health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

ANNUAL PERFORMANCE PLAN 2019/2020

Submission Date: April 2019

MPUMALANGA
THE PLACE OF THE RISING SUN

"A Long and Healthy Life For All South Africans..."

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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

This second Draft APP 2019/20 is in preparation for the last cycle of the current administration (MTSF 2014 – 2019). It would also form the basis for the projection of the new administrative cycle horizon.

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 grappled with was the shortage of managers and health professionals. The Department has indeed met its plans of filling most vacant posts although there is still a lot to be done.

The Department has appointed the following three keys positions to strengthen top management structure: Deputy Director General, Finance; Deputy Director General Clinical Health Services and Chief Director Hospital Services. The Department has advertised the post for Director: Emergency Services, Chief Director: Primary Health Care, Director: Quality assurance, Director: HIV & AIDS, STI and TB, Director: Engineering and Technical Services and Clinical posts. The Department should be on the right course to alleviate shortage of staff at both Provincial Office and Institutions. There might be a setback due to a recent budget of R173, 890 m during the budget adjustment.

The Department has reduced qualifications from seven (7) qualifications in 2015/16 and three (3) qualifications in 2016/17 to one (1) qualification in 2017/18. The Department was this time around qualified on contingent liabilities. For the first time the Department was able to get its movable asset correct. The Department will continue to strengthen its assets verification project. 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.

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MS S MANZINI
MEC: HEALTH

25/04/19

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 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 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

25/04/2019
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, Ms S Manzini**
- 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 2019/20.

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Mr P.P. Mamogale
Chief Financial Officer

25/04/2019
Date

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

25/04/2019
Date

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Dr S Mohangi
Accounting Officer

28/04/2019
Date

APPROVED BY:

.....
Ms S Manzini
Executive Authority

25/04/2019
Date

PART A –

4. STRATEGIC OVERVIEW

4.1 VISION

"A Healthy Developed Society".

4.2 MISSION

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

4.3 VALUES

- Commitment
- Appropriateness
- Timeousness
- Collectiveness
- Competency

4.4 STRATEGIC GOALS

National Development Plan 2030

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

By 2030, South Africa should have:

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

Sustainable Development Goals 2030

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

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

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

Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

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

NDP Goals 2030	SDG Goals 2030
Average male and female life expectancy at birth increased to 70 years	
Tuberculosis (TB) prevention and cure progressively improved;	• End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
Maternal, infant and child mortality reduced	• Reduce the global maternal mortality ratio to less than 70 per 100,000 live births. • End preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
Prevalence of Non-Communicable Diseases reduced	• Reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol • Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
Injury, accidents and violence reduced by 50% from 2010 levels	• By 2020, halve the number of global deaths

NDP Goals 2030	SDG Goals 2030
	and injuries from road traffic accidents
Health systems reforms completed	• Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
Primary health care teams deployed to provide care to families and communities	• Ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
Universal health coverage achieved	• Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
Posts filled with skilled, committed and competent individuals	• Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States

Strategic Goals 2020

TABLE A1: STRATEGIC GOALS AND STRATEGIC OBJECTIVES

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

TABLE A2: IMPACT INDICATORS AND TARGETS

Impact Indicator	South Africa Baseline (20091)	South Africa Baseline (20142)	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 SITUATIONAL ANALYSIS

4.5.1 Demographic Profile

Mpumalanga Province has an estimated total population of above 4.5 million people according to the Mid-Year Estimates conducted by Statistics South Africa (StatsSA 2018). It is estimated that the population growth rate has been 2% per annum since 2001. 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, with a population density of 59 people per square kilometre. The Province contribute 7.8% of the total population in South Africa. The municipal area is predominantly rural in nature and the majority of the population reside in the rural areas. The province comprises of three districts municipalities, namely Ehlanzeni, Nkangala and Gert Sibande District, all sharing a total of 320 health facilities.

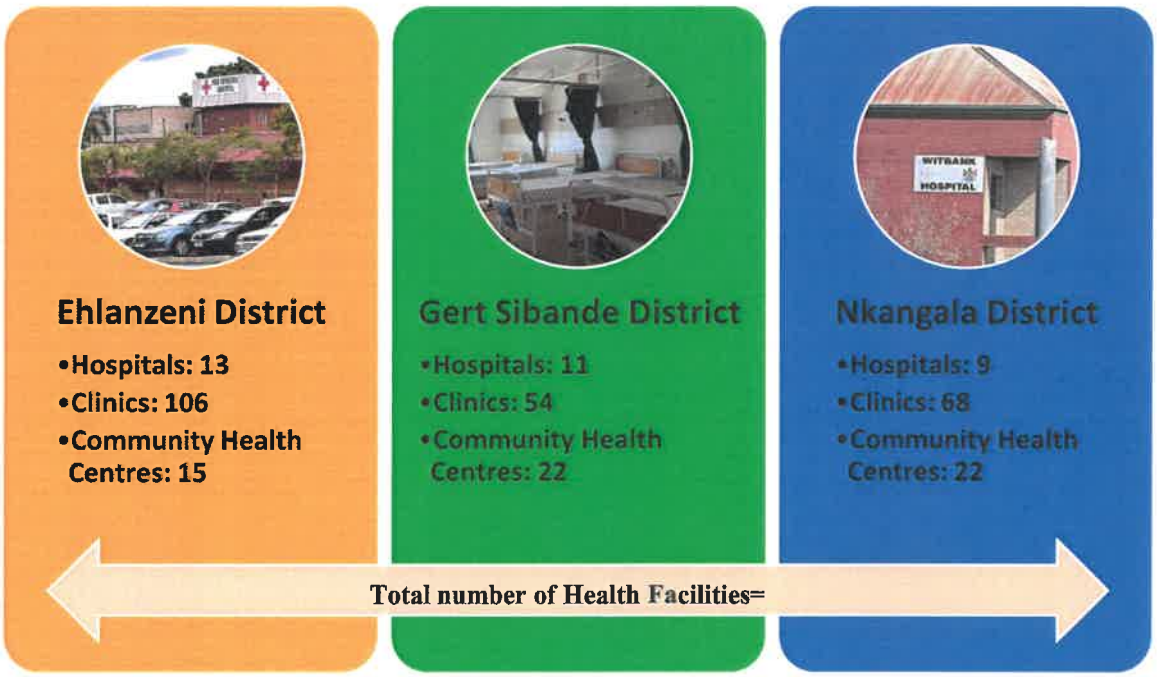


Figure 1: Health facilities in Mpumalanga Province

Geographic location

Mpumalanga Province is proximal to the international borders of Mozambique (located east of the province) and eSwatini (on the southeast of the province). Provincial borders include Limpopo Province to the north, KwaZulu-Natal to the south-east, Free State Province to the south-west and Gauteng Province to the west (see figure 2). The capital city of Mpumalanga Province is in Mbombela (Swati: A lot of people together in a small space), a town previously known as Nelspruit.

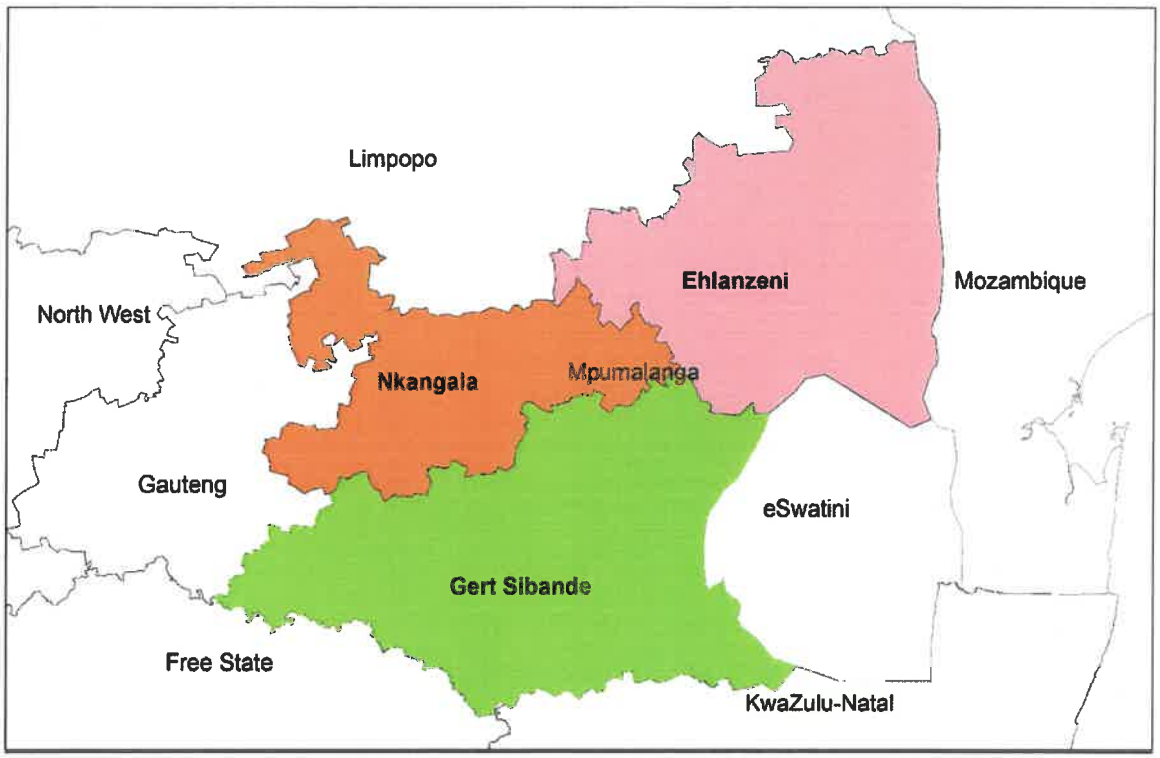


Figure 2: Mpumalanga Provincial Map

Mpumalanga's economy

Mpumalanga's economy is dominated by mining, mostly coal for the Eskom power plants that are also located in the province. The province also has extensive heavy industry, which forms part of the long-standing Highveld complex, and a strong commercial agricultural sector. Furthermore, the province has always been one of South Africa's top tourist destination with its extraordinary attractiveness of the Lowveld and escarpment, and to the north of the Ehlanzeni District is the south-eastern section of the Sabie River in the Kruger National Park which attract a significant number of tourist to the province.

Table 1: Main economic activities in Mpumalanga Province

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

Source: CS 2016: Community Survey STATSSA

Provincial population

The mid-year population estimates of 2018 by Statistics South Africa indicates that Mpumalanga population grew from 4,444,212 in 2017 to 4,523,874 in 2018 (StatsSA, 2018), an increase by 76,662 people. This reflect a growth of 1.8%, which could also be attributed to the inter-provincial as well as international migration patterns across these borders in pursuit of economic opportunities offered by the province.

Table 2: Population per province

Provinces	Census 1996	Census 2001	Census 2011	CS 2016	Mid-year estimation 2017	Mid-year estimation 2018	% of total population
Eastern Cape	6,147,244	6,278,651	6,562,053	6,996,976	6 498 683	6 522 700	11.3
Free State	2,633,504	2,706,775	2,745,590	2,834,714	2 866 678	2 954 300	5.1
Gauteng	7,624,893	9,178,873	12,272,263	13,399,725	14 278 669	14 717 000	25.5
Kwazulu-Natal	8,572,302	9,584,129	10,267,300	11,065,240	11 074 784	11 384 700	19.7
Limpopo	4,576,133	4,995,534	5,404,868	5,799,090	5 778 442	5 797 300	10.0
Mpumalanga	**3,124,203**	**3,365,885**	**4,039,939**	**4,335,964**	**4 444 212**	**4 523 900**	**7.8**
Northern Cape	1,011,864	1,058,060	1,145,861	1,193,780	1 213 996	1 225 600	2.1
North West	2,936,554	3,271,948	3,509,953	3,748,436	3 856 174	3 979 000	6.9
Western Cape	3,956,875	4,524,335	5,822,734	6,279,730	6 510 312	6 621 100	11.5
South Africa	40,583,573	44,819,778	51,770,560	55,653,655	56 521 948	57 725 600	100.0

(Source: Census 1996: Census 2001, Census 2011, CS 2016, Mid-year estimate (StatsSA, 2017,2018)

Forty-nine percent of South Africans are males with females having the slightest majority of 51%. Mpumalanga Province displays similar trends as the South African population with females dominating at 51%. According to StatsSA (2018), youth of the age group 15-34 years account for 36.0% of the population in the province.

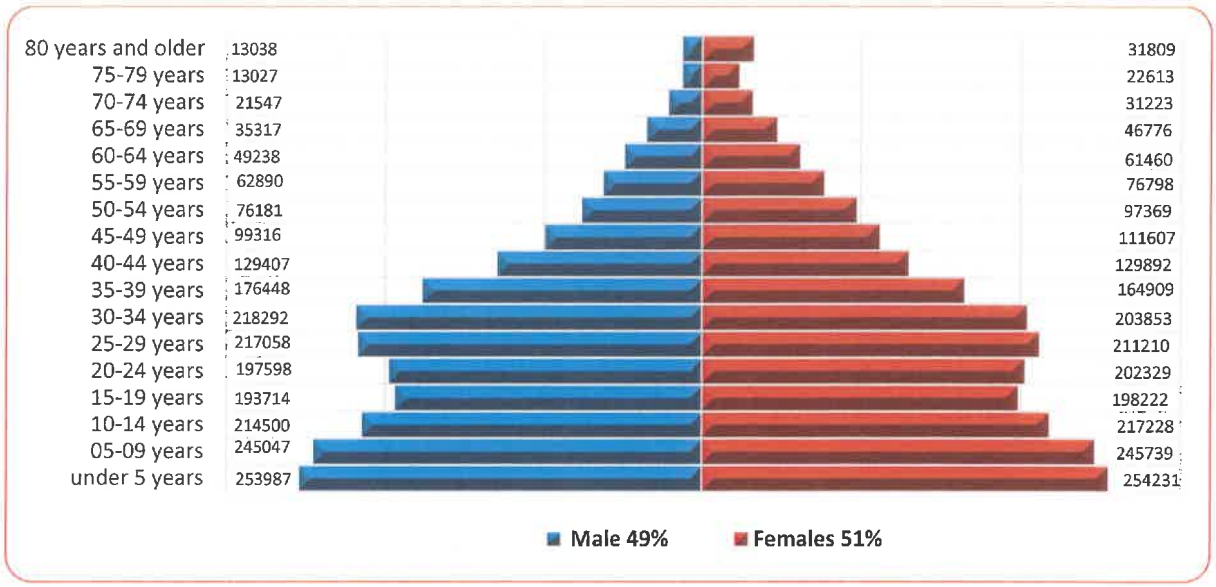


Figure 3: Mpumalanga Population Pyramid
Source: Mid-Year Estimates 2018 (StatsSa)

The figure above shows the provincial pyramid as per the mid-year estimate of 2018 by StatsSA, indicating a tremendous growth of above 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 the middle age of 25-39 years old, where the proportion of males is higher. The increase in population attest the need to procure more resources for attainment of health outcomes, with emphasis on mother and child programme. Further analysis should be done since this is a nationwide phenomenon.

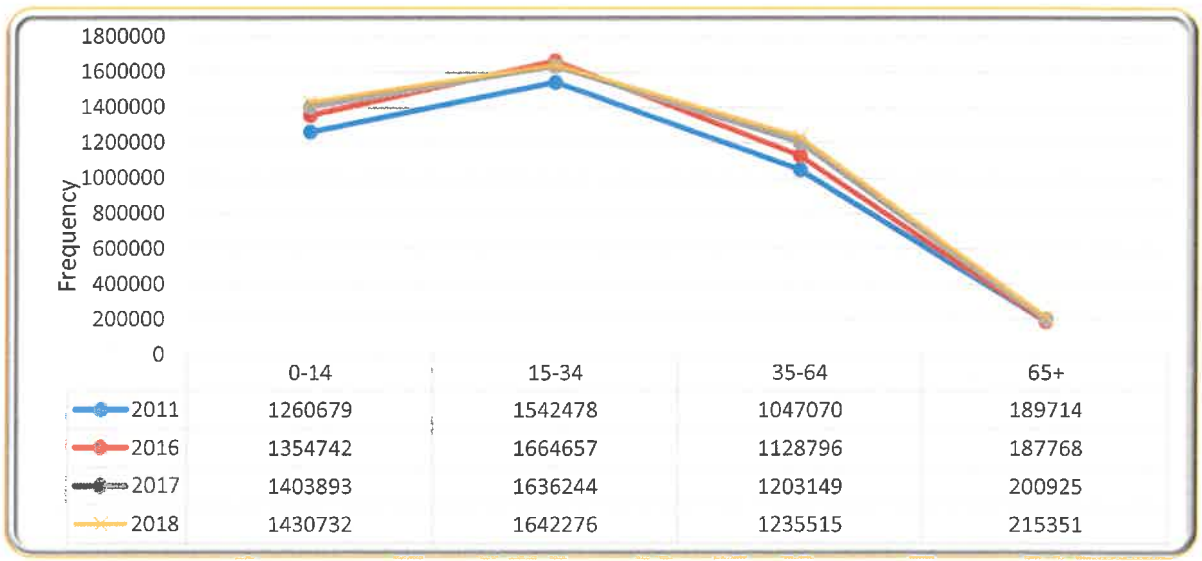


Figure 4: Mpumalanga Population Size
Source: Mid-Year Estimates 2018 (StatsSa)

All age groups as indicated in the figure above showed an increase in population size in 2018 compared to 2017, although the population size of the age group 15-34 is still in 2018 compared to the population size in 2016 (see figure 4 above).

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.

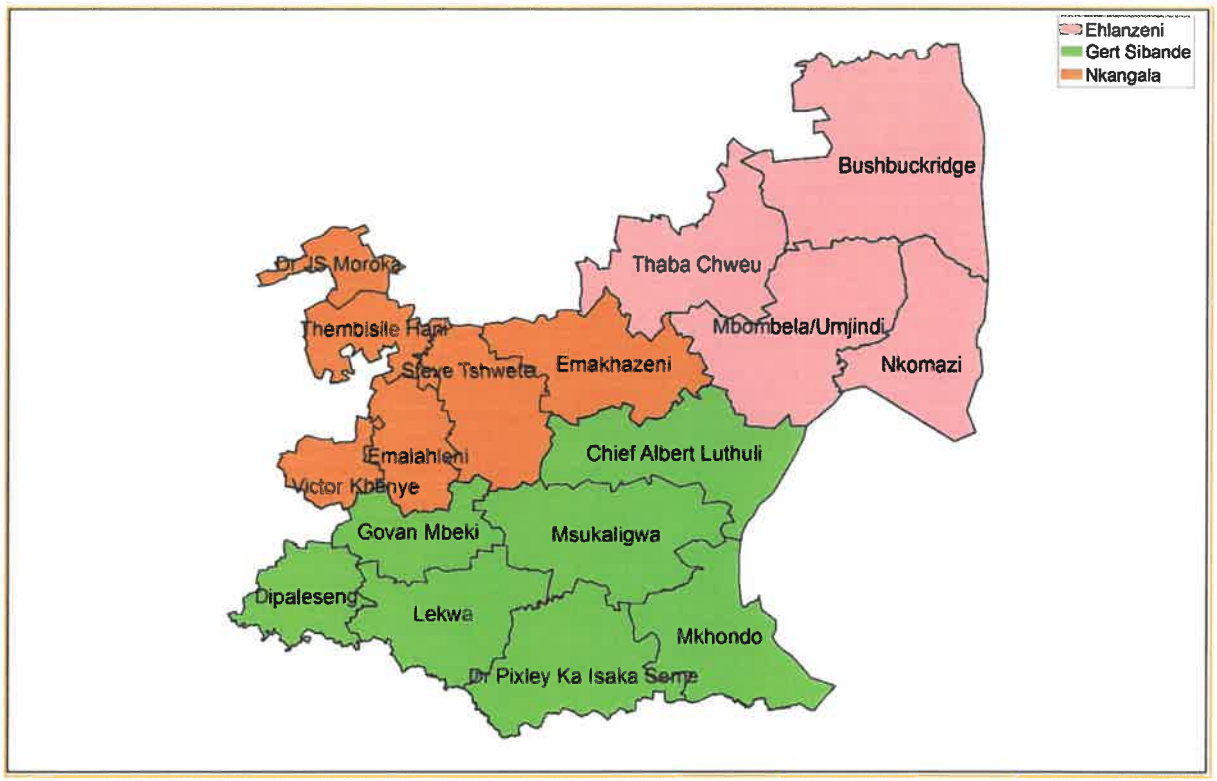


Figure 5: District Municipalities in Mpumalanga Province

i. Demographics in Ehlanzeni District

The Mid-Year estimates report for 2018 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% of the people in the province (CS 2016).

Forty one percent (41%) of the people in Mpumalanga Province reside in Ehlanzeni District as per the Community Survey of 2016 which is higher than of the other two districts. The district has the second highest total surface area of 27 896 square kilometres in the province, accommodating at least 63 people per square meter.

There are four sub-districts at Ehlanzeni District, which are Bushbuckridge, Mbombela, Nkomazi, and Thaba Chweu. Nkomazi is further divided into Nkomazi East and West, and incorporates a number of small towns including Louw's Creek; Kaapmuiden; Malelane, Hectorspruit, Marloth Park, Komatipoort, KaMhlushwa, Tonga and KaMaqhekeza. These areas are in close proximity with the province's international borders and therefore require a substantial investment in infrastructure and the general provision of healthcare services to these communities.

Mbombela Municipality, which houses the capital city of Mpumalanga, is situated in the North Eastern part of South Africa within the Lowveld sub region of the Mpumalanga Province, and is divided into Mbombela South and North. Mbombela is one of the fastest growing cities in South Africa, and recently amalgamated with the former Umjindi Sub-district to form the City of Mbombela, which is home to approximately 16% of the total population in Mpumalanga Province.

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).

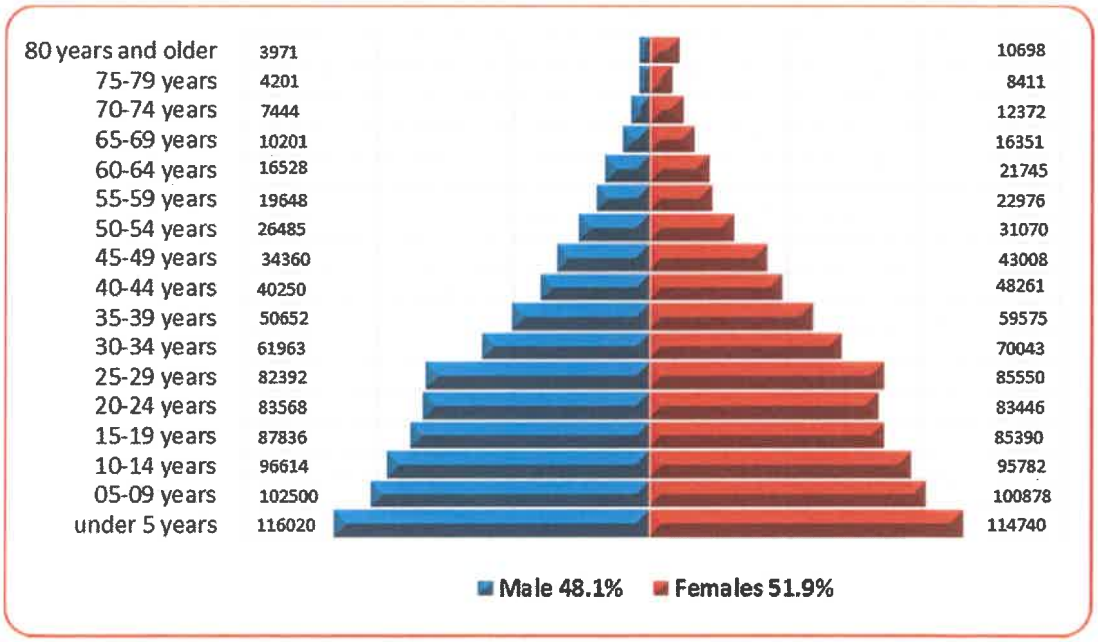


Figure 6: Ehlanzeni District: Source CS 2016

ii. Demographics in Gert Sibande District

Only a total of 26% of the people in Mpumalanga Province reside in Gert Sibande District as per the Community Survey of 2016, which is less than the other two districts. In comparison with the other districts in Mpumalanga Province, Gert Sibande District is sparsely populated, and has a total surface area of 31 841 square kilometres, with at least 36 people per square meter.

There are seven sub-districts in Gert Sibande District, which are Albert Luthuli, Dipaliseng, Govan Mbeki, Lekwa, Mkhonto, Msukaligwa, and Pixley Ka Seme sub-districts municipalities. The district's headquarters are in Ermelo (Msukaligwa Sub-district Municipality).The eastern extent of the Gert Sibande District forms the anchor of the tourism corridor in the district, with its R23 and R541 routes connecting KZN to the Kruger National Park. Since 2008 to 2013, the district also had the highest HIV prevalence in the province.

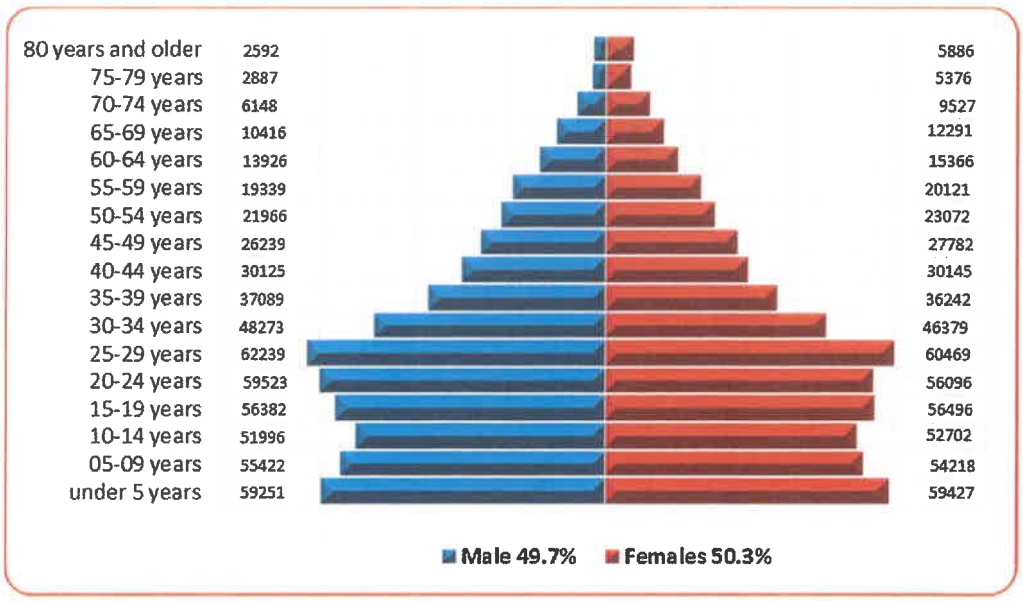


Figure 7: Gert Sibande District: Source CS 2016

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 makes up 33% of the population in Mpumalanga Province as per the Community Survey of 2016, and has the smallest surface area of 16758 square kilometres. The six sub-districts of Nkangala District, Dr JS Moroka, Thembisile, Emalahleni, Emakhazeni, Dr Victor Khanye and Steve Tshwete, are densely populated with 86 people per square meter as compared with the other two districts of Mpumalanga Province.

The district's headquarters are in Middelburg town, and connects the province to provinces like Limpopo, Gauteng and Northwest. The proximity to Gauteng has potential to create opportunities to a larger market, which is of benefit to the district's agricultural and manufacturing sectors.

As per the Community Survey of 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.

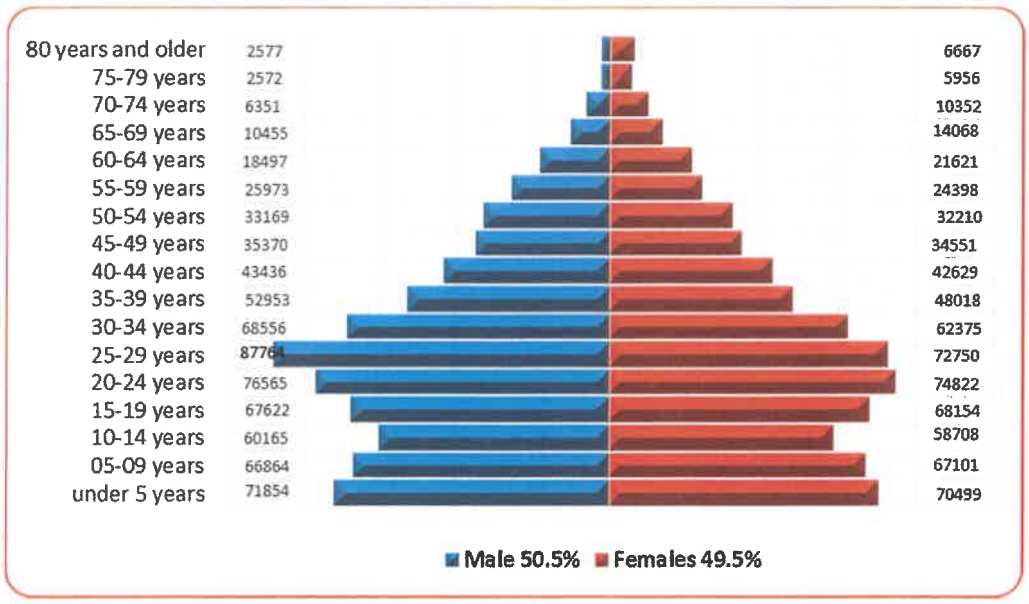


Figure 8: Nkangala District Municipality: Source CS 2016

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. From 2016 to 2017, the province grew by 2.5%, whereas from 2017 to 2018, there was a 1.8 growth in the province. This illustrate that on average, a 2% growth should be expected annually in Mpumalanga Province.

Table 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	Population Mid-Year Estimates 2018	% Change from 2017-2018
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**	***4,523,874**	**1.8%**

(Source: Stats SA 2007: Census 2001, Community Survey 2007, and Census 2011-Midyear estimates 2017&18, 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 sub-districts municipalities as indicated in Table 4 below. From the year 2001 to 2016 (15 year period), Steve Tshwete Sub-district almost doubled the population size, with a percentage change of 95.2. This is as a results of a number of economic opportunities available at this sub-district. It is followed by Emalahleni Sub-District at a percentage change of 64.7 population growth from 2001 to 2016. Govan Mbeki and Victor Khanye Sub-Districts 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 Sub-District registered a negative population growth of -0.2. Dr JS Moroka and Pixley Ka Seme Sub-Districts grew by less than 10% for the period 2001 to 2016, as indicated in Table 4 below.

Table 4: Population by Geographic Distribution (Sub-Districts) within the total population per municipality

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

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

4.5.2 Socio-Economic Profile

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, although the poverty headcount in Mpumalanga achieved a slight decrease from 7.9% in 2011 and 7.8% in 2016. A total of 273 886 of households in Mpumalanga reported that they had ran out of money in the last 12 months before the community survey of 2016 was conducted.

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.

Table 5: Rural vs. Urban Areas of Mpumalanga Province

	2016 Classification of Population			
	South Africa		Mpumalanga	
	Frequency	Percentage	Frequency	Percentage
Traditional	18019427	32.4	2127106	49.1
Farms	2178781	3.9	297683	6.9
Urban	35455447	63.7	1911175	44.0
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, 2016/17).

Climate change

Global climate change is arguably the greatest contemporary geographical challenge. Climate change, also called global warming, refers to the rise in average surface temperatures on Earth. It 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. Scientist believe that it will likely become more difficult in the future to address the potential serious health implications of climate change if efforts are not put into place currently to mitigate climate change, by reducing greenhouse gas emissions, as this has many health co-benefits and should be a top public health priority.

