District Hospitals)	%	66%	94.5%	90.6%	96%	96% % (1056/1100)	98%% 1131/1155)	98% (1189/1213)	98%% (1189/1213)

2.5.2 QUARTERLY TARGETS FOR DISTRICT HOSPITALS

TABLE DHS 7: QUARTERLY TARGETS FOR DISTRICT HOSPITALS

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	TARGETS			
				Q1	Q2	Q3	Q4
1. Hospital achieved 75% and more on National Core Standards self assessment rate (District Hospitals)	Quarterly	%	30% 7/23	9% (2/23)	17% (4/23)	26% (6/23)	30% (7/23)
2. Average Length of Stay (District Hospitals)	Quarterly	No	3.7 days	4 days	3.9 days	3.8 days	3.7 days
3. Inpatient Bed Utilisation Rate (District Hospitals)	Quarterly	%	3% (109794/150000)	3% (109794/150000)	3% (109794/150000)	3% (109794/150000)	3% (109794/150000)
4. Expenditure per PDE (District Hospitals)	Quarterly	R	R2,250.00	R2,250.00	R2,250.00	R2,250.00	R2,250.00
5. Complaints resolution rate(District Hospitals)	Quarterly	%	90% (1100/1220)	90%	90%	90%	90%
6. Complaint Resolution within 25 working days rate (District Hospitals)	Quarterly	%	96% % (1056/1100)	96% %	96%	96%	96%

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

TABLE DHS 8: SITUATION ANALYSIS INDICATORS FOR HAST

Programme Performance Indicator	Indicator Type	Province wide value 2015/16	District A EHLANZENI	District B GERT SIBANDE	District C NKANGALA
1. Total clients remaining on ART.	No	318 228	1,854,986	1,004,982	841,144
2. TB/HIV co-infected client on ART rate	%	Not in plan	Not in Plan	Not in Plan	Not in Plan
3. Client tested for HIV (incl ANC)	No	Not in plan	Not in Plan	Not in Plan	Not in Plan
4. TB symptom 5yrs and older screened rate	%	12.5%	16.1%	19.7%	12.3%
5. Male condom distribution Coverage	No	30 per male	35.2	36.8	27.8
6. Medical male circumcision performed - Total	%	38 439	20,118	13,051	5,270
7. TB client treatment success rate	%	88.6% (2014)	91.3%(2014)	82.1%(2014)	86.9%(2014)
8. TB client lost to follow up rate	%	4% (2014)	3%(2014)	5.3%(2014)	5.4%(2014)
9. TB client death rate	%	4.5% (2014)	3.4%(2014)	7.5%(2014)	4.8%(2014)
10. TB MDR confirmed treatment initiation rate	%	95.3% (2015)	99.3%(2015)	98.3%(2015)	99.1%(2015)
11. TB MDR treatment success rate	%	45% (2013)	50.5%(2013)	36%(2013)	49%(2013)
12. TB cure rate	%	78.7%(2014)	79.5%(2014)	74.7%(2014)	79.8%(2014)

2.6.1 STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR HAST

PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
1. Female condom distributed	Quarterly	No
2. Improve TB cure rate	Annual	%
3. ART client remain on ART end of month -total	Quarterly	No
4. TB/HIV co-infected client on ART rate	Quarterly	%
5. HIV test done - total	Quarterly	No
6. Male condom distributed	Quarterly	No
7. Medical male circumcision – Total	Quarterly	No
8. TB symptom 5yrs and older start on treatment rate	Quarterly	%
9. TB client treatment success rate	Quarterly	%

PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
10. TB client lost to follow up rate	Quarterly	%
11. TB client death rate	Annual	%
12. TB MDR treatment success rate	Annual	%

TABLE DHS9: STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR HAST

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
	Strategic Objective/Provincial Indicators									
1. Improve Health Care Outcomes	1. Female Condom Distribution	No	1 349 001	842 882	1 828 571	1 315 607	3 737 321	3 812 067	3 888 209	3 908 222
	2. Improve TB cure rate	%	77%	76.1% (2013)	78.7% (2014)	85%	81% (17458/21554)	82% (17674/21554)	85% (18320/21554)	85% (18320/21554)
	Programme Performance/Customized Indicators (Sector Indicators)									
	3. ART client remain on ART end of month - total	No	243 374 (adults)	283 932 (Adults)	318 228	372 014	454 982	508 986	557 590	557590
	4. TB/HIV co-infected client on ART rate	%	91.4%	77.9%	Not In plan	100%	90% (13186/14651)	93% (13625/14651)	95% (13918/14651)	95% (13918/14651)
	5. HIV test done - total	No	556 354	1 772 361	868 897	756 892	777 884	777 884	777 884	777 884
	6. Male condom distributed	No	29.3	Not in Plan	30 per male	50 per male (57 178 214)	71 009 095	72 429 277	73 877 863	73 877 863
	7. Medical male circumcision - Total	No	92 353	49 685	38 439	85 084 (204,405 cumulative)	79 007	72 929	66 852	60 852
	8. TB symptom 5yrs and older started on treatment rate	%	Not in plan	Not in Plan	Not in Plan	Not in Plan	70% (7000/10000)	80% (8000/10000)	90% (9000/10000)	90% (9000/10000)

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
	9. TB client treatment success rate	%	80% (2012)	81.8% (2013)	88.6% (2014)	>85%	87% (18752/21554)	89% (19183/21554)	90% (19399/21554)	90% (19399/21554)
	10. TB client lost to follow up rate	%	5.4 (2012)	5.4%(2013)	4% (2014)	< 5%	4.30 (927/21554)	4.10 (884/21554)	4 (862/21554)	4 (862/21554)
	11. TB client death rate	%	6% (2012)	5.6%(2013)	4.5% (2014)	5%	4.70 (1013/21554)	4.30 (927/21554)	4 (862/21554)	4 (862/21554)
	12. TB MDR treatment success rate	%	49% (2011)	47%(2012)	45% (2013)	58%	60% (694/1157)	62% (732/1182)	65% (781/1202)	65% (781/1202)

2.6.2 QUARTERLY TARGETS FOR HAST

TABLE DHS 10: QUARTERLY TARGETS FOR HAST

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	TARGETS			
				Q1	Q2	Q3	Q4
1. Female Condom Distribution	Quarterly	No	3 737 321	934 330	934 330	934 330	934 331
2. Improve TB cure rate	Annual	%	81%	81% (17458/21554)	81%	81%	81%
3. ART client remain on ART end of month - total	Quarterly	No	454 982	404 528	421 346	438 164	454 982
4. TB/HIV co-infected client on ART rate	Quarterly	%	90% (13186/14651)	90%	90%	90%	90%
5. HIV test done – total	Quarterly	No	777 884	194 471	194 471	194 471	194 471
6. Male condom distributed	Quarterly	No	71 009 095	17 752 273	17 752 273	17 752 273	17 752 276
7. Medical male circumcision - Total	Quarterly	No	79 007	26 336	17 557	17 557	17 557
8. TB symptom 5yrs and older started on treatment rate	Quarterly	%	70% (7000/10000)	70%	70%	70%	70%

9. TB client treatment success rate	Quarterly	%	87% (18752/21554)	87%	87%	87%	87%
10. TB client lost to follow up rate	Quarterly	%	4.30 (927/21554)	4.30%	4.30%	4.30%	4.30%
11. TB client death rate	Annual	%	4.70 (1013/21554)	Annual Target	Annual Target	Annual Target	4.70%
12. TB MDR treatment success rate	Annual	%	60% (694/1157)	Annual Target	Annual Target	Annual Target	60%

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

TABLE DHS 11: SITUATIONAL ANALYSIS INDICATORS FOR MCWH&N

Programme Performance Indicator	Indicator Type	Province wide value 2015/16	Ehlanzeni 2015/16	Gert Sibande 2015/16	Nkangala 2015/16
1. Antenatal 1st visit before 20 weeks rate	%	65.9%	71.7	56	63.9
2. Mother postnatal visit within 6 days rate	%	62.5%	62.8	49.7	74.1
3. Antenatal client initiated on ART rate	%	95.8%	98.3%	89.8%	97.3%
4. Infant 1st PCR test positive around 10 weeks rate	%	1.6%	1.5	1.8	1.6
5. Immunisation coverage under 1 year (annualised)	%	87.1%	90.8	80.2	87.5
6. Measles 2nd dose coverage (annualised)	%	78.7%	72.4	82	78.5
7. DTaP-IPV/Hib 3 - Measles 1st dose drop-out rate	%	(-14.3%)	-21.4	-4.7	-10.9
8. Child under 5 years diarrhoea case fatality rate	%	2.7/1 000	3.6/1000	2.1/1000	2.0/1000
9. Child under 5 years pneumonia case fatality rate	%	3.7/1 000	4.7/1000	3.3/1000	2.7/1000
10. Child under 5 years severe acute malnutrition case fatality rate	%	12.5%	10.7%	18.2%	9.5%
11. School Grade 1 screened	%	20%	10.7%	18.2%	9.5%
12. School Grade 8 screened	%	13.1	10.4%	26%	14.7
13. Couple year protection rate (annualised)	%	38.6%	2.3%	10.9%	6.4%
14. Cervical cancer screening coverage (annualised)	%	66.7%	41.7%	39.9%	34.3%

Programme Performance Indicator	Indicator Type	Province wide value 2015/16	Ehlanzeni 2015/16	Gert Sibande 2015/16	Nkangala 2015/16
15. Human Papilloma Virus Vaccine 1st dose coverage	%	95%%	89.2%	52%	52.8%
16. Human Papilloma Virus Vaccine 2nd dose coverage	%	102%	98	96	88
17. Vitamin A 12-59 months coverage (annualised)	%	51.3%	54.1%	44.1%	52.7%
18. Infant exclusively breastfed at HepB 3rd dose rate	%	Not in plan	Not in plan	Not in plan	Not in plan
19. Maternal mortality in facility ratio (annualised)	per 100 000 Live Births	125,3 /100 000	122.0	97.0	157.5
20. Inpatient early neonatal death rate	per 1000	9,3 per 1 000	9.8	9.8	7.2

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

PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
1. Number of School Health Service Teams established	Annual	Number
2. Antenatal 1st visit before 20 weeks rate	Quarterly	%
3. Mother postnatal visit within 6 days rate	Quarterly	%
4. Antenatal client start on ART rate	Annual	%
5. Infant 1st PCR test positive around 10 weeks rate	Quarterly	%
6. Immunisation under 1 year coverage	Quarterly	%
7. Measles 2nd dose coverage	Quarterly	%

PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
8. DTaP-IPV-HepB-Hib 3 - Measles 1st dose drop-out rate	Quarterly	%
9. Diarrhoea case fatality rate	Quarterly	%
10. Pneumonia case fatality rate	Quarterly	%
11. Severe acute malnutrition case fatality rate	Quarterly	%
12. School Grade 1 - learners screened	Quarterly	No
13. School Grade 8 - learners screened	Quarterly	No
14. Delivery in 10 to 19 years in facility rate	Quarterly	%
15. Couple year protection rate (Int)	Quarterly	%
16. Cervical cancer screening coverage 30 years and older	Quarterly	%
17. HPV 1st dose	Annual	No
18. HPV 2nd dose	Annual	No
19. Vitamin A 12-59 months coverage	Quarterly	%
20. Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	Quarterly	%
21. Maternal mortality in facility ratio	Annual	per 100 000 Live Births
22. Neonatal death in facility rate	Annual	per 1000

TABLE DHS 12: PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR MCWH&N

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
1. Improve health care outcomes	**Strategic Objective/Provincial Indicators**									
	1. Number of School Health Service Teams established	No	17	9 (26 cumulative)	0	26 (68 cumulative)	32 (75 cumulative)	33 (108 cumulative)	13 (121 cumulative)	13 (121 cumulative)
	Programme Performance/Customized Indicators (Sector Indicators)									
	2. Antenatal 1st visit before 20 weeks rate	%	49%	56.5%	65.9%	70%	72% (582758/80941)	74% (59896/80941)	75% (60706/80941)	75% (60706/80941)
	3. Mother postnatal visit within 6 days rate	%	Not in plan	Not in plan	62.5%	70%	65% (47571/73186)	70% (51230/73186)	75% (54890/73186)	75% (54890/73186)
	4. Antenatal client initiated on ART rate	%	Not in plan	Not in plan	95.8%	100%	97% (18775/19356)	97.5% (18872/19356)	98% (18969/19356)	98% (18969/19356)
	5. Infant 1st PCR test positive around 10 weeks rate	%	2.1%	1.7%	1.6%	<1.6%	1.50% (271/18043)	1.45% (262/18043)	1.40% (253/18043)	1.40% (253/18043)
	6. Immunisation under 1 year coverage	%	71.4%	80.2%	87.1%	90%	87% (74777/85950)	89% (77362/86924)	90% (79069/87854)	90% (79069/87854)
	7. Measles 2nd dose coverage	%	78.%	Not in plan	78.7%	90%	85% (74025/87088)	88% (76637/87088)	90% (78379/87088)	90% (78379/87088)

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
	8. DTaP-IPV-Hib-HBV 3-Measles 1st dose drop-out rate	%	17.8%	Not in plan	(-14.3%)	Less than 10%	Less than 10%	Less than 10%	Less than 10%	Less than 10%
	9. Diarrhoea case fatality rate	%	Not in plan	5.3/1 000	2.7/1 000	4 per1000	3.5% (118/3373)	3% (101/3373)	2..5% (84/3373)	2..5% (84/3373)
	10. Pneumonia case fatality rate	%	Not in plan	5.3/1 000	3.7/1 000	3.6 per 1000	4% (162/4050)	3.8% (154/4050)	3.5% (142/4050)	3.5% (142/4050)
	11. Severe acute malnutrition case fatality rate	%	Not in plan	19.1%	12.5%	12%	13% (152/1169)	11% (129/1169)	10% (117/1169)	10% (117/1169)
	12. School Grade 1 - learners screened	No	Not in plan	15.8%	20%	28%	19767	29650	39534	39534
	13. School Grade 8 - learners screened	No	Not in plan	6.1%	13.1	15%	17192	21490	25788	25788
	14. Delivery in 10 to 19 years in facility rate	%	Not in plan	Not in plan	Not in plan	Not in plan	13% (10164/78181)	11% (8600/78181)	10% (7818/78181)	10% (7818/78181)
	15. Couple year protection rate (Int)	%	36.1%	39.7%	38.6%	45%	55% (56622/102950)	60% (62548/104247)	65% (68588/105519)	65% (68588/105519)

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
	16. Cervical cancer screening coverage 30 years and older	%	55%	63.3%	66.7%	70%	65% (609010/936932)	75% (724820/966431)	80% (796780/995971)	80% (796780/995971)
	17. HPV 1st dose	No	Not in plan	90.2%	95%	80%	72800	77350	81900	81900
	18. HPV 2nd dose	No	Not in plan	91.2	102.8	80%	72800	77350	81900	81900
	19. Vitamin A 12-59 months coverage	%	36.2%	49.9%	51.4%	55%	58% (198700/342587)	60% (205552/342587)	62% (212404/342587)	62% (212404/342587)
	20. Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	%	Not in Plan	Not in Plan	Not In plan	35%	45% (13290/29533)	50% (14767/29533)	55% (16243/29533)	55% (16243/29533)
	21. Maternal mortality in facility ratio	per 100 000 Live Births	133 per 100,000	108/100 000	125,3 /100 000	102 per 100,000	140 per 100 000 Live Births	120 per 100 000 Live Births	100 per 100 000 Live Births	100 per 100 000 Live Births
	22. Neonatal death in facility rate	per 1000	Not in plan	Not in plan	9,3 per 1 000	8 per 1000	9.5per 1000	9.25 per 1000	9 per 1000	9 per 1000

QUARTERLY TARGETS FOR MCWH&N

Ensure the indicators and their respective annual targets are consistent with the information in the tables above.

TABLE DHS13: QUARTERLY TARGETS FOR MCWH&N

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	TARGET			
				Q1	Q2	Q3	Q4
1. Number of School Health Service Teams established	Annual	Number	32	Annual Target	32	Annual Target	Annual Target
2. Antenatal 1st visit before 20 weeks rate	Quarterly	%	72% (582758/80941)	72 %	72%	72%	72%
3. Mother postnatal visit within 6 days rate	Quarterly	%	65% (47571/73186)	65%	65%	65%	65%
4. Antenatal client initiated on ART rate	Quarterly	%	97% (18775/19356)	97%	97%	97%	97%
5. Infant 1st PCR test positive around 10 weeks rate	Quarterly	%	1.50% (271/18043)	<1.50%	<1.50%	<1.50%	<1.50%
6. Immunisation under 1 year coverage	Quarterly	%	87% (74777/85950)	87%	87%	87%	87%
7. Measles 2nd dose coverage	Quarterly	%	85% (74025/87088)	85%	85%	85%	85%
8. DTaP-IPV-Hib-HBV 3- Measles 1st dose drop-out rate	Quarterly	%	Less than 10%	Less than 10%	Less than 10%	Less than 10%	Less than 10%
9. Diarrhoea case fatality rate	Quarterly	%	3.5% (118/3373)	3.5%	3.5%	3.5%	3.5%
10. Pneumonia case fatality rate	Quarterly	%	4% (162/4050)	4%	4%	4%	4%

11. Severe acute malnutrition case fatality rate	Quarterly	%	13% (152/1169)	13%	13%	13%	13%
12. School Grade 1 - learners screened	Quarterly	No	19767	7320	10320	16520	19767
13. School Grade 8 - learners screened	Quarterly	No	17192	5522	8696	15200	17192
14. Delivery in 10 to 19 years in facility rate	Quarterly	%	13% (10164/78181)	13%	13%	13%	13%
15. Couple year protection rate (Int)	Quarterly	%	55% (56622/102950)	55%	55%	55%	55%
16. Cervical cancer screening coverage 30 years and older	Quarterly	%	65% (609010/936932)	65%	65%	65%	65%
17. HPV 1st dose	Annual	No	72800	Annual Target	72800	Annual Target	Annual Target
18. HPV 2nd dose	Annual	No	72800	Annual Target	Annual Target	72800	Annual Target
19. Vitamin A 12-59 months coverage	Quarterly	%	58% (198700/342587)	58%	58%	58%	58%
20. Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	Quarterly	%	45% (13290/29533)	42%	43%	44%	45%
21. Maternal mortality in facility ratio	Annual	per 100 000 Live Births	140 per 100 000 Live Births	140 per 100 000 Live Births	140 per 100 000 Live Births	140 per 100 000 Live Births	140 per 100 000 Live Births
22. Neonatal death in facility rate	Annual	per 1000	9.5 per 1000	9.,5 per 1 000	9.5 per 1000	9.5 per 1000	9.5 per 1000

2.7 DISEASE PREVENTION AND CONTROL (DPC)

This section should provide the purpose and brief overview of the DPC Programme as stated in the budget documentation.

TABLE DHS14: SITUATION ANALYSIS INDICATORS FOR DISEASE PREVENTION AND CONTROL

Programme Performance Indicator	Indicator Type	Province wide value 2015/16	Ehlanzeni 2015/16	Gert Sibande 2015/16	Nkangala 2015/16
1. Cataract Surgery Rate annualized	Rate per 1 Million (uninsured population)	CSR 805 (2 657)	1399	730	528
2. Malaria case fatality rate	%	0.5%	0.4%	2.5%	4.65%

2.7.1 PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR DPC

PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
1. Cataract Surgery Rate	Quarterly	Rate per 1 Million (uninsured population)
2. Malaria case fatality rate	Quarterly	%

TABLE DHS15: STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR DISEASE PREVENTION AND CONTROL

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
1 Improve health care outcomes	**Programme Performance/Customized Indicators (Sector Indicators)**									
	1. Cataract Surgery Rate	Rate per 1 Million (uninsured population)	CSR 670 (2413)	CSR 718	CSR 805 (2 657)	CSR 1000 (3,600)	CSR 1000 (3,600)	CSR 1000 (3,600)	CSR 1000 (3,600)	CSR 1000 (3,600)
	2. Malaria case fatality rate	%	0.73%	0.77 % per 1000 population	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%

2.7.2 QUARTERLY TARGETS FOR DPC

TABLE DHS 16: QUARTERLY TARGETS FOR DISEASE PREVENTION AND CONTROL

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	TARGETS			
				Q1	Q2	Q3	Q4
1. Cataract Surgery Rate	Quarterly	Rate per 1 Million (uninsured population)	CSR 1000 (3,600)	600	1 200	1 200	600
2. Malaria case fatality rate	Quarterly	%	0.5%	0.5%	0.5%	0.5%	0.5%

2.8 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE DHS17: DISTRICT HEALTH SERVICES

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20
1. District Management	354 366	307 736	349 625	362 696	329 125	326 890	376 008	407 013	429 805
2. Community Health Clinics	825 510	1 021 072	1 246 101	1 190 021	1 199 986	1 199 941	1 244 601	1 339 317	1 461 178
3. Community Health Centres	586 932	686 592	753 732	780 365	792 318	798 665	836 866	912 477	974 575
4. Community-based Services	71 577	78 674	89 841	93 045	93 045	90 846	140 562	105 968	111 902
5. Other Community Services	–	–	–	–	–	–	–	–	–
6. HIV/Aids	864 832	840 587	936 447	1 047 410	1 274 358	1 269 788	1 313 179	1 396 298	1 514 490
7. Nutrition	14 602	10 937	12 667	15 100	13 882	13 882	14 931	18 013	19 020
8. Coroner Services	–	–	–	–	–	–	–	–	–
9. District Hospitals	2 189 350	2 529 833	2 786 993	2 866 604	2 839 774	2 842 476	3 007 367	3 233 170	3 444 228
Total payments and estimates	**4 907 169**	**5 475 431**	**6 175 406**	**6 355 241**	**6 542 488**	**6 542 488**	**6 933 514**	**7 412 256**	**7 955 198**

Summary of Provincial Expenditure Estimates by Economic Classification[4]

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20
Current payments	**4 715 247**	**5 251 052**	**5 756 986**	**6 153 449**	**6 346 047**	**6 344 704**	**6 691 301**	**7 169 818**	**7 677 325**
Compensation of employees	3 085 645	3 485 659	3 921 759	4 272 991	4 276 025	4 276 025	4 636 336	5 044 617	5 327 114
Salaries and wages	2 624 450	3 064 966	3 422 489	3 691 879	3 707 003	3 707 003	4 053 004	4 377 936	4 623 100
Social contributions	461 195	420 693	499 270	581 112	569 022	569 022	583 332	666 681	704 014
Goods and services	1 629 561	1 762 564	1 835 065	1 880 458	2 070 022	2 068 624	2 054 965	2 125 201	2 350 211
Administrative fees	3 426	1 381	1 193	2 492	32 347	96 736	37 295	50 160	72 968
Advertising	730	1 066	126	1 309	600	1 018	600	–	–
Minor Assets	16 968	6 255	8 680	6 730	3 372	5 813	2 243	2 514	2 655
Catering: Departmental activities	2 451	728	1 516	353	1 211	1 576	463	488	516
Communication (G&S)	23 961	24 753	26 374	24 524	22 709	22 374	22 478	23 917	25 257
Computer services	417	311	–	6 800	9	8	(991)	848	895
Consultants and professional services: Busin	–	–	585	1 220	2 577	1 774	–	–	–
Laboratory services	180 681	278 663	250 486	255 818	254 464	270 334	254 464	269 854	292 966
Contractors	108 921	25 254	14 952	3 046	7 752	16 173	7 707	8 597	9 078
Agency and support / outsourced services	38 516	43 524	43 253	53 304	38 582	38 335	38 462	38 928	41 108
Fleet services (including government motor tr	42 721	50 057	48 531	49 483	40 557	43 668	40 557	41 680	44 014
Inventory: Clothing material and accessories	1 698	1 106	1 412	–	–	–	–	–	–
Inventory: Farming supplies	4 163	2 614	4 086	4 255	4 255	–	4 255	4 522	4 775
Inventory: Food and food supplies	42 657	52 730	54 482	55 699	45 405	45 403	56 129	49 597	52 375
Inventory: Fuel, oil and gas	10 584	19 145	20 030	21 891	18 623	17 606	18 623	20 533	21 683
Inventory: Materials and supplies	578	2 170	3 426	2 969	–	–	–	842	889
Inventory: Medical supplies	220 884	165 979	180 991	173 947	172 752	204 197	175 855	190 770	201 453
Inventory: Medicine	761 654	909 985	978 311	996 975	1 235 169	1 134 332	1 202 274	1 200 678	1 345 916
Inventory: Other supplies	–	46	–	81	–	–	–	–	–
Consumable supplies	32 190	36 153	40 739	36 550	39 462	36 699	34 139	37 527	39 629
Consumable: Stationery,printing and office su	12 692	16 929	19 082	21 546	11 614	9 125	10 362	7 721	8 154
Operating leases	15 379	21 341	18 934	28 166	22 317	18 493	22 317	23 017	24 306
Property payments	54 029	71 352	84 451	95 069	95 230	79 493	114 808	140 377	148 238
Transport provided: Departmental activity	110	183	115	265	196	196	20	312	329
Travel and subsistence	39 467	24 277	26 835	24 206	15 550	20 968	11 026	10 752	11 353
Training and development	2 809	656	577	2 352	495	118	–	(0)	–
Operating payments	3 372	2 716	3 588	7 427	3 226	2 228	1 458	1 417	1 496
Venues and facilities	8 465	3 033	1 712	3 318	991	1 200	–	–	–
Rental and hiring	38	157	598	663	557	757	421	150	158
Interest and rent on land	41	2 829	162	–	–	55	–	–	–
Interest (Incl. interest on finance leases)	41	2 829	162	–	–	55	–	–	–
Transfers and subsidies	**158 705**	**185 026**	**342 462**	**193 319**	**193 319**	**193 319**	**235 208**	**207 345**	**218 956**
Provinces and municipalities	314	441	139 626	181	181	–	120	127	134
Provinces	9	212	–	181	181	–	102	108	114
Provincial agencies and funds	9	212	–	181	181	–	102	108	114
Municipalities	305	229	139 626	–	–	–	18	19	20
Municipal bank accounts	–	–	139 626	–	–	–	18	19	20
Municipal agencies and funds	305	229	–	–	–	–	–	–	–
Departmental agencies and accounts	83	164	112	96	96	73	101	107	113
Departmental agencies (non-business entities)	83	164	112	96	96	73	101	107	113
Non-profit institutions	141 872	164 191	187 335	187 331	187 331	181 009	228 702	200 460	211 686
Households	16 436	20 230	15 389	5 711	5 711	12 237	6 285	6 651	7 023
Social benefits	13 927	17 163	13 622	5 173	5 173	10 598	5 720	6 053	6 392
Other transfers to households	2 509	3 067	1 767	538	538	1 639	565	598	631
Payments for capital assets	**33 217**	**39 353**	**75 958**	**8 473**	**3 122**	**4 465**	**7 005**	**35 093**	**58 917**
Machinery and equipment	33 217	39 353	75 958	8 473	3 122	4 465	7 005	35 093	58 917
Transport equipment	–	25 188	47 001	–	–	1 829	3 752	30 372	53 932
Other machinery and equipment	33 217	14 165	28 957	8 473	3 122	2 636	3 253	4 721	4 985
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme (numb	**4 907 169**	**5 475 431**	**6 175 406**	**6 355 241**	**6 542 488**	**6 542 488**	**6 933 514**	**7 412 256**	**7 955 198**

This economic classification table should be the same as the classification used by each Provincial Department in Budget Statement No. 2.

