health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

# Annual Performance Plan 2018/19

**Tabling Date: 10 April 2018**

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# 1. INTRODUCTION

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 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 and Infrastructure during 2016/17. The CEO has been appointed at Witbank Hospital with effect from 1st June 2017. 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 specialists such as Orthopaedic Surgeons have been drawn into the province to assist with back logs. The Department has recently appointed Chief Director Hospital Services to strengthen hospital services. The Department will be making appointment of the DDG Clinical Services and Chief Director Health Facility Management together with other 551 priority posts.

The province like the rest of the country faces a quadruple burden of diseases. HIV and AIDS, Tuberculosis, high Maternal and Child Mortality and 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 and movable assets during 2016/17 financial year. These qualification issues are fewer compared to previous years. The Department will continue with assets verification project in order resolve the asset related findings during forthcoming audits. 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 G.P. MASHEGO
MEC: HEALTH

27/03/2018
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.

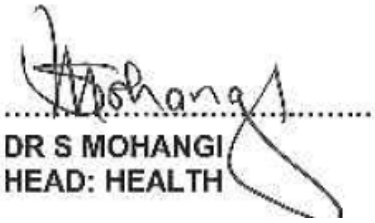
The Department has taken note of these needs hence the infrastructure programme works around the clock to ensure that all health facilities are functional. This is a programme that builds, upgrades, renovates, rehabilitates and maintains health facilities. Despite the financial challenges the country is experiencing, more work has been carried out including upgrading of hospitals and primary health care facilities. This is 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 primary health facilities reach the Ideal Status by 2019. This will contribute immensely to the Sub-Outcomes 1, 2 and 3 which are:

- *Sub-Outcome 1* – Universal Health coverage progressively achieved through implementation of National Health Insurance (NDoH)
- *Sub-Outcome 2* – Improved quality of health care
- *Sub-Outcome 3* – Implement the re-engineering of Primary Health Care

For these three Sub-Outcomes and Ideal Clinic Initiative to succeed, the Department has to ensure that there is a link between all the ten (10) Sub-Outcomes.

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 put in place to manage movable and immovable assets. All these to ensure that better health services are offered to the people of the province of the Rising Sun.



**DR S MOHANGI**
**HEAD: HEALTH**

27/03/18
**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**.**

pp .....
Mr C.B. Mnisi
Chief Financial Officer

26/03/2018
Date

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

26/03/2018
Date

.....
Dr S Mohangi
Accounting Officer

27/03/18
Date

**APPROVED BY:**

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

27/03/2018
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.<br>• 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<br>• 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, |

| NDP Goals 2030 | SDG Goals 2030 |
|---|---|
| | 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 |
| 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<br>• Improve health care outcomes<br>• Improve quality of health care | • Universal Health coverage progressively achieved through implementation of National Health Insurance<br>• HIV & AIDS and Tuberculosis prevented and successfully managed<br>• Maternal, infant and child mortality reduced<br>• Implement the re-engineering of Primary Health Care<br>• 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<br>• Strengthening Health Systems Effectiveness<br>• Improved health facility planning and accelerate infrastructure delivery | • Improved health facility planning and infrastructure delivery<br>• Efficient Health Management Information System developed and implemented for improved decision making<br>• Improved health management and leadership<br>• Improved human resources for health<br>• 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 in 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 in 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 has just over 4.4 million people who constitutes 7.9% of the South African population. The province has a total surface area of 76 495 square kilometres, a second smallest province after Gauteng taking up 6.3% of South Africa's total land area. It is one of the rural provinces in the country, with more than half of the people residing in deep rural/farm pockets. The province comprises of three districts municipalities, namely Ehlanzeni, Nkangala and Gert Sibande District.

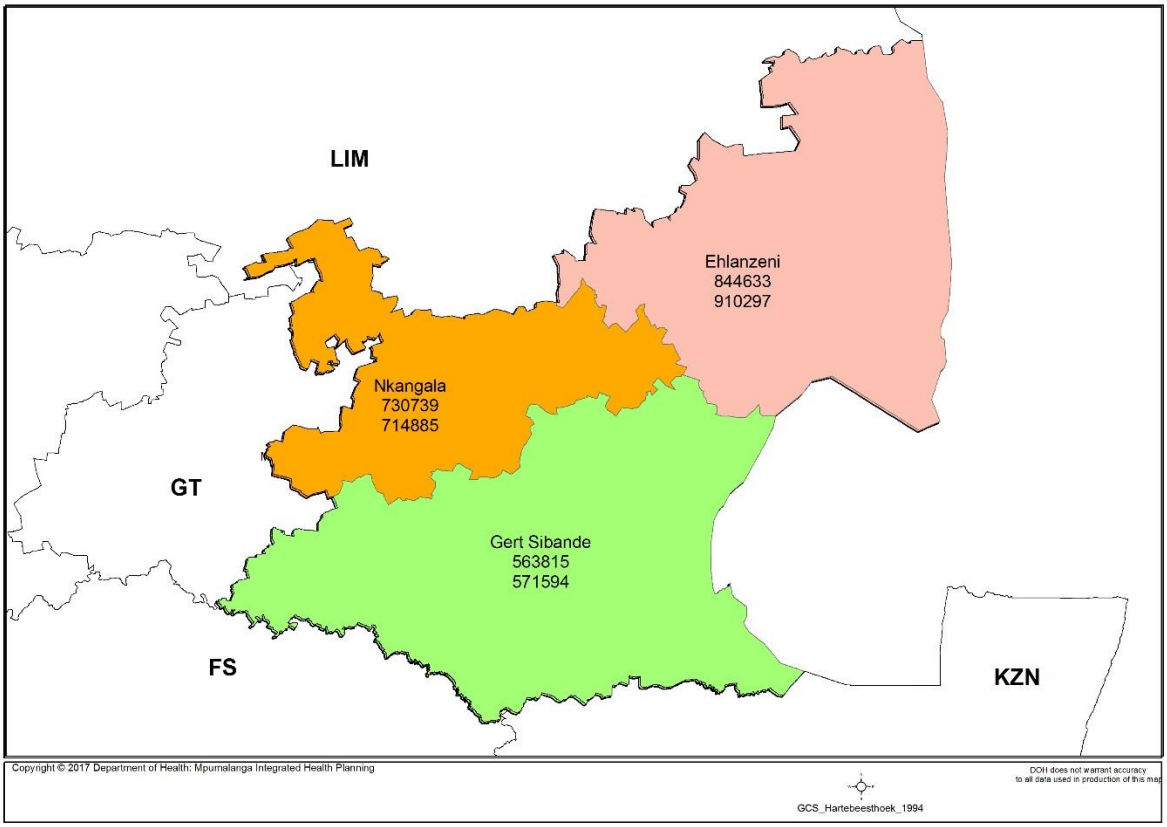



**Figure 1: Mpumalanga Provincial Map**

The province share common borders with Limpopo Province to the north, KwaZulu-Natal to the south-east, Free State Province to the south-west and Gauteng Province to the west. With regard to international borders, the province is bordering Mozambique to the east and Swaziland to the south-east. The capital city of Mpumalanga Province in Mbombela, formerly known as Nelspruit. It is one of the fastest growing cities in South Africa, and recently amalgamated with the former Umjindi Sub-district. Other major towns include eMalahleni (Witbank), Ermelo, Standerton, Piet Retief, Secunda, 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 town:

**Table 4.5. 1: Main economic activities in Mpumalanga Province**

| 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 mid-year population estimates of 2017 by Statistics South Africa indicates that Mpumalanga population grew from 4,335,964 in 2016 to 4,444,212 (StatsSA, 2017). This reflect a growth of 2.5% (by 108248 people), which could also be attributed to the inter-provincial as well as international migration patterns across these borders.

**Table 4.5. 2: Population per province**

| Provinces | Census 1996 | Census 2001 | CS 2007 | Census 2011 | CS 2016 | Mid-year estimation 2017 | % of total population |
|---|---|---|---|---|---|---|---|
| Eastern Cape | 6,147,244 | 6,278,651 | 6,527,747 | 6,562,053 | 6,996,976 | 6 498 683 | 11.5 |
| Free State | 2,633,504 | 2,706,775 | 2,773,059 | 2,745,590 | 2,834,714 | 2 866 678 | 5.1 |
| Gauteng | 7,624,893 | 9,178,873 | 10,451,713 | 12,272,263 | 13,399,725 | 14 278 669 | 25.3 |
| KwaZulu-Natal | 8,572,302 | 9,584,129 | 10,259,230 | 10,267,300 | 11,065,240 | 11 074 784 | 19.6 |
| Limpopo | 4,576,133 | 4,995,534 | 5,238,286 | 5,404,868 | 5,799,090 | 5 778 442 | 10.2 |
| **Mpumalanga** | **3,124,203** | **3,365,885** | **3,643,435** | **4,039,939** | **4,335,964** | **4 444 212** | **7.9** |
| Northern Cape | 1,011,864 | 1,058,060 | 1,058,060 | 1,145,861 | 1,193,780 | 1 213 996 | 2.1 |
| North West | 2,936,554 | 3,271,948 | 3,271,948 | 3,509,953 | 3,748,436 | 3 856 174 | 6.8 |
| Western Cape | 3,956,875 | 4,524,335 | 5278585 | 5,822,734 | 6,279,730 | 6 510 312 | 11.5 |
| South Africa | 40,583,573 | 44,819,778 | 48,502,063 | 51,770,560 | 55,653,655 | 56 521 948 | 100.0 |

(Source: Census 1996: Census 2001, Community Survey 2007, Census 2011, CS 2016, Mid-year estimate (StatsSA, 2017)

Forty-nine percent of South Africans are males with females having the slightest majority of 51%. Mpumalanga Province has the same trends with females dominating at 51%. According to StatsSA (2017), youth of the age group 15-34 years account for 36.8% of the population in the province.

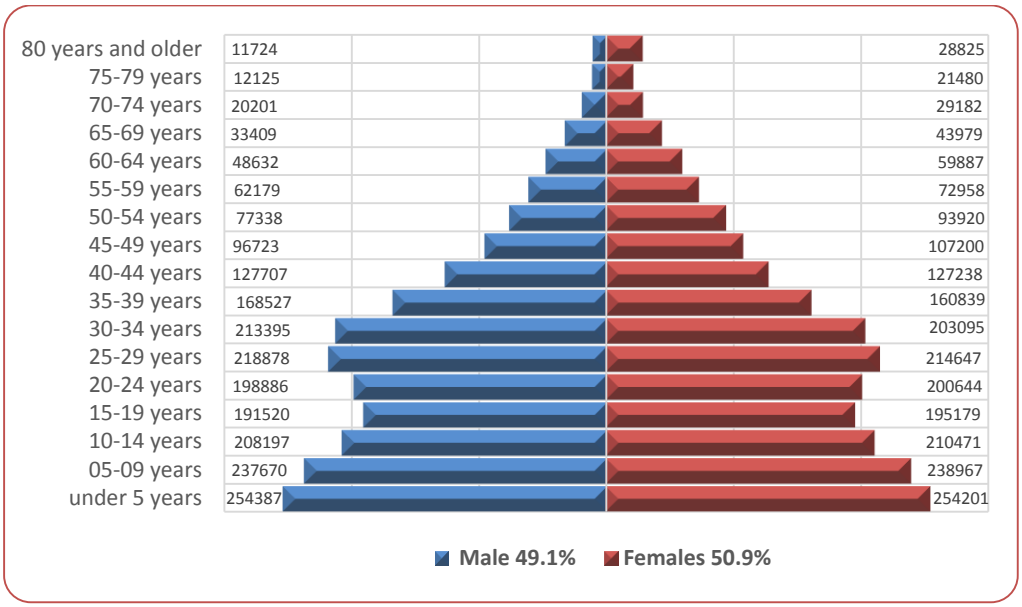



**Figure 2: Mpumalanga Population Pyramid**

The figure above shows the provincial pyramid as per the mid-year estimate of 2017 by StatsSA, indicating a tremendous growth of 10% when 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 (0-5 years) and the middle age of 25-44 years old, where proportion of males is higher. 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.

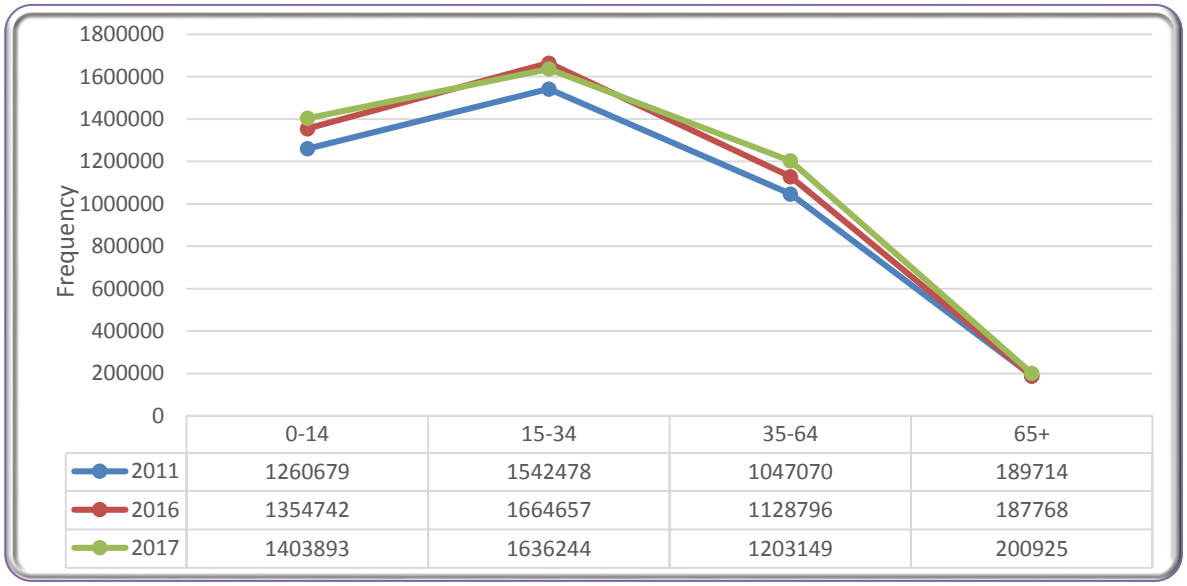



**Figure 3: Mpumalanga Population Size**

All age groups as indicated in the figure above showed an increase in population size, with the exception of youth of the age group 15-34 which recorded a 1.7% decrease in 2017 when compared to 2016 provincial population.

### 4.5.1.1 Mpumalanga Health Districts

Mpumalanga Province consists of three districts, namely Ehlanzeni, Gert Sibande and Nkangala Districts, which all consisting of 17 sub-districts municipalities as from 2017. The sub-districts were reduced from 18 in 2016 as a result of the merger between Umjindi and Mbombela municipalities at Ehlanzeni District to form the City of Mbombela.

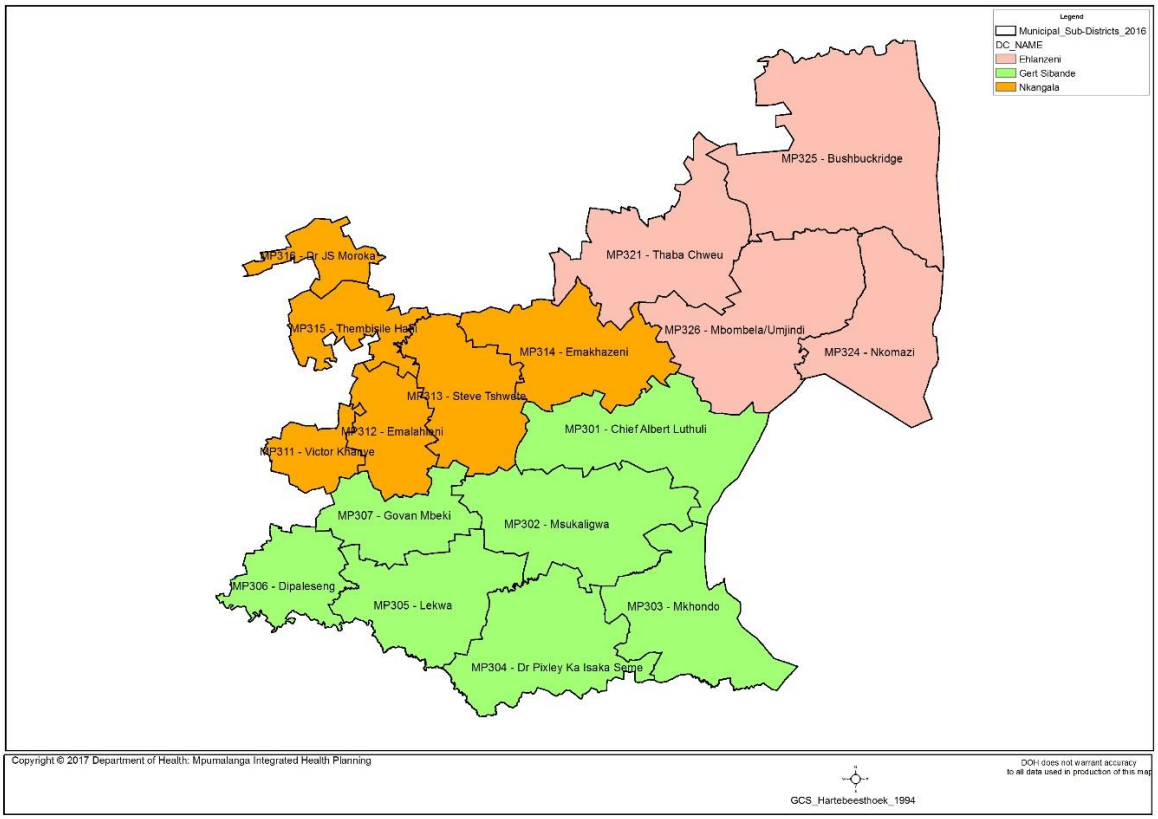



**Figure 4: District Municipalities in Mpumalanga Province**

#### i. Demographics in Ehlanzeni District

The Mid-Year estimates report for 2017 does not provide a breakdown in terms of the changes in population per districts, however, the Community Survey of 2016 indicated that the population at Ehlanzeni District represented 41% (1,754,931) of the people in the province (CS 2016). The district consist of four sub-districts which are Bushbuckridge, Mbombela, Nkomazi, and Thaba Chweu. Nkomazi is further divided into Nkomazi East and West and Mbombela into Mbombela South and North, with Umjindi merging with Mbombela Sub-district. The district comprises of more people per square meter that Gert Sibande District.

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 the figure below).

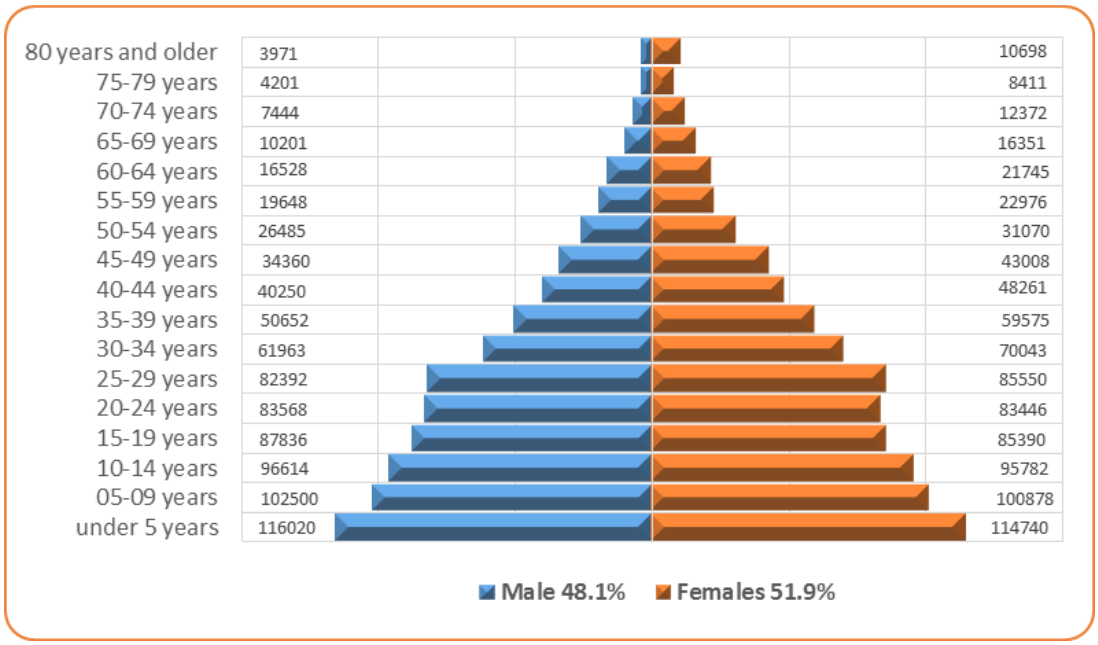



**Figure 5: Ehlanzeni District: Source CS 2016**

## ii. Demographics in Gert Sibande District

Gert Sibande District has a catchment population 1,135,409 as per the Community Survey of 2016 which is less than the other two districts. It represented 26% of the provincial population. 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.

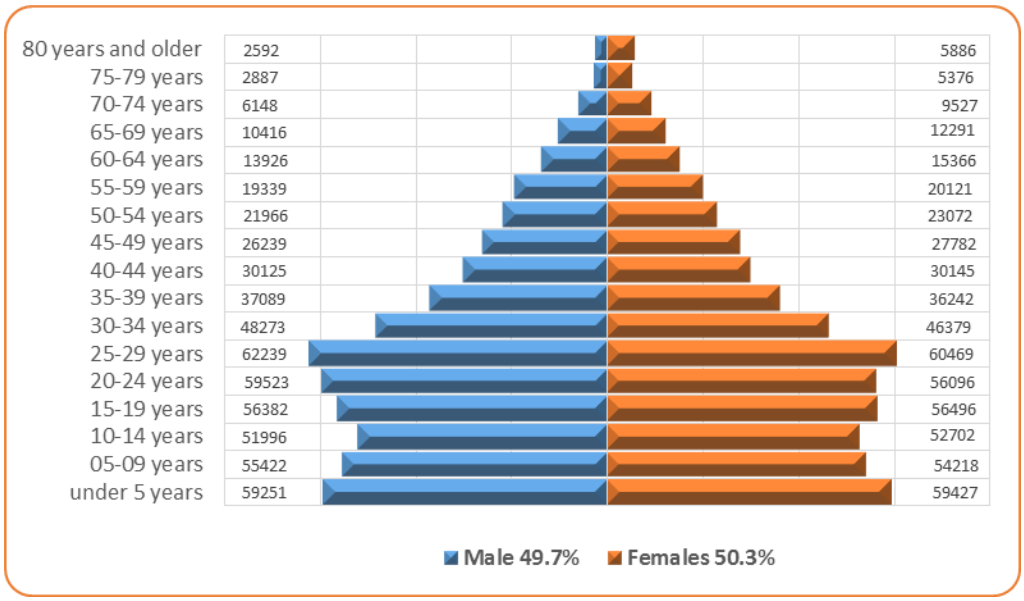



**Figure 6: Gert Sibande District: Source CS 2016**

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 above). It can also be noted that the age group 25-29 contribute the highest proportion of both males and females.

### iii. Demographics in Nkangala District

Nkangala District has a catchment population of 1,445,624 (CS 2016) representing 33% of the provincial population. It consists of six sub-districts which are Dr JS Moroka, Thembisile, Emalahleni, Emakhazeni, Dr Victor Khanye and Steve Tshwete.

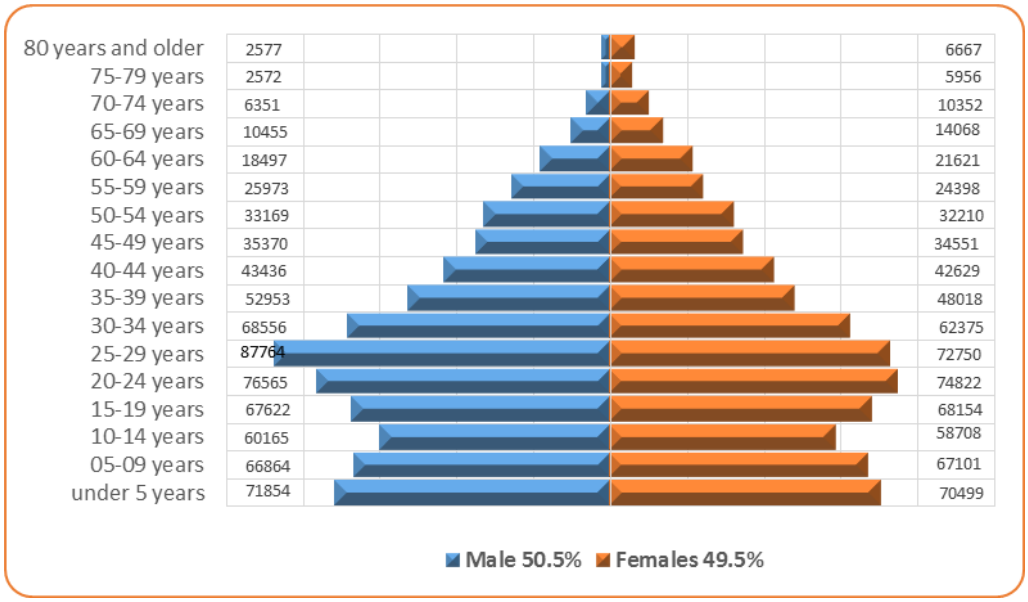



**Figure 7: Nkangala District Municipality: Source CS 2016**

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 attributed to the number of mines located in the district which attracts a substantial number of male workers. This is in contrast to the provincial proportions, which depicts females slightly above the males.

### 4.5.1.2 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 4.5.3: Population by Geographic Distribution (Districts)**

| District Municipality | Population (Census 2001) | Population (Community Survey 2007) | Population (Census 2011) | Population Community Survey 2016 | *Population Mid-Year Estimates 2017 | % Change from 2001-2016 |
|---|---|---|---|---|---|---|
| Ehlanzeni District Municipality | 1,447,053 | 1,526,236 | 1,688,615 | 1,754,931 | - | - |
| Gert Sibande District Municipality | 900,007 | 890,699 | 1,043,194 | 1,135,409 | - | - |
| Nkangala District Municipality | 1,018,826 | 1,226,500 | 1,308,129 | 1,445,624 | - | - |
| **Total** | **3,365,885** | **3 ,643,435** | **4,039,939** | **4,335,964** | **4,444,212** | **32.0** |

(Source: Stats SA 2007: Census 2001, Community Survey 2007, and Census 2011-Midyear estimates 2015, CS 2016)
* Mid-Year estimates only provide data at a provincial level

### 4.5.1.3 Population by Geographic Distribution (Sub-Districts)

The province comprises of 17 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 4.5.4: 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** |
| Albert Luthuli | 187,936 | 194,083 | 186,010 | 187,630 | -0.2 |
| Dipaliseng | 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

The Community Survey of 2016 (CS2016) depict Mpumalanga Province as the third most rural province in South Africa with 56% of its total population living in rural areas. The majority of the population resides in the former homelands of Kwa-Ndebele, Kwangwane and Lebowa, areas that have historically lagged behind in terms of development and delivery of basic services such as health and education. Relative to other provinces, Mpumalanga's population base exhibits low economic activity and the poverty rate (with an index of 50.5%) is higher than the national average. It is estimated that approximately 23% of households in the province have no regular source of income.

The table below indicates the urban and rural percentage of Mpumalanga Province versus that of South Africa. Whereas the majority of people in South Africa live in urban areas, most people in Mpumalanga Province reside in rural areas.

**Figure 4.5.6: 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 | 44.0 |
| **Total** | **55653654** | **100.0** | **4335964** | **100.0** |

*(Source: CS 2016)*

Approximately 64% of people in South Africa live in urban areas, whereas only 44% of the people of Mpumalanga Province reside in urban areas. Of the 56% people living in rural areas, 88% live in traditional rural villages, while 12% live in farm areas. The impact of health services in these communities (rural and farm communities) needs to be investigated thoroughly to determine accessibility challenges, especially as this group constitute the majority in the province. Hence it is expected that the majority of these people in rural and farm communities rely on public healthcare facilities. At present, the Provincial Department of Health comprises of 33 hospitals and 279 Primary Health Care Facilities supplemented by the use of scheduled visits by mobile clinics (Annual Performance Plan, 2015/16).

## Climate change

Climate change is a real 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. Health effects of climate change are serious and widespread, which include heat-related illness, pest- and waterborne diseases, air and water pollution and damage to crops and drinking water sources. Children, the poor, the elderly, and those with a weak or impaired immune system are especially vulnerable. For this reason, climate change needs to be considered a priority area when addressing health inequalities. This requires improving our public health infrastructure, disease surveillance, and emergency response capabilities.

## Access to basic services

Basic services such as electricity, water, sanitation, and refuse removal are critical services to improve the lives of people. Availability of these basic services 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 4.5.7: 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 4.5.8: 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 4.5.9: 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 4.5.10: 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

As one of the rural province in South Africa with 56% residing in rural areas, the majority of the people rely on the provincial health facilities scattered throughout the province. 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. In addition to the health facilities, the province provide mobile health services to areas where there are no/fewer health facilities.

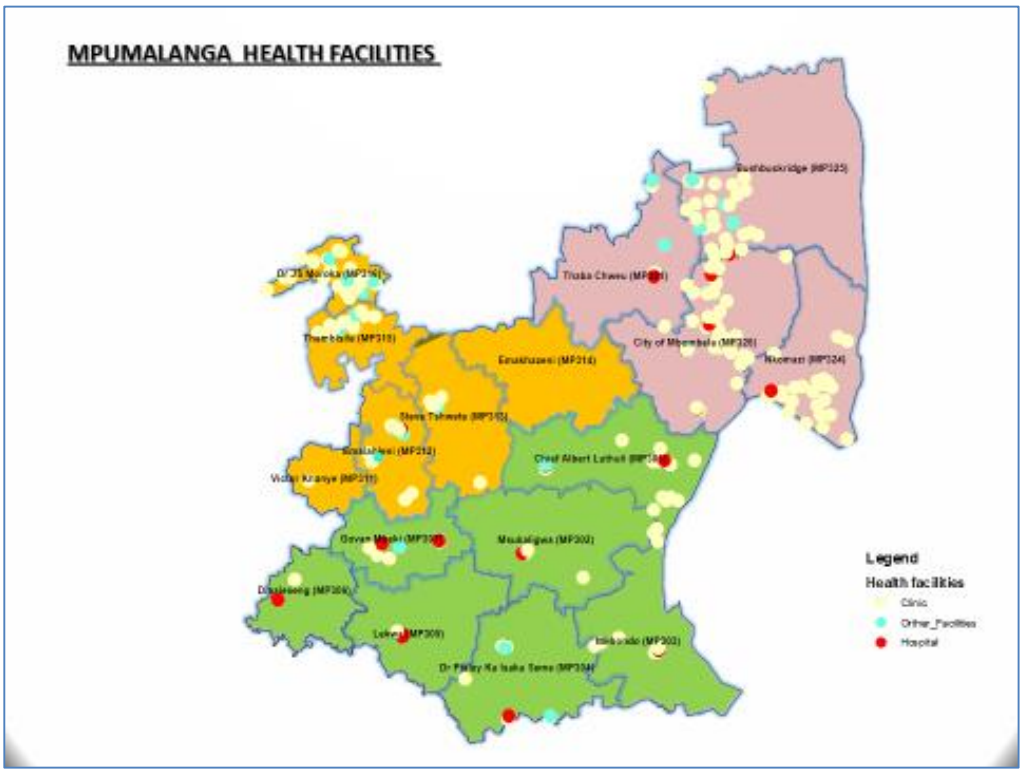
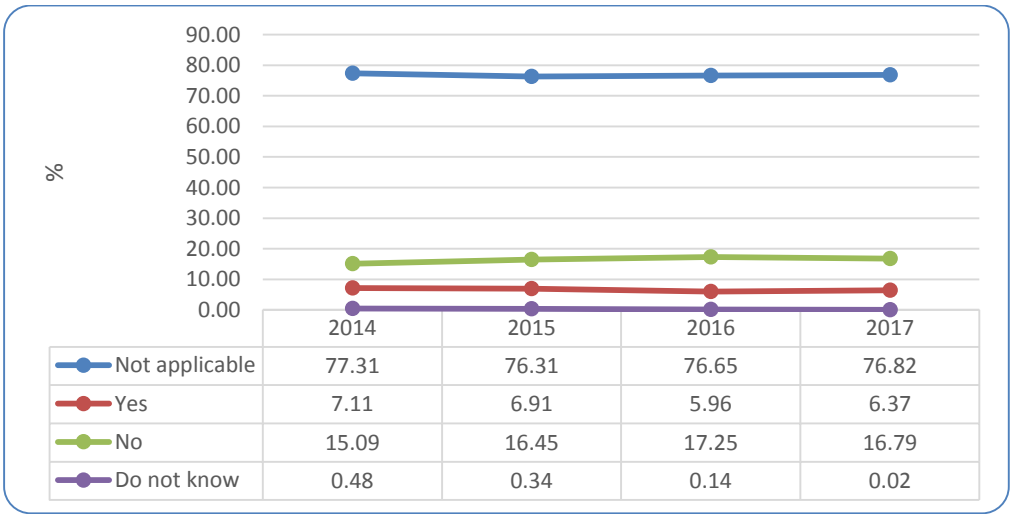



**Figure 8: Mpumalanga Provincial Health Facilities**

StatsSA (Quarterly Labour Force Survey: Quarter: 2:2017), indicates that approximately 6.3% of total population is insured, which means that the majority of the uninsured rely on the public health sector for health care, placing an excessive burden on the primary health care system in Mpumalanga. Although the figure improved from 5.96% same time in 2016, the number of insured people is low when compared to 2014, where 7.11% of people where insured during the second quarter.




| | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|
| Not applicable | 77.31 | 76.31 | 76.65 | 76.82 |
| Yes | 7.11 | 6.91 | 5.96 | 6.37 |
| No | 15.09 | 16.45 | 17.25 | 16.79 |
| Do not know | 0.48 | 0.34 | 0.14 | 0.02 |

**Figure 9: Quarterly Labour Force Survey 2014 (Quarter 2)**

According the Quarterly Labour Force Survey (Quarter 1: 2017), the official Unemployment rate for Mpumalanga Province stands at 31.5%, which represent a 1.7% increase from the same period last year. However, the expanded unemployment rate is at 41.2% which did not increase when compared with the same period last year. It is widely known that 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.