Climate change is currently affecting the health of populations and is projected to do so far into the future. Health effects of climate change 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

The quality of life is a fundamental aspect of development and advancement of human societies, and often this quality of life is measured and expressed in terms of the availability of basic services in communities. 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 6: Percentage households with no access to improved sanitation

Main Type of Toilet Facility	Frequency	Percentage
Flush toilet connected to a public sewerage system	1717273	39.6
Flush toilet connected to a septic tank or conservancy tank	106880	2.5
Chemical toilet	146208	3.4
Pit latrine/toilet with ventilation pipe	707532	16.3
Pit latrine/toilet without ventilation pipe	1350560	31.1
Ecological toilet (e.g. urine diversion; enviroloo; etc.)	22333	0.5
Bucket toilet (collected by municipality)	7605	0.2
Bucket toilet (emptied by household)	29058	0.7

Other	128618	3.0
None	119896	2.8
Grand Total	**4335964**	**100.0**

Source: CS 2016

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

- One percent of the people in Mpumalanga Province still uses bucket toilets, while 5.8% either uses a different form of toilet system or do not have toilets;
- About 3.7% fetch water from river, dam, stream, well, spring or any other than the tap, which may expose people to a number of diseases;
- About 6.0% do not have refuse removal;
- About 6.8% have no access to electricity for lighting.

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

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

Source: CS 2016

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

Access to refuse removal	Frequency	Percentage
Removed by local authority/private company/community members at least once a week	1598974	36.9
Removed by local authority/private company/community members less often than once a week	131876	3.0
Communal refuse dump	183389	4.2
Communal container/central collection point	39743	0.9

Own refuse dump	2054914	47.4
Dump or leave rubbish anywhere (no rubbish disposal)	260346	6.0
Other	66722	1.5
Grand Total	**4335964**	**100.0**

Source: CS 2016

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

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

Source: CS 2016

Reliance on Public Facilities

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 2017 General Household Survey reveals that seven in every ten (71.2%) households in the country went to public clinics and hospitals as their first point of access when household members fell ill or got injured. More importantly was that the study found that 81.7% of households that attended public health-care facilities were either very satisfied or satisfied with the service they received compared to 97.3% of households that attended private health-care facilities. In addition to the health facilities as indicated on the table below, the province provide mobile health services to areas where there are no/fewer health facilities.

Table 10: Public Health Facilities in Mpumalanga Province

District	Hospitals	Clinics	Community Health Centres (CHCs)
Ehlanzeni District	1 Tertiary Hospital (Rob Ferreira)	106 Clinics	15 CHCs
	2 Regional Hospitals (Mapulaneng and Themba)		
	2 TB Hospitals (Barberton & Bongani)		
	8 District Hospitals		
Sub-Total	13 Hospitals	106 Clinics	15 CHCs
Gert Sibande District	0 Tertiary Hospital	54 Clinics	22 CHCs
	1 Regional Hospitals (Ermelo Hospital)		
	2 TB Hospitals (Standerton and Sesifuba TB)		
	8 District Hospitals		
Sub-Total	11 Hospitals	54 Clinics	22 CHCs

District	Hospitals	Clinics	Community Health Centres (CHCs)
Nkangala District	1 Tertiary Hospital (Witbank Hospital)	68 Clinics	22 CHCs
	0 Regional Hospital		
	1 TB Hospital (Witbank TB Hospital)		
	7 District Hospitals		
Sub-Total	9 Hospitals	68 Clinics	22 CHCs
Total	33 Hospitals	228 Clinics	59 CHCs
		287 PHC Facilities	
Grand Total	**320 Health Facilities**		

The figure below shows the density of public health facilities in Mpumalanga Province, which comprises of a total of 320 health facilities, made up of 33 Hospitals and 287 PHC facilities. Ehlanzeni District where 41% of the people in Mpumalanga Province reside, has 42% of the PHC facilities, and 39% of Hospitals.

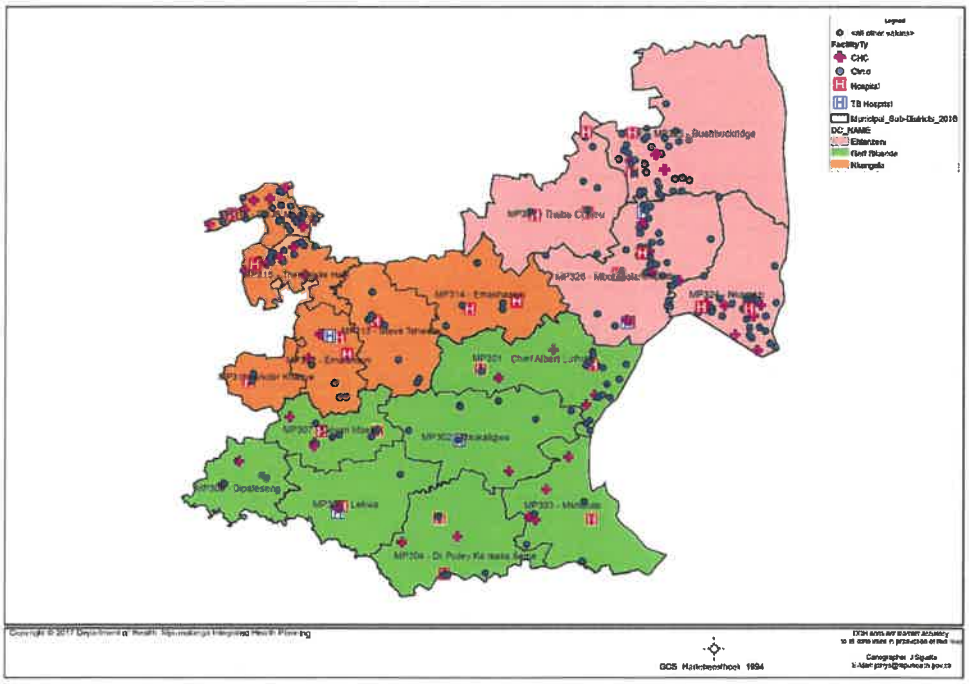


Figure 9: Mpumalanga Provincial Health Facilities

Insured population and Unemployment Rate

The General Household Survey of 2017 by Statistics South Africa indicates that about seven in every ten households reported that they made use of public clinics, hospitals or other public institutions as their first point of access when household members fell ill or got injured. Approximately 16.9% of the people in South Africa belonged to a medical aid scheme in 2017. The leading barrier to private healthcare in South Africa continues to be the price. The millions of South Africans living without medical cover put increasing pressure on the public health system, and Mpumalanga Province is no exception.

The Departmental Annual Patient Satisfaction Survey (APSS) of 2016/17 financial year shows that 84% of patients interviewed were without medical aid. Only 6% of the patients were users of medical aid (APSS 2016/17).

According the Quarterly Labour Force Survey (Quarter 2: 2018 (Apr-Jun 2018), the official Unemployment rate for Mpumalanga Province stands at 33.2%, which represent a 0.9% increase from the same period last year. However, the expanded unemployment rate is at 41.7% which increased by 0.3% 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 11: Unemployment Rate by Province

	Official unemployment rate					Expanded unemployment rate				
	Apr-Jun 2017	Jan-Mar 2018	Apr-Jun 2018	Qtr-to-qtr change	Year-on-year change	Apr-Jun 2017	Jan-Mar 2018	Apr-Jun 2018	Qtr-to-qtr change	Year-on-year change
	Per cent			Percentage points		Per cent			Percentage points	
South Africa	27,7	26,7	27,2	0,5	-0,5	36,6	36,7	37,2	0,5	0,5
Western Cape	20,7	19,7	20,7	1,0	0,0	24,6	22,5	23,2	0,7	-1,4
Eastern Cape	34,4	35,6	34,2	-1,3	-0,2	44,5	46,0	45,8	-0,3	1,3
Northern Cape	30,5	29,5	28,9	-0,6	-1,6	45,3	41,0	42,4	1,4	-2,9
Free State	34,4	32,8	34,4	1,6	0,0	40,5	38,4	40,1	1,7	-0,4
KwaZulu-Natal	24,0	22,3	21,8	-0,5	-2,2	40,4	40,6	40,9	0,3	0,5
North West	27,2	25,8	26,1	0,3	-1,1	42,0	41,8	43,4	1,6	1,4
Gauteng	29,9	28,6	29,7	1,1	-0,2	32,9	33,6	34,4	0,8	1,5
Mpumalanga	32,3	32,4	33,2	0,8	0,9	41,4	42,5	41,7	-0,8	0,3
Limpopo	20,8	19,9	19,3	-0,6	-1,5	37,1	37,6	37,4	-0,2	0,3

Source: StatsSA (Quarterly Labour Force Survey: Quarter: 2:2018)
* 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 (StatsSA, 2018). 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. Of the 8.7% of the GDP that is spend on health,

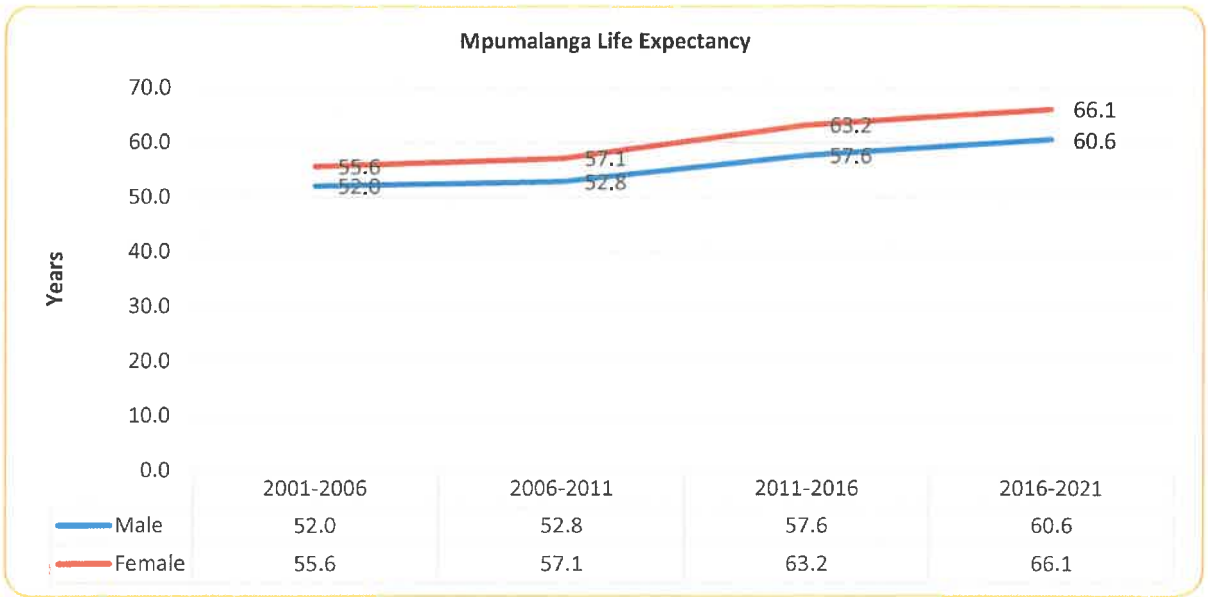
4.5% is spent on 16% of the population, the well-to-do who have medical aid. The rest of the 84% of the population have to make do with the remaining 4.2% of the GDP. The South African health care system has been characterized as fragmented and inequitable due to the huge disparities that exist between 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 16% of the population. The distribution of key health professionals between the two sectors is also skewed for example, the doctor patient ratio is as high as 1:4000 in the public sector while it is 1:250 in the private sector. The poor health outcomes can be attributed to a number of factors however, are evidenced through a decline in life expectancy in the country.

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 61.4 in 2002 which increased to 64.5 in 2018. Whereas for females it increased from 68.3 in 2002 to 71.5 in 2018. The average life expectancy for South Africa in 2017 is 64.0 (Mid-Year Estimates, 2018). It is noted also that life expectancy has always remained high in females than males in all years by approximately 5.5 years in the last 5 years.

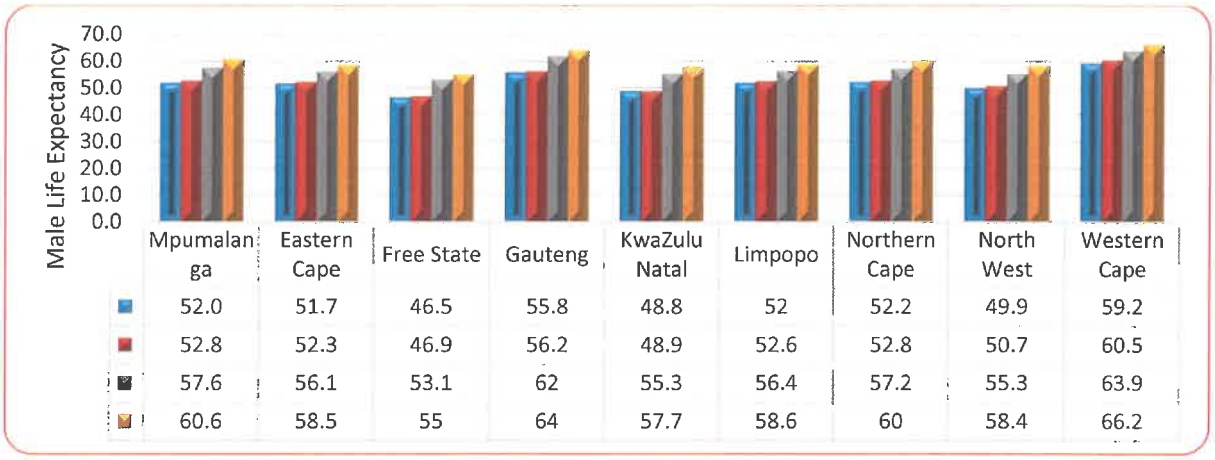
According to Statistics South Africa, the projected life expectancy for males in the province increased from 57.6 in the period 2011-2016, to 60.6 for the period 2016 to 2021. These projections show an improvement by 3.0 years for males. The projections for females show an improvement by 2.9 years, from 63.2 in the period 2011-2016 to 66.1 for the period 2016-2021. The average life expectancy for Mpumalanga Province increased from 60.4 in 2011-2016 period to 63.4 years for the period 2016-2021 (Mid-Year Estimates, 2018).



	2001-2006	2006-2011	2011-2016	2016-2021
Male	52.0	52.8	57.6	60.6
Female	55.6	57.1	63.2	66.1

Figure 10: Illustrates life expectancy pattern since 2001 – 2021 (Source: Mid-year population estimates 2018 (StatsSA))

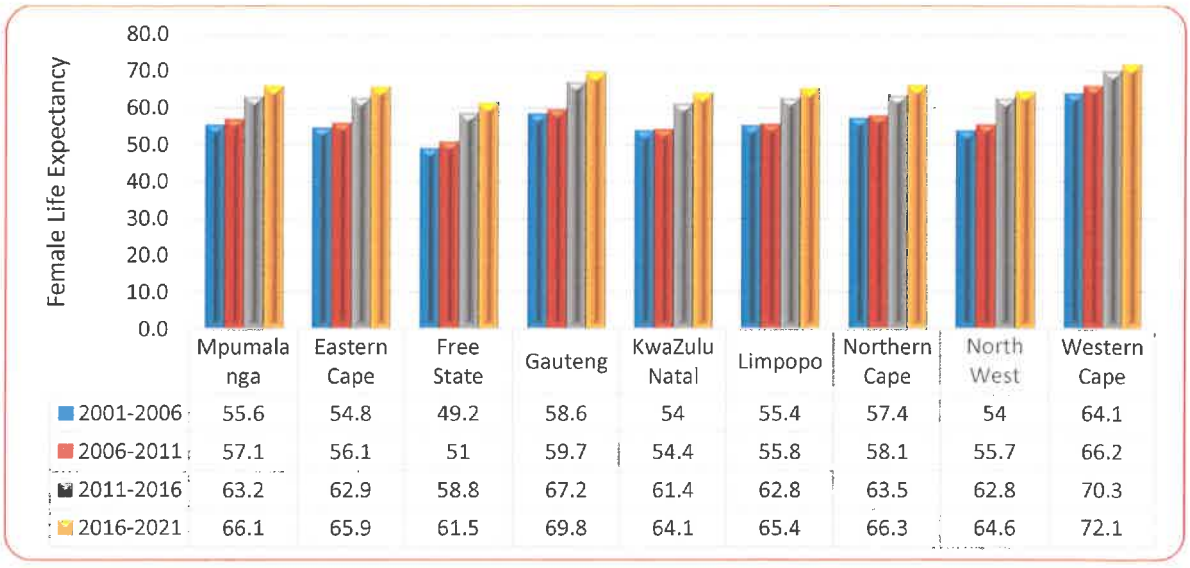
With regard to life expectancy for males in South Africa, Mpumalanga has now the third highest life expectancy figure after Western Cape (66.2 years) and Gauteng (64.0 years), respectively. Free State province being the lowest on a life expectancy of 55.0 years, followed by KwaZulu Natal with 57.7 years. However, from the life expectancy period of 2011-2016 to 2016-2011, North West Province has the highest improvement figure of 3.1 years, followed by Mpumalanga with an improvement figure of 3.0 years.



	Mpumalanga	Eastern Cape	Free State	Gauteng	KwaZulu Natal	Limpopo	Northern Cape	North West	Western Cape
	52.0	51.7	46.5	55.8	48.8	52	52.2	49.9	59.2
	52.8	52.3	46.9	56.2	48.9	52.6	52.8	50.7	60.5
	57.6	56.1	53.1	62	55.3	56.4	57.2	55.3	63.9
	60.6	58.5	55	64	57.7	58.6	60	58.4	66.2

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 66.1 years. Western Cape is the highest with an average of 72.1 years (2016-2021), followed by Gauteng (69.8 years) and Northern Cape (66.3 years) for the same period (Mid-Year Estimates, 2018). 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	55.6	54.8	49.2	58.6	54	55.4	57.4	54	64.1
2006-2011	57.1	56.1	51	59.7	54.4	55.8	58.1	55.7	66.2
2011-2016	63.2	62.9	58.8	67.2	61.4	62.8	63.5	62.8	70.3
2016-2021	66.1	65.9	61.5	69.8	64.1	65.4	66.3	64.6	72.1

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. High risk persons remain children under the age of five years, pregnant women & immune-compromised people (e.g. HIV, a person who has had a splenectomy, or who is on immunosuppressant medication). 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.

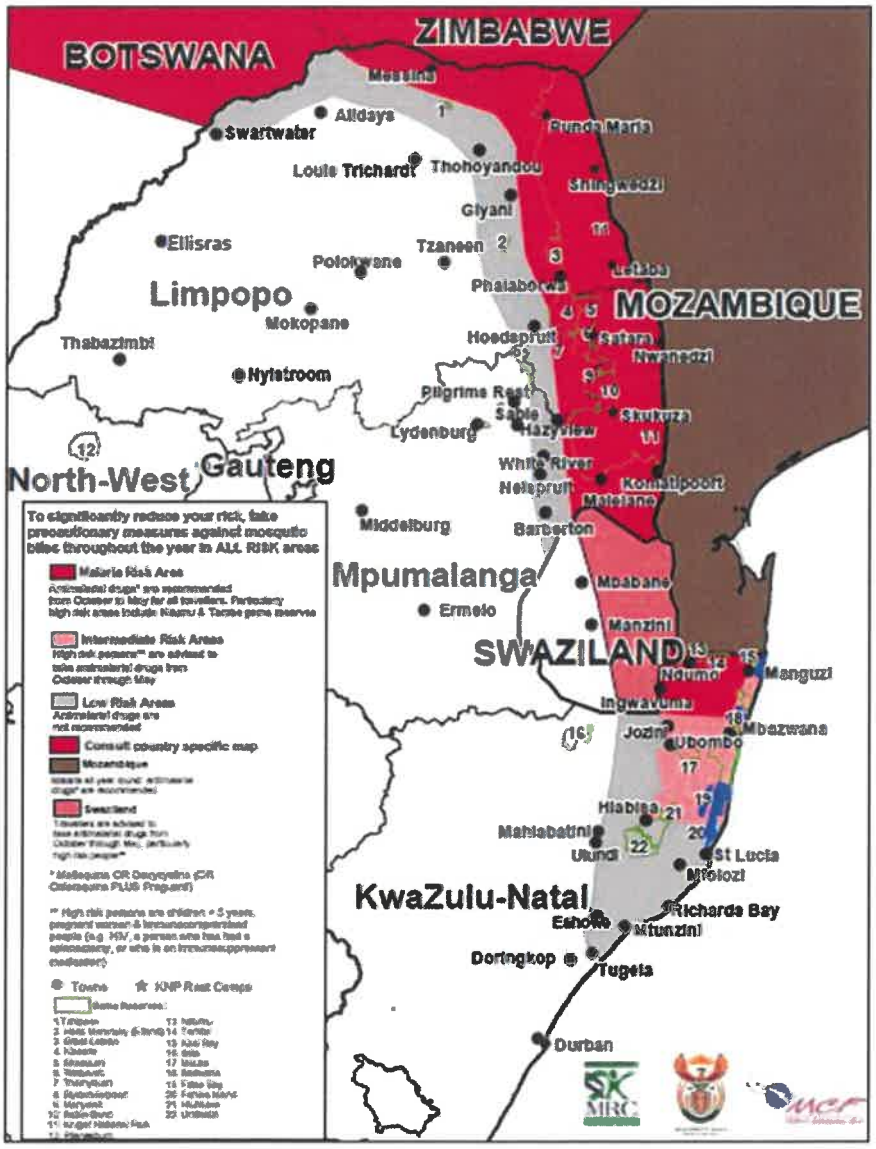


Figure 13: Malaria High Risk Areas in South Africa (Source: National Department of Health: 2018)

The figure above shows that Malaria in South Africa is present along the border with Zimbabwe and Mozambique. It is also found in Mopani, Vhembe, and Waterberg district municipalities of Limpopo Province; Ehlanzeni district municipality in Mpumalanga Province; and UMkhanyakude in KwaZulu-Natal Province. It is also present in the Kruger National Park. Although Mpumalanga is progressively doing well on the Management of Malaria, the 2017/18 financial year saw an increase in the number of malaria cases, majority of which emanated from neighbouring countries and the Limpopo Province. Malaria transmission normally occurs in October after the first rains with high peaks in January and February and waning towards May. An estimated 1,754,931 of the

population is at risk of contracting the disease locally in Ehlanzeni District thus, affecting the five Ehlanzeni municipalities and Kruger National Park. Local malaria transmission is most intense in Kruger National Park areas, Nkomazi and Bushbuckridge Municipalities.

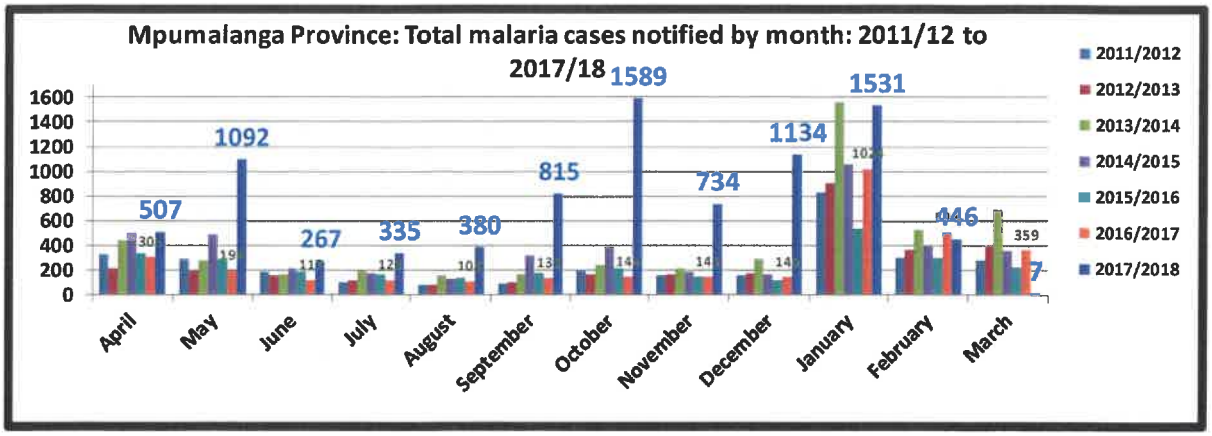


Figure 14: Total malaria cases by month: 2011/12 to 2017/18 financial years (Source: MPDoH malaria statistics: 2018)

DIET-RELATED NON-COMMUNICABLE AILMENTS

Foods, diet and nutritional status can affect cardiovascular diseases, some types of cancer and diabetes. Scholars have demonstrated that 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. Furthermore, researchers would be encouraged to proactively engage and monitor policy actions and conduct studies in order to build the evidence base, and communicate the full range of available evidence clearly and consistently to policymakers on diet-related non-communicable ailments.

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 Department conducted the 2014-15 and 2017 Antenatal HIV Survey, however the results of these survey are still embargoed (have not yet been signed-off by the Health Minister). As such the Department uses the 2013 Antenatal HIV Survey results for its planning purpose.

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 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.

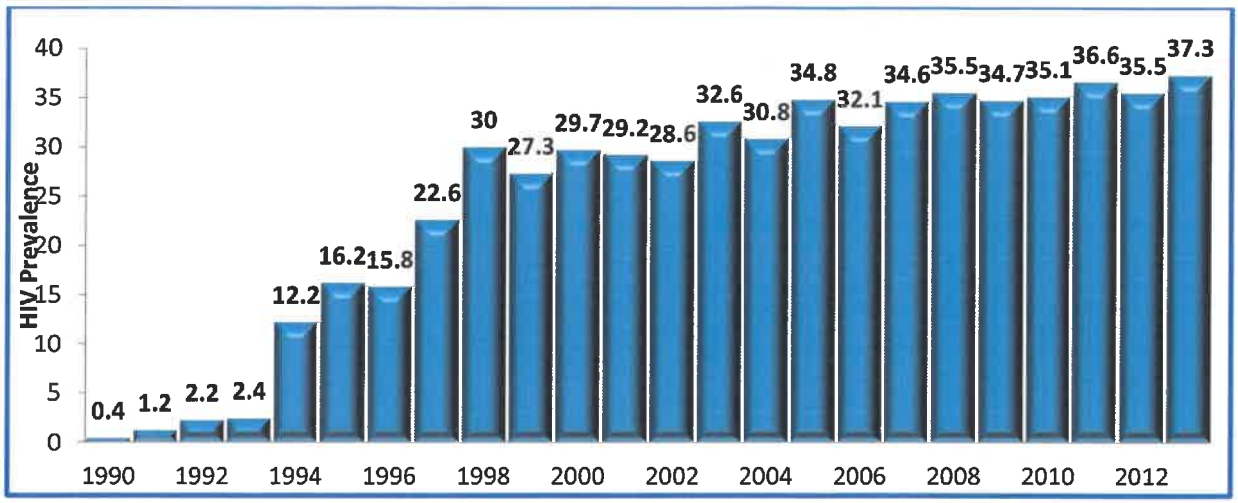


Figure 15: Mpumalanga HIV Epidemic Graph 1990 – 2013 (Source: Mpumalanga Antenatal Sentinel HIV and Syphilis Prevalence Survey in Mpumalanga, 2013)

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.

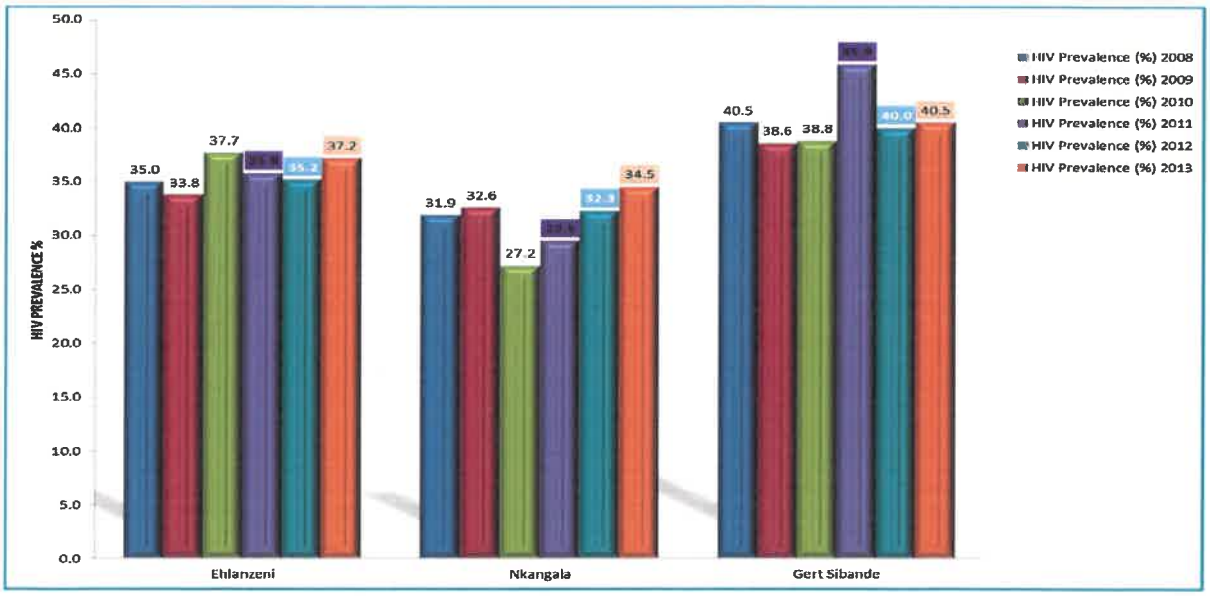


Figure 16: Mpumalanga HIV Epidemic Graph by District: 2008 – 2013 (Source: Mpumalanga Antenatal Sentinel HIV and Syphilis Prevalence Survey in Mpumalanga, 2013)

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.

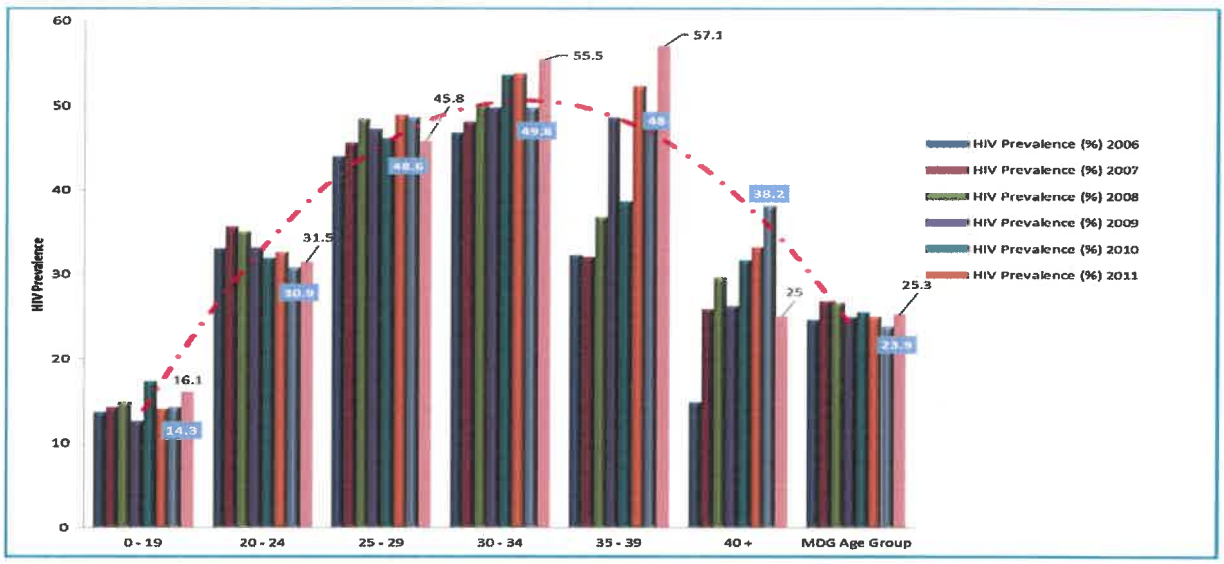


Figure 17: Mpumalanga HIV Epidemic Graph by Age group: 2006 – 2013 (Source: National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2010 – 13)

Since the last Antenatal HIV Survey results of 2013, it was observed that the HIV prevalence has reached a plateau, with the prevalence expected to remain the same or begin to decline owing to the robust number of initiatives the department has embarked on, which include the campaign programs, distribution of condoms, and the availability of ARVs.