2.9 PERFORMANCE AND EXPENDITURE TRENDS

Programme 2: District Health Services shows a growth of 6 per cent on the revised Baseline for the first year of the Medium Term Expenditure Framework Period. The Spending on Community health clinics and Community health Centre's have been inconsistent due to slow procurement of goods including non-payment of utilities as a result of inadequate support for PHC.

2.10 RISK MANAGEMENT

RISK	MITIGATING FACTORS
1. Inadequate skilled human resources to render health care service	a. Contribute in the development and implement an HR strategy as per the prescripts of DPSA. This strategy will, inter alia, address the following: • Recruitment and retention • HR Delegation Framework • Determine a baseline for vacancies and an acceptable vacancy rate. This must be decreased by 20%
2. Insufficient basic equipment to provide quality healthcare services	a. Contribute to the development and implement a SCM strategy b. Appointment of dedicated Supply Chain management staff c. Procure maintenance plan to cover all equipment
3. Absence of a psychiatric facility in the province	a. Contribute to the development of Comprehensive Tertiary Health Services plan b. Contribute to the implementation of the promulgation of the Premier by providing specification of the structure as per Mental Health Act
4. Inadequate information management	a. Procure equipment and appoint Data management personnel b. Skills gap analysis and requisite training c. Adhere to the National Archives Act by securing adequate facilities for record storage. d. Contribute to the drafting and implementation of Record Management Policy
5. Inadequate implementation of MCWYH&N guidelines	a. Appoint skilled health care workers to provide Maternal and Child healthcare services b. Conduct continuous training and orientation c. Conduct mentoring and onsite in-services training d. Conduct monitoring and evaluation of MCWYH services Continue training of Community Health Care workers on MCWH issues
6. Inadequate management of health care waste	a. Appoint/delegate responsible managers in the facilities b. Ensure substantive contract management of service provider c. Develop an annual training plan for health care workers

RISK	MITIGATING FACTORS
7. Inadequate community awareness on HIV/Aids/Tuberculosis	a. Implement ACSM strategy b. Integrate with other partners in addressing poverty c. Contribute to the development of Cross boarder MOU

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.

3.2 PRIORITIES

- Improved quality of health care
- Reduce Maternal, infant and child mortality
- Improvement of referrals to all institutions
- Obtain accreditation for the EMS college to increase the level of care through training
- Strengthen management capacity to improve on service delivery
- Procurement of Primary Response Vehicles and Planned Patient Transport Vehicles

The department will improve the services through the recruitment, appointment of emergency care practitioners and training to increasing the number of EMS bases and the number of rostered ambulances in the province.

TABLE EMS 1: SITUATION ANALYSIS INDICATORS FOR EMS

Programme Performance Indicator	Frequency of Reporting (Quarterly / Annual)	Indicator Type	Province wide value 2015/16	Ehlanzeni	Nkangala	Gert Sibande
1. EMS P1 urban response under 15 minutes rate	Quarterly	%	75,5%	72.5%	79%	75%
2. EMS P1 rural response under 40 minutes rate	Quarterly	%	71,5%	75%	68 %	71.5%
3. EMS inter-facility transfer rate	Quarterly	%	4,6%	4.9	4.7	4.2

3.3.1 PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGET FOR EMS

PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
1. Improve response time by increasing the number of Operational Ambulances	Annual	No
2. Improve the use of resources by integrating PPTS into EMS operations	Quarterly	%
3. Improve maternal outcomes by increasing the number of Obstetric ambulances	Annual	No
4. EMS P1 urban response under 15 minutes rate	Quarterly	%
5. EMS P1 rural response under 40 minutes rate	Quarterly	%
6. EMS inter-facility transfer rate	Quarterly	%

TABLE EMS 2: STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR EMERGENCY MEDICAL SERVICES

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
Improve access to health care services	**Strategic Objective/Provincial Indicators**									
	1. Improve response time by increasing the number of Operational Ambulances	No	Not in plan	Not in plan	108 Operational Ambulances	105	115	125	130	130
	2. Improve the use of resources by integrating PPTS into EMS operations	%	Not in plan	0%	20%	60%	80%	100%	100%	100%
	3. Improve maternal outcomes by increasing the number of Obstetric ambulances	No	Not in plan	Not in plan	18	6 (cumulative 18)	24	30	36	36
	Programme Performance/Customized Indicators (Sector Indicators)									
	4. EMS P1 urban response under 15 minutes rate	%	65.25%	73%	75.5%	85%	85%	90%	90%	90%
	5. EMS P1 rural response under 40 minutes rate	%	67.5%	66%	71.5%	75%	80%	80%	80%	80%
	6. EMS inter-facility transfer rate	%	4%	Not in plan	4.6%	30%	40%	60%	65%	65%

3.3.2 QUARTERLY TARGETS FOR EMS

TABLE EMS 3: QUARTERLY TARGETS FOR EMS

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	TARGETS			
				Q1	Q2	Q3	Q4
1. Improve response time by increasing the number of Operational Ambulances	Annually	No	115	108	108	108	115
2. Improve the use of resources by integrating PPTS into EMS operations	Quarterly	%	80%	45%	45%	70%	80%
3. Improve maternal outcomes by increasing the number of Obstetric ambulances	Annually	No	24	18	18	18	24
4. EMS P1 urban response under 15 minutes rate	Quarterly	%	85%	85%	85%	85%	85%
5. EMS P1 rural response under 40 minutes rate	Quarterly	%	80%	80%	80%	80%	80%
6. EMS inter-facility transfer rate	Quarterly	%	40%	10%	20%	30%	40%

3.4 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

TABLE EMS 4: EXPENDITURE ESTIMATES: EMERGENCY MEDICAL SERVICES

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20
1. Emergency transport	244 355	299 274	305 351	323 036	317 816	317 816	345 238	347 560	367 024
2. Planned Patient Transport	5 229	20 073	4 245	10 765	6 808	6 808	6 808	7 202	7 605
Total payments and estimates	**249 584**	**319 347**	**309 596**	**333 801**	**324 624**	**324 624**	**352 046**	**354 762**	**374 629**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20
Current payments	**245 134**	**285 973**	**286 847**	**315 283**	**314 636**	**314 528**	**342 058**	**340 062**	**359 106**
Compensation of employees	199 702	217 007	232 102	261 182	261 182	261 074	288 606	282 906	298 749
Salaries and wages	169 747	190 173	199 095	226 148	226 148	226 040	251 233	255 384	269 686
Social contributions	29 955	26 834	33 007	35 034	35 034	35 034	37 373	27 522	29 063
Goods and services	45 323	68 720	54 715	54 101	53 454	53 447	53 452	57 156	60 357
Administrative fees	19	9	13	53	19	19	19	21	22
Minor Assets	–	8	–	–	183	200	183	–	–
Catering: Departmental activities	19	22	36	44	24	97	22	22	23
Communication (G&S)	1 767	2 082	2 001	2 038	2 038	2 038	2 038	2 164	2 286
Fleet services (including government motor tr	31 844	48 883	38 409	35 856	35 856	35 856	35 856	38 079	40 211
Inventory: Clothing material and accessories	1 777	–	–	–	–	–	–	–	–
Inventory: Fuel, oil and gas	55	64	40	79	115	99	115	122	129
Inventory: Medical supplies	161	34	442	515	–	–	–	547	578
Inventory: Medicine	31	1	2	36	–	–	–	38	40
Consumable supplies	44	25	5	274	112	112	112	119	126
Consumable: Stationery,printing and office su	579	244	1 124	1 271	950	950	950	1 009	1 066
Operating leases	8 366	16 172	11 842	12 858	13 378	13 378	13 378	14 207	15 003
Property payments	286	186	139	340	228	228	228	242	255
Transport provided: Departmental activity	–	702	386	422	152	152	152	162	171
Travel and subsistence	330	288	216	239	239	268	239	254	268
Operating payments	45	–	–	76	160	50	160	170	179
Rental and hiring	–	–	60	–	–	–	–	–	–
Interest and rent on land	109	246	30	–	–	7	–	–	–
Interest (Incl. interest on finance leases)	109	246	30	–	–	7	–	–	–
Transfers and subsidies	**37**	**322**	**544**	**–**	**–**	**108**	**–**	**–**	**–**
Households	37	322	544	–	–	108	–	–	–
Social benefits	37	322	544	–	–	108	–	–	–
Payments for capital assets	**4 413**	**33 052**	**22 205**	**18 518**	**9 988**	**9 988**	**9 988**	**14 700**	**15 523**
Machinery and equipment	4 413	33 052	22 205	18 518	9 988	9 988	9 988	14 700	15 523
Transport equipment	4 413	32 853	22 026	15 338	3 508	3 508	9 295	13 945	14 726
Other machinery and equipment	–	199	179	3 180	6 480	6 480	693	755	797
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme (numb	**249 584**	**319 347**	**309 596**	**333 801**	**324 624**	**324 624**	**352 046**	**354 762**	**374 629**

[1]This economic classification table should be the same as the classification used by each Provincial Department in Budget Statement No. 2.

3.5 PERFORMANCE AND EXPENDITURE TRENDS

Programme 3 has had a consistent growth over the past MTEF period maintaining its 2.9 per cent share of the total allocation of the department. The increase of fuel and non-appointment of EMS practitioners has put the baseline under pressure to achieve APP targets. The PPT has assisted health institutions with procurement of vehicles although there is a need to replace old fleet, which will be prioritised in the next MTEF period.

3.6 RISK MANAGEMENT

RISK	MITIGATING FACTORS
1. EMS failure to take control of PPTS (Planned Patient Transport Services)	d. Awareness campaigns and information sharing to be held with communities and Health facilities where the role of EMS system is explained e. Commission an Organisational Design (OD) exercise to establish numbers and types of staff f. Create and fill vacant posts g. Determine exact needs for equipment, including vehicles and populate demand plan h. Establish monthly meetings between EMS and hospitals i. Secure budget for procurement off new vehicles and equipment
2. Inadequate/ inappropriate emergency vehicles	a. Engagement with COGTA and DPWRT b. Secure budget to procure new fleet c. Monitor SLA for maintenance of fleet d. Train EMS staff on emergency driving e. Implement consequence management i.e. disciplinary measures in terms of damage to vehicles
3. Poor response time of EMS	a. Procurement of additional ambulances b. Appointment of EMS staff c. Budget and procure state-of-the-art communication systems d. Implement Shift policy

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 TB specialized hospital services**.**

4.2 PRIORITIES

- Improve quality of care by ensuring that regional hospitals comply with extreme and vital measures
- Improve Ermelo and Mapulaneng regional hospitals' capacity to function as referral hospitals in their districts by strengthening specialist outreach services and appoint specialists
- Coordinate the referral network within the district through quarterly cluster meetings

TABLE PHS: SITUATION ANALYSIS INDICATORS FOR REGIONAL HOSPITALS

Programme Performance Indicator	Frequency of Reporting (Quarterly / Annual)	Indicator Type	Province wide value 2015/16	Ermelo Hospital	Themba Hospital	Mapulaneng Hospital
1. National Core Standards self assessment rate (Regional Hospitals)	Quarterly	%	100%	100%	100%	100%
2. Percentage of Hospitals that achieved an overall performance of ≥75% compliance with the national core standards for health facilities (Regional Hospitals)	Quarterly	%	100%	86%	70%	84%
3. Patient Satisfaction Survey Rate (Regional Hospitals)	Annual	%	100%	100%	100%	100%
4. Patient Satisfaction Rate (Regional Hospitals)	Quarterly	No	87%	85%	72%	93%
5. Average Length of Stay (Regional Hospitals)	Quarterly	%	4.7 days	3.5 days	5.4 days	4.7 days
6. Inpatient Bed Utilisation Rate (Regional Hospitals)	Quarterly	R	75%	69%	89%	77.4%
7. Expenditure per PDE (Regional Hospitals)	Quarterly	%	R2,722	R2,914	R2,517	R2,839
8. Complaints resolution rate (Regional Hospitals)	Quarterly	%	90%	85%	43%	80%
9. Complaint Resolution within 25 working days rate (Regional Hospitals)	Quarterly	%	90%	85%	97%	100%

4.2.1 STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR REGIONAL HOSPITALS

PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
1. Functional Adverse Events Committees	Quarterly	No
2. Hospital achieved 75% and more on National Core Standards self assessment rate (Regional Hospitals)	Quarterly	%
3. Average Length of Stay (Regional Hospitals)	Quarterly	No
4. Inpatient Bed Utilisation Rate (Regional Hospitals)	Quarterly	%
5. Expenditure per PDE (Regional Hospitals)	Quarterly	R
6. Complaints resolution rate (Regional Hospitals)	Quarterly	%
7. Complaint Resolution within 25 working days rate (Regional Hospitals)	Quarterly	%

TABLE PHS1: STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR REGIONAL HOSPITALS

(The Strategic goals, Strategic Objectives and Strategic Plan targets used in below table must be word for word identical to that of the 5 year Strategic Plan. This is applicable for all budget programmes in the plan).

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
Improve quality of health care	**Strategic Objective/Provincial Indicators**									
	1. Functional Adverse Events Committees	No	Not in plan	Not in plan	0	3	3	3	3	3
	Programme Performance/Customized Indicators (Sector Indicators)									
	2. Hospital achieved 75% and more on National Core Standards self assessment rate (Regional Hospitals)	%	New Indicator	New Indicator	New Indicator	New Indicator	100% 3/3	100% 3/3	100% 3/3	100% 3/3
	3. Average Length of Stay (Regional Hospitals)	No	5.1 days	4.4 days	4.6 days	4.7 days	4.6 days	4.7 days	4.7 days	4.7 days
	4. Inpatient Bed Utilisation Rate (Regional Hospitals)	%	79.4%	74.1%	80.3%	75%	75%	75%	75%	75%
	5. Expenditure per PDE (Regional Hospitals)	R	R2,174	R2,411	R2,614	R2,722	R2.885	R3.058	R3.200	R3.200
	6. Complaints resolution rate (Regional Hospitals)	%	Not in plan	Not in plan	58.9%	90%	90% (249/277)	90% (262/291)	90% (275/306)	90% (275/306)
	7. Complaint Resolution within 25 working days rate (Regional Hospitals)	%	73,5%	93.6%	98.7%	90%	95% (237/249)	98% (256/261)	98% (269/274)	98% (269/274)

TABLE PHS2: QUARTERLY TARGETS FOR REGIONAL HOSPITALS

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	TARGETS			
				Q1	Q2	Q3	Q4
1. Functional Adverse Events Committees	Quarterly	No	3	3	3	3	3
2. Hospital achieved 75% and more on National Core Standards self assessment rate (Regional Hospitals)	Quarterly	%	100% (3/3)	0% (0/3)	0% (0/3)	100% (3/3)	100% (3/3)
3. Average Length of Stay (Regional Hospitals)	Quarterly	No	4.6 days	4.6 days	4.6 days	4.6 days	4.6 days
4. Inpatient Bed Utilisation Rate (Regional Hospitals)	Quarterly	%	75%	75%	75%	75%	75%
5. Expenditure per PDE (Regional Hospitals)	Quarterly	R	R2.885	R2.914	R2.885	R2.914	R2.885
6. Complaints resolution rate (Regional Hospitals)	Quarterly	%	90% (249/277)	90%	90%	90%	90%
7. Complaint Resolution within 25 working days rate (Regional Hospitals)	Quarterly	%	95% (237/249)	95%	95%	95%	95%

4.3 PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR SPECIALISED HOSPITALS

	PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
1	Improve access to TB services through effective movement TB patients rate for continuity of care	Quarterly	%
2	Hospital achieved 75% and more on National Core Standards self assessment rate (specialised hospitals)	Quarterly	%
3	Complaints resolution rate (specialised hospitals)	Quarterly	%
4	Complaint Resolution within 25 working days rate (specialised hospitals)	Quarterly	%

TABLE PHS 3: PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR SPECIALISED HOSPITALS

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
Improve quality of health care	**Strategic Objective/Provincial Indicators**									
	1. Improve access to TB services through effective movement TB patients rate for continuity of care	%	Not in plan	Not in plan	100%	100%	100%	100%	100%	100%
	Programme Performance/Customized Indicators (Sector Indicators)									
	2. Hospital achieved 75% and more on National Core Standards self assessment rate (specialized hospitals	%	New Indictor	New Indicator	New Indicator	New Indicator	40% (2/5)	60% (3/5)	80% (4/5)	80% (4/5)
	3. Complaints resolution rate (Specialised Hospitals)	%	Not in plan	Not in plan	58.9%	90%	90% (20/22)	90% (21/23)	90% (22/24)	90% (22/24)
	4. Complaint Resolution within 25 working days rate (Specialised Hospitals)	%	99.4%	93.6%	98.7%	87%	95% (19/20)	96% (21/22)	96% (23/24)	96% (23/24)

TABLE PHS4: QUARTERLY TARGETS FOR SPECIALISED HOSPITALS

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	TARGETS			
				Q1	Q2	Q3	Q4
1. Improve access to TB services through effective movement TB patients rate for continuity of care	Quarterly	%	100%	100%	100%	100%	100%
2. Hospital achieved 75% and more on National Core Standards self assessment rate (specialised hospitals)	Quarterly	%	40% (2/5)	0% (0/5)	0% (0/5)	40% (2/5)	40% (2/5)
3. Complaints resolution rate (Specialised Hospitals)	Quarterly	%	90% (20/22)	90%	90%	90%	90%
4. Complaint Resolution within 25 working days rate (Specialised Hospitals)	Quarterly	%	95% (19/20)	95%	95%	95%	95%

4.1 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE PHS 5: EXPENDITURE ESTIMATES: PROVINCIAL HOSPITAL SERVICES

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20
1. General (Regional) Hospitals	793 559	854 240	937 555	997 666	993 072	993 072	1 086 558	1 150 961	1 215 415
2. Tuberculosis Hospitals	125 475	158 034	183 459	175 080	168 863	168 863	176 708	192 184	202 947
3. Psychiatric/ Mental Hospitals	28 529	34 992	53 371	39 431	39 431	39 431	41 639	44 054	46 521
4. Sub-acute, Step down and Chronic Medical Hospital	–	–	–	–	–	–	–	–	–
5. Dental Training Hospitals	–	–	–	–	–	–	–	–	–
6. Other Specialised Hospitals	–	–	–	–	–	–	–	–	–
Total payments and estimates	**947 563**	**1 047 266**	**1 174 385**	**1 212 177**	**1 201 366**	**1 201 366**	**1 304 905**	**1 387 199**	**1 464 883**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20
Current payments	**910 988**	**1 001 131**	**1 106 323**	**1 168 735**	**1 197 705**	**1 195 716**	**1 301 206**	**1 378 002**	**1 455 171**
Compensation of employees	732 859	769 083	828 934	910 203	910 203	908 214	1 009 847	1 056 663	1 115 837
Salaries and wages	622 930	686 926	736 559	806 894	809 199	807 210	899 421	936 544	988 991
Social contributions	109 929	82 157	92 375	103 309	101 004	101 004	110 426	120 119	126 846
Goods and services	178 122	232 047	277 188	258 532	287 502	287 494	291 359	321 339	339 334
Administrative fees	36	17	36	75	8 740	7 887	8 740	9 592	10 129
Minor Assets	341	511	527	1 060	1 416	913	604	604	638
Catering: Departmental activities	–	33	24	52	5	6	5	8	8
Communication (G&S)	3 861	3 744	3 619	3 768	3 888	3 574	3 888	4 080	4 308
Computer services	9	–	5	11	458	507	458	480	507
Consultants and professional services: Busin	8	–	–	–	–	–	–	–	–
Laboratory services	20 244	30 680	33 216	38 523	37 589	35 721	37 589	39 920	42 156
Contractors	1 515	1 619	588	681	40 077	39 789	42 285	44 741	47 246
Agency and support / outsourced services	6 296	2 924	4 456	4 502	4 267	3 800	4 267	4 350	4 594
Fleet services (including government motor tr	8 243	9 149	9 744	9 934	9 988	9 748	9 988	10 608	11 202
Inventory: Clothing material and accessories	962	710	487	800	–	–	–	–	–
Inventory: Food and food supplies	18 665	23 274	19 812	22 852	17 507	17 108	17 507	18 592	19 633
Inventory: Fuel, oil and gas	1 393	6 390	5 796	4 054	3 501	3 501	3 501	3 719	3 927
Inventory: Materials and supplies	632	862	270	489	–	–	–	440	465
Inventory: Medical supplies	37 098	50 724	62 708	64 611	63 325	64 972	63 325	70 526	74 475
Inventory: Medicine	46 617	61 228	88 466	65 105	54 127	55 899	54 127	60 331	63 710
Consumable supplies	7 569	8 396	7 834	7 871	9 613	9 427	9 613	10 535	11 125
Consumable: Stationery,printing and office su	1 288	1 798	2 179	2 499	2 415	1 923	2 415	2 610	2 756
Operating leases	4 204	5 317	4 439	3 223	4 290	4 290	4 290	4 555	4 810
Property payments	15 368	22 256	30 430	26 545	24 222	24 222	27 322	34 124	36 035
Transport provided: Departmental activity	10	8	42	33	50	22	–	–	–
Travel and subsistence	3 454	2 270	2 053	1 685	1 069	2 227	1 069	1 136	1 200
Training and development	5	9	176	–	589	1 773	–	–	–
Operating payments	304	128	281	159	366	185	366	388	410
Interest and rent on land	7	1	201	–	–	8	–	–	–
Interest (Incl. interest on finance leases)	7	1	201	–	–	8	–	–	–
Transfers and subsidies	**31 890**	**39 779**	**56 090**	**40 340**	**909**	**2 898**	**947**	**1 004**	**1 060**
Provinces and municipalities	34	44	–	–	–	–	–	–	–
Municipalities	34	44	–	–	–	–	–	–	–
Municipal bank accounts	34	44	–	–	–	–	–	–	–
Departmental agencies and accounts	55	42	39	96	96	40	101	71	75
Departmental agencies (non-business entities)	55	42	39	96	96	40	101	71	75
Non-profit institutions	28 529	34 992	53 371	39 431	–	–	–	–	–
Households	3 272	4 701	2 680	813	813	2 858	846	933	985
Social benefits	3 272	4 701	2 680	813	813	2 858	846	933	985
Payments for capital assets	**4 685**	**6 356**	**11 972**	**3 102**	**2 752**	**2 752**	**2 752**	**8 193**	**8 652**
Machinery and equipment	4 685	6 356	11 972	3 102	2 752	2 752	2 752	8 193	8 652
Transport equipment	–	3 821	4 214	–	25	–	25	4 000	4 224
Other machinery and equipment	4 685	2 535	7 758	3 102	2 727	2 752	2 727	4 193	4 428
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme (numb	**947 563**	**1 047 266**	**1 174 385**	**1 212 177**	**1 201 366**	**1 201 366**	**1 304 905**	**1 387 199**	**1 464 883**

4.2 PERFORMANCE AND EXPENDITURE TRENDS

Programme 4: The Provincial Hospital Services shows a growth of 8.6 per cent which is aimed at strengthening of General (Regional) hospitals services for patients. The purpose of this programme is to render level 1 and 2 health services in regional hospitals and to render TB specialised hospital services. This programme received 10.9 per cent of the allocated budget for 2017/18 financial year. The Programme will focus on the following areas in the MTEF period:

- Establish eight-core specialists clinical domain for each of the three regional hospitals.
- Implementation and monitoring of national core standards
- Provide outreach services to district hospitals and PHC facilities

4.3 RISK MANAGEMENT

RISK	MITIGATING FACTORS
1. Inadequate compliance with infection control guidelines	a. Motivate for infrastructure project for the construction of isolation wards b. Create and fill adequate number of posts for infection control officers c. Improve monitoring of compliance with policies and procedure d. Allocation of adequate resources and consumables
2. Inadequate HIV/ AIDS and TB inpatient care	a. Secure budget for multi-year programme for improvement for TB infrastructure b. Enter into MOU with DPW to correct leases c. Increase security measures for visitor control d. Implement Records Management Control e. Awareness campaign on TB f. Monitor TB cure rate g. Determine number of vacant posts and commence with recruitment h. Enter into MOU with private sector laboratories
3. Incomplete access of level 2 services	a. Develop equipment procurement plan b. Regional hospitals to hold referral meetings with feeder facilities c. Monitor compliance to attendance registers by sessional doctors d. Implement recruitment and retention strategy for scarce skills
4. Non-compliance with professional clinical standards and protocols	a. Strengthen quarterly clinical audits b. Enforce compliance to policies and procedures c. Motivate for appointment of senior professional staff for supervision and mentoring purposes Training of clinical audit committees d. Staff debriefing, motivation and team-building

RISK	MITIGATING FACTORS
5. Inadequate medical and condemned pharmaceutical waste management	a. Appointment of dedicated Waste Manager b. Secure budget and approval for waste storage facilities

5. BUDGET PROGRAMME 5: CENTRAL & TERTIARY HOSPITALS (C&THS)

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.