**Table 4.5.11: 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 | Official Unemployment rate (Jan-Mar 2017)* | Year-on-Year change | Expanded Unemployment Rate (Jan-Mar 2017)** | Year-on-Year change |
|---|---|---|---|---|---|---|---|---|
| South Africa | 26.7 | 0.3 | 36.3 | 0.2 | 27.7 | 1.0 | 36.4 | 0.1 |
| Western Cape | 20.9 | -0.1 | 23.0 | -0.3 | 21.5 | 0.6 | 24.7 | 1.7 |
| Eastern Cape | 28.6 | -1.0 | 44.5 | 1.3 | 32.2 | 3.6 | 43.6 | -1.0 |
| Northern Cape | 27.8 | -6.3 | 38.7 | -3.9 | 30.7 | 2.9 | 43.9 | 5.2 |
| Free State | 33.9 | 3.5 | 39.4 | 1.0 | 35.5 | 1.6 | 41.7 | 2.3 |
| KwaZulu-Natal | 23.2 | -0.4 | 39.3 | 1.1 | 25.8 | 2.7 | 41.0 | 2.2 |
| North West | 28.1 | -0.3 | 43.0 | -0.2 | 26.5 | -1.6 | 41.7 | -1.4 |
| Gauteng | 30.1 | 1.7 | 33.3 | 0.5 | 29.2 | -1.0 | 32.0 | -1.3 |
| **Mpumalanga** | **29.8** | **1.4** | **41.2** | **0.5** | **31.5** | **1.7** | **41.2** | **0.0** |
| Limpopo | 18.2 | -1.9 | 38.4 | -2.4 | 21.6 | 3.3 | 38.2 | -0.3 |

Source: StatsSA (Quarterly Labour Force Survey: Quarter: 1:2017)
* 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.

## 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 due to an increase in the number of HIV related deaths, Statistics South Africa indicates that life expectancy started to increase since 2005 for males and 2007 for females. For males, the life expectancy in South Africa was 52.9 in 2002 which increased to 61.2 in 2017. Whereas for females it increased from 56.6 in 2002 to 66.7 in 2017. The average life expectancy for South Africa in 2017 is 64.0 (Mid-Year Estimates, 2017). It is noted also that life expectancy has always remained high in females than males in all years by 5.5 years in the last 5 years.

According to Statistics South Africa, the projected life expectancy for males in the province increased from 56.9 in the period 2011-2016, to 59.5 for the period 2016 to 2021. These projections show an improvement by 2.6 years for males. The projections for females show an improvement by 1.9 years, from 63.2 in the period 2011-2016 to 65.1 for the period 2016-2021. The average life expectancy for Mpumalanga Province increased from 60.1 in 2011-2016 period to 62.3 years for the period 2016-2021 (Mid-Year Estimates, 2017).

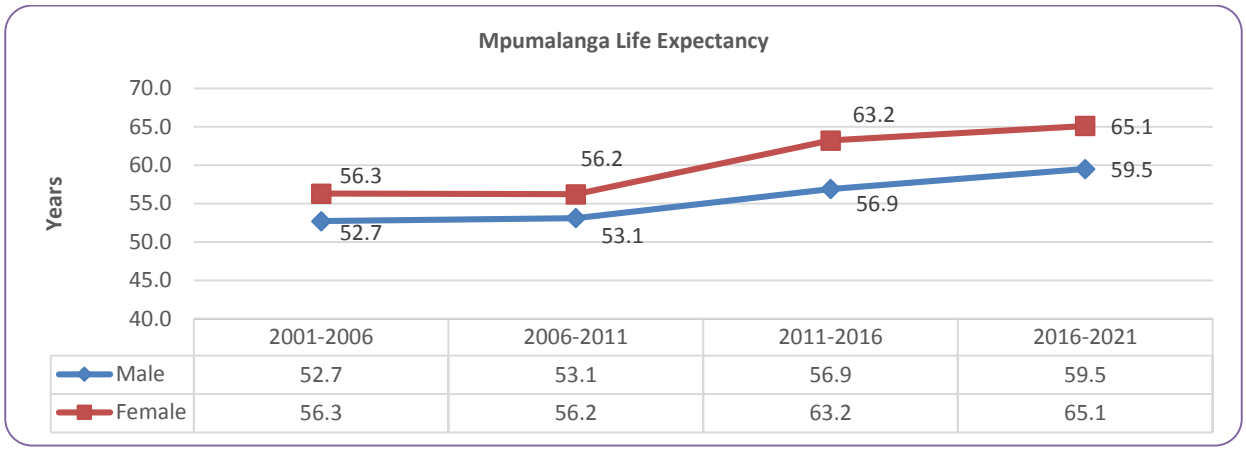
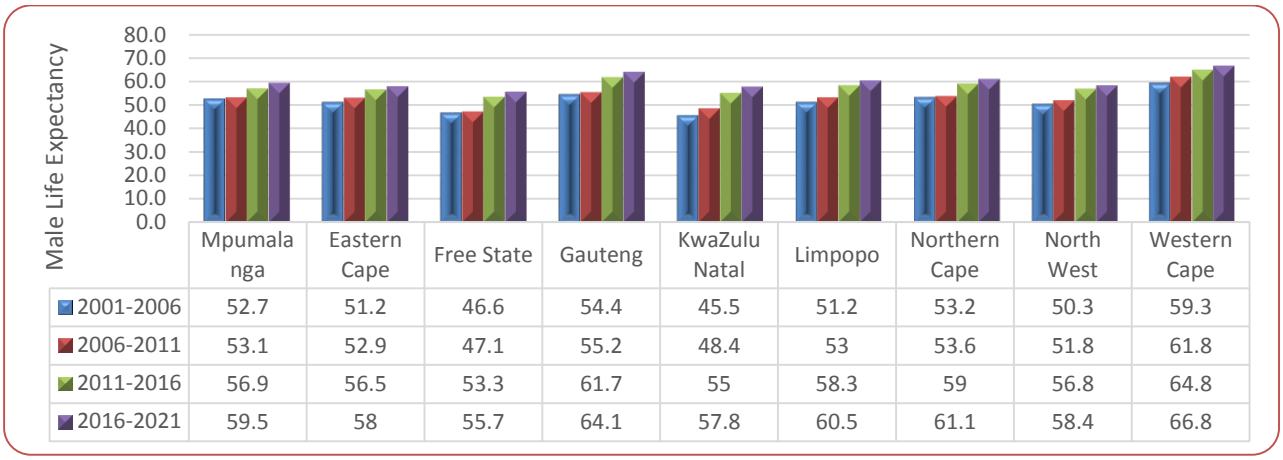



**Figure 10: Illustrates life expectancy pattern since 2001 – 2021 ( Source: Mid-year population estimates 2017, StatsSA)**

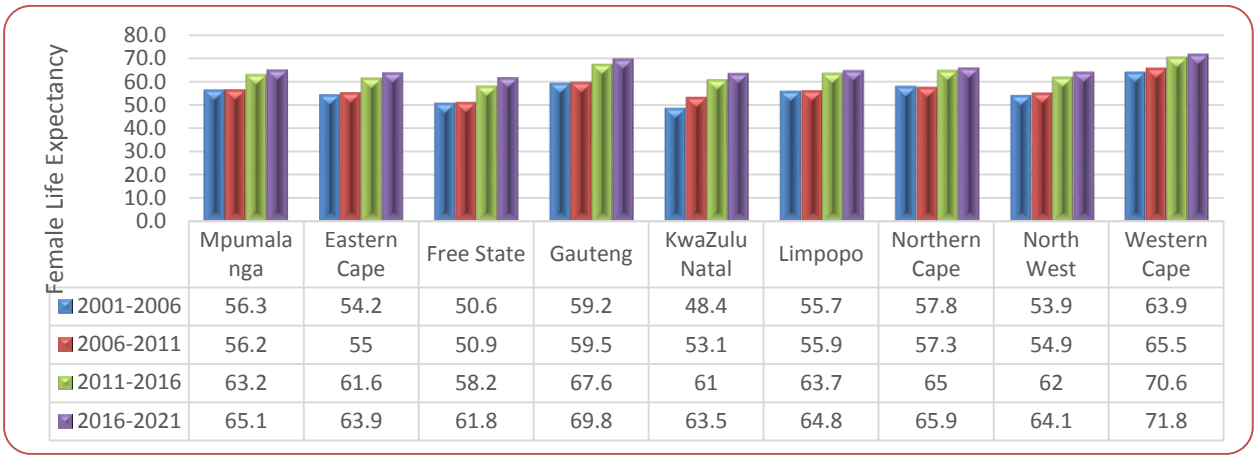
With regard to life expectancy for males in South Africa, Mpumalanga has the fifth highest life expectancy figure after Western Cape, Gauteng, Northern Cape and Limpopo, respectively. Free State province being the lowest on a life expectancy of 55.7 years, followed by KwaZulu Natal with 57.8 years. However, from the life expectancy period of 2011-2016 to 2016-2011, KwaZulu Natal has the highest improvement figure of 2.8 years, followed by Mpumalanga with an improvement figure of 2.6 years. The two provinces have also the highest HIV prevalence in the country.




| | Mpumalanga | Eastern Cape | Free State | Gauteng | KwaZulu Natal | Limpopo | Northern Cape | North West | Western Cape |
|---|---|---|---|---|---|---|---|---|---|
| 2001-2006 | 52.7 | 51.2 | 46.6 | 54.4 | 45.5 | 51.2 | 53.2 | 50.3 | 59.3 |
| 2006-2011 | 53.1 | 52.9 | 47.1 | 55.2 | 48.4 | 53 | 53.6 | 51.8 | 61.8 |
| 2011-2016 | 56.9 | 56.5 | 53.3 | 61.7 | 55 | 58.3 | 59 | 56.8 | 64.8 |
| 2016-2021 | 59.5 | 58 | 55.7 | 64.1 | 57.8 | 60.5 | 61.1 | 58.4 | 66.8 |

**Figure 11: Males Life Expectancy**

The life expectancy for females figures place Mpumalanga as the fourth highest province where females live longer at an average of 65.1 years. Western Cape is the highest with an average of 71.8 years (2016-2021), followed by Gauteng (69.8 years) and Northern Cape (65.9 years) for the same period (Mid-Year Estimates, 2017). This shows that there has been an improvement as results of mainly ART rollout, Prevention of Mother-to-Child Transmission (PMTCT) programmes and other initiatives implemented by the department.




| | Mpumalanga | Eastern Cape | Free State | Gauteng | KwaZulu Natal | Limpopo | Northern Cape | North West | Western Cape |
|---|---|---|---|---|---|---|---|---|---|
| 2001-2006 | 56.3 | 54.2 | 50.6 | 59.2 | 48.4 | 55.7 | 57.8 | 53.9 | 63.9 |
| 2006-2011 | 56.2 | 55 | 50.9 | 59.5 | 53.1 | 55.9 | 57.3 | 54.9 | 65.5 |
| 2011-2016 | 63.2 | 61.6 | 58.2 | 67.6 | 61 | 63.7 | 65 | 62 | 70.6 |
| 2016-2021 | 65.1 | 63.9 | 61.8 | 69.8 | 63.5 | 64.8 | 65.9 | 64.1 | 71.8 |

**Figure 12: Female Life Expectancy**

## 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).

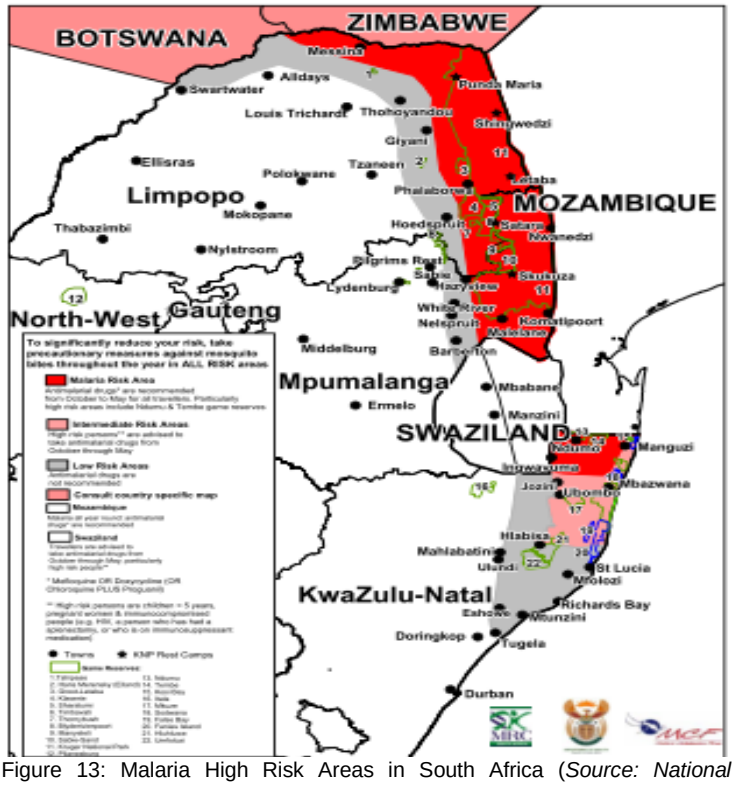



Figure 13: Malaria High Risk Areas in South Africa (*Source: National Department of Health)*

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.

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.

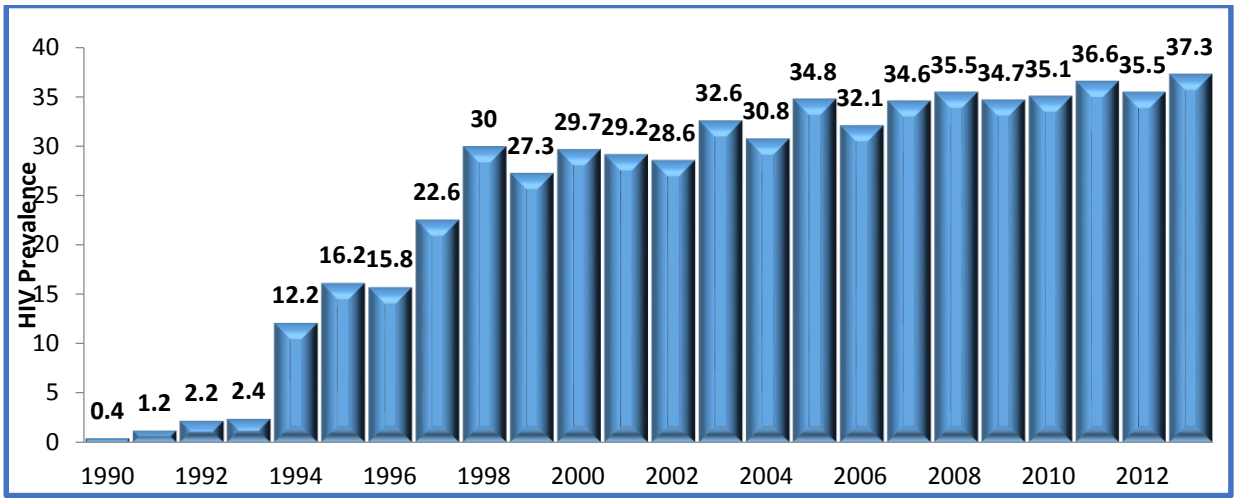



**Figure 14: Mpumalanga HIV Epidemic Graph 1990 – 2013 (***Source:* ***Mpumalanga Antenatal Sentinel HIV and Syphilis Prevalence Survey in Mpumalanga, 2013)***

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.

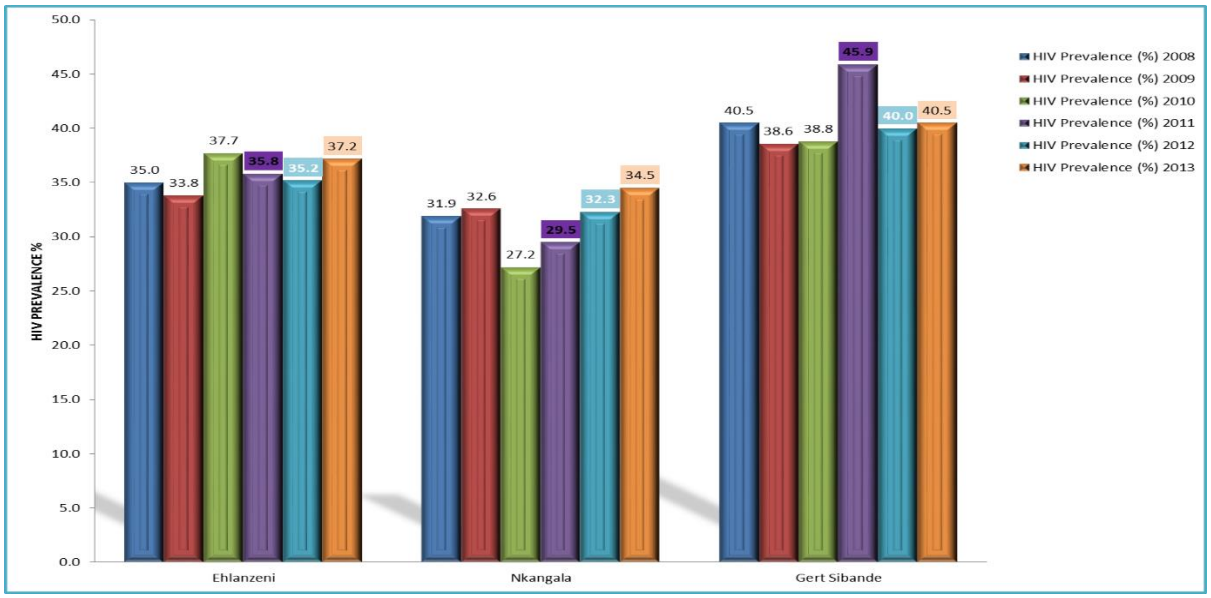



**Figure 15: Mpumalanga HIV Epidemic Graph by District: 2008 – 2013 (***Source:* ***Mpumalanga Antenatal Sentinel HIV and Syphilis Prevalence Survey in Mpumalanga, 2013)***

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.

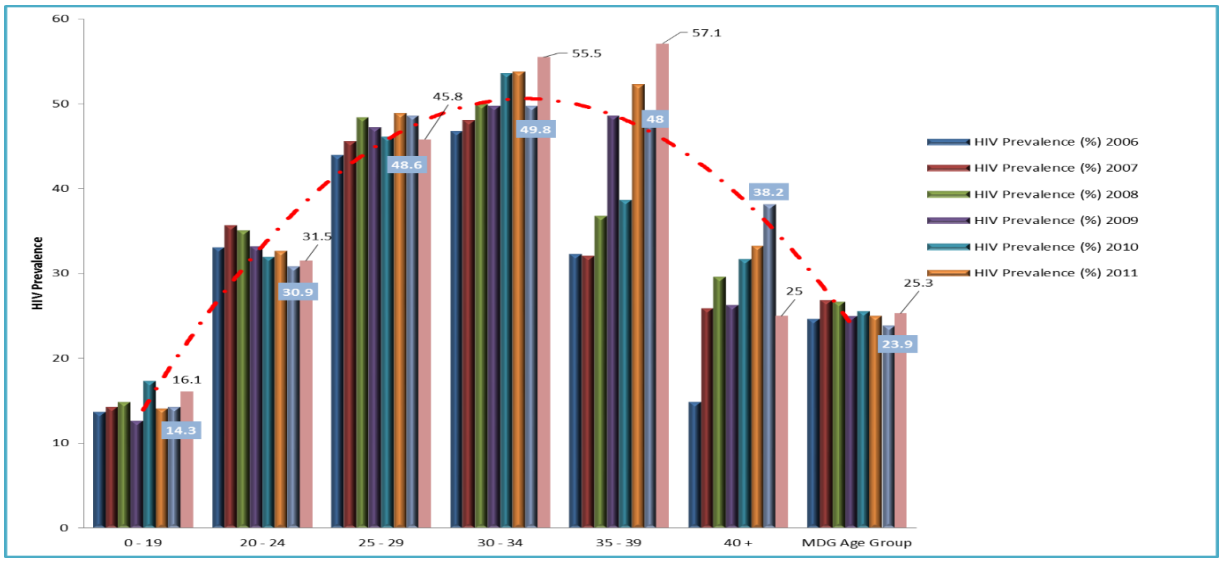



**Figure 16: Mpumalanga HIV Epidemic Graph by Age group: 2006 – 2013 (*Source: National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2010 – 13)***

## 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 in incidence rate was recorded in the number of TB case findings from 23,312 in 2010, to 17 345 in 2015. Death rate associated with Tuberculosis was reduces by a percentage from 7.0% in 2010 to 4.6% in 2015.

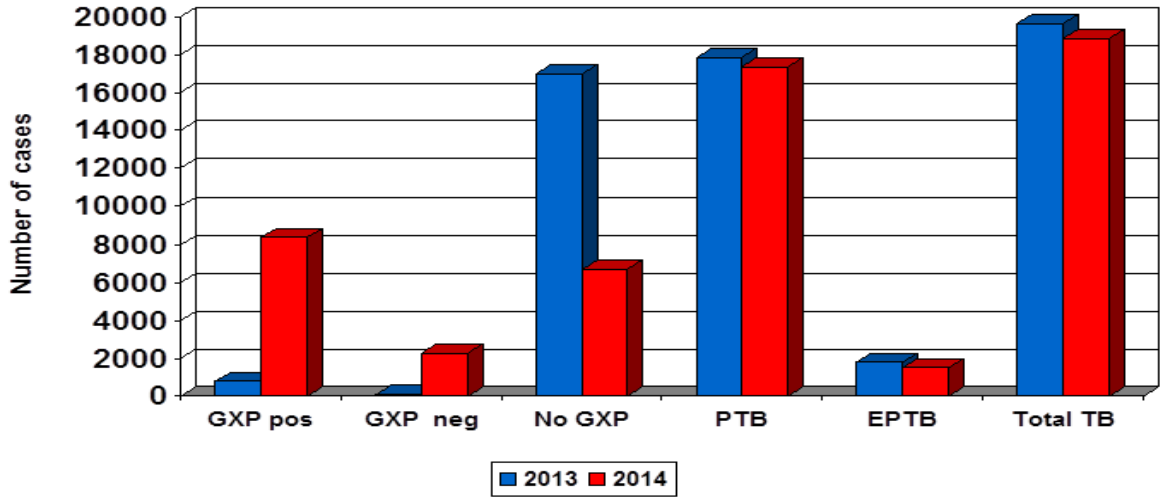



**Figure 17: Mpumalanga TB Case Findings: 2013 to 2014 ***

*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.

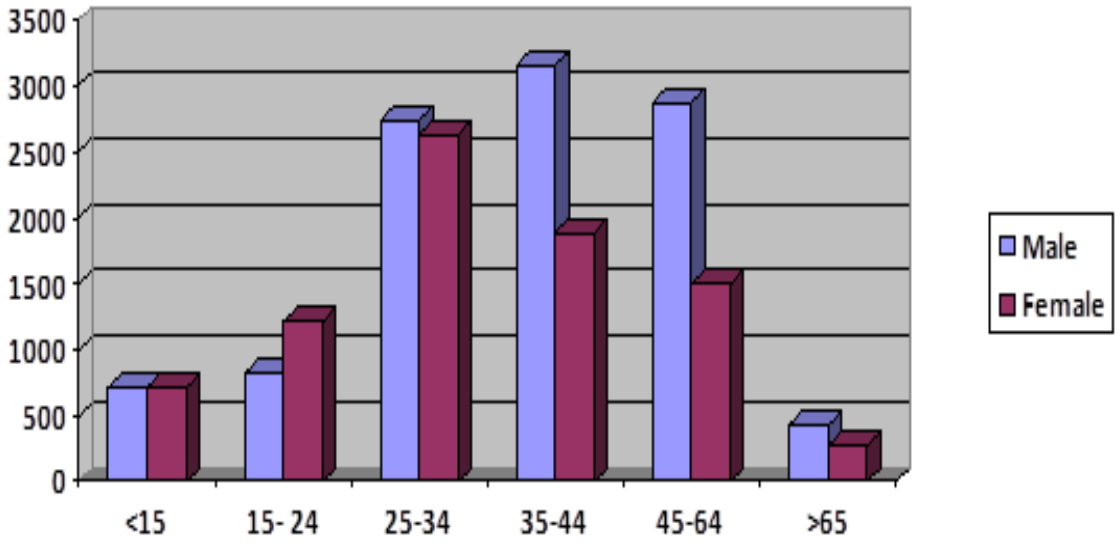



**Figure 18: TB Cases by Age Group and Gender, 2014 (Source: Mpumalanga TB Database (ETR Net))**

## 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 4.5.12: 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 4.5.13: 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 D

## DEPARTMENTAL RATING ON MANAGEMENT PERFORMANCE ASSESSMENT TOOL (MPAT)

The Department was assessed on the following four key performance areas (KPAs):

- KPA 1: Strategic Management
- KPA 2 governance and Accountability
- KPA 3: Human Resource Management
- KPA 4: Financial Management

### KPA 1: Strategic Management

The Departmental performance is improving performance on KPA 1: Strategic Management, the strategic planning processes are fully compliant with regulatory requirements at **level 4** and achieved **level 3** on the Integration of performance monitoring and strategic management. The Department is not compliant with regulatory requirements **(Level 1)** on the standard for Planning of Implementation Programmes which requires developing guidelines that are compliance to the following models:

- Theory of Change
- Logistical framework
- Roles and responsibilities
- Risk Management Plan
- Cost Estimates
- Plan for the life cycle Evaluation for the programme

### KPA 2: Governance and Accountability

The Department aims at improving governance and accountability by developing standards that will encourage batho pele, professional ethics, financial disclosures and strengthening corporate governance of Information Communication Technology (ICT). In most of the Standards, the Department is not compliant (Level 1) such as Service Delivery Improvement (SDIP) Mechanisms,

Assessment of policies and systems to ensure Professional ethics, Anti- corruption and ethics management and corporate governance of ICT. The Department has developed an improvement plan to address these challenges. The standards on Assessment of risk management arrangements is achieved at **level 3** while Assessment of financial disclosures is achieved at **level 2.5** which means that the Department is compliant with basic/legal/regulatory requirements but non-compliant with one or more level 3 requirements.

**KPA 3: Human Resource Management**

The Department has improved scores on the **Organisational Design and Implementation** which achieved a **level 3** and the Application of recruitment and retention practices at **level 2.5**, while all other human resources management standards are achieved at **level 2.** The Department is adamant that the results of the MPAT 1.7 will improve this KPA.

**KPA 4: Financial Management**

Financial Management remains a key pillar in ensuring that resources are utilised in an efficient and effective manner to achieve service delivery. The Department has achieved **level 4** on the Financial Delegations in terms of PFMA, while all other standards on Supply Chain Management and Expenditure Management are scored **level 2**. The Department is implementing an improvement plan to ensure that mechanisms are developed to improve the scores during the next MPAT cycle.

The Department has an audit opinion which will measure performance of the Department across all these four KPAs to ensure that there is an improvement.

# 4.6 ORGANISATIONAL ENVIRONMENT

### 4.6.1 Organisational Structure and Human Resources

The Department is currently reviewing the approved organizational and establishment structure aimed at ensuring that the structure is aligned to policy changes and well and new programmes introduced.

The branch Financial Management was revised through the process of organizational design and development and was consulted with the Office of the Minister of Public Service and Administration.

The post provisioning of the newly established Primary Health Care facilities is aligned to the Workload Indicators of Staffing Need (WISN) normative guide which ensures that there is equitable distribution of human resource throughout the Department of such health facilities.

This re-alignment process is aimed at better positioning and strengthening the capacity of the Department to implement on its mandate as well as the National Development Plan 2030.

The implementation of these alignments will evolve throughout the MTEF period.

The department's strategic objectives are implemented by the following programmes
1) Programme 1: Administration
2) Programme 2: District Health Services
3) Programme 3: Emergency Medical Services
4) Programme 4: Provincial Hospital Services
5) Programme 5: Tertiary Hospital Services
6) Programme 6: Health Sciences and Training
7) Programme 7: Health Care Support Services
8) Programme 8: Health Facilities Management

Due to the fiscal constraints, the department's budget has been reduced over the 2016/18 MTEF period. As a result, the Department has introduced a number of cost containment measures to ensure that it remains within the allocated funds.

The Departmental Performance against the Provincial Human Resource Plan is outlined as follows:

- Current staff compliment (See Table A2 below)
- Accuracy of staff establishment at all level against service requirements

  The Department has identified the inaccuracy in the staff establishment since the organisational structure is under review and there has been posts that were filled as a result of service delivery needs. The proposed organisational structure has taken consideration of new policy initiatives.

- 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 Department has prioritised 551 critical posts to be filled during the 2017/18 financial as a result of budgetary constraints. These include the posts that have been prioritised in the Annual Performance Plan. The Department will not be able to retain health professionals that are non-bursary holders on completion of the one year compulsory community service. The

Department envisages to replace those employees that will be vacating posts with effect from 01 June 2017 since those posts are funded.

The following initiatives were introduced during 2015/16 financial year:-

- 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

The Department will engage in the process of analysis of leave taken in order to be able to come up with the absenteeism rate.