TB MANAGEMENT

According to the World Health Organisation (WHO) 2016 report, South Africa is listed amongst the high burdened countries for TB, TB/HIV and MDR-TB as per the diagram below.

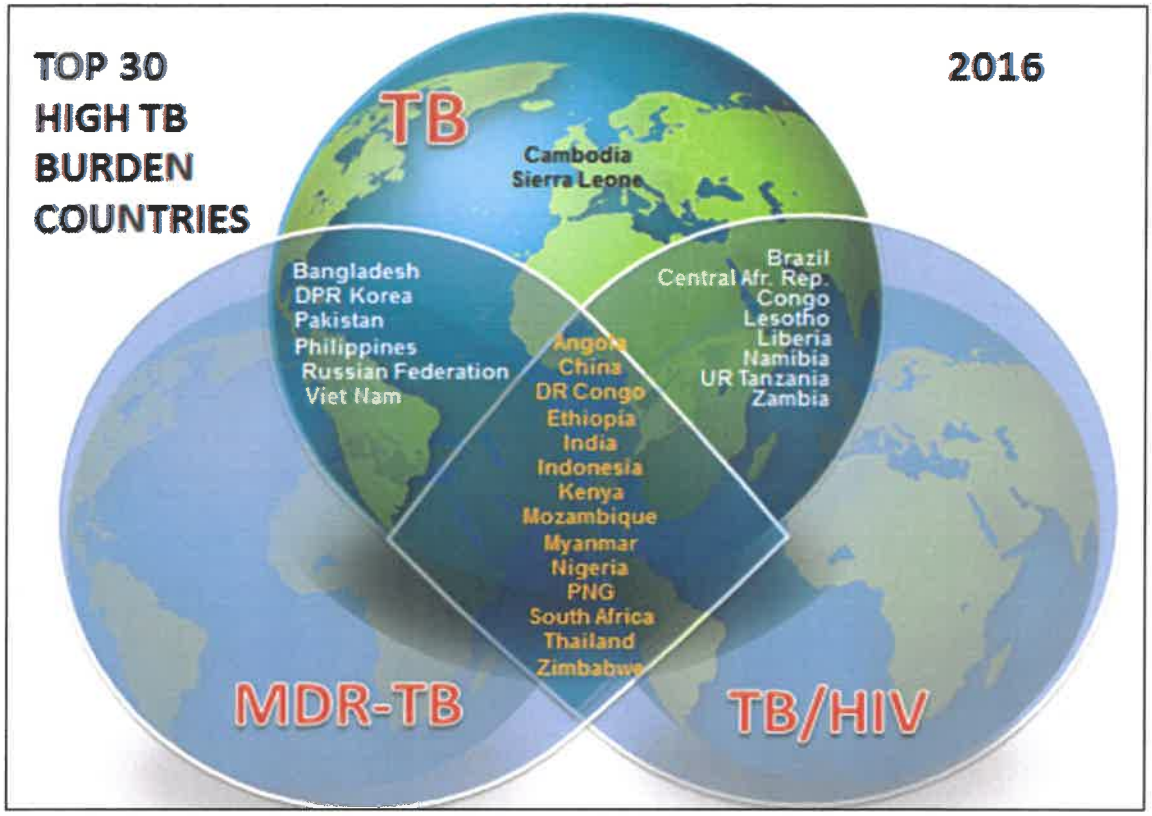


Figure 18: TB, MDR-TB and TB/HIV: Source: 2016 Global TB Report - TB, MDR-TB and TB/HIV.

Tuberculosis is a medical condition linked to social problem and poverty. Crowded informal settlements compounded by low-socio economic status provide fertile ground for breeding TB infection and disease.

TB (MDR and XDR) have increased significantly due to late detection or presentation, poor management and failure to retain TB patients on treatment. 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, this includes Mpumalanga Province.

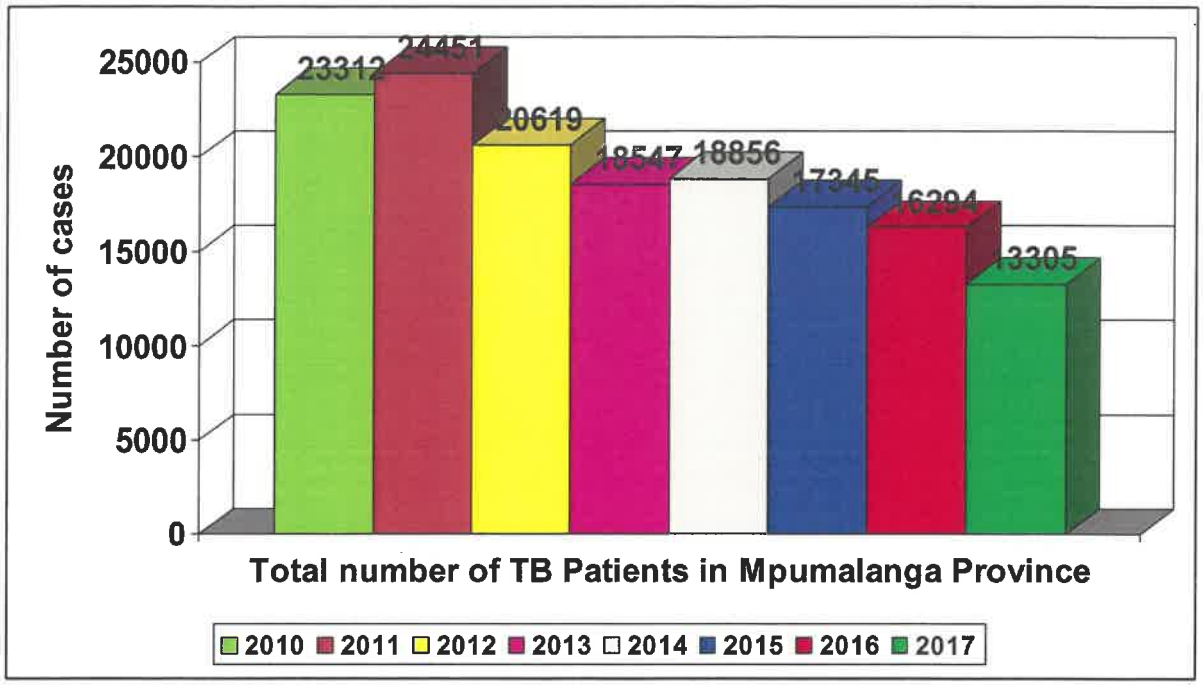


Figure 19: TB patients in Mpumalanga Province (Source: Mpumalanga TB Database (ETR.Net))

According to the graph above, Mpumalanga has a decline in TB case finding leading to fewer patients diagnosed and initiated on treatment. The highest TB patients were 24451 in 2011 which has declined to 13305 in 2017, and TB treatment success rate improved from 78.3% in 2010 to 87.1% in 2016.

This therefore requires the department to intensify TB screening and testing, diagnosis, treatment initiation and adherence counselling, efficient tracing of TB contacts and improved quality of recording and reporting.

Mpumalanga 10 Leading Underlying Natural Causes of Death

In South Africa, tuberculosis remained the main leading cause of death in the three-year period, although the proportion of deaths due to TB declined in the three-year period from 8.3% in 2014 to 6.5% in 2016. Diabetes mellitus became second most common natural cause of death and maintained the same position in 2016, being responsible for 5.5%% deaths. The top two were followed by other forms of heart disease, ranked 3 on 5.1%, then Cerebrovascular diseases moved to position four in 2016 and was responsible for 5.1% deaths while human immunodeficiency virus (HIV) disease which was the sixth leading cause of death in 2014, moved to the fifth position in 2015 and 2016 responsible for about 5% of all deaths in all the three years (StatsSA, 2018).

In Mpumalanga Province, the "Findings of the Mortality and Causes of Death in South Africa Report, 2016 released by Statistics South Africa depict tuberculosis as the most commonly mentioned cause of death on death notification forms accounting for 9.5% of death. It is followed by Influenza and pneumonia at 5.0%, other viral diseases at 4.7%, and HIV at 4.7%, with cerebrovascular diseases at 4.1%. This is represented in Table 11 below.

In the districts, tuberculosis is the leading cause of death at Ehlanzeni and Gert Sibande Districts, while it is important to take note of Diabetes mellitus as the fourth leading cause of death in all the districts of Mpumalanga Province. At Nkangala District, HIV was the ninth cause of deaths in 2016 (see table below).

*Table 12: The ten leading underlying natural causes of death by district municipality of death occurrence, Mpumalanga, 2016**

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	1364	9.9	Tuberculosis (A15-A19)**	1	624	6.9	Hypertensive diseases (I10-I15)	1	731	7.1
Cerebrovascular diseases (I60-I69)	2	964	7.0	Human immunodeficiency virus [HIV] disease (B20-B24)	2	616	6.9	Tuberculosis (A15-A19)	2	664	6.4
Human immunodeficiency virus [HIV] disease (B20-B24)	3	742	5.4	Other viral diseases (B25-B34)	3	507	5.6	Influenza and pneumonia (J09-J18)	3	627	6.1
Diabetes mellitus (E10-E14)	4	712	5.2	2 Diabetes mellitus (E10-E14)	4	473	5.3	Diabetes mellitus (E10-E14)	4	556	5.4
Other viral diseases (B25-B34)	5	682	5.0	Certain disorders involving the immune mechanism (D80-D89)	5	472	5.3	Other viral diseases (B25-B34)	5	540	5.2
Other forms of heart disease (I30-I52)	6	645	4.7	Influenza and pneumonia (J09-J18)	6	415	4.6	Cerebrovascular diseases (I60-I69)	6	456	4.4
Influenza and pneumonia (J09-J18)	7	629	4.6	Cerebrovascular diseases (I60-I69)	7	379	4.2	Other forms of heart disease (I30-I52)	7	415	4.0
Hypertensive diseases (I10-I15)	8	557	4.0	Hypertensive diseases (I10-I15)	8	377	4.2	Chronic lower respiratory diseases (J40-J47)	8	276	2.7
Ischaemic heart diseases (I20-I25)	9	525	3.8	Other forms of heart disease (I30-I52)	9	282	3.1	Human immunodeficiency virus [HIV] disease (B20-B24)	9	273	2.6
Certain disorders involving the immune mechanism (D80-D89)	10	381	2.8	Intestinal infectious diseases (A00-A09)	10	227	2.5	Ischaemic heart diseases (I20-I25)	10	256	2.5
Other natural causes		5 192	37.7	Other natural causes		3568	39.7	Other natural causes		4184	40.4
Non-natural causes		1 375	10.0	Non-natural causes		1043	11.6	Non-natural causes		1385	13.4
All causes		**13 768**	**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, 2016: Findings from Death Notification Prevalence)
*Excluding cases with unspecified district municipality.
**Including deaths due to *MDR-TB* and *XDR-TB*

Mpumalanga Leading Underlying Non-natural Causes of Death

The table below shows the underlying non-natural causes of death for 2009, 2010, 2014 and 2016 in Mpumalanga Province (StatsSA, 2018). It is observed that Mpumalanga had 11.5% of deaths due to non-natural causes in 2016, with the most common cause of non-natural deaths being other external causes of accidental injury, which accounted for 78.1% of all un-natural deaths in the province. Transport accidents came second at 12.9%, which is a slightest increase of 1.5% compared to 2014 underlying non-natural causes of death. These causes of un-natural deaths were followed by assaults which accounted for 5.2% of deaths, a percentage increase from the 2014 underlying non-natural causes of death.

Table 13: Mpumalanga Underlying Non-natural Causes of Death, 2009 to 2016

	2009		2010		2014		2016	
Causes of death*	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Other external causes of accidental injury	3 373	84,9	2791	80.8	2 610	70.4	2997	78.1
Event of undetermined intent	79	2,0	103	3.0	394	10.6	70	1.8
Transport Accidents	330	8,3	370	10.7	421	11.4	494	12.9
Assault	125	3,1	117	3.4	160	4.3	199	5.2
Complications of medical and surgical care	38	1,0	40	1.2	76	2.0	47	1.2
Intentional self-harm	24	0,6	31	0.9	45	1.2	27	0.7
Sequelae of external causes of morbidity and mortality	2	0,1	3	0.1	2	0.1	2	0.1
Subtotal	**3 971**	**100,0**	**3455**	**100**	**3 708**	**100**	**3836**	**100**
Non-natural causes	3 971	8,7	3455	8.3	3 708	10.6	3836	11.5
Natural causes	41 732	91,3	38318	91.7	31 294	89.4	29425	88.5
All causes	**45 703**	**100,0**	**41773**	**100**	**35 002**	**100**	**33261**	**100**

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

Source: Statistic s SA: Mortality and Causes of Death in South Africa, 2010-2016: Findings from Death Notification Prevalence)

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

The Department has recently participated in the MPAT Version 1.8. The Department has identified the following gaps and is currently developing the action plan to address the identified gaps:

Standard Name	Identified Gaps	Interventions
KPA 1: Strategic Management		
2018/19 Annual Performance Plan	None	None
Integration of Performance Monitoring and Strategic Management	None	None
KPA 2: Governance and Accountability		
Assessment of policies and systems to ensure professional ethics	None	None
Assessment of financial disclosures	Experienced challenges with network at some facilities and employees were unable access to the eDisclosure system	ICT at Provincial Office was notified and officials will be allocated as part of the team during visits to support officials.
Anti- corruption and ethics management	Lack of capacity to conduct ethics and corruption risk assessment	Engage DPSA and OTP (PACCC) to provide guidance and support on conducting an ethics and corruption risk assessment.
Assessment of risk management arrangements	None	None
Corporate governance of ICT	None	None
KPA 3: Human Resource Management		
Human Resource Planning	No co-ordination and linkage of the HR Plan, MTEF Budget and Strategic Plan of the Department.	Link the HR Planning to the MTEF budget
	Lack of support on the development of the HR Plan by Program Managers	Source and encourage support of all stakeholders.
	Non-compliance to deadline on submission of the HR Plan and HR Plan Implementation Report to OTP and DPSA	Adhere to deadlines for submission of reports.
Organisational Design and Implementation	Outdated organizational Structure	Fast-track the development of the Organizational Structure.
	Delays in the consultation process and submission of inputs by relevant stakeholders Lack of consistency of implementation of Resolution	Adherence and implementation of the resolutions.
Application of recruitment and retention processes	Outdated Recruitment and Retention Strategy	Review the Recruitment and Retention Strategy.
	Non-compliance to conducting and analysis of the exit	Establishment and appointment of the Exit

Standard Name	Identified Gaps	Interventions
	questionnaires	Committee members.
	Non-appointment of Exit Interview Committees	Use of the standardized DPSA format for Exit Interview Questionnaires.
	Use of a non-standardised Climate (Staff Satisfaction) Survey Questionnaire	Alignment of the Climate Survey Questionnaire to the DPSA questionnaire.
Approved EA and HOD delegations	Delays in the HR processes resulting from limited HR Delegations	Review the HR Delegations and conduct a workshop on thereof.
	Unavailability of EA to HOD HR Delegations	Monitoring and evaluation of the implementation of the HR Delegations.
Implementation of Level 1-12 Performance Management System	Lack of understanding of the implementation process	Ongoing training on PMDS for supervisors and supervisees
Implementation of SMS Performance Management System	Lack of optimum compliance by all SMS	Continuous training of the SMS with OTP
Implementation of Performance Management System for HOD	Delay in feedback from OTP	Request support from OTP
Management of disciplinary cases	Shortage of staff at Facility level	Prioritize the filling of posts
	Delays in finalization of disciplinary case	Appointment of personnel to fast track all cases
	Shortage and non-availability of presiding officers in the Department	Conduct training of Investigating and Presiding Officers
KPA 4: Financial Management		
Demand Management	Lack of approved demand plan	Demand plans will be developed for implementation in 2019/20 financial year.
	Lack of commodity sourcing strategy	Commodity sourcing strategy will be developed for implementation in 2019/20 financial year.
Logistics management	Unavailability of inventory analysis report.	Conduct quarterly inventory analysis.
	Customer surveys on inventory are not conducted.	Conduct bi-annual customer surveys.
Movable Asset management	Department does not have an Asset Management Plan linked to the MTEF budget.	The Department will develop an asset management Plan for 2019/20 financial year
	Department does not periodically review the asset-management strategy\ policy	Asset Management policy will be reviewed.
Payment of suppliers	The Department does not implement an invoice tracking system	The Department will track invoices on a monthly basis.
Management of unauthorised, irregular, fruitless, and wasteful expenditure	The Department does not have evidence of disciplinary action taken against negligent officials or condonation	The Department will improve record management on cases already dealt with and

Standard Name	Identified Gaps	Interventions
	of unauthorised, irregular, fruitless and wasteful expenditure	reports will be provided.
Payroll certification	Pay sheet certification process is in place	The Department will develop a SOP on payroll certification.
	Pay sheet certification process is fully implemented on a monthly basis	The Department will implement a SOP on payroll certification.

4.6 ORGANISATIONAL ENVIRONMENT

4.6.1 Organisational Structure and Human Resources

The Department is currently reviewing the approved organizational of 2010 in order to be aligned and respond to the current service delivery platform. The review and alignment of the organizational structure aimed at ensuring that the structure is aligned to policy changes new programmes introduced mandated by the NDOH. The Department is currently developing the interim normative guides for implementation by the hospitals while awaiting the finalization of staffing norms for district hospitals by the National Department of Health. The Organisational Structures for the PHC facilities will be aligned to the WISN results to determine the number of the required human resources.

The branch Financial Management was revised through the process of organizational redesign and development and was consulted with the Office of the Minister of Public Service and Administration. The Department currently prioritized the creation of Mental Health Unit in selected hospitals within the province.

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 Human Resource Health capacity of the Department and 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 558 and 333 critical posts to be filled during the 2018/19 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 2018 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.

Further, more the Department has taken an initiative to conduct an analysis on the exit questionnaire to determine the impact of increased staff turnover rate and come up with an appropriate recruitment and retention strategy.

TABLE A2: HEALTH PERSONNEL IN 2018/19

Occupational Class	Number employed	% of total employed	Number per 100, 000 people	Number per 100,000 uninsured people2	Vacancy rate5	% of total personnel budget	Annual cost per staff member
ADMINISTRATIVE RELATED, Permanent	327	1,6%	7,36	8,37	7,90	2%	504 427
ALL ARTISANS IN THE BUILDING METAL MACHINERY ETC., Permanent	65	0,3%	1,46	1,66	1,50	0%	296 887
AMBULANCE AND RELATED WORKERS, Permanent	640	3,1%	14,41	16,37	2,90	3%	286 676
ARTISAN PROJECT AND RELATED SUPERINTENDENTS, Permanent	11	0,1%	0,25	0,28	8,30	0%	256 326
AUXILIARY AND RELATED WORKERS, Permanent	473	2,3%	10,65	12,10	4,60	2%	230 317
BIOCHEMISTRY PHARMACOL. ZOOLOGY & LIFE SCIE.TECHNI, Permanent	10	0,0%	0,23	0,26	9,10	0%	651 013
BUILDING AND OTHER PROPERTY CARETAKERS, Permanent	270	1,3%	6,08	6,91	2,90	1%	141 594
BUS AND HEAVY VEHICLE DRIVERS, Permanent	19	0,1%	0,43	0,49	-	0%	236 747
CIVIL ENGINEERING TECHNICIANS, Permanent	1	0,0%	0,02	0,03	50,00	0%	1 483 612
CLEANERS IN OFFICES WORKSHOPS HOSPITALS ETC., Permanent	2 643	12,9%	59,50	67,61	2,50	5%	146 002
CLIENT INFORM CLERKS(SWITCHB RECEPT INFORM CLERKS), Permanent	97	0,5%	2,18	2,48	1,00	0%	222 278
COMMUNICATION AND INFORMATION RELATED, Permanent	4	0,0%	0,09	0,10	-	0%	291 043
COMMUNITY DEVELOPMENT WORKERS, Permanent	53	0,3%	1,19	1,36	1,90	0%	301 450
COMPUTER PROGRAMMERS., Permanent	1	0,0%	0,02	0,03	-	0%	382 211
COMPUTER SYSTEM DESIGNERS AND ANALYSTS., Permanent	4	0,0%	0,09	0,10	-	0%	367 431
DENTAL PRACTITIONERS, Permanent	118	0,6%	2,66	3,02	4,80	1%	884 634
DENTAL PRACTITIONERS, Temporary	3	0,0%	0,07	0,08	-	0%	884 634
DENTAL SPECIALISTS, Permanent	1	0,0%	0,02	0,03	-	0%	1 016 332
DENTAL TECHNICIANS, Permanent	1	0,0%	0,02	0,03	-	0%	349 801
DENTAL THERAPY, Permanent	15	0,1%	0,34	0,38	6,30	0%	379 945
DIETICIANS AND NUTRITIONISTS, Permanent	147	0,7%	3,31	3,76	3,90	1%	396 801
DIETICIANS AND NUTRITIONISTS, Temporary	1	0,0%	0,02	0,03	-	0%	396 801
ELECTRICAL AND ELECTRONICS ENGINEERING TECHNICIANS, Permanent	29	0,1%	0,65	0,74	3,30	0%	435 308
EMERGENCY SERVICES RELATED, Permanent	290	1,4%	6,53	7,42	9,10	1%	248 139
ENGINEERING SCIENCES RELATED, Permanent	5	0,0%	0,11	0,13	-	0%	280 695
ENGINEERS AND RELATED PROFESSIONALS, Permanent	3	0,0%	0,07	0,08	57,10	0%	1 025 740
ENVIRONMENTAL HEALTH, Permanent	66	0,3%	1,49	1,69	5,70	0%	457 163
FARM HANDS AND LABOURERS, Permanent	1	0,0%	0,02	0,03	-	0%	93 664
FINANCE AND ECONOMICS RELATED, Permanent	19	0,1%	0,43	0,49	5,00	0%	568 503
FINANCIAL AND RELATED PROFESSIONALS, Permanent	41	0,2%	0,92	1,05	2,40	0%	380 082

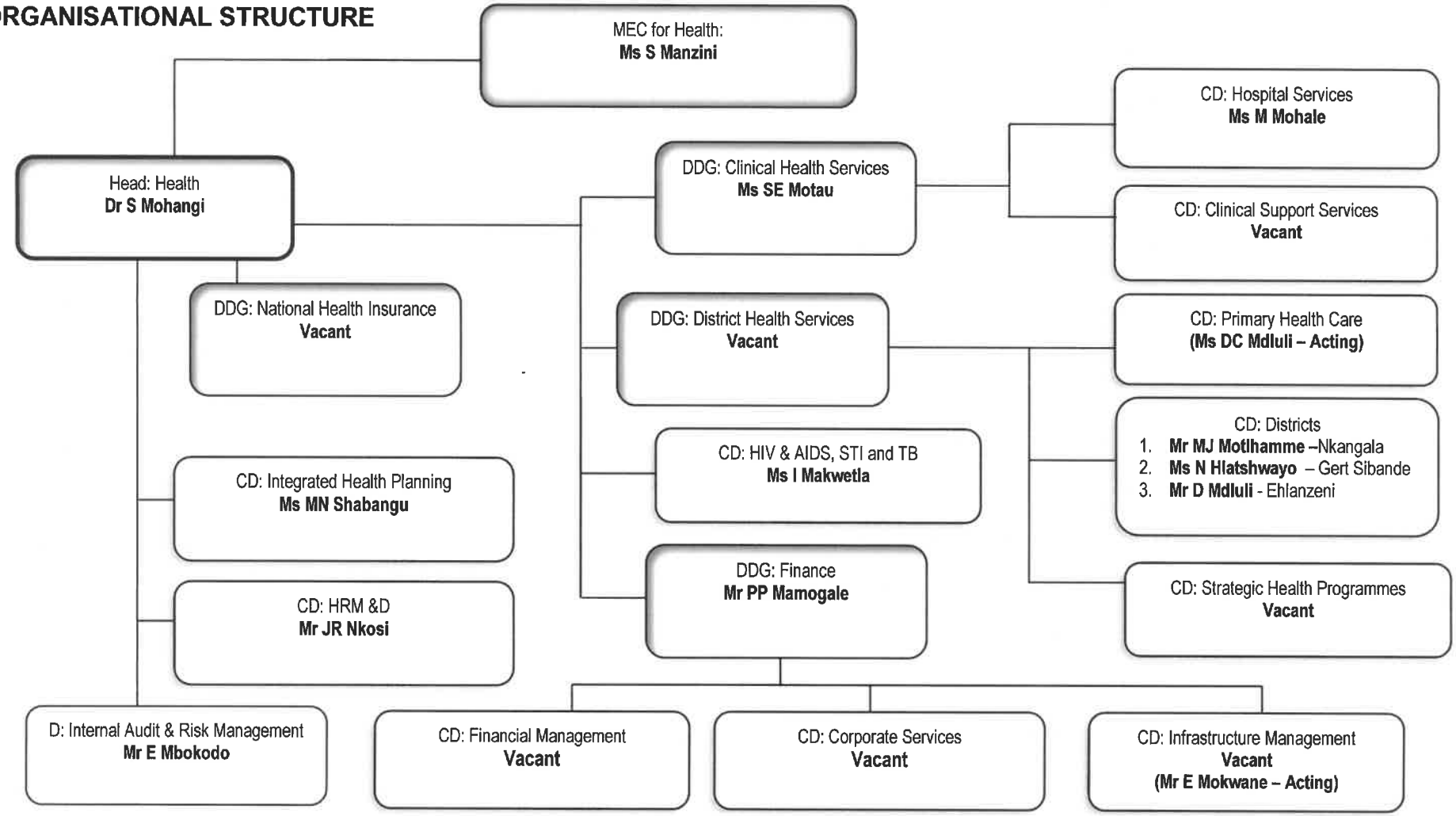
Occupational Class	Number employed	% of total employed	Number per 100, 000 people	Number per 100,000 uninsured people2	Vacancy rate5	% of total personnel budget	Annual cost per staff member
FINANCIAL CLERKS AND CREDIT CONTROLLERS, Permanent	209	1,0%	4,70	5,35	3,70	1%	275 804
FOOD SERVICES AIDS AND WAITERS, Permanent	416	2,0%	9,36	10,64	3,30	1%	165 613
FOOD SERVICES WORKERS, Permanent	18	0,1%	0,41	0,46	5,30	0%	309 253
FORESTRY LABOURERS, Permanent	1	0,0%	0,02	0,03	-	0%	138 046
HEAD OF DEPARTMENT/CHIEF EXECUTIVE OFFICER, Permanent	-	0,0%	-	-	100,00	0%	-
HEALTH SCIENCES RELATED, Permanent	19	0,1%	0,43	0,49	9,50	0%	344 591
HEALTH SCIENCES RELATED, Temporary	1	0,0%	0,02	0,03	-	0%	344 591
HORTICULTURISTS FORESTERS AGRICUL.& FORESTRY TECHN, Permanent	1	0,0%	0,02	0,03	-	0%	223 881
HOUSEHOLD AND LAUNDRY WORKERS, Permanent	311	1,5%	7,00	7,96	4,30	1%	162 463
HOUSEHOLD FOOD AND LAUNDRY SERVICES RELATED, Permanent	5	0,0%	0,11	0,13	-	0%	182 466
HOUSEKEEPERS LAUNDRY AND RELATED WORKERS, Permanent	8	0,0%	0,18	0,20	-	0%	228 743
HUMAN RESOURCES & ORGANISAT DEVELOPM & RELATE PROF, Permanent	17	0,1%	0,38	0,43	10,50	0%	461 126
HUMAN RESOURCES CLERKS, Permanent	123	0,6%	2,77	3,15	5,40	1%	303 392
HUMAN RESOURCES RELATED, Permanent	33	0,2%	0,74	0,84	2,90	0%	381 693
INFORMATION TECHNOLOGY RELATED, Permanent	1	0,0%	0,02	0,03	-	0%	362 873
INSPECTORS OF APPRENTICES WORKS AND VEHICLES, Permanent	1	0,0%	0,02	0,03	-	0%	803 906
INSTITUTION BASED PERSONAL CARE WORKERS, Permanent	7	0,0%	0,16	0,18	-	0%	118 661
LIBRARIANS AND RELATED PROFESSIONALS, Permanent	1	0,0%	0,02	0,03	-	0%	242 366
LIBRARY MAIL AND RELATED CLERKS, Permanent	31	0,2%	0,70	0,79	-	0%	240 254
LIGHT VEHICLE DRIVERS, Permanent	183	0,9%	4,12	4,68	4,20	1%	244 594
LOGISTICAL SUPPORT PERSONNEL, Permanent	23	0,1%	0,52	0,59	4,20	0%	361 239
MATERIAL-RECORDING AND TRANSPORT CLERKS, Permanent	82	0,4%	1,85	2,10	1,20	0%	217 172
MEDICAL EQUIPMENT OPERATORS, Permanent	2	0,0%	0,05	0,05	-	0%	327 480
MEDICAL PRACTITIONERS, Permanent	785	3,8%	17,67	20,08	10,20	12%	1 137 328
MEDICAL PRACTITIONERS, Temporary	296	1,4%	6,66	7,57	-	5%	1 137 327
MEDICAL RESEARCH AND RELATED PROFESSIONALS, Permanent	1	0,0%	0,02	0,03	-	0%	258 004
MEDICAL SPECIALISTS, Permanent	65	0,3%	1,46	1,66	9,70	2%	1 996 627
MEDICAL SPECIALISTS, Temporary	9	0,0%	0,20	0,23	-	0%	1 996 627
MEDICAL TECHNICIANS/TECHNOLOGISTS, Permanent	8	0,0%	0,18	0,20	11,10	0%	418 465
MESSENGERS PORTERS AND DELIVERERS, Permanent	211	1,0%	4,75	5,40	1,40	1%	177 081
MOTOR VEHICLE DRIVERS, Permanent	20	0,1%	0,45	0,51	9,10	0%	287 623
NURSING ASSISTANTS, Permanent	1 446	7,1%	32,55	36,99	4,90	4%	189 483

Occupational Class	Number employed	% of total employed	Number per 100, 000 people	Number per 100,000 uninsured people2	Vacancy rate5	% of total personnel budget	Annual cost per staff member
OCCUPATIONAL THERAPY, Permanent	89	0,4%	2,00	2,28	6,30	0%	396 028
OPTOMETRISTS AND OPTICIANS, Permanent	6	0,0%	0,14	0,15	-	0%	534 433
OPTOMETRISTS AND OPTICIANS, Temporary	1	0,0%	0,02	0,03	-	0%	534 433
ORAL HYGIENE, Permanent	9	0,0%	0,20	0,23	10,00	0%	515 731
OTHER ADMINISTRAT & RELATED CLERKS AND ORGANISERS, Permanent	1 243	6,1%	27,98	31,80	3,00	4%	234 171
OTHER ADMINISTRATIVE POLICY AND RELATED OFFICERS, Permanent	122	0,6%	2,75	3,12	5,40	1%	337 410
OTHER INFORMATION TECHNOLOGY PERSONNEL., Permanent	5	0,0%	0,11	0,13	-	0%	601 278
OTHER OCCUPATIONS, Permanent	16	0,1%	0,36	0,41	5,90	0%	404 438
PHARMACEUTICAL ASSISTANTS, Permanent	178	0,9%	4,01	4,55	2,20	1%	265 446
PHARMACEUTICAL ASSISTANTS, Temporary	1	0,0%	0,02	0,03	-	0%	265 446
PHARMACISTS, Permanent	335	1,6%	7,54	8,57	6,70	3%	584 374
PHARMACISTS, Temporary	2	0,0%	0,05	0,05	-	0%	-
PHARMACOLOGISTS PATHOLOGISTS & RELATED PROFESSIONA, Permanent	6	0,0%	0,14	0,15	-	0%	287 237
PHYSICISTS, Permanent	1	0,0%	0,02	0,03	-	0%	1 570 081
PHYSICISTS, Temporary	1	0,0%	0,02	0,03	-	0%	15 681 080
PHYSIOTHERAPY, Permanent	93	0,5%	2,09	2,38	10,60	1%	395 076
PHYSIOTHERAPY, Temporary	1	0,0%	0,02	0,03	-	0%	395 076
PROFESSIONAL NURSE, Permanent	5 603	27,4%	126,13	143,33	5,80	35%	446 702
PSYCHOLOGISTS AND VOCATIONAL COUNSELLORS, Permanent	40	0,2%	0,90	1,02	2,40	0%	652 841
QUANTITY SURVEYORS & RELA PROF NOT CLASS ELSEWHERE, Permanent	-	0,0%	-	-	100,00	0%	-
RADIOGRAPHY, Permanent	137	0,7%	3,08	3,50	5,50	1%	433 337
RADIOGRAPHY, Temporary	2	0,0%	0,05	0,05	-	0%	433 338
RISK MANAGEMENT AND SECURITY SERVICES, Permanent	9	0,0%	0,20	0,23	-	0%	176 847
ROAD WORKERS, Permanent	1	0,0%	0,02	0,03	-	0%	131 760
SECRETARIES & OTHER KEYBOARD OPERATING CLERKS, Permanent	260	1,3%	5,85	6,65	2,30	1%	230 233
SECURITY OFFICERS, Permanent	1	0,0%	0,02	0,03	-	0%	187 657
SENIOR MANAGERS, Permanent	36	0,2%	0,81	0,92	16,30	1%	1 083 339
SOCIAL WORK AND RELATED PROFESSIONALS, Permanent	47	0,2%	1,06	1,20	2,10	0%	415 419
SPEECH THERAPY AND AUDIOLOGY, Permanent	79	0,4%	1,78	2,02	6,00	0%	371 795
SPEECH THERAPY AND AUDIOLOGY, Temporary	2	0,0%	0,05	0,05	-	0%	371 795
STAFF NURSES AND PUPIL NURSES, Permanent	1 854	9,1%	41,74	47,43	6,40	5%	212 176
STUDENT NURSE, Permanent	580	2,8%	13,06	14,84	27,00	1%	123 947

Occupational Class	Number employed	% of total employed	Number per 100, 000 people	Number per 100,000 uninsured people2	Vacancy rate5	% of total personnel budget	Annual cost per staff member
SUPPLEMENTARY DIAGNOSTIC RADIOGRAPHERS, Permanent	6	0,0%	0,14	0,15	-	0%	433 338
TRADE LABOURERS, Permanent	3	0,0%	0,07	0,08	-	0%	136 907
TOTAL	**20 461**	**100,0%**	**460,61**	**523,43**	**5,70**	**100%**	**588 315**

Data Source: Persal (or use latest information from South African Health Review 2018 - 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 2017/18, 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 for Programme 2. There is significant improvement in Programme 4 with audit outcome at Unqualified Audit Opinion. The contributory factor on Programme 2 audit outcome is due to lack of Records Management System. There are many of Patient files which could not be submitted for audit resulting in Limitation of Scope. Some of the files in the PHC facilities are Patient held, compromising validity and completeness of performance information. As the Department, there is a need for alternatives to ensure that Patient files or source of data remain in the facility. The good practice method that the department needs to learn from all NHI facilities in Gert Sibande which performed well on Validity and Completeness of Performance Information.