5.2 PRIORITIES

- Improve quality of care by ensuring compliance to all extreme and vital measures of the national core standards
- Reduce average length of stay (ALOS)
- Improve clinical governance at tertiary hospitals in order to reduce.
- Improve hospital efficiency

TABLE PHS1: SITUATION ANALYSIS INDICATORS FOR TERTIARY HOSPITAL

Programme Performance Indicator	Frequency of Reporting (Quarterly / Annual)	Indicator Type	Province wide value 2015/16	Witbank Hospitals	Robs Ferreira Hospital
1. National Core Standards self-assessment rate (Tertiary Hospitals)	Quarterly	%	100%	100%	100%
2. Percentage of Hospitals that achieved an overall performance of ≥75% compliance with the national core standards for health facilities (Tertiary Hospitals)	Quarterly	%	100%	76%	61%
3. Patient Satisfaction Survey Rate (Tertiary Hospitals)	Quarterly	%	100%	100%	100%
4. Patient Satisfaction Rate (Tertiary Hospitals)	Annual	%	85%	76.5%	71.2%
5. Average Length of Stay (Tertiary Hospitals)	Quarterly	No	5.3 days	5.9 days	7.7 days
6. Inpatient Bed Utilisation Rate (Tertiary Hospitals)	Quarterly	%	75%	78.2%	80.9%
7. Expenditure per PDE (Tertiary Hospitals)	Quarterly	R	R3,221	R2,797	R2,810
8. Complaints resolution rate (Tertiary Hospitals)	Quarterly	%	85%	54.5%	73.5%
9. Complaint Resolution within 25 working days rate (Tertiary Hospitals)	Quarterly	%	85%	95.8%	97.9%

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

PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
1. Functional Adverse Events Committee	Quarterly	No
2. Hospital achieved 75% and more on National Core Standards self assessment rate (Tertiary Hospitals)	Quarterly	%
3. Average Length of Stay (Tertiary Hospitals)	Quarterly	No
4. Inpatient Bed Utilisation Rate (Tertiary Hospitals)	Quarterly	%
5. Expenditure per PDE (Tertiary Hospitals)	Quarterly	R
6. Complaints resolution rate (Tertiary Hospitals)	Quarterly	%
7. Complaint Resolution within 25 working days rate (Tertiary Hospitals)	Quarterly	%

TABLE C&THS 1: PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR TERTIARY HOSPITALS

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
Improve quality of health care	**Strategic Objective/Provincial Indicators**									
	1. Functional Adverse Events Committee	No	Not in plan	Not in plan	Not in plan	Not in plan	2	2	2	2
	Programme Performance/Customized Indicators (Sector Indicators)									
	2. Hospital achieved 75% and more on National Core Standards self assessment rate (Tertiary Hospitals)	%	New Indicator	New Indicator	New Indicator	New Indicator	100% (2/2)	100% (2/2)	100% (2/2)	100% (2/2)
	3. Average Length of Stay (Tertiary Hospitals)	No	6.4 days	5.7 days	6.8 days	5.6 days	5.3 days	5.3days	5.3 days	5.3 days
	4. Inpatient Bed Utilisation Rate (Tertiary Hospitals)	%	84.3%	80.5%	81%	75%	75%	75%	75%	75%
	5. Expenditure per PDE (Tertiary Hospitals)	R	R2, 696	R2,207	R2,785	R3,414	R3,619	R3,836	R3,800	R3,800
	6. Complaints resolution rate (Tertiary Hospitals)	%	Not in plan	Not in plan	83.2%	90%	90% (250/277)	90% (276/290)	90% (290/305)	90% (290/305)

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
Improve quality of health care	7. Complaint Resolution within 25 working days rate (Tertiary Hospitals)	%	99.5%	100%	99.4%	90%	95% (238/250)	98% (257/263)	98% (270/276)	98% (270/278)

QUARTERLY TARGETS FOR TERTIARY HOSPITALS

TABLE C&THS 2: QUARTERLY TARGETS FOR TERTIARY HOSPITALS

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	TARGETS			
				Q1	Q2	Q3	Q4
1. Functional Adverse Events Committee	Quarterly	No	2	2	2	2	2
2. Hospital achieved 75% and more on National Core Standards self assessment rate (Tertiary Hospitals)	Quarterly	%	100% (2/2)	0% (0/2)	0% (0/2)	100% (2/2)	100% (2/2)
3. Average Length of Stay (Tertiary Hospitals)	Quarterly	No	5.3 days	5.3 days	5.3 days	5.3 days	5.3 days
4. Inpatient Bed Utilisation Rate (Tertiary Hospitals)	Quarterly	%	75%	75%	75%	75%	75%
5. Expenditure per PDE (Tertiary Hospitals)	Quarterly	R	R3,619	R3,419	R3,719	R3,719	R3,619
6. Complaints resolution rate (Tertiary Hospitals)	Quarterly	%	90% (250/277)	90%	90%	90%	90%
7. Complaint Resolution within 25 working days rate (Tertiary Hospitals)	Quarterly	%	95% (238/250)	95%	95%	95%	95%

5.4 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

TABLE C&TH 7: EXPENDITURE ESTIMATES: CENTRAL AND TERTIARY SERVICES

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20
1. Central Hospital Services	–	–	–	–	–	–	–	–	–
2. Provincial Tertiary Hospital Services	812 087	943 975	991 759	1 039 902	1 072 127	1 072 127	1 101 054	1 150 735	1 215 176
Total payments and estimates	**812 087**	**943 975**	**991 759**	**1 039 902**	**1 072 127**	**1 072 127**	**1 101 054**	**1 150 735**	**1 215 176**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20
Current payments	**803 646**	**931 234**	**984 741**	**1 026 517**	**1 046 863**	**1 046 220**	**1 084 000**	**1 134 445**	**1 197 974**
Compensation of employees	594 809	638 397	674 804	723 490	753 490	752 847	789 605	819 600	865 497
Salaries and wages	505 588	571 532	601 270	642 317	667 317	666 674	698 147	733 558	774 637
Social contributions	89 221	66 865	73 534	81 173	86 173	86 173	91 458	86 042	90 860
Goods and services	208 828	292 837	309 919	303 027	293 373	293 369	294 395	314 845	332 477
Administrative fees	68	68	37	16	6 971	6 971	6 971	7 404	7 819
Minor Assets	203	718	1 311	996	895	895	453	448	473
Catering: Departmental activities	–	7	11	21	2	3	2	10	11
Communication (G&S)	4 995	3 925	4 570	3 633	3 623	3 623	3 623	3 837	4 052
Computer services	–	396	356	–	23	22	23	25	26
Laboratory services	26 415	48 039	45 233	40 735	37 773	37 773	37 773	40 132	42 379
Contractors	15 584	16 854	27 882	10 620	13 648	12 873	13 494	15 159	16 008
Agency and support / outsourced services	10 718	5 565	10 861	9 968	9 379	10 154	9 379	10 783	11 387
Fleet services (including government motor tr	3 475	4 472	4 143	5 581	5 581	5 581	5 581	5 927	6 259
Inventory: Clothing material and accessories	266	526	303	106	–	–	–	–	–
Inventory: Food and food supplies	11 068	13 965	12 019	14 416	12 416	12 416	12 416	13 186	13 924
Inventory: Fuel, oil and gas	1 929	5 629	7 556	5 272	5 271	5 271	5 271	5 599	5 913
Inventory: Materials and supplies	75	26	222	23	–	–	–	24	25
Inventory: Medical supplies	66 333	100 919	105 468	114 426	111 539	111 539	111 539	118 120	124 735
Inventory: Medicine	42 681	49 116	51 439	52 616	43 057	43 057	43 057	45 617	48 172
Consumable supplies	2 251	5 552	6 308	6 842	5 502	5 502	5 502	5 827	6 153
Consumable: Stationery,printing and office su	654	1 758	1 685	1 400	1 712	1 712	1 156	1 156	1 221
Operating leases	3 620	3 800	886	1 000	1 000	1 000	1 000	1 062	1 121
Property payments	17 358	30 515	28 679	34 582	33 952	33 952	36 352	39 657	41 878
Transport provided: Departmental activity	–	–	–	–	50	50	33	33	35
Travel and subsistence	922	780	594	620	598	594	598	658	695
Training and development	–	17	–	11	220	220	12	12	13
Operating payments	213	190	356	143	160	160	160	169	178
Rental and hiring	–	–	–	–	1	1	–	–	–
Interest and rent on land	9	–	18	–	–	4	–	–	–
Interest (Incl. interest on finance leases)	9	–	18	–	–	4	–	–	–
Transfers and subsidies	**1 552**	**4 582**	**1 891**	**1 030**	**1 030**	**1 673**	**1 081**	**1 145**	**1 209**
Provinces and municipalities	25	29	–	–	–	–	–	–	–
Municipalities	25	29	–	–	–	–	–	–	–
Municipal bank accounts	25	29	–	–	–	–	–	–	–
Departmental agencies and accounts	–	11	80	42	42	–	44	47	50
Departmental agencies (non-business entities)	–	11	80	42	42	–	44	47	50
Households	1 527	4 542	1 811	988	988	1 673	1 037	1 098	1 159
Social benefits	1 527	4 542	1 811	988	988	1 673	1 037	1 098	1 159
Payments for capital assets	**6 889**	**8 159**	**5 127**	**12 355**	**24 234**	**24 234**	**15 973**	**15 145**	**15 993**
Machinery and equipment	6 889	8 159	5 127	12 355	24 234	24 234	15 973	15 145	15 993
Transport equipment	–	282	703	–	–	–	–	–	–
Other machinery and equipment	6 889	7 877	4 424	12 355	24 234	24 234	15 973	15 145	15 993
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme (numb	**812 087**	**943 975**	**991 759**	**1 039 902**	**1 072 127**	**1 072 127**	**1 101 054**	**1 150 735**	**1 215 176**

5.5 PERFORMANCE AND EXPENDITURE TRENDS

Programme 5: Central Hospital Services consists of Rob Ferreira Hospital and Witbank Hospital budget increase of 2.5 per cent in 2017/18 financial year. The programme provides tertiary services to patients and includes the National Tertiary Services Grant which shares between the two facilities. This programme receives 9.2 per cent of the allocated budget for 2017/18 financial year.

5.6 RISK MANAGEMENT

RISK	MITIGATING FACTORS
1. Incomplete package of level 3 services	a. Increase number of registrars b. Provincial tender for medical equipment and consumables, as opposed to quotation system c. Strengthen relationship with academic institutions d. Implement Delegation Framework of HR authority to CEOs
2. Clinical adverse events	a. Fill the vacant positions b. Develop implement and monitor clinical policies and procedures c. Match the list to the current state and procure the needed equipment and consumables d. Strengthen security measures in the units (in relation to record keeping) e. Strengthen supervision/Conduct clinical audits and peer reviews
3. Poor patient care and long patient waiting times	a. Train staff in customer care b. Re-launch Batho Pele Principles c. Reinforcement of referral policy d. Strengthen PHC services and outreach programmes by sharing information

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.

6.2 PRIORITIES

Improved human resources for health by implementing training for health professionals

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

PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
1. Improve human resource efficiency by training health care professionals on critical clinical skills	Quarterly	No
2. Number of Bursaries awarded for first year medicine students	Annual	No
3. Number of Bursaries awarded for first year nursing students	Annual	No

TABLE HST 1: STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR HST

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
	Strategic Objective/Provincial Indicators									
	1. Improve human resource efficiency by training health care professionals on critical clinical skills	No	Not in plan	Not in plan	4 473	2500	5000	5000	5000	20 000
	Programme Performance/Customized Indicators (Sector Indicators)									
	2. Number of Bursaries awarded for first year medicine students	No	Not in plan	Not in plan	99	99	10	10	10	218
	3. Number of Bursaries awarded for first year nursing students	No	Not in plan	Not in plan	310	310	250	300	300	1470

QUARTERLY TARGETS FOR HEALTH SCIENCES AND TRAINING

TABLE HST 2: QUARTERLY TARGETS FOR HST

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	TARGETS			
				Q1	Q2	Q3	Q4
1. Improve human resource efficiency by training health care professionals on critical clinical skills	Quarter	No	5000	700	1500	2000	800
2. Number of Bursaries awarded for first year medicine students	Annual	No	10	Annual Target	Annual Target	10	Annual Target
3. Number of Bursaries awarded for first year nursing students	Annual	No	250	Annual Target	Annual Target	Annual Target	250

6.4 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE HST 4: EXPENDITURE ESTIMATES: HEALTH SCIENCES AND TRAINING

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20
1. Nurse Training Colleges	141 010	172 097	179 593	193 043	189 755	188 947	203 216	225 561	238 193
2. EMS Training Colleges	2 330	2 152	2 473	1 090	872	2 018	812	995	1 050
3. Bursaries	1 064	1 588	43 317	54 996	68 996	69 645	68 912	73 244	77 346
4. Primary Health Care Training	5 302	3 322	4 081	4 489	3 905	3 971	20 885	23 267	24 571
5. Training Other	121 966	126 049	139 769	132 595	112 345	111 292	139 810	150 348	158 768
Total payments and estimates	**271 672**	**305 208**	**369 233**	**386 213**	**375 873**	**375 873**	**433 635**	**473 415**	**499 928**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20
Current payments	**229 769**	**275 891**	**312 862**	**335 213**	**310 873**	**310 320**	**361 259**	**397 614**	**419 882**
Compensation of employees	181 922	221 611	240 541	283 961	268 961	268 444	318 345	342 989	362 196
Salaries and wages	169 634	198 402	215 523	253 592	241 597	240 872	280 947	303 901	320 919
Social contributions	12 288	23 209	25 018	30 369	27 364	27 572	37 398	39 088	41 277
Goods and services	47 847	54 280	72 321	51 252	41 912	41 876	42 914	54 625	57 686
Administrative fees	515	449	359	560	395	192	395	2 248	2 373
Advertising	54	–	–	183	–	–	–	134	142
Minor Assets	126	40	14	–	–	–	–	–	–
Bursaries: Employees	1 749	2 627	1 798	1 500	600	611	–	–	–
Catering: Departmental activities	858	615	333	79	293	268	–	–	–
Communication (G&S)	188	209	210	77	233	328	233	264	279
Contractors	51	279	265	–	–	–	–	–	–
Agency and support / outsourced services	15 343	21 614	32 404	19 609	17 387	18 504	17 387	21 465	22 667
Fleet services (including government motor tr	822	1 127	917	1 495	1 495	806	1 495	1 588	1 677
Inventory: Clothing material and accessories	163	218	150	–	–	–	–	–	–
Inventory: Fuel, oil and gas	10	–	19	11	–	–	–	–	–
Inventory: Learner and teacher support mater	–	–	–	640	–	–	–	–	–
Inventory: Materials and supplies	–	–	51	–	–	–	–	–	–
Consumable supplies	1 787	2 303	2 347	2 353	2 108	1 897	2 708	2 840	3 000
Consumable: Stationery,printing and office su	444	320	531	951	946	216	1 446	2 704	2 856
Operating leases	214	300	93	459	300	108	300	319	337
Property payments	622	487	1 569	954	954	334	954	1 013	1 070
Travel and subsistence	16 148	19 018	24 408	14 833	13 759	15 220	14 009	17 854	18 854
Training and development	7 415	4 589	6 518	6 464	3 370	3 063	3 367	3 576	3 776
Operating payments	394	71	248	1 084	49	245	620	620	655
Venues and facilities	944	7	87	–	–	34	–	–	–
Rental and hiring	–	7	–	–	23	50	–	–	–
Interest and rent on land	–	–	–	–	–	–	–	–	–
Transfers and subsidies	**41 806**	**26 807**	**56 371**	**51 000**	**65 000**	**65 517**	**69 214**	**73 631**	**77 754**
Provinces and municipalities	9	16	–	–	–	–	–	–	–
Municipalities	9	16	–	–	–	–	–	–	–
Municipal bank accounts	9	16	–	–	–	–	–	–	–
Departmental agencies and accounts	4 298	–	–	–	–	–	3 785	4 179	4 413
Departmental agencies (non-business entities)	4 298	–	–	–	–	–	3 785	4 179	4 413
Households	37 499	26 791	56 371	51 000	65 000	65 517	65 429	69 452	73 341
Social benefits	37 499	26 791	56 371	51 000	65 000	65 517	65 429	69 452	73 341
Payments for capital assets	**97**	**2 510**	**–**	**–**	**–**	**36**	**3 162**	**2 170**	**2 292**
Machinery and equipment	97	2 510	–	–	–	36	3 162	2 170	2 292
Transport equipment	–	2 504	–	–	–	–	162	170	180
Other machinery and equipment	97	6	–	–	–	36	3 000	2 000	2 112
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme (numb	**271 672**	**305 208**	**369 233**	**386 213**	**375 873**	**375 873**	**433 635**	**473 415**	**499 928**

6.5 PERFORMANCE AND EXPENDITURE TRENDS

Nursing Training College – has shown high growth over the past seven years which include the development of professional nurses in the nursing college. The expenditure of the sub-programme includes payment of accommodation for students and providing of catering at the college. Funds allocated to the college are increased due to a need to address challenges at the nursing college.

EMS Training College – the baselines for this programme has been reduced due to slow implementation of programmes.

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

Bursaries – bursary payments were transferred to Department of Education as from 2012/13 financial year throughout the MTEF period. Only funding CUBAN program has remained with the Department.

Training Other – the sub programme includes HPTD Conditional Grant which supports the departmental Health Sciences and Training Programme in funding services relating to training and development of health professions.

6.6 RISK MANAGEMENT

RISK	MITIGATING FACTORS
1. Ineffective management of performance	a. Develop PMDS implementation guidelines b. Establish quarterly assessment committees c. Identify gaps and Implement continuous training on the management of performance
2. High attrition of Healthcare professionals	a. Implement recruitment and retention strategy b. Provide training further training opportunities in collaboration with Higher Education intuitions as well as in-house training opportunities c. Finalise retention strategy
3. Inadequate Management of the Bursary system.	a. Implement recruitment and retention strategy b. Provide training further training opportunities in collaboration with Higher Education intuitions as well as in-house training opportunities c. Finalise retention strategy

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.

There are four directorates within programme 7 namely:

- **Pharmaceutical Services (**Pharmaceutical Depot, Policy Systems and Norms, Essential Medicine List (EML) and Programme Support and African Traditional Health Practices)
- **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, Telemedicine and Laundry Services
- **Health Technology Services** (Clinical Engineering, Imaging Services)

7.2 PRIORITIES

The strategic goal of this programme, is to improve quality of health care

The **strategic priority** of the programme is to overhaul the health care system by improving quality of care including implementation of the National Health Insurance.

- Provision of quality pharmaceutical services in all the facilities
- Provision of quality Clinical Forensic Medicine Services
- Provision of quality Forensic Pathology 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;

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

PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
1. Improve quality of care by increasing availability of medicines and surgical sundries at the Medical Depot.	Quarter	%
2. Number of patients initiated on Central Chronic Medicine Dispensing and Distribution (CCMDD)	Quarter	No
3. Improve access to quality of care through compliance with Radiation Control prescripts by all facilities with X-Ray equipment	Quarter	%
4. Improve laundry services by developing a provincial laundry model	Annual	Text
5. Number of hospitals providing laundry services	Quarterly	No
6. Number of Orthotic and Prosthetic devices issued	Quarterly	No
7. Number of hospitals with functional transfusion committees	Quarterly	No
8. Number of sites rendering Forensic Pathology Services (FPS)	Quarterly	No

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

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
Improved quality of health care	**Strategic Objective/Provincial Indicators**									
	1. Improve quality of care by increasing availability of medicines and surgical sundries at the Medical Depot.	%	Not in plan	Not in plan	79%	95%	95%	95%	95%	95%
	2. Number of patients initiated on Central Chronic Medicine Dispensing and Distribution (CCMDD)	No	Not in plan	Not in plan	Not in plan	30 000	135 179	195 000	255 000	315 000
	3. Improve access to quality of care through compliance with Radiation Control prescripts by all facilities with X-Ray equipment	%	Not in plan	Not in plan	70% (21/30 facilities)	100% (30/30 facilities)	100% (30/30 facilities)	100% (30/30 facilities)	100% (30/30 facilities)	100% (30/30 facilities)
	4. Improve laundry services by developing a provincial laundry model	Text	Not in plan	Not in plan	Not in plan	Approved laundry model	Approved provincial laundry service model	-	-	Approved provincial laundry service model
	5. Number of hospitals providing laundry services	No	Not in plan	Not in plan	18/33	21	21/33	26/33	33/33	33/33
	6. Number of Orthotic and Prosthetic devices issued	No	Not in plan	Not in plan	Not in plan	3 500	3675	3675	3859	3859

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
	7. Number of hospitals with functional transfusion committees	No	Not in plan	Not in plan	Not in plan	33/33	33/33 (Maintained)	33/33 (Maintained)	33/33 (Maintained)	33/33 (Maintained)
	8. Number of sites rendering Forensic Pathology Services (FPS)	No	Not in plan	Not in plan	Not in plan	21	21	21	21	21

7.3.1 QUARTERLY TARGETS FOR HEALTH CARE SUPPORT SERVICES

Ensure the indicators and their respective annual targets are consistent with the information in the tables above.

TABLE HCSS 2: QUARTERLY TARGETS FOR HEALTH CARE SUPPORT SERVICES FOR 2017/18

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	TARGETS			
				Q1	Q2	Q3	Q4
1. Improve quality of care by increasing availability of medicines and surgical sundries at the Medical Depot.	Quarterly	%	95%	95%	95%	95%	95%
2. Number of patients initiated on Central Chronic Medicine Dispensing and Distribution (CCMDD)	Quarterly	No	135 179	13 500	13 500	13 500	13 500
3. Improve access to quality of care through compliance with Radiation Control prescripts by all facilities with X-Ray equipment	Quarterly	%	100% (30/30 facilities)	100% 5/5	100% 9/9	100% 8/8	100% 8/8
4. Improve laundry services by developing a provincial laundry model	Annual	Text	Approved provincial laundry service model	Annual Target	Annual Target	Annual Target	Approved provincial laundry service model
5. Number of hospitals providing laundry services	Quarterly	No	21/33	21/33	21/33	21/33	21/33
6. Number of Orthotic and Prosthetic devices issued	Quarterly	No	3675	612	612	1837	612
7. Number of hospitals with functional transfusion committees	Quarterly	No	33/33	33/33	33/33	33/33	33/33
8. Number of sites rendering Forensic Pathology Services (FPS)	No	No.	21	21	21	21	21

7.4 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE HCSS 4: EXPENDITURE ESTIMATES: HEALTH CARE SUPPORT SERVICES

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20
1. Laundries	20 796	21 438	23 704	28 811	28 145	28 101	27 516	33 541	35 420
2. Engineering	19 055	17 464	21 915	56 606	45 395	45 395	40 669	52 473	55 411
3. Forensic Services	52 481	51 910	61 998	67 822	69 843	69 861	66 765	81 671	86 246
4. Orthotic and Prosthetic Services	3 347	1 968	3 963	4 383	3 983	3 983	4 138	4 560	4 816
5. Medicine Trading Account	10 208	8 927	11 871	18 302	12 748	12 774	18 687	19 953	21 071
Total payments and estimates	**105 887**	**101 707**	**123 451**	**175 924**	**160 114**	**160 114**	**157 775**	**192 198**	**202 964**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20
Current payments	**102 971**	**100 325**	**118 063**	**138 394**	**135 244**	**135 244**	**134 893**	**157 955**	**166 803**
Compensation of employees	72 242	73 781	81 955	101 031	101 631	101 631	105 762	121 873	128 700
Salaries and wages	61 406	64 381	71 051	88 726	88 768	88 768	92 639	107 750	113 786
Social contributions	10 836	9 400	10 904	12 305	12 863	12 863	13 123	14 123	14 914
Goods and services	30 729	26 544	36 108	37 363	33 613	33 613	29 131	36 082	38 103
Administrative fees	107	116	215	138	318	224	318	351	371
Minor Assets	30	208	–	121	12	73	12	92	97
Catering: Departmental activities	38	46	72	2	19	18	–	–	–
Communication (G&S)	1 386	2 233	1 449	1 418	900	1 208	900	967	1 021
Consultants and professional services: Busin	–	–	–	3 000	2 024	2 024	2 024	2 149	2 269
Contractors	9 569	5 199	8 078	10 583	6 297	6 041	6 297	7 773	8 208
Agency and support / outsourced services	31	–	412	–	663	–	41	41	43
Fleet services (including government motor tr	3 505	4 320	3 823	3 389	3 289	3 912	3 226	3 399	3 590
Inventory: Clothing material and accessories	1	75	28	–	–	–	–	–	–
Inventory: Fuel, oil and gas	–	–	1 869	–	–	–	–	–	–
Inventory: Materials and supplies	1 807	3 550	3 195	2 532	–	–	–	2 961	3 127
Inventory: Medical supplies	6 248	2 428	6 044	5 519	6 329	6 329	6 329	6 747	7 125
Consumable supplies	1 408	2 889	5 169	4 790	8 534	8 332	5 233	5 558	5 869
Consumable: Stationery,printing and office su	599	358	350	93	901	848	855	994	1 051
Operating leases	1 305	1 135	1 111	846	975	975	763	842	889
Property payments	1 708	1 438	840	1 240	721	677	721	766	809
Transport provided: Departmental activity	178	86	179	159	120	120	120	167	176
Travel and subsistence	2 553	2 141	3 007	2 790	2 315	2 689	2 189	2 739	2 893
Training and development	11	35	40	593	13	13	3	184	194
Operating payments	200	122	57	117	100	47	100	352	371
Venues and facilities	45	165	170	33	83	83	–	–	–
Interest and rent on land	–	–	–	–	–	–	–	–	–
Transfers and subsidies	**47**	**138**	**655**	**228**	**228**	**228**	**240**	**313**	**331**
Provinces and municipalities	37	37	–	–	–	–	–	59	62
Municipalities	37	37	–	–	–	–	–	59	62
Municipal bank accounts	37	37	–	–	–	–	–	59	62
Households	10	101	655	228	228	228	240	254	269
Social benefits	10	101	655	228	228	228	240	254	269
Payments for capital assets	**2 869**	**1 244**	**4 733**	**37 302**	**24 642**	**24 642**	**22 642**	**33 930**	**35 830**
Machinery and equipment	2 869	1 244	4 733	37 302	24 642	24 642	22 642	33 930	35 830
Transport equipment	–	526	4 240	1 000	–	–	–	1 058	1 117
Other machinery and equipment	2 869	718	493	36 302	24 642	24 642	22 642	32 872	34 713
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme (numb	**105 887**	**101 707**	**123 451**	**175 924**	**160 114**	**160 114**	**157 775**	**192 198**	**202 964**

7.5 PERFORMANCE AND EXPENDITURE TRENDS

Health Care Support Services will reduced by 0.1 per cent for the 2016/17 financial year due to reduction on baseline. There is still a need to prioritise the provision of clean linen and overall laundry services to the Engineering allocation has been protected as an effort to ensure improved functionality of essential medical equipment in various facilities.