**TABLE A2: HEALTH PERSONNEL IN 2017/18**

| OCCUPATIONAL CLASS | 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 | 349 | 87.25 | 7.9 | 8.9 | 12.75 | 2.63% | 547,902.20 |
| ALL ARTISANS IN THE BUILDING METAL MACHINERY ETC. | 63 | 95.45 | 1.4 | 1.6 | 4.55 | 0.27% | 311,113.70 |
| AMBULANCE AND RELATED WORKERS | 598 | 95.22 | 13.5 | 15.3 | 4.78 | 2.94% | 357,613.65 |
| ARTISAN PROJECT AND RELATED SUPERINTENDENTS | 15 | 100.00 | 0.3 | 0.4 | - | 0.06% | 286,586.07 |
| AUXILIARY AND RELATED WORKERS | 516 | 91.17 | 11.6 | 13.2 | 8.83 | 2.08% | 293,968.82 |
| BIOCHEMISTRY PHARMACOL. ZOOLOGY & LIFE SCIE.TECHNI | 13 | 86.67 | 0.3 | 0.3 | 13.33 | 0.11% | 626,543.56 |
| BOILER AND RELATED OPERATORS | 1 | 100.00 | 0.0 | 0.0 | - | 0.00% | 194,240.87 |
| BUILDING AND OTHER PROPERTY CARETAKERS | 264 | 95.31 | 5.9 | 6.8 | 4.69 | 0.55% | 150,661.71 |
| BUS AND HEAVY VEHICLE DRIVERS | 17 | 100.00 | 0.4 | 0.4 | - | 0.06% | 258,244.69 |
| CASHIERS TELLERS AND RELATED CLERKS | 1 | 100.00 | 0.0 | 0.0 | - | 0.00% | 239,372.28 |
| CIVIL ENGINEERING TECHNICIANS | 1 | 50.00 | 0.0 | 0.0 | 50.00 | 0.00% | 349,791.62 |
| CLEANERS IN OFFICES WORKSHOPS HOSPITALS ETC. | 2653 | 93.55 | 59.7 | 67.9 | 6.45 | 5.85% | 160,546.53 |
| CLERKS AND RELATED PERSONNEL | 2 | 100.00 | 0.0 | 0.1 | - | 0.01% | 201,712.39 |
| CLIENT INFORM CLERKS(SWITCHB RECEPT INFORM CLERKS) | 94 | 90.38 | 2.1 | 2.4 | 9.62 | 0.33% | 252,305.96 |
| COMMUNICATION AND INFORMATION RELATED | 4 | 100.00 | 0.1 | 0.1 | - | 0.02% | 403,378.37 |
| COMMUNITY DEVELOPMENT WORKERS | 14 | 100.00 | 0.3 | 0.4 | - | 0.06% | 290,650.66 |
| COMPUTER PROGRAMMERS. | 2 | 100.00 | 0.0 | 0.1 | - | 0.01% | 373,337.01 |
| COMPUTER SYSTEM DESIGNERS AND ANALYSTS. | 2 | 100.00 | 0.0 | 0.1 | - | 0.01% | 427,739.84 |
| CUSTOMER SERVICES PERSONNEL | 1 | 100.00 | 0.0 | 0.0 | - | 0.01% | 506,797.35 |
| DENTAL PRACTITIONERS | 120 | 86.96 | 2.7 | 3.1 | 13.04 | 1.48% | 898,172.05 |
| DENTAL SPECIALISTS | 3 | 75.00 | 0.1 | 0.1 | 25.00 | 0.05% | 1,193,271.43 |
| DENTAL TECHNICIANS | 1 | 100.00 | 0.0 | 0.0 | - | 0.01% | 412,411.31 |
| DENTAL THERAPY | 15 | 88.24 | 0.3 | 0.4 | 11.76 | 0.09% | 444,184.26 |
| DIETICIANS AND NUTRITIONISTS | 140 | 86.96 | 3.2 | 3.6 | 13.04 | 0.75% | 392,595.56 |
| DOMEST BUILD& HELPERS CLEAN SWEEP AND LAUNDERERS | | - | 0.0 | 0.0 | 100.00 | 0.00% | - |
| ELECTRICAL AND ELECTRONICS | 29 | 85.29 | 0.7 | 0.7 | 14.71 | 0.18% | 439,413.52 |

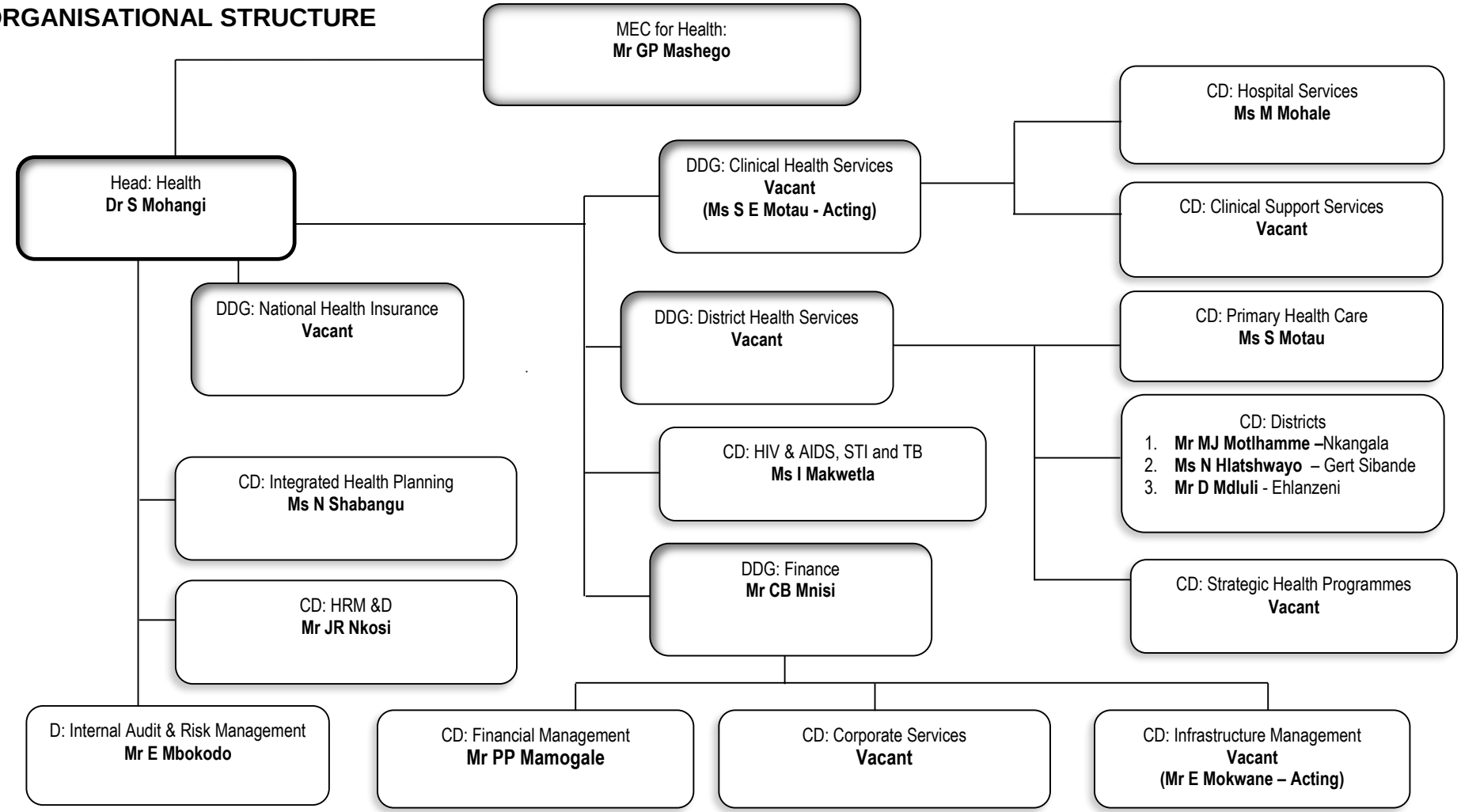
| OCCUPATIONAL CLASS | Number employed | % of total employed | Number per 100, 000 people | Number per 100,000 uninsured people[2] | Vacancy rate[5] | % of total personnel budget | Annual cost per staff member |
|---|---|---|---|---|---|---|---|
| ENGINEERING TECHNICIANS | | | | | | | |
| EMERGENCY SERVICES RELATED | 266 | 97.08 | 6.0 | 6.8 | 2.92 | 1.15% | 315,869.72 |
| ENGINEERING SCIENCES RELATED | 4 | 100.00 | 0.1 | 0.1 | - | 0.01% | 206,067.70 |
| ENGINEERS AND RELATED PROFESSIONALS | 1 | 33.33 | 0.0 | 0.0 | 66.67 | 0.02% | 1,649,035.24 |
| ENVIRONMENTAL HEALTH | 63 | 75.90 | 1.4 | 1.6 | 24.10 | 0.40% | 457,609.91 |
| FINANCE AND ECONOMICS RELATED | 23 | 92.00 | 0.5 | 0.6 | 8.00 | 0.19% | 586,745.46 |
| FINANCIAL AND RELATED PROFESSIONALS | 51 | 98.08 | 1.1 | 1.3 | 1.92 | 0.31% | 443,669.66 |
| FINANCIAL CLERKS AND CREDIT CONTROLLERS | 191 | 93.17 | 4.3 | 4.9 | 6.83 | 0.81% | 307,324.00 |
| FOOD SERVICES AIDS AND WAITERS | 409 | 94.68 | 9.2 | 10.5 | 5.32 | 1.01% | 178,982.20 |
| FOOD SERVICES WORKERS | 22 | 91.67 | 0.5 | 0.6 | 8.33 | 0.10% | 340,187.60 |
| FORESTRY LABOURERS | 1 | 100.00 | 0.0 | 0.0 | - | 0.00% | 165,037.46 |
| HEAD OF DEPARTMENT/CHIEF EXECUTIVE OFFICER | 1 | 33.33 | 0.0 | 0.0 | 66.67 | 0.01% | 1,066,804.36 |
| HEALTH SCIENCES RELATED | 59 | 92.19 | 1.3 | 1.5 | 7.81 | 0.41% | 504,108.97 |
| HORTICULTURISTS FORESTERS AGRICUL.& FORESTRY TECHN | 1 | 100.00 | 0.0 | 0.0 | - | 0.00% | 306,366.19 |
| HOUSEHOLD AND LAUNDRY WORKERS | 274 | 86.98 | 6.2 | 7.0 | 13.02 | 0.70% | 184,885.35 |
| HOUSEHOLD FOOD AND LAUNDRY SERVICES RELATED | 6 | 85.71 | 0.1 | 0.2 | 14.29 | 0.01% | 143,103.10 |
| HOUSEKEEPERS LAUNDRY AND RELATED WORKERS | 6 | 75.00 | 0.1 | 0.2 | 25.00 | 0.02% | 219,268.71 |
| HUMAN RESOURCES & ORGANISAT DEVELOPM & RELATE PROF | 17 | 94.44 | 0.4 | 0.4 | 5.56 | 0.10% | 446,911.30 |
| HUMAN RESOURCES CLERKS | 98 | 93.33 | 2.2 | 2.5 | 6.67 | 0.46% | 344,769.76 |
| HUMAN RESOURCES RELATED | 48 | 87.27 | 1.1 | 1.2 | 12.73 | 0.28% | 418,117.65 |
| INFORMATION TECHNOLOGY RELATED | 1 | 100.00 | 0.0 | 0.0 | - | 0.01% | 511,883.58 |
| LIBRARIANS AND RELATED PROFESSIONALS | 1 | 100.00 | 0.0 | 0.0 | - | 0.00% | 352,320.36 |
| LIBRARY MAIL AND RELATED CLERKS | 22 | 84.62 | 0.5 | 0.6 | 15.38 | 0.09% | 294,733.36 |
| LIGHT VEHICLE DRIVERS | 183 | 93.37 | 4.1 | 4.7 | 6.63 | 0.64% | 255,778.91 |
| LOGISTICAL SUPPORT PERSONNEL | 18 | 85.71 | 0.4 | 0.5 | 14.29 | 0.11% | 441,213.44 |
| MANAGEMENT RELATED SUPPORT PROFESSIONALS | 1 | 100.00 | 0.0 | 0.0 | - | 0.01% | 807,934.90 |
| MATERIAL-RECORDING AND TRANSPORT CLERKS | 74 | 93.67 | 1.7 | 1.9 | 6.33 | 0.26% | 254,656.51 |

| OCCUPATIONAL CLASS | 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 EQUIPMENT OPERATORS | 1 | 50.00 | 0.0 | 0.0 | 50.00 | 0.00% | 137,128.68 |
| MEDICAL PRACTITIONERS | 803 | 69.58 | 18.1 | 20.5 | 30.42 | 12.73% | 1,154,768.85 |
| MEDICAL RESEARCH AND RELATED PROFESSIONALS | 1 | 100.00 | 0.0 | 0.0 | - | 0.00% | 34,332.06 |
| MEDICAL SPECIALISTS | 65 | 80.25 | 1.5 | 1.7 | 19.75 | 1.55% | 1,732,556.26 |
| MEDICAL TECHNICIANS/TECHNOLOGISTS | 5 | 71.43 | 0.1 | 0.1 | 28.57 | 0.04% | 651,536.78 |
| MESSENGERS PORTERS AND DELIVERERS | 206 | 89.96 | 4.6 | 5.3 | 10.04 | 0.56% | 197,852.24 |
| MOTOR VEHICLE DRIVERS | 19 | 95.00 | 0.4 | 0.5 | 5.00 | 0.08% | 318,735.89 |
| NURSING ASSISTANTS | 1565 | 82.80 | 35.2 | 40.0 | 17.20 | 4.44% | 206,611.09 |
| OCCUPATIONAL THERAPY | 91 | 73.39 | 2.0 | 2.3 | 26.61 | 0.49% | 394,702.50 |
| OFFICE CLERKS AND RELATED KEYBOARD OPERATORS | 3 | 100.00 | 0.1 | 0.1 | - | 0.01% | 261,125.63 |
| OPTOMETRISTS AND OPTICIANS | 7 | 100.00 | 0.2 | 0.2 | - | 0.05% | 486,335.07 |
| ORAL HYGIENE | 11 | 100.00 | 0.2 | 0.3 | - | 0.07% | 494,172.37 |
| OTHER ADMINISTRAT & RELATED CLERKS AND ORGANISERS | 1202 | 91.13 | 27.1 | 30.7 | 8.87 | 4.16% | 252,120.65 |
| OTHER ADMINISTRATIVE POLICY AND RELATED OFFICERS | 131 | 86.18 | 2.9 | 3.4 | 13.82 | 0.73% | 404,469.01 |
| OTHER INFORMATION TECHNOLOGY PERSONNEL. | 6 | 100.00 | 0.1 | 0.2 | - | 0.06% | 670,517.92 |
| OTHER MANAGEMENT SUPPORT PERSONNEL | 1 | 100.00 | 0.0 | 0.0 | - | 0.00% | 237,818.31 |
| OTHER OCCUPATIONS | 16 | 80.00 | 0.4 | 0.4 | 20.00 | 0.08% | 363,768.59 |
| PHARMACEUTICAL ASSISTANTS | 147 | 93.04 | 3.3 | 3.8 | 6.96 | 0.60% | 296,020.32 |
| PHARMACISTS | 345 | 81.75 | 7.8 | 8.8 | 18.25 | 2.76% | 582,289.04 |
| PHARMACOLOGISTS PATHOLOGISTS & RELATED PROFESSIONA | 8 | 100.00 | 0.2 | 0.2 | - | 0.03% | 310,191.78 |
| PHYSICISTS | 1 | 50.00 | 0.0 | 0.0 | 50.00 | 0.01% | 1,060,974.49 |
| PHYSIOTHERAPY | 99 | 73.33 | 2.2 | 2.5 | 26.67 | 0.55% | 404,365.63 |
| PROFESSIONAL NURSE | 5328 | 89.08 | 119.9 | 136.3 | 10.92 | 35.30% | 482,372.86 |
| PSYCHOLOGISTS AND VOCATIONAL COUNSELLORS | 36 | 85.71 | 0.8 | 0.9 | 14.29 | 0.35% | 705,627.54 |
| QUANTITY SURVEYORS & RELA PROF NOT CLASS ELSEWHERE | 1 | 100.00 | 0.0 | 0.0 | - | 0.01% | 678,458.04 |
| RADIOGRAPHY | 137 | 85.63 | 3.1 | 3.5 | 14.38 | 0.80% | 425,862.88 |

| OCCUPATIONAL CLASS | 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 |
|---|---|---|---|---|---|---|---|
| RISK MANAGEMENT AND SECURITY SERVICES | 5 | 83.33 | 0.1 | 0.1 | 16.67 | 0.02% | 249,770.37 |
| ROAD WORKERS | 1 | 100.00 | 0.0 | 0.0 | - | 0.00% | 154,878.27 |
| SECRETARIES & OTHER KEYBOARD OPERATING CLERKS | 248 | 93.94 | 5.6 | 6.3 | 6.06 | 0.83% | 244,454.96 |
| SENIOR MANAGERS | 39 | 90.70 | 0.9 | 1.0 | 9.30 | 0.58% | 1,088,572.71 |
| SOCIAL SCIENCES SUPPLEMENTARY WORKERS | 1 | 100.00 | 0.0 | 0.0 | - | 0.00% | 269,298.76 |
| SOCIAL WORK AND RELATED PROFESSIONALS | 46 | 88.46 | 1.0 | 1.2 | 11.54 | 0.30% | 467,362.27 |
| SPEECH THERAPY AND AUDIOLOGY | 77 | 70.64 | 1.7 | 2.0 | 29.36 | 0.33% | 309,377.50 |
| STAFF NURSES AND PUPIL NURSES | 1825 | 89.42 | 41.1 | 46.7 | 10.58 | 6.22% | 248,295.58 |
| STUDENT NURSE | 752 | 92.27 | 16.9 | 19.2 | 7.73 | 1.54% | 148,670.90 |
| SUPPLEMENTARY DIAGNOSTIC RADIOGRAPHERS | 7 | 77.78 | 0.2 | 0.2 | 22.22 | 0.03% | 335,459.42 |
| TRADE LABOURERS | 3 | 75.00 | 0.1 | 0.1 | 25.00 | 0.01% | 183,537.85 |
| **TOTAL** | **19998** | **88.51** | **450.2** | **511.6** | **11.49** | **100.00 %** | **364,113.01** |

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 has received qualified audit opinion with improvement in terms of issues from previous financial years. The plans to improve the financial management emanates from the following challenges:

1. Non-compliance with laws and regulations
2. Weaknesses in control environment
3. Inadequate capacity building for the existing finance staff

Plan in addressing the above mentioned challenges are as follows:

1. Finance managers forum has been established and meeting will be held to share best practises
2. Trainings will be held to address other issues identified in SCM, Assets Management, Expenditure Management, etc.
3. Checklists will be reviewed within finance management to ensure compliance with latest laws and regulations
4. Internal Control unit will be assist to execute the monitoring the internal controls within the districts and hospitals

### 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 its 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 2016/17, 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 and Qualified Audit Opinion" for Programme 2 and Programme 4, respectively. 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 rolled out these systems to Ehlanzeni and Nkangala Districts. 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

The infrastructure unit has strengthened its sound relations; planning and implementation with the Implementing Agent of the province (Department of Public Works, Roads and Transport) and has yielded drastic improvements on performance. Partnerships have also been formed with the National Department of Health whereby doctors consultation rooms in the National Health Insurance pilot district have been constructed; the renovations in Middelburg Hospital Nursing accommodation, Amajuba hospital, Elsie ballot hospital and Standerton hospital currently underway for completion in the 2017/18 financial year and lastly contractors have been appointed to undertake comprehensive maintenance in the NHI district.

## 4.8 REVISIONS TO LEGISLATIVE AND OTHER MANDATES

The National Department of Health has recently approved a new policy for youth health care services, National Adolescent and Youth Policy 2017 that aims at addressing the health challenges faced by youth in the country.

The National Health Council has approved the National Policy on Commuted Overtime for Medical Practitioners to ensure that there is uniformity in the application of commuted overtime by different provinces.

South Africa is among the first countries to formally adopt Universal Test and Treat initiative in accordance with the World Health Organization (WHO) new guidelines on HIV treatment. Universal Test and Treat (UTT) directly supports UNAIDS 90 90 90 targets of ensuring that 90% of all people living with HIV know their HIV status, 90% of people with diagnosed HIV infection receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy have viral suppression. South Africa embraces UTT to complement case finding and rolling out strategies that are reflected in the revised 2016 national HTS policy the 2016 HIV disclosure guidelines. Key to success of UTT is implementation of the national Adherence policy and service delivery guidelines interventions for linkage to care, adherence to treatment and retention in care.

## 4.9 OVERVIEW OF THE 2017/18 BUDGET AND MTEF ESTIMATES

The Department shows an average increase of 6.0 per cent as compared to 2016/17 FY allocated budget. Services delivery programmes show an average increase of 6.7 per cent which include District Health Services, Emergency Medical Services, Provincial Hospital Services and Central Hospitals. *Programme 1: Administration* has reduced by 10.1 per cent which due to prioritization of service delivery programmes on the non-negotiables items.

*Programme 2: District Health Services* shows a growth of 6.6 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 2018/19 financial year budget increase include additional funding received for HIV/AIDS for ARV's, CPIX increase of 11.3 per cent and increase on procurement of Medical items.
*Programme 3: Emergency Medical Services* shows an increase of 6.0 per cent in the 2018/19 financial year. The programme still receives 2.9 per cent of the overall allocation of the Vote as compared to 2017/18 financial year.

*Programme 4: The Provincial Hospital Services* shows a growth of 8.6 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 11.2 per cent of the allocated budget for 2018/19 financial year.

*Programme 5: Central Hospital Services* consists of Rob Ferreira Hospital and Witbank Hospital budget increase of 10.5 per cent in 2018/19 financial year. 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 9.6 per cent of the allocated budget for 2018/19 financial year.

*Programme 6: Health Science & Training* will decrease by 5.3 per cent from the 2017/18 FY budget. The programme receives 3.2 per cent of the allocated budget for the Vote. *Programme 7: Health Care Support Services* will decrease by 12.3 per cent during the 2018/19 financial year due to need address challenges within forensic services. The Department has still centralised procurement of medical equipment in order to improve compliance on National Core Standards.

Over the MTEF period, *Programme 8: Health Facilities Management* has shown a high increase 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

**Table 10.3: Summary of payments and estimates: Health**

| | Outcome | | | Main appropriation | Adjusted appropriation | Revised estimate | Medium-term estimates | | |
|---|---|---|---|---|---|---|---|---|---|
| R thousand | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | | 2018/19 | 2019/20 | 2020/21 |
| 1. Administration | 196 542 | 297 298 | 282 001 | 300 668 | 311 458 | 410 294 | 265 526 | 279 429 | 281 388 |
| 2. District Health Services | 5 475 431 | 6 175 406 | 6 524 844 | 6 933 514 | 7 172 984 | 7 389 393 | 8 048 071 | 8 644 913 | 9 218 854 |
| 3. Emergency Medical Services | 319 347 | 309 596 | 328 189 | 352 046 | 366 800 | 379 810 | 388 002 | 419 614 | 447 449 |
| 4. Provincial Hospital Services | 1 047 266 | 1 174 385 | 1 221 480 | 1 304 905 | 1 301 264 | 1 347 606 | 1 393 406 | 1 500 741 | 1 594 897 |
| 5. Central Hospital Services | 943 975 | 991 759 | 1 026 751 | 1 101 054 | 1 112 100 | 1 177 393 | 1 218 481 | 1 314 584 | 1 393 989 |
| 6. Health Sciences and Training | 305 208 | 369 233 | 372 901 | 433 635 | 419 376 | 367 640 | 388 773 | 410 272 | 424 780 |
| 7. Health Care Support Services | 101 707 | 123 451 | 140 693 | 157 775 | 200 452 | 212 276 | 182 640 | 192 620 | 203 634 |
| 8. Health Facilities Management | 469 050 | 639 264 | 683 021 | 1 436 440 | 1 160 619 | 1 161 281 | 1 393 275 | 1 228 854 | 1 292 221 |
| **Total payments and estimates:** | **8 858 526** | **10 080 392** | **10 579 880** | **12 020 037** | **12 045 053** | **12 445 693** | **13 278 174** | **13 991 027** | **14 857 212** |

# Table A3: Summary of Provincial Expenditure Estimates by Economic Classification

| R thousand | Outcome 2014/15 | Outcome 2015/16 | Outcome 2016/17 | Main appropriation 2017/18 | Adjusted appropriation 2017/18 | Revised estimate 2017/18 | Medium-term estimates 2018/19 | Medium-term estimates 2019/20 | Medium-term estimates 2020/21 |
|---|---|---|---|---|---|---|---|---|---|
| **Current payments** | **8 159 984** | **9 005 288** | **9 753 872** | **10 319 190** | **10 679 511** | **11 007 665** | **11 596 322** | **12 426 433** | **13 246 991** |
| Compensation of employees | 5 516 897 | 6 102 017 | 6 686 678 | 7 329 114 | 7 282 617 | 7 245 550 | 7 877 247 | 8 561 805 | 9 246 749 |
| Salaries and wages | 4 874 606 | 5 353 167 | 5 877 405 | 6 435 931 | 6 370 588 | 6 376 282 | 6 897 523 | 7 508 123 | 8 109 100 |
| Social contributions | 642 291 | 748 850 | 809 273 | 893 183 | 912 029 | 869 268 | 979 724 | 1 053 682 | 1 137 649 |
| Goods and services | 2 639 473 | 2 902 264 | 3 064 888 | 2 990 076 | 3 396 894 | 3 761 843 | 3 719 075 | 3 864 628 | 4 000 242 |
| *Administrative fees* | 2 717 | 3 195 | 160 334 | 54 991 | 242 558 | 244 168 | 204 874 | 211 282 | 201 739 |
| *Advertising* | 1 879 | 3 220 | 6 077 | 1 449 | 6 111 | 6 141 | 9 238 | 8 743 | 9 033 |
| *Minor Assets* | 8 111 | 11 079 | 9 462 | 7 612 | 12 632 | 13 270 | 19 079 | 14 715 | 15 931 |
| *Audit cost: External* | 17 895 | 16 580 | 14 819 | 16 171 | 14 594 | 15 425 | 17 184 | 18 146 | 18 146 |
| *Bursaries: Employees* | 2 627 | 1 798 | 604 | – | 1 211 | 1 182 | – | – | – |
| *Catering: Departmental activities* | 2 497 | 3 196 | 2 903 | 1 223 | 1 948 | 2 740 | 3 110 | 2 705 | 2 850 |
| *Communication (G&S)* | 42 342 | 42 697 | 44 325 | 37 348 | 34 312 | 34 881 | 38 811 | 36 674 | 36 719 |
| *Computer services* | 19 660 | 57 478 | 16 269 | 30 532 | 40 615 | 60 283 | 30 546 | 32 236 | 32 236 |
| *Consultants and professional services: Business and* | 4 418 | 10 543 | 15 328 | 16 675 | 6 593 | 6 593 | 7 004 | 8 122 | 8 398 |
| *Infrastructure and planning* | – | 3 756 | – | 10 000 | – | – | – | – | – |
| *Laboratory services* | 357 413 | 328 947 | 373 723 | 329 826 | 444 579 | 525 354 | 524 218 | 645 666 | 747 389 |
| *Legal costs* | – | 27 222 | 16 576 | 21 227 | 35 184 | 31 018 | 20 182 | 21 312 | 21 312 |
| *Contractors* | 67 224 | 65 631 | 83 778 | 69 783 | 107 142 | 117 032 | 123 192 | 118 291 | 150 331 |
| *Agency and support / outsourced services* | 74 436 | 92 172 | 117 582 | 74 051 | 84 333 | 134 320 | 92 934 | 93 308 | 94 122 |
| *Fleet services (including government motor transpo* | 125 474 | 110 053 | 104 309 | 98 293 | 84 800 | 94 174 | 97 204 | 99 238 | 99 265 |
| *Inventory: Clothing material and accessories* | 2 635 | 2 380 | – | – | 1 486 | 1 854 | – | – | – |
| *Inventory: Farming supplies* | 2 614 | 4 086 | – | 4 255 | 8 539 | 5 444 | 14 128 | 14 918 | 14 918 |
| *Inventory: Food and food supplies* | 89 969 | 86 313 | 86 076 | 86 052 | 77 029 | 77 471 | 92 508 | 92 205 | 92 205 |
| *Inventory: Fuel, oil and gas* | 31 228 | 40 261 | 30 952 | 27 510 | 3 832 | 7 648 | 266 | 524 | 524 |
| *Inventory: Learner and teacher support material* | – | – | – | – | – | – | 15 | 16 | 17 |
| *Inventory: Materials and supplies* | 7 638 | 8 950 | 199 | – | – | – | – | 235 | 238 |
| *Inventory: Medical supplies* | 320 387 | 355 748 | 360 796 | 357 438 | 341 829 | 363 860 | 375 045 | 390 323 | 393 626 |
| *Inventory: Medicine* | 1 020 330 | 1 118 218 | 1 077 749 | 1 299 458 | 1 297 755 | 1 446 336 | 1 596 576 | 1 661 480 | 1 681 571 |
| *Inventory: Other supplies* | 46 | – | – | – | 11 642 | 11 657 | 11 300 | 11 985 | 11 985 |
| *Consumable supplies* | 55 929 | 103 274 | 117 007 | 81 132 | 92 091 | 96 479 | 59 566 | 59 574 | 57 371 |
| *Consumable: Stationery,printing and office supplies* | 24 189 | 29 294 | 19 994 | 20 325 | 16 923 | 16 417 | 16 509 | 15 379 | 15 457 |
| *Operating leases* | 54 347 | 42 123 | 45 716 | 47 288 | 44 415 | 45 084 | 51 384 | 53 044 | 53 307 |
| *Property payments* | 228 295 | 243 163 | 280 374 | 247 294 | 312 238 | 321 072 | 245 389 | 187 191 | 179 019 |
| *Transport provided: Departmental activity* | 979 | 722 | 216 | 546 | 563 | 376 | 328 | 351 | 353 |
| *Travel and subsistence* | 59 880 | 73 295 | 67 613 | 37 346 | 55 311 | 63 127 | 59 131 | 55 374 | 50 545 |
| *Training and development* | 6 249 | 8 147 | 5 090 | 6 760 | 10 359 | 10 150 | 6 531 | 8 581 | 8 532 |
| *Operating payments* | 4 057 | 5 590 | 4 307 | 4 962 | 4 944 | 6 195 | 2 780 | 2 966 | 3 059 |
| *Venues and facilities* | 3 510 | 2 475 | 1 871 | 108 | 1 199 | 1 905 | – | – | – |
| *Rental and hiring* | 498 | 658 | 839 | 421 | 127 | 187 | 43 | 44 | 44 |
| Interest and rent on land | 3 614 | 1 007 | 2 306 | – | – | 272 | – | – | – |
| Interest (Incl. interest on finance leases) | 3 614 | 1 007 | 2 306 | – | – | 272 | – | – | – |
| **Transfers and subsidies** | **264 468** | **479 149** | **306 487** | **335 280** | **315 560** | **388 046** | **345 676** | **353 677** | **356 245** |
| Provinces and municipalities | 584 | 140 141 | 552 | 576 | 576 | 519 | 833 | 859 | 512 |
| Provinces | 229 | 515 | 551 | 558 | 558 | 519 | 833 | 859 | 512 |
| Provincial agencies and funds | 229 | 515 | 551 | 558 | 558 | 519 | 833 | 859 | 512 |
| Municipalities | 355 | 139 626 | 1 | 18 | 18 | – | – | – | – |
| Municipal bank accounts | 126 | 139 626 | 1 | 18 | 18 | – | – | – | – |
| Municipal agencies and funds | 229 | – | – | – | – | – | – | – | – |
| Departmental agencies and accounts | 217 | 231 | 177 | 9 631 | 7 031 | 6 883 | 14 294 | 15 061 | 15 030 |
| Departmental agencies (non-business entities) | 217 | 231 | 177 | 9 631 | 7 031 | 6 883 | 14 294 | 15 061 | 15 030 |
| Non-profit institutions | 202 567 | 240 706 | 182 733 | 228 702 | 198 511 | 193 466 | 229 140 | 230 671 | 243 288 |
| Households | 61 100 | 98 071 | 123 025 | 96 371 | 109 442 | 187 178 | 101 409 | 107 086 | 97 415 |
| Social benefits | 56 759 | 82 859 | 88 770 | 73 975 | 68 200 | 85 094 | 78 294 | 82 677 | 82 804 |
| Other transfers to households | 4 341 | 15 212 | 34 255 | 22 396 | 41 242 | 102 084 | 23 115 | 24 409 | 14 611 |
| **Payments for capital assets** | **434 074** | **595 955** | **509 496** | **1 365 567** | **1 049 982** | **1 049 982** | **1 336 176** | **1 210 917** | **1 253 976** |
| Buildings and other fixed structures | 312 522 | 453 725 | 437 594 | 1 263 888 | 851 522 | 851 531 | 1 225 816 | 1 125 913 | 1 164 395 |
| Buildings | 312 522 | 453 725 | 437 594 | 1 263 888 | 851 522 | 851 531 | 1 225 816 | 1 125 913 | 1 164 395 |
| Machinery and equipment | 121 552 | 142 230 | 71 902 | 101 679 | 198 460 | 198 451 | 110 360 | 85 004 | 89 581 |
| Transport equipment | 66 240 | 81 840 | 4 823 | 13 391 | 24 033 | 16 415 | 24 763 | 14 475 | 14 954 |
| Other machinery and equipment | 55 312 | 60 390 | 67 079 | 88 288 | 174 427 | 182 036 | 85 597 | 70 529 | 74 627 |
| **Payments for financial assets** | – | – | 10 025 | – | – | – | – | – | – |
| **Total economic classification** | **8 858 526** | **10 080 392** | **10 579 880** | **12 020 037** | **12 045 053** | **12 445 693** | **13 278 174** | **13 991 027** | **14 857 212** |

## 4.9.2 RELATING EXPENDITURE TRENDS TO STRATEGIC GOALS

*Compensation of Employees* - shows an increase of 8.1 per cent on the revised estimate that is slightly more than the CPI provision. The Department has provided for physical staff available on PERSAL in 2017/18 financial year. An additional budget was set aside to provide for the cost of living adjustments. Although there are still challenges with the mix of skills in the Department, rationalization of staff will commerce in order to ensure proper distribution of personnel in appropriate facilities where there is a need. The Department has allocated an amount of R7.877 billion for the payment of salaries of warm bodies to be carried from the 2017/18 financial year. This classification received 59.3 per cent of the main appropriation.