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 partnership between National and Mpumalanga Department of Health has yielded positive results in construction of 22 consultation rooms for doctors in the National Health Insurance pilot district. Furthermore this partnership has contributed to the renovations of Middelburg Hospital Nursing accommodation, Amajuba Hospital, Carolina Hospital, Evander Hospital, Elsie Ballot Hospital and Standerton Hospital which will be completed in the 2019/20 financial year. Over and above these projects, the Department together with National DOH is constructing the four (4) of the eight (8) PHC facilities which are, Nhlazatse 6, Vukuzakhe, Oakley, and Pankop Clinics. The remaining four (4) facilities are planned to start with construction in 2019/20 financial year. These PHC facilities are KaNyamazane, Ethandukunya, Msukaligwa and Balfour CHCs

The Infrastructure Unit has improved in the planning and implementation together with the Implementing Agent, Department of Public Works, Roads and Transport. The Department is currently undertaking the following major infrastructure projects such as construction of Bethal, Mmametlhake, New Middelburg and New Mapulaneng Hospitals.

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.

In South Africa, all people diagnosed HIV-positive are eligible to start ARV treatment regardless of their CD4 count levels. The country 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 2018/19 BUDGET AND MTEF ESTIMATES

The Department shows a health growth on the service delivery porgrammes namely; District Health Services, Emergency Medical Services, Provincial Hospital Services and Central Hospital Services over the seven-year period. In 2017/18, a substantial increase is seen in Health Facility Management due to the resolution taken by the country to invest in infrastructure and the budget is responding it. The department has projected an overspending on all programmes due to pressure on current budget resulting from accruals carried over from 2017/18

Programme 1: Administration The high increase in 2017/18 due to once off projects funded during the budget adjustment that include litigations and back up for ICT as well as addressing pressure on audit cost, computer services-payment of Microsoft licence and legal cost. The negative growth

in 2018/19 due to non-maintenance litigation, legal cost baseline and reduction in non-essential items.

Programme 2: District Health Services shows an incline in 2017/18 due to appointments of the 551-priority post, rank translations, absorption of community services nurses and doctors and pressures on medicine especial ARV and laboratory. The health growth in 2018/19 caters for the carry-through effect of the above appointments, increase of the HIV/AIDS Grant allocation, funding ideal clinics, high growth on insecticides for Malaria and conversion of HPV (Human Papilloma Virus) into a direct Grant and
Programme 3: Emergency Medical Services in 2017/18 the increase is due to procurement of a high number of ambulances and planned patient motor vehicles to replace the old fleet backlog and appointment of staff. The growth in 2018/18 relates to planned patient take-over project that will decrease fuel and maintenance cost due to coordinated trips.

Programme 4: The Provincial Hospital Services the incline in 2017/18 relates to appointment staff on 551 Priority post rank translations, absorption of community services nurses and doctors and payment of exit costs. The growth in 2018/19 is to cater for the carry-through effect of the prior year's appointments and for growth in key accounts.

Programme 5: Central Hospital Services consists of Rob Ferreira Hospital and Witbank Hospital budget, and benefits from the National Tertiary Services grant. In 2017/18, the programme incurred an unauthorized expenditure on payments for overtime, renal dialysis and medical supplies. The health growth in 2018/19 addresses the pressures in key accounts and non-negotiables.

Programme 6: Health Science & Training will decrease in the 2017/18 financial year budget is due to the efficiency gains from change of funding methodology for the nursing college from paying a salary to a stipend and reprioritization on goods and services to key accounts on service delivery programmes. The growth in 2018/19 relates to the increased funding of HWSETA and catering for nursing students to cater for accruals as well as inflation.

Programme 7: Health Care Support Services the spike in 2017/18 is due to an increased allocation of centralized medical equipment in engineering in an attempt to address the dire need in hospitals and is maintained throughout the 2019/20 MTEF.

Programme 8: Health Facilities Management the high incline in 2017/18 relates to the construction of new hospitals Mapulaneng and Middelburg hospital, and upgrade of Bethal hospital and Mammetlake on equitable share. The rest of the building and other fixed structures projects are funded through Heath Facility Revitalisation grant. The projected overspending in 2017/18 revised estimate is relates to the pressure on capital project due to accruals from 2017/18.

4.9.1 EXPENDITURE ESTIMATES

Expenditure estimates

R thousand	Outcome 2015/16	Outcome 2016/17	Outcome 2017/18	Main appropriation 2018/19	Adjusted appropriation 2018/19	Revised estimate 2018/19	Medium-term estimates 2019/20	Medium-term estimates 2020/21	Medium-term estimates 2021/22
1. Administration	297 298	282 001	342 113	265 526	268 369	335 427	322 276	368 652	389 407
2. District Health Services	6 175 406	6 524 844	7 182 004	8 048 071	7 988 074	8 419 685	8 795 457	9 433 713	10 159 218
3. Emergency Medical Services	309 596	328 189	371 519	388 002	364 097	364 097	435 317	426 280	449 378
4. Provincial Hospital Services	1 174 385	1 221 480	1 302 741	1 393 406	1 362 723	1 424 854	1 541 312	1 684 984	1 800 911
5. Central Hospital Services	991 759	1 026 751	1 154 506	1 218 481	1 208 932	1 313 471	1 327 268	1 484 427	1 821 143
6. Health Sciences and Training	369 233	372 901	367 797	388 773	375 435	375 435	452 353	475 474	502 012
7. Health Care Support Services	123 451	140 693	177 021	182 640	184 080	184 080	194 851	194 086	204 043
8. Health Facilities Management	639 264	683 021	1 185 312	1 393 275	1 437 881	1 437 881	1 317 975	1 300 887	1 380 945
Total payments and estimates:	**10 080 392**	**10 579 880**	**12 083 013**	**13 278 174**	**13 189 591**	**13 854 930**	**14 386 809**	**15 368 503**	**16 707 057**

Table A3: Summary of Provincial Expenditure Estimates by Economic Classification

R thousand	Outcome 2015/16	Outcome 2016/17	Outcome 2017/18	Main appropriation 2018/19	Adjusted appropriation 2018/19	Revised estimate 2018/19	Medium-term estimates 2019/20	Medium-term estimates 2020/21	Medium-term estimates 2021/22
Current payments	**9 005 288**	**9 753 872**	**10 657 396**	**11 596 322**	**11 516 519**	**12 156 399**	**12 829 578**	**13 946 580**	**14 959 168**
Compensation of employees	6 102 017	6 886 678	7 217 105	7 877 247	7 708 843	7 708 741	8 467 251	9 080 922	9 664 058
Salaries and wages	5 353 167	5 877 405	6 339 940	6 897 523	6 732 959	6 732 857	7 441 429	7 976 084	8 504 197
Social contributions	748 850	809 273	877 165	979 724	975 884	975 884	1 025 822	1 104 838	1 159 861
Goods and services	2 902 264	3 064 888	3 439 974	3 719 075	3 807 676	4 447 118	4 362 327	4 865 658	5 295 110
Administrative fees	3 195	160 334	216 139	204 874	206 889	237 181	198 932	208 243	221 273
Advertising	3 220	6 077	5 031	9 238	6 668	6 668	10 533	10 278	10 843
Minor Assets	11 079	9 462	4 939	19 079	17 721	17 042	26 418	22 414	23 650
Audit cost: External	16 580	14 819	18 820	17 184	17 194	17 194	18 146	19 144	20 197
Bursaries: Employees	1 798	804	1 057	–	–	–	–	–	–
Catering: Departmental activities	3 196	2 903	2 708	3 110	3 540	5 510	9 282	3 462	3 652
Communication (G&S)	42 697	44 325	37 048	38 811	36 553	39 884	41 502	43 297	45 678
Computer services	57 478	16 269	38 649	30 546	33 977	48 977	54 836	86 605	90 631
Consultants: Business and advisory services	10 543	15 328	5 594	7 004	5 180	5 113	7 770	5 560	5 866
Infrastructure and planning	3 756	–	–	–	–	–	–	–	–
Laboratory services	328 947	373 723	411 385	524 218	501 456	567 158	687 683	836 833	913 924
Legal costs	27 222	16 576	28 640	20 182	22 182	36 090	21 252	22 421	23 654
Contractors	65 631	83 778	113 767	123 192	131 417	154 805	172 116	283 813	199 890
Agency and support / outsourced services	92 172	117 582	73 931	92 934	91 011	115 229	103 827	106 474	101 682
Fleet services (incl. government motor transport)	110 053	104 309	107 886	97 204	94 178	134 542	102 161	107 876	123 826
Inventory: Clothing material and accessories	2 380	–	1 650	–	1 277	1 273	–	–	–
Inventory: Farming supplies	4 086	–	4 048	14 128	7 956	7 956	11 646	18 546	19 506
Inventory: Food and food supplies	86 313	86 076	87 220	92 508	88 808	88 460	96 788	102 817	107 793
Inventory: Chemicals,fuel,oil,gas,wood and coal	40 261	30 952	7 021	266	1 284	3 259	243	257	271
Inventory: Learner and teacher support material	–	–	–	15	–	–	16	17	18
Inventory: Materials and supplies	8 950	199	–	–	93	49	750	791	835
Inventory: Medical supplies	355 748	360 796	363 126	375 045	373 821	462 954	491 844	522 686	609 992
Inventory: Medicine	1 118 218	1 077 749	1 399 628	1 596 576	1 535 800	1 846 579	1 655 886	1 794 590	2 089 490
Inventory: Other supplies	–	–	12 138	11 300	10 264	10 218	11 932	12 549	13 239
Consumable supplies	103 274	117 007	92 517	59 566	89 132	98 962	122 674	132 697	113 636
Cons: Stationery,printing and office supplies	29 294	19 994	16 257	18 509	20 320	18 546	24 813	19 395	20 463
Operating leases	42 123	45 716	44 526	51 384	55 705	57 132	54 911	57 798	60 976
Property payments	243 163	280 374	274 759	245 389	378 353	388 615	336 836	346 430	367 946
Transport provided: Departmental activity	722	216	280	328	494	499	354	373	393
Travel and subsistence	73 295	67 613	60 403	59 131	65 470	66 163	75 825	78 083	82 369
Training and development	8 147	5 090	5 310	6 531	6 035	5 930	9 622	7 331	7 734
Operating payments	5 590	4 307	4 147	2 780	3 126	3 158	13 186	14 097	14 859
Venues and facilities	2 475	1 871	1 290	–	1 001	1 001	700	738	779
Rental and hiring	658	839	60	43	971	971	43	43	45
Interest and rent on land	1 007	2 306	317	–	–	540	–	–	–
Interest (Incl. interest on finance leases)	1 007	2 306	317	–	–	540	–	–	–
Transfers and subsidies	**479 149**	**306 487**	**368 261**	**345 676**	**444 796**	**470 245**	**376 138**	**375 701**	**510 270**
Provinces and municipalities	140 141	552	519	833	1 083	1 083	859	906	956
Provinces	515	551	519	833	1 083	1 083	859	906	956
Provincial agencies and funds	515	551	519	833	1 083	1 083	859	906	956
Municipalities	139 626	1	–	–	–	–	–	–	–
Municipal bank accounts	139 626	1	–	–	–	–	–	–	–
Departmental agencies and accounts	231	177	6 925	14 294	14 359	14 359	15 052	15 111	15 941
Departmental agencies (non-business entities)	231	177	6 925	14 294	14 359	14 359	15 052	15 111	15 941
Non-profit institutions	240 706	182 733	194 987	229 140	326 364	325 976	264 641	258 832	386 961
Households	98 071	123 025	165 830	101 409	102 990	128 827	95 586	100 852	106 412
Social benefits	82 859	88 770	97 988	78 294	11 887	21 177	9 340	9 874	10 418
Other transfers to households	15 212	34 255	67 842	23 115	91 103	107 650	86 246	90 978	95 994
Payments for capital assets	**595 955**	**509 496**	**1 057 356**	**1 336 176**	**1 228 276**	**1 228 286**	**1 181 093**	**1 046 222**	**1 237 619**
Buildings and other fixed structures	453 725	437 594	936 812	1 225 816	1 088 978	1 088 978	952 804	927 966	1 111 094
Buildings	453 725	437 594	936 812	1 225 816	1 088 978	1 088 978	952 804	927 966	1 111 094
Machinery and equipment	142 230	71 902	120 544	110 360	139 298	139 308	228 289	118 256	126 525
Transport equipment	81 840	4 823	24 299	24 763	23 248	23 268	70 304	25 558	28 319
Other machinery and equipment	60 390	67 079	96 245	85 597	116 050	116 040	157 985	92 698	98 206
Payments for financial assets	–	10 025	–	–	–	–	–	–	–
Total economic classification	**10 080 392**	**10 579 880**	**12 083 013**	**13 278 174**	**13 189 591**	**13 854 930**	**14 386 809**	**15 368 503**	**16 707 057**

4.9.2 RELATING EXPENDITURE TRENDS TO STRATEGIC GOALS

Compensation of Employees – shows an increase of 10 per cent due to the need to appoint additional personnel in 2019/20 FY. The Department has received a new grant, which is aimed at improving personnel level in various health facilities. A budget of R41 million was allocated in the 2019/20 FY for this purpose. The Department has further receive additional funding for the operationalization of Bethal and Mmametlhake hospital which were upgraded in the previous financial year. The Nursing College will appoint additional personnel for the insourcing of catering services for students.
The annual appointment of Bursary Holders also results in the increase in the annual Compensation of employee. The Department will be able to sustain the personnel number with the 10 per cent growth provided in the budget. Various cost efficiency projects will be implemented in order to reduce health costs.

Goods and Services – budget has not increased but shows a decline of 2 per cent. The decline is a result of recurring accruals and payables of the previous financial years. The Department will have difficulties to sustain payments until the end of the financial year as a result. Key Accounts and Non-negotiables could not be fully funded as result of a declining budget for operational activities. The Department will continue to intensify efficiency measures and internal controls to reduce health costs and provide sustainable health essential services to the community.

Transfers and subsidies - the budget decrease was due to inability to fund litigations and increase stipend for CHWs for the home base care Organizations. The Department will continue to implement the litigation strategy in order to reduce payment of high litigation, which may lead to bankruptcy of the Department.

Payments of Capital Assets –budget has decreased by 3 per cent due to a high investment made in 2018/19 FY on infrastructure and procurement essential equipment. The Department will continue to procure medical equipment and the replacement of EMS vehicles.

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 2019/20 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 2019/20, 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. Audit opinion from Auditor-General	Annual	Categorical
5. Percentage of Hospitals with broadband access	Quarterly	%
6. Percentage of fixed PHC facilities with broadband access	Quarterly	%

TABLE ADMIN 2: STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR ADMINISTRATION

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets		
			2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
	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	10/33	18/33	26/28	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	1	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	7/18	7/18	18 maintained	18 maintained	18 maintained	18 maintained
	Programme Performance/Customized Indicators (Sector Indicators)								
Improve health care outcome	4. Audit opinion from Auditor-General	Categorical	Qualified	Qualified	Qualified	Unqualified	Unqualified	Unqualified	Unqualified
Strengthening Health Systems Effectiveness	5. Percentage of Hospitals with broadband access	%	100% (33/33 maintained)	100% (33/33 maintained)	100% (33/33 maintained)	100% (33/33 maintained)	100% (33/33 maintained)	100% (33/33 maintained)	100% (33/33 maintained)
	6. Percentage of fixed PHC facilities with broadband access	%	29% (80/279)	80% (227/284)	96% 277/289	100% (287/287 maintained)	100% (287/287 maintained)	100% (287/287 maintained)	100% (287/287 maintained)

1.6 QUARTERLY TARGETS

TABLE ADMIN 3: QUARTERLY TARGETS

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2019/20	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 maintained	Annual Target	Annual Target	Annual Target	18 maintained
4. Audit opinion from Auditor-General	Annual	Categorical	Unqualified	Annual Target	Annual Target	Annual Target	Unqualified
5. Percentage of Hospitals with broadband access	Quarterly	Number	100% (33/33 maintained)	100% (33/33 maintained)	100% (33/33 maintained)	100% (33/33 maintained)	100% (33/33 maintained)
6. Percentage of fixed PHC facilities with broadband access	Quarterly	Number	100% (287/287)	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

R thousand	Outcome 2015/16	Outcome 2016/17	Outcome 2017/18	Main appropriation 2018/19	Adjusted appropriation 2018/19	Revised estimate 2018/19	Medium-term estimates 2019/20	Medium-term estimates 2020/21	Medium-term estimates 2021/22
1. Office of the MEC	7 600	7 752	7 140	8 628	8 628	8 628	9 980	10 047	10 594
2. Management	289 698	274 249	334 973	256 898	259 741	326 799	312 296	358 605	378 813
Total payments and estimates: Programme 1	**297 298**	**282 001**	**342 113**	**265 526**	**268 369**	**335 427**	**322 276**	**368 652**	**389 407**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

R thousand	Outcome 2015/16	Outcome 2016/17	Outcome 2017/18	Main appropriation 2018/19	Adjusted appropriation 2018/19	Revised estimate 2018/19	Medium-term estimates 2019/20	Medium-term estimates 2020/21	Medium-term estimates 2021/22
Current payments	**267 454**	**232 997**	**265 063**	**239 432**	**240 147**	**290 028**	**282 742**	**330 110**	**347 376**
Compensation of employees	110 825	124 420	135 808	133 645	132 020	132 020	142 449	156 626	185 084
Salaries and wages	97 391	109 191	119 424	116 350	114 879	114 879	123 860	136 272	143 631
Social contributions	13 434	15 229	16 384	17 295	17 141	17 141	18 589	20 354	21 453
Goods and services	156 033	108 476	129 216	105 787	108 127	157 692	140 293	173 484	182 292
Administrative fees	1 280	1 024	875	636	1 542	1 542	655	691	729
Advertising	2 913	4 483	3 826	4 238	2 591	2 591	4 463	4 708	4 967
Minor Assets	218	700	84	35	160	160	37	39	41
Audit cost: External	16 580	14 819	18 820	17 184	17 194	17 194	18 146	19 144	20 197
Catering: Departmental activities	1 091	784	399	610	547	639	642	677	714
Communication (G&S)	4 427	5 285	4 991	5 223	5 221	8 246	5 500	5 802	6 121
Computer services	57 117	15 732	30 940	29 673	29 661	44 661	53 918	85 637	89 610
Consultants: Business and advisory services	9 941	11 219	5 337	4 751	4 076	4 076	6 003	5 278	5 568
Laboratory services	12	10	2	–	–	–	–	–	–
Legal costs	27 222	16 576	28 640	20 182	22 182	34 117	21 252	22 421	23 654
Contractors	–	75	43	–	3	3	–	–	–
Agency and support / outsourced services	660	895	1 876	1 988	400	400	1 988	2 097	2 212
Fleet services (incl. government motor transport)	4 486	3 999	9 884	1 570	1 390	20 021	1 570	1 656	1 747
Inventory: Clothing material and accessories	–	–	49	–	–	–	–	–	–
Inventory: Food and food supplies	–	–	–	–	42	42	50	53	56
Inventory: Materials and supplies	790	–	–	–	–	–	–	–	–
Inventory: Medical supplies	–	6	–	–	–	–	6	6	6
Inventory: Other supplies	–	–	59	–	120	120	–	–	–
Consumable supplies	676	2 526	693	1 301	224	224	981	1 036	1 092
Cons: Stationery,printing and office supplies	3 914	3 530	2 219	1 482	3 378	3 378	3 560	1 645	1 736
Operating leases	4 818	6 220	3 498	3 024	2 824	3 264	4 184	4 414	4 656
Property payments	3 458	5 449	4 517	4 365	4 365	5 240	4 606	4 859	5 126
Travel and subsistence	14 590	13 351	11 189	9 207	10 372	9 939	11 696	12 229	12 908
Training and development	430	322	239	–	508	403	–	–	–
Operating payments	904	968	826	318	662	767	336	354	373
Venues and facilities	506	503	210	–	471	471	700	738	779
Rental and hiring	–	–	–	–	194	194	–	–	–
Interest and rent on land	596	101	39	–	–	316	–	–	–
Interest (Incl. interest on finance leases)	596	101	39	–	–	316	–	–	–
Transfers and subsidies	**21 105**	**35 152**	**69 025**	**24 094**	**25 458**	**42 635**	**25 422**	**26 819**	**28 294**
Provinces and municipalities	515	552	519	833	1 083	1 083	859	906	956
Provinces	515	551	519	833	1 083	1 083	859	906	956
Provincial agencies and funds	515	551	519	833	1 083	1 083	859	906	956
Municipalities	–	1	–	–	–	–	–	–	–
Municipal bank accounts	–	1	–	–	–	–	–	–	–
Households	20 590	34 600	68 506	23 261	24 375	41 552	24 563	25 913	27 338
Social benefits	5 378	345	724	146	1 260	1 260	154	162	171
Other transfers to households	15 212	34 255	67 782	23 115	23 115	40 292	24 409	25 751	27 167
Payments for capital assets	**8 739**	**3 827**	**8 025**	**2 000**	**2 764**	**2 764**	**14 112**	**11 723**	**13 737**
Machinery and equipment	8 739	3 827	8 025	2 000	2 764	2 764	14 112	11 723	13 737
Transport equipment	3 656	–	363	–	1 384	1 384	3 000	–	1 368
Other machinery and equipment	5 083	3 827	7 662	2 000	1 380	1 380	11 112	11 723	12 369
Payments for financial assets	–	10 025	–	–	–	–	–	–	–
Total economic classification: Programme 1	**297 298**	**282 001**	**342 113**	**265 526**	**268 369**	**335 427**	**322 276**	**368 652**	**389 407**

1.8 PERFORMANCE AND EXPENDITURE TRENDS

The budget increase of the programme is at minus 4 per cent due inadequacy of the budget of the Department. The programme will prioritize payment of accruals and payables for ICT programme and various fixed accounts of the programme. The Programme provides leadership in the reduction of health costs across all programmes. An amount of R10 million was earmarked for the improvement of revenue collection by procuring computers, patients files and photocopier machines for hospitals

1.9 RISK MANAGEMENT

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

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

2.1 PROGRAMME PURPOSE

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

2.2 PRIORITIES

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.

- Universal Test and Treat is a strategy in which all HIV infected individuals receive treatment whether in need or not. It is aimed at eliminating HIV as it reduces the rate of spreading the virus to other people. The Mpumalanga province is implementing the strategy.

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.
    - Men who access the MMC programme need to be given a package of services in order to prevent new HIV infections. Modelling studies have shown that MMC is cost-effective. The latest Human Sciences Research Council (HSRC) study has acknowledged the good performance of the MMC programme and recommended that the MMC programme scale-up its performance with a focus on 15-34 age groups for immediacy and of impact on the HIV epidemic.

9. SheConquers campaign: HIV Prevention in girls and young women in South Africa

    - She Conquers is a three-year national campaign that aims to improve the lives of adolescent girls and young women in South Africa. The idea is that every adolescent girl and young woman in the country should be provided with resources that they need to lead a healthy and productive life. The Mpumalanga Department of Health is collaborating with NPOs that are funded to implement the programme.
    - 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

    - The Department provides HIV testing services at health facilities and through community testing. The focus is on communities with very high HIV prevalence and clients are linked to care. Innovative strategies are being introduced so as to attract hard to reach groups such as men and key populations. The province has started with the implementation of HIV self-screening (HIVSS) which will improve HIV testing among

the historical HIV under-tested. Index testing modality has been introduced in the province, this will assist with tracking of partners of those that have tested positive to go for testing in order to get the high yield. The National Department of Health has introduced the National Wellness Campaign (Cheka Impilo). The campaign aims to ensure that an additional 14 million people in the country have are tested by 2019/20.

11. The Surge Plan/ Acceleration Plan

In 2017, the NDoH together with PEPFAR SA developed an HIV Treatment Surge plan to accelerate epidemic control in SA by putting a total of 6.1 million individuals on ART in the public health system by December 2020. The Treatment Surge will support interventions and direct service delivery in the 27 priority districts that account for 82% of the HIV burden in SA, and high-impact technical assistance and *above*-site interventions that support the national ART programme.

12. Pre-Exposure Prophylaxis (PrEP) targeted at key population groups.

In June 2016 the South African National Department of Health (NDoH) rolled out oral PrEP to select sex workers sites. At that time, the guidelines were specific for the sex worker rollout. These guidelines have now been updated to include additional target populations, including men who have sex with men, serodiscordant couples, and adolescent girls and young women. The inclusion of these additional target populations in the PrEP rollout will be at the direction of the NDoH, over time, targeting prioritized populations in phased approaches.

13. ACSM Strategy

Purpose

To market and promote HIV/AIDS, STIs and TB programmes and consequently create demand for increase uptake of Health Services. ACSM is one of the key interventing programmes that educates and advocate healthy lifestyles, promote and increase awareness among key populations such as youth, sex workers, inmates, farming and mining communities as well as business sector. The program makes accessible condoms as one of the many preventative strategies the department adopted to the general population. it does educate in many different platforms such as comprehensive health campaigns, radio and other forms of media. There is an adopted communication strategy by Management which helps direct all the activities of the directorate.