This programme includes a number of programmes which are aimed at achieving output 4: Strengthening Health System effectiveness. Though programme 7 is mainly supportive, highly skilled personnel and high tech equipment have to be managed.

7.6 RISK MANAGEMENT

RISK	MITIGATING FACTORS
1. Inadequate Forensic Pathology Services	a. Implementation of recruitment and retention strategy b. Implementation of internal training programme while awaiting for finalization of the National Curriculum c. Conduct information sharing sessions through presentations at both individual and community level d. Submission of infrastructural need to the Infrastructure section e. Submission of prioritised needs to budget section f. Procurement of capital assets in line with allocated capital budget. g. Submission of prioritized posts to be advertised h. Provision of wellness programme to employees i. Submission of ICT needs to Departmental ICT section j. Monitor compliance by the Service Provider to the Service Level Agreement
2. Shortage of pharmacy personnel	a. Approved new organisational structure b. Employment of CSP and Pharmacists at facilities c. Ensure proper planning to increase budget allocation d. Adhere to recruitment and selection policy
3. Shortage of Pharmaceuticals and Surgicals in the Province	a. Install stock management system in all facilities b. Secure budget for warehouse facilities (infrastructure) c. Improve pharmaceutical warehouse management
4. 'Inadequate maintenance of medical equipment	a. Fast track the filling of critical vacant posts. b. Review and implementation of medical equipment SLAs with Service providers. Development of maintenance plans for medical equipment for all hospitals. c. Emphasise motivation for more maintenance of medical equipment budget. d. Develop an SOP on medical equipment maintenance.

RISK	MITIGATING FACTORS
	e. Replacement of old vehicles for the CE workshops. f. Engage SCM section to expedite the processing of requisitions for maintenance.
5. Critical shortage of Clinical Engineering (CE) Technicians and Radiographers	a. Secure budget for filling of vacant posts b. Streamline recruitment processes c. Implementation of OSD for Engineering to be corrected.

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.

8.2 PRIORITIES

The Programme will be prioritize the construction of the following health facilities for the MTEF period:

(a) Hi-Tech Hospitals:

1. New/replacement

- Middleburg District Hospital
- Mapulaneng Regional Hospital

2. Upgrade and additions

- Mmametlhake District Hospital
- Bethal District Hospital
- KwaMhlanga District Hospital
- Themba Regional Hospital and,
- Rob Ferreira Tertiary Hospital

(b) Ideal Clinics:

- Vukuzakhe and Nhlazathse 6 Clinics,
- Msukaligwa, Thandukukhanya and Balfour CHC's are implemented through Inkind Grant from National Department of Health.
- Oakley, Pankop Clinics and KaNyamazane CHC

8.3 PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR HFM

PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
1. Improve access to healthcare by increasing number of PHC facilities maintained	Annual	No
2. Number of PHC facilities constructed (new/replacement)	Annual	No
3. Number of Hospitals under maintenance	Annual	No
4. Enhance patient care & safety and improving medical care by constructing Modern hi-tech hospitals	Annual	No
5. Improve maintenance of health facilities by appointing cooperatives	Annual	No
6. Number of health facilities that have undergone major and minor refurbishment in NHI Pilot District	Annual	No
7. Number of health facilities that have undergone major and minor refurbishment outside NHI pilot District (excluding facilities in NHI Pilot District)	Annual	No

TABLE HFM 1: PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR HEALTH FACILITIES MANAGEMENT

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
Improved health facility planning and accelerate infrastructure delivery	**Strategic Objective / Provincial Indicators**									
	1. Improve access to healthcare by increasing number of PHC facilities maintained	No	Not in plan	48/279	107 PHC	90 (Cumulative 240/284)	39 (Cumulative 279/287)	5 (Cumulative 287/287	287/287	287/287
	2. Number of PHC facilities constructed (new/replacement)	No	Not in plan	Not in plan	Not in plan	8 Ehlanzeni: 2 Gert Sibande: 5 Nkangala: 1	6 (cumulative 14) Ehlanzeni: 5 Gert Sibande: 7 Nkangala: 2	0 (cumulative 14) Ehlanzeni: 4 Gert Sibande: 2 Nkangala: 3	17 Ehlanzeni: 5 Gert Sibande: 8 Nkangala: 3	17 (including 3 from 2015/16) Ehlanzeni: 5 Gert Sibande: 8 Nkangala: 3
	3. Number of Hospitals under maintenance	No	Not in plan	Not in plan	Not in plan	31	31	31	31	31
	4. Enhance patient care & safety and improving medical care by constructing Modern hi-tech hospitals	No	Not in plan	Not in plan	4 (Planning phase)	3 (Planning phase)	3 (Construction)	1 (Cumulative 4)	1 (Cumulative 5)	5
	5. Improve maintenance of health facilities by appointing cooperatives	No	Not in plan	Not in plan	Not in plan	10 cooperatives appointed	16 cooperatives appointed (cumulative 26)	15 cooperatives appointed (cumulative 41)	15 cooperatives appointed (cumulative 56)	16 cooperatives appointed (cumulative 26)
	Programme Performance / Customized Indicators (Sector Indicators)									

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets			Strategic Plan target
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2019/20
Improved health facility planning and accelerate infrastructure delivery	6. Number of health facilities that have undergone major and minor refurbishment in NHI Pilot District	No	Not in plan	Not in plan	Not in plan	15 PHC*	25 PHC* (cumulative 40)	25 PHC* (cumulative 65)	6 Hospitals 77 PHC	6 Hospitals 77 PHC
	7. Number of health facilities that have undergone major and minor refurbishment outside NHI pilot District (excluding facilities in NHI Pilot District)	No	Not in plan	Not in plan	Not in plan	5 Hospitals 13 PHC	4 Hospitals 10 PHC	5 Hospitals 13 PHC	2 Hospitals 10 PHC	5 Hospitals 10 PHC

7.1 QUARTERLY TARGETS FOR HFM

TABLE HFM3: QUARTERLY TARGETS FOR HEALTH FACILITES MANAGEMENT

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	TARGETS			
				Q1	Q2	Q3	Q4
1. Improve access to healthcare by increasing number of PHC facilities maintained	Annual	No	39	9	10	10	10
2. Number of PHC facilities constructed (new/replacement)	Annual	No	Ehlanzeni: 5 Gert Sibande: 7 Nkangala: 2	Construction Ehlanzeni: 2 Gert Sibande: 5 Nkangala: 1 6 Planning Phase (Ehlanzeni: 3 Gert Sibande: 2 Nkangala: 1)	Construction Ehlanzeni: 2 Gert Sibande: 5 Nkangala: 1 6 Planning Phase (Ehlanzeni: 3 Gert Sibande: 2 Nkangala: 1)	Construction Ehlanzeni: 2 Gert Sibande: 5 Nkangala: 1 6 Planning Phase (Ehlanzeni: 3 Gert Sibande: 2 Nkangala: 1)	Construction Ehlanzeni: 5 Gert Sibande: 7 Nkangala: 2
3. Number of Hospitals under maintenance	Annual	No	31	6	9	12	4
4. Enhance patient care & safety and improving medical care by constructing Modern hi-tech hospitals	Annual	No	3 (Construction)	3 (Construction)	3 (Construction)	3 (Construction)	3 (Construction)
5. Improve maintenance of health facilities by appointing cooperatives	Annual	No	16 cooperatives appointed	2	6 (Cumulative 8)	4 (Cumulative12)	2 (Cumulative 6)
6. Number of health facilities that have undergone major and minor refurbishment in NHI Pilot District	Annual	No	25 PHC* (cumulative 40)	5	7	8	5
7. Number of health facilities that have undergone major and minor refurbishment in NHI Pilot District	No	Not in plan	Not in plan	Not in plan	15 PHC*	25 PHC* (cumulative 40)	25 PHC* (cumulative65)

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	TARGETS			
				Q1	Q2	Q3	Q4
8. Number of health facilities that have undergone major and minor refurbishment outside NHI pilot District (excluding facilities in NHI Pilot District)	No	Not in plan	Not in plan	Not in plan	5 Hospitals 13 PHC	4 Hospitals 10 PHC	5 Hospitals 13 PHC

8.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE HFM 4: EXPENDITURE ESTIMATES: HEALTH CARE SUPPORT SERVICES

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20
1. Community Health Facilities	226 807	197 534	294 978	433 600	372 580	372 580	1 110 823	1 099 446	1 161 324
2. Emergency Medical Rescue Services	–	–	–	–	–	–	–	–	–
3. District Hospital Services	49 531	60 615	96 247	49 777	58 333	68 047	59 860	63 839	67 412
4. Provincial Hospital Services	254 782	210 901	248 039	231 397	231 397	221 683	265 757	275 837	291 284
5. Central Hospital Services	–	–	–	–	–	–	–	–	–
6. Other Facilities	–	–	–	–	–	–	–	–	–
Total payments and estimates	**531 120**	**469 050**	**639 264**	**714 774**	**662 310**	**662 310**	**1 436 440**	**1 439 122**	**1 520 020**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20
Current payments	**36 536**	**124 440**	**172 012**	**218 050**	**194 164**	**198 378**	**137 552**	**125 937**	**132 989**
Compensation of employees	8 264	9 783	11 097	29 657	18 023	18 003	32 177	33 680	35 566
Salaries and wages	7 025	8 705	9 789	26 121	15 640	15 640	28 470	29 758	31 424
Social contributions	1 239	1 078	1 308	3 536	2 383	2 363	3 707	3 922	4 142
Goods and services	28 272	114 657	160 915	188 393	176 141	179 223	105 375	92 257	97 423
Administrative fees	23	17	62	126	89	48	132	136	144
Advertising	–	–	181	–	671	–	–	–	–
Minor Assets	218	239	329	3 888	178	270	4 082	4 319	4 561
Catering: Departmental activities	27	14	113	115	12	3	121	128	135
Communication (G&S)	37	14	47	259	95	12	272	287	303
Consultants and professional services: Busin	–	–	17	–	–	–	–	–	–
Infrastructure and planning	–	–	3 756	10 000	9 000	–	10 000	10 000	10 560
Contractors	42	16 693	13 866	–	94	3 081	–	–	–
Agency and support / outsourced services	1 222	–	126	5 076	12 734	21 776	27	29	31
Inventory: Fuel, oil and gas	–	–	4 951	–	–	–	–	–	–
Inventory: Materials and supplies	–	–	996	–	–	–	–	–	–
Inventory: Medical supplies	–	303	95	366	150	–	384	–	–
Consumable supplies	92	363	40 196	52 303	10 938	25 478	22 986	20 686	21 845
Consumable: Stationery,printing and office su	–	–	429	144	100	29	151	151	159
Operating leases	–	–	–	–	–	687	–	–	–
Property payments	25 142	95 956	93 597	107 750	140 162	127 560	63 223	52 321	55 249
Transport provided: Departmental activity	–	–	–	210	–	–	221	234	247
Travel and subsistence	1 454	788	1 592	4 459	330	279	354	354	374
Training and development	2	214	406	2 156	1 218	–	2 264	2 395	2 529
Operating payments	13	56	156	1 103	370	–	1 158	1 217	1 286
Venues and facilities	–	–	–	438	–	–	–	–	–
Interest and rent on land	–	–	–	–	–	1 152	–	–	–
Interest (Incl. interest on finance leases)	–	–	–	–	–	1 152	–	–	–
Transfers and subsidies	**–**	**3 456**	**31**	**–**	**–**	**20**	**–**	**–**	**–**
Non-profit institutions	–	3 384	–	–	–	–	–	–	–
Households	–	72	31	–	–	20	–	–	–
Social benefits	–	72	31	–	–	20	–	–	–
Payments for capital assets	**494 584**	**341 154**	**467 221**	**496 724**	**468 146**	**463 912**	**1 298 888**	**1 313 185**	**1 387 031**
Buildings and other fixed structures	460 130	312 522	453 725	445 363	429 610	440 713	1 263 888	1 301 985	1 375 204
Buildings	460 130	312 522	453 725	445 363	429 610	440 713	1 263 888	1 301 985	1 375 204
Machinery and equipment	34 454	28 632	13 496	51 361	38 536	23 199	35 000	11 200	11 827
Other machinery and equipment	34 454	28 632	13 496	51 361	38 536	23 199	35 000	11 200	11 827
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme (numb	**531 120**	**469 050**	**639 264**	**714 774**	**662 310**	**662 310**	**1 436 440**	**1 439 122**	**1 520 020**

8.6 PERFORMANCE AND EXPENDITURE TRENDS

Programme 8 which is Health Facilities Management has shown increase of 117 per cent due to additional budget for infrastructure projects.

8.7 RISK MANAGEMENT

RISK	MITIGATING FACTORS
1. Poor maintenance of infrastructure and equipment	a. Include maintenance requirements in infrastructure planning (3 year maintenance plan) b. Conclude service level agreements with the MRTT for placement of artisans c. Secure adequate budget via Construction Procurement Standard for multi-year programme
2. Cost over-runs on projects	a. Establishment a fully functional infrastructure unit b. Peer review process for all projects c. Monitoring and attending oversight progress meeting
3. Inadequate infrastructure designs	a. Project management, monitoring and evaluation for compliance b. Accelerate CSIR process of development of norms and standards for Health Facilities
4. Inadequate budget for Programme 8	a. Finalise the Service Transformation Plan (STP) b. Develop costed Provincial Maintenance Master Plan c. Motivate for needs driven budget
5. Inadequate facilities management skills and capacity	a. Appoint resident engineers as recommended by NDOH b. Develop capacitation plans for existing staff in the construction industry c. Obtaining technical skills for the PMO unit to be fully functional and improve monitoring of projects and compliance with the norms and standards

PART C: LINKS TO OTHER PLANS

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

NO	PROJECT NAME	PROGRAMME	MUNICIPALITY	OUTPUTS	OUTCOME R'000			R'000			MEDIUM TERM ESTIMATES		
								MAIN APPRO PRIATION	ADJUSTED APPRO PRIATION	REVISED ESTIMATE			
					2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
1	New and replacement assets (R'000)												
1.1	KaNyamazane CHC:	8	Mbombela	Construction of new 2 x 2 accommodation and new CHC	0	0	500	4000			3 500	0	0
1.2	Pankop Clinic	8	Dr JS Moroka	Construction of new Clinic & 2x2 accommodation units	0	0	0	3500			28 750	26 575	8 000
1.3	Oakley Clinic	8	Bushbuckridge	Construction of new Clinic & 2x2 accommodation units	0	0	0	3500			34 850	50 760	9 710
1.7	Msukaligwa CHC	8	Msukaligwa	Construction of new CHC and accommodation units	0	0	500	3 500			7 947	10 000	3 053
1.8	Thandukukhanya CHC	8	Mkhondo	Construction of new CHC and accommodation units	0	0	0	3 500			7 947	8 153	2 000
1.9	Nhlazatshe 6 Clinic	8	Chief Albert Luthuli	Construction of new clinic and accommodation units	0	0	500	2 200			3 140	7 060	2 000
1.10	Vukuzakhe Clinic	8	Isak Pixley Ka Seme	Construction of new clinic and accommodation units	0	0	500	2 200			3 140	7 060	2 000
1.11	Balfour CHC	8	Dipaliseng	Construction of CHC and accommodation units	0	0	1750	5 500			7 947	8 153	2 000
1.13	Middelburg Hospital	8	Steve Tshwete	Planning a and construction of new Hospital	0	0	0	90 000			268 000	279 775	295 552
1.15	Themba Hospital	8	Mbombela	Construction of New maternity, helipad and resource centre)	0	0	0	1 707			10 000	30 000	96 486

NO	PROJECT NAME	PROGRAMME	MUNICIPALITY	OUTPUTS	OUTCOME R'000			R'000			MEDIUM TERM ESTIMATES		
								MAIN APPRO PRIATION	ADJUSTED APPRO PRIATION	REVISED ESTIMATE			
					2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
1.16	Mapulaneng Hospital Phase 1	8	Bushbuckridge	Fencing and earthworks	0	0	0	255			20 000	0	0
1.17	Mapulaneng Hospital Phase 2	8	Bushbuckridge	Construction of new hospital	0	0	0	112 073			108 368	420 601	644 259
1.18	Construction of new septic tanks	8	Various	Construction of new septic tanks	0	0	0	3 687			3 687	4 129	4 625
1.19	Machinery and Equipment and Upgrade of lifts	8	Various	New Machinery and Equipment and Upgrade of lifts	0	0	12 268	42 877			3 578	0	0
1.20	Drilling and construction of new boreholes33	8	Various	Drilling and construction of new boreholes33	0	0	0	33 455			7 000	7 840	8 781
1.21	Transaction Advisor	8	Provincial office	Transaction Advisor	0	0	40 450				0	0	0
1.22	Matikwane Hospital	8	Bushbuckridge	Payment for Matikwane Hospital	0	0	0	38 000			38 000	0	0
Total new and replacement assets					0	0	56 468	349 954			555 854	860 106	1 097 566

NO	PROJECT NAME	PROGRAMME	MUNICIPALITY	OUTPUTS	OUTCOME R'000			R'000			MEDIUM TERM ESTIMATES		
								MAIN APPRO PRIATION	ADJUSTED APPRO PRIATION	REVISED ESTIMATE			
					2014/15	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
2.	Upgrades and Additions												
2.1	Mmametlhake hospital (Phase 1)	8	Dr JS Moroka	Upgrading and Additions of wards	60 000	0	74 000	97 884			141 908	40 212	0
2.2	Mmametlhake hospital (Phase 2)	8	Dr JS Moroka	Upgrading and Additions of support buildings	0	0	0	0			40 212	67 479	92 636
2.3	Bethal Hospital	8	Govan Mbeki	Major Upgrade of hospital, including rehabilitation of existing facilities and stepdown of the hospital)	0	0	0	14 499			368 784	190 270	0
2.4	Rob Ferreira Hospital	8	Mbombela	Construction of a compactor room, Grease Trap Unit and Associated External Works	0	0		10 806			5 998	500	0

NO	PROJECT NAME	PROGRAMME	MUNICIPALITY	OUTPUTS	OUTCOME R'000			R'000			MEDIUM TERM ESTIMATES		
								MAIN APPRO PRIATION	ADJUSTED APPRO PRIATION	REVISED ESTIMATE			
					2014/15	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
25		8	Mbombela	Parking Deck	0	0	14 499	150 000			20 721	46 030	15 309
2.6		8	Mbombela	Upgrading of existing internal road and parking	0	0	0	17 791			15 122	2 669	0
2.7		8	Mbombela	Construction of New Mortuary	0	0	14 498	26 760			10 663	1 599	0
2.8	KwaMhlanga hospital	8	Thembisile Hani	Master planning, Re-location of Psychiatric [Mental] Ward, Maternity Ward and Sub-Soil water investigation	0	0	573	604 316			54 382	40 292	96 486
2.9	Khumbula Clinic	8	Mbombela	Paving, and erection of Waiting area	0	0	2 311	2 000			2 000	0	0
2.10	KwaMhlanga Hospital	8	Thembisile	Renovations to accommodation for staff	0	858		2 003			0	0	0
2.11	KwaMhlanga Hospital	8	Thembisile Hani	Phase 3c, Construction of ICU, Casualty and additions to existing theatre	8 256	0		0			218	0	0
2.12	Sabie Hospital	8	Thaba Chweu	Site establishment, Demolition of asbestos and construction of wards	0	0	4 465	5 730			1 948	0	0
Total upgrades and additions					68 256	90 512	110 346	931 789			666 107	389 051	204 431
3.	Rehabilitation, Refurbishment, Repairs												
3.1	MARITE CLINIC:	8	Bushbuckridge	Renovations., rehabilitations and refurbishmnet	0	0	0	2 000			0	0	0
3.2	MPAKENI CLINIC	8	Mbombela	Renovations., rehabilitations and refurbishment	0	0	7 953	7 953			4 000	0	0
3.5	SIBANGE CLINIC	8	Nkomazi	Repairs, rehabilitation & refurbishment	0	0	1 781	1 781			6 000	0	0
3.6	Anderson Street Ehlanzeni District Office	8	Mbombela	Repairs, rehabilitation & refurbishment	0	0	4 815	4 815			111	0	0

NO	PROJECT NAME	PROGRAMME	MUNICIPALITY	OUTPUTS	OUTCOME R'000			R'000			MEDIUM TERM ESTIMATES		
								MAIN APPRO PRIATION	ADJUSTED APPRO PRIATION	REVISED ESTIMATE			
					2014/15	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
3.7	Allenmansdrift B Clinic	8	Dr JS Moroka	Repairs, rehabilitation and refurbishment of the clinic	0	0	1 848	1 848			0	0	0
3.8	Siyathuthuka Clinic	8	Emakhazeni	Repairs, rehabilitation and refurbishment of the clinic	0	0	1 848	1 848			188	0	0
3.9	Exten. 8 Clinic	8	Steve Tshwete	Repairs, rehabilitation and refurbishment of the clinic	0	0	1 848	1 848			19	0	0
3.10	Polly Cinic	8	Emalahleni	Repairs, rehabilitation and refurbishment of the CHC	0	0	1 848	1 848			0	0	0
3.11	Nkangala District Office	8	Emalahleni	Repairs, rehabilitation and refurbishment of the district office	0	0	4 716	4 716			1 697	0	0
3.12	Nelspruit CHC	8	Mbombela	Repairs, rehabilitation & refurbishment	0	0	1 860	1 860			1 919	0	0
3.13	Waterval CHC	8	Dr JS Moroka	Expanded Public Works Programme	0	0		755			830	0	0
3.14	Waterval CHC	8	Dr JS Moroka	Minor Renovations	0	0	755	6 912				0	0
3.16	Mthimba Clinic	8	Mbombela	Expanded Public Works Programme	0	0	6 912	755			498	0	0
3.17	Khumbula Clinic	8	Mbombela	Expanded Public Works Programme	0	0	755	2 311			0	0	0
3.20	Evander Hospital	8	Govan Mbeki	Minor Renovations	0	0	0	4 210			326	0	0
3.21	Witbank hospital	8	Steve Tshwete	Renovation of Doctors residence in Witbank Hospital in Emalahleni Local	0	0	6 807	0			340		
3.22	Goromane clinic	8	Ehlanzeni	(Renovations, rehabilitation and refurbishment of existing Clinic facilities)	0	0	0	7 700			7 7000	0	0
3.23	Luphisi Clinic	8	Gert Sibande	Renovations, rehabilitation and refurbishment of existing Clinic facilities) (Phase 1) (Palisade Fencing)	0	0	0	7 075			7 075	0	0
3.24	Makoko clinic	8	Nkangala (All municipalities)	Renovations, rehabilitation and refurbishment of existing Clinic facilities)	0	0	0	7 075			7 075	0	0