*Goods and Services* – This item has increased by 8.1 per cent which shall cater for the key cost drivers. The Department will continue to intensify measures and internal controls in the attempt to reduce health costs and provide sustainable health essential services to the community. Goods and services accounts for 27.7 per cent of the main appropriation.

*Transfers and Subsidies* – shows an increase of 9.5 per cent on the revised estimate, which is due to additional funding received for community health services within the Comprehensive HIV/AIDS grant. The Budget provides for funding for the Non-Profit Organizations that provide households.

*Payments of Capital Assets* – The classification will increase by 31.7 per cent due to increase in infrastructure.

The Department's strategic goals, comprising of a number of strategic objectives and sub-outcomes have been aligned with the National Development Plan (NDP) 2030, Sustainable Development Goals 2030, MTSF 2014-2019 and the National Health sector priorities. The strategic objectives statements are:

- Expand access to health care services
- Improve health care outcomes
- Improve quality of health care
- Re-alignment of human resource to Departmental needs
- Strengthening Health Systems Effectiveness
- Improved health facility planning and accelerate infrastructure delivery
- Reduction of health costs

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

| Expenditure | Audited/ Actual | | | Estimate | Medium term projection | | |
|---|---|---|---|---|---|---|---|
| | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| **Current prices[1]** | | | | | | | |
| Total[2] | | | | | | --- | --- |
| Total per person | | | | | | --- | --- |
| Total per uninsured person | | | | | | --- | --- |
| CPI | | | | | | | |
| Index (Multiplier) | | | | | | | |
| **Constant (2016/17) prices[3]** | | | | | | | |
| Total | | | | | | | |
| Total per person | | | | | | | |
| Total per uninsured person | | | | | | | |
| **% of Total spent on:-** | | | | | | | |
| DHS[4] | | | | | | | |
| PHS[5] | | | | | | | |
| CHS[6] | | | | | | | |
| All personnel | | | | | | | |
| Capital[2] | | | | | | | |
| Health as % of total public expenditure | | | | | | | |

1. Current price projections for the MTEF period are not required as these figures will be the same as the Constant price projections for the same years
2. Including maintenance. Capital spending under the public works budget for health should be included. This should equal the amounts indicated in tables HFM 1 and 2 and should exclude non-HFM capital falling under the Treasury definition of Capex (i.e. more than R5, 000 and lasts more than a year).
3. The CPIX multipliers in Table A4 should be used to adjust expenditure in previous years to 2018/19 prices.
4. District health services; any change in content of the budget programme should be indicated.
5. Provincial hospital services or previous designation; any change in content of the budget programme should be indicated.
6. Central hospital services or previous designation; any change in content of the budget programme should be indicated.

# 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

The priorities for Programme 1 have been categorised as per following sections

1. Supply Chain Management:
    1.1. Training of bid committee members (Bid Specifications, Bid Evaluations, Bid Adjudication, Economizing Committee, District Acquisition Committees and Hospital Finance Committee)

2. Financial Management:
   Improve financial management through:
    2.1. Asset management
    2.2. Management of accruals
    2.3. Management of irregular expenditure

3. Human Resources:
    3.1. Recruitment and selection of staff in critical posts
    3.2. Achievement of Employment Equity Targets
    3.3. Human resource development
    3.4. Performance management
    3.5. Employee Relations and People Management
    3.6. Implementation of Employee Health and Wellness Programs

4. ICT Services:
    4.1. The focus will be on Systems, ICT Infrastructure and strengthening broadband connectivity in all facilities.
    4.2. The main systems will be Patient and Administration System (PEIS) in Hospitals and Health Patient Registration System (HPRS) that will be implemented in all PHC facilities.
    4.3. Parallel to Systems, ICT infrastructure will be strengthened to ensure that there is a stable backborne upon which systems will operate. The last key area in the 2018/19 period is to ensure that all the facilities have reliable, efficient broadband connectivity.

5. Legal Services:
    5.1. Appointment of legal officers and supporting staff as required by the Legal Services Directorate organogram must be prioritized in 2018/19, as the number of medico cases is becoming disproportionate to the number of files which are received on daily basis.

5.2. Due to the high influx of medico cases health professionals staff need to be appropriately trained and managed to provide quality health care

5.3. Capacitating of legal officers should be prioritised as there is a need for the establishment of a special units dealing with medico claims.

5.4. The training of health professionals in high risk targeted areas for litigation should be adequately funded as the focus should be on monitoring and implementation of policies to avoid errors and curb claims

## 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) | Annually | 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. Communication strategy developed | Annual | No |
| 5. Audit opinion from Auditor-General | Annual | Categorical |
| 6. Percentage of Hospitals with broadband access | Quarterly | % |
| 7. 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 | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| | **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 | 7/33 | 10/33 | 18/33 | 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 | 1 | 1 | 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 | 0 | 0 | 7/18 | 11 appointed (18 cumulative) | 18 maintained | 18 maintained | 18 maintained |
| | 4. Communication strategy developed | Number | Not in plan | Not in plan | Not in plan | Not in plan | 1 | 1 Implemented | 1 Implemented |
| | **Programme Performance/Customized Indicators (Sector Indicators)** | | | | | | | | |
| Improve health care outcome | 5. Audit opinion from Auditor-General | Categorical | Not in plan | Qualified | Qualified | Unqualified | Unqualified | Unqualified | Unqualified |
| Strengthening Health Systems Effectiveness | 6. Percentage of Hospitals with broadband access | % | 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) |
| | 7. 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) |

**Note:**

## 1.6 QUARTERLY TARGETS

### TABLE ADMIN 3: QUARTERLY TARGETS

| INDICATOR | Frequency of Reporting (Quarterly, Bi-annual, Annual) | Indicator Type | ANNUAL TARGET 2018/19 | TARGETS | | | |
|---|---|---|---|---|---|---|---|
| | | | | Q1 | Q2 | Q3 | Q4 |
| 1. Improve Hospital Management by appointing Executive Management in all hospitals (Key Management Positions) | Annual | Number | 28/28 | 28/28 | Annual Target | 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 | 18 | Annual Target | Annual Target | Annual Target | 18 |
| 4. Communication strategy developed | Annual | Number | 1 | Annual Target | Annual Target | Annual Target | 1 |
| 5. Audit opinion from Auditor-General | Annual | Categorical | Unqualified | Annual Target | Annual Target | Annual Target | Unqualified |
| 6. 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) |
| 7. Percentage of fixed PHC facilities with broadband access | Quarterly | Number | 100% (287/287) | 100% (287/287) | 100% (287/287) | 100% (287/287) | 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 | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | | 2018/19 | 2019/20 | 2020/21 |
| 1. Office of the MEC | 7 169 | 7 600 | 7 752 | 9 281 | 8 306 | 7 703 | 8 628 | 7 913 | 8 423 |
| 2. Management | 189 373 | 289 698 | 274 249 | 291 387 | 303 152 | 402 591 | 256 898 | 271 516 | 272 965 |
| **Total payments and estimates** | **196 542** | **297 298** | **282 001** | **300 668** | **311 458** | **410 294** | **265 526** | **279 429** | **281 388** |

**C**

## Summary of Provincial Expenditure Estimates by Economic Classification[3]

| | Outcome | | | Main appropriation | Adjusted appropriation | Revised estimate | Medium-term estimates | | |
|---|---|---|---|---|---|---|---|---|---|
| R thousand | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | | 2018/19 | 2019/20 | 2020/21 |
| **Current payments** | **189 938** | **267 454** | **232 997** | **266 921** | **257 721** | **295 386** | **239 432** | **251 895** | **263 875** |
| Compensation of employees | 101 576 | 110 825 | 124 420 | 148 436 | 135 244 | 153 909 | 133 645 | 149 736 | 161 716 |
| Goods and services | 87 824 | 156 033 | 108 476 | 118 485 | 122 477 | 141 446 | 105 787 | 102 159 | 102 159 |
| Interest and rent on land | 538 | 596 | 101 | – | – | 31 | – | – | – |
| **Transfers and subsidies** | **4 358** | **21 105** | **35 152** | **28 590** | **41 836** | **103 007** | **24 094** | **25 422** | **15 285** |
| Provinces and municipalities | 17 | 515 | 552 | 456 | 456 | 519 | 833 | 859 | 512 |
| Departmental agencies and accounts | – | – | – | 5 600 | – | – | – | – | – |
| Higher education institutions | – | – | – | – | – | – | – | – | – |
| Foreign governments and international organisations | – | – | – | – | – | – | – | – | – |
| Public corporations and private enterprises | – | – | – | – | – | – | – | – | – |
| Non-profit institutions | – | – | – | – | – | – | – | – | – |
| Households | 4 341 | 20 590 | 34 600 | 22 534 | 41 380 | 102 488 | 23 261 | 24 563 | 14 773 |
| **Payments for capital assets** | **2 246** | **8 739** | **3 827** | **5 157** | **11 901** | **11 901** | **2 000** | **2 112** | **2 228** |
| Buildings and other fixed structures | – | – | – | – | – | – | – | – | – |
| Machinery and equipment | 2 246 | 8 739 | 3 827 | 5 157 | 11 901 | 11 901 | 2 000 | 2 112 | 2 228 |
| Heritage assets | – | – | – | – | – | – | – | – | – |
| Specialised military assets | – | – | – | – | – | – | – | – | – |
| Biological assets | – | – | – | – | – | – | – | – | – |
| Land and sub-soil assets | – | – | – | – | – | – | – | – | – |
| Software and other intangible assets | – | – | – | – | – | – | – | – | – |
| **Payments for financial assets** | – | – | 10 025 | – | – | – | – | – | – |
| **Total economic classification: Programme (number and** | **196 542** | **297 298** | **282 001** | **300 668** | **311 458** | **410 294** | **265 526** | **279 429** | **281 388** |

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

## 1.8 PERFORMANCE AND EXPENDITURE TRENDS

*Programme 1: Administration* has reduced by 14.7 per cent, which due to once off projects funded during the budget adjustment that include litigations and back up for ICT. The programme plans the following key performance areas in the MTEF period to ensure sustained support and leadership for Health include:

- Strengthen the implementation of Financial Delegations and HR Delegations to create autonomy in preferred facilities as part of the NHI implementation.
- Filling of posts to be finalized within 3 months as when they are vacant and funded
- Retention of Health Professionals and other skilled Personnel and the finalization of all outstanding HR matter.

## 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<br>b. Improvement of the attraction strategy and Review the organizational structure and implementation of WISN in PHC facilities<br>c. Implementation of HR delegations<br>d. Adherence to the prescripts when advertising and filling of posts<br>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<br>b. Enhance the security system (electronic devices)<br>c. Regular update of the asset register<br>d. Enforce compliance with the asset management policy<br>e. Intensive training of Asset Managers<br>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

1. Universal Health coverage progressively achieved through implementation of National Health Insurance

Mpumalanga Department of Health is committed towards achieving Universal Healthcare Coverage (UHC) that will be attained through the implementation of National Health Insurance (NHI). The provincial coverage under NHI will ensure that all citizens of the province have access to comprehensive quality health care services. 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.

The Department acknowledges that implementation of the NHI demands a high level of commitment that must be coupled with consistent application of the World Health Organization's health system six building blocks which are:
i. Leadership/governance
ii. Health care financing
iii. Health workforce
iv. Medical products and technologies
v. Information and research; and
vi. Service delivery

The absence, weakness and/or inefficiency of any one of these six blocks will render any Health care system ineffective and adversely impact on its overall performance. The Department is ensuring that all the above building blocks are being strengthened so that the strategy of NHI can benefit all healthcare users

2. Implement the Re-engineering of PHC

Strengthening primary health care through re-engineering of PHC services, is a provincial priority in order to improve quality of care, health outcomes, reduce inequity and to pave the way for National Health Insurance;
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.

The province has total number of 235 established teams that covers 402 electoral wards. These WBPHCOT reach out to the communities at household level. The plan for this financial year is to increase outreach and registration of households to 59% (5876/10000) and 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 100% (287) of PHC facilities have their Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realization and Maintenance (PPTICRM).in this financial year

3. 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 continuously 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.

4. Maternal, infant and child mortality reduced

Sustainable Development Goals is having the reduction of maternal, neonatal and child morbidity and mortality is a priority and a goal to be reached by 2030. Hence the department also prioritizing the services to women and children and planning to strengthen the provision sexual reproductive health care services by increasing the coverage of Couple Year Protection rate which is the first line of defense in the morbidity and mortality of children and women to be at 60% . Reducing the delivery rate of girls below the age of 19 to be below 11%.
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 diarrhea to be below 3% and those dying from Pneumonia to be below 3.8% and from Severe Acute Malnutrition to be below 11% 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 Centers in collaboration with the Department of Education and Social Development

5. 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
- Behavioral 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 & faster tracked service delivery

6. 90 90 90 Policy Strategy
    - The 90-90-90 is a concept introduced by the United Nation's programme on HIV and AIDS (UNAIDS ) in 2013.
    - The country adopted and started to implement the policy in 2015.
    - The idea is that by 2020, 90% of people who are infected with HIV will know their HIV status.
    - 90% of people who test HIV positive will be put on antiretroviral therapy.
    - 90% of those who receive antiretroviral therapy will be virally suppressed.

    TB 90 90 90 targets

        - 90% of vulnerable groups/key populations screened for TB
        - PHC headcount; Inmates in correctional service facilities; Miners; People living in informal settlements/peri-mining communities screen contacts of index cases
        - 90% of people with TB diagnosed & treated
        - 90% treatment success

7. Universal Test and Treat Initiative
    - In line with the National Development Plan (NDP) 2030, the United Nations Sustainable Development Goals and UNAIDS 90 90 90 targets of 2020, the Minister of Health announced during his budget speech on the 10th May 2016, that South Africa would scale-up NHI facility decongestion to reach 800, 000 patients in the 16/17 financial year.

The country would implement the World Health Organization (WHO) evidence based guidelines of Universal Test and Treat (UTT) by 1st September 2016.

8. Voluntary Medical Male Circumcision (VMMC)
    - Voluntary Medical Male Circumcision (VMMC) reduces female-to-male sexual transmission of HIV by 60%. The World Health Organization (WHO) and UNAIDS recommend the implementation of VMMC programmes in countries with a high HIV prevalence among the general population. VMMC is cost-effective and should be included alongside behavioural and structural strategies, as part of a comprehensive HIV prevention plan.

9. SheConquers campaign: HIV Prevention in girls and young women in South Africa
    - Responding to the heightened vulnerability of young women and adolescent girls to HIV, the Government of South Africa has launched a nationwide HIV prevention campaign. Entitled SheConquers, the three year, multimillion rand campaign was launched at a session hosted by the South African Ministry of Health during the 21st International AIDS Conference, that took place in Durban, South Africa. Across sub-Saharan Africa, HIV is a leading cause of deaths among adolescents aged 10-19, and two thirds of all new HIV infections among adolescents occur among adolescent girls. SheConquers is built around a five-point strategy that aims to decrease:
        - New HIV infections;
        - Teenage pregnancies;
        - Gender based violence among young women and adolescent girls;
        - Increase and retain young women and adolescent girls in school;
        - Increase economic opportunities for young people, particularly young women.
10. HIV Testing Services
    - HIV testing services are offered to clients through community testing. The focus is on communities with very high HIV prevalence and clients are linked to care.

11. ACSM Strategy
    - Awareness campaigns are conducted and male and female condoms are distributed as a preventative measure. Communities are educated so as to create awareness on TB and encourage community members to use Primary health care facilities. As part of health talk, communities are informed that TB treatment is free.

**2.2.4 EHLANZENI DISTRICT**

Primary Health Care:

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(a) Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) in all fixed clinic and CHC
(b) Increase access to Community Based Health Services by increasing the coverage of Outreach House Hold registration visit
(c) Increase the number of School Health Service Teams established
(d) Curb the burden of HIV and TB by Increase number of patients initiated on ART , Increasing number of Male medical circumcision performed and increase TB success rate
(e) Reduce child morbidity by increasing coverage of Immunisation for the under 1 year

(f) Reduce maternal mortality by increasing Couple year protection rate reduce delivery rate in facility of the 10 to 19 years , Increase the rate of Antenatal 1st visit before 20 weeks

District Hospitals:

(a) Increase the percentage of Hospital achieved 75% and more on National Core Standards self-assessment rate (District Hospitals)
(b) Reduce the Average Length of Stay (District Hospitals)

### 2.2.5 Gert Sibande District

Primary Health Care:

(a) Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realization and Maintenance (PPTICRM) in all fixed clinic and CHC
(b) Increase access to Community Based Health Services by increasing the coverage of Outreach House Hold registration visit
(c) Increase the number of School Health Service Teams established
(d) Curb the burden of HIV and TB by Increase number of patients initiated on ART , and increase TB success rate
(e) Reduce child morbidity by increasing coverage of Immunization for the under 1 year and reduce case fatality from Severe Acute Malnutrition
(f) Reduce maternal mortality by increasing Couple year protection rate reduce delivery rate in facility of the 10 to 19 years , Increase the rate of Antenatal 1st visit before 20 weeks and increase the mother postnatal visit within six weeks

District Hospitals:

(a) Increase the percentage of Hospital achieved 75% and more on National Core Standards self-assessment rate (District Hospitals)

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### 2.2.6 Nkangala District

Primary Health Care:

(a) Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realization and Maintenance (PPTICRM) in all fixed clinic and CHC
(b) Increase access to Community Based Health Services by increasing the coverage of Outreach House Hold registration visit
(c) Increase the number of School Health Service Teams established
(d) Curb the burden of HIV and TB by Increase number of patients initiated on ART , Increasing number of Male medical circumcision performed and increase TB success rate
(e) Reduce child morbidity by increasing coverage of Immunization for the under 1 year and reduce case fatality from Severe Acute Malnutrition
(f) Reduce maternal mortality by increasing Couple year protection rate reduce delivery rate in facility of the 10 to 19 years , Increase the rate of Antenatal 1st visit before 20 weeks and increase the mother postnatal visit within six weeks

District Hospitals:

(a) Increase the percentage of Hospital achieved 75% and more on National Core Standards self-assessment rate (District Hospitals)

Reduce the Average Length of Stay (District Hospitals)

## 2.1 SERVICE DELIVERY PLATFORM FOR DHS

### TABLE DHS1: DISTRICT HEALTH SERVICE FACILITIES BY HEALTH DISTRICT IN 2017/18

| Health district | Facility type | No.[5] | Population | Population per facility[3] or per hospital bed | PHC Headcount Or Inpatient Separations[3] | Per capita utilisation[3] |
|---|---|---|---|---|---|---|
| **Gert Sibande District** | Non fixed clinics[1] | 25 mobile clinics<br>1116 mobile clinic points; 3 satellite clinics | 1 043 194<br>1 101 Beds | 32 695 | 148 166 | 1.8 |
| | Fixed Clinics operated by Provincial Government[2] | 54 | | 14 765 | 1 156 378 | |
| | CHCs | 22 | | 53 850 | 574 893 | |
| | **Sub-total clinics + CHCs** | 76 | | 8 556 | 1 879 437 | |
| | District hospitals[4] | 8 | | 831 | 55 462 | N/A |
| **Ehlanzeni District** | Non fixed clinics[1] | 29 mobile clinics<br>984 mobile clinic points | 1 688 615<br>1 209 Beds | 3 097 | 239 225 | 2.9 |
| | Fixed Clinics operated by Provincial Government[2] | 106 | | 10 780 | 1 140 568 | |
| | CHCs | 15 | | 23 840 | 1 140 568 | |
| | **Sub-total clinics + CHCs** | 121 | | 12 399 | 4 944 406 | |
| | District hospitals[4] | 8 | | 1 319 | 68 932 | N/A |
| **Nkangala District** | Non fixed clinics[1] | 27 mobile clinics<br>461 mobile clinic points | 1 308 129<br>716 Beds | 56 694 | 158 031 | 1.9 |
| | Fixed Clinics operated by Provincial Government[2] | 68 | | 6 143 | 1 523 216 | |
| | CHCs | 22 | | 65 522 | 876 434 | |
| | **Sub-total clinics + CHCs** | 90 | | 10 508 | 2 557 681 | |
| | District hospitals[4] | 7 | | 1 556 | 31 072 | N/A |
| **Province** | Non fixed clinics[1] | 79 mobile clinics<br>2561 mobile clinic points | 4 039 939<br>(Stats SA 2007)<br>3026 Beds | 45 241 | 545 422 | 2.3 |
| | Fixed Clinics operated by Provincial Government[2] | 228 | | 15 467 | 6 244 207 | |
| | CHCs | 59 | | 75 401 | 2 591 895 | |
| | **Sub-total clinics + CHCs** | 287 | | 9 998 | 9 381 524 | |
| | District hospitals[4] | 23 | | 1 196 | 155 466 | N/A |

**Source**: Population : 2016 mid-year population estimates provided by StatsSA for 2018/19 year (Refer to Annexure A);

1. Non-fixed clinics should include mobile and satellite clinics (exclude visiting points).
2. Fixed clinics operated by Provincial Government must include gateway clinics.
3. PHC facility headcounts and hospital inpatient separations should be used for per capita utilisation.

4. Include state aided designated District hospitals (ie. that provide Level 1 care) - include facilities that may not be providing full package of Level 1 care. The Provincial Office may combine the rates, where the District Hospital is serving more than one District, with a foot note indicating the catchment.
5. Total Number of Facilities – DHIS 2017/18

## 2.2 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 2016/17 | Ehlanzeni 2016/17 | Gert Sibande 2016/17 | Nkangala 2016/17 |
|---|---|---|---|---|---|
| 1. Ideal clinic status rate | % | New Indicator | New Indicator | New Indicator | New Indicator |
| 2. PHC utilisation rate - Total | No | 2.2% | 2.8 | 1.7 | 1.75% |
| 3. Complaint resolution within 25 working days rate (PHC) | % | 93.7% | 94.6 | 95.3 | 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 rate | Annual | % |
| 2. PHC utilisation rate - Total | Quarterly | No |
| 3. 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 | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/28 | 2018/19 | 2019/20 | 2020/21 |
| | **Programme Performance/Customized Indicators (Sector Indicators)** | | | | | | | | |
| Improve quality of health care | 1. Ideal clinic status rate | % | New indicator | New indicator | New indicator | 100% (287/287) | 40.4% (116/287) | 66.6% (191/287) | 100% (287/287) |
| | 2. PHC utilisation rate - Total | No | 2.3 | 2.2 | 2.2 | 2.6 (11500000/4397250) | 2.2 (9449034/4290009) | 2.2 (9449034/4290009) | 2.2 (9449034/4290009) |
| Improve quality of health care | 3. Complaint resolution within 25 working days rate (PHC) | % | 93.9% | 95.5% | 93.7% | 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 2018/19 | TARGETS | | | |
|---|---|---|---|---|---|---|---|
| | | | | Q1 | Q2 | Q3 | Q4 |
| 1. Ideal clinic status rate | Annual | % | 40.4% (116/287) | Annual Target | Annual Target | Annual Target | 40.4% (116/287) |
| 2. PHC utilisation rate - Total | Quarterly | No | 2.2 (9449034/4290009) | 2.2 (9449034/4290009) | 2.2 (9449034/4290009) | 2.2 (9449034/4290009) | 2.2 (9449034/4290009) |
| 3. Complaint resolution within 25 working days rate (PHC) | Quarterly | % | 98% (2058/2100) | 98% | 98% | 98% | 98% |

## 2.3 SUB – PROGRAMME 2.9: DISTRICT HOSPITALS

### TABLE DHS 5: SITUATION ANALYSIS INDICATORS FOR DISTRICT HOSPITALS

| Programme Performance Indicator | Indicator Type | Province wide value 2016/17 | Ehlanzeni 2016/17 | Gert Sibande 2016/17 | Nkangala 2016/17 |
|---|---|---|---|---|---|
| 1. Hospital achieved 75% and more on National Core Standards self-assessment rate (District Hospitals) | % | 0% | 12.5 | 60% | 0% |
| 2. Average Length of Stay (District Hospitals) | No | 3.7 | 5.2 | 4.2 | 5 |
| 3. Inpatient Bed Utilisation Rate (District Hospitals) | % | 75.3% | 80.9 | 66.3 | 73.3% |
| 4. Expenditure per PDE (District Hospitals) | No | R2 283.2 | R2 213.6 | R2 293.4 | R2 555.5 |
| 5. Complaint Resolution within 25 working days rate (District Hospitals) | % | 95.4% | 94.6 | 95.3 | 100% |

## 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. 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 | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| 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 | 30 % ( 7 / 23 ) | 44% (10/23) | 57% (13/23) | 69% (16/23) |
| | 2. Average Length of Stay (District Hospitals) | No | 4.3 days | 4.5 days | 4.8 | 3.7 days | 4.2 days | 4.2 days | 4.2 days |
| | 3. Inpatient Bed Utilisation Rate (District Hospitals) | % | 70.5% | 71.4% | 75% | 73% (109794/150000) | 75% (113500/151000 | 75% (113500/151000) | 75% (113500/151000) |
| | 4. Expenditure per PDE (District Hospitals) | R | R1830 | R2.153.40 | R2 283.2 | R2,250.00 | R2,500.00 | R2,500.00 | R2,500.00 |

| Strategic objective statement | Indicator | Indicator Type | Audited/Actual performance | | | Estimated performance | Medium term targets | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| Improve quality of health care | 5. Complaint Resolution within 25 working days rate (District Hospitals) | % | 94.5% | 90.6% | 95.4% | 96% % (1056/1100) | 95% (1131/1155) | 95.5% (1189/1213) | 96% (1189/1213) |

## 2.5.1 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 2018/19 | TARGETS | | | |
|---|---|---|---|---|---|---|---|
| | | | | Q1 | Q2 | Q3 | Q4 |
| 1. Hospital achieved 75% and more on National Core Standards self assessment rate (District Hospitals) | Quarterly | % | 44% (10/23) | 0% | 0% | 0% | 44% (10/23) |
| 2. Average Length of Stay (District Hospitals) | Quarterly | No | 4.2 days | 4.2 days | 4.2 days | 4.2 days | 4.2 days |
| 3. Inpatient Bed Utilisation Rate (District Hospitals) | Quarterly | % | 75% (113500/151000) | 75% (113500/151000) | 75% (113500/151000) | 75% (113500/151000) | 75% (113500/151000) |
| 4. Expenditure per PDE (District Hospitals) | Quarterly | R | R2,500.00 | R2,500.00 | R2,500.00 | R2,500.00 | R2,500.00 |
| 5. Complaint Resolution within 25 working days rate (District Hospitals) | Quarterly | % | 95% (1131/1155) | 95% | 95% | 95% | 95% |

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## 2.4 HIV & AIDS, STI & TB CONTROL (HAST)

### TABLE DHS 8: SITUATION ANALYSIS INDICATORS FOR HAST

| Programme Performance Indicator | Indicator Type | Province wide value 2016/17 | Ehlanzeni 2016/17 | Gert Sibande 2016/17 | Nkangala 2016/17 |
|---|---|---|---|---|---|
| 1. Female condom distributed | No | 1 981 572 | 1 034 446 | 560 846 | 386 280 |
| 2. Improve TB cure rate | % | 75.9% | 75.4% | 76.3% | 78.8% |
| 3. ART client remain on ART end of month -total | No | 377 288 | 186 606 | 104 641 | 86 041 |
| 4. TB/HIV co-infected client on ART rate | % | 39.7% | 95.2% | 93.8% | 95.5% |
| 5. HIV test done - total | No | 1 053 082 | 483 795 | 257 337 | 288 218 |
| 6. Male condom distributed | No | 77 703 335 | 33 959 665 | 21 406 424 | 22 337 246 |
| 7. Medical male circumcision – Total | No | 38 262 | 20 201 | 12 791 | 5 270 |
| 8. TB symptom 5yrs and older start on treatment rate | % | 39.8% | 95.6% | 96% | 95.1% |
| 9. TB client treatment success rate | % | 87.4% | 88.6% | 84.5% | 88.5% |
| 10. TB client lost to follow up rate | % | 5.4% | 6.2% | 4.7% | 4.7% |
| 11. TB client death rate | % | 4.7% | 3.9% | 6.7% | 4% |
| 12. TB MDR treatment success rate | % | 54.4% | N/A | N/A | N/A |

## 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 | % |
| 10. TB client lost to follow up rate | Quarterly | % |

| PROGRAMME PERFORMANCE INDICATOR | Frequency of Reporting (Quarterly, Bi-annual, Annual) | Indicator Type |
|---|---|---|
| 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 | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| | **Strategic Objective/Provincial Indicators** | | | | | | | | |
| 1. Improve Health Care Outcomes | 1. Female Condom Distributed | No | 842 882 | 1 828 571 | 1 981 572 | 3 737 321 | 3 812 067 | 3 888 209 | 4 000 000 |
| | 2. Improve TB cure rate | % | 76.1% (2013) | 78.7% (2014) | 75.9% | 81% (17458/21554) | 82% (17674/21554) | 85% (18320/21554) | 87% (4756/5800) |
| | **Programme Performance/Customized Indicators (Sector Indicators)** | | | | | | | | |
| | 3. ART client remain on ART end of month -total | No | 283 932 (Adults) | 318 228 | 377 288 | 454 982 | 477 288 | 527 288 | 577 288 |
| | 4. TB/HIV co-infected client on ART rate | % | 77.9% | Not In plan | 39.7% | 90% (11501/12779) | 93% (13625/14651) | 95% (13918/14651) | 97% (14211/14651) |
| | 5. HIV test done - total | No | 1 772 361 | 868 897 | 1 053 082 | 777 884 | 1 060 313 | 1 087 881 | 1 116 166 |
| | 6. Male condom distributed | No | Not in Plan | 30 per male | 77 703 335 | 71 009 095 | 72 429 277 | 73 877 863 | 80 000 000 |
| | 7. Medical male circumcision - Total | No | 49 685 | 38 439 | 38 262 | 79 007 | 44 000 | 40 000 | 38 000 |
| | 8. TB symptom 5yrs and older started on treatment rate | % | Not in Plan | Not in Plan | 39.8% | 70% (7000/10000) | 80% (8000/10000) | 90% (9000/10000) | 92% (8900/1000) |
| | 9. TB client treatment success rate | % | 81.8% (2013) | 88.6% (2014) | 87.4% | 87% (18752/21554) | 89% (19183/21554) | 90% (19399/21554) | 90% (19399/21554) |
| 1. Improve Health Care Outcomes | 10. TB client lost to follow up rate | % | 5.4%(2013) | 4% (2014) | 5.4% | 4.3% (927/21554) | 4.1% (884/21554) | 4.0% (862/21554) | 3.0% (489/16300) |

| Strategic objective statement | Indicator | Indicator Type | Audited/Actual performance | | | Estimated performance | Medium term targets | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| | 11. TB client death rate | % | 5.6%(2013) | 4.5% (2014) | 4.7% | 4.70 (1013/21554) | 4.30 (927/21554) | 4.0% (862/21554) | 3.4% (489/16300) |
| | 12. TB MDR treatment success rate | % | 47%(2012) | 45% (2013) | 54.4% | 60% (694/1157) | 62% (732/1182) | 65% (781/1202) | 65% (819/1222) |

## 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 2018/19 | TARGETS | | | |
|---|---|---|---|---|---|---|---|
| | | | | Q1 | Q2 | Q3 | Q4 |
| 1. Female Condom Distribution | Quarterly | No | 3 812 067 | 953 016 | 953 017 | 953 017 | 953 017 |
| 2. Improve TB cure rate | Annual | % | 82% (17674/21554) | 82% (17674/21554 | 82% (17674/21554) | 82% (17674/21554) | 82% (17674/21554) |
| 3. ART client remain on ART end of month – total | Quarterly | No | 477 288 | 428 635 | 444 853 | 461 070 | 477 288 |
| 4. TB/HIV co-infected client on ART rate | Quarterly | % | 93% (13625/14651) | 93% (13625/14651) | 93% (13625/14651) | 93% (13625/14651) | 93% (13625/14651) |
| 5. HIV test done – total | Quarterly | No | 1 060 313 | 265 078 | 265 078 | 265 078 | 265 079 |
| 6. Male condom distributed | Quarterly | No | 72 429 277 | 18 107 320 | 18 107 319 | 18 107 319 | 18 107 319 |
| 7. Medical male circumcision - Total | Quarterly | No | 44 000 | 17 600 | 13 200 | 6 600 | 6 600 |
| 8. TB symptom 5yrs and older started on treatment rate | Quarterly | % | 80% (8000/10000) | 80% (8000/10000) | 80% (8000/10000) | 80% (8000/10000) | 80% (8000/10000) |