ACSM Functions

- Market and promote HIV/AIDS, STI s and TB Health services
- Compile Annual Integrated ACSM plan
- Spread critical messages on HAST programmes using Multi-level Communication Approach
- Create Demand on utilization of Health Services
- Coordinate campaigns and community dialogues at all levels (Provincial, District and Sub-Districts)

2.2.4 EHLANZENI DISTRICT

Primary Health Care:

(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)

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]	26 mobile clinics 1055 mobile clinic points; 3 satellite clinics	1 043 194 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]	31 mobile clinics 720 mobile clinic points	1 688 615 1 209 Beds	3 097	239 225	2.7
	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]	26 mobile clinics 396 mobile clinic points	1 308 129 716 Beds	56 694	158 031	1.6
	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 2561 mobile clinic points	4 039 939 (Stats SA 2007) 3026 Beds	45 241	545 422	2.1
	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 2017/18	Ehlanzeni 2017/18	Gert Sibande 2017/18	Nkangala 2017/18
1. Ideal clinic status rate	%	30.3% (87/287)	8.3% (10/121)	72.3% (55/76)	24.4% (22/90)
2. PHC utilisation rate - Total	No	2.1	2.7	1.8	1.6
3. Complaint resolution within 25 working days rate (PHC)	%	95%	81.4%	96.0%	83.1%

2.4.1 STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR DHS

PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
1. Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) rate (fixed clinic/CHC/CDC)	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		
			2015/16	2016/17	2017/18	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	99.3% (285/287)	40.4% (116/287)	66.5% (191/287)	100% (287/287)	100% (287/287)
Expand access to health care services	2. PHC utilisation rate - Total	No	2.2	2.2	2.1	2.2 (9449034/4290009)	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)	%	95.5%	93.7%	95%	98% (2058/2100)	98% (2161/2205)	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 2019/20	TARGETS			
				Q1	Q2	Q3	Q4
1. Ideal clinic status rate	Annual	%	66.5% (191/287)	Annual Target	Annual Target	Annual Target	66.5% (191/287)
2. PHC utilisation rate - Total	Quarterly	No	2.2 (9449034/4290009)	2.2	2.2	2.2	2.2
3. Complaint resolution within 25 working days rate (PHC)	Quarterly	%	98% (2161/2205)	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 2017/18	Ehlanzeni 2017/18	Gert Sibande 2017/18	Nkangala 2017/18
1. Hospital achieved 75% and more on National Core Standards self-assessment rate (District Hospitals)	%	10/23 43.4%	4/8	4/8	2/7
2. Average Length of Stay (District Hospitals)	No	4.2 days	4	4.3	4.7
3. Inpatient Bed Utilisation Rate (District Hospitals)	%	69.5%	69.4%	69.2%	70.3%
4. Expenditure per PDE (District Hospitals)	No	R2433.3	R2387.30	R2298.50	R2727.30
5. Complaint Resolution within 25 working days rate (District Hospitals)	%	96%	97.5%	95.2%	93.4%

STRATEGIC OBJECTIVES, INDICATORS AND MTEF TARGETS FOR DISTRICT HOSPITALS

PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
1. Average Length of Stay (District Hospitals)	Quarterly	No
2. Inpatient Bed Utilisation Rate (District Hospitals)	Quarterly	%
3. Expenditure per PDE (District Hospitals)	Quarterly	R
4. 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		
			2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Improve quality of health care	**Programme Performance/Customized Indicators (Sector Indicators)**								
	1. Average Length of Stay (District Hospitals)	No	4.5 days	4.8	4.2 days	4.2 days	4.2 days	4.2 days	4.2 days
	2. Inpatient Bed Utilisation Rate (District Hospitals)	%	71.4%	75%	69.5%	75% (113500/151000	75% (113500/151000)	75% (113500/151000)	75% (113500/151000)
	3. Expenditure per PDE (District Hospitals)	R	R2.153.40	R2 283.2	R 2 433.3	R2,500.00	R2,650.00	R2,810.00	R2980.00
	4. Complaint Resolution within 25 working days rate (District Hospitals	%	90.6%	95.4%	86.7%	95% (1131/1155)	95.5% (1189/1213)	96% (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 2019/20	TARGETS			
				Q1	Q2	Q3	Q4
1. Average Length of Stay (District Hospitals)	Quarterly	No	4.2 days	4.2 days	4.2 days	4.2 days	4.2 days
2. Inpatient Bed Utilisation Rate (District Hospitals)	Quarterly	%	75% (113500/151000)	75%	75%	75%	75%
3. Expenditure per PDE (District Hospitals)	Quarterly	R	R2,650.00	R2,650.00	R2,650.00	R2,650.00	R2,650.00
4. Complaint Resolution within 25 working days rate (District Hospitals)	Quarterly	%	95.5%	95.5%	95.5%	95.5%	95.5%

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

TABLE DHS 8: SITUATION ANALYSIS INDICATORS FOR HAST

Programme Performance Indicator	Indicator Type	Province wide value 2017/18	Ehlanzeni 2017/18	Gert Sibande 2017/18	Nkangala 2017/18
1. Female condom distributed	No	1 040 630	572 500	197100	271 030
2. Improve TB cure rate	%	79.5% (2016)	83.5% (2016)	72.8% (2016)	78.8% (2016)
3. ART client remain on ART end of month -total	No	411 905	197 364	115 677	98 864
4. TB/HIV co-infected client on ART rate	%	96.2%	99.4%	90.5%	93.7%
5. HIV test done - total	No	1 302 122	520 028	296 311	485 505
6. Male condom distributed	No	62 703 737	28 696 100	15 517 609	18 490 028
7. Medical male circumcision – Total	No	79 187	20 830	12 644	45 713
8. TB symptom 5yrs and older start on treatment rate	%	72.5% (96%)	96.8%	96.1%	95.8%
9. TB client treatment success rate	%	87.1% (2016)	88% (2016)	83.2% (2016)	89%(2016)
10. TB client lost to follow up rate	%	5.2% (2016)	5.5% (2016)	6.2% (2016)	3.7% (2016)
11. TB client death rate	%	4.3%(2016)	3.8% (2016)	5.6%	4.2%
12. TB MDR treatment success rate	%	56.7%(2015)	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		
			2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
	Strategic Objective/Provincial Indicators								
1. Improve Health Care Outcomes	1. Female Condom Distributed	No	1 828 571	1 981 572	1 040 630	3 812 067	1 500 000	2 000 000	2 500 000
	2. Improve TB cure rate	%	78.7% (2014)	75.9%	78.9%	82% (17674/21554)	82%	83%	83%
	3. ART client remain on ART end of month -total	No	318 228	377 288	411 905	477 288	521 028	557 590	608 895
	4. TB/HIV co-infected client on ART rate	%	Not In plan	39.7%	96.2%	93% (13625/14651)	96%	96%	96%
	5. HIV test done - total	No	868 897	1 053 082	1 302 122	1 060 313	1 082 313	1 415 292	1 514 362
	6. Male condom distributed	No	30 per male	77 703 335	62 703 737	72 429 277	75 499 519	75 107 920	80 660 353
	7. Medical male circumcision - Total	No	38 439	38 262	79 187	44 000	66 853	37 120	37 120
	8. TB symptom 5yrs and older started on treatment rate	%	Not in Plan	39.8%	72.5%	80% (8000/10000)	90%	90%	90%
	9. TB client treatment success rate	%	88.6% (2014)	87.4%	87.1%	89% (19183/21554)	88%	89%	90%
1. Improve Health Care Outcomes	10. TB client lost to follow up rate	%	4% (2014)	5.4%	5.2%	4.1% (884/21554)	<5%	<5%	<5%

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets		
			2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
	11. TB client death rate	%	4.5% (2014)	4.7%	4.3%	4.30 (927/21554)	<5%	<5%	<5%
	12. TB MDR treatment success rate	%	45% (2013)	54.4%	56.7%	62% (732/1182)	61%	62%	62%

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 2019/20	TARGETS			
				Q1	Q2	Q3	Q4
1. Female Condom Distribution	Quarterly	No	1 500 000	375 000	375 000	375 000	375 000
2. Improve TB cure rate	Annual	%	82%	82%	82%	82%	82%
3. ART client remain on ART end of month – total	Quarterly	No	521 028	439 186	466 461	493 748	521 028
4. TB/HIV co-infected client on ART rate	Quarterly	%	96%	96%	96%	96%	96%
5. HIV test done – total	Quarterly	No	1 082 313	270 578	270 578	270 578	270 579
6. Male condom distributed	Quarterly	No	75 499 519	18 874 880	18 874 880	18 874 880	18 874 879
7. Medical male circumcision - Total	Quarterly	No	66 853	16 713	16 713	16 713	16 714
8. TB symptom 5yrs and older started on treatment rate	Quarterly	%	90%	90%	90%	90%	90%

9. TB client treatment success rate	Quarterly	%	88%	88%	88%	88%	88%
10. TB client lost to follow up rate	Quarterly	%	<5%	<5%	<5%	<5%	<5%
11. TB client death rate	Annual	%	<5%	<5%	<5%	<5%	<5%
12. TB MDR treatment success rate	Annual	%	61%	61%	61%	61%	61%

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 2017/18	Ehlanzeni 2017/18	Gert Sibande 2017/18	Nkangala 2017/18
1. Number of School Health Service Teams established	No	32	9	11	12
2. Antenatal 1st visit before 20 weeks rate	%	73.8%	79.5%	67.6%	70.5%
3. Mother postnatal visit within 6 days rate	%	63.4%	59.6%	63.4%	71.4%
4. Antenatal client initiated on ART rate	%	99%	99.5%	98%	97.5%
5. Infant 1st PCR test positive around 10 weeks rate	%	1.1%	1.1%	0.77%	1.3%
6. Immunisation coverage under 1 year (annualised)	%	90.4%	94.8%	88.4%	85.2%
7. Measles 2nd dose coverage (annualised)	%	89.2%	100.5%	80.8%	79.1%
8. Child under 5 years diarrhoea case fatality rate	%	1.9	2.4%	1.4%	2.1%
9. Child under 5 years pneumonia case fatality rate	%	2.4	2.5%	1.6%	3.4%
10. Child under 5 years severe acute malnutrition case fatality rate	%	9.1	9.4	9	8.4
11. School Grade 1 screened	%	20587	6258	6885	4954
12. School Grade 8 screened	%	9661	3232	4637	1822
13. Delivery 10 to 19 years in facility rate	%	12.5%	14.9%	14.1%	7.9%
14. Couple year protection rate (annualised)	%	62.4%	74.6%	57.9%	52%
15. Cervical cancer screening coverage (annualised)	%	78.7%	90.4%	74.8%	68.8%

Programme Performance Indicator	Indicator Type	Province wide value 2017/18	Ehlanzeni 2017/18	Gert Sibande 2017/18	Nkangala 2017/18
16. Human Papilloma Virus Vaccine 1st dose coverage	%	77.9%	-	-	-
17. Human Papilloma Virus Vaccine 2nd dose coverage	%	55%	-	-	-
18. Vitamin A 12-59 months coverage (annualised)	%	58.3	68.3	46.8	52.5
19. Maternal mortality in facility ratio (annualised)	per 100 000 Live Births	120/100 000	103.5/100 000	96.5/100 000	176.4/100 000
20. Inpatient early neonatal death rate	per 1000	9.7/1000	9.2/1000	14.3/1000	10.4/1000

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. Antenatal 1st visit before 20 weeks rate	Quarterly	%
3. Mother postnatal visit within 6 days rate	Quarterly	%
4. Antenatal client start on ART rate	Annual	%
5. Infant 1st PCR test positive around 10 weeks rate	Quarterly	%
6. Immunisation under 1 year coverage	Quarterly	%
7. Measles 2nd dose coverage	Quarterly	%
8. Diarrhoea case fatality rate	Quarterly	%
9. Pneumonia case fatality rate	Quarterly	%
10. Severe acute malnutrition case fatality rate	Quarterly	%
11. School Grade 1 - learners screened	Quarterly	No
12. School Grade 8 - learners screened	Quarterly	No
13. Delivery in 10 to 19 years in facility rate	Quarterly	%
14. Couple year protection rate (Int)	Quarterly	%
15. Cervical cancer screening coverage 30 years and older	Quarterly	%
16. HPV 1st dose	Annual	No

PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type
17. HPV 2nd dose	Annual	No
18. Vitamin A 12-59 months coverage	Quarterly	%
19. Maternal mortality in facility ratio	Annual	per 100 000 Live Births
20. 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		
			2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
1. Improve health care outcomes	**Strategic Objective/Provincial Indicators**								
	1. Number of School Health Service Teams established	No	12	13 (43 cumulative)	32 (75 Cumulative)	33 (108 cumulative)	30 (121 cumulative)	0 121 cumulative	0 121 cumulative
	Programme Performance/Customized Indicators (Sector Indicators)								
	2. Antenatal 1st visit before 20 weeks rate	%	65.9%	71.9%	73.8%	74% (56623/76518)	75% (57389/76518)	77% (58919/76518)	77% (58919/76518)
	3. Mother postnatal visit within 6 days rate	%	62.5%	60.2%	63.4%	65% (47345/72839)	65.5% (47710/72839)	66% (48074/72839)	66% (48074/72839)
	4. Antenatal client initiated on ART rate	%	95.8%	94.9% (14842/15640)	99%	97.5% (14235/14600)	98% (13328/13600)	98% (12348/12600)	98% (12348/12600)
	5. Infant 1st PCR test positive around 10 weeks rate	%	1.6%	1.7% (241/14406)	1.1%	1.45% (262/18043)	1.3% (253/18043)	1.35% (243/18043)	1.35% (243/18043)
	6. Immunisation under 1 year coverage	%	87.1%	79.7%	90.4%	89% (72120/81034)	90% (72930/81034)	90% (72930/81034)	90% (72930/81034)
	7. Measles 2nd dose coverage	%	78.7%	86.4 %	89.2%	88% (73857/83928)	90% (75535/83928)	93% (75535/83928)	94% (75535/83928)
	8. Diarrhoea case fatality rate	%	2.7%	1.5%	1.9%	3% (92/3075)	< 2. % (77/3075)	< 2.% (77/3075)	< 2.% (77/3075)

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets		
			2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
	9. Pneumonia case fatality rate	%	3.7%	3.4%	2.4%	3.8% (139/3667)	2.5% (128/3667)	2.5% (128/3667)	2.5% (128/3667)
	10. Severe acute malnutrition case fatality rate	%	12.5%	8.4%	9.1%	11% (108/986)	9% (99/986)	8.5% (94/986)	8 89/986
	11. School Grade 1 - learners screened	No	20%	21.1%	20 587	29 650	20 587	20 587	20 587
	12. School Grade 8 - learners screened	No	13.1	6.8%	9 661	21 490	10 000	10 000	10 000
	13. Delivery in 10 to 19 years in facility rate	%	Not in plan	Not in plan	12.5%	11% (8012/72839)	11% (8012/72839)	9.5% (5827/72839)	8% (5827/72839)
	14. Couple year protection rate (int)	%	38.6%	50.4%	62.4%	60% (717034/1195057)	65% (776787/1195057)	68% (836540/1195057)	70% (836540/1195057)
	15. Cervical cancer screening coverage 30 years and older	%	66.7%	66.5%	78,7%	75% (692531/923374)	80% (720232/923374)	82% (738699/923374)	84% (738699/923374
	16. HPV 1st dose	No	95%	77.2%	30 876	77350	81900	81900	81900
	17. HPV 2nd dose	No	102.8%	58%	23 292	77350	81900	81900	81900
	18. Vitamin A 12-59 months coverage	%	51.4%	55.1%	58.3%	60% (205552/342587)	60% (212404/342587)	62% (214830/342587)	64% (219256/342587)

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets		
			2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
	19. Maternal mortality in facility ratio	per 100 000 Live Births	125.3/100 000	129.6/100 000	120 per 100 000	145 per 100 000 Live Births (103/70988)	141 per 100 000 Live Births (100/70988)	135 per 100 000 live births (96/70988)	135 per 100 000 live births (96/70988)
	20. Neonatal death in facility rate	per 1000	9.3/1000	9.5/1000	9.7 per 1 000	9,25/1000 (657/70995)	10,0/1000 (639/70995)	9/1000 (621/70995)	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 2019/20	TARGET			
				Q1	Q2	Q3	Q4
1. Number of School Health Service Teams established	Annual	Number	30	Annual Target	30	Annual Target	Annual Target
2. Antenatal 1st visit before 20 weeks rate	Quarterly	%	75% (57389/76518)	75% (57389/76518)	75% (57389/76518)	75% (57389/76518)	75% (57389/76518)
3. Mother postnatal visit within 6 days rate	Quarterly	%	65.5% (47710/72839)	65.5% (47710/72839)	65.5% (47710/72839)	65.5% (47710/72839)	65.5% (47710/72839)
4. Antenatal client initiated on ART rate	Quarterly	%	98% (13328/13600)	98% (13328/13600)	98% (13328/13600)	98% (13328/13600)	98% (13328/13600)
5. Infant 1st PCR test positive around 10 weeks rate	Quarterly	%	1,3% (253/18043)	1,3% (253/18043)	1,3% (253/18043)	1,3% (253/18043)	1,3% (253/18043)
6. Immunisation under 1 year coverage	Quarterly	%	90% (72930/81034)	90% (72930/81034)	90% (72930/81034)	90% (72930/81034)	90% (72930/81034)
7. Measles 2nd dose coverage	Quarterly	%	90% (75535/83928)	90% (75535/83928)	90% (75535/83928)	90% (75535/83928)	90% (75535/83928)
8. Diarrhoea case fatality rate	Quarterly	%	< 2. % (77/3075)	< 2. % (77/3075)	< 2. % (77/3075)	< 2. % (77/3075)	< 2. % (77/3075)
9. Pneumonia case fatality rate	Quarterly	%	2.5% (128/3667)	2.5% (128/3667)	2.5% (128/3667)	2.5% (128/3667)	2.5% (128/3667)
10. Severe acute malnutrition case fatality rate	Quarterly	%	9% (99/986)	9% (99/986)	9% (99/986)	9% (99/986)	9% (99/986)
11. School Grade 1 - learners screened	Quarterly	No	20 587	7 413	7 413	7 413	7 411
12. School Grade 8 - learners screened	Quarterly	No	10 000	5 372	5 372	5 374	5 372

13. Delivery in 10 to 19 years in facility rate	Quarterly	%	11% (8012/72839)	11% (8012/72839)	11% (8012/72839)	11% (8012/72839)	11% (8012/72839)
14. Couple year protection rate (Int)	Quarterly	%	65% (776787/1195057)	65% (776787/1195057)	65% (776787/1195057)	65% (776787/1195057)	65% (776787/1195057)
15. Cervical cancer screening coverage 30 years and older	Quarterly	%	80% (720232/923374)	80% (720232/923374)	80% (720232/923374)	80% (720232/923374)	80% (720232/923374)
16. HPV 1st dose	Annual	No	81900	Annual Target	81900	Annual Target	Annual Target
17. HPV 2nd dose	Annual	No	81900	Annual Target	Annual Target	81900	Annual Target
18. Vitamin A 12-59 months coverage	Quarterly	%	60% (212404/342587)	60% (51 388 / 85 647)	60% (51 388 / 85 647)	60% (51 388 / 85 647)	60% (51 388 / 85 616)
19. Maternal mortality in facility ratio	Annual	per 100 000 Live Births	141 per 100 000 Live Births (100/70988)	141/100 000 (100/70988)	141/100 000 (100/70988)	141/100 000 (100/70988)	141/100 000 (100/70988)
20. Neonatal death in facility rate	Annual	per 1000	10,0/1000 (639/70995)	10,0/1000 (639/70995)	10,0/1000 (639/70995)	10,0/1000 (639/70995)	10,0/1000 (639/70995)

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 20/17/18	Ehlanzeni 20/17/18	Gert Sibande 20/17/18	Nkangala 20/17/18
1. Cataract Surgery Rate annualized	Rate per 1 Million (uninsured population)	313/1 million	101.2	380	312.6
2. Malaria case fatality rate	%	1.02%	1.02%	0	0

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. Cataract Surgeries performed	Quarterly	Rate per 1 Million (uninsured population)
2. Malaria case fatality rate	Quarterly	%

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

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets		
			2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	
1 Improve health care outcomes	**Programme Performance/Customized Indicators (Sector Indicators)**								
	1. Cataract Surgeries performed	Rate per 1 Million (uninsured population)	CSR 805 (2 657)	CSR 1,333 (1 303)	CSR 313 (1 157)	CSR 1000 (3,600)	1,600	1,600	1,600
	2. Malaria case fatality rate	%	0.5%	0.67%	1.02%	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 2019/20	TARGETS			
				Q1	Q2	Q3	Q4
1. Cataract Surgeries performed	Quarterly	Rate per 1 Million (uninsured population)	1,600	200	600	600	200
2. 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

R thousand	Outcome 2015/16	2016/17	2017/18	Main appropriation	Adjusted appropriation 2018/19	Revised estimate	Medium-term estimates 2019/20	2020/21	2021/22
1. District Management	349 625	341 758	331 895	383 965	397 704	408 874	431 666	451 399	475 854
2. Community Health Clinics	1 246 101	1 202 502	1 302 677	1 448 290	1 423 686	1 510 953	1 544 366	1 650 612	1 740 140
3. Community Health Centres	753 732	833 433	895 515	898 241	910 220	969 970	983 592	1 060 314	1 117 753
4. Community-based Services	89 841	91 150	136 745	18 526	19 076	19 076	21 738	5 965	6 292
5. Other Community Services	–	–	–	–	–	–	–	–	–
6. HIV/Aids	936 447	1 120 040	1 420 824	1 903 549	1 898 883	2 066 431	2 132 510	2 342 459	2 674 787
7. Nutrition	12 667	13 199	16 838	18 187	10 832	10 879	16 712	17 555	18 519
8. Coroner Services	–	–	–	–	–	–	–	–	–
9. District Hospitals	2 786 993	2 922 762	3 077 510	3 377 313	3 327 673	3 433 502	3 664 873	3 905 409	4 125 873
Total payments and estimates: Programme 2	**6 175 406**	**6 524 844**	**7 182 004**	**8 048 071**	**7 988 074**	**8 419 685**	**8 795 457**	**9 433 713**	**10 159 218**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

R thousand	Outcome 2015/16	2016/17	2017/18	Main appropriation	Adjusted appropriation 2018/19	Revised estimate	Medium-term estimates 2019/20	2020/21	2021/22
Current payments	**5 756 986**	**6 321 584**	**6 955 798**	**7 790 528**	**7 632 914**	**8 058 762**	**8 482 703**	**9 146 723**	**9 741 558**
Compensation of employees	3 921 759	4 293 015	4 616 513	5 089 808	5 035 880	5 035 880	5 526 431	5 889 998	6 217 719
Salaries and wages	3 422 489	3 753 979	4 031 856	4 437 673	4 372 574	4 372 574	4 846 537	5 163 390	5 454 552
Social contributions	499 270	539 036	584 657	652 135	663 306	663 306	679 894	726 608	763 167
Goods and services	1 835 065	2 028 435	2 339 010	2 700 720	2 597 034	3 022 790	2 956 272	3 256 725	3 523 839
Administrative fees	1 193	137 126	185 969	185 324	186 233	207 036	178 096	186 485	198 320
Advertising	126	1 594	1 205	5 000	4 077	4 077	6 070	5 570	5 876
Minor Assets	8 680	5 786	3 430	16 035	11 191	11 019	13 643	14 375	15 169
Catering: Departmental activities	1 516	1 717	2 268	2 500	2 739	2 772	8 640	2 785	2 938
Communication (G&S)	26 374	27 466	22 568	23 125	21 578	21 578	24 684	25 888	27 311
Computer services	–	8	6 973	848	4 061	4 061	892	941	993
Consultants: Business and advisory services	585	1 774	–	–	–	–	–	–	–
Laboratory services	250 486	304 018	334 797	435 554	412 661	445 281	548 285	657 432	733 430
Legal costs	–	–	–	–	–	1 973	–	–	–
Contractors	14 952	16 688	13 508	14 850	8 540	25 540	45 237	46 624	49 189
Agency and support / outsourced services	43 253	46 501	30 916	40 016	40 561	57 160	42 136	44 454	36 882
Fleet services (incl. government motor transport)	48 531	48 376	43 486	38 680	37 164	52 649	31 555	33 378	45 240
Inventory: Clothing material and accessories	1 412	–	559	–	72	72	–	–	–
Inventory: Farming supplies	4 086	–	3 977	14 128	7 929	7 929	11 646	18 546	19 506
Inventory: Food and food supplies	54 482	52 742	51 963	57 080	53 298	52 950	59 432	63 406	66 214
Inventory: Chemicals,fuel,oil,gas,wood and coal	20 030	19 759	495	115	613	649	121	128	135
Inventory: Materials and supplies	3 426	199	–	–	3	3	750	791	835
Inventory: Medical supplies	180 991	200 348	191 454	213 818	213 013	245 359	228 037	259 029	273 254
Inventory: Medicine	978 311	969 297	1 278 336	1 469 741	1 409 479	1 692 257	1 534 128	1 666 148	1 804 945
Inventory: Other supplies	–	–	4 811	4 300	5 135	5 135	4 531	4 780	5 043
Consumable supplies	40 739	48 677	35 769	33 374	26 963	32 707	36 899	38 923	41 079
Cons: Stationery,printing and office supplies	19 082	11 325	8 748	9 002	10 931	9 806	12 480	11 255	11 874
Operating leases	18 934	18 734	17 273	21 465	23 465	23 869	16 950	17 886	18 876
Property payments	84 451	85 464	76 057	90 299	89 985	91 817	114 199	119 506	126 236
Transport provided: Departmental activity	115	137	159	212	243	243	223	235	248
Travel and subsistence	26 835	25 637	19 662	22 169	23 684	23 422	23 972	23 732	25 036
Training and development	577	458	697	1 075	765	765	1 135	1 197	1 263
Operating payments	3 588	2 564	2 955	2 010	1 725	1 735	12 531	13 231	13 947
Venues and facilities	1 712	1 251	915	–	149	149	–	–	–
Rental and hiring	598	789	60	–	777	777	–	–	–
Interest and rent on land	162	134	275	–	–	92	–	–	–
Interest (Incl. interest on finance leases)	162	134	275	–	–	92	–	–	–
Transfers and subsidies	**342 462**	**198 577**	**219 509**	**235 930**	**333 581**	**339 344**	**271 810**	**266 395**	**394 941**
Provinces and municipalities	139 626	–	–	–	–	–	–	–	–
Municipalities	139 626	–	–	–	–	–	–	–	–
Municipal bank accounts	139 626	–	–	–	–	–	–	–	–
Departmental agencies and accounts	112	113	105	139	204	204	146	154	162
Departmental agencies (non-business entities)	112	113	105	139	204	204	146	154	162
Non-profit institutions	187 335	182 733	194 987	229 140	326 364	325 976	264 641	258 832	386 961
Households	15 389	15 731	24 417	6 651	7 013	13 164	7 023	7 409	7 818
Social benefits	15 389	15 731	24 417	6 651	7 013	13 164	7 023	7 409	7 818
Payments for capital assets	**75 958**	**4 683**	**6 697**	**21 613**	**21 579**	**21 579**	**40 944**	**20 595**	**22 719**
Machinery and equipment	75 958	4 683	6 697	21 613	21 579	21 579	40 944	20 595	22 719
Transport equipment	47 001	1 829	3 031	11 028	9 729	9 739	10 094	–	–
Other machinery and equipment	28 957	2 854	3 666	10 585	11 850	11 840	30 850	20 595	22 719
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme 2	**6 175 406**	**6 524 844**	**7 182 004**	**8 048 071**	**7 988 074**	**8 419 685**	**8 795 457**	**9 433 713**	**10 159 218**

2.10 PERFORMANCE AND EXPENDITURE TRENDS

The significant allocation supports the policy of provision access to quality health care. The budget increase in 2019/20 FY is due the significant increase in HIV grant funding to address the pressure in ART drugs. The Department has also budgeted for the ideal clinics and school health.

A budget of amounting to R15 million was allocated for the improvement of the IDEAL status for all Primary Health Facilities. An amount of R63 million was set aside to reduce the malaria fatality rate, which also include funding from the Comprehensive HIV/AIDS conditional grant. The Programme will receive R78 million additional budget on Compensation of Employees in order to improve staffing needs within the programme. Additional funding amounting to R9.5 million was allocated to procure the tools of trade for employees.

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: • Recruitment and retention • HR Delegation Framework • Determine a baseline for vacancies and an acceptable vacancy rate. This must be decreased by 20% • 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 b. Increase from 9 to 18 Sub-district Mental Health Care Coordinators 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 b. Conduct continuous training and orientation c. Conduct mentoring and onsite in-services training d. Conduct monitoring and evaluation of MCWYH services Continue training of Community Health Care workers on MCWH issues
4. Increased incidence and mortalities from Malaria	a. Appoint Temporal Sprayers b. Conduct indoor residual sprays c. Conduct surveillance on Malaria prone breeding areas Conduct community awareness campaigns 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 b. Ensure substantive contract management of service provider

RISK	MITIGATING FACTORS
	e. Develop an annual training plan for health care workers
6. Inadequate community awareness on HIV/Aids/Tuberculosis	a. Implement ACSM strategy • ACSM campaigns are conducted as per operational Plan 2019/20 and the schedule for the ACSM campaigns. • Integrate with other Partners in addressing poverty- PIP 2017-2022 is being implemented. In response to the NSP and PIP 2017 -2022 yearly DOH activity plans are developed for formal commitment to implementation of the PIP activities by each sector. • Contribute to the development of cross boarder MOU - The Department is part of the Ehlanzeni Migrant Health Forum which aims to ensure migrants have access to health services, particularly HIV.
7. Inadequate information management	a. Procure equipment and appoint Data management personnel b. Skills gap analysis and requisite training c. Adhere to the National Archives Act by securing adequate facilities for record storage. a. 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

- Reduction of maternal, infant and child mortality through provision of obstetric ambulance.
- Improvement of referrals through integration of PPTS into EMS.
- Improve response time

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 2017/18	Ehlanzeni 2017/18	Gert Sibande 2017/18	Nkangala 2017/18
1. EMS P1 urban response under 15 minutes rate	Quarterly	%	71%	73	N/A	69%
2. EMS P1 rural response under 40 minutes rate	Quarterly	%	68%	71.5%	64.5%	69%
3. EMS inter-facility transfer rate	Quarterly	%	5%	8%	4%	3%

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		
			2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Improve access to health care services	**Strategic Objective/Provincial Indicators**								
	1. Improve response time by increasing the number of Operational Ambulances	No	108 Operational Ambulances	95	96 Operational Ambulances	100	100	105	115
	2. Improve the use of resources by integrating PPTS into EMS operations	%	20%	20%	20%	60%	40%	100%	100%
	3. Improve maternal outcomes by increasing the number of Obstetric ambulances	No	18	24	24	6 (cumulative 30)	6 (cumulative 30)	6 (cumulative 36)	6 (cumulative 42)
	Programme Performance/Customized Indicators (Sector Indicators)								
	4. EMS P1 urban response under 15 minutes rate	%	75.5%	72.3%	71%	80%	73%	75%	78%
	5. EMS P1 rural response under 40 minutes rate	%	71.5%	69.5%	68%	75%	69%	72%	75%
	6. EMS inter-facility transfer rate	%	4.6%	5%	5.0%	40%	25%	30%	40%

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 2019/20	TARGETS			
				Q1	Q2	Q3	Q4
1. Improve response time by increasing the number of Operational Ambulances	Annually	No	100	98	98	98	100
2. Improve the use of resources by integrating PPTS into EMS operations	Quarterly	%	40%	20%	20%	40%	40%
3. Improve maternal outcomes by increasing the number of Obstetric ambulances	Annually	No	6 (cumulative 30)	24	24	24	30
4. EMS P1 urban response under 15 minutes rate	Quarterly	%	73%	73%	73%	73%	73%
5. EMS P1 rural response under 40 minutes rate	Quarterly	%	69%	69%	69%	69%	69%
6. EMS inter-facility transfer rate	Quarterly	%	25%	5.2%	10%	20%	25%

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	2015/16	2016/17	2017/18		2018/19		2019/20	2020/21	2021/22
1. Emergency transport	305 351	321 913	357 188	380 800	356 895	356 895	413 036	402 751	424 579
2. Planned Patient Transport	4 245	6 276	14 331	7 202	7 202	7 202	22 281	23 529	24 799
Total payments and estimates: Programme 3	**309 596**	**328 189**	**371 519**	**388 002**	**364 097**	**364 097**	**435 317**	**426 280**	**449 378**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2015/16	2016/17	2017/18		2018/19		2019/20	2020/21	2021/22
Current payments	**286 847**	**318 671**	**350 037**	**374 726**	**352 321**	**352 219**	**385 640**	**405 507**	**427 472**
Compensation of employees	232 102	267 257	291 567	314 963	291 058	290 956	314 052	329 976	347 795
Salaries and wages	199 095	228 697	248 952	268 345	245 399	245 297	266 067	279 304	294 386
Social contributions	33 007	38 560	42 615	46 618	45 659	45 659	47 985	50 672	53 409
Goods and services	54 715	51 407	58 470	59 763	61 263	61 263	71 588	75 531	79 677
Administrative fees	13	20	7	17	15	15	18	19	20
Minor Assets	–	–	–	–	1 500	1 500	–	–	–
Catering: Departmental activities	36	97	24	–	–	–	–	–	–
Communication (G&S)	2 001	1 952	1 496	1 547	1 588	1 588	1 629	1 719	1 814
Fleet services (incl. government motor transport)	38 409	32 687	36 498	38 257	37 955	37 955	49 285	52 005	54 856
Inventory: Clothing material and accessories	–	–	1 026	–	1 000	1 000	–	–	–
Inventory: Chemicals,fuel,oil,gas,wood and coal	40	50	1	–	–	–	–	–	–
Inventory: Medical supplies	442	200	95	111	182	182	118	124	131
Inventory: Medicine	2	–	–	–	–	–	–	–	–
Consumable supplies	5	956	209	1 145	20	20	1 206	1 272	1 342
Cons: Stationery,printing and office supplies	1 124	557	1 304	1 009	1 130	1 110	1 062	1 120	1 182
Operating leases	11 842	14 345	13 311	17 151	17 355	17 355	17 706	18 678	19 706
Property payments	139	193	4 269	379	319	319	400	422	445
Transport provided: Departmental activity	386	–	–	–	–	–	9	9	9
Travel and subsistence	216	350	209	127	199	219	135	142	150
Operating payments	–	–	21	20	–	–	20	21	22
Rental and hiring	60	–	–	–	–	–	–	–	–
Interest and rent on land	30	7	–	–	–	–	–	–	–
Interest (Incl. interest on finance leases)	30	7	–	–	–	–	–	–	–
Transfers and subsidies	**544**	**129**	**483**	**–**	**–**	**102**	**–**	**–**	**–**
Households	544	129	483	–	–	102	–	–	–
Social benefits	544	129	483	–	–	102	–	–	–
Payments for capital assets	**22 205**	**9 389**	**20 999**	**13 276**	**11 776**	**11 776**	**49 677**	**20 773**	**21 906**
Machinery and equipment	22 205	9 389	20 999	13 276	11 776	11 776	49 677	20 773	21 906
Transport equipment	22 026	2 994	20 905	12 677	11 177	11 177	49 046	20 107	21 203
Other machinery and equipment	179	6 395	94	599	599	599	631	666	703
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Total economic classification: Programme 3	**309 596**	**328 189**	**371 519**	**388 002**	**364 097**	**364 097**	**435 317**	**426 280**	**449 378**

[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

Emergency Services provides for all emergency medical services including ambulance service, communication and air ambulance services. The increase in the 2019/19 FY relates to the integration of PPT into EMS. The Department has planned to implement the project at Gert Sibande, which is highest spender on fleet services account. A budget amounting to R35 million was set aside for the procurement of additional ambulances in order to reduce dissatisfaction by the Mpumalanga community. The Department will continue to invest in the fleet infrastructure of the programme in the MTEF period.