NO	PROJECT NAME	PROGRAMME	MUNICIPALITY	OUTPUTS	OUTCOME R'000			R'000			MEDIUM TERM ESTIMATES		
								MAIN APPRO PRIATION	ADJUSTED APPRO PRIATION	REVISED ESTIMATE			
					2014/15	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
				(Phase 1) (Palisade Fencing)									
3.26	KaMdladla Clinic:	8	Bushbuckridge	Renovations., rehabilitations and refurbishment	0	0	0	10 000			0	0	0
3.27	Mgobotsi Clinic	8	Mbombela	Repairs, rehabilitation & refurbishment	0	0	0	13 000			2 000	0	0
3.28	Shongwe Hospital	8	Nkomazi	Repairs to Storm Damages	0	0	6000	6000			1 250	0	0
3.29	Tintswalo Hospital	8	Bushbuckridge	Repairs to doctors and nurses accommodation and underground infrastructure	0	0	0	5000			3 188	0	0
3.30	Lefiso clinic existing Clinic facilities)	8	Dr JS Moroka	(Renovations, rehabilitation and refurbishment of	0	0	0	8 897			8 897	0	0
3.32	Tonga Hospital	8	Ehlanzeni	(Repair of storm damages)	0	0	0	1 172			483	0	0
3.33	Barberton Hospital	8	Ehlanzeni	(Repair of storm damages)	0	0	0	1 280			269	0	0
3.34	Mangweni Clinic (Repair of storm damages)	8	Ehlanzeni	Provision of Coal	0	0	0	5 726			3 271	0	0
	Fig tree	8	Ehlanzeni	(Repair of storm damages)	0	0	0	219			11	0	0
3.35	Dludluma Clinic	8	Ehlanzeni	(Repair of storm damages)	0	0	0	1 597			560	0	0
3.36	Masibekela Clinic	8	Ehlanzeni	(Repair of storm damages)	0	0	0	146			4	0	0
3.37	Thubelihle CHC	8	Nkangala	(Repair of storm damages)	0	0	0	3 068			373	0	0
3.38	Naas Malaria Centre	8	Ehlanzeni	(Repair of storm damages)	0	0	0	1559			39	0	0
3.39	Various Clinics in Thembisile Hani Local Municipality	8	Nkangala	Repair of storm damages)	0	0	0	674			43	0	0

NO	PROJECT NAME	PROGRAMME	MUNICIPALITY	OUTPUTS	OUTCOME R'000			R'000 MAIN APPRO PRIATION	R'000 ADJUSTED APPRO PRIATION	R'000 REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2014/15	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
3.40	Various Clinics in Dr JS Moroka Local Municipality	8	Nkangala	(Repair of storm damages)	0	0		7 321			4 298	0	0
3.41	Mpumalanga Nursing College	8	Ehlanzeni	Renovations., rehabilitations and refurbishment	0	0	0	0			4 000	4 280	4 580
Total Repairs, Rehabilitation and refurbishment					0	0	0	49 746			82 517	75 954	92 005

NO	PROJECT NAME	PROGRAMME	MUNICIPALITY	OUTPUTS	OUTCOME R'000			R'000 MAIN APPRO PRIATION	R'000 ADJUSTED APPRO PRIATION	R'000 REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
4	Maintenance												
4.1	Maintenance District Services: Hospitals, Clinics and Other (Ehlanzeni)	8	Ehlanzeni	Maintenance Various Facilities	9 088	97 622	44 951	9 626		2 591	8 455	6 520	4 537
4.2	Maintenance District Services: Hospitals, Clinics and Other (Gert Sibande)	8	Gert Sibande	Maintenance Various Facilities	0	57 987	22 919	1 962		2 591	10 636	6 017	7 128
4.3	Maintenance District Services: Hospitals, Clinics and Other (Nkangala)	8	Nkangala	Maintenance Various Facilities	9 088	97 622	44 951	9 626		2 591	2 206	2 338	2 479
4.7	Maintenance Big 5: Rob Ferreira	8	Ehlanzeni	Maintenance	0	57 987	22 919	1 962		500	2 000	2 120	2 247
4.8	Maintenance Big 5: Mapulaneng	8	Ehlanzeni	Maintenance	0	44 417	54 020	6 626		500	2 000	2 120	2 247
4.9	Maintenance Big 5: Themba	8	Ehlanzeni	Maintenance	0	0	1 000	620		500	2 000	2 120	2 247
4.10	Maintenance Big 5: Witbank	8	Nkangala	Maintenance	0	0	26 850	19 955		500	2 000	2 120	2 247

NO	PROJECT NAME	PROGRAMME	MUNICIPALITY	OUTPUTS	OUTCOME R'000			R'000			MEDIUM TERM ESTIMATES		
								MAIN APPRO PRIATION	ADJUSTED APPRO PRIATION	REVISED ESTIMATE			
					2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
4.11	Maintenance Big 5: Ermelo	8	Gert Sibande	Maintenance	0	0	4 301	4 817		500	5 657	9 000	10 000
4.12	Maintenance of Health Technology equipment	8	All District	Maintenance Various Facilities	0	0	6 941	1 200		0	6 000	6 360	6 742
4.13	Maintenance of generators, autoclaves, aircons etc	8	All District	Maintenance Various Facilities	0	0	0			7 835	8 500	8 953	10 000
4.14	Provision of Coal, 9 Hospitals	8	Ehlanzeni	Provision of Coal, 9 Hospitals	0	0	0			6 000	7 600	8 200	12 000
4.15	Provision of Coal, 6 Hospitals	8	Gert Sibande	Provision of Coal, 6 Hospitals						6 000	5 794	6 500	6 890
4.16	Provision of Coal, 2 Hospitals	8	Nkangala	Provision of Coal, 2 Hospitals	0	0	0			6 000	8 455	6 520	4 537
4.17													
Total Maintenance					18 176	160 391	183 901	46 768	0	0	73 033	67 907	75 384
Grand Total											1 377 511	1 393 018	1 469 385

8. CONDITIONAL GRANTS

NAME OF CONDITIONAL GRANT	PURPOSE OF THE GRANT	PERFORMANCE INDICATORS	INDICATOR TARGETS FOR 2017/18
Comprehensive HIV and AIDS Conditional Grant	• To enable the health sector to develop an effective response to HIV and AIDS including universal access to HIV Counselling and Testing • To support the implements of the National operational plan for comprehensive HIV and AIDS treatment and care • To subsidise in-part funding for the antiretroviral treatment plan	1. Total Number of fixed public health facilities offering ART Services	317
		2. Total number of patients on ART remaining in care.	454 982
		3. Number of beneficiaries served by home-based categories	5 589
		4. Number of active home-based carers receiving stipends	5 511
		5. Number of male and female condoms distributed	M: 71 009 095 F: 3 737 321
		6. Number of High Transmission Areas (HTA) intervention sites	100
		7. Number of HIV positive clients screened for TB	104 428
		8. Number of HIV positive patients that started on IPT	83 542
		9. Number of HIV tests done	777 884
		10. Number of health facilities offering MMC services	70
		11. Number of Medical Male Circumcisions performed	79 007
National Tertiary Services Grant (NTSG)	• To ensure provision of tertiary health services for all south African citizens • To compensate tertiary facilities for the costs associated with provision of these services including cross boundary patients	1. Number of National Central and Tertiary hospitals providing components of Tertiary services	2
Health Professional Training and Development (HPTD) Grant	• Support provinces to fund service costs associated with training of health science trainees on the public service platform	1. Number of specialists associated with training on the public health service delivery platform funded	41
		2. Number of registrars associated with training on the public health service delivery platform funded	9
		3. Number of clinical supervisors associated with training on the public health service delivery platform funded	13
		4. Number of grant administration staff	0
National Health Facility Revitalization Grant	• To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health including, inter alia, health technology, organisational	1. Number of health facilities planned,	8
		2. Number of Health facilities designed,	2
		3. Number of Health facilities constructed	7
		4. Number of Health facilities equipped	7

NAME OF CONDITIONAL GRANT	PURPOSE OF THE GRANT	PERFORMANCE INDICATORS	INDICATOR TARGETS FOR 2017/18
	systems (OD) and quality assurance (QA). • Supplement expenditure on health infrastructure delivered through public-private partnerships	5. Number of Health facilities operationalized	1
National Health Insurance (NHI) Grant	• Test innovations in health service delivery for implementing NHI, allowing for each district to interpret and design innovations relevant to its specific context in line with the vision for realising universal health coverage for all • To undertake health system strengthening activities in identified focus areas • To assess the effectiveness of interventions/activities undertaken in the district funded through this grant	**NHI Pilot Districts:** 1. Number of WBOTs with data collection tools	170
		2. Evaluation report of current SCM processes with recommendations	1 report
		3. Number of quarterly reports	4

9. PUBLIC ENTITIES

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NAME OF PUBLIC ENTITY	MANDATE	OUTPUTS	CURRENT ANNUAL BUDGET (R'THOUSAND)	DATE OF NEXT EVALUATION
1. None				
2.				
3.				
4.				

10. PUBLIC-PRIVATE PARTNERSHIPS (PPPs)

NAME OF PPP	PURPOSE	OUTPUTS	CURRENT ANNUAL BUDGET (R'THOUSAND)	DATE OF TERMINATION	MEASURES TO ENSURE SMOOTH TRANSFER OF RESPONSIBILITIES
1. None					
2.					
3.					
4.					
5.					
6					
7.					

11. CONCLUSIONS

The Department has compiled this Annual Performance Plan based on the Customised Sector Annual Performance Plan. It has taken into consideration of 2016/17 auditing findings during the compilation of this APP. The targets are set considering that the resource limitations coupled with accruals always have effect on the implementation of Annual Performance Plans.

ANNEXURE A: StatsSA Population 2002-2018

StatsSA Population Estimates 2002-2018																		
District	**Sub District**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Ehlanzeni DM	Bushbuckridge LM	486 783	492 903	499 091	505 315	511 446	517 357	523 153	528 928	534 753	540 525	545 853	551 215	556 632	562 082	567 479	572 030	576 335
	Mbombela LM	516 896	524 132	531 331	538 518	545 689	552 983	560 211	567 397	574 529	581 576	588 646	595 707	602 767	609 807	616 810	623 353	629 537
	Nkomazi LM	352 789	357 242	361 725	366 234	370 711	375 062	379 324	383 546	387 756	391 914	395 848	399 788	403 748	407 710	411 625	414 967	418 102
	Thaba Chweu LM	84 711	86 033	87 336	88 619	89 889	91 208	92 529	93 857	95 188	96 521	97 915	99 316	100 721	102 124	103 521	104 894	106 202
	Umjindi LM	58 475	59 344	60 203	61 053	61 901	62 769	63 635	64 501	65 366	66 230	67 125	68 022	68 918	69 808	70 687	71 532	72 328
G Sibande DM	Albert Luthuli LM	170 681	172 324	173 948	175 539	177 056	178 541	180 007	181 442	182 856	184 263	185 672	187 066	188 424	189 738	191 000	192 323	193 534
	Dipaleseng LM	37 973	38 400	38 831	39 266	39 706	40 166	40 638	41 119	41 607	42 102	42 603	43 108	43 614	44 121	44 634	45 171	45 686
	Govan Mbeki LM	263 657	266 657	269 720	272 827	276 008	279 282	282 623	286 002	289 395	292 812	296 294	299 822	303 381	306 966	310 595	314 312	317 864
	Lekwa LM	103 820	105 000	106 201	107 414	108 643	109 909	111 181	112 452	113 715	114 968	116 236	117 516	118 804	120 108	121 436	122 820	124 154
	Mkhondo LM	158 406	159 894	161 372	162 824	164 215	165 568	166 910	168 218	169 497	170 766	172 043	173 313	174 576	175 841	177 101	178 431	179 685
	Msukaligwa LM	135 153	136 576	138 017	139 468	140 924	142 403	143 902	145 402	146 897	148 394	149 916	151 450	152 988	154 530	156 080	157 681	159 200
	Pixley Ka Seme LM	75 904	76 675	77 439	78 188	78 908	79 627	80 346	81 058	81 768	82 478	83 192	83 904	84 608	85 308	86 005	86 750	87 458
Nkangala DM	Dr JS Moroka LM	215 284	218 871	222 490	226 129	229 760	233 563	237 407	241 273	245 178	249 148	253 297	257 518	261 783	266 096	270 480	275 234	279 743
	Emakhazeni LM	40 079	40 816	41 571	42 341	43 125	43 922	44 736	45 562	46 401	47 260	48 141	49 041	49 956	50 888	51 839	52 835	53 791
	Emalahleni LM	332 892	339 272	345 811	352 498	359 379	366 309	373 464	380 804	388 294	395 958	403 724	411 623	419 634	427 774	436 107	444 705	452 991
	Steve Tshwete LM	193 189	196 917	200 751	204 682	208 729	212 813	217 009	221 299	225 669	230 142	234 695	239 345	244 080	248 910	253 861	258 977	263 925
	Thembisile Hani LM	269 288	273 770	278 299	282 861	287 438	292 147	296 915	301 711	306 553	311 480	316 616	321 847	327 145	332 505	337 936	343 719	349 214
	Victor Khanye LM	64 146	65 309	66 497	67 709	68 949	70 212	71 511	72 836	74 183	75 551	76 949	78 370	79 815	81 292	82 813	84 412	85 955
Provincial total`		3 560 126	3 610 135	3 660 633	3 711 485	3 762 476	3 813 841	3 865 501	3 917 407	3 969 605	4 022 088	4 074 765	4 127 971	4 181 594	4 235 608	4 290 009	4 344 146	4 395 704

ANNEXURE B: REVISED MEDIUM TERM STRATEGIC FRAMEWORK 2014-2019 (15 JULY 2016)

Revised: 15 July 2016

APPROVED BY CABINET: 19 OCTOBER 2017

Outcome 2: A long and healthy life for all South Africans

1. National Development Plan 2030 vision and trajectory

The National Development Plan (NDP) 2030 envisions a health system that works for everyone and produces positive health outcomes, and is accessible to all. By 2030, South Africa should have:

(a) Raised the life expectancy of South Africans to at least 70 years;
(b) Produced a generation of under-20s that is largely free of HIV;
(c) Reduced the burden of disease;
(d) Achieved an infant mortality rate of less than 20 deaths per thousand live births, including an under-5 Mortality rate of less than 30 per thousand;
(e) Achieved a significant shift in equity, efficiency and quality of health service provision;
(f) Achieved universal coverage;
(g) Significantly reduced the social determinants of disease and adverse ecological factors.

The overarching outcome that the country seeks to achieve is ***A Long and Healthy Life for All South Africans.*** The NDP asserts that by 2030, it is possible to have raised the life expectancy of South Africans (both males and females) to at least 70 years. Over the next 5-years, the country will harness all its efforts - within and outside - the health sector, to achieve this outcome. Key interventions to improve life expectancy include addressing the social determinants of health; promoting health; as well as reducing the burden of disease from both Communicable Diseases and Non-Communicable Diseases as well as achieving meaningful progress towards universal health coverage through the phased implementation of National Health Insurance. An effective and responsive health system is an essential bedrock for attaining this.

Both the NDP 2030 and the World Health Organization (WHO) converge around the fact that a well-functioning and effective health system is an important bedrock for the attainment of the health outcomes envisaged in the NDP 2030. Equitable access to quality healthcare will be achieved through various interventions that are outlined in this strategic document and will be realisable through the phased implementation of National Health Insurance. The trajectory for the 2030 vision, therefore, commences with strengthening of the health system, to ensure that it is efficient and responsive, and offers financial risk protection. The critical focus areas proposed by the NDP 2030 are consistent with the WHO perspective.

The adoption of the Sustainable Development Goals (SDGs) in September 2015 also has significant implications for South Africa, as the country will have to ensure that its health strategies and programmes contribute to the attainment of the SDGs. The United Nations (UN) has emphasized that all 17 SDGs

and their 169 associated targets are integrated and indivisible. They should not be conceived of or implemented parochially. Taking cognisance of this, the following SDGs are immediately pertinent to the work of the South African health sector:
Goal 1. End poverty in all its forms everywhere
Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture
Goal 3. Ensure healthy lives and promote well-being for all at all ages
Goal 5. Achieve gender equality and empower all women and girls
Goal 10. Reduce inequality within and among countries

2. Constraints and Strategic Approach

Following the advent of the democratic dispensation in 1994, progressive policies were introduced to transform the health system into an integrated, comprehensive national health system. Despite this, and significant investment and expenditure, the South African health sector has largely been beset by key challenges inclusive of:

(a) a complex, quadruple burden of diseases;
(b) serious concerns about the quality of public health care;
(c) an ineffective and inefficient health system;
(d) ineffective operational management at the coalface; and
(e) spiralling private health care costs.

As a result, quality health care has mostly been accessible to those who can afford and access it, and not those who need it. Until recently, South Africa's performance against key health indicators has consistently compared poorly with other countries with similar or less levels of investment and expenditure. Between 2009-2014 the Ministry of Health implemented massive reforms focusing on strengthening health system effectiveness by addressing health management and personnel challenges, financing challenges, and quality of care concerns. Major milestones have been achieved, including improvements in health outcomes such as the Infant Mortality Ratio; Under-5 mortality Ratio and to some extent the Maternal Mortality Ratio (MMR). The current phase of implementation focuses on the 2014-2019 period.

2.1. The gains made

Empirical evidence highlights several gains made by the democratic government towards improving the health status of all South Africans. These include the following:

(a) An increase in overall life expectancy from 57.1 years in 2009 to 62.9 years in 2014[5].
(b) An increase in female life expectancy from 59.7 years in 2009 to 65.8 years in 2014[5].
(c) An increase in male life expectancy from 54.6 years in 2009 to 60.0 years in 2014[5].
(d) A decrease in the Under-5 mortality rate (U5MR) from 56 deaths per 1 000 live births in 2009, to 39 deaths per 1 000 live births in 2014.

[5] Medical Research Council (2015): Rapid Mortality Surveillance (RMS) Report 2014

(e) A decrease in the Infant Mortality Rate (IMR) from 39 deaths per 1 000 live births in 2009, to 28 deaths per 1 000 live births in 2014.
(f) A decrease in mother-to-child transmission (MTCT) of HIV from 8.5% in 2008, to 3.5% in 2010 and to 2.7% in 2011.
(g) An increase in the number of people initiated on antiretroviral therapy from 47 000 in 2004[6] to 3.2million in 2014[7].
(h) A decrease in the total number of people dying from AIDS from 300 000 in 2010 to 270 000 in 2011.
(i) A 50% decline in the number of aged 0-4 years who acquired HIV between 2006 and 2011.
(j) A 50% decrease in the number of people acquiring HIV infection, from 700 000 in the 1990's to 350 000 in 2011.
(k) A 25% decrease in the annual number of infants and children younger than 5 years dying in the past two years.

Empirical evidence reflects that the estimated overall prevalence of HIV in South Africa increased from 10.6% in the 2008 to 12.2% in 2012, a trend attributed to the combined effects of a successfully expanded antiretroviral treatment (ART) programme and new infections[8]. This evidence also confirms that the availability and use of ART has increased survival among HIV-infected individuals. Furthermore, HIV prevalence among youth aged 15-24 years has declined from 8.7% in 2008 to 7.3% in 2012. The country's successful PMTCT programme has also resulted in a further decrease in HIV infection levels amongst infants 12 months and younger, from 2.0% in 2008 to 1.3% in 2012[8].All these gains must be protected and consolidated during the 2014-2019 planning and implementation cycle.

3. NDP priorities to achieve the Vision

The NDP sets out nine long-term health goals for South Africa. Five of these goals relate to improving the health and well-being of the population, and the other four deal with aspects of health systems strengthening. These are as follows:

(a) Average male and female life expectancy at birth increased to 70 years;
(b) Tuberculosis (TB) prevention and cure progressively improved;
(c) Maternal, infant and child mortality reduced;
(d) Prevalence of Non-Communicable Diseases reduced by 28%
(e) Injury, accidents and violence reduced by 50% from 2010 levels;
(f) Health systems reforms completed;
(g) Primary health Care (PHC) teams deployed to provide care to families and communities;
(h) Universal Health Coverage (UHC) achieved; and
(i) Posts filled with skilled, committed and competent individuals.

[6] Johnson, LF (2012): "Access to Antiretroviral Treatment In South Africa 2004 – 2011", the Southern African Journal of HIV Medicine, Vol 13, No 1, 2012
[7] National DoH (2015): Annual Report 2014/15, Pretoria
[8] Shisana, O, Rehle, T, Simbayi LC, Zuma, K, Jooste, S, Zungu N, Labadarios, D, Onoya, D et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.

The NDP 2030 states explicitly that there are no quick fixes for achieving the nine goals outlined above. The NDP also identifies a set of nine priorities that highlight the key interventions required to achieve a more effective health system, which will contribute to the achievement of the desired outcomes. These priorities include: addressing the social determinants that affect health and diseases; strengthening the health system; improving health information systems; preventing and reducing the disease burden and promoting health; achieving universal healthcare coverage through the implementation of NHI, improving human resources in the health sector; reviewing management positions and appointments and strengthening accountability mechanisms; improving quality by using evidence and creating meaningful public-private partnerships

4. Management of implementation

The implementation of the strategic priorities for steering the health sector towards Vision 2030 should continue to be managed by the Implementation Forum for Outcome 2*: "A long and healthy life for all South Africans*", which is the National Health Council (NHC). This Implementation Forum consists of the Minister of Health and the 9 Provincial Members of the Executive Council (MECs) for Health. The Technical Advisory Committee of the NHC (Tech NHC) functions as the Technical Implementation Forum. The Tech NHC consists of the Director-General of the National Department of Health (DoH) and the Provincial Heads of Department (HoDs) of Health in the 9 Provinces. Both the Implementation Forum and the Technical Implementation Forum should enhance the participation of government departments responsible for line functions that are social determinants of health, such as; clean water and proper sanitation; appropriate housing; quality education and decent employment, which alleviates poverty levels.

5. MTSF sub-outcomes and component actions, responsible Ministry, indicators and targets

5.1. Sub-outcome 1: Universal Health coverage progressively achieved through implementation of National Health Insurance

The NDP 2030 explores diverse financing mechanisms for UHC including: general tax income; private health insurance; social health insurance; payroll taxes; and user fees. The NDP 2030 proposes that NHI should be implemented in a phased manner in South Africa, focusing on: improving quality of care in public facilities; reducing the relative cost of private medical care; increasing the number of medical professionals and introducing a patient record system and supporting information technology.

The NDP 2030 views general taxation as the most progressive form of raising revenue for NHI, though personal income tax, as the level of income will determine the amount of contributions, with the poor not being taxed. Social health insurance is viewed as more progressive than private health insurance in that its contributions are typically mandatory, income linked and not risk rated. One limitation of social health insurance is that it typically provides a limited set of benefits. Private health insurance is not an effective financing mechanism, due to the fact that it is voluntary, uses risk rating and may exclude many people from access, and contributions required are not linked to income. Payroll taxes, which are used in some countries to fund NHI, have diminishing advantages as coverage becomes universal. The NDP 2030 views user fees or out-of-pocket payments (OOPs) as a regressive form of health financing, which can retract from access to health services. Table 1 below reflects the specific actions required from the health sector and other relevant sectors during the MTSF cycle 2014-2019.The NDP 2030 emphasizes that meaningful public-private partnerships in the health sector are important, particularly for NHI.

Government has set itself the target of establishing a publicly funded and publicly administered National Health Insurance (NHI) Fund through legislation, to drive the roll-out of the NHI programme. The country's NHI funding model will give effect to the three key principles of the NHI: universal provision of quality health care; social solidarity through cross-subsidisation; and equity, which delivers free health care at the point of service. A solid foundation is being laid for the introduction of NHI. The White Paper on NHI was approved by Cabinet and released for public comment in December 2015. A dedicated NHI technical support unit will be established within the National Department of Health to steer the implementation of NHI.

Table 1: Activities, indicators and targets for the implementation of NHI

	Actions	Minister Responsible	Indicators	Baselines[9]	Targets
1	Phased implementation of the building blocks of NHI	Minister of Health	National Health Insurance (NHI) Act Promulgated	None	Draft National Health Insurance Bill gazetted for public consultation by 2017/18 National Health Insurance Act promulgated by 2019
			NHI fund created	None	Funding Modality for the budget allocation to the public primary health care (PHC) facilities in the District Health System developed by 2017/18 NHI Fund purchasing services on behalf of the population from accredited and contracted health care providers by 2019
2	Reform of Central Hospitals and increase their capacity for local decision making and accountability to facilitate semi-autonomy.	Minister of Health	No. of central hospitals with standardised organisational structures and appropriate delegations	None	All 10 Central Hospitals having revised normative and approved organisational structures and appropriate delegations by 2019

[9] Estimated performance of the health sector for 2013/14, as reflected in the Annual Performance Plan of the National DoH for 2014/15

	Actions	Minister Responsible	Indicators	Baselines[9]	Targets

5.2. Sub-outcome 2: Improved quality of health care

Improved quality of care is an important goal of the health sector and an essential building block for NHI. During 2012/13, an audit of all 3,880 public health facilities was completed by an independent organisation. The National Health Amendment Bill, which provides the important legal framework for the establishment of an independent Office of Health Standards Compliance, was assented to by the President in September 2013. The OHSC is mandated to monitor and enforce compliance by health establishments with norms and standards prescribed by the Minister, covering both public and private sector facilities. A key focus during the 2014-2019 MTSF will be devoted to accelerating the establishment and operationalisation of the Office of Health Standards Compliance. Table 2 below reflects the key actions required from the health sector to achieve this.