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| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 9. TB client treatment success rate | Quarterly | % | 89% (19183/21554) | 89% (19183/21554) | 89% (19183/21554) | 89% (19183/21554) | 89% (19183/21554) |
| 10. TB client lost to follow up rate | Quarterly | % | 4.1% (884/21554) | 4.10 (884/21554) | 4.10 (884/21554) | 4.10 (884/21554) | 4.10 (884/21554) |
| 11. TB client death rate | Annual | % | 4.30 (927/21554) | 4.30 (927/21554) | 4.30 (927/21554) | 4.30 (927/21554) | 4.30 (927/21554) |
| 12. TB MDR treatment success rate | Annual | % | 62% (732/1182) | 62% (732/1182) | 62% (732/1182) | 62% (732/1182) | 62% (732/1182) |

## 2.5 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 2016/17 | Ehlanzeni 2016/17 | Gert Sibande 2016/17 | Nkangala 2016/17 |
|---|---|---|---|---|---|
| 1. Number of School Health Service Teams established | No | 13 | 5 | 5 | 3 |
| 2. Strategy to amplify implementation of programmes focusing on the reduction of maternal and infant mortalities developed | No | New Indicator | New Indicator | New Indicator | New Indicator |
| 3. Antenatal 1st visit before 20 weeks rate | % | 71,9% | 77.8 | 61.1 | 68.3% |
| 4. Mother postnatal visit within 6 days rate | % | 59 | 63.2 | 39.3 | 73.3% |
| 5. Antenatal client initiated on ART rate | % | 94.9% | 99.2 | 83.4 | 96.4% |
| 6. Infant 1st PCR test positive around 10 weeks rate | % | 1.7% | 1 | 4.9 | 2.1% |
| 7. Immunisation coverage under 1 year (annualised) | % | 77.7 | 89.4 | 83 | 79% |
| 8. Measles 2nd dose coverage (annualised) | % | 84.8 | 97.4 | 88.6 | 86.8% |
| 9. Child under 5 years diarrhoea case fatality rate | % | 1.6 | 2.1 | 2.2 | 0.8 |
| 10. Child under 5 years pneumonia case fatality rate | % | 3.5 | 4.8 | 2 | 2.7 |
| 11. Child under 5 years severe acute malnutrition case fatality rate | % | 7.8 | 8.9 | 9.2 | 6.5 |
| 12. School Grade 1 screened | % | 21.1% | 6789 | 52.3 | 8 285 (23.8%) |
| 13. School Grade 8 screened | % | 6.8% | 2630 | 32.4 | 2 187 (7.4%) |
| 14. Delivery 10 to 19 years in facility rate | % | New Indicator | New Indicator | New Indicator | New Indicator |

| Programme Performance Indicator | Indicator Type | Province wide value 2016/17 | Ehlanzeni 2016/17 | Gert Sibande 2016/17 | Nkangala 2016/17 |
|---|---|---|---|---|---|
| 15. Couple year protection rate (annualised) | % | 46.9 | 83.1 | 71 | 43.7% |
| 16. Cervical cancer screening coverage (annualised) | % | 71.1 | 95.4 | 37 | 55.8% |
| 17. Human Papilloma Virus Vaccine 1st dose coverage | % | No data | No data | No data | 53.2% |
| 18. Human Papilloma Virus Vaccine 2nd dose coverage | % | No data | No data | No data | No data |
| 19. Vitamin A 12-59 months coverage (annualised) | % | 55.6 | 69.1 | 41.6 | 52.9% |
| 20. Maternal mortality in facility ratio (annualised) | per 100 000 Live Births | 127,3 / 100 000 | 125.2/100 000 | 67.2/100 000 | 137.9/100 000 |
| 21. Inpatient early neonatal death rate | per 1000 | 11/1000 | 10/1000 | 1.3/1000 | 0,98/1000 |

## 2.7.1 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. Strategy to amplify implementation of programmes focusing on the reduction of maternal and infant mortalities developed | Annual | Number |
| 3. Antenatal 1st visit before 20 weeks rate | Quarterly | % |
| 4. Mother postnatal visit within 6 days rate | Quarterly | % |
| 5. Antenatal client start on ART rate | Annual | % |
| 6. Infant 1st PCR test positive around 10 weeks rate | Quarterly | % |
| 7. Immunisation under 1 year coverage | Quarterly | % |
| 8. Measles 2nd dose coverage | 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 | % |

| PROGRAMME PERFORMANCE INDICATOR | Frequency of Reporting (Quarterly, Bi-annual, Annual) | Indicator Type |
|---|---|---|
| 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. Maternal mortality in facility ratio | Annual | per 100 000 Live Births |
| 21. 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 | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 20120/21 |
| 1. Improve health care outcomes | **Strategic Objective/Provincial Indicators** | | | | | | | | |
| | 1. Number of School Health Service Teams established | No | 0 | 12 | 13 (43 cumulative) | 32 (75 cumulative) | 33 (108 cumulative) | 13 (121 cumulative) | 0 121 cumulative |
| | 2. Strategy to amplify implementation of programmes focusing on the reduction of maternal and infant mortalities developed | No | New Indicator | New Indicator | New Indicator | New Indicator | 1 | 1 | 1 |
| | **Programme Performance/Customized Indicators (Sector Indicators)** | | | | | | | | |
| | 3. Antenatal 1st visit before 20 weeks rate | % | 56.5% | 65.9% | 71,9% | 72% (55093/76518) | 74% (56623/76518) | 75% (57389/76518) | 77% (58919/76518) |
| | 4. Mother postnatal visit within 6 days rate | % | Not in plan | 62.5% | 60.2% | 65% (47345/72839) | 65% (47345/72839) | 65.5% (47710/72839) | 66% (48074/72839) |
| | 5. Antenatal client initiated on ART rate | % | Not in plan | 95,8% | 94,9% (14842/15640) | 97% (18775/19356) | 97,5% (14235/14600) | 98% (13328/13600) | 98% (12348/12600) |

| Strategic objective statement | Indicator | Indicator Type | Audited/Actual performance | | | Estimated performance | Medium term targets | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 20120/21 |
| | 6. Infant 1st PCR test positive around 10 weeks rate | % | 1.7% | 1.6% | 1,7% (241/14406) | 1,5% (271/18 043) | 1,45% (262/18043) | 1,40% (253/18043) | 1.35% (243/18043) |
| | 7. Immunisation under 1 year coverage | % | 80.2% | 87.1% | 79.7% | 87% (70499/81034) | 89% (72120/81034) | 90% (72930/81034) | 90% (72930/81034) |
| | 8. Measles 2nd dose coverage | % | Not in plan | 78.7% | 86.4 % | 85% (71339/83928) | 88% (73857/83928) | 90% (75535/83928) | 90% (75535/83928) |
| | 9. Diarrhoea case fatality rate | % | 5.3% | 2.7% | 1.5% | 3.5% (108/3075) | 3% (92/3075) | 2.5% (77/3075) | 2.5% (77/3075) |
| | 10. Pneumonia case fatality rate | % | 5.3% | 3.7% | 3.4% | 4% (147/3667) | 3.8% (139/3667) | 3.5% (128/3667) | 3.5% (128/3667) |
| | 11. Severe acute malnutrition case fatality rate | % | 19.1% | 12.5% | 8.4% | 13% (128/986) | 11% (108/986) | 10% (99/986) | 9.5% (94/986) |
| | 12. School Grade 1 - learners screened | No | 15.8% | 20% | 21.1% | 19 767 | 29 650 | 39 534 | 39 534 |
| | 13. School Grade 8 - learners screened | No | 6.1% | 13.1 | 6.8% | 17 192 | 21 490 | 25 788 | 25 788 |
| | 14. Delivery in 10 to 19 years in facility rate | % | Not in plan | Not in plan | Not in plan | 13% (9469/72839) | 11% (8012/72839) | 10% (7284/72839) | 8% (5827/72839) |

| Strategic objective statement | Indicator | Indicator Type | Audited/Actual performance | | | Estimated performance | Medium term targets | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 20120/21 |
| | 15. Couple year protection rate (Int) | % | 39.7% | 38.6% | 50.4% | 55% (657281/ 1195057) | 60% (717034/1195057) | 65% (776787/1195057) | 70% (836540/1195057) |
| | 16. Cervical cancer screening coverage 30 years and older | % | 63.3% | 66.7% | 66.5% | 65% (600193/923374) | 75% (692531/923374) | 78% (720232/923374) | 80% (738699/923374) |
| | 17. HPV 1st dose | No | 90.2% | 95% | 77.2% | 72800 | 77350 | 81900 | 81900 |
| | 18. HPV 2nd dose | No | 91.2% | 102.8% | 58% | 72800 | 77350 | 81900 | 81900 |
| | 19. Vitamin A 12-59 months coverage | % | 49.9% | 51.4% | 55.1% | 58% (198700/342587) | 60% (205552/342587) | 62% (212404/342587) | 65% (222682/342587) |
| | 20. Maternal mortality in facility ratio | per 100 000 Live Births | 108/100 000 | 125,3/100 00 0 | 129.6/100 000 | 151 per 100 000 Live Births (107/70988) | 145 per 100 000 Live Births (103/70988) | 141 per 100 000 Live Births (100/70988) | 135 per 100 000 live births (96/70988) |
| | 21. Neonatal death in facility rate | per 1000 | Not in Plan | 9.3/1000 | 9.5/1000 | 9,5/1000 (674/70995) | 9,25/1000 (657/70995) | 9,00/1000 (639/70995) | 8.75/1000 (621/70995) |

## 2.7.2 QUARTERLY TARGETS FOR MCWH&N

### TABLE DHS13: QUARTERLY TARGETS FOR MCWH&N

| INDICATOR | Frequency of Reporting (Quarterly, Bi-annual, Annual) | Indicator Type | ANNUAL TARGET 2018/19 | TARGET | | | |
|---|---|---|---|---|---|---|---|
| | | | | Q1 | Q2 | Q3 | Q4 |
| 1. Number of School Health Service Teams established | Annual | Number | 33 | Annual Target | 33 | Annual Target | Annual Target |
| 2. Strategy to amplify implementation of programmes focusing on the reduction of maternal and infant mortalities developed | Annual | Number | 1 | Annual Target | Annual Target | Annual Target | 1 |
| 3. Antenatal 1st visit before 20 weeks rate | Quarterly | % | 74% (56623/76518) | 74% (14156/19129) | 74% (14 156 / 19130) | 74% (14 155 / 19129) | 74% (14 156 / 19130) |
| 4. Mother postnatal visit within 6 days rate | Quarterly | % | 65% (47345/72839) | 65% (11836/18210) | 65% (11 837/18 210) | 65% (11 835/18 209) | 65% (11 837/18 210) |
| 5. Antenatal client initiated on ART rate | Quarterly | % | 97,5% (14235/14600) | 97.5% (3558/3650) | 97.5% (3559/3650) | 97.5% (3557/3650) | 97.5% (3562/3650) |
| 6. Infant 1st PCR test positive around 10 weeks rate | Quarterly | % | 1,45% (262/18043) | 1.45% (65/4510) | 1.45% (66/4511) | 1.45% (65/4510) | 1.45% (66/4511) |
| 7. Immunisation under 1 year coverage | Quarterly | % | 89% (72120/81034) | 89% (19340/21 731) | 89% (19341/21731) | 89% (19340/21731) | 89% (19341/21731) |
| 8. Measles 2nd dose coverage | Quarterly | % | 88% (73857/83928) | 88% (19159/21772) | 88% (19159/21772) | 88% (19159/21772) | 88% (19160/21772) |
| 9. Diarrhoea case fatality rate | Quarterly | % | 3% (92/3075) | 3% (25 / 843) | 3% (25 / 844) | 3% (25 / 843) | 3% (26 / 844) |
| 10. Pneumonia case fatality rate | Quarterly | % | 3.8% (139/3667) | 3.8% (38 / 1 012) | 3.8% (39 / 1 012) | 3.8% (38 / 1 012) | 3.8% (39 / 1 013) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 11. Severe acute malnutrition case fatality rate | Quarterly | % | 11% (108/986) | 11% (32 / 292) | 11% (32 / 292) | 11% (32 / 292) | 11% (33 / 293) |
| 12. School Grade 1 - learners screened | Quarterly | No | 29 650 | 7 413 | 7 413 | 7 413 | 7 411 |
| 13. School Grade 8 - learners screened | Quarterly | No | 21 490 | 5 372 | 5 372 | 5 374 | 5 372 |
| 14. Delivery in 10 to 19 years in facility rate | Quarterly | % | 11% (8012/72839) | 11% (2003/18209) | 11% (2003/18210) | 11% (2003/18210) | 11% (2003/18210) |
| 15. Couple year protection rate (Int) | Quarterly | % | 60% (717034/ 1195057) | 60% (15 604 / 26 106) | 60% (15 604 / 26 107) | 60% (15 604 / 26 107) | 60% (15 604 / 26 107) |
| 16. Cervical cancer screening coverage 30 years and older | Quarterly | % | 75% (692531/923374) | 75% (181205/241607) | 75% (181206/241608) | 75% (181206/241608) | 75% (181206/241608) |
| 17. HPV 1st dose | Annual | No | 77350 | Annual Target | 77350 | Annual Target | Annual Target |
| 18. HPV 2nd dose | Annual | No | 77350 | Annual Target | Annual Target | 77350 | Annual Target |
| 19. Vitamin A 12-59 months coverage | Quarterly | % | 60% (205552/342587) | 60% (51 388 / 85 647) | 60% (51 388 / 85 647) | 60% (51 388 / 85 647) | 60% (51 388 / 85 616) |
| 20. Maternal mortality in facility ratio | Annual | per 100 000 Live Births | 145 per 100 000 Live Births (103/70988) | 145/100 000 (25 / 17747) | 145/100 000 (26 / 17747) | 145 /100 000 (26 / 17747) | 145 /100 000 (26 / 17747) |
| 21. Neonatal death in facility rate | Annual | per 1000 | 9,25/1000 (657/70995) | 9.25 / 1 000 (164/17749) | 9.25 / 1 000 (164/17749) | 9.25 / 1 000 (165/17749)) | 9.25 / 1 000 (164/17749) |

## 2.6 DISEASE PREVENTION AND CONTROL (DPC)

**TABLE DHS14: SITUATION ANALYSIS INDICATORS FOR DISEASE PREVENTION AND CONTROL**

| Programme Performance Indicator | Indicator Type | Province wide value 20/16/17 | Ehlanzeni 2016/17 | Gert Sibande 2016/17 | Nkangala 2016/17 |
|---|---|---|---|---|---|
| 1. Cataract Surgery Rate annualized | Rate per 1 Million (uninsured population) | CSR 1,333 (1 303) | 600 | 350 | 353 |
| 2. Malaria case fatality rate | % | 0.67% | 0.54% | 6.25% | 0 |

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

| PROGRAMME PERFORMANCE INDICATOR | Frequency of Reporting (Quarterly, Bi-annual, Annual) | Indicator Type |
|---|---|---|
| 1. Number of District Mental Health Teams established | Annual | Number |
| 2. Cataract Surgery Rate | Quarterly | Rate per 1 Million (uninsured population) |
| 3. 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 | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| 1 Improve health care outcomes | **Strategic Objective/Provincial Indicators** | | | | | | | | |
| | 1. Number of District Mental Health Teams established | Number | New Indicator | New Indicator | New Indicator | New Indicator | 2 | 1 (cumulative 3) | 3 maintained |
| | **Programme Performance/Customized Indicators (Sector Indicators)** | | | | | | | | |
| | 2. Cataract Surgery Rate | Rate per 1 Million (uninsured population) | CSR 718 | CSR 805 (2 657) | CSR 1,333 (1 303) | CSR 1000 ( 3,600) | CSR 1000 ( 3,600) | CSR 1000 ( 3,600) | CSR 1000 ( 3,600) |
| | 3. Malaria case fatality rate | % | 0.77 % per 1000 population | 0.5% | 0.67% | 0.5% | 0.5% | 0.5% | 0.5% |

## 2.8.2 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 2018/19 | TARGETS | | | |
|---|---|---|---|---|---|---|---|
| | | | | Q1 | Q2 | Q3 | Q4 |
| 1. Number of District Mental Health Teams established | Annual | Number | 2 | 2 | Annual Target | Annual Target | Annual Target |
| 2. Cataract Surgery Rate | Quarterly | Rate per 1 Million (uninsured population) | CSR 1000 ( 3,600) | 600 | 1 200 | 1 200 | 600 |
| 3. Malaria case fatality rate | Quarterly | % | 0.5% | 0.5% | 0.5% | 0.5% | 0.5% |

# 2.9 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

## TABLE DHS17: DISTRICT HEALTH SERVICES

| | Outcome | | | Main appropriation | Adjusted appropriation | Revised estimate | Medium-term estimates | | |
|---|---|---|---|---|---|---|---|---|---|
| R thousand | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | | 2018/19 | 2019/20 | 2020/21 |
| 1. District Management | 307 736 | 349 625 | 341 758 | 376 008 | 345 577 | 332 342 | 383 965 | 410 347 | 437 674 |
| 2. Community Health Clinics | 1 021 072 | 1 246 101 | 1 202 502 | 1 244 601 | 1 298 031 | 1 188 850 | 1 448 290 | 1 518 857 | 1 573 815 |
| 3. Community Health Centres | 686 592 | 753 732 | 833 433 | 836 866 | 861 779 | 848 994 | 898 241 | 964 940 | 1 028 749 |
| 4. Community-based Services | 78 674 | 89 841 | 91 150 | 140 562 | 137 781 | 137 005 | 18 526 | 5 712 | 6 140 |
| 5. Other Community Services | – | – | – | – | – | – | – | – | – |
| 6. HIV/Aids | 840 587 | 936 447 | 1 120 040 | 1 313 179 | 1 401 468 | 1 491 257 | 1 903 549 | 2 093 782 | 2 311 794 |
| 7. Nutrition | 10 937 | 12 667 | 13 199 | 14 931 | 14 209 | 14 181 | 18 187 | 14 300 | 14 688 |
| 8. Coroner Services | – | – | – | – | – | – | – | – | – |
| 9. District Hospitals | 2 529 833 | 2 786 993 | 2 922 762 | 3 007 367 | 3 114 139 | 3 376 764 | 3 377 313 | 3 636 975 | 3 845 994 |
| **Total payments and estimates** | **5 475 431** | **6 175 406** | **6 524 844** | **6 933 514** | **7 172 984** | **7 389 393** | **8 048 071** | **8 644 913** | **9 218 854** |

## Summary of Provincial Expenditure Estimates by Economic Classification[4]

| | Outcome | | | Main appropriation | Adjusted appropriation | Revised estimate | Medium-term estimates | | |
|---|---|---|---|---|---|---|---|---|---|
| R thousand | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | | 2018/19 | 2019/20 | 2020/21 |
| **Current payments** | **5 251 052** | **5 756 986** | **6 321 584** | **6 691 301** | **6 949 215** | **7 163 084** | **7 790 528** | **8 403 978** | **8 962 688** |
| Compensation of employees | 3 485 659 | 3 921 759 | 4 293 015 | 4 636 336 | 4 658 279 | 4 618 956 | 5 089 808 | 5 519 672 | 5 961 246 |
| Salaries and wages | 3 064 966 | 3 422 489 | 3 753 979 | 4 053 004 | 4 052 367 | 4 040 911 | 4 437 673 | 4 815 714 | 5 201 114 |
| Social contributions | 420 693 | 499 270 | 539 036 | 583 332 | 605 912 | 578 045 | 652 135 | 703 958 | 760 132 |
| Goods and services | 1 762 564 | 1 835 065 | 2 028 435 | 2 054 965 | 2 290 936 | 2 543 890 | 2 700 720 | 2 884 306 | 3 001 442 |
| *Administrative fees* | 1 381 | 1 193 | 137 126 | 37 295 | 194 496 | 194 515 | 185 324 | 190 596 | 181 046 |
| *Advertising* | 1 066 | 126 | 1 594 | 600 | 1 910 | 1 940 | 5 000 | 5 280 | 5 570 |
| *Minor Assets* | 6 255 | 8 680 | 5 786 | 2 243 | 8 409 | 7 174 | 16 035 | 10 148 | 10 156 |
| *Catering: Departmental activities* | 728 | 1 516 | 1 717 | 463 | 1 415 | 2 203 | 2 500 | 2 666 | 2 811 |
| *Communication (G&S)* | 24 753 | 26 374 | 27 466 | 21 487 | 21 262 | 21 321 | 23 125 | 22 623 | 22 635 |
| *Computer services* | 311 | – | 8 | – | 10 020 | 14 688 | 848 | 848 | 848 |
| *Consultants and professional services: Business and* | – | 585 | 1 774 | – | 699 | 699 | – | – | – |
| *Laboratory services* | 278 663 | 250 486 | 304 018 | 254 464 | 368 139 | 434 937 | 435 554 | 548 515 | 650 238 |
| *Contractors* | 25 254 | 14 952 | 16 688 | 7 707 | 17 509 | 19 598 | 14 850 | 15 684 | 15 684 |
| *Agency and support / outsourced services* | 43 524 | 43 253 | 46 501 | 38 462 | 33 279 | 65 936 | 40 016 | 40 996 | 40 996 |
| *Fleet services (including government motor transpo* | 50 057 | 48 531 | 48 376 | 40 557 | 32 495 | 36 492 | 38 680 | 40 846 | 40 873 |
| *Inventory: Clothing material and accessories* | 1 106 | 1 412 | – | – | 443 | 754 | – | – | – |
| *Inventory: Farming supplies* | 2 614 | 4 086 | – | 4 255 | 8 450 | 5 355 | 14 128 | 14 918 | 14 918 |
| *Inventory: Food and food supplies* | 52 730 | 54 482 | 52 742 | 56 129 | 48 278 | 48 278 | 57 080 | 55 276 | 55 276 |
| *Inventory: Fuel, oil and gas* | 19 145 | 20 030 | 19 759 | 18 623 | 217 | 317 | 115 | 170 | 170 |
| *Inventory: Materials and supplies* | 2 170 | 3 426 | 199 | – | – | – | – | 44 | 47 |
| *Inventory: Medical supplies* | 165 979 | 180 991 | 200 348 | 175 855 | 203 516 | 221 708 | 213 818 | 217 473 | 220 535 |
| *Inventory: Medicine* | 909 985 | 978 311 | 969 297 | 1 202 274 | 1 176 699 | 1 288 108 | 1 469 741 | 1 526 740 | 1 546 831 |
| *Inventory: Other supplies* | 46 | – | – | – | 5 076 | 5 076 | 4 300 | 4 541 | 4 541 |
| *Consumable supplies* | 36 153 | 40 739 | 48 677 | 34 139 | 33 330 | 36 830 | 33 374 | 35 284 | 35 337 |
| *Consumable: Stationery,printing and office supplies* | 16 929 | 19 082 | 11 325 | 10 362 | 9 937 | 9 929 | 9 002 | 9 194 | 9 260 |
| *Operating leases* | 21 341 | 18 934 | 18 734 | 22 317 | 19 756 | 19 756 | 21 465 | 22 739 | 22 957 |
| *Property payments* | 71 352 | 84 451 | 85 464 | 114 808 | 71 148 | 78 657 | 90 299 | 95 186 | 95 244 |
| *Transport provided: Departmental activity* | 183 | 115 | 137 | 20 | 209 | 209 | 212 | 215 | 215 |
| *Travel and subsistence* | 24 277 | 26 835 | 25 637 | 11 026 | 17 704 | 21 381 | 22 169 | 21 055 | 21 841 |
| *Training and development* | 656 | 577 | 458 | – | 3 252 | 2 895 | 1 075 | 1 135 | 1 197 |
| *Operating payments* | 2 716 | 3 588 | 2 564 | 1 458 | 2 306 | 3 465 | 2 010 | 2 134 | 2 216 |
| *Venues and facilities* | 3 033 | 1 712 | 1 251 | – | 855 | 1 482 | – | – | – |
| *Rental and hiring* | 157 | 598 | 789 | 421 | 127 | 187 | – | – | – |
| Interest and rent on land | 2 829 | 162 | 134 | – | – | 238 | – | – | – |
| Interest (Incl. interest on finance leases) | 2 829 | 162 | 134 | – | – | 238 | – | – | – |
| **Transfers and subsidies** | **185 026** | **342 462** | **198 577** | **235 208** | **205 017** | **211 219** | **235 930** | **237 807** | **250 424** |
| Provinces and municipalities | 441 | 139 626 | – | 120 | 120 | – | – | – | – |
| Provinces | 212 | – | – | 102 | 102 | – | – | – | – |
| Provincial agencies and funds | 212 | – | – | 102 | 102 | – | – | – | – |
| Municipalities | 229 | 139 626 | – | 18 | 18 | – | – | – | – |
| Municipal bank accounts | – | 139 626 | – | 18 | 18 | – | – | – | – |
| Municipal agencies and funds | 229 | – | – | – | – | – | – | – | – |
| Departmental agencies and accounts | 164 | 112 | 113 | 101 | 101 | 83 | 139 | 113 | 113 |
| Departmental agencies (non-business entities) | 164 | 112 | 113 | 101 | 101 | 83 | 139 | 113 | 113 |
| Non-profit institutions | 164 191 | 187 335 | 182 733 | 228 702 | 198 511 | 193 413 | 229 140 | 230 671 | 243 288 |
| Households | 20 230 | 15 389 | 15 731 | 6 285 | 6 285 | 17 723 | 6 651 | 7 023 | 7 023 |
| Social benefits | 20 230 | 15 389 | 15 731 | 6 285 | 6 285 | 17 723 | 6 651 | 7 023 | 7 023 |
| **Payments for capital assets** | **39 353** | **75 958** | **4 683** | **7 005** | **18 752** | **15 090** | **21 613** | **3 128** | **5 742** |
| Machinery and equipment | 39 353 | 75 958 | 4 683 | 7 005 | 18 752 | 15 090 | 21 613 | 3 128 | 5 742 |
| Transport equipment | 25 188 | 47 001 | 1 829 | 3 752 | 3 662 | – | 11 028 | – | – |
| Other machinery and equipment | 14 165 | 28 957 | 2 854 | 3 253 | 15 090 | 15 090 | 10 585 | 3 128 | 5 742 |
| **Payments for financial assets** | – | – | – | – | – | – | – | – | – |
| **Total economic classification: Programme (number and** | **5 475 431** | **6 175 406** | **6 524 844** | **6 933 514** | **7 172 984** | **7 389 393** | **8 048 071** | **8 644 913** | **9 218 854** |

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

## 2.10 PERFORMANCE AND EXPENDITURE TRENDS

*Programme 2: District Health Services* shows a growth of 12.2 per cent on the adjusted budget for the first year of the Medium Term Expenditure Framework Period. The increase is due to increase of the HIV/AIDS Grant of R394 million in 2018/19 financial year.

The appropriated funding will be directed to the following services delivery priorities:

- Improve clinic and community health centres to achieve the IDEAL clinic status.
- Primary Health care services are provided within the District Health system (DHS).
- Reduction of maternal, infant and child mortality.
- Operation Vuka Sisebente (OVS) Partner with the private sector in order to accelerate the implementation of the MMC programme and expand access to ART for all citizens living with HIV and AIDS

## 2.11 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:<br>• Recruitment and retention<br>• HR Delegation Framework<br>• Determine a baseline for vacancies and an acceptable vacancy rate. This must be decreased by 20%<br>• Use of WISN to fill in vacant posts especially at PHC level |
| 2. Inadequate Mental Health Care Services in the province | a. Appoint 3 Mental Health Care Review Board<br>b. Increase from 9 to 18 Sub-district Mental Health Care Coordinators<br>c. Upgrade and build infrastructure for psychiatric patients that is compliant with Infrastructure Unit Support System (IUSS) guidelines. |
| 3. Increasing rate of maternal and child mortality | a. Appoint skilled health care workers to provide Maternal and Child healthcare services<br>b. Conduct continuous training and orientation<br>c. Conduct mentoring and onsite in-services training<br>d. Conduct monitoring and evaluation of MCWYH services<br>Continue training of Community Health Care workers on MCWH issues |
| 4. Increased incidence and mortalities from Malaria | a. Appoint Temporal Sprayers<br>b. Conduct indoor residual sprays<br>c. Conduct surveillance on Malaria prone breeding areas<br>Conduct community awareness campaigns |

| RISK | MITIGATING FACTORS |
|---|---|
| | d. Train Healthcare workers on diagnosing and management of malaria |
| 5. Inadequate management of health care waste | a. Appoint/delegate responsible managers in the facilities<br>b. Ensure substantive contract management of service provider<br>e. Develop an annual training plan for health care workers |
| 6. Inadequate community awareness on HIV/Aids/Tuberculosis | a. Implement ACSM strategy<br>b. Integrate with other partners in addressing poverty<br>c. Contribute to the development of Cross boarder MOU |
| 7. Inadequate information management | a. Procure equipment and appoint Data management personnel<br>b. Skills gap analysis and requisite training<br>c. Adhere to the National Archives Act by securing adequate facilities for record storage.<br>c. Contribute to the drafting and implementation of Record Management Policy |

# 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
- Maternal, infant and child mortality reduced
- Improvement of referrals to all institutions

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 2016/17 | Ehlanzeni 2016/17 | Gert Sibande 2016/17 | Nkangala 2016/17 |
|---|---|---|---|---|---|---|
| 1. EMS P1 urban response under 15 minutes rate | Quarterly | % | 72.3% | 75.5% | 73.4% | 68% |
| 2. EMS P1 rural response under 40 minutes rate | Quarterly | % | 69.5% | 71% | 69% | 68.5% |
| 3. EMS inter-facility transfer rate | Quarterly | % | 5% | 5% | 4% | 4% |

## 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 | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| 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 | 108 Operational Ambulances | 95 | 115 | 100 | 105 | 115 |
| | 2. Improve the use of resources by integrating PPTS into EMS operations | % | 0% | 20% | 20% | 80% | 60% | 100% | 100% |
| | 3. Improve maternal outcomes by increasing the number of Obstetric ambulances | No | Not in plan | 18 | 24 | 6 (cumulative 24) | 6 (cumulative 30) | 6 (cumulative 36) | 6 (cumulative 42) |
| | **Programme Performance/Customized Indicators (Sector Indicators)** | | | | | | | | |
| | 4. EMS P1 urban response under 15 minutes rate | % | 73% | 75.5% | 72.3% | 85% | 80% | 85% | 90% |
| | 5. EMS P1 rural response under 40 minutes rate | % | 66% | 71.5% | 69.5% | 80% | 75% | 80% | 85% |
| | 6. EMS inter-facility transfer rate | % | Not in plan | 4.6% | 5% | 40% | 40% | 45% | 60% |

## 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 2018/19 | TARGETS | | | |
|---|---|---|---|---|---|---|---|
| | | | | Q1 | Q2 | Q3 | Q4 |
| 1. Improve response time by increasing the number of Operational Ambulances | Annually | No | 100 Operational Ambulances | Annual Target | Annual Target | Annual Target | 100 Operational Ambulances |
| 2. Improve the use of resources by integrating PPTS into EMS operations | Quarterly | % | 60% | 60% | 60% | 60% | 60% |
| 3. Improve maternal outcomes by increasing the number of Obstetric ambulances | Annually | No | 6 (cumulative 30) | Annual Target | Annual Target | Annual Target | 6 (cumulative 30) |
| 4. EMS P1 urban response under 15 minutes rate | Quarterly | % | 80% | 80% | 80% | 80% | 80% |
| 5. EMS P1 rural response under 40 minutes rate | Quarterly | % | 75% | 75% | 75% | 75% | 75% |
| 6. EMS inter-facility transfer rate | Quarterly | % | 40% | 40% | 40% | 40% | 40% |

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# 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 | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | | 2018/19 | 2019/20 | 2020/21 |
| 1. Emergency transport | 299 274 | 305 351 | 321 913 | 345 238 | 352 404 | 365 414 | 380 800 | 412 009 | 439 426 |
| 2. Planned Patient Transport | 20 073 | 4 245 | 6 276 | 6 808 | 14 396 | 14 396 | 7 202 | 7 605 | 8 023 |
| **Total payments and estimates** | **319 347** | **309 596** | **328 189** | **352 046** | **366 800** | **379 810** | **388 002** | **419 614** | **447 449** |

### Summary of Provincial Expenditure Estimates by Economic Classification[1]

| | Outcome | | | Main appropriation | Adjusted appropriation | Revised estimate | Medium-term estimates | | |
|---|---|---|---|---|---|---|---|---|---|
| R thousand | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | | 2018/19 | 2019/20 | 2020/21 |
| **Current payments** | **285 973** | **286 847** | **318 671** | **342 058** | **345 830** | **362 407** | **374 726** | **405 715** | **433 132** |
| Compensation of employees | 217 007 | 232 102 | 267 257 | 288 606 | 290 509 | 306 310 | 314 963 | 342 698 | 370 114 |
| Salaries and wages | 190 173 | 199 095 | 228 697 | 251 233 | 253 136 | 264 987 | 268 345 | 292 350 | 315 789 |
| Social contributions | 26 834 | 33 007 | 38 560 | 37 373 | 37 373 | 41 323 | 46 618 | 50 348 | 54 325 |
| Goods and services | 68 720 | 54 715 | 51 407 | 53 452 | 55 321 | 56 097 | 59 763 | 63 017 | 63 018 |
| *Administrative fees* | 9 | 13 | 20 | 19 | 11 | 11 | 17 | 7 | 7 |
| *Minor Assets* | 8 | – | – | 183 | – | – | – | – | – |
| *Catering: Departmental activities* | 22 | 36 | 97 | 22 | 52 | 52 | – | – | – |
| *Communication (G&S)* | 2 082 | 2 001 | 1 952 | 2 038 | 1 468 | 1 468 | 1 547 | 1 633 | 1 634 |
| *Fleet services (including government motor transpo* | 48 883 | 38 409 | 32 687 | 35 856 | 36 297 | 34 919 | 38 257 | 40 399 | 40 399 |
| *Inventory: Clothing material and accessories* | – | – | – | – | 1 035 | 1 035 | – | – | – |
| *Inventory: Fuel, oil and gas* | 64 | 40 | 50 | 115 | – | – | – | 7 | 7 |
| *Inventory: Medical supplies* | 34 | 442 | 200 | – | 212 | 212 | 111 | 118 | 118 |
| *Inventory: Medicine* | 1 | 2 | – | – | – | – | – | 2 | 2 |
| *Consumable supplies* | 25 | 5 | 956 | 112 | 454 | 454 | 1 145 | 1 209 | 1 209 |
| *Consumable: Stationery,printing and office supplies* | 244 | 1 124 | 557 | 950 | 967 | 967 | 1 009 | 967 | 967 |
| *Operating leases* | 16 172 | 11 842 | 14 345 | 13 378 | 14 050 | 14 050 | 17 151 | 18 111 | 18 111 |
| *Property payments* | 186 | 139 | 193 | 228 | 328 | 2 482 | 379 | 400 | 400 |
| *Transport provided: Departmental activity* | 702 | 386 | – | 152 | – | – | – | 9 | 9 |
| *Travel and subsistence* | 288 | 216 | 350 | 239 | 287 | 287 | 127 | 135 | 135 |
| *Operating payments* | – | – | – | 160 | 160 | 160 | 20 | 20 | 20 |
| *Rental and hiring* | – | 60 | – | – | – | – | – | – | – |
| Interest and rent on land | 246 | 30 | 7 | – | – | – | – | – | – |
| Interest (Incl. interest on finance leases) | 246 | 30 | 7 | – | – | – | – | – | – |
| **Transfers and subsidies** | **322** | **544** | **129** | **–** | **–** | **389** | **–** | **–** | **–** |
| Households | 322 | 544 | 129 | – | – | 389 | – | – | – |
| Social benefits | 322 | 544 | 129 | – | – | 389 | – | – | – |
| **Payments for capital assets** | **33 052** | **22 205** | **9 389** | **9 988** | **20 970** | **17 014** | **13 276** | **13 899** | **14 317** |
| Machinery and equipment | 33 052 | 22 205 | 9 389 | 9 988 | 20 970 | 17 014 | 13 276 | 13 899 | 14 317 |
| Transport equipment | 32 853 | 22 026 | 2 994 | 9 295 | 20 371 | 16 415 | 12 677 | 13 358 | 13 776 |
| Other machinery and equipment | 199 | 179 | 6 395 | 693 | 599 | 599 | 599 | 541 | 541 |
| **Payments for financial assets** | – | – | – | – | – | – | – | – | – |
| **Total economic classification: Programme (number and** | **319 347** | **309 596** | **328 189** | **352 046** | **366 800** | **379 810** | **388 002** | **419 614** | **447 449** |

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

# 3.4 PERFORMANCE AND EXPENDITURE TRENDS

*Programme 3: Emergency Medical Services* shows an increase of 5.8 per cent in the 2018/19 financial year. The programme will prioritize the strengthening of PPT by ensuring the procurement of vehicles for District Hospitals, Provincial Hospitals and Tertiary Hospitals.