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 b. Implement Operational PPTS plan
2. Ineffective Emergency Communication Center (ECC)	a. Emergency Communication Center staff training. b. Multilingual Emergency Communication Center c. Appointment of shift leaders. d. Upgrading of the communication center system
3. Inadequate/ inappropriate emergency vehicles Inadequate/ inappropriately qualified personnel	a. Procure an additional EMS vehicles b. Appropriate skilled ALS practitioners 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 eight core domains: Obstetrics & Gynaecology, Paediatrics, Orthopaedics, Internal Medicine, Radiology, Psychiatry, General Surgery, Anaesthesia
    - Appointment of Health Professionals to support the specialists.

2. Improve quality of care by ensuring that regional hospitals comply with the national core standards
    - Procurement and maintenance of medical equipment
    - Improve quality of care by ensuring that regional hospitals comply with the ideal hospital framework.

3. Improve the referral network within the district through quarterly cluster meeting
    - Conduct quarterly cluster meetings with feeder facilities

Specialised TB

1. Improve compliance with National Core Standards:
    - Improve quality of care by ensuring that TB specialized hospitals comply with the ideal hospital framework
    - Decentralization of DR TB treatment

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. Average Length of Stay (Regional Hospitals)	Quarterly	No
3. Inpatient Bed Utilisation Rate (Regional Hospitals)	Quarterly	%
4. Expenditure per PDE (Regional Hospitals)	Quarterly	R
5. 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		
			2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Improve quality of health care	**Strategic Objective/Provincial Indicators**								
	1. Functional Adverse Events Committees	No	0	3	3	3	3	3	3
	Programme Performance/Customized Indicators (Sector Indicators)								
	2. Average Length of Stay (Regional Hospitals)	No	4.6 days	4.4 days	4 days	4.7 days	4.7 days	4.7 days	4.7 days
	3. Inpatient Bed Utilisation Rate (Regional Hospitals)	%	80.3%	81.2%	77.9%	75%	75%	75%	75%
	4. Expenditure per PDE (Regional Hospitals)	R	R2,614	R2 985	R 3 281.60	R3.058	R3,272	R3,501	R3,746
	5. Complaint Resolution within 25 working days rate (Regional Hospitals)	%	98.7%	100%	89.1%	90%	90%	90%	90%

TABLE PHS2: QUARTERLY TARGETS FOR REGIONAL HOSPITALS

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2019/20	TARGETS			
				Q1	Q2	Q3	Q4
1. Functional Adverse Events Committees	Quarterly	No	3	3	3	3	3
2. Average Length of Stay (Regional Hospitals)	Quarterly	No (Range)	4.7 days	4.7 days	4.7 days	4.7 days	4.7 days
3. Inpatient Bed Utilisation Rate (Regional Hospitals)	Quarterly	% (Range)	75 %	75 %	75 %	75 %	75 %
4. Expenditure per PDE (Regional Hospitals)	Quarterly	R	R3,272	R3,544	R3,272	R3,272	R3,000
5. 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	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		
			2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Improve quality of health care	**Programme Performance/Customized Indicators (Sector Indicators)**								
	1. Complaint Resolution within 25 working days rate (Specialised Hospitals)	%	100%	97.3%	90%	95%	95%	95%	95%

TABLE PHS4: QUARTERLY TARGETS FOR SPECIALISED HOSPITALS

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2019/20	TARGETS			
				Q1	Q2	Q3	Q4
1. 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

R thousand	Outcome 2015/16	Outcome 2016/17	Outcome 2017/18	Main appropriation 2018/19	Adjusted appropriation 2018/19	Revised estimate 2018/19	Medium-term estimates 2019/20	Medium-term estimates 2020/21	Medium-term estimates 2021/22
1. General (Regional) Hospitals	937 555	1 005 225	1 084 521	1 152 331	1 119 852	1 180 375	1 295 723	1 423 680	1 525 375
2. Tuberculosis Hospitals	183 459	181 906	176 879	197 021	198 817	200 425	199 068	212 224	223 757
3. Psychiatric/ Mental Hospitals	53 371	34 349	41 341	44 054	44 054	44 054	46 521	49 080	51 779
4. Sub-acute, Step down and Chronic Medical Hospitals	–	–	–	–	–	–	–	–	–
5. Dental Training Hospitals	–	–	–	–	–	–	–	–	–
6. Other Specialised Hospitals	–	–	–	–	–	–	–	–	–
Total payments and estimates: Programme 4	**1 174 385**	**1 221 480**	**1 302 741**	**1 393 406**	**1 362 723**	**1 424 854**	**1 541 312**	**1 684 984**	**1 800 911**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

Table B.3(iv): Payments and estimates by economic classification: Provincial Hospital Services

R thousand	Outcome 2015/16	Outcome 2016/17	Outcome 2017/18	Main appropriation 2018/19	Adjusted appropriation 2018/19	Revised estimate 2018/19	Medium-term estimates 2019/20	Medium-term estimates 2020/21	Medium-term estimates 2021/22
Current payments	**1 106 323**	**1 214 547**	**1 295 426**	**1 391 602**	**1 360 305**	**1 420 767**	**1 536 581**	**1 682 978**	**1 798 795**
Compensation of employees	828 934	924 303	1 003 800	1 074 783	1 043 486	1 043 486	1 127 441	1 234 497	1 325 775
Salaries and wages	736 559	822 764	893 302	951 458	923 953	923 953	1 000 239	1 100 781	1 186 735
Social contributions	92 375	101 539	110 498	123 325	119 533	119 533	127 202	133 716	139 040
Goods and services	277 188	290 234	291 623	316 819	316 819	377 262	409 140	448 481	473 020
Administrative fees	36	11 282	14 093	9 297	9 420	13 312	9 818	10 358	10 928
Minor Assets	527	789	29	383	540	530	391	413	436
Catering: Departmental activities	24	6	7	–	16	16	–	–	–
Communication (G&S)	3 619	3 592	3 255	3 797	3 598	3 598	3 999	4 219	4 451
Computer services	5	507	39	–	–	–	–	–	–
Consultants: Business and advisory services	–	–	–	–	–	–	1 500	–	–
Laboratory services	33 216	28 227	31 003	42 832	42 963	47 245	75 222	107 386	104 540
Contractors	588	35 093	41 557	44 538	44 361	44 361	46 950	49 532	52 256
Agency and support / outsourced services	4 456	8 024	6 348	7 358	14 773	22 771	11 970	12 629	13 319
Fleet services (incl. government motor transport)	9 744	9 604	8 665	8 818	8 728	13 225	9 285	9 795	10 333
Inventory: Clothing material and accessories	487	–	8	–	10	10	–	–	–
Inventory: Farming supplies	–	–	71	–	27	27	–	–	–
Inventory: Food and food supplies	19 812	19 012	21 467	22 242	22 282	22 282	23 421	24 709	26 068
Inventory: Chemicals,fuel,oil,gas,wood and coal	5 796	4 985	3 844	46	430	1 057	11	12	13
Inventory: Materials and supplies	270	–	–	–	–	–	–	–	–
Inventory: Medical supplies	62 708	63 277	59 110	66 189	65 772	81 644	124 682	96 945	110 917
Inventory: Medicine	88 468	61 868	62 391	66 411	65 897	81 897	58 132	61 317	64 703
Inventory: Other supplies	–	–	2 033	1 995	1 014	1 014	2 103	2 218	2 340
Consumable supplies	7 834	11 315	6 947	9 107	3 670	6 803	9 593	10 121	10 678
Cons: Stationery,printing and office supplies	2 179	2 305	2 007	2 297	1 335	1 216	2 233	2 356	2 486
Operating leases	4 439	4 103	5 305	5 038	5 481	6 047	1 939	2 046	2 158
Property payments	30 430	21 453	18 840	21 961	22 221	25 938	23 125	49 396	52 088
Transport provided: Departmental activity	42	44	56	79	129	129	83	88	93
Travel and subsistence	2 053	2 676	2 172	1 974	1 974	1 962	2 079	2 194	2 315
Training and development	176	1 773	2 286	2 388	2 115	2 115	2 515	2 653	2 799
Operating payments	281	299	90	89	63	63	89	94	99
Interest and rent on land	201	10	3	–	–	19	–	–	–
Interest (Incl. interest on finance leases)	201	10	3	–	–	19	–	–	–
Transfers and subsidies	**56 090**	**4 433**	**6 327**	**1 040**	**2 418**	**4 077**	**1 098**	**1 158**	**1 221**
Departmental agencies and accounts	39	48	25	107	107	107	113	119	125
Departmental agencies (non-business entities)	39	48	25	107	107	107	113	119	125
Non-profit institutions	53 371	–	–	–	–	–	–	–	–
Households	2 680	4 385	6 302	933	2 311	3 970	985	1 039	1 096
Social benefits	2 680	4 385	6 302	933	2 311	3 970	985	1 039	1 096
Payments for capital assets	**11 972**	**2 500**	**988**	**764**	**–**	**10**	**3 633**	**848**	**895**
Machinery and equipment	11 972	2 500	988	764	–	10	3 633	848	895
Transport equipment	4 214	–	–	–	–	10	–	–	–
Other machinery and equipment	7 758	2 500	988	764	–	–	3 633	848	895
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme 4	**1 174 385**	**1 221 480**	**1 302 741**	**1 393 406**	**1 362 723**	**1 424 854**	**1 541 312**	**1 684 984**	**1 800 911**

[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

The growth in Programme 4 relates to the need to improve the budget allocation for the programme that was the most pressured in the 2018/19 FY. The additional budget allocation will fund NHLS, Medical waste and Medical Supplies. The Programme will also initiate efficiency projects, which will be aimed at making the programme more efficient and financially viable.

A budget amounting to R8 million was reprioritized from medicine due to funding of the new TB drugs in the Comprehensive HIV/ AIDS conditional grant. The TB programme will realize savings due to the decentralization of patient treatment and the introduction of the new drug.

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 b. Improve monitoring of compliance with policies and procedure c. Allocation of adequate resources and consumables
2. Inadequate HIV/ AIDS and TB inpatient care	a. Secure budget for multi-year programme for improvement for TB infrastructure b. Increase security measures for visitor control c. Awareness campaign on TB d. Enter into MOU with private sector laboratories
3. Incomplete access of level 2 services	a. Develop equipment procurement plan b. Regional hospitals to hold quarterly referral meetings with feeder facilities c. Monitor compliance to attendance registers by sessional doctors d. Implement recruitment and retention strategy for scarce skills
4. Non-compliance with professional clinical standards and protocols	a. Conduct quarterly clinical audits b. Enforce compliance to policies and procedures c. Motivate for appointment of senior professional staff for supervision and mentoring purposes d. Staff debriefing, motivation and team-building
5. Inadequate medical and condemned pharmaceutical waste management	a. Appointment of dedicated Waste Manager b. Secure budget and approval for waste storage facilities c. Improve management of expired pharmaceutical stock and disposal processes

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 that tertiary hospitals comply with the national core standards
   - Procurement and maintenance of medical equipment
   - Improve quality of care by ensuring that tertiary hospitals comply with the ideal hospital framework.

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

3. Establish oncology and cardiology services at Rob Ferreira hospital and nephrology services at Witbank hospital.

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. Average Length of Stay (Tertiary Hospitals)	Quarterly	No
3. Inpatient Bed Utilisation Rate (Tertiary Hospitals)	Quarterly	%
4. Expenditure per PDE (Tertiary Hospitals)	Quarterly	R
5. Complaints resolution rate (Tertiary Hospitals)	Quarterly	%
6. 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		
			2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
	Strategic Objective/Provincial Indicators								
Improve quality of health care	1. Functional Adverse Events Committee	No	2	2	2	2	2	2	2
	Programme Performance/Customized Indicators (Sector Indicators)								
	2. Average Length of Stay (Tertiary Hospitals)	No	6.8 days	7.1 days	6.1 days	5.6 days	6 days	6 days	6 days
	3. Inpatient Bed Utilisation Rate (Tertiary Hospitals)	%	81%	85.8%	79.8%	75%	75 %	75%	75%
	4. Expenditure per PDE (Tertiary Hospitals)	R	R2,785	R2,910	R 3 619	R3,836	R4,105	R4,392	R4,700
	5. Complaint Resolution within 25 working days rate (Tertiary Hospitals)	%	99.4%	88.3%	90%	90%	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 2019/20	TARGETS			
				Q1	Q2	Q3	Q4
1. Functional Adverse Events Committee	Quarterly	No	2	2	2	2	2
2. Average Length of Stay (Tertiary Hospitals)	Quarterly	No	6 days	6 days	6 days	6 days	6 days
3. Inpatient Bed Utilisation Rate (Tertiary Hospitals)	Quarterly	%	75 %	75%	75 %	75%	75%
4. Expenditure per PDE (Tertiary Hospitals)	Quarterly	R	R4,105	R4,310	R4,105	R4,105	R4,900
5. 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	2015/16	2016/17	2017/18		2018/19		2019/20	2020/21	2021/22
1. Central Hospital Services	–	–	–	–	–	–	–	–	–
2. Provincial Tertiary Hospital Services	991 759	1 026 751	1 154 506	1 218 481	1 208 932	1 313 471	1 327 268	1 484 427	1 821 143
Total payments and estimates: Programme 5	**991 759**	**1 026 751**	**1 154 506**	**1 218 481**	**1 208 932**	**1 313 471**	**1 327 268**	**1 484 427**	**1 821 143**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2015/16	2016/17	2017/18		2018/19		2019/20	2020/21	2021/22
Current payments	**984 741**	**1 009 360**	**1 128 763**	**1 178 611**	**1 175 755**	**1 279 546**	**1 276 306**	**1 456 462**	**1 791 640**
Compensation of employees	674 804	713 991	803 214	872 071	834 771	834 771	896 488	984 258	1 094 571
Salaries and wages	601 270	637 784	719 081	775 650	748 486	748 486	800 620	883 050	987 927
Social contributions	73 534	76 207	84 133	96 421	86 285	86 285	95 868	101 208	106 644
Goods and services	309 919	295 365	325 549	306 540	340 984	444 662	379 818	472 204	697 069
Administrative fees	37	10 446	14 248	8 565	8 466	14 515	9 045	9 542	10 067
Minor Assets	1 311	925	67	–	282	282	138	–	–
Catering: Departmental activities	11	10	10	–	10	10	–	–	–
Communication (G&S)	4 570	4 241	3 145	3 467	3 425	3 425	3 651	3 852	4 064
Computer services	356	22	1	25	55	55	26	27	28
Laboratory services	45 233	41 468	45 583	45 832	45 832	74 632	64 176	72 015	75 954
Contractors	27 882	19 417	33 725	23 096	57 540	65 540	23 665	72 133	76 054
Agency and support / outsourced services	10 861	15 892	13 234	14 641	15 262	18 643	18 217	19 219	20 273
Fleet services (incl. government motor transport)	4 143	3 619	3 263	4 176	4 176	5 300	4 410	4 653	4 909
Inventory: Clothing material and accessories	303	–	3	–	–	–	–	–	–
Inventory: Food and food supplies	12 019	14 322	13 790	13 186	13 186	13 186	13 885	14 649	15 455
Inventory: Chemicals,fuel,oil,gas,wood and coal	7 556	6 158	71	105	9	9	111	117	123
Inventory: Materials and supplies	222	–	–	–	–	–	–	–	–
Inventory: Medical supplies	105 468	91 105	96 357	88 425	88 534	129 127	131 920	159 333	218 036
Inventory: Medicine	51 439	46 584	58 901	60 424	60 424	72 425	63 626	67 125	219 842
Inventory: Other supplies	–	–	2 450	2 254	1 050	1 050	2 365	2 495	2 632
Consumable supplies	6 308	5 852	4 687	4 259	4 369	4 369	4 477	4 732	4 992
Cons: Stationery,printing and office supplies	1 685	1 378	1 347	1 156	1 483	1 370	1 218	1 285	1 356
Operating leases	886	566	1 035	1 235	1 235	1 235	1 304	1 376	1 452
Property payments	28 679	32 393	32 643	34 970	34 987	38 825	36 823	38 848	40 985
Transport provided: Departmental activity	–	–	–	–	42	47	–	–	–
Travel and subsistence	594	615	914	654	449	449	691	729	769
Training and development	–	219	3	–	–	–	–	–	–
Operating payments	356	133	72	70	168	168	70	74	78
Interest and rent on land	18	4	–	–	–	113	–	–	–
Interest (Incl. interest on finance leases)	18	4	–	–	–	113	–	–	–
Transfers and subsidies	**1 891**	**2 389**	**2 438**	**885**	**1 132**	**1 880**	**934**	**986**	**1 040**
Departmental agencies and accounts	80	16	10	47	47	47	50	53	56
Departmental agencies (non-business entities)	80	16	10	47	47	47	50	53	56
Households	1 811	2 373	2 428	838	1 085	1 833	884	933	984
Social benefits	1 811	2 373	2 368	838	1 025	1 773	884	933	984
Other transfers to households	–	–	60	–	60	60	–	–	–
Payments for capital assets	**5 127**	**15 002**	**23 305**	**38 985**	**32 045**	**32 045**	**50 028**	**26 979**	**28 463**
Machinery and equipment	5 127	15 002	23 305	38 985	32 045	32 045	50 028	26 979	28 463
Transport equipment	703	–	–	–	–	–	–	–	–
Other machinery and equipment	4 424	15 002	23 305	38 985	32 045	32 045	50 028	26 979	28 463
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme 5	**991 759**	**1 026 751**	**1 154 506**	**1 218 481**	**1 208 932**	**1 313 471**	**1 327 268**	**1 484 427**	**1 821 143**

[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

Central Hospital Services provides tertiary health services and includes the National Tertiary Services Grant provided to scale up tertiary services in the two tertiary facilities. The Programme is underfunded in the National Tertiary Services Grant of which the Department only receives 1 per cent of the provincial allocation. The Programme will receive 7 per cent growth in the compensation of employees and goods and services shows a decline of 15 per cent. The Department plans to implement stringent austerity measures in order to remain within the budget. The Department has planned to build a partnership with WITS which will improve a number of challenges faced at Rob Ferreira and Witbank Hospitals.

The budget for the Programme will be accelerated in the 2020 MTEF in order to improve services in these hospitals and reduce referrals of patients to Gauteng and Private sector. In addition, the Department plans to build partnerships with the private sector on the certain services needed by patients.

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5.5 RISK MANAGEMENT

RISK	MITIGATING FACTORS
1. Incomplete package of level 3 services	a. Increase number of registrars b. Strengthen relationship with academic institutions c. Increase the number of clinical specialists domains
2. Clinical adverse events	a. Fill the critical vacant positions b. Develop implement and monitor clinical policies and procedures c. Procure the needed medical equipment and consumables d. Strengthen security measures in the units (in relation to record keeping) e. Conduct clinical audits and peer reviews per discipline
3. Poor patient care and long patient waiting times	a. Train staff in customer care b. Re-launch Batho Pele Principles c. Tertiary hospitals to conduct quarterly referral meeting with feeder hospitals d. Strengthen outreach programmes to regional and district hospitals

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

1. Development of the skills of health care professionals by implementing the workplace skills plan
2. Preparing for the accreditation of the EMS college
3. Capacity development by increasing number of Intake of first year nursing students

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. Improve access to EMS training by increasing the number of accredited EMS colleges	Annual	No
3. Number of Bursaries awarded for first year medicine students	Annual	No
4. 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		
			2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
	Strategic Objective/Provincial Indicators								
Re-alignment of human resource to Departmental needs	1. Improve human resource efficiency by training health care professionals on critical clinical skills	No	4 473	2841	6 104	5000	5000	5500	5500
	2. Improve access to EMS training by increasing the number of accredited EMS colleges	No	New Indicator	New Indicator	New Indicator	New Indicator	1	1	1
	Programme Performance/Customized Indicators (Sector Indicators)								
	3. Number of Bursaries awarded for first year medicine students[3]	No	99	10	10	0	0	0	0
	4. Number of Bursaries awarded for first year nursing students	No	310	241	250	90	80	140	160

[3] Services are rendered by the Department of Basic Education with effect from 2018/19 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 2019/20	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. Improve access to EMS training by increasing the number of accredited EMS colleges	Annual	No	1	Annual Target	Annual Target	Annual Target	1
3. Number of Bursaries awarded for first year medicine students[4]	Annual	No	0	0	0	0	0
4. Number of Bursaries awarded for first year nursing students	Annual	No	80	Annual Target	Annual Target	Annual Target	80

[4] 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	2015/16	2016/17	2017/18		2018/19		2019/20	2020/21	2021/22
1. Nurse Training Colleges	179 593	181 769	169 789	165 671	146 612	146 630	217 978	222 469	235 110
2. EMS Training Colleges	2 473	4 634	4 578	4 795	4 559	4 559	4 912	2 525	2 660
3. Bursaries	43 317	70 575	73 111	73 957	73 945	73 315	77 905	82 151	86 667
4. Primary Health Care Training	4 081	4 627	4 776	6 140	5 374	5 410	5 807	5 805	5 909
5. Training Other	139 769	111 296	115 543	138 210	144 945	145 521	145 751	162 724	171 666
Total payments and estimates: Programme 6	**369 233**	**372 901**	**367 797**	**388 773**	**375 435**	**375 435**	**452 353**	**475 474**	**502 012**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2015/16	2016/17	2017/18		2018/19		2019/20	2020/21	2021/22
Current payments	**312 862**	**307 244**	**289 852**	**303 120**	**283 716**	**283 716**	**372 158**	**393 175**	**415 174**
Compensation of employees	240 541	253 997	241 162	248 659	231 913	231 913	304 937	325 466	344 379
Salaries and wages	215 523	229 182	217 950	226 020	209 116	209 116	269 926	275 558	292 266
Social contributions	25 018	24 815	23 212	22 639	22 797	22 797	35 011	49 908	52 113
Goods and services	72 321	53 146	48 690	54 461	51 803	51 803	67 221	67 709	70 795
Administrative fees	359	281	822	882	585	545	937	978	1 031
Minor Assets	14	–	–	132	1 205	945	209	147	155
Bursaries: Employees	1 798	604	1 057	–	–	–	–	–	–
Catering: Departmental activities	333	268	–	–	178	2 023	–	–	–
Communication (G&S)	210	213	217	258	190	189	274	280	295
Computer services	–	–	201	–	200	200	–	–	–
Consultants: Business and advisory services	–	315	–	253	104	37	267	282	298
Contractors	265	–	–	–	32	32	–	–	–
Agency and support / outsourced services	32 404	23 529	17 495	24 666	18 916	15 156	24 887	23 042	23 687
Fleet services (incl. government motor transport)	917	1 047	1 273	1 107	706	983	1 166	1 230	1 298
Inventory: Clothing material and accessories	150	–	5	–	195	191	–	–	–
Inventory: Chemicals,fuel,oil,gas,wood and coal	19	–	11	–	30	–	–	–	–
Inventory: Learner and teacher support material	–	–	–	15	–	–	16	17	18
Inventory: Materials and supplies	51	–	–	–	–	–	–	–	–
Inventory: Medical supplies	–	–	470	–	27	27	10	–	–
Inventory: Other supplies	–	–	21	–	100	96	36	–	–
Consumable supplies	2 347	2 047	1 809	2 686	1 351	2 530	2 780	2 985	3 149
Cons: Stationery,printing and office supplies	531	244	354	926	1 757	1 362	1 050	1 029	1 085
Operating leases	93	144	102	152	175	192	160	169	178
Property payments	1 569	441	388	466	550	550	490	517	545
Travel and subsistence	24 408	21 383	22 427	20 582	23 121	24 404	32 675	34 407	36 286
Training and development	6 518	2 300	1 973	2 068	2 002	2 002	2 116	2 296	2 422
Operating payments	248	246	65	225	238	198	105	287	303
Venues and facilities	87	34	–	–	141	141	–	–	–
Rental and hiring	–	50	–	43	–	–	43	43	45
Interest and rent on land	–	101	–	–	–	–	–	–	–
Interest (Incl. interest on finance leases)	–	101	–	–	–	–	–	–	–
Transfers and subsidies	**56 371**	**65 621**	**70 288**	**83 473**	**81 953**	**81 953**	**76 605**	**80 060**	**84 475**
Departmental agencies and accounts	–	–	6 785	14 001	14 001	14 001	14 743	14 785	15 598
Departmental agencies (non-business entities)	–	–	6 785	14 001	14 001	14 001	14 743	14 785	15 598
Households	56 371	65 621	63 503	69 472	67 952	67 952	61 862	65 275	68 877
Social benefits	56 371	65 621	63 503	69 472	24	654	25	48	50
Other transfers to households	–	–	–	–	67 928	67 298	61 837	65 227	68 827
Payments for capital assets	**–**	**36**	**7 657**	**2 180**	**9 766**	**9 766**	**3 590**	**2 239**	**2 363**
Machinery and equipment	–	36	7 657	2 180	9 766	9 766	3 590	2 239	2 363
Transport equipment	–	–	–	–	958	958	–	–	–
Other machinery and equipment	–	36	7 657	2 180	8 808	8 808	3 590	2 239	2 363
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme 6	**369 233**	**372 901**	**367 797**	**388 773**	**375 435**	**375 435**	**452 353**	**475 474**	**502 012**

[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

The sub-programme: *Nursing Training College* provides for 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. The Department plans to insource provision of catering services to student, which will realize over R2 million savings. The project is at advanced stage and will be implemented in the 2019/20 FY.

The Programme has reprioritized R11 million from transfers and subsidies in order to make provision for accommodation and transport for CUBA program students. The Programme will

continue to implement the new curriculum and a special project was initiated to ensure success of the two campuses (Rob Ferreira and Nursing College).

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)
- **Clinical Support Services** (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.

- Improve availability of medicines
- Procurement of FPS vehicles and medical equipment to improve quality of medical investigations
- Support rational use of laboratory and blood services.
- Provision of imaging services compliant to Radiation Control prescripts;
- Procurement and maintenance of medical equipment;
- Provision of comprehensive medical orthotic and prosthetic care;
- Provision of quality healthcare through provision of Laundry Services

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. Number of hospitals providing laundry services	Quarterly	No
5. Number of Orthotic and Prosthetic devices issued	Quarterly	No
6. Number of hospitals with functional transfusion committees	Quarterly	No
7. 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		
			2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
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.	%	79% (246/310)	92 % (286/310)	89%	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	87 063	186 407	220 000	244 000	268 000	292 000
	3. Improve access to quality of care through compliance with Radiation Control prescripts by all facilities with X-Ray equipment	%	70% (21/30 facilities)	80% (24/30)	86.7% (26/30 facilities complied)	100% (30/30)	100% (30/30)	100% (30/30)	100% (30/30)
	4. Number of hospitals providing laundry services	No	18/33	21/33	18/33	23/33	23/33	24/33	25/33
	5. Number of Orthotic and Prosthetic devices issued	No	Not in plan	3 500	5 277	4000	4 250	4 500	5 000
	6. Number of hospitals with functional transfusion committees	No	Not in plan	25/33	33	28/28 (Maintained)	28/28 (Maintained)	28/28 (Maintained)	28/28 (Maintained)
	7. Number of sites rendering Forensic Pathology Services (FPS)	No	Not in plan	21	20	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 2019/20	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%	95%	95%	95%
2. Number of patients initiated on Central Chronic Medicine Dispensing and Distribution (CCMDD)	Quarterly	No	244 000	6 000 (226 000)	6 000 (232 000)	6 000 (238 000)	6 000 (244 000)
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% (6/6)	100% (8/8)	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	4 250	1 062	1 063	1 063	1 062
6. Number of hospitals with functional transfusion committees	Quarterly	No	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	2015/16	2016/17	2017/18		2018/19		2019/20	2020/21	2021/22
1. Laundries	23 704	26 725	25 113	33 951	33 072	33 072	35 710	32 259	34 013
2. Engineering	21 915	27 171	63 159	43 139	47 213	47 213	45 065	46 900	48 878
3. Forensic Services	61 998	69 995	71 996	86 537	85 080	85 080	94 014	94 045	99 138
4. Orthotic and Prosthetic Services	3 963	3 994	4 042	4 531	4 500	4 500	4 763	4 974	5 246
5. Medicine Trading Account	11 871	12 808	12 711	14 482	14 215	14 215	15 299	15 908	16 768
Total payments and estimates: Programme 7	**123 451**	**140 693**	**177 021**	**182 640**	**184 080**	**184 080**	**194 851**	**194 086**	**204 043**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2015/16	2016/17	2017/18		2018/19		2019/20	2020/21	2021/22
Current payments	**118 063**	**131 779**	**149 180**	**154 564**	**151 870**	**151 870**	**162 277**	**166 504**	**175 531**
Compensation of employees	81 955	98 241	109 032	120 897	117 792	117 792	127 094	129 387	136 374
Salaries and wages	71 051	85 690	95 207	105 212	102 160	102 160	112 037	113 138	119 247
Social contributions	10 904	12 551	13 825	15 685	15 632	15 632	15 057	16 249	17 127
Goods and services	36 108	33 538	40 148	33 667	34 078	34 078	35 183	37 117	39 157
Administrative fees	215	134	118	134	339	127	142	149	156
Minor Assets	–	225	69	14	363	363	–	–	–
Catering: Departmental activities	72	18	–	–	–	–	–	–	–
Communication (G&S)	1 449	1 487	1 253	1 242	801	1 108	1 307	1 379	1 455
Consultants: Business and advisory services	–	2 020	257	–	–	–	–	–	–
Contractors	8 078	5 557	9 422	6 070	5 629	5 629	6 264	6 609	6 973
Agency and support / outsourced services	412	500	–	41	125	125	43	45	47
Fleet services (incl. government motor transport)	3 823	4 977	4 817	4 596	4 059	4 293	4 890	5 159	5 443
Inventory: Clothing material and accessories	28	–	–	–	–	–	–	–	–
Inventory: Chemicals,fuel,oil,gas,wood and coal	1 869	–	203	–	202	202	–	–	–
Inventory: Materials and supplies	3 195	–	–	–	90	46	–	–	–
Inventory: Medical supplies	6 044	5 829	11 151	6 522	6 293	6 377	6 871	7 249	7 648
Inventory: Other supplies	–	–	2 764	2 751	2 845	2 801	2 897	3 056	3 224
Consumable supplies	5 169	8 212	5 666	7 694	7 335	7 101	8 178	8 628	9 103
Cons: Stationery,printing and office supplies	350	628	117	608	277	275	640	675	712
Operating leases	1 111	574	530	1 051	1 412	1 412	855	902	952
Property payments	840	442	621	761	602	602	801	845	891
Transport provided: Departmental activity	179	35	65	37	80	80	39	41	43
Travel and subsistence	3 007	2 738	2 829	2 118	3 331	3 285	2 227	2 350	2 479
Training and development	40	–	–	–	5	5	–	–	–
Operating payments	57	79	101	28	50	7	29	30	31
Venues and facilities	170	83	165	–	240	240	–	–	–
Interest and rent on land	–	–	–	–	–	–	–	–	–
Transfers and subsidies	**655**	**123**	**91**	**254**	**254**	**254**	**269**	**283**	**299**
Households	655	123	91	254	254	254	269	283	299
Social benefits	655	123	91	254	254	254	269	283	299
Payments for capital assets	**4 733**	**8 791**	**27 750**	**27 822**	**31 956**	**31 956**	**32 305**	**27 299**	**28 213**
Machinery and equipment	4 733	8 791	27 750	27 822	31 956	31 956	32 305	27 299	28 213
Transport equipment	4 240	–	–	1 058	–	–	5 164	5 451	5 748
Other machinery and equipment	493	8 791	27 750	26 764	31 956	31 956	27 141	21 848	22 465
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme 7	**123 451**	**140 693**	**177 021**	**182 640**	**184 080**	**184 080**	**194 851**	**194 086**	**204 043**

[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

The *Laundry Services* sub-programme provides laundry services to Middelburg, Bethal, Tinswalo, Mmametlhake, Themba, Mapulaneng and Barberton hospital. The growth for the sub-programme is at 8 per cent, which will improve the supply of clean linen at the right time. The Department still encounters a number of challenges in the laundry programme. These challenges will be identified and analyzed with an aim to develop an improvement plan. Mini laundry points will be established in the MTEF period in order to provide an efficient service.