Table 2: Key actions, indicators and targets for enhancing Quality of Care

	Actions	Minister responsible	Indicators	Baselines[10]	Targets
1	Complete the regulatory framework for the Office of Health Standards Compliance (OHSC)	Minister of Health –	Regulations for the functioning of the OHSC promulgated and implemented	OHSC Board established in January 2014 and OHSC Operational	Finalise regulations for the functioning of the OHSC by March 2017
2	Appointment of the Ombudsperson and establishment of a functional office.	Minister of Health	Functional Ombuds Person Office established	Board of the OHSC established in January 2014	Functional Ombuds Person office established by March 2017
3	Improve compliance with National Core Standards	Minister of Health	Number of Regional, Specialised, Tertiary and Central Hospitals that achieved an overall performance of ≥75% compliance with the national core standards for health facilities	Non-compliance with extreme and vital measures of the National Core Standards	≥ 75% compliance with National Core Standards in 5 Central Hospitals by 2016/17 ≥ 75% compliance with National Core Standards in 10 Central, 17 Tertiary, 30 Regional and 15 Specialised Hospitals by 2019
4	Improve quality of District Hospitals		Status determination elements for Ideal District Hospitals	None	Ideal District Hospital status determination elements developed by 2018 25% of District Hospital conducting status determinations by 2019

[10] Estimated performance of the health sector for 2013/14, as reflected in the Annual Performance Plan of the National DoH for 2014/15

	Actions	Minister responsible	Indicators	Baselines[10]	Targets
5	Ensure quality primary health care services with functional clinics by developing all clinics into Ideal Clinics	Minister of Health	Number of primary health care clinics in the 52 districts that qualify as Ideal Clinics	None	2823 clinics in the 52 districts that qualify as Ideal Clinics by 2019
6	Improve the acceptability, quality and safety of health services by increasing user and community feedback and involvement	Minister of Health	Patient experience of care (PEC) survey rate	65%	75% of health facilities that conduct PEC surveys at least once a year by 2017/18 100% of health facilities that conduct PEC surveys at least once a year by 2019
			Patient satisfaction rate	New Indicator	50% of health facilities that conducted PEC survey and scored 85% or more by 2019 Nationally 85% of patients are satisfied with health services received in public health facilities by 2019

5.3. Sub-outcome 3. Implement the re-engineering of Primary Health Care

A strong PHC service delivery platform is the heartbeat for the implementation of NHI. The health sector has developed and begun implementing a re-engineered PHC model, which consists of three streams, namely: creation and deployment of ward-based PHC Outreach Teams; establishment of District Clinical Specialist Teams and strengthening of Integrated School Health Services. The health sector has begun establishing municipal Ward-based PHC Teams across all 9 Provinces. These teams are led by a professional nurse, and have 6 Community Health Care (CHWs) each. These teams are providing a range of community-based health promotion and disease prevention programmes including strengthening nutrition interventions. Their brief includes supporting and promoting health in households and community settings such as at crèches, Early Childhood Centres, and old age homes.

The establishment of District Clinical Specialist Teams has also commenced. These teams consist of: a Principal Obstetrician and Gynaecologist; Principal Paediatrician; an Anaesthetist; Principal Family Physician; Principal Midwife; Advanced Paediatric nurse and Principal PHC nurse. A national school health policy was developed, in a partnership programme between the National DoH, the Department of Basic Education (DBE) and the Department of Social Department. The NDP 2030 is supportive of health sector's model of PHC re-engineering. Table 3 below reflects the key actions

required from the health sector for accelerating the re-engineering of PHC. Table 3 below reflects the specific actions required from the health sector and other relevant sectors during the MTSF cycle 2014-2019.

Another major social and public health problem facing South Africa is the high burden of disease from violence and injuries. The country has an injury death rate of 158 per 100 000, which is twice the global average of 86,9 per 100 000 population and higher than the African average of 139,5 per 100 000[11]. Key drivers of the injury death rates are intentional injuries due to interpersonal violence (46% of all injury deaths) and road traffic injuries (26%), followed by suicide (9%), fires (7%), drowning (2%), falls (2%) and poisoning (1%). It also stretches state resources in other sectors, such as the South African Police, the Criminal Justice System and the Welfare Sector. A need exists to implement a comprehensive and intersectoral response to combat violence and injury, and significantly reduce the country's injury death rate. This should be led by the Ministers of Police; Justice and Correctional Services; and Transport, with the Minister of Health playing a supporting role. The root causes of violence and injuries fall outside of the health system. However, these social ills place a huge strain on the limited resources of the health system.

Social determinants of health are defined as the economic and social conditions that influence the health of people and communities, and include employment, education, housing, water and sanitation, and the environment. The priority interventions recommended by the NDP 2030 to address the social determinants of health require the health sector and its implementation partners to:

(a) Implement a comprehensive approach to early life, which includes strengthening of existing child survival programmes;
(b) ensure collaboration across sectors; and
(c) promote healthy diets and physical activity.

The prevalence of Non-Communicable Diseases (NCD), such as cardiovascular diseases, diabetes, chronic respiratory conditions, cancer, kidney disease and muscular-skeletal conditions, has increased globally, and in South Africa. Modifiable risk factors for NCDs, which are also emphasized in the NDP 2030 and the National Strategic Plan for NCDs 2013-2017, produced by the health sector in 2012, include the following:

(a) tobacco use;
(b) physical inactivity;
(c) unhealthy diets; and
(d) harmful use of alcohol.

The National Strategic Plan for NCDs 2013-2017 reflects 10 goals and associated targets that must be achieved by 2020. Combating NCDs requires behaviour change and lifestyle change, which are extremely difficult to implement. Full participation of all government departments is required to meet the set targets. A need exists for the health sector to establish the National Health Commission (NHC) which will be an intersectoral platform to promote healthy lifestyles, encourage prevention of diseases and promote health care; and which will also enforce health regulations.

Table 3 below reflects the specific and concrete actions required from the health sector and its implementation partners to strengthen primary health care services, to address the social determinants of health and other interventions that have an impact on NCDs, during the MTSF cycle 2014-2019.

[11] National DoH and Health Policy Initiative (2012):Integrated Strategic Framework for the Prevention of Injury and Violence in South Africa, Pretoria.

Table 3: Key actions, indicators and targets for Re-engineering PHC (Including Non-Communicable Diseases and Mental Health)

	Actions	Minister Responsible	Indicators	Baselines	Targets
1	Expand coverage of ward-based primary health care outreach teams (WBPHCOTs)	Minister of Health	Number of functional WBPHCOTs	1063 functional WBPHCOTs	1500 functional WBPHCOTs in 2014/15 3000 functional[12] WBPHCOTs by 2019
2	Expansion and strengthening of integrated school health services	Minister of Health Minister of Basic Education	School Grade 1 screening coverage (annualised)	7%	40% School Grade 1 screening coverage by 2019
			School Grade 8 screening coverage (annualised)	4%	25% School Grade 8 screening coverage by 2019

[12] visiting at least 250 households annually

	Actions	Minister Responsible	Indicators	Baselines	Targets
3	Improve intersectoral collaboration with a focus on population wide interventions (to promote healthy lifestyles in the whole population) and community based interventions (to promote healthy lifestyles in communities) and addressing social and economic determinants of Non-Communicable Diseases	Primary responsibility: Minister of Health Supporting Ministers: • Minister of Basic Education • Minister of Correctional Services • Minister of Justice and Constitutional Development • Minister of Social Development • Minister of Trade and Industry Minister of Transport • Minister of Water and Sanitation • Minister of Cooperative Governance and Traditional Affairs	Establish the National Health Commission	None	National Health Commission established by March 2019
4	Improve awareness of and management of NCDs through screening and counselling for high blood pressure and raised blood glucose levels	Minister of Health	Number of people[13] counselled and screened for blood pressure	None (New Indicator)	5 million people[13] counselled and screened annually for blood pressure by 2019
			Number of people[13] counselled and screened for blood glucose levels	None (New Indicator)	5 million people[13] counselled and screened annually for blood glucose levels by 2019

[13] People refers to those attending public health facilities

	Actions	Minister Responsible	Indicators	Baselines	Targets
5	Expand provision of rehabilitation services, and accessibility of Primary Health Services to people with physical disabilities	Minister of Health	Proportion of health facilities accessible to people with physical disabilities	39% (1384 PHC health facilities)	70% (of 2823) of PHC health facilities are accessible to people with physical disabilities and are meeting the 4 compulsory criteria (ramp, compacted access from gate to entrance, Toilets, signage) of accessibility by 2019
			Number of Districts with a multi-disciplinary rehabilitation team (physiotherapist, optometrist, speech and hearing/audiologist, occupational therapist, medical orthotist/prosthetist)	Unknown	Survey conducted on number of Districts with a multi-disciplinary rehabilitation team and Baseline Established by March 2017 10 percentage points increase (on the baseline) by 2019
6	Screening the users of public primary health care (PHC) services for mental health disorders	Minister of Health	Number of people using public PHC services screened for mental health disorders annually	1.8m	2.2m people that use public PHC services screened for mental health disorders annually by 2019
7	Contribute to a comprehensive and intersectoral response by government to violence and injury, and to ensure action	Minister of Health	Eliminate backlog of blood alcohol tests at Forensic Chemistry Laboratories	Backlog of blood alcohol testing eliminated at Cape Town and Durban laboratories	Backlog of blood alcohol tests eliminated (0% backlog) Pretoria and Johannesburg laboratories by 2018

	Actions	Minister Responsible	Indicators	Baselines	Targets
		Minister of Transport and Minister of Health	Roadside testing programme implemented to monitor driving under the influence of alcohol	None	Mobile laboratories established and roadside testing programme implemented by March 2018 to significantly reduce the country's injury and death rate

5.4. Sub-outcome 4: Reduced health care costs

The NDP 2013 identifies a need for the development and implementation of mechanisms to improve the efficiency and control of health care costs in the private sector. These mechanisms include regulation of prices primary care gate-keeping;, diagnostic and therapeutic protocols; preferred providers; alternate and reimbursement strategies (capitation or global budgets instead of fee-for-service). Mechanisms will be implemented to improve efficiencies and control the spiralling costs of health care. Reforms will also be implemented to reduce private health care costs.

Table 4: Key actions, indicators and targets to reduce health care costs

	Actions	Minister Responsible	Indicators	Baselines	Target
1	Regulation of the price on medicines through the transparent pricing system	Minister of Health	Regulations relating to the single exit price increase, dispensing fees published	Transparent pricing regulations promulgated in 2004	Regulations relating to the single exit price increase, dispensing fees published for public comment by 2018 Regulations relating to the single exit price

					increase, dispensing fees published for implementation by 2019
2	Reform of the procurement system for medicines in the public sector	Minister of Health	Changes in tender price managed to not exceed inflation and currency variance	Previous tender price	Zero real price increase in tender prices for medicines by 2019 (net result of inflation and currency variance)

5.5. Sub-outcome 5: Improved human resources for health

The NDP 2030 highlights the disparity in the distribution of health care providers between the public and private sectors in South Africa. The NDP emphasizes that the shortage of trained health workers and CHWs to provide health-promoting, disease preventing and curative services, is a major obstacle to service delivery. A new strategy for strengthening community-based services has been developed by the health sector, known as the re-engineering of Primary Health Care. The NDP accentuates the need to prioritise the training of more midwives, and distribute them to appropriate levels in the health system. This will contribute significantly to improving maternal, neonatal and child health.

The NDP articulates a concern about the training of specialists in South Africa, which encourages the continued production of system specialists, and which is not consistent with the needs of the country. A major change in the training and distribution of specialists is proposed. This should include speeding up the training of community specialists in five specialist areas namely: medicine; surgery including anaesthetics; obstetrics; paediatrics and psychiatry. Training of specialists should include compulsory placement in resource-scarce regions, under the supervision of Provincial specialists.
Measures will be implemented to ensure adequate availability of well qualified, appropriately skilled and competent Human Resources for Health. The number of doctors trained locally and abroad will be doubled, at an average of 2,000 doctors a year. The Cuban Medical Training programme will be strengthened to ensure successful integration of medical students returning from Cuba to complete their training in South Africa. The revitalisation and resourcing of nursing colleges will be prioritised

The health sector's priority during 2009-2014 has been on professionalising nursing training and re-introducing a caring ethos in nursing through a greater focus on bedside nurse training provided through colleges and public sector hospitals. The key objectives were to develop a new nursing curriculum and enable 5 public nursing colleges to offer this new curriculum by the end of 2014/15. Protracted negotiations between the health sector and the Department of Higher Education and Training (DHET) constrained the achievement of this target.

Table 5: Key actions, indicators and targets for improving Human Resource production, development and management

	Actions	Minister Responsible	Indicators	Baselines[14]	Targets
1	Increase production of Human Resources for Health to strengthen capacity in the health system	Minister of Health and Minister of Higher Education and Training	Percentage of Cuban trained doctors employed in the public sector	2971 medical students enrolled into the RSA- Cuba programme Prep year: 419 1st Year: 609 2nd Year: 883 3rd Year: 919 4th Year: 73 5th Year: 68	90% (951 /1060) of Cuban trained medical students that are in their 3rd, 4th and 5th years complete training by 2019. 100% (951 of 951) of qualified Cuban trained medical doctors employed in the public sector by 2020
2	Develop a new nursing curricula to ensure a balance between bedside training and theoretical training at all public Nursing Collages in South Africa	Minister of Health and Minister of Higher Education	Number of nursing colleges offering the new nursing curriculum	None	All 17 public nursing colleges offering the new nursing curriculum by 2019

[14] Estimated performance of the health sector for 2013/14, as reflected in the Annual Performance Plan of the National DoH for 2014/15.

5.6. Sub-outcome 6: Improved health management and leadership

The NDP 2030 identifies an important need to ensure that people who lead health institutions must have the required leadership capability and a high level of technical competence in a clinical discipline.
Central hospitals are national assets and, as integral parts of universities, are primary training platforms for health professionals. The health sector will ensure that their governance, funding and management becomes a national public sector competency and that they play their role as part of a seamless referral system. Management and related capacity of central hospitals will be enhanced to enable them to deliver services efficiently and effectively.
A key important area that also requires strengthening is financial management in the health sector. At the end of 2013/14, four health departments, the National DoH, Limpopo; North West and the Western Cape received an unqualified audit opinion from the AGSA. **This reflects improvement from 2012/13, during which only 3/10 departments received unqualified audit opinions.** Concerted effort must be made to increase this figure to at least 7/9 by 2019.
Key interventions include:

(a) Improving financial management and audit outcomes in the health sector
(b) Improve District Health governance and strengthen management and leadership of the district health system
(c) Development of a training programme for Hospital CEOs and PHC Facility Managers

Table 6 below reflects other key specific actions required from the health sector and other relevant sectors during the MTSF cycle 2014-2019.

Table 6 : Key actions, indicators and targets for improving health management and leadership

	Actions	Minister Responsible	Indicators	Baselines[15]	Targets
1	Improve financial management skills and audit outcomes for the health sector	Minister of Health	Number of Health Departments receiving unqualified audit reports from the Auditor-General of South Africa (AGSA)	4 Health Departments in 2012/13 (National DoH; Limpopo North West and Western Cape)	5 health departments (1 National and 4 Provincial DoHs) receiving unqualified audit reports from the Auditor-General of South Africa (AGSA) by 2017/18 7 Departments (1 National and 6 Provincial DoHs) receiving unqualified audit reports from the Auditor-General of South Africa (AGSA) by 2019
2	Improve District Health governance and strengthen management and leadership of the District Health System	Minister of Health	Number of districts with normative management structures	None	Normative District management structure developed and approved by 2017 52 districts with normative management structures by 2019

[15] Estimated performance of the health sector for 2013/14, as reflected in the Annual Performance Plan of the National DoH for 2014/15

	Actions	Minister Responsible	Indicators	Baselines[15]	Targets
3	Ensure equitable access to specialised health care by increasing the training platform for medical specialists	Minister of Health	Number of gazetted tertiary hospitals providing the full package of tertiary 1 services	None	17 gazetted tertiary hospitals providing the full package of Tertiary 1 services by 2019
4	Address skills gap at all levels of the health care system	Minister of Health	Training programme for Hospital CEOs and PHC Facility Managers	The training platform (knowledge management hub) established	90% of Hospitals CEOs, and PHC Facility Managers accessing the training programme platform for Hospital CEOs and PHC Facility Managers (knowledge management hub) by 2019

5.7. Sub-outcome 7: Improved health facility planning and infrastructure delivery

Health Facilities and Infrastructure Management continue focuses on coordinating and funding health infrastructure to enable provinces to plan, manage, modernise, rationalise and transform infrastructure, health technology and hospital management, and improve the quality of care in line with national policy objectives. To improve health facility planning and infrastructure delivery a more systematic and professional approach to infrastructure delivery was introduced by the health sector, this entailed the establishment of a Project Office at macro level to deliver on the major infrastructure programs. The pace of infrastructure delivery will be accelerated using alternative methods of delivery where possible to accelerate progress. Teams for health facility planning and infrastructure delivery will be strengthened by restructuring of the current infrastructure establishment. For the MTSF

2014-2019 period, 106 new clinics and community health centres and 22 hospitals will be built and over 435 health facilities in all 9 provinces will undergo major and minor refurbishments.

Table 7: Key actions, indicators and targets for improved health facility planning and accelerated Infrastructure Delivery

	Key Action	Minister Responsible	Indicator	Baselines[16]	Targets
1	Improve the quality of health infrastructure in South Africa by ensuring that all health facilities are compliant with facility norms and standards	Minister of Health	Percentage of facilities that comply with gazetted infrastructure Norms & Standards	None	Health facility norms and standards developed and gazetted by March 2015 100% of new facilities comply with gazetted infrastructure Norms and Standards by 2019
2	Construction of new clinics, community health centres and hospital	Minister of Health	Number of additional clinics and community health centres constructed	-	106 clinics and community health centres constructed by 2019
			Number of additional hospitals constructed or revitalised	-	22 hospitals constructed or revitalised hospitals by 2019
3	Major and minor refurbishment of health facilities	Minister of Health	Number of health facilities that have undergone major and minor refurbishment	95 health facilities	435 health facilities undergone major and minor refurbishment by 2019

[16] Estimated performance of the health sector for 2013/14, as reflected in the Annual Performance Plan of the National DoH for 2014/15

5.8. Sub-outcome 8: HIV & AIDS and Tuberculosis prevented and successfully managed

Strategies and actions to combat the HIV&AIDS epidemic are outlined in the National Strategic Plan (NSP) on HIV, STIs and TB 2012-2016, which was produced by the South African National AIDS Council (SANAC), chaired by the Deputy President of South Africa. The NDP 2030 recognises the pivotal role of the NSP on HIV, STIs and TB 2012-2016 in harnessing the efforts of all sectors of society towards reducing the burden of disease from HIV and AIDS and Tuberculosis.

The NSP 2012-2016 has adopted as a 20-year vision, the four zeros advocated by the Joint United Nations Programme on HIV and AIDS (UNAIDS). It, therefore, entails the following targets for South Africa:

- zero new HIV and TB infections
- zero new infections due to vertical transmission
- zero preventable deaths associated with HIV and TB
- zero discrimination associated with HIV and TB.

With respect to achieving an "HIV-free" generation of under-20s, the NSP 2012-2016 has two pertinent objectives namely Strategic Objective 1 and Strategic Objective 2. Strategic Objective 1 (SO 1) of the NSP 2012-2016 focuses specifically on addressing the structural, social, economic and behavioural factors that drive the HIV and TB epidemics. Strategic Objective 2 (SO 2) is focused on primary strategies to prevent sexual and vertical transmission of HIV and STIs, and to prevent TB infection and disease, using a combination of prevention approaches. The NSP 2012-2016 defines combination prevention as a mix of biomedical, behavioural, social and structural interventions that will have the greatest impact on reducing transmission and mitigating susceptibility and vulnerability to HIV, STIs and TB. This implies that different combinations of interventions will be designed for the different key populations. The NSP 2012-2016 identifies a total of 7 sub-objectives for HIV, STI and TB prevention, which if effectively implemented will yield the desired effect of reducing new HIV and TB infections

Strategic Objective (SO) 3 of the NSP 2012-2016 outlines pertinent interventions to reduce morbidity and mortality from AIDS related causes and Tuberculosis. SO 3 focuses on sustaining health and wellness, and achieving a significant reduction in deaths and disability as a result of HIV and TB infection through universal access to accessible, affordable and good quality diagnosis, treatment and care.

The health sector will implement diverse interventions to deal with the burden of TB. Screening, treatment and prevention will be strengthened in the following vulnerable groups:

(a) **Correctional Services** - 150 000 inmates in the 242 correctional services, and the families of those who test positive,
(b) **Mineworkers** - A total of the 500 000 mineworkers and the families of those found positive
(c) **Peri-mining communities** - 600 000 communities in the peri-mining communities
(d) **Schools and households** - intensified screening of TB in schools and households using primary ward-based outreach teams

The public health sector will decentralise the management of MDR-TB. The decentralisation will enable the sector to implement an approach similar to that used to address the burden of diseases from HIV, for instance, the Nurse Initiated Management of Antiretroviral therapy (NIMART), which enables nurses

to diagnose and manage accordingly. Multi-Drug Resistant (MDR) sites will expanded. Table 8 below reflects the specific actions required from the health sector and its implementation partners to reduce mortality from AIDS related causes and Tuberculosis (TB).

Table 8: Key actions, indicators and targets for the prevention and successful management of HIV&AIDS and Tuberculosis

	Action	Minister Responsible	Indicator	Baselines[17] [18]	Target
1	Maximising opportunities for testing and screening to ensure that everyone in South Africa has an opportunity to test for HIV and to be screened for TB at least annually	Minister of Health	Number of clients tested for HIV annually	8.9 million (2012/13)	10 million HIV tests administered annually by 2019
			Number of people screened for TB annually	8 million (in 2011)	8 million TB screenings annually by 2019
2	Maximising opportunities for testing and screening to ensure that everyone in South Africa's Correctional Facilities is screened for TB at least annually	Minister of Health Minister of Justice and Correctional Services	Percentage of correctional services centres conducting routine TB screening	23% (56/242)	95% (230/242) of correctional services centres conducting routine TB screening by 2019
3	The National HIV Prevention Campaign for Girls and Young Women implemented to among others focus on new HIV infections and unwanted pregnancies,	Minister of Health Minister of Basic Education Minister of Higher Education Minister of Social Development Minister of Rural	Delivery under 20 years in facility rate	7.5% (72 200 of 961 200) for 2013	<5.25% (50 540 of 961 200) of total deliveries in public health facilities by 2019 (30% reduction)

[17] Estimated performance of the health sector for 2013/14, as reflected in the Annual Performance Plan of the National DoH for 2014/15.
[18] South African National AIDS Council (SANAC): National Strategic Plan on HIV, STIs and TB 2012-2016

		Development Minister of Economic Development Minister of Labour			
3	Increasing access to a preventive package of sexual and reproductive health (SRH) services, including medical male circumcision and provision of both male and female condoms	Minister of Health	Number of male condoms distributed annually	387 million (in 2012/13)[19]	800 million male condoms distributed annually by 2019
			Number of female condoms distributed annually	5,1 million (2010/11)[20]	25 million female condoms distributed annually by March 2019
			Number of males medically circumcised (cumulative)	804 285 (2012/13)	5 million males medically cumulatively circumcised by 2019
3	Expand access to Antiretroviral Therapy (ART) for people living with HIV/AIDS	Minister of Health	Total clients remaining on ART (TROA)	2.7m	5.0 million patient on ART by 2019
4	Improve the effectiveness and efficiency of the TB control programme	Minister of Health	TB new client treatment success rate	79%	85% of new TB clients successfully completing treatment by 2019
5	Improve TB treatment outcomes	Minister of Health	TB client lost to follow up	6%	Less than 5% of clients lost to follow up by 2019

[19] Health Systems Trust, District Health Barometer, 2012/13
[20] South African National AIDS Council (SANAC): National Strategic Plan on HIV, STIs and TB 2012-2016

6	Implement interventions to reduce TB mortality	Minister of Health	TB Death Rate	6%	5% (or less) of clients that started on TB treatment died during treatment period by 2019
7	Combat MDR TB by ensuring access to treatment	Minister of Health	TB MDR confirmed client start on treatment	56%	80% of MDR-TB patients initiated on treatment by 2019
		Minister of Health	TB MDR client successfully completing treatment	42%	65% of MDR-TB patients successfully completing treatment by 2019

5.9. Sub-outcome 9: Maternal, infant and child mortality reduced

South Africa's efforts to reduce maternal deaths date back to 1997, when the then Minister of Health established the National Committee of Confidential Enquiry into Maternal Deaths (NCCEMD), which was the first on the African continent. The NCCEMD has since released five triennial reports. A positive development is that South Africa's MMR, both population-based and institutional, reflect a downward trend.Data from the NCCEMD reflect that institutional MMR has decreased from 188.9 per 100 000 live births in 2009 to 141 per 100 000 live births in 2013. Estimates from the Rapid Mortality Surveillance (RMS) system of the Medical Research Council and the University of Cape Town reflects South Africa's MMR for 2013 at 155/100 000.

As is the case with MMR, Infant Mortality Rates (IMR) in South Africa reflect a decline. IMR in South Africa has decreased from 39 deaths per 1 000 live births in 2009, to 28 deaths per 1 000 live births in 2014. Similarly, the Under-5 mortality rate decreased from 56 deaths per 1 000 live births in 2009, to 39 deaths per 1 000 live births in 2014.

With respect to under-nutrition, the South African National Health and Nutrition Examination Survey, conducted by the Human Sciences Research Council found that found that young children youngest boys and girls (0–3 years of age) had the highest prevalence of stunting (26.9% in boys and 25.9% in girls), which was significantly different from the other age groups, with the lowest prevalence in the group aged 7–9 years (10.0% and 8.7% for boys and girls, respectively). It was also found that among boys, rural informal areas had significantly more stunting (23.2%) than urban formal areas (13.6%). Furthermore, girls living in urban informal areas had the highest prevalence of stunting (20.9%) and those in urban formal areas, the lowest (10.4%), the difference in prevalence being significant.