The Programme aims to achieve the following targets:

- Improve response time of P1 calls to less than 15 minutes in urban areas, from 80 per cent to 85 per cent of calls received.
- Improve the response time of P1 calls to less than 40 minutes in rural areas, from 65 per cent to 70 per cent of calls received.
- Increase from 4 to 10 (6 new) number of dedicated obstetric ambulances.

## 3.5 RISK MANAGEMENT

| RISK | MITIGATING FACTORS |
|---|---|
| 1. EMS failure to take control of PPTS (Planned Patient Transport Services) | a. Integration of PPTS into EMS<br>b. Implement Operational PPTS plan |
| 2. Ineffective Emergency Communication Center (ECC) | a. Emergency Communication Center staff training.<br>b. Multilingual Emergency Communication Center<br>c. Appointment of shift leaders.<br>d. Upgrading of the communication center system |
| 3. Inadequate/ inappropriate emergency vehicles<br>Inadequate/ inappropriately qualified personnel | a. Procure an additional EMS vehicles<br>b. Appropriate skilled ALS practitioners<br>c. Appointment of Emergency Care Technicians and ALS Practitioners |

# 4. BUDGET PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

## 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

### Regional Hospitals

1. Provision of eight core clinical domains for secondary services
    - Appointment of specialists in the core domains: Obstetrics & Gynaecology, Paediatrics, Orthopaedics, Internal Medicine, Radiology, Psychiatry, General Surgery, Anaesthesia
    - Appointment of Medical Officers to support the specialists as per HPCSA guidelines (six full time Medical Officers per clinical domain)
    - Acquiring services of an Ophthalmologist through appointment or outreach services by tertiary hospitals

2. Improve quality of care by ensuring that regional hospitals comply with the national core standards
    - Procurement of lifesaving equipment (emergency trolleys, defibrillators)
    - Coordination with Department of Community Safety Liaison & Security for additional security personnel so as to cover all strategic areas and access control

3. Coordinate the referral network within the district through quarterly cluster meeting
    - Conduct quarterly cluster meetings with feeder facilities
    - Improve quality of care by ensuring that regional hospitals comply with the extreme and vital measures of the national core standards

### Specialised TB

1. None of the TB hospitals comply with all vital and extreme measures of the National Core standards. The following are the underlying causes:
    - TB hospitals are currently assessed as district hospitals, while they do not render the same services and have not been allocated the same resources. There is not a specific tool in place to assess TB hospitals.
    - When TB hospitals were integrated in the Public Health Services, a generic organisational structure was provided which does not address the special needs at TB hospitals in terms of providing comprehensive care. For example, some TB hospitals do not have posts for Audiologists or Data capturers on their organisational structure
    - Two of the 5 TB hospitals in Mpumalanga are currently leased from SANTA and this poses challenges in terms of the maintenance and cost involved in the leasing of the structure. 4 out of the 5 TB hospitals have infrastructure challenges which contribute to the relatively low scores achieved.

2. Patient complaints can be reduced if the decentralisation of DR TB care is escalated to satellite level.

3. The decentralisation of the implementation of the Bedaquiline regimen will also assist in improving patient care.

## PRIORITIES

1. Improve compliance with National Core Standards:

    - TB specific NCS tool to be developed and implemented.
    - Increase of 5 % per institution per annum in terms of the National Core standards assessments. This priority will then be universal to all TB institutions
    - Decentralisation of DR treatment to satellite level

2. Decentralisation of the implementation of the Bedaquiline regimen to 80% of the TB institutions

3. Improved monitoring of lease agreement and improved infrastructure support

## 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. Complaint Resolution within 25 working days rate (Regional Hospitals) | Quarterly | % |

## TABLE PHS1: STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR REGIONAL HOSPITALS

| Strategic objective statement | Indicator | Indicator Type | Audited/Actual performance | | | Estimated performance | Medium term targets | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| Improve quality of health care | **Strategic Objective/Provincial Indicators** | | | | | | | | |
| | 1. Functional Adverse Events Committees | No | Not in plan | 0 | | 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 | 100% 3/3 | 100% 3/3 | 100% 3/3 | 100% 3/3 |
| | 3. Average Length of Stay (Regional Hospitals) | No | 4.4 days | 4.6 days | 4.4 days | 4.6 days | 4.7 days | 4.7 days | 4.7 days |
| | 4. Inpatient Bed Utilisation Rate (Regional Hospitals) | % | 74.1% | 80.3% | 81.2% | 75% | 75% | 75% | 75% |
| | 5. Expenditure per PDE (Regional Hospitals) | R | R2,411 | R2,614 | R2 985 | R2.885 | R3.058 | R3.241 | R3,435 |
| | 6. Complaint Resolution within 25 working days rate (Regional Hospitals) | % | 93.6% | 98.7% | 100% | 95% (237/249) | 90% | 90% | 90% |

## TABLE PHS2: QUARTERLY TARGETS FOR REGIONAL HOSPITALS

| INDICATOR | Frequency of Reporting (Quarterly, Bi-annual, Annual) | Indicator Type | ANNUAL TARGET 2018/19 | 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 | 4.7 days | 4.7 days | 4.7 days | 4.7 days | 4.7 days |
| 4. Inpatient Bed Utilisation Rate (Regional Hospitals) | Quarterly | % | 75% | 75% | 75% | 75% | 75% |
| 5. Expenditure per PDE (Regional Hospitals) | Quarterly | R | R3.058 | R3158 | R2 958 | R3158 | R2 958 |
| 6. Complaint Resolution within 25 working days rate (Regional Hospitals) | Quarterly | % | 90% | 90% | 90% | 90% | 90% |

## 4.4 PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR SUB PROGRAMMES 4.2 to 4.6: 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 | 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 | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| 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 | % | 100% | 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 | 40% (2/5) | 100% (5/5) | 100% (5/5) | 100% (5/5) |
| | 3. Complaint Resolution within 25 working days rate (Specialised Hospitals) | % | 80% | 100% | 97.3% | 95% (19/20) | 95% | 95% | 95% |

## TABLE PHS4: QUARTERLY TARGETS FOR SPECIALISED HOSPITALS

| INDICATOR | Frequency of Reporting (Quarterly, Bi-annual, Annual) | Indicator Type | ANNUAL TARGET 2018/19 | 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 | % | 100% (5/5) | Annual target | Annual target | Annual target | 100% (5/5) |
| 3. Complaint Resolution within 25 working days rate (Specialised Hospitals) | Quarterly | % | 95% | 95% | 95% | 95% | 95% |

# 4.5 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 | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | | 2018/19 | 2019/20 | 2020/21 |
| 1. General (Regional) Hospitals | 854 240 | 937 555 | 1 005 225 | 1 086 558 | 1 066 415 | 1 120 886 | 1 152 331 | 1 245 104 | 1 325 043 |
| 2. Tuberculosis Hospitals | 158 034 | 183 459 | 181 906 | 176 708 | 193 210 | 185 081 | 197 021 | 209 116 | 220 774 |
| 3. Psychiatric/ Mental Hospitals | 34 992 | 53 371 | 34 349 | 41 639 | 41 639 | 41 639 | 44 054 | 46 521 | 49 080 |
| 4. Sub-acute, Step down and Chronic Medical Hospitals | – | – | – | – | – | – | – | – | – |
| 5. Dental Training Hospitals | – | – | – | – | – | – | – | – | – |
| 6. Other Specialised Hospitals | – | – | – | – | – | – | – | – | – |
| **Total payments and estimates** | **1 047 266** | **1 174 385** | **1 221 480** | **1 304 905** | **1 301 264** | **1 347 606** | **1 393 406** | **1 500 741** | **1 594 897** |

### Summary of Provincial Expenditure Estimates by Economic Classification[1]

| | Outcome | | | Main appropriation | Adjusted appropriation | Revised estimate | Medium-term estimates | | |
|---|---|---|---|---|---|---|---|---|---|
| R thousand | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | | 2018/19 | 2019/20 | 2020/21 |
| **Current payments** | **1 001 131** | **1 106 323** | **1 214 547** | **1 301 206** | **1 299 707** | **1 341 615** | **1 391 602** | **1 498 931** | **1 593 067** |
| Compensation of employees | 769 083 | 828 934 | 924 303 | 1 009 847 | 1 004 718 | 1 009 748 | 1 074 783 | 1 173 186 | 1 267 040 |
| Salaries and wages | 686 926 | 736 559 | 822 764 | 899 421 | 894 292 | 901 205 | 951 458 | 1 039 995 | 1 123 193 |
| Social contributions | 82 157 | 92 375 | 101 539 | 110 426 | 110 426 | 108 543 | 123 325 | 133 191 | 143 847 |
| Goods and services | 232 047 | 277 188 | 290 234 | 291 359 | 294 989 | 331 864 | 316 819 | 325 745 | 326 027 |
| *Administrative fees* | 17 | 36 | 11 282 | 8 740 | 30 492 | 30 492 | 9 297 | 9 818 | 9 818 |
| *Minor Assets* | 511 | 527 | 789 | 604 | 692 | 692 | 383 | 382 | 382 |
| *Catering: Departmental activities* | 33 | 24 | 6 | 5 | 6 | 7 | – | – | – |
| *Communication (G&S)* | 3 744 | 3 619 | 3 592 | 3 888 | 3 294 | 3 294 | 3 797 | 3 311 | 3 311 |
| *Computer services* | – | 5 | 507 | 458 | 40 | 40 | – | 27 | 27 |
| *Laboratory services* | 30 680 | 33 216 | 28 227 | 37 589 | 29 690 | 33 990 | 42 832 | 45 117 | 45 117 |
| *Contractors* | 1 619 | 588 | 35 093 | 42 285 | 42 032 | 42 032 | 44 538 | 47 032 | 49 591 |
| *Agency and support / outsourced services* | 2 924 | 4 456 | 8 024 | 4 267 | 6 886 | 14 886 | 7 358 | 7 711 | 7 711 |
| *Fleet services (including government motor transpo* | 9 149 | 9 744 | 9 604 | 9 988 | 7 905 | 8 192 | 8 818 | 7 207 | 7 207 |
| *Inventory: Clothing material and accessories* | 710 | 487 | – | – | 8 | 8 | – | – | – |
| *Inventory: Farming supplies* | – | – | – | – | 89 | 89 | – | – | – |
| *Inventory: Food and food supplies* | 23 274 | 19 812 | 19 012 | 17 507 | 16 112 | 16 554 | 22 242 | 23 005 | 23 005 |
| *Inventory: Fuel, oil and gas* | 6 390 | 5 796 | 4 985 | 3 501 | 43 | 3 545 | 46 | 236 | 236 |
| *Inventory: Materials and supplies* | 862 | 270 | – | – | – | – | – | 25 | 25 |
| *Inventory: Medical supplies* | 50 724 | 62 708 | 63 277 | 63 325 | 55 723 | 55 723 | 66 169 | 66 527 | 66 527 |
| *Inventory: Medicine* | 61 228 | 88 466 | 61 868 | 54 127 | 63 009 | 82 009 | 66 411 | 70 130 | 70 130 |
| *Inventory: Other supplies* | – | – | – | – | 1 681 | 1 681 | 1 995 | 2 104 | 2 104 |
| *Consumable supplies* | 8 396 | 7 834 | 11 315 | 9 613 | 6 397 | 7 477 | 9 107 | 9 613 | 7 336 |
| *Consumable: Stationery,printing and office supplies* | 1 798 | 2 179 | 2 305 | 2 415 | 2 155 | 2 155 | 2 297 | 2 094 | 2 094 |
| *Operating leases* | 5 317 | 4 439 | 4 103 | 4 290 | 4 314 | 4 314 | 5 038 | 4 467 | 4 467 |
| *Property payments* | 22 256 | 30 430 | 21 453 | 27 322 | 20 087 | 20 087 | 21 961 | 22 131 | 22 131 |
| *Transport provided: Departmental activity* | 8 | 42 | 44 | – | 104 | 104 | 79 | 83 | 83 |
| *Travel and subsistence* | 2 270 | 2 053 | 2 676 | 1 069 | 2 032 | 2 032 | 1 974 | 2 114 | 2 114 |
| *Training and development* | 9 | 176 | 1 773 | – | 2 023 | 2 286 | 2 388 | 2 522 | 2 522 |
| *Operating payments* | 128 | 281 | 299 | 366 | 175 | 175 | 89 | 89 | 89 |
| Interest and rent on land | 1 | 201 | 10 | – | – | 3 | – | – | – |
| Interest (Incl. interest on finance leases) | 1 | 201 | 10 | – | – | 3 | – | – | – |
| **Transfers and subsidies** | **39 779** | **56 090** | **4 433** | **947** | **947** | **5 181** | **1 040** | **1 098** | **1 118** |
| Provinces and municipalities | 44 | – | – | – | – | – | – | – | – |
| Municipalities | 44 | – | – | – | – | – | – | – | – |
| Municipal bank accounts | 44 | – | – | – | – | – | – | – | – |
| Departmental agencies and accounts | 42 | 39 | 48 | 101 | 101 | 25 | 107 | 113 | 79 |
| Departmental agencies (non-business entities) | 42 | 39 | 48 | 101 | 101 | 25 | 107 | 113 | 79 |
| Non-profit institutions | 34 992 | 53 371 | – | – | – | 53 | – | – | – |
| Households | 4 701 | 2 680 | 4 385 | 846 | 846 | 5 103 | 933 | 985 | 1 039 |
| Social benefits | 4 701 | 2 680 | 4 385 | 846 | 846 | 5 103 | 933 | 985 | 1 039 |
| **Payments for capital assets** | **6 356** | **11 972** | **2 500** | **2 752** | **610** | **810** | **764** | **712** | **712** |
| Machinery and equipment | 6 356 | 11 972 | 2 500 | 2 752 | 610 | 810 | 764 | 712 | 712 |
| Transport equipment | 3 821 | 4 214 | – | 25 | – | – | – | – | – |
| Other machinery and equipment | 2 535 | 7 758 | 2 500 | 2 727 | 610 | 810 | 764 | 712 | 712 |
| **Payments for financial assets** | – | – | – | – | – | – | – | – | – |
| **Total economic classification: Programme (number and** | **1 047 266** | **1 174 385** | **1 221 480** | **1 304 905** | **1 301 264** | **1 347 606** | **1 393 406** | **1 500 741** | **1 594 897** |

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

# 4.6 PERFORMANCE AND EXPENDITURE TRENDS

*Programme 4: The Provincial Hospital Services* shows a growth of 7.1 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 specialized hospital services. This programme received 10.8 per cent of the allocated budget for 2018/19 financial year.

The Programme will focus on the following areas in the MTEF period:

- Establishment of blood banks in a regional hospitals
- Increase number of neonatal ICU beds in level 2 & 3 hospitals according to norms and standards (1:1000 live birth)
- Establish more clinical domains according to the level of care (by appointing specialist)
- Continuous implementation and monitoring of core standards
- Revitalize the existing Psychiatric unit in Ermelo in line with mental health norms and standards

## 4.7 RISK MANAGEMENT

| RISK | MITIGATING FACTORS |
|---|---|
| 1. Inadequate compliance with infection control guidelines | a. Motivate for infrastructure project for the construction of isolation wards<br>b. Create and fill posts for infection control officers<br>c. Improve monitoring of compliance with policies and procedure<br>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<br>b. Increase security measures for visitor control<br>c. Awareness campaign on TB<br>d. Monitor TB cure rate<br>e. Determine number of vacant posts and commence with recruitment<br>f. Enter into MOU with private sector laboratories |
| 3. Incomplete access of level 2 services | a. Develop equipment procurement plan<br>b. Regional hospitals to hold referral meetings with feeder facilities<br>c. Monitor compliance to attendance registers by sessional doctors<br>d. Implement recruitment and retention strategy for scarce skills |
| 4. Non-compliance with professional clinical standards and protocols | a. Strengthen quarterly clinical audits<br>b. Enforce compliance to policies and procedures<br>c. Motivate for appointment of senior professional staff for supervision and mentoring purposes<br>d. Staff debriefing, motivation and team-building |
| 5. Inadequate medical and condemned pharmaceutical waste management | a. Appointment of dedicated Waste Manager<br>b. Secure budget and approval for waste storage facilities |

# 5. BUDGET PROGRAMME 5: PROVINCIAL TERTIARY HOSPITAL SERVICES

## 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 SUB-PROGRAMME 5.2 – PROVINCIAL TERTIARY HOSPITAL SERVICES

### 5.2.1 PRIORITIES

1. Improve quality of care by ensuring compliance to the national core standards
   - Procurement of lifesaving equipment (Rob Ferreira: C-Paps, ventilators)
   - Coordination with Department of Community Safety Liaison & Security for additional security personnel so as to cover all strategic areas and access control

2. Reduce average length of stay (ALOS)
   - Down referral of patients to district hospitals

3. Improve clinical governance at tertiary hospitals
   - Conduct the monthly Mortality and Morbidity reviews in all domains

# 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 | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| Improve quality of health care | **Strategic Objective/Provincial Indicators** | | | | | | | | |
| | 1. Functional Adverse Events Committee | No | 2 | 2 | 2 | 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 | 100% (2/2) | 100% (2/2) | 100% (2/2) | 100% (2/2) |
| | 3. Average Length of Stay (Tertiary Hospitals) | No | 5.7 days | 6.8 days | 7.1 days | 5.3 days | 5.6 days | 5.6 days | 5.6 days |
| | 4. Inpatient Bed Utilisation Rate (Tertiary Hospitals) | % | 80.5% | 81% | 85.8% | 75% | 75% | 75% | 75% |
| | 5. Expenditure per PDE (Tertiary Hospitals) | R | R2,207 | R2,785 | R2,910 | R3,619 | R3,836 | R4066 | R4310 |
| Improve quality of health care | 6. Complaint Resolution within 25 working days rate (Tertiary Hospitals) | % | 100% | 99.4% | 88.3% | 95% (238/250) | 90% | 90% | 90% |

## TABLE C&THS 2: QUARTERLY TARGETS FOR PROVINCIAL TERTIARY HOSPITAL SERVICES

| INDICATOR | Frequency of Reporting (Quarterly, Bi-annual, Annual) | Indicator Type | ANNUAL TARGET 2018/19 | 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 | 5.6 days | 5.6 days | 5.6 days | 5.6 days | 5.6 days |
| 4. Inpatient Bed Utilisation Rate (Tertiary Hospitals) | Quarterly | % | 75% | 75% | 75% | 75% | 75% |
| 5. Expenditure per PDE (Tertiary Hospitals) | Quarterly | R | R3,836 | R3,419 | R3,719 | R3,719 | R3,619 |
| 6. Complaint Resolution within 25 working days rate (Tertiary Hospitals) | Quarterly | % | 90% | 90% | 90% | 90% | 90% |

# 5.3 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 | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | | 2018/19 | 2019/20 | 2020/21 |
| 1. Central Hospital Services | – | – | – | – | – | – | – | – | – |
| 2. Provincial Tertiary Hospital Services | 943 975 | 991 759 | 1 026 751 | 1 101 054 | 1 112 100 | 1 177 393 | 1 218 481 | 1 314 584 | 1 393 989 |
| **Total payments and estimates** | **943 975** | **991 759** | **1 026 751** | **1 101 054** | **1 112 100** | **1 177 393** | **1 218 481** | **1 314 584** | **1 393 989** |

### Summary of Provincial Expenditure Estimates by Economic Classification[1]

| | Outcome | | | Main appropriation | Adjusted appropriation | Revised estimate | Medium-term estimates | | |
|---|---|---|---|---|---|---|---|---|---|
| R thousand | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | | 2018/19 | 2019/20 | 2020/21 |
| **Current payments** | **931 234** | **984 741** | **1 009 360** | **1 084 000** | **1 079 049** | **1 143 931** | **1 178 611** | **1 288 303** | **1 366 033** |
| Compensation of employees | 638 397 | 674 804 | 713 991 | 789 605 | 781 072 | 796 595 | 872 071 | 953 177 | 1 029 431 |
| Salaries and wages | 571 532 | 601 270 | 637 784 | 698 147 | 689 614 | 712 870 | 775 650 | 851 739 | 919 980 |
| Social contributions | 66 865 | 73 534 | 76 207 | 91 458 | 91 458 | 83 725 | 96 421 | 101 438 | 109 451 |
| Goods and services | 292 837 | 309 919 | 295 365 | 294 395 | 297 977 | 347 336 | 306 540 | 335 126 | 336 602 |
| *Administrative fees* | 68 | 37 | 10 446 | 6 971 | 15 461 | 15 461 | 8 565 | 9 045 | 9 045 |
| *Minor Assets* | 718 | 1 311 | 925 | 453 | 410 | 410 | – | – | – |
| *Catering: Departmental activities* | 7 | 11 | 10 | 2 | 12 | 12 | – | – | – |
| *Communication (G&S)* | 3 925 | 4 570 | 4 241 | 3 623 | 3 238 | 3 238 | 3 467 | 3 682 | 3 682 |
| *Computer services* | 396 | 356 | 22 | 23 | 22 | 22 | 25 | 26 | 26 |
| *Laboratory services* | 48 039 | 45 233 | 41 468 | 37 773 | 46 750 | 56 425 | 45 832 | 52 034 | 52 034 |
| *Contractors* | 16 854 | 27 882 | 19 417 | 13 494 | 22 150 | 31 472 | 23 096 | 23 346 | 24 822 |
| *Agency and support / outsourced services* | 5 565 | 10 861 | 15 892 | 9 379 | 13 891 | 23 701 | 14 641 | 15 460 | 15 460 |
| *Fleet services (including government motor transpor* | 4 472 | 4 143 | 3 619 | 5 581 | 3 962 | 3 962 | 4 176 | 4 410 | 4 410 |
| *Inventory: Clothing material and accessories* | 526 | 303 | – | – | – | 3 | – | – | – |
| *Inventory: Food and food supplies* | 13 965 | 12 019 | 14 322 | 12 416 | 12 639 | 12 639 | 13 186 | 13 924 | 13 924 |
| *Inventory: Fuel, oil and gas* | 5 629 | 7 556 | 6 158 | 5 271 | 171 | 171 | 105 | 111 | 111 |
| *Inventory: Materials and supplies* | 26 | 222 | – | – | – | – | – | – | – |
| *Inventory: Medical supplies* | 100 919 | 105 468 | 91 105 | 111 539 | 77 588 | 79 877 | 88 425 | 101 403 | 101 403 |
| *Inventory: Medicine* | 49 116 | 51 439 | 46 584 | 43 057 | 58 047 | 76 307 | 60 424 | 64 608 | 64 608 |
| *Inventory: Other supplies* | – | – | – | – | 2 139 | 2 139 | 2 254 | 2 365 | 2 365 |
| *Consumable supplies* | 5 552 | 6 308 | 5 852 | 5 502 | 5 762 | 5 762 | 4 259 | 4 498 | 4 498 |
| *Consumable: Stationery,printing and office supplies* | 1 758 | 1 685 | 1 378 | 1 156 | 1 337 | 1 337 | 1 156 | 1 221 | 1 221 |
| *Operating leases* | 3 800 | 886 | 566 | 1 000 | 1 172 | 1 172 | 1 235 | 1 304 | 1 304 |
| *Property payments* | 30 515 | 28 679 | 32 393 | 36 352 | 32 249 | 32 249 | 34 970 | 36 928 | 36 928 |
| *Transport provided: Departmental activity* | – | – | – | 33 | 63 | 63 | – | – | – |
| *Travel and subsistence* | 780 | 594 | 615 | 598 | 827 | 827 | 654 | 691 | 691 |
| *Training and development* | 17 | – | 219 | 12 | 4 | 4 | – | – | – |
| *Operating payments* | 190 | 356 | 133 | 160 | 83 | 83 | 70 | 70 | 70 |
| Interest and rent on land | – | 18 | 4 | – | – | – | – | – | – |
| Interest (Incl. interest on finance leases) | – | 18 | 4 | – | – | – | – | – | – |
| **Transfers and subsidies** | **4 582** | **1 891** | **2 389** | **1 081** | **881** | **1 557** | **885** | **934** | **986** |
| Provinces and municipalities | 29 | – | – | – | – | – | – | – | – |
| Municipalities | 29 | – | – | – | – | – | – | – | – |
| Municipal bank accounts | 29 | – | – | – | – | – | – | – | – |
| Departmental agencies and accounts | 11 | 80 | 16 | 44 | 44 | 3 | 47 | 50 | 53 |
| Departmental agencies (non-business entities) | 11 | 80 | 16 | 44 | 44 | 3 | 47 | 50 | 53 |
| Households | 4 542 | 1 811 | 2 373 | 1 037 | 837 | 1 554 | 838 | 884 | 933 |
| Social benefits | 4 542 | 1 811 | 2 373 | 1 037 | 837 | 1 554 | 838 | 884 | 933 |
| **Payments for capital assets** | **8 159** | **5 127** | **15 002** | **15 973** | **32 170** | **31 905** | **38 985** | **25 347** | **26 970** |
| Buildings and other fixed structures | – | – | – | – | – | 9 | – | – | – |
| Buildings | – | – | – | – | – | 9 | – | – | – |
| Machinery and equipment | 8 159 | 5 127 | 15 002 | 15 973 | 32 170 | 31 896 | 38 985 | 25 347 | 26 970 |
| Transport equipment | 282 | 703 | – | – | – | – | – | – | – |
| Other machinery and equipment | 7 877 | 4 424 | 15 002 | 15 973 | 32 170 | 31 896 | 38 985 | 25 347 | 26 970 |
| **Payments for financial assets** | – | – | – | – | – | – | – | – | – |
| **Total economic classification: Programme (number and** | **943 975** | **991 759** | **1 026 751** | **1 101 054** | **1 112 100** | **1 177 393** | **1 218 481** | **1 314 584** | **1 393 989** |

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

# 5.4 PERFORMANCE AND EXPENDITURE TRENDS

*Programme 5: Central Hospital Services* consists of Rob Ferreira Hospital and Witbank Hospital budget increase of 9.6 per cent in 2018/19 financial year, the increase mainly went to key cost drivers. 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.