The provision of maintenance services for medical and allied equipment have been centralized to Programme 7. This will improvement coordination of the services including the response time by service providers. Funds for the maintenance were also allocated in Programme 8. The programme has settled accruals and payables for previous financial years, which implies that the 2019/20 FY budget will be have less pressure.

7.6 RISK MANAGEMENT

RISK	MITIGATING FACTORS
1. Inadequate Forensic Pathology Services	a. Submission of infrastructural needs to the Infrastructure Section b. Submission of prioritized posts to be advertised c. Provision of wellness programme to employees d. Monitor compliance by the Service Provider to the Service Level Agreement
2. Shortage of pharmacy personnel	a. Approved new organisational structure b. Employment of CSP and Pharmacists at facilities c. Adhere to recruitment and selection policy
3. Shortage of Pharmaceuticals and Surgicals in the Province	a. Install stock management system in all facilities b. Secure budget for warehouse facilities (infrastructure) c. Improve pharmaceutical warehouse management
4. 'Inadequate maintenance of medical equipment	a. Fast track the filling of critical vacant posts. b. Review and implementation of medical equipment SLAs with Service providers. Development of maintenance plans for medical equipment for all hospitals. c. Develop an SOP on medical equipment maintenance. d. Replacement of old vehicles for the CE workshops.

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

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		
			2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
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	107 PHC	90 PHC facilities maintained	55 (Ehlanzeni) 32 (Nkangala) 16 (Gert Sibande)	5 (Cumulative 287/287	287/287	287/287	287/287
	2. Number of PHC facilities constructed (new/replacement)	No	Not in plan	8 (Ehlanzeni:2 Gert Sibande: 5 Nkangala:1)	6 (14 Cumulative) 3 (Ehlanzeni) 1 (Nkangala) 2 (Gert Sibande)	8 Ehlanzeni: 2 Gert Sibande: 5 Nkangala: 1	8 Ehlanzeni: 2 Gert Sibande: 5 Nkangala: 1	8 Ehlanzeni: 2 Gert Sibande: 5 Nkangala: 1	0
	3. Number of Hospitals under maintenance	No	Not in plan	31 Hospital Facilities maintained	31	31	31	33	33
	4. Enhance patient care & safety and improving medical care by constructing Modern hi-tech hospitals	No	0	3 (Planning phase)	4 (Construction)	3 (Construction) Ehlanzeni: 1 Gert Sibande: 1 Nkangala: 1	2 (Construction) Ehlanzeni: 1 Gert Sibande: 0 Nkangala: 1	2 (Construction) Ehlanzeni: 1 Gert Sibande: 0 Nkangala: 1	2 (Construction) Ehlanzeni: 1 Gert Sibande: 0 Nkangala: 1

Strategic objective statement	Indicator	Indicator Type	Audited/Actual performance			Estimated performance	Medium term targets		
			2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Improved health facility planning and accelerate infrastructure delivery	5. Improve maintenance of health facilities by appointing cooperatives	No	11	10 cooperatives appointed for multi-year projects (2015/16-2016/17)	16 cooperatives appointed (26 Cumulative)	15 cooperatives appointed (cumulative 41)	15 cooperatives appointed (cumulative 56)	0 cooperatives appointed (cumulative 56)	0 cooperatives appointed (cumulative 56)
	Programme Performance / Customized Indicators (Sector Indicators)								
	6. Number of health facilities that have undergone major and minor refurbishment in NHI Pilot District	No	Not in plan	19 PHC facilities completed	25 PHC (40 Cumulative)	6 Hospitals 77 PHC	6 Hospitals 5 PHC	6 Hospitals 5 PHC	6 Hospitals 5 PHC
	7. Number of health facilities that have undergone major and minor refurbishment outside NHI pilot District (excluding facilities in NHI Pilot District)	No	Not in plan	5 Hospital completed 13 PHC completed	5 Hospitals 10 PHC	2 Hospitals 6 PHC	5 Hospitals 17 PHC (10 Nkangala,10 Ehlanzeni and Ehlanzeni 7)	5 Hospitals 17 PHC (10 Nkangala,10 Ehlanzeni and Gert Sibande 7)	3 Hospitals 10 PHC (5 Nkangala,3 Ehlanzeni and Gert Sibande 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 2019/20	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** (Oakley & Kanyamazane) **Gert Sibande: 5** (Balfour,Vukuzakhe,Msukaligwa ,Ethandukukhanya and Nhlazatshe 6 **Nkangala: 1** (Pankop)	**Planning Ehlanzeni** Kanyamazane (100%), **Gert Sibande** Ethandukukhanya (100%), (Balfour (100%), **Ehlanzeni** (Oakley 90% & **Gert Sibande: 5** Vukuzakhe (70%) Msukaligwa (5%), Nhlazatshe 6 (80%) **Nkangala: 1** (Pankop 50%)	**Gert Sibande: 5** (Balfour (Contractor appointed), Vukuzakhe (80%) Msukaligwa (5%), Ethandukukhanya (Contractor appointed Nhlazatshe 90% **Ehlanzeni: 2** Oakley 95% **Nkangala: 1** (Pankop 55%)	**8 (Construction)** **Gert Sibande: 5** (Balfour (5%), Vukuzakhe (90%) Msukaligwa (10%), Ethandukukhanya (5%), Nhlazatshe 6 (100%) **Ehlanzeni: 2** Kanyamazane Contractor appointed) Oakley 100% **Nkangala: 1** (Pankop 60%)	7 **(Construction)** **Gert Sibande: 5** (Balfour (10%), Vukuzakhe Msukaligwa (15%), Ethandukukhanya (5%), **Ehlanzeni: 1** Kanyamazane (5%) **Nkangala: 1** (Pankop 65%)
3. Number of Hospitals under maintenance	Annual	No	31	6	9	12	4

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2019/20	TARGETS			
				Q1	Q2	Q3	Q4
4. Enhance patient care & safety and improving medical care by constructing Modern hi-tech hospitals	Annual	No	**4Planning** (Witbank TB, New Impungwe Psychiatric, New Witbank Tertiary and New Witbank District Hospitals **4(Construction)** Ehlanzeni: 1 (Mapulaneng) 1Gert Sibande: Bethal Nkangala: 2(Mmammethlake & New Middelburg)	**04 Planning (5%)** Witbank TB,New Witbank District,New Middelburg & New Impungwe Hospital's, **03Construction** New Middelburg (27%) Bethal (20%) Mmamethlake (5%)	**04 Planning (10%)** Witbank TB,New Witbank District,New Middelburg & New Impungwe Hospital's, **04Construction** New Middelburg (35%) Bethal(50% Mmamethlake(10 %) New Mapulaneng (3%)	**04 Planning (35%)** Witbank TB,New Witbank District,New Middelburg & New Impungwe Hospital's, **04Construction** New Middelburg (40%) Bethal (75%) Mmamethlake(15%) New Mapulaneng(7%)	**04 Planning (50%)** Witbank TB,New Witbank District,New Middelburg & New Impungwe Hospital's, **04Construction** New Middelburg (55%) Bethal (100%) Mmamethlake (20%) New Mapulaneng (10%)
5. Improve maintenance of health facilities by appointing cooperatives	Annual	No	15 cooperatives appointed (cumulative 41)	0	5	10	0
6. Number of health facilities that have undergone major and minor refurbishment in NHI Pilot District	Annual	No	6 Hospitals 5PHC	1 Hospitals 1 PHC	2 Hospitals 2 PHC	2 Hospitals 1 PHC	1 Hospitals 1 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 6 PHC	(Planning) 2 Hospitals 6 PHC	2 Hospitals 6 PHC (Construction)	2 Hospitals 6 PHC (Construction)	2 Hospitals 6 PHC (Construction)

8.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE HFM 4: EXPENDITURE ESTIMATES: HEALTH CARE SUPPORT SERVICES

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2015/16	2016/17	2017/18		2018/19		2019/20	2020/21	2021/22
1. Community Health Facilities	294 978	389 276	925 027	1 059 340	1 073 342	1 073 342	973 060	935 725	987 162
2. Emergency Medical Rescue Services	–	–	–	–	–	–	–	–	–
3. District Hospital Services	96 247	99 060	57 751	133 150	97 387	97 387	77 971	2 000	2 110
4. Provincial Hospital Services	248 039	194 685	202 534	200 785	267 152	267 152	266 944	363 162	391 673
5. Central Hospital Services	–	–	–	–	–	–	–	–	–
6. Other Facilities	–	–	–	–	–	–	–	–	–
Total payments and estimates: Programme 8	639 264	683 021	1 185 312	1 393 275	1 437 881	1 437 881	1 317 975	1 300 887	1 380 945

Summary of Provincial Expenditure Estimates by Economic Classification[1]

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2015/16	2016/17	2017/18		2018/19		2019/20	2020/21	2021/22
Current payments	**172 012**	**217 690**	**223 277**	**163 739**	**319 491**	**319 491**	**331 171**	**365 121**	**261 622**
Compensation of employees	11 097	11 454	16 009	22 421	21 923	21 923	28 359	30 714	32 361
Salaries and wages	9 789	10 118	14 168	16 815	16 392	16 392	22 143	24 591	25 453
Social contributions	1 308	1 336	1 841	5 606	5 531	5 531	6 216	6 123	6 908
Goods and services	160 915	204 287	207 268	141 318	297 568	297 568	302 812	334 407	229 261
Administrative fees	62	21	7	19	89	89	221	21	22
Advertising	181	–	–	–	–	–	–	–	–
Minor Assets	329	1 037	1 260	2 480	2 480	2 243	12 000	7 440	7 849
Catering: Departmental activities	113	3	–	–	50	50	–	–	–
Communication (G&S)	47	89	123	152	152	152	458	158	167
Computer services	–	–	495	–	–	–	–	–	–
Consultants: Business and advisory services	17	–	–	2 000	1 000	1 000	–	–	–
Infrastructure and planning	3 756	–	–	–	–	–	–	–	–
Contractors	13 866	6 948	15 512	34 638	15 312	13 700	50 000	108 915	15 418
Agency and support / outsourced services	126	22 241	4 062	4 224	974	974	4 586	4 988	5 262
Fleet services (incl. government motor transport)	–	–	–	–	–	116	–	–	–
Inventory: Chemicals,fuel,oil,gas,wood and coal	4 951	–	2 396	–	–	1 342	–	–	–
Inventory: Materials and supplies	996	–	–	–	–	–	–	–	–
Inventory: Medical supplies	95	31	4 489	–	–	238	–	–	–
Inventory: Other supplies	–	–	–	–	–	2	–	–	–
Consumable supplies	40 196	37 422	36 737	–	45 200	45 208	58 560	65 000	42 201
Cons: Stationery,printing and office supplies	429	27	161	29	29	29	2 570	30	32
Operating leases	–	1 030	3 472	2 268	3 758	3 758	11 813	12 327	12 998
Property payments	93 597	134 539	137 424	92 188	225 324	225 324	156 392	132 037	141 630
Travel and subsistence	1 592	863	1 001	2 300	2 340	2 483	2 350	2 300	2 426
Training and development	406	18	112	1 000	640	640	3 856	1 185	1 250
Operating payments	156	18	17	20	220	220	6	6	6
Interest and rent on land	–	1 949	–	–	–	–	–	–	–
Interest (Incl. interest on finance leases)	–	1 949	–	–	–	–	–	–	–
Transfers and subsidies	**31**	**63**	**100**	**–**	**–**	**–**	**–**	**–**	**–**
Households	31	63	100	–	–	–	–	–	–
Social benefits	31	63	100	–	–	–	–	–	–
Payments for capital assets	**467 221**	**465 268**	**961 935**	**1 229 536**	**1 118 390**	**1 118 390**	**986 804**	**935 766**	**1 119 323**
Buildings and other fixed structures	453 725	437 594	936 812	1 225 816	1 088 978	1 088 978	952 804	927 966	1 111 094
Buildings	453 725	437 594	936 812	1 225 816	1 088 978	1 088 978	952 804	927 966	1 111 094
Machinery and equipment	13 496	27 674	25 123	3 720	29 412	29 412	34 000	7 800	8 229
Transport equipment	–	–	–	–	–	–	3 000	–	–
Other machinery and equipment	13 496	27 674	25 123	3 720	29 412	29 412	31 000	7 800	8 229
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Total economic classification: Programme 8	**639 264**	**683 021**	**1 185 312**	**1 393 275**	**1 437 881**	**1 437 881**	**1 317 975**	**1 300 887**	**1 380 945**

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

8.6 PERFORMANCE AND EXPENDITURE TRENDS

The bulk of the budget pertains to the construction of new infrastructure, upgrades and additions, rehabilitation, renovations and refurbishments of the department's infrastructure, with the sub-programmes aligned to the main service delivery programmes. The most significant funding is against the Community Health Facilities sub-programme, which houses the new Mapulaneng, bethal, Middelburg and Mammetlake Hospital.

Buildings and other fixed structures is the main cost-driver in this programme, is largely linked to a drive to improve and maintain the infrastructure of the department, and is related to the Health Facility Revitalization grant, as well as the department's equitable share. The increase in 2018/19 is for funding of the Community Health facilities project infrastructure project listed above, which has resulted in no budget for maintenance and Coal. The decrease in 2017/18 was due to a

reduction in the allocation for the Health Facility Revitalization grant over the MTEF period. The increase in 2019/20 and over the MTEF is also in line with various project requirements.

The increase in *Compensation of employees* in 2019/20 FY relates to the filling of the vacant funded posts as required by DORA, and in terms of the Health Facility Revitalization grant framework, including engineers, architects and quantity surveyors.

The day-to-day *maintenance* drive accounts for the trend against *Goods and services* over the entire period and is an effort to bring facilities up to standard. The Department has reprioritized funds from buildings and other fixed structure to provide for maintenance of health facilities including the provision of coal and diesel. A budget amounting to R156 million was set aside for maintenance and R58 million for the provision of coal and diesel.

Additional funding amounting to R37 million is allocated in the 2019/20 FY for the procurement of medical and allied equipment. The Department plans to allocate funding in the MTEF period for the procurement of Medical and Allied Equipment.

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8.7 RISK MANAGEMENT

RISK	MITIGATING FACTORS
1. Poor maintenance of infrastructure and equipment	a. Include maintenance requirements in infrastructure planning (3 year maintenance plan) b. Conclude service level agreements with the MRTT for placement of artisans c. Secure adequate budget via Construction Procurement Standard for multi-year programme
2. Cost over-runs on projects	a. Coordinate development of a business case and clinical briefs prior to design b. Planning in accordance with the allocated budget c. Continuous professional skills development d. Establishment of individual project budget estimates
3. Inadequate budget for Programme 8	a. Develop costed Provincial Maintenance Master Plan 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	Project Status	Municipality / Region	Economic Classification (Buildings and Other fixed Structures, Goods & Services, Plant, Machinery & Equipment, COE)	Type of infrastructure		Project duration		Source of funding	Objective	Budget programme name	2019/20	2020/21	2021/2022
R thousands					Regional/ District/Central Hospital; Clinic; Community Health Centre; Pharmaceutical Depots, Mortuary etc	Delivery Mechanism (Individual project or Packaged Program)	Date: Start	Date: Finish				Main Appropriation	Main Appropriation	Classification
	1. New infrastructure assets													
1	Pankop Clinic (Construction of new Clinic and accommodation units including associated external works)	Construction	Dr JS Moroka	Buildings and Other fixed Structures	Clinic	Individual	43032	43783	Health Facilities Revitalisation Grant	District Hospital Services	Health Facilities Revitalisation Grant	27,634	0	New
2	Oakley Clinic (Construction of new Clinic and accomodation units, including associated external works))	Construction	Bushbuckridge	Buildings and Other fixed Structures	Clinic	Individual	43031	43782	Health Facilities Revitalisation Grant	District Hospital Services	Health Facilities Revitalisation Grant	21,347	-	New
3	Balfour Mini Hospital (Construction of new Community Health Centre and accommodation units including associated external works)	Planning Stage	Dipaliseng	Buildings and Other fixed Structures	CHC	Individual	TBA	TBA	Health Facilities Revitalisation Grant	District Hospital Services	Health Facilities Revitalisation Grant	3,500	2,000	New
4	Msukaligwa Community Health Centre (Construction of new Community Health Centre and accomodation units) (Phase 2)	Tender	Msukaligwa	Buildings and Other fixed Structures	Hospital	Individual	TBA	TBA	Health Facilities Revitalisation Grant	District Hospital Services	Health Facilities Revitalisation Grant	3,500	2,000	New

No.	Project name	Project Status	Municipality / Region	Economic Classification (Buildings and Other fixed Structures, Goods & Services, Plant, Machinery & Equipment, COE)	Type of infrastructure		Project duration		Source of funding	Objective	Budget programme name	2019/20	2020/21	2021/2022
R thousands					Regional/ District/Central Hospital; Clinic; Community Health Centre; Pharmaceutical Depots, Mortuary etc	Delivery Mechanism (Individual project or Packaged Program)	Date: Start	Date: Finish				Main Appropriation	Main Appropriation	Classification
5	Thandukhanya Community Health Centre (Construction of new Community Health Centre and accomodation units)(Phase 2)	Tender	Mkhondo	Buildings and Other fixed Structures	Hospital	Individual	TBA	TBA	Health Facilities Revitalisation Grant	District Hospital Services	Health Facilities Revitalisation Grant	3,500	2,000	New
6	Vukuzakhe Clinic (Construction of new Clinic and accommodation units including associated external works)(Phase 2)	Construction	Pixley kaSeme	Buildings and Other fixed Structures	Clinic	Individual	43125	43641	Health Facilities Revitalisation Grant	District Hospital Services	Health Facilities Revitalisation Grant	1,060	-	New
7	Kanyamazane community health centre (Construction of new community Health Centre and accomodation units including associated external works)		Mbombela	Buildings and Other fixed Structures	CHC	Individual	TBA	TBA	Equitable Share	Community Health Facilities	Equitable Share	15,000	15,000	New
8	Nhlazatshe 6 clinic (Construction of new Clinic and accommodation units including associated external works) (Phase 2)	Construction	Albert Luthuli	Buildings and Other fixed Structures	Clinic	Individual	43125	43641	Health Facilities Revitalisation Grant	District Hospital Services	Health Facilities Revitalisation Grant	1,060	-	New
9	Middelburg Regional Hospital (Construction of a new district hospital)	Construction	Steve Tshwete	Buildings and Other fixed Structures	Regional Hospital	Individual	42826	43830	Equitable Share	Community Health Facilities	Equitable Share	331,783	254,366	New
10	Mapulaneng Hospital (Construction of New Hospital) Phase 1	Planning Stage	Bushbuckridge	Buildings and Other fixed Structures	Regional Hospital	Individual	42627	43630	Equitable Share	Community Health Facilities	Equitable Share	6,775	-	New

No.	Project name	Project Status	Municipality / Region	Economic Classification (Buildings and Other fixed Structures, Goods & Services, Plant, Machinery & Equipment, COE)	Type of infrastructure		Project duration		Source of funding	Objective	Budget programme name	2019/20	2020/21	2021/2022
R thousands					Regional/ District/Central Hospital; Clinic; Community Health Centre; Pharmaceutical Depots, Mortuary etc	Delivery Mechanism (Individual project or Packaged Program)	Date: Start	Date: Finish				Main Appropriation	Main Appropriation	Classification
11	Mapulaneng Hospital (Construction of New Hospital) Phase 2	Planning Stage	Bushbuckridge	Buildings and Other fixed Structures	Regional Hospital	Individual	43054	43630	Equitable Share	Community Health Facilities	Equitable Share	7,940	-	New
14	Mapulaneng Hospital (Construction of New Hospital) Phase 3	Planning Stage	Bushbuckridge	Buildings and Other fixed Structures	Regional Hospital	Individual	42627	44818	Equitable Share	Community Health Facilities	Equitable Share	212,809	318,447	New
	1. Total New infrastructure assets											635,908	593,813	
	2. Total Upgrades and additions													
1	Themba Hospital (New maternity, helipad and resource centre)	Planning Stage	Mbombela	Buildings and Other fixed Structures	Hospital	Individual	42462	43556	Health Facilities Revitalisation Grant	Provincial hospital services	Health Facilities Revitalisation Grant	30,000	125,634	Upgrades and additions
2	KwaMhlanga hospital (Masterplanning, Re-location of Psychiatric [Mental] Ward, Maternity Ward and Sub-Soil water investigation)	Planning Stage	Dr JS Moroka	Buildings and Other fixed Structures	Hospital	Individual	42667	43950	Health Facilities Revitalisation Grant	Provincial hospital services	Health Facilities Revitalisation Grant	12,219	124,912	Upgrades and additions
3	Tintswalo hospital (Upgrading of existing Kitchen and Nursing acccomodations)	Pre Construction	Bushbuckridge	Buildings and Other fixed Structures	Hospital	Individual	43397	43762	Health Facilities Revitalisation Grant	Provincial hospital services	Health Facilities Revitalisation Grant	21,889	-	Upgrades and additions
4	Rob Ferreira hospital (Construction of a compactor room, Grease Trap Unit and Associated External Works)	Completed	Mbombela	Buildings and Other fixed Structures	Hospital	Individual	42814	43003	Health Facilities Revitalisation Grant	Provincial hospital services	Health Facilities Revitalisation Grant	-	510	Upgrades and additions
5	Rob Ferreira hospital (Parking Deck)	Planning Stage	Mbombela	Buildings and Other fixed Structures	Hospital	Individual	TBA	TBA	Health Facilities Revitalisation Grant	Provincial hospital services	Health Facilities Revitalisation Grant	-	5,000	Upgrades and additions

No.	Project name	Project Status	Municipality / Region	Economic Classification (Buildings and Other fixed Structures, Goods & Services, Plant, Machinery & Equipment, COE)	Type of infrastructure		Project duration		Source of funding	Objective	Budget programme name	2019/20	2020/21	2021/2022
R thousands					Regional/ District/Central Hospital; Clinic; Community Health Centre; Pharmaceutical Depots, Mortuary etc	Delivery Mechanism (Individual project or Packaged Program)	Date: Start	Date: Finish				Main Appropriation	Main Appropriation	Classification
6	Rob Ferreira hospital (Upgrading of existing internal road and parking)	Construction	Mbombela	Buildings and Other fixed Structures	Hospital	Individual	42814	43636	Health Facilities Revitalisation Grant	Provincial hospital services	Health Facilities Revitalisation Grant	3,106	2,669	Upgrades and additions
7	Rob Ferreira Hospital (Construction of Mortuary)	Construction	Mbombela	Buildings and Other fixed Structures	Hospital	Individual	42831	43714	Equitable Share	Community Health Facilities	Equitable Share	5,126	-	Upgrades and additions
8	Rob Ferreira hospital (Upgrading of Allied building to an Oncology Ward)				Hospital	Individual	43561	43714	Equitable Share	Community Health Facilities	Equitable Share	12,372	-	Upgrades and additions
9	Rob Ferreira Hospital (Upgrading of Nursing Accomodations)	Pre Construction	Mbombela	Buildings and Other fixed Structures	Hospital	Individual	42831	44261	Health Facilities Revitalisation Grant	Community Health Facilities	Health Facilities Revitalisation Grant	19,313	-	Upgrades and additions
10	Bethal Hospital (Major Upgrade of hospital, including rehabilitation of existing facilities and stepdown of the hospital)	Construction	Govan Mbeki	Buildings and Other fixed Structures	Hospital	Individual	42653	43763	Equitable Share	Community Health Facilities	Equitable Share	59,849	-	Upgrades and additions
11	Mammethlake Hospital Phase 1: (Alterations and additions to existing Hospital)	Completed	Dr JS Moroka	Buildings and Other fixed Structures	Hospital	Individual	42235	43701	Equitable Share	Community Health Facilities	Equitable Share	8,936	-	Upgrades and additions
12	Mammethlake Hospital Phase 2: (Alterations and additions to existing Hospital)	Completed	Dr JS Moroka	Buildings and Other fixed Structures	Hospital	Individual	43696	44797	Equitable Share	Community Health Facilities	Equitable Share	92,636	-	Upgrades and additions
13	Newtown Clinic (Construction of a new Ablution Block and Septic Tank)				Clinic	Individual	43331	43701	Health Facilities Revitalisation Grant	District Hospital Services	Health Facilities Revitalisation Grant	584		Upgrades and additions
14	Schunzendale clinic - Construction of the IBT Structures	Identified	Ehlanzeni	Upgrades and additions	Clinic	Individual	43331	43701	Health Facilities Revitalisati	District Hospital Services	Health Facilities Revitalisati	6,615	-	Upgrades and additions

No.	Project name	Project Status	Municipality / Region	Economic Classification (Buildings and Other fixed Structures, Goods & Services, Plant, Machinery & Equipment, COE)	Type of infrastructure		Project duration		Source of funding	Objective	Budget programme name	2019/20	2020/21	2021/2022
R thousands					Regional/ District/Central Hospital; Clinic; Community Health Centre; Pharmaceutical Depots, Mortuary etc	Delivery Mechanism (Individual project or Packaged Program)	Date: Start	Date: Finish				Main Appropriation	Main Appropriation	Classification
									on Grant		on Grant			
15	Middelplaas Clinic - Construction of the IBT Structure	Identified	Ehlanzeni	Upgrades and additions	Clinic	Individual	43331	43701	Health Facilities Revitalisation Grant	District Hospital Services	Health Facilities Revitalisation Grant	4,075	-	Upgrades and additions
16	Shongwe Hospital (Updrading and refurbishment of the Water and sewer Treatment Plants Project (2018/19)			Buildings and Other fixed Structures	Hospital	Individual	43574	43940	Health Facilities Revitalisation Grant	Provincial hospital services	Health Facilities Revitalisation Grant	4,855	-	Upgrades and additions
17	Simile Clinic (Construction of a guardhouse, refuse area and upgrading of existing fence)				Clinic	Individual	42814	43003	Health Facilities Revitalisation Grant	District Hospital Services	Health Facilities Revitalisation Grant	169		Upgrades and additions
8	EMS College Parkhome offices - Procurement of Parkhomes for EMS college	Identified	Ehlanzeni	New	College	Individual	TBA	TBA	Health Facilities Revitalisation Grant	District Hospital Services	Health Facilities Revitalisation Grant	3,000		Upgrades and additions
12	Witbank Hospital (Construction of new Laundry building and Renovation of Mental ward)				Hospital	Individual	43521	43918	Equitable Share	Community Health Facilities	Equitable Share	14,065	9,065	Upgrades and additions
	2.Total Upgrades and additions											298,809	267,790	
1	3. Rehabilitation, renovations and refurbishments													

No.	Project name	Project Status	Municipality / Region	Economic Classification (Buildings and Other fixed Structures, Goods & Services, Plant, Machinery & Equipment, COE)	Type of infrastructure		Project duration		Source of funding	Objective	Budget programme name	2019/20	2020/21	2021/2022
R thousands					Regional/ District/Central Hospital; Clinic; Community Health Centre; Pharmaceutical Depots, Mortuary etc	Delivery Mechanism (Individual project or Packaged Program)	Date: Start	Date: Finish				Main Appropriation	Main Appropriation	Classification
2	Rob Ferreira Hospital (Renovations and alterations to the existing nurses accomodation building for laundry facility at Rob Ferreira Hospital, Mbombela Local Municipality, Ehlanzeni District)(Phase 2)			Buildings and Other fixed Structures	Hospital	Individual	43383	43595	Health Facilities Revitalisation Grant	Provincial hospital services	Health Facilities Revitalisation Grant	661	-	Rehabilitation, refurbishment and repairs
3	Kamdladla clinic (Renovations,rehabilitation and refurbishment of existing Clinic facilities)	Post Construction	Mbombela	Buildings and Other fixed Structures	Clinic	Individual	43565	43774	Health Facilities Revitalisation Grant	District Hospital Services	Health Facilities Revitalisation Grant	6,060	-	Rehabilitation, refurbishment and repairs
4	Rob Ferreira Hospital (Renovations and alterations to the existing nurses accomodation building at Rob Ferreira Hospital, Mbombela Local Municipality, Ehlanzeni District)[Part A]	Construction	Mbombela	Maintanance	Hospital	Individual	43444	43621	Health Facilities Revitalisation Grant	Provincial hospital services	Health Facilities Revitalisation Grant	2,728	-	Rehabilitation, refurbishment and repairs
5	Makoko Clinic (Renovations,rehabilitation and refurbishment of existing Clinic facilities)			Buildings and Other fixed Structures	Clinic	Individual	43200	43595	Health Facilities Revitalisation Grant	District Hospital Services	Health Facilities Revitalisation Grant	1,238	-	Rehabilitation, refurbishment and repairs
6	Matibidi Hospital (Repairs, rehabilitation and refurbishment Project to the causulty and other building facilities (2019/20))				Hospital	Individual	10-Apr-19	05-Nov-19	Health Facilities Revitalisation Grant	Provincial hospital services	Health Facilities Revitalisation Grant	1,218	-	Rehabilitation, refurbishment and repairs

No.	Project name	Project Status	Municipality / Region	Economic Classification (Buildings and Other fixed Structures, Goods & Services, Plant, Machinery & Equipment, COE)	Type of infrastructure		Project duration		Source of funding	Objective	Budget programme name	2019/20	2020/21	2021/2022
R thousands					Regional/ District/Central Hospital; Clinic; Community Health Centre; Pharmaceutical Depots, Mortuary etc	Delivery Mechanism (Individual project or Packaged Program)	Date: Start	Date: Finish				Main Appropriation	Main Appropriation	Classification
7	Matikwana Hospital (Sealing and repair of roof coverings for martnity ward, X-ray, Pharmacy and other building facilities at Matikwane Hospital, Bushbuckridge Local Municipality, Bohlabela District)				Hospital	Individual	10-Apr-18	10-May-19	Health Facilities Revitalisation Grant	District Hospital Services	Health Facilities Revitalisation Grant	-	-	Rehabilitation, refurbishment and repairs
8	Rob Ferreira Hospital (Renovations and alterations to the existing nurses accomodation building for laundry facility at Rob Ferreira Hospital, Mbombela Local Municipality, Ehlanzeni District)				Hospital	Individual	10-Oct-18	10-May-19	Health Facilities Revitalisation Grant	Provincial hospital services	Health Facilities Revitalisation Grant	1,114	-	Rehabilitation, refurbishment and repairs
9	Witbank hospital (Repairs and Refurbishment of EMS station)	Identified	Mbombela	Maintanance	Hospital	Packaged	03-Apr-19	11-Feb-20	Health Facilities Revitalisation Grant	Provincial hospital services	Health Facilities Revitalisation Grant	5,068	-	Rehabilitation, refurbishment and repairs
	3. Total Rehabilitation, renovations and refurbishments											18,087	-	
	4. Maintenance and repairs													
1	Elijah Mango EMS College(General Building Maintenance)	Identified	Ehlanzeni	Maintanance	College	Individual	03-Apr-18	31-Mar-19	EPWP - Maintenance	Provincial hospital services	EPWP - Maintenance	2,126	-	EPWP - Maintenance
2	Hoxane Sub - District General building maintenance	Identified	various	Maintanance	Various	Individual	Per financial year	Per financial year	Equitable Share	Community Health Facilities	Equitable Share	13,230	-	Maintenance
1	Mkhuhlu Clinic (Repair of January 2018 storm damges)	Identified			Clinic	Individual	03-Jan-18	11-Jun-19	Health Facilities Revitalisati	District Hospital Services	Health Facilities Revitalisati	355		Maintenance

No.	Project name	Project Status	Municipality / Region	Economic Classification (Buildings and Other fixed Structures, Goods & Services, Plant, Machinery & Equipment, COE)	Type of infrastructure		Project duration		Source of funding	Objective	Budget programme name	2019/20	2020/21	2021/2022
R thousands					Regional/ District/Central Hospital; Clinic; Community Health Centre; Pharmaceutical Depots, Mortuary etc	Delivery Mechanism (Individual project or Packaged Program)	Date: Start	Date: Finish				Main Appropriation	Main Appropriation	Classification
									on Grant		on Grant			
4	Ntunda Community Health Centre (Repair of January 2018 Storm damages)				Clinic	Individual	03-Jan-18	11-Jun-19	Health Facilities Revitalisation Grant	District Hospital Services	Health Facilities Revitalisation Grant	1,991		Maintenance
5	Ntunda Community Health Centre (Repairs and Maintenance of various facilities at Ntunda Community Health Centre)				Clinic	Individual	03-Jan-18	11-Jun-19	Health Facilities Revitalisation Grant	District Hospital Services	Health Facilities Revitalisation Grant	1,063		maintenance
6	Repairs of Steam Boilers and related Installations at Various Health Facilities within the Province	Maintenance	various	Goods and services	Various	Packaged	10-Apr-19	27-Mar-20	Health Facilities Revitalisation Grant	Provincial hospital services	Health Facilities Revitalisation Grant	10,000	-	Maintenance
	4. Total Maintenance and repairs											28,765	-	

8. CONDITIONAL GRANTS

NAME OF CONDITIONAL GRANT	PURPOSE OF THE GRANT	PERFORMANCE INDICATORS	INDICATOR TARGETS FOR 2019/20
Comprehensive HIV and AIDS Conditional Grant	• To enable the health sector to develop an effective response to HIV and AIDS including universal access to HIV Counselling and Testing • To support the implements of the National operational plan for comprehensive HIV and AIDS treatment and care • To subsidise in-part funding for the antiretroviral treatment plan	1. Total Number of fixed public health facilities offering ART Services	321
		2. Total number of patients on ART remaining in care.	521 028
		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: 73 877 863 F: 1 186 278
		6. Number of High Transmission Areas (HTA) intervention sites	100
		7. Number of HIV positive clients screened for TB	113 613
		8. Number of HIV positive patients that started on IPT	65 441
		9. Number of HIV tests done	1 322 703
		10. Number of health facilities offering MMC services	70
		11. Number of Medical Male Circumcisions performed	37 584
National Tertiary Services Grant (NTSG)	• To ensure provision of tertiary health services for all south African citizens • To compensate tertiary facilities for the costs associated with provision of these services including cross boundary patients	1. Number of National Central and Tertiary hospitals providing components of Tertiary services	2
Health Professional Training and Development (HPTD) Grant	• Support provinces to fund service costs associated with training of health science trainees on the public service platform	1. Number of specialists associated with training on the public health service delivery platform funded	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). • 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				

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 second draft Annual Performance Plan based on the Customised Sector Annual Performance Plan format. It has taken into consideration of Annual Report 2017/18 and First and Second Quarter Performance Reports 2018/19. The targets are set considering that the resource limitations coupled with accruals always have effect on the implementation of Annual Performance Plans. The Department has conducted strategic planning session on 8 and 9 November 2018 to review its Strategic Plan 2015 – 2020 and develop Annual Performance Plan 2019/20.