Table 9 below shows the key actions, indicators and targets to reduce maternal, infant and child mortality.

	Actions	Minister responsible	Indicators	Baselines[21]	Target
1.	Improve the implementation of Basic Antenatal and Postnatal Care	Minister of Health	Antenatal visits before 20 weeks rate	50.6%	70% of pregnant women attending PHC facility for Antenatal care before they are 20 weeks pregnant by 2019
			Proportion of mothers visiting a PHC facility for postnatal care within 6 days of delivery of their babies	74.8%	80% of mothers visiting a PHC facility for postnatal care within 6 days of delivery of their babies by 2019
2.	Expand the PMTCT coverage to pregnant woman	Minister of Health	Antenatal client initiated on ART rate	90%	98% of HIV positive pregnant women initiated on ART by 2019
			Infant 1st Polymerase Chain Reaction (PCR) test positive around 10 week rate	2.5%[22]	<1.5% of babies born to HIV positive mothers testing HIV positive at the age of 10 weeks by 2019
3.	Protection of children against vaccine preventable diseases	Minister of Health	Immunisation coverage under 1 year (annualised)	82.6% (2012/13)	95% infants fully immunised by 2019
			DTaP-IPV-HepB-Hib3 -Measles 1st dose drop-out rate	8%	<5% of infants who dropped out of the immunisation schedule between DTaP-IPV-Hep3/ Hib 3rd dose and measles 1st dose by 2019

[21] Estimated performance of the health sector for 2013/14, as reflected in the Annual Performance Plan of the National DoH for 2014/15

[22] Baseline provided for Infant 1st Polymerase Chain Reaction (PCR) test positive around 6 week rate. Baseline for PCT test positive at 10 weeks will be determined during 2016/17 financial year.

	Actions	Minister responsible	Indicators	Baselines[21]	Target
			Measles 2nd dose coverage	77% (2012/13)	85% of children receiving Measles 2nd dose by 2019
			Confirmed measles case incidence per million total population	<5 per 1,000,000	<1 confirmed cases of Measles incidence per 1,000,000 population by 2019
4	Reduce fatality caused by leading causes of death	Minister of Health	Child under 5 years diarrhoea case fatality rate	4.2%	<2% of children under 5 years admitted with diarrhoea who died by 2019
		Minister of Health	Child under 5 years severe pneumonia case fatality rate	3.8%	<2.5% of children under 5 years admitted with pneumonia who died by 2019
		Minister of Health	Child under 5 years severe acute malnutrition case fatality rate	9%	<5% of children under 5 years admitted with severe acute malnutrition who died by 2019

	Actions	Minister responsible	Indicators	Baselines[21]	Target
5	Improve nutrition levels among infants	Minister of Health	Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	45% (2014/15)	65% infants exclusively breastfed at 14 weeks as a proportion of the infants receiving DTaP-IPV-Hib-HBV 3rd dose vaccination
6.	Expand access to sexual and reproductive health by expanding availability of contraceptives and access to cervical and HPV cancer screening services	Minister of Health	Couple year protection rate	36%	75% of 15 to 49 year old women protected against unwanted pregnancies by 2019
		Minister of Health	Cervical cancer screening Coverage	55%	70% of women screening for cervical cancer at least once every 10 years by 2019
		Minister of Health	Human Papilloma Virus (HPV) Vaccine 1st dose coverage -	None (new indicator)	90% of grade 4 girls that are 9 years and older receiving 1st dose of HPV vaccine by 2019

5.10. Sub-outcome 10: Efficient Health Management Information System developed and implemented for improved decision making

The NDP 2030 emphasizes the widely accepted fact that credible data are necessary for decision-making and regular system-wide monitoring. The NDP 2030 accentuates the need to implement effective health information systems. Key interventions include: prioritizing the development and management of effective data systems; integrating the national health information system with the provincial, district, facility and community-based information systems; establishing national standards for integrating health information systems; undertaking regular data quality audits, developing human resources for health information; strengthening the use of information; focusing access on web based and mobile data entry and retrieval linked to the existing DHIS; and investing in improving data quality. Diverse health information systems exist in the public sector, which play a key role in tracking the performance of the health system. However, these systems have various limitations, including: lack of interoperability between different systems; inability to facilitate harmonious data exchange; prevalence of manual systems and lack of automation.

Table 10: Key actions, indicators and targets for the development of an integrated and well-functioning national patient-based information system

6. Impact (or outcome) Indicators

Table 11 below reflects the key impacts expected from the interventions of the health sector during 2014-2019.

	Key Actions	Minister Responsible	Indicators	Baselines[23]	Targets
1	Develop a complete System design for a National Integrated Patient based information system	Minister of Health Minister of Science and Technology	System design for a National Integrated Patient based information system completed	Health Normative Standards Framework for eHealth produced and gazetted in terms of the National Health Act (61 of 2003) in 2014	System design for a National Integrated Patient based information system completed by March 2019

[23] Estimated performance of the health sector for 2013/14, as reflected in the Annual Performance Plan of the National DoH for 2014/15

Impact Indicator	Minister responsible	Baseline 2009[24]	Baseline[25] 2014	2019 targets
Life expectancy at birth: Total	Minister of Health	57.1 years	62.9 years (increase of 3,5years)	Life expectancy of at least 65 years by March 2019
Life expectancy at birth: Male	Minister of Health	54.6 years	60.0 years	Life expectancy of at least 61.5 years amongst Males by March 2019 (increase of 3 years)
Life expectancy at birth: Female	Minister of Health	59.7 years	65.8 years	Life expectancy of at least 67 years amongst females by March 2019 (increase of 3years)
Under-5 Mortality Rate (U5MR)	Minister of Health	56 per 1,000 live-births	39 under 5 deaths per 1,000 live-births (25% decrease)	33 under 5 year deaths per 1,000 live-births by March 2019
Neonatal Mortality Rate	Minister of Health	-	14 neonatal deaths per 1000 live births	8 neonate deaths per 1000 live births
Infant Mortality Rate (IMR)	Minister of Health	39 per 1,000 live-births	28 infant deaths per 1,000 live-births (25% decrease)	23 infant deaths per 1000 live births (15% decrease)

[24] Dorrington RE, Bradshaw D, Laubscher R (2015): Rapid Mortality Surveillance Report 2014, Cape Town: South African Medical Research Council.

[25] Dorrington RE, Bradshaw D, Laubscher R (2015): Rapid Mortality Surveillance Report 2014, Cape Town: South African Medical Research Council.

Impact Indicator	Minister responsible	Baseline 2009[24]	Baseline[25] 2014	2019 targets
Maternal Mortality Ratio (MMR)	Minister of Health	280 per 100,000 live-births (2008 data)	269 maternal deaths per 100,000 live-births (2010 data)	<100 maternal deaths per 100,000live-births by March 2019
Live Birth under 2500g in facility rate	Minister of Health Minister of Social Development Minister of Agriculture Minister of Economic Development	-	12.9%	11.6% (10 percentage point reduction)

ANNEXURE C: TECHNICAL INDICATOR DESCRIPTIONS OF CUSTOMIZED INDICATORS

PROGRAMME 1: ADMINISTRATION

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Improve Hospital Management by appointing Executive Management teams in all hospitals (Key Management Positions)	Is a count of vacant key Executive Management posts filled in hospitals inclusive of CEO, Corporate, Finance, Medical and Nursing Managers	Strengthen leadership and governance in hospitals	Persal Report	Numerator: Total number vacant funded posts for top five hospital executive management filled	Depends on accuracy of PERSAL data	Input	Number	Annual	Yes	Increase in filling of post	Chief Director HRM & D
Improve quality of care by developing and implementing Recruitment & Retention strategy	Documented and approved Recruitment & Retention strategy reviewed by continuous update of staff needs as determined in the Human Resource Plan and utilised/implemented by the department for retention of staff and recruitment as evident in the Human Resource Plan	To improve service delivery and responsive to needs of departmental clients	Recruitment and retention strategy v/s appointment as per human resource plan	Documented Recruitment &Retention strategy review and evidential staff appointment as per schedule of human resource plan	None	Input	Number	Annual	Yes	Increase in filling of post	Chief Director HRM & D
Improve quality of information by appointing information officers in all sub-districts	Number of Health Information Officers appointed at sub-district to manage sub district performance information	Monitor staff compliment at district level	PERSAL	Total number of Health Information Officers appointed in sub district	Depends on accuracy of PERSAL data	Input	Number	Quarterly	Yes	Increase number of health information officers appointed	Chief Director HRM & D

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Audit opinion from Auditor General	Audit opinion for Provincial Departments of Health for financial performance	To strengthen financial management monitoring and evaluation	Documented Evidence: Annual Report Auditor General's Report	N/A Categorical	N/A	Outcome	N/A	Annual	No	Unqualified Audit Opinion from the Auditor General	Chief Financial Officers of Provincial Departments of Health
Percentage of Hospitals with broadband access	Percentage of Hospitals with broadband access	To track broadband access to hospitals	Network reports that confirm availability of broadband; OR Network rollout report for sites that are not yet live	**Numerator:** Total Number of hospitals with minimum 2 Mbps connectivity **Denominator**Total Number of Hospitals	NA	Output	Percentage	Quarterly	No	Higher Proportion of broadband access is more favorable for connectivity to ensure that South African health system can implement the eHealth Programme	ICT Directorate / Chief Directorate
Percentage of fixed PHC facilities with broadband access	Percentage of fixed PHC facilities with broadband access	To ensure broadband access to PHC facilities	Network reports that confirm availability of broadband; OR Network rollout report for sites that are not yet live	**Numerator:** Total Number of fixed PHC facilities with minimum 1Mbps connectivity **Denominator** Total Number of fixed PHC Facilities	NA	Output	Percentage	Quarterly	No	Higher Proportion of broadband access is more favorable for connectivity	ICT Directorate / Chief Directorate

PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS)

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) rate (fixed clinic/CHC/CDC)	Fixed clinics, CHCs and CDCs where Ideal clinic status determinations are conducted by PPTICRM as a proportion Fixed clinics plus fixed CHCs/CDCs	Monitors whether PHC health establishments are measuring their level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	Ideal Clinic review tools	**Numerator:** SUM([Ideal clinic status determinations conducted by PPTICRM]) **Denominator**: SUM([Fixed PHC clinics/fixed CHCs/CDCs])	The indicator measures self or peer assessment, and performance is reliant on accuracy of interpretation of ideal clinic data elements	Cumulative	Percentage	Quarterly	Yes	Higher percentage indicates greater level of ideal clinic principles	District Health Services and Quality Assurance Directorates
OHH registration visit coverage	Outreach households registered by Ward Based Outreach Teams as a proportion of OHH in population	Monitors implementation of the PHC re-engineering strategy	DHIS, household registration visits registers, patient records	**Numerator:** SUM([OHH registration visit]) **Denominator:** Household mid-year estimate	Dependant on accuracy of OHH in population	Output	Percentage	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system.	CBS / Outreach Services programme manager
PHC utilisation rate - total	Average number of PHC visits per person per year in the population.	Monitors PHC access and utilisation.	Daily Reception Headcount register (or HPRS where available) and DHIS Denominator: Stats SA	**Numerator:** SUM ([PHC headcount under 5 years] + [PHC headcount 5-9 years] + [PHC headcount 10-19 years] + [PHC headcount 20 years and older])	Dependant on the accuracy of estimated total population from StatsSA	Output	Number	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system. A lower uptake may indicate	DHS Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
				Denominator: Sum([Population - Total)]						underutilization of facility	
Complaints Resolution Rate	Complaints resolved as a proportion of complaints received	Monitors public health system response to customer concerns	DHIS, complaints register,	**Numerator:** SUM([Complaint resolved]) **Denominator:** SUM([Complaint received])	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in PHC facilities	Quality Assurance
Complaint resolution within 25 working days rate	Complaints resolved within 25 working days as a proportion of all complaints resolved	Monitors the time frame in which the public health system responds to complaints	DHIS, complaints register,	**Numerator:** SUM([Complaint resolved within 25 working days]) **Denominator:** SUM([Complaint resolved])	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in PHC Facilities	Quality Assurance

SUB – PROGRAMME: DISTRICT HOSPITALS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Hospital achieved 75% and more on National Core Standards (NCS) self assessment rate (District Hospitals)	Fixed health facilities that have conducted annual National Core Standards self-assessment as a proportion of fixed health facilities.	Monitors whether health establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - NCS Reports	Numerator: SUM([Hospital achieved 75% and more on National Core Standards self assessment]) Denominator: SUM([Hospitals conducted National Core Standards self assessment])	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
Average Length of Stay (District Hospitals)	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of day clients, Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialities	Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it should only include Inpatient days for those clients separated during the reporting month. Use in all hospitals and CHCs with Inpatient beds	DHIS, midnight census register	**Numerator:** Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) **Denominator:** SUM([inpatient deaths-total])+([inpatient discharges-total])+([inpatient transfers out-total])	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	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. High ALOS might reflect inefficient quality of care	District Health Services
Inpatient Bed Utilisation Rate (District Hospitals)	Inpatient bed days used as proportion of maximum	Track the over/under utilisation of	DHIS, midnight census	**Numerator:** Sum ([Inpatient days total x 1])+([Day	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or	Hospital Services Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	Inpatient bed days (inpatient beds x days in period) available. Include all specialities	district hospital beds		patient total x 0.5]) **Denominator:** Inpatient bed days (Inpatient beds * 30.42) available						higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility	
Expenditure per patient day equivalent (PDE) (District Hospitals)	Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.33333333	Monitors effective and efficient management of inpatient facilities. Note that multiplied by 0.5 is the same as division by 2, and multiplied by 0.33333333 is the same as division by 3	BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records Admission, expenditure, midnight census	**Numerator:** SUM([Expenditure - total]) **Denominator:** Sum ([Inpatient days total x 1])+([Day patient total x 0.5])+([OPD headcount not referred new x 0.3333333])+ SUM([OPD headcount referred new x 0.3333333])+([OPD headcount follow-up x 0.3333333])+([Emergency headcount - total x 0.3333333])	Accurate reporting sum of daily usable beds	Outcome	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	Hospital Services Manager
Complaints Resolution Rate (District Hospitals)	Complaints resolved as a proportion of complaints received	Monitors public health system response to customer concerns	Complaints register	**Numerator:** SUM([Complaint resolved]) **Denominator:**	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Hospital Services and Quality Assurance Managers

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
				SUM([Complaint received])							
Complaint resolution within 25 working days rate (District Hospitals)	Complaints resolved within 25 working days as a proportion of all complaints resolved	Monitors the time frame in which the public health system responds to complaints	Complaints register	**Numerator:** SUM([Complaint resolved within 25 working days]) **Denominator:** SUM([Complaint resolved])	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Hospital Services and Quality Assurance Managers

HIV & AIDS, STI & TB (HAST) CONTROL

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Female condom distributed	Total number of female condoms supplied or distributed in the province	Tracks the supply of female condoms in the Province	Numerator: Stock/Bin card Denominator: StatsSA	Numerator: Total number of Male condoms distributed in the province Denominator: Male Population 15 years and older	None	Process	Percentage	Quarterly	No	Higher number indicated better distribution (and indirectly better uptake) of condoms in t he province	HIV/AIDS Cluster
Improve TB cure rate	Percentage of TB clients who successfully cured for TB during the reporting period	Monitors impact of of TB treatment Programme	ETR.net report	Numerator: TB client cured Denominator: TB client start on treatment	Depends on management of registers	Outcome	Percentage	Annual	No	Increase in number of TB client successfully treated	TB Program
ART client remain on ART end of month - total	Total clients remaining on ART (TROA) are the sum of the following: - Any client on treatment in the reporting month - Any client without an outcome reported in the reporting month Clients remaining on ART equals [new starts	Monitors the total clients remaining on life-long ART at the month	ART Register; TIER.Net; DHIS	**Numerator:** SUM([ART adult remain on ART end of period])+SUM([ART child under 15 years remain on ART end of period])	None	Output	Cumulative total	Quarterly	no	Higher total indicates a larger population on ART treatment	HIV/AIDS Programme Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	(naive) + Experienced (Exp) + Transfer in (TFI) + Restart] minus [Died (RIP) + loss to follow-up (LTF) + Transfer out (TFO)]										
TB/HIV co-infected client on ART rate	TB/HIV co-infected clients on ART as a proportion of HIV positive TB clients	. Monitors ART coverage for TB clients	TB register; ETR.Net; Tier.Net	**Numerator:** SUM([TB/HIV co-infected client on ART]) **Denominator:** SUM([TB client known HIV positive])	Availability of data in ETR.net, TB register, patient records	Outcome	Percentage	Quarterly	No	Higher proportion of TB/HIV co-infected on ART treatment will reduce co-infection rates	TB/HIV manager
HIV test done - total	The total number of HIV tests done in all age groups	Monitors the impact of the pandemic and assists in better planning for effective combating of HIV and AIDS and decreasing the burden of diseases from TB	PHC Comprehensive Tick Register; HTS Register (HIV Testing Services) or HCT module in TIER.Net,DHIS	SUM([Antenatal client HIV 1st test]) + SUM([Antenatal client HIV re-test]) + SUM([HIV test 19-59 months]) + SUM([HIV test 5-14 years]) + SUM([HIV test 15 years and older (excl ANC)])	Dependent on the accuracy of facility register	Process	Number	Quarterly	No	Higher percentage indicate increased population knowing their HIV status.	HIV/AIDS Programme Manager
Male Condoms Distributed	Male condoms distributed from a primary distribution site to health facilities or points in the	Monitors distribution of male condoms for prevention of HIV and other STIs, and for contraceptive	Numerator: Stock/Bin card	SUM([Male condoms distributed])	None	Process	Percentage	Quarterly	No	Higher number indicated better distribution (and indirectly	HIV/AIDS Cluster

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	community (e.g. campaigns, non-traditional outlets, etc.).	purposes. Primary distribution sites (PDS) report to sub-districts on a monthly basis								better uptake) of condoms in t he province	
Medical male circumcision - Total	Total number of males 10 years and older whose foreskin was removed using surgical medical procedure.	Monitors medical male circumcisions performed under supervision	Theatre Register/ PHC tick register, DHIS	SUM([Males 10 to 14 years who are circumcised under medical supervision])+([Males 15 years and older who are circumcised under medical supervision])	Assumed that all MMCs reported on DHIS are conducted under supervision	Output	Rate	Quarterly	No	Higher number indicates greater availability of the service or greater uptake of the service	HIV/AIDS Programme Manager
TB client 5 years and older start on treatment rate	TB client 5 years and older start on treatment as a proportion of TB symptomatic client 5 years and older test positive	Monitors trends in early identification of children with TB symptoms in health care facilities	PHC Comprehe nsive Tick Register	**Numerator:** SUM([TB client 5 years and older start on treatment]) **Denominator**: SUM([TB symptomatic client 5 years and older tested positive])	- Accuracy dependent on quality of data from reporting facility	Process/ Activity	Rate	Quarterly	No	Screening will enable early identification of TB suspect in health facilities	TB Programme Manager
TB client treatment success rate	TB clients successfully completed treatment (both cured and treatment completed) as a proportion of ALL TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other,	Monitors success of TB treatment for ALL types of TB. This follows a cohort analysis therefore the clients would have been started on treatment at least 6 months prior	TB Register; ETR.Net	Numerator: SUM([TB client successfully completed treatment])Denominator: SUM([TB client start on treatment])	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Quarterly	No	Higher percentage suggests better treatment success rate.	TB Programme Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	pulmonary and extra pulmonary)										
TB Client lost to follow up rate	TB clients who are lost to follow up (missed two months or more of treatment) as a proportion of TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary and extra-pulmonary).	Monitors the effectiveness of the retention in care strategies. This follows a cohort analysis therefore the clients would have been started on treatment at least 6 months prior	TB Register; ETR.Net	Numerator: SUM [TB client lost to follow up] Denominator: SUM [TB client start on treatment]	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Quarterly	No	Lower levels of interruption reflect improved case holding, which is important for facilitating successful TB treatment	TB Programme Manager
TB Client death rate	TB clients who died during treatment as a proportion of TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary and extra pulmonary)	Monitors death during TB treatment period. The cause of death may not necessarily be due to TB. This follows a cohort analysis therefore the clients would have been started on treatment at least 6 months prior	TB Register; ETR.Net	Numerator: SUM([TB client died during treatment]) Denominator: SUM([TB client start on treatment])	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Annually	Yes	Lower levels of death desired	TB Programme Manager
TB MDR treatment success rate	TB MDR client successfully completing treatment as a	Monitors success of MDR TB treatment	TB Register; EDR Web	Numerator:	Accuracy dependent on quality of data submitted	Outcome	Percentage	Annually	Yes	Higher percentage indicates a	TB Programme Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	proportion of TB MDR confirmed clients started on treatment			SUM([TB MDR client successfully complete treatment]) Denominator: SUM([TB MDR confirmed client start on treatment])	health facilities					better treatment rate	

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

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Antenatal 1st visit before 20 weeks rate	Women who have a booking visit (first visit) before they are 20 weeks into their pregnancy as proportion of all antenatal 1st visits	Monitors early utilisation of antenatal services	PHC Comprehensive Tick Register	**Numerator:** SUM([Antenatal 1st visit before 20 weeks]) **Denominator:** SUM([Antenatal 1st visit 20 weeks or later]) + SUM([Antenatal 1st visit before 20 weeks])	Accuracy dependent on quality of data submitted health facilities	Process	Percentage	Quarterly	No	Higher percentage indicates better uptake of ANC services	MNCWH programme manager
Mother postnatal visit within 6 days rate	Mothers who received postnatal care within 6 days after delivery as proportion of deliveries in health facilities	Monitors access to and utilisation of postnatal services. May be more than 100% in areas with low delivery in facility rates if many mothers who delivered outside health facilities used postnatal visits within 6 days after delivery	PHC Comprehensive Tick Register	Numerator: SUM([Mother postnatal visit within 6 days after delivery]) Denominator: SUM([Delivery in facility total])	Accuracy dependent on quality of data submitted health facilities	Process	Percentage	Quarterly	No	Higher percentage indicates better uptake of postnatal services	MNCWH programme manager
Antenatal client start on ART rate	Antenatal clients who started on ART as a proportion of the total number of antenatal clients who are HIV positive and not previously on ART	Monitors implementation of PMTCT guidelines in terms of ART initiation of eligible HIV positive antenatal clients.	ART Register, Tier.Net	**Numerator:** SUM([Antenatal client start on ART]) **Denominator:** Sum([Antenatal client known HIV positive but NOT on ART at 1st visit]) + SUM([Antenatal client HIV 1st test positive]) + SUM([Antenatal client HIV re-test positive])	Accuracy dependent on quality of data Reported by health facilities	Output	Percentage	Annually	No	Higher percentage indicates greater coverage of HIV positive clients on HIV Treatment	MNCWH programme manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Infant 1st PCR test positive around 10 weeks rate	Infants tested PCR positive for follow up test as a proportion of Infants PCR tested around 10 weeks	Monitors PCR positivity rate in HIV exposed infants around 10 weeks	PHC Comprehensive Tick Register	Numerator: SUM([Infant PCR test positive around 10 weeks]) Denominator: SUM([Infant PCR test around 10 weeks])	Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	No	Lower percentage indicate fewer HIV transmissions from mother to child	PMTCT Programme
Immunisation under 1 year coverage	Children under 1 year who completed their primary course of immunisation as a proportion of population under 1 year.	Track the coverage of immunization services	Numerator: PHC Comprehensive Tick Register Denominator: StatsSA	Numerator: SUM([Immunised fully under 1 year new]) Denominator: SUM([Female under 1 year]) + SUM([Male under 1 year])	Road to Health charts are not retained by Health facility. Reliant on under 1 population estimates from StatsSA, and accurate recording of children under 1 year who are fully immunised at facilities (counted only ONCE when last vaccine is administered.)	Output	Percentage Annualised	Quarterly	No	Higher percentage indicate better immunisation coverage	EPI Programme manager
Measles 2nd dose coverage	Children 1 year (12 months) who received measles 2nd dose, as a	Monitors protection of children against measles. Because the 1st	PHC Comprehensive Tick Register	Numerator: SUM([Measles 2nd dose]) Denominator:	Accuracy dependent on quality of data submitted	Output	Percentage	Quarterly	No	Higher coverage rate indicate greater protection	EPI

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	proportion of the 1 year population..	measles dose is only around 85% effective the 2nd dose is important as a booster. Vaccines given as part of mass vaccination campaigns should not be counted here	Denominator: StatsSA	SUM([Female 1 year]) + SUM([Male 1 year])	health facilities					against measles	
DTaP-IPV-Hib-HBV 3 - - Measles 1st dose drop-out rate	Children who dropped out of the immunisation schedule between DTaP-IPV-Hib-HBV 3rd dose, normally at 14 weeks and measles 1st dose, normally at 6 months as a proportion of population under 1 year	Monitors protection of children against diphtheria, tetanus, a-cellular pertussis, polio, Haemophilus influenza and Hepatitis B. DTaP-IPV-Hib-HBV (known as Hexavalent) was implemented in 2015 to replace DTaP-IPV/Hib (Pentaxim) and HepB.	PHC Comprehensive Tick Register	Numerator: (SUM([DTaP-IPV/Hib (Pentavalent) 3rd dose]) + SUM([DTaP-IPV-Hib-HBV (Hexavalent) 3rd dose])) - SUM([Measles 1st dose under 1 year]) Denominator: SUM([DTaP-IPV-Hib-HBV (Hexavalent) 3rd dose]) + SUM([DTaP-IPV/Hib (Pentavalent) 3rd dose])	Accuracy dependent on quality of data submitted health facilities	Outcome	Percentage	Quarterly	No	Lower dropout rate indicates better vaccine coverage	EPI
Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	Infants exclusively breastfed at 14 weeks as a proportion of the DTaP-IPV-Hib-HBV 3rd dose	Monitors infant feeding practices at 14 weeks to identify where community interventions	PHC Comprehensive Tick Register	Numerator: SUM([Infant exclusively breastfed at DTaP-IPV-Hib-HBV (Hexavalent) 3rd dose]) Denominator:	Reliant on honest response from mother; and Accuracy dependent	Output	Percentage	Quarterly	Yes	Higher percentage indicate better exclusive breastfeeding rate	Cluster: Child Health