## 5.5 RISK MANAGEMENT

| RISK | MITIGATING FACTORS |
|---|---|
| 1. Incomplete package of level 3 services | a. Increase number of registrars<br>b. Provincial tender for medical equipment and consumables, as opposed to quotation system<br>c. Strengthen relationship with academic institutions<br>d. Implement Delegation Framework of HR authority to CEOs<br>e. Increase the number of clinical specialists domains |
| 2. Clinical adverse events | a. Fill the critical vacant positions<br>b. Develop implement and monitor clinical policies and procedures<br>c. Procure the needed medical equipment and consumables<br>d. Strengthen security measures in the units ( in relation to record keeping)<br>e. Strengthen supervision<br>f. Conduct clinical audits and peer reviews |
| 3. Poor patient care and long patient waiting times | a. Train staff in customer care<br>b. Re-launch Batho Pele Principles<br>c. Reinforcement of referral policy<br>d. Tertiary hospitals to conduct referral meeting with feeder hospitals<br>e. 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

| Training Programme | Target Group (Professional Nurses; Data Capturers; Senior Managers; etc) | Estimated Number of Beneficiaries | Quarter (Q1, Q2, Q3 or Q4) |
|---|---|---|---|
| Training of Nurse students | Nurses | 200 | Quarter 1 & 4 |
| Training of Health professionals | All health professionals | 500 | All quarters |
| Training of Health workers | All health workers | 100 | All quarters |

## 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 | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| | **Strategic Objective/Provincial Indicators** | | | | | | | | |
| | 1. Improve human resource efficiency by training health care professionals on critical clinical skills | No | Not in plan | 4 473 | 2841 | 5000 | 5000 | 5000 | 5000 |
| | **Programme Performance/Customized Indicators (Sector Indicators)** | | | | | | | | |
| | 2. Number of Bursaries awarded for first year medicine students[5] | No | Not in plan | 99 | 10 | 10 | 0 | 0 | 0 |
| | 3. Number of Bursaries awarded for first year nursing students | No | Not in plan | 310 | 241 | 250 | 90 | 90 | 90 |

[5] Services are rendered by the Department of Basic Education with effect from 2018/17 henceforth

## 6.4 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[6] | Annual | No | 0 | 0 | 0 | 0 | 0 |
| 3. Number of Bursaries awarded for first year nursing students | Annual | No | 90 | Annual Target | Annual Target | Annual Target | 90 |

[6] Services are rendered by the Department of Basic Education with effect from 2018/17 henceforth

# 6.5 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 | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | | 2018/19 | 2019/20 | 2020/21 |
| 1. Nurse Training Colleges | 172 097 | 179 593 | 181 769 | 203 216 | 199 944 | 159 915 | 165 671 | 166 812 | 175 453 |
| 2. EMS Training Colleges | 2 152 | 2 473 | 4 634 | 812 | 4 841 | 2 595 | 4 795 | 5 016 | 5 414 |
| 3. Bursaries | 1 588 | 43 317 | 70 575 | 68 912 | 69 064 | 73 443 | 73 957 | 83 973 | 78 389 |
| 4. Primary Health Care Training | 3 322 | 4 081 | 4 627 | 20 885 | 6 451 | 7 441 | 6 140 | 5 917 | 6 383 |
| 5. Training Other | 126 049 | 139 769 | 111 296 | 139 810 | 139 076 | 124 246 | 138 210 | 148 554 | 159 141 |
| **Total payments and estimates** | **305 208** | **369 233** | **372 901** | **433 635** | **419 376** | **367 640** | **388 773** | **410 272** | **424 780** |

### Summary of Provincial Expenditure Estimates by Economic Classification[1]

| | Outcome | | | Main appropriation | Adjusted appropriation | Revised estimate | Medium-term estimates | | |
|---|---|---|---|---|---|---|---|---|---|
| R thousand | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | | 2018/19 | 2019/20 | 2020/21 |
| **Current payments** | **275 891** | **312 862** | **307 244** | **361 259** | **337 452** | **285 642** | **303 120** | **320 002** | **336 620** |
| Compensation of employees | 221 611 | 240 541 | 253 997 | 318 345 | 289 693 | 232 146 | 248 659 | 268 552 | 290 036 |
| Salaries and wages | 198 402 | 215 523 | 229 182 | 280 947 | 256 029 | 209 402 | 226 020 | 245 478 | 265 132 |
| Social contributions | 23 209 | 25 018 | 24 815 | 37 398 | 33 664 | 22 744 | 22 639 | 23 074 | 24 904 |
| Goods and services | 54 280 | 72 321 | 53 146 | 42 914 | 47 759 | 53 496 | 54 461 | 51 450 | 46 584 |
| *Administrative fees* | 449 | 359 | 281 | 395 | 163 | 820 | 882 | 941 | 941 |
| *Minor Assets* | 40 | 14 | – | – | 10 | 10 | 132 | 139 | 147 |
| *Bursaries: Employees* | 2 627 | 1 798 | 604 | – | 1 211 | 1 182 | – | – | – |
| *Catering: Departmental activities* | 615 | 333 | 268 | – | 84 | 84 | – | – | – |
| *Communication (G&S)* | 209 | 210 | 213 | 233 | 246 | 253 | 258 | 227 | 228 |
| *Computer services* | – | – | – | – | 209 | 209 | – | – | – |
| *Consultants and professional services: Business and* | – | – | 315 | – | 122 | 122 | 253 | 267 | 267 |
| *Contractors* | 279 | 265 | – | – | – | – | – | – | – |
| *Agency and support / outsourced services* | 21 614 | 32 404 | 23 529 | 17 387 | 19 494 | 18 427 | 24 666 | 22 567 | 22 979 |
| *Fleet services (including government motor transpo* | 1 127 | 917 | 1 047 | 1 495 | 750 | 1 051 | 1 107 | 777 | 777 |
| *Inventory: Clothing material and accessories* | 218 | 150 | – | – | – | 5 | – | – | – |
| *Inventory: Fuel, oil and gas* | – | 19 | – | – | – | 11 | – | – | – |
| *Inventory: Learner and teacher support material* | – | – | – | – | – | – | 15 | 16 | 17 |
| *Inventory: Materials and supplies* | – | 51 | – | – | – | – | – | – | – |
| *Inventory: Other supplies* | – | – | – | – | – | 21 | – | – | – |
| *Consumable supplies* | 2 303 | 2 347 | 2 047 | 2 708 | 1 725 | 1 876 | 2 686 | 1 735 | 1 743 |
| *Consumable: Stationery,printing and office supplies* | 320 | 531 | 244 | 1 446 | 144 | 349 | 926 | 280 | 286 |
| *Operating leases* | 300 | 93 | 144 | 300 | 106 | 106 | 152 | 115 | 115 |
| *Property payments* | 487 | 1 569 | 441 | 954 | 306 | 337 | 466 | 336 | 336 |
| *Travel and subsistence* | 19 018 | 24 408 | 21 383 | 14 009 | 20 691 | 26 094 | 20 582 | 21 551 | 15 849 |
| *Training and development* | 4 589 | 6 518 | 2 300 | 3 367 | 2 382 | 2 409 | 2 068 | 2 184 | 2 573 |
| *Operating payments* | 71 | 248 | 246 | 620 | 116 | 130 | 225 | 272 | 283 |
| *Venues and facilities* | 7 | 87 | 34 | – | – | – | – | – | – |
| *Rental and hiring* | 7 | – | 50 | – | – | – | 43 | 43 | 43 |
| Interest and rent on land | – | – | 101 | – | – | – | – | – | – |
| Interest (Incl. interest on finance leases) | – | – | 101 | – | – | – | – | – | – |
| **Transfers and subsidies** | **26 807** | **56 371** | **65 621** | **69 214** | **66 539** | **66 539** | **83 473** | **88 147** | **88 149** |
| Provinces and municipalities | 16 | – | – | – | – | – | – | – | – |
| Municipalities | 16 | – | – | – | – | – | – | – | – |
| Municipal bank accounts | 16 | – | – | – | – | – | – | – | – |
| Departmental agencies and accounts | – | – | – | 3 785 | 6 785 | 6 772 | 14 001 | 14 785 | 14 785 |
| Departmental agencies (non-business entities) | – | – | – | 3 785 | 6 785 | 6 772 | 14 001 | 14 785 | 14 785 |
| Households | 26 791 | 56 371 | 65 621 | 65 429 | 59 754 | 59 767 | 69 472 | 73 362 | 73 364 |
| Social benefits | 26 791 | 56 371 | 65 621 | 65 429 | 59 754 | 59 767 | 69 472 | 73 362 | 73 364 |
| **Payments for capital assets** | **2 510** | **–** | **36** | **3 162** | **15 385** | **15 459** | **2 180** | **2 123** | **11** |
| Machinery and equipment | 2 510 | – | 36 | 3 162 | 15 385 | 15 459 | 2 180 | 2 123 | 11 |
| Transport equipment | 2 504 | – | – | 162 | – | – | – | – | – |
| Other machinery and equipment | 6 | – | 36 | 3 000 | 15 385 | 15 459 | 2 180 | 2 123 | 11 |
| **Payments for financial assets** | – | – | – | – | – | – | – | – | – |
| **Total economic classification: Programme (number and** | **305 208** | **369 233** | **372 901** | **433 635** | **419 376** | **367 640** | **388 773** | **410 272** | **424 780** |

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

# 6.6 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 increase due to capacity to implement programmes.

*PHC Training* – has shown a slight decline in 2018/19. It includes 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.

## 6.7 RISK MANAGEMENT

| RISK | MITIGATING FACTORS |
|---|---|
| 1. Inadequate Management of the Bursary system. | Monitor compliance through Persal |
| 2. Inadequate implementation of the training cycle | Conduct needs analysis and training evaluation |
| 3. Ineffective management of performance | Conduct training on PMDS |

# 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 (LBTO), Telemedicine
- **Health Technology Services** (Clinical Engineering, Imaging Services)
- **Laundry Services**

## 7.2 PRIORITIES

List in point form the key priorities of the Health Care Support Budget programme for the MTEF period

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 | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| 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. | % | 82% (255/310) | 79% (246/310) | 92 % (286/310) | 95% (295/310) | 95% (295/310) | 95 % (295/310) | 95 % (295/310) |
| | 2. Number of patients initiated on Central Chronic Medicine Dispensing and Distribution (CCMDD) | No | Not in plan | Not in plan | 87 063 | 135 179 | 220 000 | 235 000 | 250 000 |
| | 3. Improve access to quality of care through compliance with Radiation Control prescripts by all facilities with X-Ray equipment | % | Not in plan | 70% (21/30 facilities) | 80% (24/30) | 100% (30/30 facilities) | 100% (30/30) | 100% (30/30) | 100% (30/30) |
| | 4. Improve laundry services by developing a provincial laundry model | Text | Not in plan | Not in plan | Not in plan | Approved provincial laundry service model | - | - | - |
| | 5. Number of hospitals providing laundry services | No | Not in plan | 18/33 | 21/33 | 21/33 | 23/33 | 25/33 | 28/33 |
| | 6. Number of Orthotic and Prosthetic devices issued | No | Not in plan | Not in plan | 3 500 | 3675 | 4000 | 4250 | 4500 |
| | 7. Number of hospitals with functional transfusion committees | No | Not in plan | Not in plan | 25/33 | 33/33 (Maintained) | 28/28 (Maintained) | 28/28 (Maintained) | 28/28 (Maintained) |

| Strategic objective statement | Indicator | Indicator Type | Audited/Actual performance | | | Estimated performance | Medium term targets | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| | *8.* Number of sites rendering Forensic Pathology Services (FPS) | No | Not in plan | Not in plan | 21 | 21 | 21 | 21 | 21 |

## 7.3.1 QUARTERLY TARGETS FOR HEALTH CARE SUPPORT SERVICES

**TABLE HCSS 2: QUARTERLY TARGETS FOR HEALTH CARE SUPPORT SERVICES FOR 2018/19**

| INDICATOR | Frequency of Reporting (Quarterly, Bi-annual, Annual) | Indicator Type | ANNUAL TARGET 2018/19 | TARGETS | | | |
|---|---|---|---|---|---|---|---|
| | | | | Q1 | Q2 | Q3 | Q4 |
| 1. Improve quality of care by increasing availability of medicines and surgical sundries at the Medical Depot. | Quarterly | % | 95% (295/310) | 95% (295/310) | 95% (295/310) | 95% (295/310) | 95% (295/310) |
| 2. Number of patients initiated on Central Chronic Medicine Dispensing and Distribution (CCMDD) | Quarterly | No | 220 000 | 10 000 (cumulative 188 889) | 10 000 (cumulative 198 889) | 10 000 (cumulative 208 889) | 11 111 (cumulative 220 000) |
| 3. Improve access to quality of care through compliance with Radiation Control prescripts by all facilities with X-Ray equipment | Quarterly | % | 100% (30/30) | 100% (5/5) | 100% (9/9) | 100% (8/8) | 100% (8/8) |
| 4. Number of hospitals providing laundry services | Quarterly | No | 23/33 | 23/33 | 23/33 | 23/33 | 23/33 |
| 5. Number of Orthotic and Prosthetic devices issued | Quarterly | No | 4000 | 1000 | 1000 | 1000 | 1000 |
| 6. Number of hospitals with functional transfusion committees | Quarterly | No | 28/28 | 28/28 | 28/28 | 28/28 | 28/28 |
| 7. 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 | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | | 2018/19 | 2019/20 | 2020/21 |
| 1. Laundries | 21 438 | 23 704 | 26 725 | 27 516 | 27 633 | 26 979 | 33 951 | 29 913 | 31 463 |
| 2. Engineering | 17 464 | 21 915 | 27 171 | 40 669 | 83 709 | 89 924 | 43 139 | 52 205 | 53 471 |
| 3. Forensic Services | 51 910 | 61 998 | 69 995 | 66 765 | 71 559 | 78 635 | 86 537 | 90 629 | 97 382 |
| 4. Orthotic and Prosthetic Services | 1 968 | 3 963 | 3 994 | 4 138 | 3 994 | 4 205 | 4 531 | 4 323 | 4 579 |
| 5. Medicine Trading Account | 8 927 | 11 871 | 12 808 | 18 687 | 13 557 | 12 533 | 14 482 | 15 550 | 16 739 |
| **Total payments and estimates** | **101 707** | **123 451** | **140 693** | **157 775** | **200 452** | **212 276** | **182 640** | **192 620** | **203 634** |

### Summary of Provincial Expenditure Estimates by Economic Classification[1]

| | Outcome | | | Main appropriation | Adjusted appropriation | Revised estimate | Medium-term estimates | | |
|---|---|---|---|---|---|---|---|---|---|
| R thousand | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | | 2018/19 | 2019/20 | 2020/21 |
| **Current payments** | **100 325** | **118 063** | **131 779** | **134 893** | **143 910** | **148 311** | **154 564** | **160 668** | **171 550** |
| Compensation of employees | 73 781 | 81 955 | 98 241 | 105 762 | 106 791 | 110 913 | 120 897 | 130 569 | 141 014 |
| Salaries and wages | 64 381 | 71 051 | 85 690 | 92 639 | 93 668 | 97 003 | 105 212 | 113 628 | 122 736 |
| Social contributions | 9 400 | 10 904 | 12 551 | 13 123 | 13 123 | 13 910 | 15 685 | 16 941 | 18 278 |
| Goods and services | 26 544 | 36 108 | 33 538 | 29 131 | 37 119 | 37 398 | 33 667 | 30 099 | 30 536 |
| *Administrative fees* | 116 | 215 | 134 | 318 | 163 | 148 | 134 | 143 | 150 |
| *Minor Assets* | 208 | – | 225 | 12 | – | 69 | 14 | 6 | 6 |
| *Catering: Departmental activities* | 46 | 72 | 18 | – | 2 | 2 | – | – | – |
| *Communication (G&S)* | 2 233 | 1 449 | 1 487 | 900 | 955 | 955 | 1 242 | 1 210 | 1 241 |
| *Consultants and professional services: Business and* | – | – | 2 020 | 2 024 | 257 | 257 | – | 120 | 120 |
| *Contractors* | 5 199 | 8 078 | 5 557 | 6 297 | 15 416 | 13 895 | 6 070 | 5 489 | 5 494 |
| *Agency and support / outsourced services* | – | 412 | 500 | 41 | – | – | 41 | – | – |
| *Fleet services (including government motor transpor* | 4 320 | 3 823 | 4 977 | 3 226 | 3 378 | 3 785 | 4 596 | 4 575 | 4 575 |
| *Inventory: Clothing material and accessories* | 75 | 28 | – | – | – | – | – | – | – |
| *Inventory: Fuel, oil and gas* | – | 1 869 | – | – | – | 203 | – | – | – |
| *Inventory: Materials and supplies* | 3 550 | 3 195 | – | – | – | – | – | 166 | 166 |
| *Inventory: Medical supplies* | 2 428 | 6 044 | 5 829 | 6 329 | 4 784 | 6 147 | 6 522 | 4 796 | 5 037 |
| *Inventory: Other supplies* | – | – | – | – | 2 665 | 2 665 | 2 751 | 2 975 | 2 975 |
| *Consumable supplies* | 2 889 | 5 169 | 8 212 | 5 233 | 5 407 | 5 119 | 7 694 | 6 770 | 6 783 |
| *Consumable: Stationery,printing and office supplies* | 358 | 350 | 628 | 855 | 137 | 124 | 608 | 167 | 173 |
| *Operating leases* | 1 135 | 1 111 | 574 | 763 | 552 | 508 | 1 051 | 1 008 | 1 053 |
| *Property payments* | 1 438 | 840 | 442 | 721 | 587 | 686 | 761 | 572 | 572 |
| *Transport provided: Departmental activity* | 86 | 179 | 35 | 120 | 187 | – | 37 | 44 | 46 |
| *Travel and subsistence* | 2 141 | 3 007 | 2 738 | 2 189 | 2 308 | 2 477 | 2 118 | 2 019 | 2 106 |
| *Training and development* | 35 | 40 | – | 3 | – | – | – | – | – |
| *Operating payments* | 122 | 57 | 79 | 100 | 130 | 193 | 28 | 39 | 39 |
| *Venues and facilities* | 165 | 170 | 83 | – | 191 | 165 | – | – | – |
| Interest and rent on land | – | – | – | – | – | – | – | – | – |
| **Transfers and subsidies** | **138** | **655** | **123** | **240** | **240** | **54** | **254** | **269** | **283** |
| Provinces and municipalities | 37 | – | – | – | – | – | – | – | – |
| Municipalities | 37 | – | – | – | – | – | – | – | – |
| Municipal bank accounts | 37 | – | – | – | – | – | – | – | – |
| Households | 101 | 655 | 123 | 240 | 240 | 54 | 254 | 269 | 283 |
| Social benefits | 101 | 655 | 123 | 240 | 240 | 54 | 254 | 269 | 283 |
| **Payments for capital assets** | **1 244** | **4 733** | **8 791** | **22 642** | **56 302** | **63 911** | **27 822** | **31 683** | **31 801** |
| Machinery and equipment | 1 244 | 4 733 | 8 791 | 22 642 | 56 302 | 63 911 | 27 822 | 31 683 | 31 801 |
| Transport equipment | 526 | 4 240 | – | – | – | – | 1 058 | 1 117 | 1 178 |
| Other machinery and equipment | 718 | 493 | 8 791 | 22 642 | 56 302 | 63 911 | 26 764 | 30 566 | 30 623 |
| **Payments for financial assets** | – | – | – | – | – | – | – | – | – |
| **Total economic classification: Programme (number and** | **101 707** | **123 451** | **140 693** | **157 775** | **200 452** | **212 276** | **182 640** | **192 620** | **203 634** |

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

# 7.5 PERFORMANCE AND EXPENDITURE TRENDS

*Programme 7: Health Care Support Services* will decrease by 8.9 per cent during the 2018/19 financial year due to funds received during adjustment for maintenance of medical and equipment and capital medical equipment not maintained throughout the MTEF and reprioritization to service delivery programme. The Department has still centralised procurement of medical equipment in order to improve compliance on National Core Standards.

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. Submission of infrastructural needs to the Infrastructure Section<br>b. Submission of prioritised needs to Budget Section<br>c. Submission of prioritized posts to be advertised<br>d. Provision of wellness programme to employees<br>e. Submission of ICT needs to Departmental ICT Section<br>f. Monitor compliance by the Service Provider to the Service Level Agreement |
| 2. Shortage of pharmacy personnel | a. Approved new organisational structure<br>b. Employment of CSP and Pharmacists at facilities<br>c. Ensure proper planning to increase budget allocation<br>d. Adhere to recruitment and selection policy |
| 3. Shortage of Pharmaceuticals and Surgicals in the Province | a. Install stock management system in all facilities<br>b. Secure budget for warehouse facilities (infrastructure)<br>c. Improve pharmaceutical warehouse management |
| 4. 'Inadequate maintenance of medical equipment | a. Fast track the filling of critical vacant posts.<br>b. Review and implementation of medical equipment SLAs with Service providers. Development of maintenance plans for medical equipment for all hospitals.<br>c. Emphasise motivation for more maintenance of medical equipment budget.<br>d. Develop an SOP on medical equipment maintenance.<br>e. Replacement of old vehicles for the CE workshops.<br>f. Engage SCM section to expedite the processing of requisitions for maintenance. |

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

## 8.1 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 | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| 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 | 48/279 | 107 PHC | 90 PHC facilities maintained | 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 | 8 (Ehlanzeni:2 Gert Sibande: 5 Nkangala:1) | 6 (cumulative 14) Ehlanzeni: 5 Gert Sibande: 7 Nkangala: 2 | 8 Ehlanzeni: 2 Gert Sibande: 5 Nkangala: 1 | 8 Ehlanzeni: 2 Gert Sibande: 5 Nkangala: 1 | 8 Ehlanzeni: 2 Gert Sibande: 5 Nkangala: 1 |
| | 3. Number of Hospitals under maintenance | No | Not in plan | Not in plan | 31 Hospital Facilities maintained | 31 | 31 | 31 | 31 |
| | 4. Enhance patient care & safety and improving medical care by constructing Modern hi-tech hospitals | No | Not in plan | 0 | 3 (Planning phase) | 3 (Construction) | 3 (Construction) Ehlanzeni: 1 Gert Sibande: 1 Nkangala: 1 | 2 (Construction) Ehlanzeni: 1 Nkangala: 1 | 2 (Construction) Ehlanzeni: 1 Nkangala: 1 |
| | 5. Improve maintenance of health facilities by appointing cooperatives | No | Not in plan | 11 | 10 cooperatives appointed for multi-year projects (2015/16-2016/17) | 16 cooperatives appointed (cumulative 26) | 15 cooperatives appointed (cumulative 41) | 15 cooperatives appointed (cumulative 56) | 0 cooperatives appointed (cumulative 56) |
| | **Programme Performance / Customized Indicators (Sector Indicators)** | | | | | | | | |

| Strategic objective statement | Indicator | Indicator Type | Audited/Actual performance | | | Estimated performance | Medium term targets | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| 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 | 19 PHC facilities completed | 25 PHC* (cumulative 40) | 6 Hospitals 6 PHC* (cumulative 46) | 6 Hospitals 5 PHC* (cumulative 51) | 6 Hospitals 4 PHC* (cumulative 55) |
| | 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 | 5 Hospital completed 13 PHC completed | 4 Hospitals 10 PHC | 2 Hospitals 6 PHC | 5 Hospitals 17 PHC | 5 Hospitals 17 PHC |

## 8.2 QUARTERLY TARGETS FOR HFM

### TABLE HFM3: QUARTERLY TARGETS FOR HEALTH FACILITES MANAGEMENT

| INDICATOR | Frequency of Reporting (Quarterly, Bi-annual, Annual) | Indicator Type | ANNUAL TARGET 2018/19 | TARGETS | | | |
|---|---|---|---|---|---|---|---|
| | | | | Q1 | Q2 | Q3 | Q4 |
| 1. Improve access to healthcare by increasing number of PHC facilities maintained | Annual | No | 5 (Cumulative 287/287 | 1 | 1 | 2 | 1 |
| 2. Number of PHC facilities constructed (new/replacement) | Annual | No | 8 Ehlanzeni: 2 Gert Sibande: 5 Nkangala: 1 | 8 (Construction) | 8 (Construction) | 8 (Construction) | 8 (Construction) |
| 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) Ehlanzeni: 1 Gert Sibande: 1 Nkangala: 1 | 2 (Construction) | 3 (Construction) | 3 (Construction) | 3 (Construction) |
| 5. Improve maintenance of health facilities by appointing cooperatives | Annual | No | 15 cooperatives appointed (cumulative 41) | 0 | 5 | 10 | 0 |

| INDICATOR | Frequency of Reporting (Quarterly, Bi-annual, Annual) | Indicator Type | ANNUAL TARGET 2018/19 | TARGETS | | | |
|---|---|---|---|---|---|---|---|
| | | | | Q1 | Q2 | Q3 | Q4 |
| 6. Number of health facilities that have undergone major and minor refurbishment in NHI Pilot District | Annual | No | 6 Hospitals<br>6 PHC*<br>(cumulative 46) | 1 Hospitals<br>2 PHC | 2 Hospitals<br>2 PHC | 2 Hospitals<br>4 PHC | 1 Hospitals<br>6 PHC |
| 7. Number of health facilities that have undergone major and minor refurbishment outside NHI pilot District (excluding facilities in NHI Pilot District) | Annual | No | 2 Hospitals<br>6 PHC | (Planning)<br>2 Hospitals<br>6 PHC | 2 Hospitals<br>6 PHC<br>(Construction) | 2 Hospitals<br>6 PHC<br>(Construction) | 2 Hospitals<br>6 PHC<br>(Construction) |

## 8.4 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 | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | | 2018/19 | 2019/20 | 2020/21 |
| 1. Community Health Facilities | 197 534 | 294 978 | 389 276 | 1 110 823 | 834 632 | 837 268 | 1 059 340 | 881 642 | 925 911 |
| 2. Emergency Medical Rescue Services | – | – | – | – | – | – | – | – | – |
| 3. District Hospital Services | 60 615 | 96 247 | 99 060 | 59 860 | 59 860 | 59 955 | 133 150 | 30 420 | 2 000 |
| 4. Provincial Hospital Services | 210 901 | 248 039 | 194 685 | 265 757 | 266 127 | 264 058 | 200 785 | 316 792 | 364 310 |
| 5. Central Hospital Services | – | – | – | – | – | – | – | – | – |
| 6. Other Facilities | – | – | – | – | – | – | – | – | – |
| **Total payments and estimates** | **469 050** | **639 264** | **683 021** | **1 436 440** | **1 160 619** | **1 161 281** | **1 393 275** | **1 228 854** | **1 292 221** |

### Summary of Provincial Expenditure Estimates by Economic Classification[1]

| | Outcome | | | Main appropriation | Adjusted appropriation | Revised estimate | Medium-term estimates | | |
|---|---|---|---|---|---|---|---|---|---|
| R thousand | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | | 2018/19 | 2019/20 | 2020/21 |
| **Current payments** | **124 440** | **172 012** | **217 690** | **137 552** | **266 627** | **267 289** | **163 739** | **96 941** | **120 026** |
| Compensation of employees | 9 783 | 11 097 | 11 454 | 32 177 | 16 311 | 16 973 | 22 421 | 24 215 | 26 152 |
| Salaries and wages | 8 705 | 9 789 | 10 118 | 28 470 | 12 604 | 15 213 | 16 815 | 18 161 | 19 613 |
| Social contributions | 1 078 | 1 308 | 1 336 | 3 707 | 3 707 | 1 760 | 5 606 | 6 054 | 6 539 |
| Goods and services | 114 657 | 160 915 | 204 287 | 105 375 | 250 316 | 250 316 | 141 318 | 72 726 | 93 874 |
| *Administrative fees* | 17 | 62 | 21 | 132 | 13 | 996 | 19 | 21 | 21 |
| *Advertising* | – | 181 | – | – | 104 | 104 | – | – | – |
| *Minor Assets* | 239 | 329 | 1 037 | 4 082 | 3 000 | 1 182 | 2 480 | 4 000 | 5 200 |
| *Catering: Departmental activities* | 14 | 113 | 3 | 121 | 4 | 4 | – | – | – |
| *Communication (G&S)* | 14 | 47 | 89 | 272 | 19 | 87 | 152 | 158 | 158 |
| *Consultants and professional services: Business and* | – | 17 | – | – | 100 | 100 | 2 000 | 2 718 | 2 994 |
| *Infrastructure and planning* | – | 3 756 | – | 10 000 | – | – | – | – | – |
| *Contractors* | 16 693 | 13 866 | 6 948 | – | 9 960 | 9 960 | 34 638 | 26 740 | 54 740 |
| *Agency and support / outsourced services* | – | 126 | 22 241 | 27 | 8 214 | 8 801 | 4 224 | 4 586 | 4 988 |
| *Fleet services (including government motor transpo* | – | – | – | – | – | 96 | – | – | – |
| *Inventory: Fuel, oil and gas* | – | 4 951 | – | – | 3 401 | 3 401 | – | – | – |
| *Inventory: Materials and supplies* | – | 996 | – | – | – | – | – | – | – |
| *Inventory: Medical supplies* | 303 | 95 | 31 | 384 | – | 187 | – | – | – |
| *Consumable supplies* | 363 | 40 196 | 37 422 | 22 986 | 38 528 | 38 542 | – | – | – |
| *Consumable: Stationery,printing and office supplies* | – | 429 | 27 | 151 | 22 | 67 | 29 | 30 | 30 |
| *Operating leases* | – | – | 1 030 | – | 1 627 | 2 116 | 2 268 | 2 395 | 2 395 |
| *Property payments* | 95 956 | 93 597 | 134 539 | 63 223 | 181 721 | 180 762 | 92 188 | 27 032 | 18 802 |
| *Transport provided: Departmental activity* | – | – | – | 221 | – | – | – | – | – |
| *Travel and subsistence* | 788 | 1 592 | 863 | 354 | 260 | 641 | 2 300 | 2 300 | 2 300 |
| *Training and development* | 214 | 406 | 18 | 2 264 | 2 320 | 2 320 | 1 000 | 2 740 | 2 240 |
| *Operating payments* | 56 | 156 | 18 | 1 158 | 1 023 | 1 038 | 20 | 6 | 6 |
| Interest and rent on land | – | – | 1 949 | – | – | – | – | – | – |
| Interest (Incl. interest on finance leases) | – | – | 1 949 | – | – | – | – | – | – |
| **Transfers and subsidies** | **3 456** | **31** | **63** | **–** | **100** | **100** | **–** | **–** | **–** |
| Non-profit institutions | 3 384 | – | – | – | – | – | – | – | – |
| Households | 72 | 31 | 63 | – | 100 | 100 | – | – | – |
| Social benefits | 72 | 31 | 63 | – | 100 | 100 | – | – | – |
| **Payments for capital assets** | **341 154** | **467 221** | **465 268** | **1 298 888** | **893 892** | **893 892** | **1 229 536** | **1 131 913** | **1 172 195** |
| Buildings and other fixed structures | 312 522 | 453 725 | 437 594 | 1 263 888 | 851 522 | 851 522 | 1 225 816 | 1 125 913 | 1 164 395 |
| Buildings | 312 522 | 453 725 | 437 594 | 1 263 888 | 851 522 | 851 522 | 1 225 816 | 1 125 913 | 1 164 395 |
| Machinery and equipment | 28 632 | 13 496 | 27 674 | 35 000 | 42 370 | 42 370 | 3 720 | 6 000 | 7 800 |
| Other machinery and equipment | 28 632 | 13 496 | 27 674 | 35 000 | 42 370 | 42 370 | 3 720 | 6 000 | 7 800 |
| **Payments for financial assets** | – | – | – | – | – | – | – | – | – |
| **Total economic classification: Programme (number and** | **469 050** | **639 264** | **683 021** | **1 436 440** | **1 160 619** | **1 161 281** | **1 393 275** | **1 228 854** | **1 292 221** |

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

## 8.5 PERFORMANCE AND EXPENDITURE TRENDS

*Programme 8: Health Facilities Management* shows an increase of 20 per cent on the budget due additional allocation of R183.0 million received to finalise the Mmametlhake infrastructure project. The Department has prioritized the rehabilitation and maintenance of our dilapidated facilities. This programme includes Hospital revitalisation conditional Grant.