ANNEXURE A: StatsSA Population 2002-2018

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

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

Revised: 15 July 2016

APPROVED BY CABINET: 19 OCTOBER 2017

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

1. National Development Plan 2030 vision and trajectory

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

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

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

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

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

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

2. Constraints and Strategic Approach

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

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

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

2.1. The gains made

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

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

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

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

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

3. NDP priorities to achieve the Vision

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

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

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

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

4. Management of implementation

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

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

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

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

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

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

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

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

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

	Actions	Minister Responsible	Indicators	Baselines[9]	Targets

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[12] visiting at least 250 households annually

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

[13] People refers to those attending public health facilities

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

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

5.4. Sub-outcome 4: Reduced health care costs

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

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

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

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

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

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

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

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

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

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

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

The NDP 2030 identifies an important need to ensure that people who lead health institutions must have the required leadership capability and a high level of technical competence in a clinical discipline.
Central hospitals are national assets and, as integral parts of universities, are primary training platforms for health professionals. The health sector will ensure that their governance, funding and management becomes a national public sector competency and that they play their role as part of a seamless referral system. Management and related capacity of central hospitals will be enhanced to enable them to deliver services efficiently and effectively.

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

A key important area that also requires strengthening is financial management in the health sector. At the end of 2013/14, four health departments, the National DoH, Limpopo; North West and the Western Cape received an unqualified audit opinion from the AGSA. **This reflects improvement from 2012/13, during which only 3/10 departments received unqualified audit opinions.** Concerted effort must be made to increase this figure to at least 7/9 by 2019. Key interventions include:

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

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

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

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

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

	Actions	Minister Responsible	Indicators	Baselines[15]	Targets
					hub) by 2019

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

Health Facilities and Infrastructure Management continue focuses on coordinating and funding health infrastructure to enable provinces to plan, manage, modernise, rationalise and transform infrastructure, health technology and hospital management, and improve the quality of care in line with national policy objectives. To improve health facility planning and infrastructure delivery a more systematic and professional approach to infrastructure delivery was introduced by the health sector, this entailed the establishment of a Project Office at macro level to deliver on the major infrastructure programs. The pace of infrastructure delivery will be accelerated using alternative methods of delivery where possible to accelerate progress. Teams for health facility planning and infrastructure delivery will be strengthened by restructuring of the current infrastructure establishment. For the MTSF 2014-2019 period, 106 new clinics and community health centres and 22 hospitals will be built and over 435 health facilities in all 9 provinces will undergo major and minor refurbishments.

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

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

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:

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

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

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

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

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

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

The public health sector will decentralise the management of MDR-TB. The decentralisation will enable the sector to implement an approach similar to that used to address the burden of diseases from HIV, for instance, the Nurse Initiated Management of Antiretroviral therapy (NIMART), which enables nurses to diagnose and manage accordingly. Multi-Drug Resistant (MDR) sites will expanded. Table 8 below reflects the specific actions required from the health sector and its implementation partners to reduce mortality from AIDS related causes and Tuberculosis (TB).

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

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

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

		Development Minister of Labour			
3	Increasing access to a preventive package of sexual and reproductive health (SRH) services, including medical male circumcision and provision of both male and female condoms	Minister of Health	Number of male condoms distributed annually	387 million (in 2012/13)[19]	800 million male condoms distributed annually by 2019
			Number of female condoms distributed annually	5,1 million (2010/11)[20]	25 million female condoms distributed annually by March 2019
			Number of males medically circumcised (cumulative)	804 285 (2012/13)	5 million males medically cumulatively circumcised by 2019
3	Expand access to Antiretroviral Therapy (ART) for people living with HIV/AIDS	Minister of Health	Total clients remaining on ART (TROA)	2.7m	5.0 million patient on ART by 2019
4	Improve the effectiveness and efficiency of the TB control programme	Minister of Health	TB new client treatment success rate	79%	85% of new TB clients successfully completing treatment by 2019
5	Improve TB treatment outcomes	Minister of Health	TB client lost to follow up	6%	Less than 5% of clients lost to follow up by 2019
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	Minister of Health	TB MDR confirmed	56%	80% of MDR-TB

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

	treatment		client start on treatment		patients initiated on treatment by 2019
		Minister of Health	TB MDR client successfully completing treatment	42%	65% of MDR-TB patients successfully completing treatment by 2019

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

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

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

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

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

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

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

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

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

	Actions	Minister responsible	Indicators	Baselines[21]	Target
		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

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

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

6. Impact (or outcome) Indicators

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

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

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

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

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

ANNEXURE C: TECHNICAL INDICATOR DESCRIPTIONS OF CUSTOMIZED INDICATORS

PROGRAMME 1: ADMINISTRATION

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Improve Hospital Management by appointing Executive Management teams in all hospitals (Key Management Positions)	Is a count of vacant key Executive Management posts filled in hospitals inclusive of CEO, Corporate, Finance, Medical and Nursing Managers	Strengthen leadership and governance in hospitals	Persal Report	Numerator: Total number vacant funded posts for top five hospital executive management filled	Depends on accuracy of PERSAL data	Input	Number	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/implemente d 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
Audit opinion from Auditor General	Audit opinion for Provincial	To strengthen financial	Documented Evidence:	N/A	N/A	Outcome	N/A	Annually	No	Unqualified Audit Opinion	Chief Financial Officers of

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	Departments of Health for financial performance	management monitoring and evaluation	Annual Report Auditor General's Report	Categorical						from the Auditor General	Provincial Departments of Health
Percentage of Hospitals with broadband access	Percentage of Hospitals with broadband access	To track broadband access to hospitals	Network reports that confirm availability of broadband; OR Network rollout report for sites that are not yet live	**Numerator:** Total Number of hospitals with minimum 2 Mbps connectivity **Denominator** Total Number of Hospitals	NA	Output	Percentage	Quarterly	No	Higher Proportion of broadband access is more favorable for connectivity to ensure that South African health system can implement the eHealth Programme	ICT Directorate / Chief Directorate
Percentage of fixed PHC facilities with broadband access	Percentage of fixed PHC facilities with broadband access	To ensure broadband access to PHC facilities	Network reports that confirm availability of broadband; OR Network rollout report for sites that are not yet live	**Numerator:** Total Number of fixed PHC facilities with minimum 1Mbps connectivity **Denominator** Total Number of fixed PHC Facilities	NA	Output	Percentage	Quarterly	No	Higher Proportion of broadband access is more favorable for connectivity	ICT Directorate / Chief Directorate
Communication strategy developed	Development of a plan that express the goals and methods of an organisational outreach activities, including what the department wishes to share with public and stakeholders	To create awareness to patients and communities with the aim of improving service delivery and quality of care	Approved communicati on strategy document	**Numerator:** Number of communication strategies developed	The strategy should inform/ incorporate policy directives of the department	Output	Number	Annually	Yes	Developed communication strategy	Communication Section

OGRAMME 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 (platinum, silver, gold) as a proportion of fixed PHC clinics and CHCs/CDCs	Monitors outcomes of Ideal Clinic PPTICRM assessments to ensure they are ready for inspections conducted by Office of Health Standards Compliance.	Ideal Clinic review tools	Numerator: SUM(Fixed PHC health facilities that obtained Ideal clinic status) Denominator: Fixed PHC clinics/fixed CHCs/CDCs	None	Process/Activity	Percentage	Annual	No	Higher Ideal clinic status rates ensures clinics will have positive outcomes and is ready for inspections conducted by Office of Health Standards Compliance.	DHS Manager
PHC utilisation rate - total	Average number of PHC visits per person per year in the population.	Monitors PHC access and utilisation.	Daily Reception Headcount register (or HPRS where available) and DHIS Denominator: Stats SA	**Numerator:** SUM ([PHC headcount under 5 years] + [PHC headcount 5-9 years] + [PHC headcount 10-19 years] + [PHC headcount 20 years and older]) **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 (including public holidays) 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 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
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 Inpatient bed days (inpatient beds x days in period) available. Include all specialities	Track the over/under utilisation of district hospital beds	DHIS, midnight census	**Numerator:** Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) **Denominator:** Inpatient bed days (Inpatient beds * 30.42) available	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels, Lower bed utilization rate indicates inefficient utilization of the facility	Hospital Services Manager
Expenditure per patient day equivalent (PDE) (District 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 as division by 2,	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	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	and multiplied by 0.33333333 is the same as division by 3		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 (District Hospitals)	Complaints resolved within 25 working days (including public holidays) as a proportion of all complaints resolved	Monitors the time frame in which the public health system responds to complaints	Complaints register	Numerator: SUM([Complaint resolved within 25 working days]) Denominator: SUM([Complaint resolved])	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Hospital Services and Quality Assurance Managers

HIV & AIDS, STI & TB (HAST) CONTROL

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Female condom distributed	Total number of female condoms supplied or distributed in the province	Tracks the supply of female condoms in the Province	Numerator: Stock/Bin card	Numerator: Total number of Male condoms distributed in the province	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 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 Performanc e	Responsibilit y
	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; 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 Comprehen sive Tick Register; HTS Register (HIV Testing Services) or HCT module in TIER.Net,D HIS	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-traditional	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 condoms in t	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
	outlets, etc.).	(PDS) report to sub-districts on a monthly basis								he province	
Medical male circumcision - Total	Total number of males 10 years and older whose foreskin was removed using surgical medical procedure.	Monitors medical male circumcisions performed under supervision	Theatre Register/ PHC tick register, DHIS	SUM([Males 10 to 14 years who are circumcised under medical supervision])+([Males 15 years and older who are circumcised under medical supervision])	Assumed that all MMCs reported on DHIS are conducted under supervision	Output	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	All Drug Susceptible 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	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([ALL TB client successfully completed treatment]) Denominator: SUM([ALL 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
	extra pulmonary)										
TB Client lost to follow up rate	TB clients who are lost to follow up (missed two months or more of treatment) as a proportion of TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary and extra-pulmonary).	Monitors the effectiveness of the retention in care strategies. This follows a cohort analysis therefore the clients would have been started on treatment at least 6 months prior	TB Register; ETR.Net	Numerator: SUM [TB client lost to follow up] Denominator: SUM [TB client start on treatment]	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Quarterly	No	Lower levels of interruption reflect improved case holding, which is important for facilitating successful TB treatment	TB Programme Manager
TB Client death rate	TB clients who died during treatment as a proportion of TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary and extra pulmonary)	Monitors death during TB treatment period. The cause of death may not necessarily be due to TB. This follows a cohort analysis therefore the clients would have been started on treatment at least 6 months prior	TB Register; ETR.Net	Numerator: SUM([TB client died during treatment]) Denominator: SUM([TB client start on treatment])	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Annually	Yes	Lower levels of death desired	TB Programme Manager
TB MDR treatment success rate	TB MDR client successfully completing treatment as a proportion of TB MDR confirmed clients started on	Monitors success of MDR TB treatment	TB Register; EDR Web	Numerator: SUM([TB MDR client successfully complete treatment]) Denominator: SUM([TB MDR confirmed	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
	treatment			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
Antenatal 1st visit before 20 weeks rate	Women who have a booking visit (first visit) before they are 20 weeks into their pregnancy as proportion of all antenatal 1st visits	Monitors early utilisation of antenatal services	PHC Comprehensive Tick Register	**Numerator:** SUM([Antenatal 1st visit before 20 weeks]) **Denominator:** SUM([Antenatal 1st visit 20 weeks or later]) + SUM([Antenatal 1st visit before 20 weeks])	Accuracy dependent on quality of data submitted health facilities	Process	Percentage	Quarterly	No	Higher percentage indicates better uptake of ANC services	MNCWH programme manager
Mother postnatal visit within 6 days rate	Mothers who received postnatal care within 6 days after delivery as proportion of deliveries in health facilities	Monitors access to and utilisation of postnatal services. May be more than 100% in areas with low delivery in facility rates if many mothers who delivered outside health facilities used postnatal visits within 6 days after delivery	PHC Comprehensive Tick Register	Numerator: SUM([Mother postnatal visit within 6 days after delivery]) Denominator: SUM([Delivery in facility total])	Accuracy dependent on quality of data submitted health facilities	Process	Percentage	Quarterly	No	Higher percentage indicates better uptake of postnatal services	MNCWH programme manager
Antenatal client start on ART rate	Antenatal clients who started on ART as a proportion of the total number of antenatal clients who are HIV positive and not previously on ART	Monitors implementation of PMTCT guidelines in terms of ART initiation of eligible HIV positive antenatal clients.	ART Register, Tier.Net	**Numerator:** SUM([Antenatal client start on ART]) **Denominator:** Sum([Antenatal client known HIV positive but NOT on ART at 1st visit]) + SUM([Antenatal client HIV 1st test positive]) + SUM([Antenatal client HIV re-test positive])	Accuracy dependent on quality of data Reported by health facilities	Output	Percentage	Annually	No	Higher percentage indicates greater coverage of HIV positive clients on HIV Treatment	MNCWH programme manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Infant 1st PCR test positive around 10 weeks rate	Infants tested PCR positive for follow up test as a proportion of Infants PCR tested around 10 weeks (6-12 weeks) (excludes confirmatory and previously tested positive)	Monitors PCR positivity rate in HIV exposed infants around 10 weeks	PHC Comprehensive Tick Register	Numerator: SUM([Infant PCR test positive around 10 weeks]) Denominator: SUM([Infant PCR test around 10 weeks])	Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	No	Lower percentage indicate fewer HIV transmissions from mother to child	PMTCT Programme
Immunisation under 1 year coverage	Children under 1 year who completed their primary course of immunisation as a proportion of population under 1 year.	Track the coverage of immunization services	Numerator: PHC Comprehensive Tick Register Denominator: StatsSA	Numerator: SUM([Immunised fully under 1 year new]) Denominator: SUM([Female under 1 year]) + SUM([Male under 1 year])	Road to Health charts are not retained by Health facility. Reliant on under 1 population estimates from StatsSA, and accurate recording of children under 1 year who are fully immunised at facilities (counted only ONCE when last vaccine is administered.	Output	Percentage Annualised	Quarterly	No	Higher percentage indicate better immunisation coverage	EPI Programme manager
Measles 2nd dose coverage	Children 1 year (12 months) who	Monitors protection of	PHC Comprehen	Numerator: SUM([Measles 2nd dose])	Accuracy dependent	Output	Percentage	Quarterly	No	Higher coverage rate	EPI

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	received measles 2nd dose, as a proportion of the 1 year population..	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	sive Tick Register Denominator: StatsSA	Denominator: SUM([Female 1 year]) + SUM([Male 1 year])	on quality of data submitted health facilities					indicate greater protection against measles	
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]) Denominator: SUM([Diarrhoea separation under 5 years])	Reliant on accuracy of diagnosis / cause of death Accuracy dependent on quality of data submitted health facilities	Impact	Percentage	Quarterly	No	Lower children mortality rate is desired	MNCWH Programme manager
Pneumonia case fatality under 5 years rate	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	Monitors treatment outcome for children under 5 years who were separated with pneumonia	Ward register	Numerator: SUM([Pneumonia death under 5 years]) Denominator: SUM([Pneumonia separation under 5 years])	Reliant on accuracy of diagnosis / cause of death; Accuracy dependent on quality of data	Impact	Percentage	Quarterly	Yes	Lower children mortality rate is desired	MNCWH Programme manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
					submitted health facilities						
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) separations under 5 years in health facilities	Monitors treatment outcome for children under 5 years who were separated but diagnosed with Severe acute malnutrition (SAM) on admission and counted on separation	Ward register	Numerator: SUM([Severe acute malnutrition (SAM) death in facility under 5 years]) Denominator: SUM([Severe Acute Malnutrition cases 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	Number of Grade 1 learners that received at least one type of screening by a nurse in 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} (No denominator)	None	Process	Number	Quartely	Yes	Higher number indicates greater proportion of school children received health services at their school	School health services
School Grade 8 – learners screened	Number of Grade 8 learners that received at least one type of	Monitors implementation of the Integrated School Health	School Health data collection forms	SUM [School Grade 8 - learners screened] (No denominator)	None	Process	Number	Quarterly	Yes	Higher number indicates greater	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
	screening by a nurse the ISHP service package	Program (ISHP)								proportion of school children received health services at their school	
Delivery in 10 to 19 years in facility rate	Deliveries to women under the age of 20 years as proportion of total deliveries in health facilities	Monitors the proportion of deliveries in facility by teenagers (young women under 20 years).	Health Facility Register, DHIS	Numerator: SUM [Delivery 10–14 years in facility] + [Delivery 15–19 years in facility] Denominator: SUM([Delivery in facility total])	None	Process	Percentage	Quarterly	Yes	Lower percentage indicates better family planning	HIV and Adolescent Health
Couple Year Protection Rate (Int)	Women protected against pregnancy by using modern contraceptive methods, including sterilisations, as proportion of female population 15-49 year. Couple year protection are the total of (Oral pill cycles / 15) + (Medroxyprogesterone injection / 4) + (Norethisterone enanthate injection / 6) + (IUCD x 4.5) +) + (Sub dermal implant x 2.5) +	Monitors access to and utilisation of modern contraceptives to prevent unplanned pregnancies. Serves as proxy for the indicator contraceptive prevalence rate by monitoring trends between official surveys	PHC Comprehensive Tick Register Denominator: StatsSA	Numerator (SUM([Oral pill cycle]) / 15) + (SUM([Medroxyprogesterone injection]) / 4) + (SUM([Norethisterone enanthate injection]) / 6) + (SUM([IUCD inserted]) * 4.5) + (SUM([Male condoms distributed]) / 120) + (SUM([Sterilisation - male]) * 10) + (SUM([Sterilisation - female]) * 10) + (SUM([Female condoms distributed]) / 120) + (SUM([Sub-dermal implant inserted]) * 2.5) Denominator: SUM {[Female 15-44 years]} + SUM{[Female 45-49 years]}	Accuracy dependent on quality of data submitted health facilities	Outcome	Percentage	Quarterly	No	Higher percentage indicates higher usage of contraceptive methods.	MCWH&N Programme

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	Male condoms distributed / 120) + (Female condoms distributed / 120) + (Male sterilisation x 10) + (Female sterilisation x 10).										
Cervical cancer screening coverage 30years and older	Cervical smears in women 30 years and older as a proportion of 10% of the female population 30 years and older years.	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 during 2019 calendar year during both 1st and 2nd rounds	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	Girls 9yrs and older HPV 1st dose (No denominator)	None	Output	Number	Annually	No	Higher number indicate better coverage	MNCWH Programme Manager
HPV 2nd dose	Girls 9yrs and older HPV 2nd dose during 2019 calendar year during both 1st and 2nd rounds	This indicator will provide overall yearly coverage value which will aggregate as the campaign progress and	HPV Campaign Register – captured electronically on HPV system	Girls 9yrs and older HPV 2nd dose (No denominator)	None	Output	Number	Annually	No	Higher number indicate better coverage	MNCWH Programme Manager

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

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	births in facility and Born alive before arrival at facility	of prevention of unplanned pregnancies, antenatal care, delivery and postnatal services									
Neonatal death in facility rate	Neonatal 0-28 days who died during their stay in the facility as a proportion of live births in facility	Monitors treatment outcome for admitted children under 28 days	Delivery register, Midnight report	**Numerator:** SUM([Inpatient death 0-7 days]) + SUM([Inpatient death 8-28 days]) **Denominator:** SUM([Live birth in facility])	Quality of reporting	Impact	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
Cataract Surgeries performed	Number of eyes on which cataract surgery was performed	Accessibility of theatres. Availability of human resources and consumables	Numerator: Theatre Register	Numerator: SUM([Cataract surgery total])	Accuracy dependent on quality of data from health facilities	Output	Number	Quarterly	Yes	Higher number of cataract surgery indicated	NCD Programme Manager
Malaria case fatality rate	Deaths from malaria as a percentage of the number of cases reported	Monitor the number deaths caused by Malaria	Malaria Information System	**Numerator:** Deaths from malaria **Denominator:** Total number of Malaria cases reported	Accuracy dependant on quality of data from health facilities	Outcome	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 responses 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	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 responses])	Accuracy dependent on quality of data from reporting EMS station	Output	Percentage	Quarterly	No	Higher percentage indicate better response times in the urban areas	EMS Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	arrives on scene										
EMS P1 rural response under 40 minutes rate	Emergency P1 responses 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 responses])	Accuracy dependent 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 facility to another facility) transfers as proportion of total EMS patients transported to a health facility	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 patients total])	Accuracy dependent on the reliability of data recorded on the Efficiency Report at EMS stations and emergency headcount reported from hospitals.	Output	Percentage	Quarterly	No	Lower percentage desired. The target is the CSP target of 10% (8:2) of acute patient contacts and measures whether capacity exists at the appropriate level of care.	EMS Manager

PROGRAMME 4 and 5: REGIONAL / TERTIARY / CENTRAL HOSPITALS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Functional Adverse Events Committees	Number of established committee that meet on frequent basis to discuss medical adverse events and implement strategies to prevents such events from occurring	To develop and implement adverse events prevention strategies	Minutes of meetings of the committee	Number of Functional adverse events committee	None	Input	No	Quarterly	Yes	Increase number of Functional adverse events committee	Chief Director Hospital services
Improve access to TB services through effective movement TB patients rate for continuity of care	Percentage of movement of TB patients from TB hospital to Primary Health Care facility with a confirmation slip as acknowledgement by the receiving facility for continuation of treatment	To monitor the efficiency and effectiveness of the institution	Acknowledgement slips (pink slips) movement book	Numerator: Number of confirmed TB patients movement Denominator: total number of TB patients moved	Accuracy dependant on quality of data and effective information systems	Output	Percentage	Quarterly	No	Increase effective movement of TB patients	Chief Director Hospital services
Hospital achieved 75% and more on National Core Standards self - assessment rate	Percentage of Hospitals that conducted self assessment on National core standards and achieved a performance of 75% scoring of National core standard results.	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - National Core Standard review tools	**Numerator:** Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year **Denominator:** Total number of Hospitals conducted National Core Standards	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
Average Length of Stay (Regional / Tertiary / Central Hospitals)	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of day clients, Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialities	Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it should only include Inpatient days for those clients separated during the reporting month. Use in all hospitals and CHCs with Inpatient beds	DHIS, midnight census	Numerator Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) Denominator SUM([inpatient deaths-total])+([inpatient discharges-total])+([inpatient transfers out-total])	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care. High ALOS might reflect inefficient quality of care	District Health Services
Inpatient Bed Utilisation Rate (Regional / Tertiary / Central Hospitals)	Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialities	Monitors effectiveness and efficiency of inpatient management	DHIS, midnight census	Numerator: Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) Denominator: Inpatient bed days (Inpatient beds * 30.42) available	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility	Hospital Services Manager
Expenditure per patient day equivalent (PDE) (Regional / Tertiary / Central Hospitals)	Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD 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	BAS, Stats SA, Council for Medical Scheme data, DHIS, midnight census	**Numerator** SUM([Expenditure - total]) **Denominator** Sum ([Inpatient days total x 1])+([Day patient total x 0.5])+([OPD headcount not	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
		division by 3		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 /Specialized/Hospitals)	Complaints resolved within 25 working days (including public holidays) 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	Responsibili
Improve human resource efficiency by training health care professionals on critical clinical skills	Number of health care professional who are trained on critical skills as detailed in the Workplace skills Plan	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 EMS training by increasing the number of accredited EMS colleges	Number of EMS colleges which received accreditation by the HPCSA and CHE to provide Higher Education programs	Tracking Number of EMS colleges accredited to offer Higher education programs	Accreditation certificate	Count of EMS colleges accredited	Depends on accrediting institutions to process applications in time.	Input	Number	Annual	Yes	Increase Number of EMS colleges accredited to offer the Higher Education programs	EMS college principal
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	Count of first year medical students awarded bursaries	Data quality depends on good record keeping by the Provincial DoH	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	Bursary contracts	Count of first year nursing students awarded bursaries	Data quality depends on good record keeping by the Provincial DoH	Input	No.	Annual	Yes	Higher numbers of students provided with bursaries are desired, as this has the potential to increase future health care providers	Director Nursing

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Improve quality of care by increasing availability of medicines and surgical sundries at the Medical Depot.	Percentage of the available items on the Essential Drugs List at depot for supply to the facilities.	Monitor drug availability	EDL Items Lists	Numerator Number of essential drugs available at depot Denominator Total number of essential drugs on the list	Only EDL drugs are counted to determine percentage of essential drugs available	Process	Percentage	Quarterly	No	Increase percentage of the essential drugs available	Pharmaceutical Services
Number of patients initiated on Central Chronic Medicine Dispensing and Distribution (CCMDD)	Number of chronic patients who are enrolled to receive their medicine through Central Chronic Medicine Dispensing and Distribution (CCMDD) at preferred pick up points.	Improve access to medical care		Number of patients initiated on Central Chronic Medicine Dispensing and Distribution (CCMDD)	none	Input	No	Quarterly	Yes	Increase Number of patients initiated on Central Chronic Medicine Dispensing and Distribution (CCMDD)	Pharmaceutical Services
Improve access to quality of care through compliance with Radiation Control prescripts by all facilities with X-Ray equipment	Percentage of facilities with X-ray equipment that comply with Radiation Control guidelines setup by South African Radiation Control Council to regulate use of medical equipment and ensure ethical considerations.	Monitor compliance of facilities to Radiation Control prescripts.	Radiology audit reports	Numerator Number of facilities complying with Radiation Control prescripts Denominator Number of facilities with X-ray equipment	Data quality depends on good record keeping	Process	Percentage	Quarterly	Yes	All facilities compliant to Radiation Control prescript	Imaging Services: Programme Manager
Number of hospitals providing laundry	Count of all hospitals where washing of	Quality control of laundry in hospitals	Physical verification	Numerator Number of hospitals	None	Input	number	Quarterly	Yes	Maintaining status of hospitals	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
services	clothing and linen from hospital wards are cleaned and dispatch to relevant wards for use			providing laundry services						providing Laundry services	
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 legal report on causes of death as evidence to court of law	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

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 maintenance work in health facilities	Improve conditions of facilities and increases access to health facilities	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
Number of health facilities that have undergone major and minor refurbishment in NHI Pilot District	Number of existing health facilities in NHI Pilot District where Capital, Scheduled Maintenance, or Professional Day-to-day Maintenance projects (Management Contract projects only) have been completed (excluding new and replacement facilities).	Tracks overall improvement and maintenance of existing facilities.	Practical Completion Certificate or equivalent, Capital infrastructure project list, Scheduled Maintenance project list, and Professional Day-to-day Maintenance project list (only Management Contract projects).	Number of health facilities in NHI Pilot District that have undergone major and minor refurbishment	Accuracy dependent on reliability of information captured on project lists.	Input	Number	Annual	No	A higher number will indicate that more facilities were refurbished.	Chief Director: Infrastructure and Technical Management
Number of health facilities that have undergone major and minor refurbishment outside NHI Pilot District	Number of existing health facilities outside NHI Pilot District where Capital, Scheduled Maintenance, or Professional Day-to-day Maintenance projects (Management Contract projects only) have been completed (excluding new and replacement facilities).	Tracks overall improvement and maintenance of existing facilities.	Practical Completion Certificate or equivalent, Capital infrastructure project list, Scheduled Maintenance project list, and Professional Day-to-day Maintenance project list (only Management Contract projects).	Number of health facilities outside NHI Pilot District that have undergone major and minor refurbishment	Accuracy dependent on reliability of information captured on project lists.	Input	Number	Annual	No	A higher number will indicate that more facilities were refurbished.	Chief Director: Infrastructure and Technical Management