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	vaccination. Take note that DTaP-IPV-Hib-HBV 3rd dose (Hexavalent) was implemented in 2015 to include the HepB dose	need to be strengthened		SUM([HepB 3rd dose under 1 year]) + SUM([DTaP-IPV-Hib-HBV (Hexavalent) 3rd dose])	on quality of data submitted health facilities						
Diarrhoea case fatality under 5 years rate	Diarrhoea deaths in children under 5 years as a proportion of diarrhoea separations under 5 years in health facilities	Monitors treatment outcome for children under 5 years who were separated with diarrhoea	ard register	Numerator: SUM([Diarrhoea death under 5 years]) Denominator: SUM([Diarrhoea separation under 5 years])	Reliant on accuracy of diagnosis / cause of death Accuracy dependent on quality of data submitted health facilities	Impact	Percentage	Quarterly	No	Lower children mortality rate is desired	MNCWH Programme manager
Pneumonia case fatality under 5 years rate	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	Monitors treatment outcome for children under 5 years who were separated with pneumonia	Ward register	Numerator: SUM([Pneumonia death under 5 years]) Denominator: SUM([Pneumonia separation under 5 years])	Reliant on accuracy of diagnosis / cause of death; Accuracy dependent on quality of data submitted health facilities	Impact	Percentage	Quarterly	Yes	Lower children mortality rate is desired	MNCWH Programme manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Severe acute malnutrition case fatality under 5 years rate	Severe acute malnutrition deaths in children under 5 years as a proportion of severe acute malnutrition (SAM) under 5 years in health facilities	Monitors treatment outcome for children under 5 years who were separated with Severe acute malnutrition (SAM)	Ward register	Numerator: SUM([Severe acute malnutrition (SAM) death in facility under 5 years]) **Denominator:** SUM([Severe Acute Malnutrition separation under 5 years	Accuracy dependent on quality of data submitted health facilities	Impact	Percentage	Quarterly	Yes	Lower children mortality rate is desired	MNCWH Programme manager
Number of School Health Service Teams established	A team of School Health Service established at the sub districts to provide school health services at school level	To improve access to PHC services BY children	Appointment letters	Number of School Health Service teams established at the sub districts	None	Input	Number	Yearly	Yes	Increase the number of School Health Service Teams	School Health Services
School Grade 1 - learners screened	Proportion of Grade 1 learners screened by a nurse in line with the ISHP service package	Monitors implementation of the Integrated School Health Program (ISHP)	Numerator: School Health data collection forms	SUM [School Grade 1 - learners screened}	None	Process	Number	Quartely	Yes	Higher percentage indicates greater proportion of school children received health services at their school	School health services
School Grade 8 – learners screened	Proportion of Grade 8 learners screened by a nurse in line with the ISHP service package	Monitors implementation of the Integrated School Health Program (ISHP)	School Health data collection forms	SUM [School Grade 8 - learners screened]	None	Process	Number	Quarterly	Yes	Higher percentage indicates greater proportion of school children received health	School health services

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
										services at their school	
Delivery in 10 to 19 years in facility rate	Deliveries to women under the age of 20 years as proportion of total deliveries in health facilities	Monitors the proportion of deliveries in facility by teenagers (young women under 20 years).	Health Facility Register, DHIS	Numerator: SUM [Delivery 10–14 years in facility] + [Delivery 15–19 years in facility] Denominator: SUM([Delivery in facility total])	None	Process	Percentage	Quarterly	Yes	Lower percentage indicates better family planning	HIV and Adolescent Health
Couple Year Protection Rate (Int)	Women protected against pregnancy by using modern contraceptive methods, including sterilisations, as proportion of female population 15-49 year. Couple year protection are the total of (Oral pill cycles / 15) + (Medroxyprogesterone injection / 4) + (Norethisterone enanthate injection / 6) + (IUCD x 4.5) +) + (Sub dermal implant x 2.5) + Male condoms distributed / 120)	Monitors access to and utilisation of modern contraceptives to prevent unplanned pregnancies. Serves as proxy for the indicator contraceptive prevalence rate by monitoring trends between official surveys	PHC Comprehensive Tick Register Denominator: StatsSA	Numerator (SUM([Oral pill cycle]) / 15) + (SUM([Medroxyprogesterone injection]) / 4) + (SUM([Norethisterone enanthate injection]) / 6) + (SUM([IUCD inserted]) * 4.5) + (SUM([Male condoms distributed]) / 120) + (SUM([Sterilisation - male]) * 10) + (SUM([Sterilisation - female]) * 10) + (SUM([Female condoms distributed]) / 120) + (SUM([Sub-dermal implant inserted]) * 2.5) Denominator: SUM {[Female 15-44 years]} + SUM{[Female 45-49 years]}	Accuracy dependent on quality of data submitted health facilities	Outcome	Percentage	Quarterly	No	Higher percentage indicates higher usage of contraceptive methods.	MCWH&N Programme

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	+ (Female condoms distributed / 120) + (Male sterilisation x 10) + (Female sterilisation x 10).										
Cervical cancer screening coverage 30years and older	Cervical smears in women 30 years and older as a proportion of 10% of the female population 30 years and olderyears.	Monitors implementation on cervical screening and policy	PHC Comprehensive Tick Register OPD tick register Denominator: StatsSA	Numerator: SUM([Cervical cancer screening 30 years and older]) Denominator: (SUM([Female 30-34 years]) + SUM([Female 35-39 years]) + SUM([Female 40-44 years]) + SUM([Female 45 years and older])) / 10	Reliant on population estimates from StatsSA, and Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	No	Higher percentage indicate better cervical cancer coverage	MNCWH Programme Manager
HPV 1st dose	Girls 9 years and older that received HPV 1st dose	This indicator will provide overall yearly coverage value which will aggregate as the campaign progress and reflect the coverage so far	HPV Campaign Register – captured electronically on HPV system	SUM([Agg_Girl_09_yrs_HPV 1st_dose]) + SUM([Agg_Girl 10_yrs_HPV_1st_dose]) + SUM([Agg_Girl_11_yrs_HPV 1st_dose]) + SUM([Agg_Girl 12_yrs_HPV_1st_dose]) + SUM([Agg_Girl_13_yrs_HPV 1st_dose]) + SUM([Agg_Girl 14_yrs_HPV_1st_dose]) + SUM([Agg_Girl_15_yrs_and older HPV 1st dose])	None	Output	Number	Annually	No	Higher percentage indicate better coverage	MNCWH Programme Manager
HPV 2nd dose	Girls 9yrs and older HPV 2nd dose	This indicator will provide overall yearly coverage value which will	HPV Campaign Register – captured electronical	SUM([Agg_Girl_09_yrs_HPV 2nd_dose]) + SUM([Agg_Girl 10_yrs_HPV_2nd_dose]) + SUM([Agg_Girl_11_yrs_HPV 2nd_dose]) + SUM([Agg_Girl	None	Output	Number	Annually	No	Higher percentage indicate better coverage	MNCWH Programme Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
		aggregate as the campaign progress and reflect the coverage so far	ly on HPV system	12 yrs HPV 2nd dose]) + SUM([Agg_Girl 13 yrs HPV 2nd dose]) + SUM([Agg_Girl 14 yrs HPV 2nd dose]) + SUM([Agg_Girl 15 yrs and older HPV 2nd dose])							
Vitamin A dose 12-59 months coverage	Children 12-59 months who received Vitamin A 200,000 units, every six months as a proportion of population 12-59 months.	Monitors Vitamin A supplementation to children aged 12-59 months. The denominator is multiplied by 2 because each child should receive supplementation twice a year	PHC Comprehensive Tick Register	**Numerator:** SUM([Vitamin A dose 12-59 months]) **Denominator:** (SUM([Female 1 year]) + SUM([Female 02-04 years]) + SUM([Male 1 year]) + SUM([Male 02-04 years])) * 2	PHC register is not designed to collect longitudinal record of patients. The assumption is the that the calculation proportion of children would have received two doses based on this calculation	Output	Percentage	Quarterly	No	Higher proportion of children 12-29 months who received Vit A will increase health	MNCWH Programme Manager
Maternal mortality in facility ratio	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of	This is a proxy for the population-based maternal mortality ratio, aimed at monitoring trends in health facilities between official surveys. Focuses on obstetric causes (around 30% of	Maternal death register, Delivery Register	**Numerator:** SUM([Maternal death in facility]) **Denominator:** SUM([Live birth in facility])+SUM([Born alive before arrival at facility])	Completeness of reporting	Impact	Ratio per 100 000 live births	Annually	No	Lower maternal mortality ratio in facilities indicate on better obstetric management practices and antenatal care	MNCWH Programme Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100,000 live births in facility	all maternal mortality). Provides indication of health system results in terms of prevention of unplanned pregnancies, antenatal care, delivery and postnatal services									
Neonatal death in facility rate	Neonatal 0-28 days who died during their stay in the facility as a proportion of live births in facility	Monitors treatment outcome for admitted children under 28 days	Delivery register, Midnight report	**Numerator:** SUM([Inpatient death 0-7 days]) + SUM([Inpatient death 8-28 days]) **Denominator:** SUM([Live birth in facility])	Quality of reporting	Impact	Percentage	Annually	No	Lower death rate in facilities indicate better obstetric management practices and antenatal and care	MNCWH Programme Manager

DISEASE PREVENTION AND CONTROL (DPC)

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Cataract Surgery Rate	Clients who had cataract surgery per 1 million uninsured population	Accessibility of theatres. Availability of human resources and consumables	Numerator: Theatre Register Denominator: DHIS based on StatsSA proportions	**Numerator:** SUM([Cataract surgery total]) **Denominator:** SUM([Total population]) - SUM([Total population (MedicAid)])	Accuracy dependant on quality of data from health facilities	Output	Rate	Quarterly	No	Higher number of cataract surgery rate indicated greater proportion of the population received cataract surgery	NCD Programme Manager
Malaria case fatality rate	Deaths from malaria as a percentage of the number of cases reported	Monitor the number deaths caused by Malaria	Malaria Information System	**Numerator:** Deaths from malaria **Denominator**: Total number of Malaria cases reported	Accuracy dependant on quality of data from health facilities	Outcome	Rate	Quarterly	No	Lower percentage indicates a decreasing burden of malaria	Communicable Diseases

PROGRAMME 3: EMERGENCY MEDICAL SERVICES (EMS)

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Improve response time by increasing the number of Operational Ambulances	Number of ambulances both old and newly procured allocated to facilities for ambulance operational use	increasing the number of Operational Ambulances	Assert Register	Number of Operational Ambulances	Reliant on availability of Funds	Input	No	Annual	Yes	increasing the number of Operational Ambulances	EMS Manager
Improve the use of resources by integrating PPTS into EMS operations	Number of Planned Patient Transport which were originally allocated in hospitals absorbed in the Emergency Medical Services	Monitor integration of PPTS to EMS	Physical verification or Assert Register	Number of Planned Patient Transport integrated into Emergency Medical Services	No	Input	No	Annual	Yes	increasing the Number of Planned Patient Transport integrated into Emergency Medical Services	EMS Manager
Improve maternal outcomes by increasing the number of Obstetric ambulances	Total number of Ambulances designed and dedicated to provide obstetric services	To monitor allocation of ambulances for Obstetric services	Physical Verification or Assert Register	Numerator: Number of Obstetric ambulances	None	Input	%	Quarterly	No	Increase in Number of Obstetric ambulances	EMS Manager
EMS P1 urban response under 15 minutes rate	Emergency P1 calls in urban locations with response times under 15 minutes as a proportion of EMS P1 urban calls. Response time is calculated from the time the call is received to the time that the first dispatched	Monitors compliance with the norm for critically ill or injured patients to receive EMS within 15 minutes in urban areas	DHIS, institutional EMS registers OR DHIS, patient and vehicle report.	**Numerator:** SUM([EMS P1 urban response under 15 minutes]) **Denominator:** SUM([EMS P1 urban calls])	Accuracy dependant on quality of data from reporting EMS station	Ouput	Percentage	Quarterly	No	Higher percentage indicate better response times in the urban areas	EMS Manager

	medical resource arrives on scene										
EMS P1 rural response under 40 minutes rate	Emergency P1 calls in rural locations with response times under 40 minutes as a proportion of EMS P1 rural call	Monitors compliance with the norm for critically ill or injured patients to receive EMS within 40 minutes in rural areas	DHIS, institutional EMS registers Patient and vehicle report.	**Numerator:** SUM([EMS P1 rural response under 40 minutes]) **Denominator:** SUM([EMS P1 rural calls])	Accuracy dependant on quality of data from reporting EMS station	Output	Percentage	Quarterly	No	Higher percentage indicate better response times in the rural areas	EMS Manager
EMS inter-facility transfer rate	Inter-facility (from one inpatient facility to another inpatient facility) transfers as proportion of total EMS patients transported	Monitors use of ambulances for inter-facility transfers as opposed to emergency responses	DHIS, institutional EMS registers Patient and vehicle report.	**Numerator** SUM([EMS emergency urban inter-facility transfer under 30 minutes])+SUM([EMS emergency rural inter-facility transfer under 60 minutes]) **Denominator** SUM([EMS clients total])	Accuracy dependant on the reliability of data recorded on the Efficiency Report at EMS stations and emergency headcount reported from hospitals.	Output	Percentage	Quarterly	No	Lower percentage desired. The target is the CSP target of 10% (8:2) of acute patient contacts and measures whether capacity exists at the appropriate level of care.	EMS Manager

PROGRAMME 4 and 5: REGIONAL / TERTIARY / CENTRAL HOSPITALS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Functional Adverse Events Committees	Number of established committee that meet on frequent basis to discuss medical adverse events and implement strategies to prevents such events from occurring	To develop and implement adverse events prevention strategies	Minutes of meetings of the committee	Number of Functional adverse events committee	None	Input	No	Quarterly	Yes	Increase number of Functional adverse events committee	Chief Director Hospital services
Improve access to TB services through effective movement TB patients rate for continuity of care	Percentage of movement of TB patients from TB hospital to Primary Health Care facility with a confirmation slip as acknowledgement by the receiving facility for continuation of treatment	To monitor the efficiency and effectiveness of the institution	Acknowledgement slips (pink slips) movement book	Numerator: Number of confirmed TB patients movement Denominator: total number of TB patients moved	Accuracy dependant on quality of data and effective information systems	Output	Percentage	Quarterly	No	Increase effective movement of TB patients	Chief Director Hospital services
Hospital achieved 75% and more on National Core Standards self - assessment rate	Percentage of Hospitals that conducted self assessment on National core standards and achieved a performance of 75% scoring of National core standard results.	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health	DHIS - National Core Standard review tools	**Numerator:** Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year **Denominator:** Total number of Hospitals conducted	Reliability of data provided	Output	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
		Standards Compliance		National Core Standards							
Average Length of Stay (Regional / Tertiary / Central Hospitals)	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of day clients, Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialities	Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it should only include Inpatient days for those clients separated during the reporting month. Use in all hospitals and CHCs with Inpatient beds	DHIS, midnight census	Numerator Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) Denominator SUM([inpatient deaths-total])+([inpatient discharges-total])+([inpatient transfers out-total])	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	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. High ALOS might reflect inefficient quality of care	District Health Services
Inpatient Bed Utilisation Rate (Regional / Tertiary / Central Hospitals)	Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialities	Monitors effectiveness and efficiency of inpatient management	DHIS, midnight census	Numerator: Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) Denominator: Inpatient bed days (Inpatient beds * 30.42) available	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. Lower bed utilization rate indicates inefficient utilization of the facility	Hospital Services Manager
Expenditure per patient day equivalent (PDE) (Regional / Tertiary / Central Hospitals)	Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD	Monitors effective and efficient management of inpatient facilities. Note that multiplied by 0.5 is the same	BAS, Stats SA, Council for Medical Scheme data, DHIS, midnight census	**Numerator** SUM([Expenditure - total]) **Denominator** Sum ([Inpatient days total x 1])+([Day	Accurate reporting sum of daily usable beds	Outcome	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	Hospital Services Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	headcount total) * 0.33333333	as division by 2, and multiplied by 0.33333333 is the same as division by 3		patient total x 0.5])+([OPD headcount not referred new x 0.3333333])+ SUM([OPD headcount referred new x 0.3333333])+([OPD headcount follow-up x 0.3333333])+([Emergency headcount - total x 0.3333333])							
Complaint Resolution Rate (Regional / Tertiary / Central Hospitals)	Complaints resolved as a proportion of complaints received	Monitors public health system response to customer concerns	complaints register,	Numerator SUM([Complaint resolved]) Denominator SUM([Complaint received])	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance
Complaint resolution within 25 working days rate (Regional / Tertiary / Central Hospitals)	Complaints resolved within 25 working days as a proportion of all complaints resolved	Monitors the time frame in which the public health system responds to complaints	complaints register,	**Numerator** SUM([Complaint resolved within 25 working days]) **Denominator** SUM([Complaint resolved])	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Improve human resource efficiency by training health care professionals on critical clinical skills	Number of health care professional who are trained on critical skills	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	Number	Quarterly	No	Increase the number of health professionals trained on critical clinical skills	Human Resources Development Programme Manager
Improve access to nursing training by increasing the number of accredited college satellite campuses	Number of nursing colleges satellite campuses which are accredited by National Qualification Authority to provide nursing training	Tracking Number of nursing colleges accredited to offer the new nursing curriculum	Accreditation certificate	Count of nursing colleges accredited	Depends on accrediting institutions to process applications in timely manner	Input	Number	Annual	Yes	Increase Number of nursing colleges accredited to offer the new nursing curriculum	Human Resources Development Programme Manager
Number of Bursaries awarded to first year medicine students	Number of new medicine students provided with bursaries by the provincial department of health	Tracks the numbers of medicine students sponsored by the Province to undergo training as future health care providers	Bursary contracts	No denominator	Data quality depends on good record keeping by both the Provincial DoH and Health Science Training institutions	Input	No.	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 Programme Manager
Number of Bursaries awarded to first year nursing students	Number of basic nursing students enrolled in nursing colleges and universities and offered bursaries by the provincial department of health	Tracks the numbers of medicine students sponsored by the Province to undergo training as future health care providers	SANC Registration form	No denominator	Data quality depends on good record keeping by both the Provincial DoH and Health Science Training institutions	Input	No.	Annual	Yes	Higher numbers of students provided with bursaries are desired, as this has the potential to increase future health care providers	Human Resources Development Programme Manager

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Improve quality of care by increasing availability of medicines and surgical sundries at the Medical Depot.	Percentage of the available items on the Essential Drugs List at depot for supply to the facilities.	Monitor drug availability	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	Percentage	Quarterly	No	Increase percentage of the essential drugs available	Pharmaceutical Services
Number of patients initiated on Central Chronic Medicine Dispensing and Distribution (CCMDD)	Number of chronic patients who are enrolled to receive their medicine through Central Chronic Medicine Dispensing and Distribution (CCMDD) at preferred pick up points.	Improve access to medical care		Number of patients initiated on Central Chronic Medicine Dispensing and Distribution (CCMDD)	none	Input	No	Quarterly	Yes	Increase Number of patients initiated on Central Chronic Medicine Dispensing and Distribution (CCMDD)	Pharmaceutical Services
Improve access to quality of care through compliance with Radiation Control prescripts by all facilities with X-Ray equipment	Percentage of facilities with X-ray equipment that comply with Radiation Control guidelines setup by South African Radiation Control Council to regulate use of medical equipment and ensure ethical considerations.	Monitor compliance of facilities to Radiation Control prescripts.	Radiology audit reports	Numerator Number of facilities complying with Radiation Control prescripts Denominator Number of facilities with X-ray equipment	Data quality depends on good record keeping	Process	Percentage	Quarterly	Yes	All facilities compliant to Radiation Control prescript	Imaging Services: Programme Manager

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Improve laundry services by developing a provincial laundry model	Development of a model that provides a guide on implementation of laundry service for all hospitals	Improve laundry service	Documented laundry service model	Numerator Laundry service models developed documented	None	Input	Number	Annual	Yes	Documented laundry service model	Laundry Services Management
Number of hospitals providing laundry services	Count of all hospitals where washing of clothing and linen from hospital wards are cleaned and dispatch to relevant wards for use	Quality control of laundry in hospitals	Physical verification	Numerator Number of hospitals providing laundry services	None	Input	number	Quarterly	Yes	Maintaining status of hospitals providing Laundry services	Laundry Services Management
Number of Orthotic and Prosthetic devices issued	Count of Medical orthotic and prosthetic devices given to people with disabilities	Improved access to services	Orthotic and Prosthetic Register	Numerator Number of Orthotic and Prosthetic devices issued	Data quality depends on good record keeping	input	Number	Quarterly	No	Increased number in O&P devices issued	Rehabilitation and Disability Services
Number of hospitals with functional transfusion committees	Count of hospitals with a committee that meet on quarterly basis to monitor the use of blood services	To reduce costs and promote rational use	Minutes of quarterly meetings	Numerator: Number of hospitals with functional hospital transfusion committee	None	input	Number	Quarterly	Yes	Increase in the number of hospital with functional transfusion committees	Clinical Support Service Management
Number of sites rendering Forensic Pathology Services (FPS)	Count of sites in public hospitals rendering forensic pathology which includes amongst others autopsies,	To establish cause of unnatural deaths	Physical verification	Numerator: Number of sites rendering forensic pathology	None	Input	Number	Quarterly	Yes	To maintain status quo of sites rendering forensic pathology	Forensic Health Service Management

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	preservation of bodies and generation of legal report on causes of death as evidence to court of law										

PROGRAMME 8: INFRASTRUCTURE NORMS AND STANDARDS

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Improve access to healthcare by increasing number of PHC facilities maintained	Number of PHC facilities where Day to day maintenance of existing PHC facilities was conducted Ideal Clinics	Track overall maintenance of existing PHC facilities and equipment	Maintenance Completion Certificate	Number of PHC facilities maintained	Accuracy dependent on reliability of information captured on completion certificates		Number	Annual	No	Increase lifespan of infrastructure and equipment	Chief Director: Infrastructure and Technical Management
Number of PHC facilities constructed (new/replacement)	Number of new PHC facilities constructed to either set a new facility of replace an old facility	To improve health care services	Completion Certificate	Number of PHC Facilities constructed	Accuracy dependent on reliability of information captured on completion certificates	Input	Number	Annual	No	Improve access to health care services	Chief Director: Infrastructure and Technical Management
Number of Hospitals under maintenance	Number of hospitals identified with infrastructural defects and under maintenance	Track overall maintenance of existing Hospitals and equipment	Maintenance Completion Certificate	Number of Hospitals maintained	Accuracy dependent on reliability of information captured on completion certificates	Process	Number	Annual	No	Increase lifespan of infrastructure and equipment	Chief Director: Infrastructure and Technical Management
Enhance patient care & safety and improving medical care by constructing Modern hi-tech hospitals	Number of health modern Hi-tech Hospital constructed which is oriented to modern medical technology in operations for patient care and safety	To enhance patient care and improve health outcomes	Physical verification, planning design documentation	Number of health modern Hi-tech Hospital	Depends on availability of funds	Input	No	Annual	Yes	Increase Number of health modern Hi-tech Hospital	Chief Director: Infrastructure and Technical Management
Improve maintenance of health facilities by appointing cooperatives	Number of community cooperatives appointed to	Improve conditions of facilities and increases	Signed contract/ appointment letters	Number of cooperatives appointed	None	input	Number	Annual	No	Increase lifespan of infrastructure	Chief Director: Infrastructure and Technical Management

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	perform maintance work in health facilities	access to helath facilities									
Number of health facilities that have undergone major and minor refurbishment in NHI Pilot District	Number of existing health facilities in NHI Pilot District where Capital, Scheduled Maintenance, or Professional Day-to-day Maintenance projects (Management Contract projects only) have been completed (excluding new and replacement facilities).	Tracks overall improvement and maintenance of existing facilities.	Practical Completion Certificate or equivalent, Capital infrastructure project list, Scheduled Maintenance project list, and Professional Day-to-day Maintenance project list (only Management Contract projects).	Number of health facilities in NHI Pilot District that have undergone major and minor refurbishment	Accuracy dependent on reliability of information captured on project lists.	Input	Number	Annual	No	A higher number will indicate that more facilities were refurbished.	Chief Director: Infrastructure and Technical Management
Number of health facilities that have undergone major and minor refurbishment outside NHI Pilot District	Number of existing health facilities outside NHI Pilot District where Capital, Scheduled Maintenance, or Professional Day-to-day Maintenance projects (Management Contract projects only) have been completed (excluding new and replacement facilities).	Tracks overall improvement and maintenance of existing facilities.	Practical Completion Certificate or equivalent, Capital infrastructure project list, Scheduled Maintenance project list, and Professional Day-to-day Maintenance project list (only Management Contract projects).	Number of health facilities outside NHI Pilot District that have undergone major and minor refurbishment	Accuracy dependent on reliability of information captured on project lists.	Input	Number	Annual	No	A higher number will indicate that more facilities were refurbished.	Chief Director: Infrastructure and Technical Management