## 8.6 RISK MANAGEMENT

| RISK | MITIGATING FACTORS |
|---|---|
| 1. Poor maintenance of infrastructure and equipment | a. Include maintenance requirements in infrastructure planning (3 year maintenance plan)<br>b. Conclude service level agreements with the MRTT for placement of artisans<br>c. Secure adequate budget via Construction Procurement Standard for multi-year programme |
| 2. Cost over-runs on projects | a. Coordinate development of a business case and clinical briefs prior to design<br>b. Planning in accordance with the allocated budget<br>c. Continuous professional skills development<br>d. Establishment of individual project budget estimates |
| 3. Inadequate budget for Programme 8 | a. Develop costed Provincial Maintenance Master Plan<br>b. Motivate for needs driven budget |

# 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 | | | |
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | | | 2018/19 | 2019/20 | 2020/21 |
| 1 | New and replacement assets (R'000) | | | | | | | | | | | | |
| 1.1 | Wakkerstroom Community Health Centre | 8 | Pixley De Seme | (Construction of new Community Health Centre and accommodation units including associated external works) | 0 | 0 | 0 | 0 | | | 1 752 | 0 | 0 |
| 1.2 | Sinqobile Community Health Centre | 8 | Pixley De Seme | (Construction of new Community Health Centre and accommodation units including associated external works) (Completion contract) | 0 | 0 | 0 | 0 | | | 2 215 | 0 | 0 |
| 1.3 | Pankop Clinic | 8 | Dr JS Moroka | Construction of new Clinic & 2x2 accommodation units | 0 | 0 | 0 | 3500 | | | 40 760 | 9900 | 0 |
| 1.4 | Oakley Clinic | 8 | Bushbuckridge | Construction of new Clinic & 2x2 accommodation units | 0 | 0 | 0 | 3500 | | | 40 760 | 9900 | 0 |
| 1.5 | Msukaligwa CHC | 8 | Msukaligwa | Construction of new CHC and accommodation units | 0 | 0 | 500 | 3 500 | | | 4 000 | 3500 | 2000 |
| 1.6 | Thandukukhanya CHC | 8 | Mkhondo | Construction of new CHC and accommodation units | 0 | 0 | 0 | 3 500 | | | 4 153 | 3500 | 2000 |
| 1.7 | Nhlazatshe 6 Clinic | 8 | Chief Albert Luthuli | Construction of new clinic and accommodation units | 0 | 0 | 500 | 2 200 | | | 3060 | 1060 | 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 | 2015/16 | 2016/17 | 2017/18 | | | 2018/19 | 2019/20 | 2020/21 |
| 1.8 | Vukuzakhe Clinic | 8 | Isak Pixley Ka Seme | Construction of new clinic and accommodation units | 0 | 0 | 500 | 2 200 | | | 3 060 | 1060 | 0 |
| 1.9 | Balfour CHC | 8 | Dipaliseng | Construction of CHC and accommodation units | 0 | 0 | 1750 | 5 500 | | | 4 153 | 3 500 | 2 000 |
| 1.10 | Middelburg Regional Hospital | 8 | Steve Tshwete | Construction of new Hospital | 0 | 0 | 0 | 90 000 | | | 279 775 | 299 832 | 579 775 |
| 1.11 | Themba Hospital | 8 | Mbombela | Construction of New maternity, helipad and resource centre ) | 0 | 0 | 0 | 1 707 | | | 10 800 | 86 043 | 125 634 |
| 1.12 | Mapulaneng Hospital Phase 1 | 8 | Bushbuckridge | Fencing and earthworks | 0 | 0 | 0 | 255 | | | 20 600 | 14 600 | 0 |
| 1.13 | Mapulaneng Hospital Phase 2 | 8 | Bushbuckridge | Construction of new hospital | 0 | 0 | 0 | 112 073 | | | 50 057 | 66 057 | 0 |
| 1.14 | Mapulaneng Hospital Phase 3 | 8 | Bushbuckridge | Construction of new hospital | 0 | 0 | 0 | 112 073 | | | 40 000 | 335 809 | 318 447 |
| **Total new and replacement assets** | | | | | 0 | **0** | **56 468** | **349 954** | | | **494 345** | **748 718** | **904 222** |

| NO | PROJECT NAME | PROGRAMME | MUNICIPALITY | OUTPUTS | OUTCOME R'000 | | | R'000 | | | MEDIUM TERM ESTIMATES | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | MAIN APPRO PRIATION | ADJUSTED APPRO PRIATION | REVISED ESTIMATE | | | |
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | | | 2018/19 | 2019/20 | 2020/21 |
| **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 | | | 27 778 | 0 | 0 |
| 2.2 | Mmametlhake hospital (Phase 2) | 8 | Dr JS Moroka | Upgrading and Additions of support buildings | 0 | 0 | 0 | 0 | | | 223 263 | 92 636 | 0 |
| 2.3 | Bethal Hospital | 8 | Govan Mbeki | Major Upgrade of hospital, including rehabilitation of existing facilities and step-down of the hospital) | 0 | 0 | 0 | 14 499 | | | 376 917 | 37 917 | 0 |
| 2.4 | Rob Ferreira Hospital | 8 | Mbombela | Construction of a compactor room, Grease Trap Unit and Associated External Works | 0 | 0 | | 10 806 | | | 827 | 500 | 510 |
| 2.5 | | 8 | Mbombela | Parking Deck | 0 | 0 | 14 499 | 150 000 | | | 10 518 | 52 330 | 5 000 |
| 2.6 | | 8 | Mbombela | Upgrading of existing internal road and parking | 0 | 0 | 0 | 17 791 | | | 3 008 | 2 669 | 2668.65 |
| 2.7 | | 8 | Mbombela | Construction of New Mortuary | 0 | 0 | 14 498 | 26 760 | | | 10 663 | 0 | 0 |
| 2.8 | | 8 | Mbombela | (Renovations and alterations to the existing nurses accommodation building for laundry facility at Rob Ferreira Hospital, Mbombela Local Municipality, Ehlanzeni District) | 0 | 0 | 0 | 0 | | | 1 157 | 0 | 0 |
| 2.9 | 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 | | | 15 100 | 100 100 | 126 060 |

| NO | PROJECT NAME | PROGRAMME | MUNICIPALITY | OUTPUTS | OUTCOME R'000 | | | R'000 | | | MEDIUM TERM ESTIMATES | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | MAIN APPRO PRIATION | ADJUSTED APPRO PRIATION | REVISED ESTIMATE | | | |
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | | | 2018/19 | 2019/20 | 2020/21 |
| 2.10 | KwaMhlanga Hospital | 8 | Thembisile Hani | Phase 3c, Construction of ICU, Casualty and additions to existing theatre | 8 256 | 0 | | 0 | | | 218 | 0 | 0 |
| 2.11 | Sabie Hospital | 8 | Thaba Chweu | Site establishment, Demolition of asbestos and construction of wards | 0 | 0 | 4 465 | 5 730 | 0 | 0 | 1 948 | 0 | 0 |
| 2.12 | Tintswalo hospital | 8 | Bushbuckridge | (Upgrading of existing Kitchen and Nursing accommodations) | 0 | 0 | 0 | 0 | 0 | 0 | 8 802 | 0 | 0 |
| 2.12 | Ermelo Hospital | 8 | Msukaligwa | (Construction of a new stores and linen rooms building, including associated external works) | 0 | 0 | 0 | 0 | 0 | 0 | 1 368 | 0 | 0 |
| 2.13 | Luphisi Clinic | 8 | | (Construction of a guardhouse, Erection of new concrete palisade fence with security gate) | 0 | 0 | 0 | 0 | 0 | 0 | 168 | 0 | 0 |
| 2.14 | Nasaret Clinic | 8 | | (Construction of a guardhouse, refuse area and upgrading of existing fence) | 0 | 0 | 0 | 0 | 0 | 0 | 45 | 0 | 0 |
| 2.15 | Marapyane Clinic | 8 | | (Construction of a guardhouse, refuse area and upgrading of existing fence) | 0 | 0 | 0 | 0 | 0 | 0 | 69 | 0 | 0 |
| 2.16 | Thembalethu Clinic | 8 | | (Construction of a guardhouse, refuse area and upgrading of existing fence) | 0 | 0 | 0 | 0 | 0 | 0 | 90 | 0 | 0 |
| 2.17 | Waterval Community Health Centre | 8 | | (Construction of a guardhouse, refuse area and upgrading of existing fence) | 0 | 0 | 0 | 0 | 0 | 0 | 56 | 0 | 0 |
| 2.18 | Extension 8 clinic | 8 | | (Construction of a guardhouse, refuse area | 0 | 0 | 0 | 0 | 0 | 0 | 66 | 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 | 2015/16 | 2016/17 | 2017/18 | | | 2018/19 | 2019/20 | 2020/21 |
| | | | | and upgrading of existing fence) | | | | | | | | | |
| 2.19 | Goromane Clinic | 8 | | (Construction of Concrete palisade fence) | 0 | 0 | 0 | 0 | 0 | 0 | 10 | 0 | 0 |
| 2.20 | Matikwana Hospital | 8 | | (Renovation to convert the existing stores building as well as supply, installation and commissioning of Laundry equipment at Matikwane Hospital, Bushbuckridge Local Municipality, Bohlabela District) | 0 | 0 | 0 | 0 | 0 | 0 | 1 143 | 0 | 0 |
| 2.21 | Oakley Clinic | 8 | Bushbuckridge | (Construction of a guardhouse, refuse area and upgrading of existing fence) | 0 | 0 | 0 | 0 | 0 | 0 | 1 270 | 0 | 0 |
| 2.22 | Simile Clinic | 8 | Thaba Chweu | (Construction of a guardhouse, refuse area and upgrading of existing fence) | 0 | 0 | 0 | 0 | 0 | 0 | 784 | 0 | 0 |
| 2.23 | Luphisi Clinic | 8 | Mbombela | (Demolition of existing structures and construction of unconventional clinic facilities at Luphisi Clinic) | 0 | 0 | 0 | 0 | 0 | 0 | 1 549 | 0 | 0 |
| 2.24 | Sabie Hospital | 8 | Thaba Chweu | (Renovations and Rehabilitation of the existing Sabie Hospital including construction of new wards and removal of asbestos structures) | 0 | 0 | 0 | 0 | 0 | 0 | 1 010 | 0 | 0 |
| Total upgrades and additions | | | | | **68 256** | **90 512** | **110 346** | **931 789** | | | **727 870** | **395 232** | **310 910** |
| | | | | | | | | | | | | | |

| NO | PROJECT NAME | PROGRAMME | MUNICIPALITY | OUTPUTS | OUTCOME R'000 | | | R'000 | | | MEDIUM TERM ESTIMATES | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | MAIN APPRO PRIATION | ADJUSTED APPRO PRIATION | REVISED ESTIMATE | | | |
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | | | 2018/19 | 2019/20 | 2020/21 |
| 3. | Rehabilitation, Refurbishment, Repairs | | | | | | | | | | | | |
| 3.1 | Middelburg Hospital | 8 | Steve Tshwete | (Repairs, rehabilitation and refurbishment Project (2014/15)) | 0 | 0 | 0 | 0 | 0 | 0 | 1 000 | 0 | 0 |
| 3.2 | Ndindindi CHC of | 8 | Nkomazi | (Renovations, rehabilitation and refurbishment existing Clinic facilities) | 0 | 0 | 0 | 0 | 0 | 0 | 25 | 0 | 0 |
| 3.3 | Mbuzini chc | 8 | Nkomazi | (Renovations, rehabilitation and refurbishment of existing Clinic facilities) | 0 | 0 | 0 | 0 | 0 | 0 | 31 | 0 | 0 |
| 3.4 | Themba Nursing College | | Mbombela | (Renovations, rehabilitation and refurbishment of existing Building facilities) | 0 | 0 | 0 | 0 | 0 | 0 | 1 089 | 0 | 0 |
| 3.5 | Marite clinic: | 8 | Bushbuckridge | Renovations., rehabilitations and refurbishment | 0 | 0 | 0 | 2 000 | | | 2 648 | 0 | 0 |
| 3.6 | Mpakeni clinic | 8 | Mbombela | Renovations., rehabilitations and refurbishment | 0 | 0 | 7 953 | 7 953 | | | 852 | 0 | 0 |
| 3.7 | Sibange clinic | 8 | Nkomazi | Repairs, rehabilitation & refurbishment | 0 | 0 | 1 781 | 1 781 | | | 3 306 | 0 | 0 |
| 3.8 | Siyathuthuka Clinic | 8 | Emakhazeni | Repairs, rehabilitation and refurbishment of the clinic | 0 | 0 | 1 848 | 1 848 | | | 65 | 0 | 0 |
| 3.9 | Exten. 8 Clinic | 8 | Steve Tshwete | Repairs, rehabilitation and refurbishment of the clinic | 0 | 0 | 1 848 | 1 848 | | | 283 | 0 | 0 |
| 3.10 | Khumbula Clinic | 8 | Mbombela | Expanded Public Works Programme | 0 | 0 | 755 | 2 311 | | | 1 210 | 0 | 0 |
| 3.11 | Evander Hospital | 8 | Govan Mbeki | Minor Renovations | 0 | 0 | 0 | 4 210 | | | 326 | 0 | 0 |
| 3.12 | Witbank hospital | 8 | Emalahleni | Witbank hospital (Renovation of Huise Louisee Nurses Residence at Witbank Hospital in Emalahleni Local | 0 | 0 | 6 807 | 0 | | | 1 479 | 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 | 2015/16 | 2016/17 | 2017/18 | | | 2018/19 | 2019/20 | 2020/21 |
| | | | | Municipality, Nkangala District Municipality) | | | | | | | | | |
| 3.13 | Goromane clinic | 8 | Bushbuckridge | (Renovations, rehabilitation and refurbishment of existing Clinic facilities) | 0 | 0 | 0 | 7 700 | | | 5 797 | 0 | 0 |
| 3.14 | Makoko clinic | 8 | Mbombela | Renovations, rehabilitation and refurbishment of existing Clinic facilities) (Phase 1) (Palisade Fencing) | 0 | 0 | 0 | 7 075 | | | 5 668 | 0 | 0 |
| 3.15 | Shongwe Hospital | 8 | Nkomazi | Shongwe Hospital (Repair and maintenance of various building facilities ) | 0 | 0 | 6000 | 6000 | | | 905 | 0 | 0 |
| 3.16 | Middelplaas Clinic - | 8 | Ehlanzeni | Construction of the IBT Structure | | | | | | | 3 520 | 2 500 | 0 |
| 3.17 | Matikwana Hospital | 8 | Bushbuckridge | (Repairs of Storm damages, and maintenance) | 0 | 0 | 0 | 0 | 0 | 0 | 10 133 | 0 | 0 |
| 3.18 | Schunzendale clinic - | 8 | Ehlanzeni | Construction of the IBT Structures | 0 | 0 | 0 | 0 | 0 | 0 | 3 520 | 2 500 | 0 |
| | | | | | | | | | | | | | |
| **Total Repairs, Rehabilitation and refurbishment** | | | | | **0** | **0** | **0** | | | | **46 922** | **5 000** | **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 | 2015/16 | 2016/17 | 2017/18 | | | 2018/19 | 2019/20 | 2020/21 |
| **4** | **Maintenance** | | | | | | | | | | | | |
| | Shongwe Hospital | | Nkomazi | (Repair of storm damages) | 0 | 0 | 0 | 0 | | | 445 | 0 | 0 |
| | Tonga Hospital | | Nkomazi | (Repair of storm damages) | 0 | 0 | 0 | 0 | | | 26 | 0 | 0 |
| | Barberton Hospital | | Ehlanzeni | (Repair of storm damages) | 0 | 0 | 0 | 0 | | | 87 | 0 | 0 |
| | Dludluma Clinic (Repair of storm damages) | | Ehlanzeni | (Repair of storm damages) | 0 | 0 | 0 | 0 | | | 80 | 0 | 0 |
| | Thubelihle CHC (Emtimbeni CHC) | | Emalahleni | (Kriel CHC) (Repair of storm damages) | 0 | 0 | 0 | 0 | | | 77 | 0 | 0 |
| | Matikwane Hospital) | | Bushbuckridge | (Repair of January 2018 storm damages at Matikwane Hospital | 0 | 0 | 0 | 0 | | | 2 946 | 0 | 0 |
| | Various Clinics in Thembisile Hani Local Municipality | | Various | (Repair of storm damages) | 0 | 0 | 0 | 0 | | | 77 | 0 | 0 |
| 3.32 | Tonga Hospital | 8 | Ehlanzeni | (Repair of storm damages) | 0 | 0 | 0 | 1 172 | | | 26 | 0 | 0 |
| 3.33 | Barberton Hospital | 8 | Ehlanzeni | (Repair of storm damages) | 0 | 0 | 0 | 1 280 | | | 87 | 0 | 0 |
| 3.35 | Dludluma Clinic | 8 | Ehlanzeni | (Repair of storm damages) | 0 | 0 | 0 | 1 597 | | | 80 | 0 | 0 |
| 3.37 | Thubelihle CHC | 8 | Nkangala | (Repair of storm damages) | 0 | 0 | 0 | 3 068 | | | 77 | 0 | 0 |
| | Shongwe Hospital | 8 | Nkomazi | (Repair of storm damages) | 0 | 0 | 0 | 0 | | | 445 | 0 | 0 |
| | Naas Malaria Centre | 8 | Nkomazi | (Repair of storm damages) | 0 | 0 | 0 | 0 | | | 38 | 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 | 2015/16 | 2016/17 | 2017/18 | | | 2018/19 | 2019/20 | 2020/21 |
| | | | | | | | | | | | | | |
| | Ntunda Community Health Centre | 8 | Nkomazi | (Repair of January 2018 Storm damages) | 0 | 0 | 0 | 0 | | | 6 808 | 0 | 0 |
| | Mkhuhlu Clinic | 8 | Bushbuckridge | (Repair of January 2018 storm damages) | 0 | 0 | 0 | 0 | | | 647 | 0 | 0 |
| | Middelburg Pharmaceutical Depot | 8 | Steve Tshwete | (Repair of Storm damages building facilities) | 0 | 0 | 0 | 0 | | | 2 277 | 0 | 0 |
| | Themba Hospital | 8 | Mbombela | (Repair of Storm damages) | 0 | 0 | 0 | 0 | | | 25 | 0 | 0 |
| | Ideal clinic Repairs and Maintenance of various facilities in Nkangala | 8 | Various | Ideal clinic Repairs and Maintenance | 0 | 0 | 0 | 0 | | | 3000 | 0 | 0 |
| | Ideal clinic Repairs and Maintenance of various facilities in Ehlanzeni | 8 | Ehlanzeni | Ideal clinic Repairs and Maintenance | 0 | 0 | 0 | 0 | | | 5 662 | 0 | 0 |
| | Elijah Mango EMS College(General Building Maintenance) | 8 | Mbombela | Elijah Mango EMS College(General Building Maintenance) | 0 | 0 | 0 | 0 | | | 2 322 | 0 | 0 |
| | Newtown Clinic | 8 | Steve Tshwete | (Construction of a new Ablution Block and Septic Tank) | 0 | 0 | 0 | 0 | | | 1 293 | 0 | 0 |
| | Shongwe Hospital | 8 | Ehlanzeni | (Repairs to underground sewer pipework project) | 0 | 0 | 0 | 0 | | | 7 802 | 8 802 | 8 802 |
| | General building repairs of Nursing Colleges | 8 | Gert Sibande | | 0 | 0 | 0 | 0 | | | 2 480 | 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 | 2015/16 | 2016/17 | 2017/18 | | | 2018/19 | 2019/20 | 2020/21 |
| | | | | | | | | | | | | | |
| | Themba Hospital | 8 | Mbombela | (Repair and Replacement of Damaged Timber Doors, Steel Doors and Screens as well as Glazing of Various Building Facilities) | 0 | 0 | 0 | 0 | | | 701 | 0 | 0 |
| | Hoxane Sub - District | 8 | Various | General building maintenance | 0 | 0 | 0 | 0 | | | 4 443 | 3 230 | 0 |
| | Servicing and Maintenance of Septic Tanks at Various Health Facilities within the Province | 8 | Various | Servicing and Maintenance of Septic Tanks at Various Health Facilities within the Province | 0 | 0 | 0 | 0 | | | 5 318 | 15 000 | 10 000 |
| | Rob Ferreira Hospital Repairs - Nursing Accommodations | 8 | Mbombela | Rob Ferreira Hospital Repairs -Nursing Accommodations | 0 | 0 | 0 | 0 | | | 4 720 | 0 | 0 |
| | Repairs and replacement of Kitchen Equipment at Various Health Facilities within the Province | 8 | Various | Repairs and replacement of Kitchen Equipment at Various Health Facilities within the Province | 0 | 0 | 0 | 0 | | | 5 000 | 0 | 0 |
| | Repairs of Steam Boilers and related Installations at Various Health Facilities within the Province | 8 | Various | | 0 | 0 | 0 | 0 | | | 25 000 | 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 | 2015/16 | 2016/17 | 2017/18 | | | 2018/19 | 2019/20 | 2020/21 |
| Total Maintenance | | | | | | | | | | | 82 197 | 27 032 | 18 802 |
| Grand Total | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| **5. HEALTH TECHNOLOGY** | | | | | | | | | | | | | |
| **5. Health Technology (Machinery & Equipment)** | | | | | | | | | | | | | |
| | New Health Technology Equipment (Procurement of new machinery and equipment etc) | 8 | | (Procurement of new machinery and equipment's etc.) | 0 | 0 | 0 | | | | 3 720 | 6 000 | 7 800 |
| | Machinery and Equipment (Repair and Maintenance of medical equipment, etc) and Minor Assets | | | | 0 | 0 | 0 | | | | 2480 | 4000 | 5200 |
| | 5. HEALTH TECHNOLOGY TOTAL | | | | | | | | | | **6 200** | **10 000** | **13 000** |
| | 6. Office Administration | | | | | | | | | | | | |
| | Compensation of Employees: Appointment of Built Environment officials in terms of DORA | | | | | | | | | | 14 023 | 15 415 | 16 356 |
| | Goods and Services | | | | | | | | | | 7 007 | 7 491 | 7 893 |

| NO | PROJECT NAME | PROGRAMME | MUNICIPALITY | OUTPUTS | OUTCOME R'000 | | | R'000 | | | MEDIUM TERM ESTIMATES | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | MAIN APPRO PRIATION | ADJUSTED APPRO PRIATION | REVISED ESTIMATE | | | |
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | | | 2018/19 | 2019/20 | 2020/21 |
| | Compensation of Employees | | | | | | | | | | 8 398 | 9 070 | 9 796 |
| | Organisational development and Quality Assurance | | | | | | | | | | - | 2 240 | 2 240 |
| | Goods and Services | | | | | | | | | | 8 234 | 8 656 | 9 002 |
| | 6. TOTAL ADMINISTRATION | | | | | | | | | | **37 662** | **42 872** | **45 287** |

# 8. CONDITIONAL GRANTS

| NAME OF CONDITIONAL GRANT | PURPOSE OF THE GRANT | PERFORMANCE INDICATORS | INDICATOR TARGETS FOR 2018/19 |
|---|---|---|---|
| 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<br>• To support the implements of the National operational plan for comprehensive HIV and AIDS treatment and care<br>• To subsidise in-part funding for the antiretroviral treatment plan | 1. Total Number of fixed public health facilities offering ART Services | 321 |
| | | 2. Total number of patients on ART remaining in care. | 477 288 |
| | | 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: 72 427 277<br>F: 3 812 067 |
| | | 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 | 1 060 313 |
| | | 10. Number of health facilities offering MMC services | 70 |
| | | 11. Number of Medical Male Circumcisions performed | 44 000 |
| National Tertiary Services Grant (NTSG) | • To ensure provision of tertiary health services for all south African citizens<br>• 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 | 37 |
| | | 2. Number of registrars associated with training on the public health service delivery platform funded | 8 |
| | | 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 systems (OD) and quality assurance (QA).<br>• Supplement expenditure on health infrastructure delivered through public-private partnerships | 1. Number of health facilities planned, | 0 |
| | | 2. Number of Health facilities designed, | 2 |
| | | 3. Number of Health facilities constructed | 8 |
| | | 4. Number of Health facilities equipped | 7 |
| | | 5. Number of Health facilities operationalized | 2 |

# 9. PUBLIC ENTITIES

| 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 First draft Annual Performance Plan based on the Customised Sector Annual Performance Plan. It has taken into consideration of Annual Report 2016/17 and First and Second Quarter Performance Reports 2017/18. 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[7].
(b) An increase in female life expectancy from 59.7 years in 2009 to 65.8 years in 2014[7].
(c) An increase in male life expectancy from 54.6 years in 2009 to 60.0 years in 2014[7].
(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.

[7] 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[8] to 3.2million in 2014[9].
(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[10]. 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[10].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.

[8] Johnson, LF (2012): "Access to Antiretroviral Treatment In South Africa 2004 – 2011", the Southern African Journal of HIV Medicine, Vol 13, No 1, 2012
[9] National DoH (2015): Annual Report 2014/15, Pretoria
[10] 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[11] | 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<br><br>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<br><br>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 |

[11] 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[11] | 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[12] | 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<br><br>≥ 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<br><br>25% of District Hospital conducting status determinations by 2019 |

[12] 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[12] | 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<br><br>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<br><br>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[13]. 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.

[13] 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<br><br>3000 functional[14] WBPHCOTs by 2019 |
| 2 | Expansion and strengthening of integrated school health services | Minister of Health<br>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 |

[14] 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<br>Supporting Ministers:<br>• Minister of Basic Education<br>• Minister of Correctional Services<br>• Minister of Justice and Constitutional Development<br>• Minister of Social Development<br>• Minister of Trade and Industry Minister of Transport<br>• Minister of Water and Sanitation<br>• 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[15] counselled and screened for blood pressure | None (New Indicator) | 5 million people[15] counselled and screened annually for blood pressure by 2019 |
| | | | Number of people[15] counselled and screened for blood glucose levels | None (New Indicator) | 5 million people[15] counselled and screened annually for blood glucose levels by 2019 |

[15] 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<br><br>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<br><br>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<br><br>(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[16] | 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<br><br>Prep year: 419<br>1st Year: 609<br>2nd Year: 883<br>3rd Year: 919<br>4th Year: 73<br>5th Year: 68 | 90% (951 /1060) of Cuban trained medical students that are in their 3rd, 4th and 5th years complete training by 2019.<br><br>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 |

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

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

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[17] | 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<br><br>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<br><br>52 districts with normative management structures by 2019 |

[17] 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[17] | 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[18] | 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<br><br>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 |
| | | | | | |

[18] 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[19] [20] | 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<br><br>Minister of Justice and Correctional Services | Percentage of correctional services centres conducting routine TB screening | 23%<br><br>(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<br><br>Minister of Basic Education<br><br>Minister of Higher Education<br><br>Minister of Social Development<br><br>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<br>(30% reduction) |

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

| | | | | | |
|---|---|---|---|---|---|
| | | Development<br><br>Minister of Economic Development<br><br>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)[21] | 800 million male condoms distributed annually by 2019 |
| | | | Number of female condoms distributed annually | 5,1 million (2010/11)[22] | 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 |

[21] Health Systems Trust, District Health Barometer, 2012/13
[22] 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[23] | 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%[24] | <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 |

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

[24] 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[23] | 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[23] | 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[25] | Targets |
|---|---|---|---|---|---|
| 1 | Develop a complete System design for a National Integrated Patient based information system | Minister of Health<br><br>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 |

[25] 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[26] | Baseline[27] 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) |

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

[27] 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[26] | Baseline[27] 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<br><br>Minister of Social Development<br><br>Minister of Agriculture<br><br>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 | Annually | 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 | Annually | 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 | Annually | 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<br><br>Categorical | N/A | Outcome | N/A | Annually | 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<br><br>**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<br><br>**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 |
| Communication strategy developed | Development of a plan that express the goals and methods of an organisational outreach activities, including what the | To create awareness to patients and communities with the aim of improving service delivery | Approved communication strategy document | **Numerator:** Number of communication strategies developed | The strategy should inform/ incorporate policy directives of | Output | Number | Annually | Yes | Developed communication strategy | Communication Section |

| Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | department wishes to share with public and stakeholders | and quality of care | | | the department | | | | | | |

**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 rate | Fixed PHC health facilities that have obtained Ideal Clinic status | Monitors outcomes of self (Ideal clinics) assessments to ensure they are ready for inspections conducted by Office of Health Standards Compliance. | Ideal Clinic review tools | **Numerator:** SUM([Ideal clinic status]) **Denominator:** Fixed PHC clinics/fixed CHCs/CDCs | None | Proces/Activity | Percentage | Annual | Yes | Higher Ideal clinic status rates ensures clinics will have positive outcomes and is ready for inspections conducted by Office of Health Standards Compliance. | Ideal Clinic review tools |
| 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<br><br>Denominator :<br>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] ) **Denominator:** Sum([Population - Total)] | 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 underutilization of facility | DHS Manager |
| 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) | Percentage of hospitals that have conducted annual self assessment of the National Core Standards scoring above 75% of extreme and vital domains to ensure quality of health care. | 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 |
| 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]) | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | **Denominator:** SUM([Complaint resolved]) | | | | | | | |

**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 | Number | Quarterly | No | Higher number indicated better distribution (and indirectly better uptake) of condoms in the province | HIV/AIDS Cluster |
| Improve TB cure rate | Percentage of TB clients who successfully cured for TB during the reporting period | Monitors impact of TB treatment Programme | ETR.net report | Numerator: TB client cured<br><br>Denominator: TB client start on treatment | Depends on management of registers | Outcome | Percentage | Annually | 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 (naive) + Experienced (Exp) + Transfer | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 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 number 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 community (e.g. campaigns, non- | Monitors distribution of male condoms for prevention of HIV and other STIs, and for contraceptive purposes. Primary distribution sites | Numerator: Stock/Bin card | SUM([Male condoms distributed]) | None | Process | Number | Quarterly | No | Higher number indicated better distribution (and indirectly better uptake) of | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | traditional outlets, etc.). | (PDS) report to sub-districts on a monthly basis | | | | | | | | condoms in the 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 | Number | 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 Comprehensive 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 | Percentage | 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, pulmonary and extra pulmonary) | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 proportion of TB MDR confirmed | Monitors success of MDR TB treatment | TB Register; EDR Web | Numerator: SUM([TB MDR client successfully complete treatment]) Denominator: | Accuracy dependent on quality of data submitted health facilities | Outcome | Percentage | Annually | Yes | Higher percentage indicates a better treatment 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | clients started on treatment | | | SUM([TB MDR confirmed client start on treatment]) | | | | | | | |

**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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Strategy to amplify implementation of programmes focusing on the reduction of maternal and infant mortalities developed | Communication strategies to aim to improve maternal health by reducing maternal mortality and ensuring universal access to reproductive health | To assist in the reduction of maternal and infant mortalities | Existing policies and plans should inform the desired output/ strategy | Numerator:<br>Number of strategies amplify implementation of programmes focusing on the reduction of maternal and infant mortalities developed | The strategy should inform/ incorporate policy directives the MNCWH programme | No | No | Annually | Yes | Developed Strategy aimed to amplify implementation of programmes focusing on the reduction of maternal and infant mortalities | MNCWH programme manager |
| 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:**<br>SUM([Antenatal 1st visit before 20 weeks])<br>**Denominator:**<br>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:<br>SUM([Mother postnatal visit within 6 days after delivery])<br>Denominator:<br>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 |

| Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 |
| 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 | Output | Percentage Annualised | Quarterly | No | Higher percentage indicate better immunisation coverage | EPI 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | (counted only ONCE when last vaccine is administered .) | | | | | | |
| Measles 2nd dose coverage | Children 1 year (12 months) who received measles 2nd dose, as a proportion of the 1 year population.. | Monitors protection of children against measles. Because the 1st 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 | PHC Comprehensive Tick Register Denominator: StatsSA | Numerator: SUM([Measles 2nd dose])<br><br>Denominator: SUM([Female 1 year]) + SUM([Male 1 year]) | Accuracy dependent on quality of data submitted health facilities | Output | Percentage | Quarterly | No | Higher coverage rate indicate greater protection against measles | EPI |
| 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 | Ward register | Numerator: SUM([Diarrhoea death under 5 years])<br>Denominator: SUM([Diarrhoea separation under 5 years]) | Reliant on accuracy of diagnosis / cause of death<br><br>Accuracy dependent on quality of data submitted health facilities | Impact | Percentage | Quarterly | No | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 |
| 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 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 | Annually | 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 | Quarterly | Yes | Higher number indicates greater proportion of school | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | children received health services at their school | |
| 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 number indicates greater proportion of school children received health services at their school | School health services |
| 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:<br>SUM [Delivery 10–14 years in facility] + [Delivery 15–19 years in facility]<br>Denominator:<br>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 | 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<br>Denominator:<br>StatsSA | Numerator<br>(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) + | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 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) + (Female condoms distributed / 120) + (Male sterilisation x 10) + (Female sterilisation x 10). | | | (SUM([Female condoms distributed]) / 120) + (SUM([Sub-dermal implant inserted]) * 2.5) Denominator: SUM {[Female 15-44 years]} + SUM{[Female 45-49 years]} | | | | | | | |
| 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 | HPV Campaign Register – captured | SUM([Agg_Girl_09_yrs_HPV 1st dose]) + SUM([Agg_Girl 10 yrs HPV 1st dose]) + SUM([Agg_Girl_11_yrs_HPV | None | Output | Number | Annually | No | Higher number indicate | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | which will aggregate as the campaign progress and reflect the coverage so far | electronically on HPV system | 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]) | | | | | | better coverage | |
| HPV 2nd dose | Girls 9yrs and older HPV 2nd 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 2nd dose]) + SUM([Agg_Girl 10 yrs HPV 2nd dose]) + SUM([Agg_Girl 11 yrs HPV 2nd dose]) + SUM([Agg_Girl 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]) | None | Output | Number | Annually | No | Higher number indicate better coverage | MNCWH Programme Manager |
| 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 |

| Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100,000 live births in facility | 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 all maternal mortality). Provides indication of health system results in terms of prevention of unplanned pregnancies, antenatal care, delivery and postnatal services | 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 |
| 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 | Rate (per 1000 live births) | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of District Mental Health Teams established | Number of Mental Health teams consisting of Psychiatrists, Psychiatric Nurse, Psychologist, Occupational therapist, and social worker as a team | Monitor and support mental health programme | PERSAL | Number of District Mental Health teams established | Accuracy of PERSAL system | Input | Number | Annual | Yes | Increase in number of mental health teams established | Mental Health Program |
| 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<br><br>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<br><br>**Denominator**: Total number of Malaria cases reported | Accuracy dependant on quality of data from health facilities | Outcome | Percentage | 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 medical resource arrives on scene | 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 | Output | Percentage | Quarterly | No | Higher percentage indicate better response times in the urban areas | EMS Manager |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 inter-facility transfer]) **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<br><br>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<br>**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<br>Sum ([Inpatient days total x 1])+([Day patient total x 0.5])<br>Denominator<br>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])<br>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**<br>SUM([Expenditure - total])<br>**Denominator**<br>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 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<br>Number of essential drugs available at depot<br><br>Denominator<br>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<br>Number of facilities complying with Radiation Control prescripts<br><br>Denominator<br>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 |
| Improve laundry services by developing a | Development of a model that provides a guide | Improve laundry service | Documented laundry service model | Numerator<br>Laundry service models | None | Input | Number | Annual | Yes | Documented laundry service model | Laundry Services Management |

| Indicator Name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|
| provincial laundry model | on implementation of laundry service for all hospitals | | | developed documented | | | | | | | |
| 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, preservation of bodies and generation of | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 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 perform | Improve conditions of facilities and increases access to | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | maintenance work in health facilities | health 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,<br><br>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 |